



Bangladesh

Health Facility Survey 2014

PRELIMINARY REPORT



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Bangladesh Health Facility Survey 2014

Preliminary Report

National Institute of Population Research and Training (NIPORT)
Ministry of Health and Family Welfare
Dhaka, Bangladesh

Associates for Community and Population Research (ACPR)
Dhaka, Bangladesh

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

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FOREWORD

The 2014 Bangladesh Health Facility Survey (BHFS) was designed to collect information from health facilities in the country on the availability of necessary conditions to provide quality health services in the areas of child health, maternal and newborn care, family planning, selected non-communicable diseases and tuberculosis. The 2014 BHFS is a nationally representative sample survey of public, NGO and private health facilities.

The 2014 BHFS is the third of its kind following implementation of BHFSs in 2009 and 2011 but unlike the earlier rounds, the 2014 BHFS used standard questionnaires under service provision assessment (SPA) of USAID's Demographic and Health Surveys (DHS) Program to provide national-level information on overall availability of services and readiness of health facilities for ensuring quality services to clients effectively and efficiently.

The survey is the result of concerted effort, dedicated support and involvement of a large number of institutions and individuals. I am deeply indebted and grateful to all those who contributed to the 2014 BHFS. I would like to put on record my sincere appreciation for the members of the Technical Review Committee (TRC), Technical Working Group (TWG), field staff, the data processing team, and particularly the survey respondents. I am thankful to Research Unit of NIPORT, ACPR, ICF International and USAID/Dhaka for completing the task professionally. Government of Bangladesh (GOB) and the U. S. Agency for International Development (USAID) provided financial support for the survey. We are deeply indebted and grateful to GOB and USAID for their generous support.

We are happy to present the preliminary report of the 2014 BHFS with provisional results on the availability, general preparedness and readiness of health facilities to provide maternal and child health, family planning and tuberculosis services. A comprehensive report on the survey findings will be published later in 2015.

We hope the preliminary report of the 2014 BHFS will be very useful to the planners, researchers, and policy makers to enhance the understanding of important issues related to health service provision and readiness of health facilities and to meet the monitoring and evaluation need for providing quality health services.


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ACRONYMS AND ABBREVIATIONS

ACPR	Associates for Community and Population Research
AMTSL	active management of third stage of labor
ANC	antenatal care
BCG	Bacillus Calmette-Guerin
BEmOC	basic emergency obstetric care
BHFS	Bangladesh Health Facility Survey
CAPI	computer assisted personal interviewing
CC	community clinic
CEmOC	comprehensive emergency obstetric care
D&C	dilatation and curettage
DDS	drug and dietary supply
DH	district hospital
DHS	Demographic and Health Survey
ELISA	enzyme-linked immune sorbent assay
EmONC	emergency obstetric and newborn care
FP	family planning
FWV	family welfare visitor
GOB	government of Bangladesh
HBB	Helping Babies Breathe
HPNSDP	Health, Population and Nutrition Sector Development Program
IHFAN	International Health Facility Assessment Network
IMCI	integrated management of childhood illnesses
IMPAC	integrated management of pregnancy and childbirth
MCH	maternal and child health
MCWC	maternal and child welfare center
MDR-TB	Multidrug-resistant tuberculosis
MOHFW	Ministry of health and family welfare
MVA	manual vacuum aspiration
NGO	nongovernmental organization
NIPORT	National Institute of Population Research and Training
QA	Quality assurance
SACMO	sub-assistant community medical officer
SPA	Service Provision Assessment
STI	sexually transmitted infection
TB	tuberculosis
TRC	technical reviewing committee
TTV	tetanus toxoid vaccine
TWG	technical working group
UHC	upazila health complex
UHFWC	union health and family welfare center
USAID	United States Agency for International Development
USC/RD	union sub-center/rural dispensary
WB	World Bank
WHO	World Health Organization

INTRODUCTION

1.1 BACKGROUND

Bangladesh has an extensive network of public, private, and non-governmental organization (NGO) facilities for providing basic health services. The government of Bangladesh is committed to strengthening health systems and improving quality of care. In the past 15 years, investments in health facilities have expanded services and improved access to quality care. Subsequently, Bangladesh has had immense success in increasing health service coverage and utilization. Although service utilization is assessed and monitored intensively through various data sources, the improvements in health systems and quality of care have not been monitored systematically. Under the Health, Population and Nutrition Sector Development Program (HPNSDP 2011-2016), the Ministry of Health and Family Welfare (MOHFW) is committed to periodic assessment of health systems and quality of care provided through various health facilities. The National Institute of Population Research and Training (NIPORT) is entrusted with conducting the 2014 Bangladesh Health Facility Survey (BHFS) under the Training, Research and Development (TRD) operational plan of the HPNSDP. The BHFS will be conducted every two years under the HPNSDP 2011-2016 to provide national-level information on overall availability of services and readiness of health facilities to provide quality care.

Around 2011-12, the World Health Organization (WHO), the United States Agency for International Development (USAID), the World Bank (WB), and other stakeholders proposed a standard set of indicators to assess readiness of health facilities to provide quality health care. These service readiness indicators have been incorporated in the Service Provision Assessment (SPA) surveys implemented by ICF International under the USAID-funded global DHS Program. SPA questionnaires were used as the basic tools for the 2014 BHFS; they were adapted to meet Bangladesh needs.

The 2014 BHFS was conducted under the authority of NIPORT. ICF International provided technical assistance under the DHS Program (formerly MEASURE DHS). Associates for Community and Population Research (ACPR), a private research agency, collected the data. The government of Bangladesh and USAID provided financial support for the survey. A Technical Review Committee (TRC) and a Technical Working Group (TWG) were constituted to oversee all policy and technical issues related to the survey.

The 2014 BHFS is the third survey of its kind and follows the 2009 and 2011 BHFS. Because the 2014 BHFS used a different set of questionnaires and defines indicators slightly differently, it may not be strictly comparable with the 2009 and 2011 surveys. As in the two previous surveys, the 2014 survey collected information from public, private, and NGO health facilities to assess how prepared the facilities are to provide quality health care. The surveys mainly focused on the availability of necessary conditions to provide quality health services in the areas of child health, maternal and newborn care, family planning, selected non-communicable diseases, and tuberculosis. Unlike the two previous surveys, however, the 2014 BHFS focused mainly on the service readiness indicators jointly developed and proposed by WHO, USAID, the International Health Facility Assessment Network (IHFAN), and other stakeholders.¹

¹ See World Health Organization (WHO). 2012. "Measuring Service Availability and Readiness: A Health Facility Assessment Methodology for Monitoring Health System Strengthening." http://www.who.int/healthinfo/systems/SARA_ServiceAvailabilityIndicators.pdf.

This preliminary report presents provisional results on the availability, general preparedness, and readiness of health facilities to provide maternal and child health, family planning, and tuberculosis services based on information collected from the different types of health facilities. This information will help health program managers and policy makers prioritize interventions to enhance the provision of quality health services. A comprehensive report on the survey findings will be published in late 2015. The data in the final report are not expected to differ substantially from the findings presented in this preliminary report; however, the results presented here should be regarded as provisional and may be subject to modification.

1.2 SURVEY OBJECTIVES

- Assess the availability of health services, including maternal and child health and family planning services.
- Ascertain general preparedness of the health facilities and availability of basic amenities, equipment, laboratory services, essential medicines, standard precautions for infection control, and human resources at the health facilities.
- Assess service-specific readiness of health facilities to provide maternal and child health, family planning, and tuberculosis treatment, measured in terms of the WHO recommended minimum conditions required to provide quality services.

2.1 SAMPLE DESIGN AND IMPLEMENTATION

The 2014 BHFS was designed to be a cross-sectional study. The sample was a stratified random sample of 1,596 health facilities, designed to provide representative results for Bangladesh, for the different facility types and different management authorities, and for each of the seven divisions of the country. The 2014 BHFS was designed to cover all types of registered public, non-governmental (NGO) static clinics/hospitals, and private hospitals in all seven divisions (Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur, and Sylhet) of the country.

All seven types of public facilities [district hospitals (DHs); maternal and child welfare centers (MCWCs), upazila health complexes (UHCs), upgraded union health and family welfare centers (upgraded UHFWCs), union health and family welfare centers (UHFWCs), union sub-centers/rural dispensaries (USCs/RDs), and community clinics (CCs)], private hospitals with at least 20 beds and NGO static clinics/hospitals were included in the study. Unlike the 2009 and 2011 BHFS, the 2014 BHFS is designed to report the survey results separately for the seven administrative divisions, seven types of public facilities, NGO static clinics/hospitals, and private hospitals. Moreover, summary indicators are presented for all facilities including CCs, and for all facilities excluding CCs. The sample size for the BHFS was determined by a combination of census and random samples. Table 2.1 presents a breakdown of the sampled facilities and outcomes following visits to those facilities.

Table 2.1 Result of facility contact, by background characteristics

Percent distribution of sampled facilities according to result of visit of the survey team to the facility, by background characteristics, Bangladesh HFS 2014

Background characteristics	Completed	Respondent not available	Refused	Closed/ not yet operational	Others	Total percent	Number of facilities surveyed
Facility type							
District and upazila public facilities	99.7	0.0	0.0	0.3	0.0	100.0	295
DH	100.0	0.0	0.0	0.0	0.0	100.0	62
MCWC	98.9	0.0	0.0	1.1	0.0	100.0	93
UHC	100.0	0.0	0.0	0.0	0.0	100.0	140
Union level public facilities	97.8	0.3	0.0	1.8	0.0	100.0	603
UHFWC	96.8	0.4	0.0	2.9	0.0	100.0	279
UHFWC (upgraded)	98.4	0.8	0.0	0.8	0.0	100.0	122
USC/RD	99.0	0.0	0.0	1.0	0.0	100.0	202
Public community clinic	97.4	0.5	0.0	2.1	0.0	100.0	431
NGO clinic/hospital	95.7	0.0	0.0	3.0	1.2	100.0	164
Private hospital	84.5	0.0	2.9	11.7	1.0	100.0	103
Location							
Urban	95.1	0.0	0.7	3.6	0.7	100.0	445
Rural	97.7	0.3	0.0	1.9	0.0	100.0	1,151
Division							
Barisal	97.8	0.4	0.0	1.8	0.0	100.0	275
Chittagong	97.1	0.3	0.0	2.6	0.0	100.0	384
Dhaka	94.4	0.3	1.0	4.2	0.0	100.0	287
Khulna	98.8	0.0	0.0	1.3	0.0	100.0	160
Rajshahi	99.4	0.0	0.0	0.6	0.0	100.0	164
Rangpur	97.4	0.7	0.0	2.0	0.0	100.0	152
Sylhet	95.4	0.0	0.0	2.9	1.7	100.0	174
Total	97.0	0.3	0.2	2.4	0.2	100.0	1,596
Total excluding CCs	96.8	0.2	0.3	2.5	0.3	100.0	1,165

Note: Some of the rows may not add up to 100 percent due to rounding.

DH = District hospital, MCWC = Maternal and child welfare center, UHC = Upazila health complex, UHFWC = Union health and family welfare center, USC/RD = Union sub-center/rural dispensary, CC = Community clinic

As shown in Table 2.1, data were successfully collected from 97 percent of the 1,596 sampled facilities (four facilities were duplicates, thus reducing the original sample size from 1,600 to 1,596). Interviewers were not able to survey 3 percent of sampled facilities for various reasons, but mainly because some facilities were closed or not yet operational at the time of the survey. Survey protocol required that facilities that could not be surveyed be replaced with the nearest facility of the same type, in the same district, and under the same managing authority. However, there were no facilities in these districts that met the replacement criteria. Consequently, data were successfully collected from 1,548 facilities. Table 2.2 shows the distribution of surveyed facilities, by background characteristics.

Table 2.2 Distribution of surveyed facilities, by background characteristics

Percent distribution and number of surveyed facilities, by background characteristics, Bangladesh HFS 2014

Background characteristics	Weighted percent distribution of surveyed facilities	Number of facilities surveyed	
		Weighted	Unweighted
Facility type			
District and upazila public facilities	3.1	47	294
DH	0.3	5	62
MCWC	0.5	8	92
UHC	2.2	35	140
Union level public facilities	24.1	374	590
UHFWC	9.6	149	270
UHFWC (upgraded)	7.8	117	120
USC/RD	7.0	108	200
Public community clinic	65.2	1,010	420
NGO clinic/hospital¹	5.2	81	157
Private hospital	2.3	36	87
Location			
Urban	8.4	130	423
Rural	91.6	1,418	1,125
Division			
Barisal	7.5	116	269
Chittagong	18.6	287	373
Dhaka	27.2	421	271
Khulna	12.7	197	158
Rajshahi	14.5	224	163
Rangpur	13.3	205	148
Sylhet	6.2	97	166
Total	100.0	1,548	1,548
Total excluding CCs	NA	538	1,128

¹ NGO category includes facilities run by local government

2.2 DATA COLLECTION INSTRUMENTS

To achieve the objectives of the assessment, data were collected using the following instruments:

1. A **Facility Inventory Questionnaire** was used to obtain information on service availability and preparedness of the facilities to provide each of the priority services assessed. The Facility Inventory Questionnaire collects information on the availability of specific items (including their location and functional status), components of support systems (e.g., logistics, maintenance, and management), and facility infrastructure, including the service delivery environment. Hence, the data collectors interviewed the person most knowledgeable about the organization of the facility and/or the most knowledgeable provider of each service. If another person or provider needed to give some specific information, that person or provider was invited (or visited, if necessary) and questioned about that information. However, only items observed by the data collectors themselves were considered available in the facility. The Facility Inventory Questionnaire is organized into the following three modules:

Module 1 collects information on service availability and consists of two sections.

Module 2 collects information on general facility readiness. This module consists of seven sections covering topics such as facility infrastructure (sources of water, electricity, etc.), staffing, health management information systems, health statistics, processing of instruments for re-use, health care waste management, availability of basic supplies and equipment, laboratory diagnostic capacity, and medicines and commodities.

Module 3 collects information on service-specific readiness. Twelve sections were applied from this module covering the following specific service areas: child health (child vaccination, growth monitoring, and curative care), family planning, antenatal care, delivery and newborn care, tuberculosis, non-communicable diseases, caesarean delivery, blood typing and compatibility, blood transfusion services, and general facility cleanliness. Sections on malaria and HIV/AIDS were not applied as part of the 2014 BHFS because these are not considered priority services for Bangladesh.

2. A **Health Provider Questionnaire** was used to collect information from a sample of health service providers on their qualifications, training, experience, continuing education, and supervision received, and in addition, their perceptions of the service delivery environment.

Table 2.3 shows the number and percent distribution of health providers who were interviewed with the Health Provider Questionnaire. A total of 4,298 providers were interviewed, most often in community clinics (48 percent).

Table 2.3 Distribution of interviewed providers

Percent distribution and number of interviewed providers, by background characteristics and provider qualification, Bangladesh HFS 2014

Background characteristics	Weighted percent distribution of interviewed providers	Number of interviewed providers	
		Weighted	Unweighted
Facility type			
District and upazila public facilities	18.1	692	1,985
DH	3.1	133	567
MCWC	1.0	43	315
UHC	12.0	516	1,103
Union level public facilities	19.9	854	955
UHFWC	7.9	340	431
UHFWC (upgraded)	6.4	274	200
USC/RD	5.6	241	324
Public community clinic	47.9	2,058	619
NGO clinic/hospital	8.9	381	436
Private hospital	7.3	312	303
Location			
Urban	25.4	1,092	2,150
Rural	74.6	3,206	2,148
Division			
Bareal	6.9	297	677
Chittagong	19.1	820	1,066
Dhaka	33.2	1,426	863
Khulna	12.8	540	472
Rajshahi	12.8	543	397
Rangpur	9.8	423	371
Sylhet	5.8	248	452
Provider type			
Specialist ¹	2.8	120	254
General practitioner ²	8.1	347	694
Paramedics ³	27.3	1,174	1,759
Nurse/midwife ⁴	7.6	329	592
Medical/pharmaceutical technician ⁵	3.6	153	256
Other health providers ⁶	50.6	2,175	743
Total	100.0	4,298	4,298
Total excluding CCs	NA	2,240	3,079

¹ Specialist (consultant obstetrics/gynecology, specialist (consultant) pediatrics, specialist (consultant) psychiatry, specialist (consultant) anesthesia or any other specialist not listed

² Medical officer (MBBS) (any non-specialist doctor, including assistant surgeon, EMO, IMO, MCH/FP, RMO, regardless of designation or title) or medical officer anesthetist or dental surgeon

³ SACMO/medical assistant, family welfare visitor (FWV), or paramedics

⁴ Nurse/midwife, matron, nursing supervisor, senior staff nurse, assistant nurse/staff nurse or midwife

⁵ Medical technologist-laboratory or medical technologist-EPI

⁶ Family welfare assistant (FWA), health assistant, community health care provider (CHCP), health inspectors, assistant health inspectors, nutritionist or health educator, other providers

Table 2.3 provides general information on the weighted proportion of providers interviewed as a percentage of the total number of providers assigned to facilities and present at the time of the survey, by background characteristics and provider qualification. It also gives the weighted and unweighted numbers of interviewed providers used for the analysis.

2.3 DATA COLLECTION APPROACHES

The Inventory and Health Provider questionnaires were translated into Bangla and loaded onto tablet computers, which were used during interviews to ask questions and also record responses (computer assisted personal interviewing–CAPI).

2.4 TRAINING AND DATA COLLECTION

2.4.1 Pre-test

The pre-test for the 2014 BHFS took place March 16–April 8, 2014, in Dhaka. Eleven medical doctors were recruited through an interview and trained as interviewers in the application of the questionnaires and computer programs. During pre-test data collection, health facilities within Dhaka district were surveyed over a four day period to test and refine the survey instruments and the computer programs. After the pre-test, the questionnaires and computer programs were finalized for the main data assessment.

Another objective of the pretest was to identify and prepare some of the pretest interviewers to become master trainers and field supervisors during the main assessment. At the end of the pretest, seven of the eleven medical doctors were identified as master trainers.

2.4.2 Main Training

The main training for the 2014 BHFS took place April 27–May 21, 2014, in Dhaka. Eighty-four (84) sub-assistant community medical officers (SACMOs) were recruited through an interview and trained as interviewers in the application of survey instruments and computer programs. The training included classroom lectures and discussions, practical demonstrations, mock interviews, role-plays, and field practices. The trainees were also given daily homework to conduct mock interviews among themselves using the survey tools. The first week of training was dedicated exclusively to training interviewers on use of paper questionnaires; this phase included two days of field practice to ensure that the trainees understood the content of the questionnaires, as well as how to organize themselves once in a health facility.

During the second week of training, trainees were first introduced to tablet computers, and then transitioned to the use of tablet computers for data collection (CAPI) for both Inventory and Health Provider Interview questionnaires; this was done using completed paper questionnaires from the facilities visited during the pretest. For the duration of the third week, trainees practiced all questionnaire types and CAPI approaches in teams and in pairs. The seven medical doctor-interviewers from the pre-test conducted the training. ICF International personnel provided support whenever needed.

Following the training, 40 data collection teams, comprised of two interviewers each, were formed; one interviewer on each team was assigned the role of the team leader. Data collection took place May 22–July 20, 2014.

Fieldwork supervision was coordinated by ACPR and NIPORT. The seven medical doctor master trainers and seven trained data processing specialists formed seven field supervision teams, each of which was assigned six data collection teams to supervise. The field supervision teams made periodic visits to their assigned data collection teams to review work and monitor data quality. In addition, supervisory teams from NIPORT periodically and simultaneously visited and monitored the data collection exercise.

2.5 DATA ANALYSIS

Several conventions were observed during the analysis of the 2014 BHFS data.

- First, unless otherwise indicated, the 2014 BHFS considered only those items observed by the interviewers themselves to be available.
- Second, in a majority of facilities, multiple health care providers contribute to the services received by clients. The health care provider who ultimately assesses the client, makes the final diagnosis, and prescribes any treatment, if necessary, is identified as the primary provider for the particular service.

3.1 AVAILABILITY OF BASIC CLIENT SERVICES

Table 3.1 and Figure 3.1 present information on the availability of family planning and basic maternal and child health services. Summary statistics are presented for all facilities, including CCs, and also for all facilities excluding CCs. Over 90 percent of all facilities (including CCs) offer antenatal and child curative care services. Family planning and child vaccination services are available in around 80 percent of facilities (including CCs). Normal delivery services are least likely to be available—less than one in five facilities (including CCs) offers normal delivery services. When CCs are excluded from the analysis, two important changes in service availability are observed—percentage of facilities offering normal delivery increases from 18 percent to 39 percent, and availability of child vaccination services declines from 78 percent to 65 percent. Availability of normal delivery services increases because such services are not expected to be available in CCs. On the contrary, vaccination services are expected at all levels of public facilities. As seen in Table 3.1, normal delivery services are offered, on average, by over 90 percent of district and upazila-level public facilities and private hospitals. Close to 50 percent of upgraded UHFWCs provide normal delivery service; however, only 7 percent of CCs provide normal delivery services.

Table 3.1 Availability of basic client services

Among all facilities, the percentages offering indicated basic client services and all basic client services, by background characteristics, Bangladesh HFS 2014

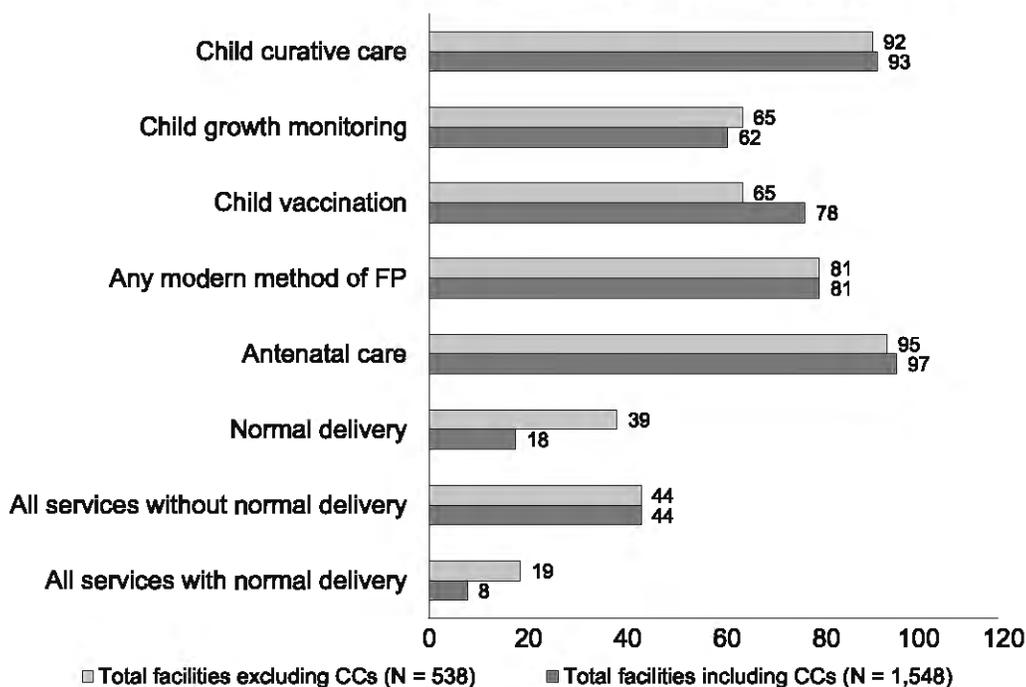
Background characteristics	Child curative care	Child growth monitoring services	Child vaccination services	Any modern methods of family planning	Antenatal care services	Normal delivery	All basic client services with normal delivery ¹	All basic client services without normal delivery ²	Number of facilities
Facility type									
District and upazila public facilities									
DH	96.6	76.9	93.7	94.2	99.1	95.7	67.5	69.4	47
MCWC	100.0	74.2	91.9	59.7	98.4	98.4	46.8	46.8	5
UHC	93.5	73.9	86.3	96.7	100.0	90.2	41.3	45.7	8
	96.7	78.0	100.0	98.7	99.0	96.6	76.4	78.0	35
Union level public facilities									
UHFWC	96.1	66.3	64.1	83.4	95.3	27.7	14.3	43.0	374
UHFWC (upgraded)	97.0	70.6	64.7	93.1	98.2	24.5	13.6	48.3	149
USC/RD	96.6	71.4	65.7	91.8	99.0	47.2	22.8	49.8	117
	94.4	55.0	81.7	60.7	87.3	10.9	6.1	28.2	108
Public community clinic									
	92.7	60.9	85.7	81.6	98.8	7.2	2.5	44.3	1,010
NGO clinic/hospital									
	82.9	68.7	71.0	88.3	97.9	30.8	14.2	48.2	81
Private hospital									
	68.2	19.5	15.8	20.5	78.5	93.2	8.2	8.2	36
Location									
Urban	81.6	55.2	63.7	72.4	92.7	63.1	25.5	42.2	130
Rural	93.6	62.8	79.7	82.2	97.8	14.0	6.5	44.3	1,418
Division									
Barisal	96.0	60.1	64.7	88.0	98.8	13.0	7.1	47.3	116
Chittagong	92.1	56.6	76.8	82.9	97.4	20.0	8.2	38.2	287
Dhaka	90.0	60.7	86.1	86.9	97.9	23.0	7.8	31.7	421
Khulna	96.6	66.5	82.3	93.5	96.7	12.6	8.1	55.8	197
Rajshahi	85.0	53.6	82.3	75.4	94.5	15.7	5.2	36.6	224
Rangpur	95.5	77.3	85.7	94.1	98.9	16.1	11.5	67.0	205
Sylhet	99.8	65.8	87.2	94.1	98.8	18.1	9.2	57.8	97
Total	92.6	62.1	76.4	81.4	97.4	18.1	6.1	44.2	1,548
Total excluding CCs	82.3	64.5	64.6	80.9	94.9	38.5	18.6	43.8	538

¹ Basic client services include outpatient curative care for sick children, child growth monitoring, facility-based child vaccination services, any modern methods of family planning, antenatal care, and normal delivery.

² Basic client services include outpatient curative care for sick children, child growth monitoring, facility-based child vaccination services, any modern methods of family planning, and antenatal care.

On average, forty-four percent of all facilities provide all the following basic services: child curative care, child growth monitoring, child vaccination, family planning, and antenatal care. This proportion does not change when CCs are excluded from the analysis. Among all facility types, UHCs are most likely to offer all these basic health services (78 percent), while private hospitals are least likely to provide these services (8 percent).

Figure 3.1 Availability of basic client services in health facilities



BHFS 2014

3.1.1 Basic Amenities for Client Services

The survey collected information to assess general readiness of health facilities to offer quality health services. It is acknowledged that all components reviewed here are neither necessary nor sufficient to provide quality services. However, the availability of basic amenities such as regular electricity, an improved water source, privacy during consultation, a client latrine, a land/mobile phone, and a computer with Internet access are important to client's satisfaction with health services rendered at a facility. The other component, for example, emergency transport, is expected to be available primarily in upper level facilities and also depends upon what services the facility provides. Table 3.2 and Figure 3.2 provide information on the availability of these basic amenities for client services.

The survey defined availability of regular electricity as follows: the facility was connected to a central power grid, and power supply remained uninterrupted for more than two hours at a time during normal working hours in the seven days before the survey, or else the facility had a functioning generator with fuel available on the day of the survey, or the facility had back-up solar power. Based on this definition, only 22 percent of all facilities have regular electricity. The proportion is low, mainly due to nonavailability of electricity in more than 90 percent of CCs. Excluding CCs, however, 45 percent of facilities have regular electricity. It is important to note that more than 70 percent of district and upazila-level public facilities, 81 percent of NGO facilities, and 98 percent of private hospitals have regular electricity.

In general, 87 percent of all facilities (91 percent, excluding CCs) have an improved water source in the facility. There is little difference among the different facility types. However, rural facilities (86 percent) and facilities in Barisal division (67 percent) are slightly less likely than urban facilities and facilities in the other divisions to have improved water source.

Table 3.2 Availability of basic amenities for client services

Among all facilities, the percentages with indicated amenities considered basic for quality services, by background characteristics, Bangladesh HFS 2014

Background characteristics	Amenities							Separate latrine for female clients	Number of facilities
	Regular electricity ¹	Improved water source ²	Visual and auditory privacy ³	Client latrine ⁴	Communication equipment ⁵	Computer with Internet ⁶	Emergency transport ⁷		
Facility type									
District and upazila public facilities	75.5	95.6	44.6	86.0	79.5	77.7	80.2	73.9	47
DH	90.3	96.8	46.8	88.7	88.7	90.3	91.9	67.7	5
MCWC	79.3	96.7	50.0	83.7	58.7	28.3	57.6	65.2	8
UHC	72.5	95.1	43.4	86.1	82.7	86.7	83.4	76.7	35
Union level public facilities	28.1	89.1	40.6	74.4	14.1	11.0	0.0	35.3	374
UHFWC	28.0	87.4	42.4	75.7	15.2	5.8	0.0	35.5	149
UHFWC (upgraded)	31.1	91.5	41.1	74.4	11.2	10.0	0.0	39.8	117
USC/RD	24.8	85.4	37.7	72.5	15.7	19.1	0.0	30.3	108
Public community clinic	9.1	84.6	32.2	68.0	12.4	41.5	0.0	14.4	1,010
NGO clinic/hospital	80.9	94.9	78.3	88.3	65.6	61.3	15.5	70.8	81
Private hospital	98.4	98.2	94.4	94.3	97.6	49.1	57.2	82.5	36
Location									
Urban	84.8	96.1	74.3	90.2	77.1	60.9	44.8	71.5	130
Rural	15.7	85.8	35.2	70.1	14.3	34.2	0.9	21.6	1,418
Division									
Barisal	16.3	87.1	28.4	70.2	17.9	29.9	4.9	24.8	116
Chittagong	20.1	87.9	43.9	74.1	14.8	40.6	5.5	23.3	287
Dhaka	23.2	82.2	31.5	61.8	23.0	26.4	5.5	26.0	421
Khulna	34.3	88.5	27.8	73.0	20.3	44.4	4.3	26.3	197
Rajshahi	12.8	94.9	50.1	74.6	16.0	28.7	2.8	23.2	224
Rangpur	21.5	94.9	46.2	78.5	20.9	56.7	3.4	31.4	205
Sylhet	19.2	85.4	39.3	87.3	25.3	26.1	5.5	27.2	97
Total	21.5	88.6	38.5	71.8	19.6	38.5	4.8	25.8	1,548
Total excluding CCs	44.9	90.5	50.2	78.8	33.2	27.0	13.2	47.2	538

Note: The indicators presented in this table comprise the basic amenities domain for assessing general service readiness within the health facility assessment methodology proposed by WHO and USAID (WHO 2012).

¹ Facility is connected to a central power grid and there has not been an interruption in power supply lasting for more than two hours at a time during normal working hours in the seven days before the survey, or facility has a functioning generator with fuel available on the day of the survey, or else facility has back-up solar power.

² Water is piped into facility or piped onto facility grounds, or else water from a public tap or standpipe, a tube well or borehole, a protected dug well, protected spring, or rain water, or bottled water and the outlet from this source is within 500 meters of the facility.

³ A private room or screened-off space available in the general outpatient service area that is a sufficient distance from other clients so that a normal conversation could be held without the client being seen or heard by others.

⁴ The facility had a functioning flush or pour-flush toilet, a ventilated improved pit latrine, or composting toilet.

⁵ The facility had a functioning land-line telephone, a functioning facility-owned cellular phone, or a private cellular phone that is supported by the facility.

⁶ The facility had a functioning computer with access to the Internet that is not interrupted for more than two hours at a time during normal working hours, or facility had access to the internet via a cellular phone inside the facility.

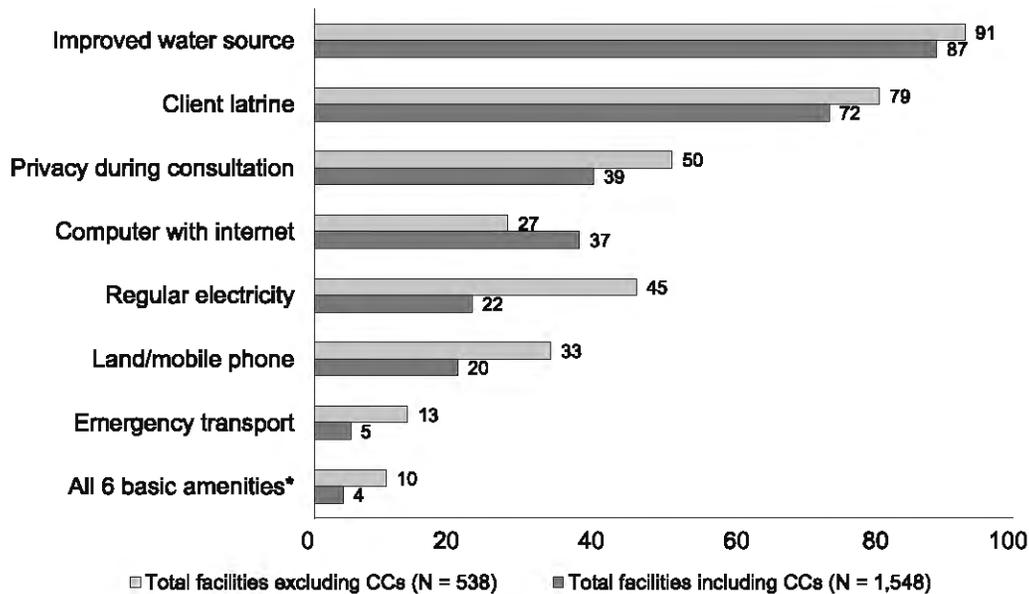
⁷ The facility had a functioning ambulance or other vehicle for emergency transport that was stationed at the facility and had fuel available on the day of the survey.

On average, 72 percent of all facilities (79 percent, excluding CCs) have a functioning client latrine. Union-level public facilities (74 percent) and CCs (68 percent) are less likely than district and upazila-level public facilities (86 percent), private hospitals (94 percent), and NGO facilities (88 percent) to have a functioning client latrine.

Overall, transport for emergencies is available in only 5 percent of all facilities (13 percent, excluding CCs). District and upazila-level public facilities (80 percent) and private hospitals (57 percent) are much more likely than NGO facilities (16 percent) to have transport for emergencies. At public facilities, over 90 percent of district hospitals, 83 percent of upazila health complexes, and 58 percent of maternal and child welfare centers have transport for emergencies. As expected, union-level public facilities (UHFWCs, upgraded UHFWCs, and USCs/RDs) and CCs do not have emergency transport.

Nearly 20 percent of all health facilities (33 percent, excluding CCs) have a land/mobile phone. District and upazila-level public facilities (80 percent), private hospitals (98 percent), and NGO facilities (66 percent) are more likely to have a land/mobile phone than union-level facilities (14 percent) and CCs (12 percent).

Figure 3.2 Availability of basic amenities for client services in health facilities



Note: Six basic amenities are regular electricity, an improved water source, privacy during consultation, a client latrine, a land/mobile phone, and a computer with Internet access

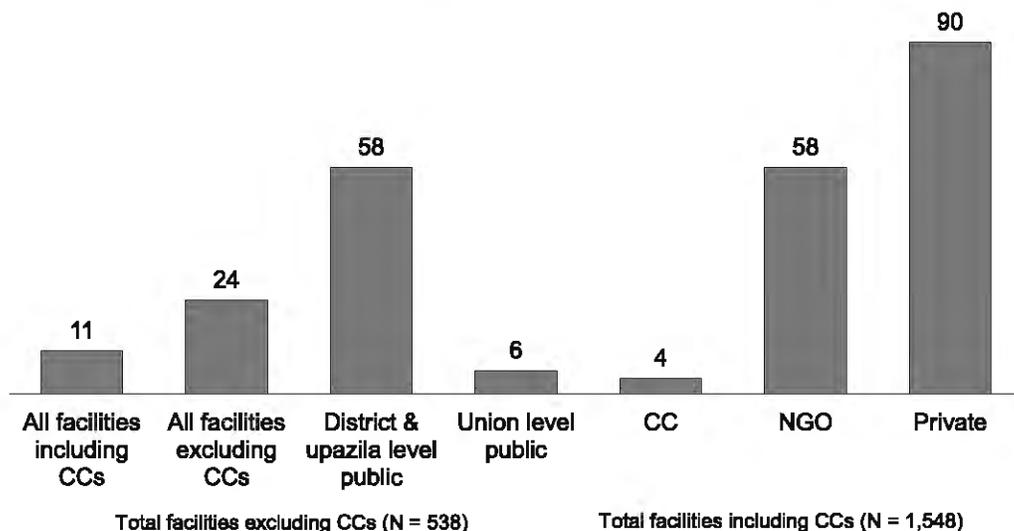
BHFS 2014

Maintaining privacy during a consultation with a health care provider is an important element of quality of care. Only 39 percent of all health facilities, including CCs (or half of all facilities, excluding CCs) have the capacity to assure privacy for clients during a consultation. This makes it difficult for clients to talk freely with health care providers.

About 37 percent of all facilities, including CCs (27 percent, excluding CCs) have a computer with Internet access. Union-level health facilities (11 percent) and MCWCs (28 percent) are less likely to have a computer with Internet access than other facilities. Forty-two percent of CCs have a computer with Internet access.

Ideally, every facility must have a safe and welcoming environment with regular electricity, an improved water source, privacy during consultation, a client latrine, a land/mobile phone, and a computer with Internet access. Figure 3.3 presents information on availability of at least five of these six basic amenities at various types of facilities. Overall only 11 percent of all facilities have at least five of the basic amenities. This low proportion is mainly due to low availability of computers with Internet at union-level facilities and unavailability of regular electricity in most CCs. Twenty-four percent of facilities have at least five basic amenities when CCs are excluded.

Figure 3.3 Availability of at least five basic amenities in health facilities, by facility type

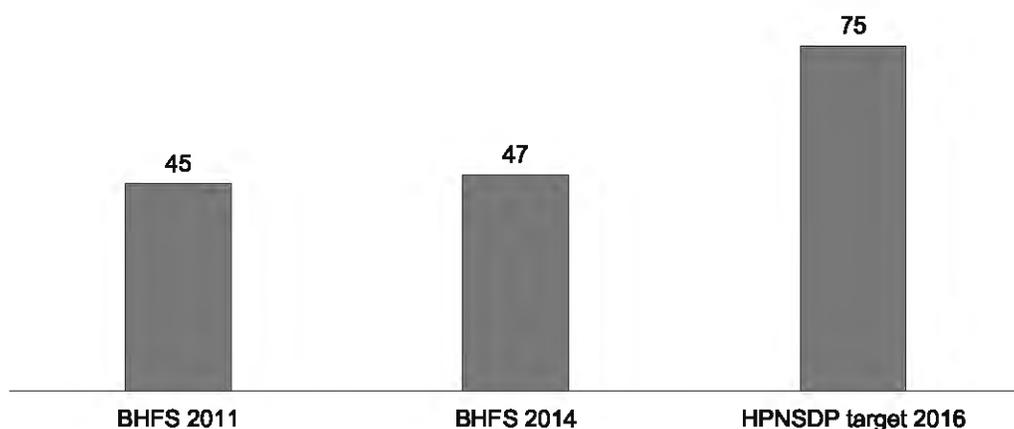


Note: At least 5 basic amenities from six: regular electricity, an improved water source, privacy during consultation, a client latrine, a land/mobile phone, and a computer with Internet access

BHFS 2014

One of the HPNSDP indicators is availability of an improved female toilet (having a functional water source) in public facilities, excluding CCs. The target is for 75 percent of facilities to have an improved female toilet by 2016. The 2014 BHFS results show that, excluding CCs, 47 percent of facilities have a separate, improved latrine for women and girls, similar to findings from the 2011 BHFS. (Table 3.2, Figure 3.4). It seems that to attain the target by 2016, the proportion of facilities with improved female toilets needs to increase substantially.

Figure 3.4 Trends in availability of separate, improved female toilet in public facilities (excluding CCs)



3.1.2 Basic Equipment for Client Services

Delivery of quality basic health services requires certain equipment. WHO and USAID proposed a list of seven basic pieces of equipment that should be available at a health facility to guarantee its readiness to deliver basic health services (WHO, 2012). These items are an adult scale, a child scale, an infant scale, a thermometer, a stethoscope, blood pressure apparatus, and a light source. Table 3.3 and Figure 3.5 report on the availability of this basic equipment.

Table 3.3 Availability of basic equipment

Among all facilities, the percentages with equipment considered basic to quality client services available in the general outpatient service area, by background characteristics, Bangladesh HFS 2014

Background characteristics	Equipment							Number of facilities
	Adult scale	Child scale ¹	Infant scale ²	Thermometer	Stethoscope	Blood pressure apparatus ³	Light source ⁴	
Facility type								
District and upazila public facilities	81.9	70.3	59.1	93.6	97.5	94.0	74.1	47
DH	83.9	83.9	71.0	95.2	98.4	95.2	87.1	5
MCWC	90.2	75.0	66.3	88.0	94.6	92.4	75.0	8
UHC	79.8	67.3	55.8	94.6	98.0	94.1	72.0	35
Union level public facilities	74.7	56.4	33.8	77.5	91.9	84.1	40.1	374
UHFWC	73.7	50.6	27.6	75.1	92.7	83.9	41.6	149
UHFWC (upgraded)	87.0	71.6	48.0	72.7	88.9	80.4	38.6	117
USC/RD	62.7	47.7	28.7	88.0	94.3	86.2	42.0	108
Public community clinic (CC)	84.2	47.5	21.2	95.6	91.1	86.0	32.9	1,010
NGO clinic/hospital	90.8	76.0	84.6	98.5	100.0	99.3	84.4	81
Private hospital	72.3	69.0	66.6	96.8	96.8	95.2	87.4	36
Location								
Urban	83.9	72.8	63.0	98.6	98.9	97.2	83.2	130
Rural	81.7	50.4	25.6	90.8	91.5	85.7	35.9	1,418
Division								
Barisal	85.8	54.7	26.3	90.7	87.8	82.3	34.8	118
Chittagong	85.8	50.9	25.2	91.9	88.8	86.5	34.2	287
Dhaka	88.2	39.9	25.6	88.7	90.5	82.1	38.9	421
Khulna	86.4	52.3	27.6	88.0	98.9	92.9	43.0	197
Rajshahi	84.1	44.8	24.8	93.3	93.7	87.7	38.4	224
Rangpur	90.7	81.6	45.3	97.6	96.1	95.5	52.8	205
Sylhet	92.0	62.6	32.1	90.4	87.9	76.5	45.7	97
Total	81.9	52.3	28.7	91.3	92.1	86.7	39.9	1,548
Total excluding CCs	77.6	61.4	42.8	83.4	94.0	88.0	52.9	538

Note: The indicators presented in this table comprise the basic equipment domain for assessing general service readiness within the health facility assessment methodology proposed by WHO and USAID (WHO 2012).

¹ A scale with gradation of 250 grams, or a digital standing scale with a gradation of 250 grams or lower where an adult can hold a child to be weighed, available somewhere in the general outpatient area

² A scale with gradation of 100 grams, or a digital standing scale with a gradation of 100 grams where an adult can hold an infant to be weighed, available somewhere in the general outpatient area

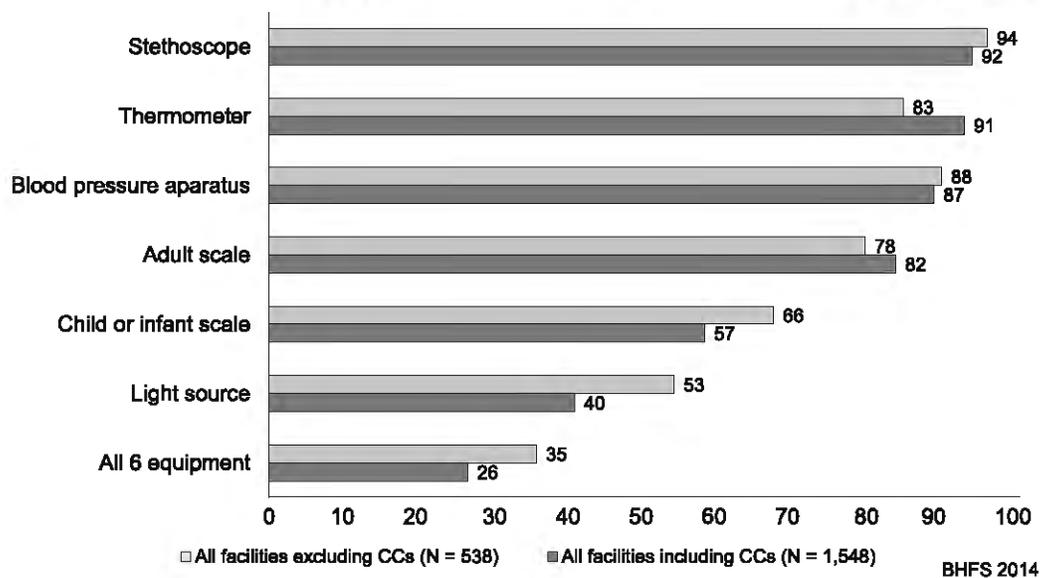
³ A digital blood pressure machine or a manual sphygmomanometer with a stethoscope available somewhere in the general outpatient area.

⁴ A spotlight source that can be used for client examination or a functioning flashlight available somewhere in the general outpatient area.

Stethoscope, thermometer, blood pressure apparatus, and adult weighing scale are each available in 80 percent or more of all Bangladesh health facilities. However, fewer facilities have a child or infant scale, or a light source.

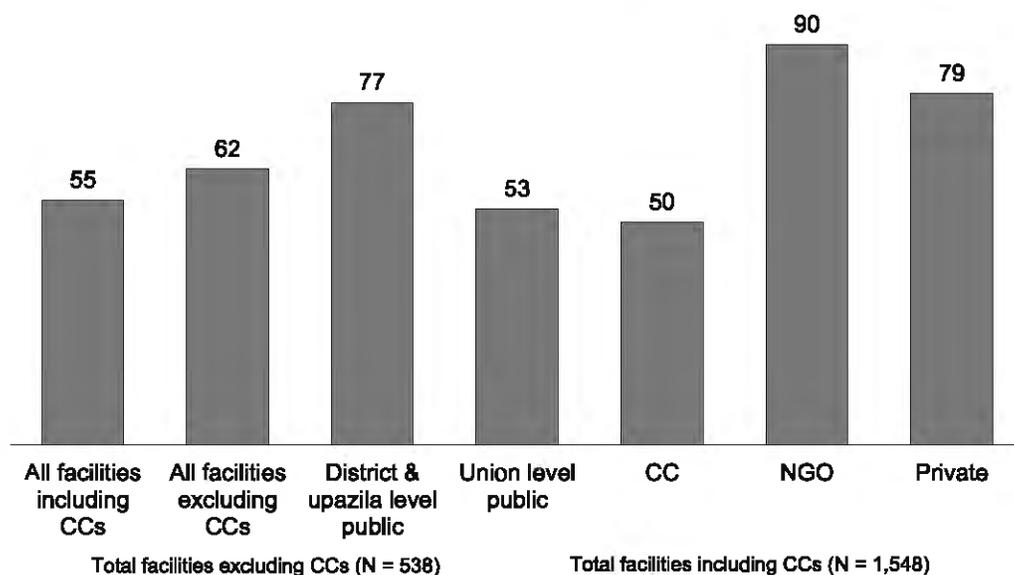
Only a quarter of all facilities (35 percent, excluding CCs) have all of the following six basic items of equipment: stethoscope, thermometer, blood pressure apparatus, adult scale, child scale/infant scale, and light source.

Figure 3.5 Availability of basic equipment for client services in health facilities



Availability of at least five basic items of equipment (out of the six specific items mentioned previously) is presented in Figure 3.6 by facility type. A majority of district and upazila-level facilities (77 percent), NGO facilities (90 percent), and private hospitals (79 percent) have at least five basic pieces of equipment. Half of union-level facilities and CCs have at least five items of basic equipment. Overall only 55 percent of all facilities, including CCs (62 percent, excluding CCs), have at least five basic items of equipment.

Figure 3.6 Availability of at least five basic items of equipment in health facilities, by facility type



Note: At least five of six basic equipment: an adult scale, a child scale, an infant scale, a thermometer, a stethoscope, blood pressure apparatus, and a light source

BHFS 2014

3.1.3 Standard Precautions for Infection Control in Service Delivery Area

Around the world, infections acquired in a health facility (known as nosocomial infections) often complicate the delivery of health care. Strict adherence to infection control guidelines and constant vigilance are necessary to prevent such infections. It is essential that a health facility have supplies and equipment for infection control appropriate to the services offered. These items can include sterilization equipment, equipment for high-level disinfection, incineration equipment, sharp containers, waste receptacles, disinfectant, disposable/single use syringes and needles, soap, running water, hand disinfectant, gloves, medical masks, gowns, eye protection, and guidelines for infection control. Table 3.4 and Figure 3.7 report on availability of these items for infection control in all facilities, including those with CCs and those without CCs.

Table 3.4 Standard precautions for infection control

Percentages of facilities with sterilization equipment somewhere in the facility and other items for standard precautions available in the general outpatient area of the facility on the day of the survey, by background characteristics, Bangladesh HFS 2014

Items	Facility type												
	District and upazila public facilities	DH	MCWC	UHC	Union level public facilities	UHFWC	UHFWC (up-graded)	USC/RD	Public community clinic	NGO clinic/hospital	Private hospital	Total	Total excluding CCs
Sterilization equipment ¹	72.7	91.9	72.8	69.9	17.6	18.9	23.3	9.7	3.9	76.7	85.8	15.0	35.9
Equipment for high-level disinfection ²	58.1	69.4	59.8	56.1	32.4	38.0	29.4	27.8	22.9	53.6	48.5	28.5	38.9
Safe final disposal of sharps waste ³	74.0	71.0	83.7	72.3	76.4	78.7	75.5	74.2	81.8	84.9	86.3	80.6	78.1
Safe final disposal of infectious waste ⁴	77.1	79.0	83.7	75.4	79.5	80.0	79.3	79.1	82.9	88.4	89.7	82.4	81.3
Appropriate storage of sharps waste ⁵	75.2	77.4	80.4	73.7	46.8	55.4	40.7	41.7	67.3	76.8	72.2	63.3	55.8
Appropriate storage of infectious waste ⁵	59.3	75.8	46.7	59.6	23.7	27.1	20.9	21.9	25.3	62.5	61.9	28.8	35.2
Disinfectant ⁷	75.4	82.3	77.2	74.1	56.6	63.8	53.9	49.5	51.7	82.1	80.8	55.9	63.7
Syringes and needles ⁸	85.0	85.5	89.1	84.0	75.6	84.1	81.5	57.4	77.3	89.1	80.9	77.8	78.8
Soap	88.0	83.9	90.2	88.2	77.3	76.9	82.7	71.8	74.2	91.1	89.3	78.6	81.1
Running water ⁹	87.9	85.5	88.0	88.2	57.6	56.9	66.1	49.3	37.4	92.4	89.4	47.9	67.6
Soap and running water	84.5	79.0	84.8	85.2	53.7	55.3	62.0	42.3	34.8	88.8	86.7	44.9	63.9
Alcohol-based hand disinfectant	60.8	59.7	58.7	61.5	27.2	30.8	22.7	27.3	28.7	66.8	65.4	32.1	38.7
Soap and running water or else alcohol-based hand disinfectant	88.3	80.6	89.1	89.3	62.1	62.1	69.4	54.2	45.7	90.2	89.3	54.3	70.5
Latex gloves ¹⁰	74.3	74.2	78.3	73.4	56.6	61.2	63.3	42.9	61.5	81.4	60.7	61.8	62.2
Medical masks	84.3	86.1	67.4	63.3	29.6	29.8	35.5	22.8	18.0	72.2	66.9	26.2	41.5
Gowns	47.1	54.8	54.3	44.4	20.9	21.1	23.7	17.4	23.0	65.2	57.7	26.2	32.3
Eye protection	24.0	37.1	22.8	22.3	10.0	9.3	9.3	11.8	4.3	47.0	30.0	9.1	18.2
Guidelines for standard precautions ¹¹	33.1	51.6	34.8	30.0	16.2	16.5	15.9	16.1	14.9	52.5	23.7	17.9	23.7
Number of facilities	47	5	6	35	374	149	117	108	1,010	81	36	1,548	538

Note: The indicators presented in this table comprise the standard precautions domain for assessing general service readiness within the health facility assessment methodology proposed by WHO and USAID (WHO 2012).

¹ Facility reports that some instruments are processed in the facility, and the facility has a functioning electric dry heat sterilizer, a functioning electric autoclave, or a non-electric autoclave with a functioning heat source available somewhere in the facility.

² Facility reports that some instruments are processed in the facility, and the facility has an electric pot or other pot with heat source for high-level disinfection by boiling or high-level disinfection by steaming, or else facility has chlorine, formaldehyde, CIDEX, or glutaraldehyde for chemical high-level disinfection available somewhere in the facility on the day of the survey.

³ The process of sharps waste disposal is incineration, and the facility has a functioning incinerator with fuel on the day of survey, or else the facility disposes of sharps waste by means of open burning in a protected area, dumping without burning in a protected area, or removal offsite with storage in a protected area prior to removal offsite.

⁴ The process of infectious waste disposal is incineration, and the facility has a functioning incinerator with fuel on the day of survey, or else the facility disposes of infectious waste by means of open burning in a protected area, dumping without burning in a protected area, or removal offsite with storage in a protected area prior to removal offsite.

⁵ Sharps container observed in general outpatient service area

⁶ Waste receptacles observed in general outpatient service area

⁷ Chlorine-based or other country-specific disinfectants used for environmental disinfection available in the general outpatient area

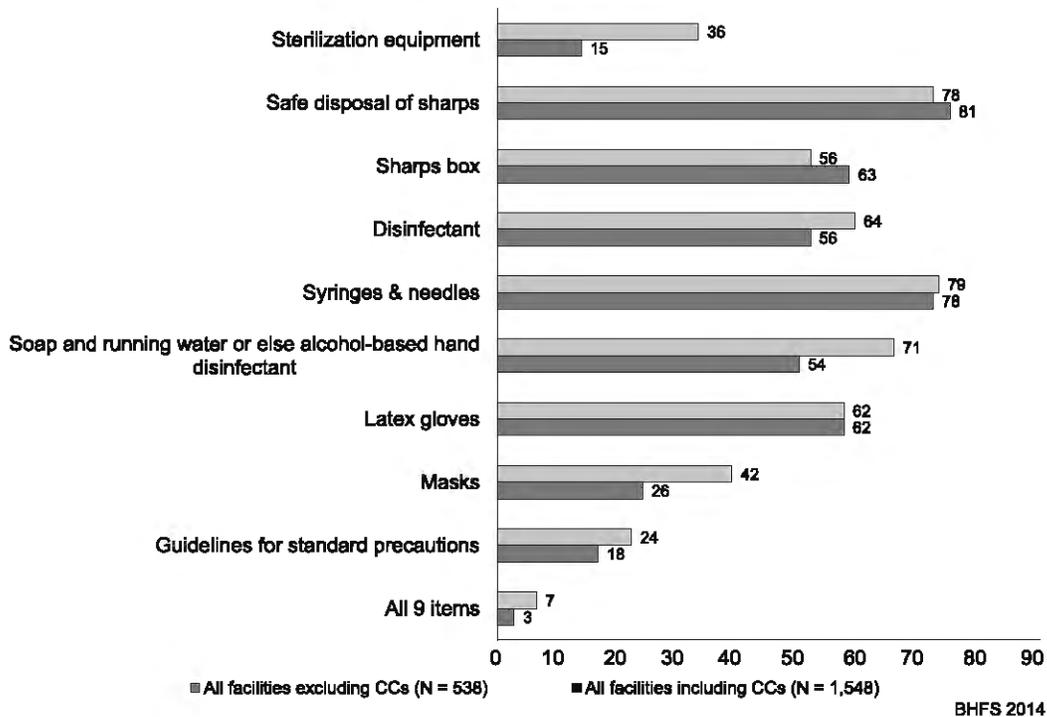
⁸ Single-use standard disposable syringes with needles or else auto-disable syringes with needles available in the general outpatient area

⁹ Piped water, water in bucket with specially fitted tap, or water in pour pitcher available in the general outpatient area

¹⁰ Non-latex equivalent gloves are acceptable.

¹¹ Any guideline for infection control in health facilities is available in the general outpatient area.

Figure 3.7 Availability of standard precaution items for infection control in health facilities



Survey findings show that about 8 in 10 of all facilities can safely dispose of sharps waste; private hospitals, NGO facilities, MCWCs, and CCs are slightly more likely to safely dispose of sharps waste than other facility types.

Syringes and needles were also available in 8 out of 10 facilities irrespective of inclusion or exclusion of CCs from the analysis.

Sharps boxes were available in a little over 60 percent of all facilities; the proportion decreases slightly after exclusion of CCs from the analysis. Disinfectants were available in 56 percent of all facilities, but the proportion increases to 64 percent when CCs are excluded from the analysis. Union-level public facilities and CCs are less likely to have disinfectant.

Overall, about half of all facilities, including CCs (71 percent, excluding CCs), had soap and running water or else alcohol-based hand disinfectant. DHs, MCWCs, UHCs, NGOs, and private hospitals are more likely to have soap and running water or else alcohol-based hand disinfectant. Union-level facilities and CCs are less likely to have these items.

Medical masks were available in only a quarter (26 percent) of all facilities (42 percent excluding CCs). Only small proportions of union-level facilities (30 percent) and CCs (18 percent) have medical masks.

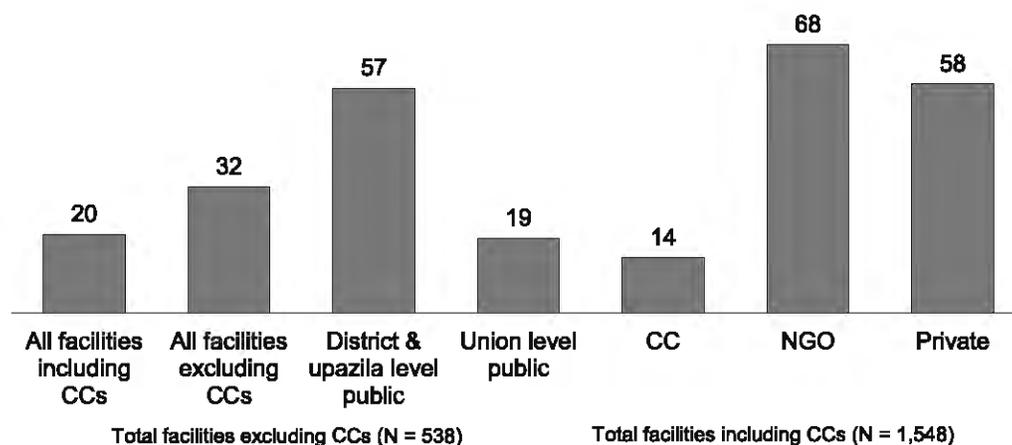
Only 15 percent of all health facilities, including CCs (36 percent, excluding CCs), have sterilization equipment for the processing of instruments for reuse.

About one in five facilities, including CCs (18 percent) or 24 percent, excluding CCs had guidelines for standard precautions.

Only 3 percent of facilities (7 percent, excluding CCs) have all the above nine items for infection control (Figure 3.7).

The 2014 BHFS also examined the availability of at least seven items for infection control (out of nine) by facility type (Figure 3.8). A majority of district and upazila-level facilities (57 percent), NGO facilities (68 percent), and private hospitals (58 percent) have at least seven items for infection control. Smaller proportions of union-level facilities (19 percent) and CCs (14 percent) have at least seven items. Overall one-fifth of all facilities have at least seven items for infection control. This low proportion is mainly due to low availability of sterilization equipment, medical masks, and guidelines for standard precautions in most union-level facilities and CCs. When CCs are excluded, the proportion of facilities having at least seven items for infection control increases slightly to about one-third.

Figure 3.8 Availability of at least seven standard precaution items for infection control in health facilities, by facility type



Note: At least seven items from among nine standard precaution items: sterilization equipment, safe disposal of sharps, syringes & needles, sharps box, latex gloves, disinfectant, soap/hand disinfectant, medical masks, and guidelines for infection control

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3.1.4 Diagnostic Capacity

Provision of diagnostic services, comprising laboratory tests and diagnostic imaging, is essential for clinical decision making and for enhancing delivery of quality health care. In fact, case management for conditions such as tuberculosis (TB) depend entirely on laboratory and/or imaging results. The 2014 BHFS assessed diagnostic capacity as a component of the methodology for assessing general service readiness proposed by the WHO and USAID (WHO, 2012). Table 3.5 and Figure 3.9 present information on diagnostic capacity in Bangladesh health facilities.

Overall, few facilities have much diagnostic capacity, and most tests are available at less than 10 percent of facilities. Generally, private hospitals are more likely to provide the range of diagnostic tests than NGO facilities and public facilities together. However, DHs and UHCs are just as likely as private hospitals to provide the range of diagnostic tests.

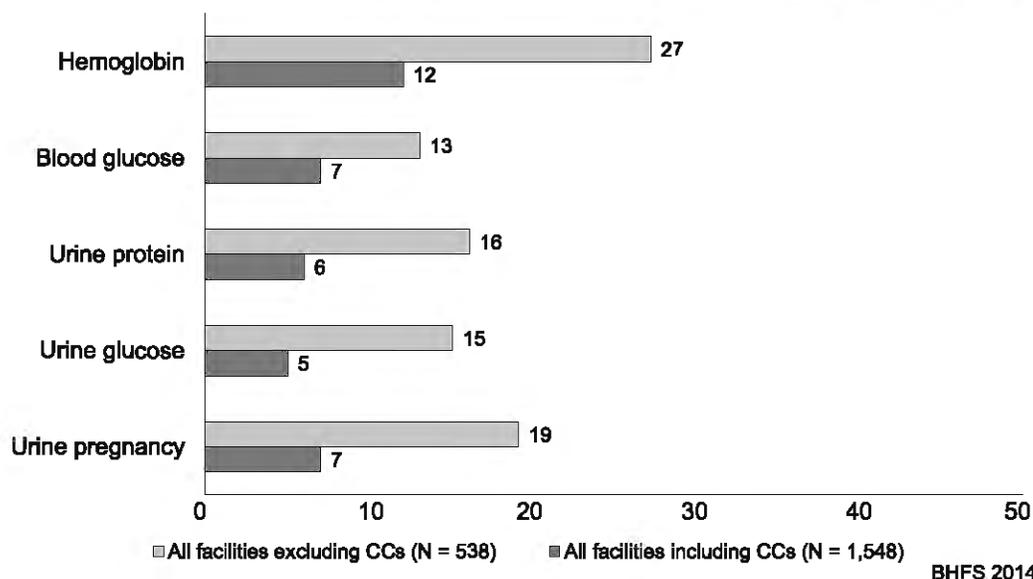
Table 3.5 Laboratory diagnostic capacity

Among all facilities, the percentages with capacity to conduct basic and advanced laboratory diagnostic tests in the facility, by background characteristics, Bangladesh HFS 2014

Laboratory tests	District and upazila public facilities	Facility type										Total	Total excluding CCs
		DH	MCWC	UHC	Union level public facilities	UHFWC	UHFWC (up-graded)	USC/RD	Public community clinic	NGO clinic/hospital	Private hospital		
Basic tests													
Hemoglobin	69.7	96.8	28.3	74.9	7.5	10.5	3.6	7.7	3.6	69.2	81.4	11.8	27.2
Blood glucose	24.6	38.7	4.3	26.9	1.4	1.1	1.2	2.1	3.3	47.9	46.4	6.8	13.4
Urine protein	32.0	48.4	3.3	35.8	0.6	0.1	0.2	1.8	0.2	54.1	66.2	5.6	15.8
Urine glucose	31.4	48.4	3.3	35.1	0.7	0.2	0.2	1.8	0.4	49.2	64.0	5.4	14.9
TB microscopy	28.3	38.7	0.0	33.0	0.0	0.0	0.0	0.0	0.0	4.1	23.6	1.8	4.7
Syphilis rapid diagnostic test	40.5	79.0	7.6	42.0	1.3	2.4	0.0	1.3	0.8	39.5	81.4	5.5	14.5
General microscopy	52.2	75.8	0.0	60.1	0.0	0.0	0.0	0.0	0.0	30.3	66.1	4.7	13.6
Urine pregnancy test	53.8	75.8	3.3	61.6	0.9	0.5	0.2	2.4	0.5	58.9	70.1	8.9	18.9
Liver or renal function test (ALT or Creatinine)	11.6	32.3	0.0	11.1	0.0	0.0	0.0	0.0	0.0	13.3	67.9	2.6	7.5
Advanced level diagnostic tests													
Serum electrolytes	22.0	41.9	2.2	23.5	0.2	0.0	0.0	0.7	0.0	24.0	57.5	3.3	9.5
Full blood count with differentials	22.0	41.9	2.2	23.5	0.2	0.0	0.0	0.7	0.0	24.0	57.5	3.3	9.5
Blood typing and cross matching	27.0	51.6	4.3	28.4	0.0	0.0	0.0	0.0	0.0	17.2	45.4	2.8	8.0
CD4 count	2.1	1.6	0.0	2.6	0.0	0.0	0.0	0.0	0.0	1.8	8.6	0.4	1.0
Syphilis serology	7.3	14.5	0.0	7.8	0.0	0.0	0.0	0.0	0.0	8.2	20.8	1.1	3.3
Gram stain	18.4	35.5	0.0	19.9	0.0	0.0	0.0	0.0	0.0	13.6	57.5	2.6	7.5
Stool microscopy	39.6	72.6	0.0	43.4	0.0	0.0	0.0	0.0	0.0	12.1	54.8	3.1	8.9
CSF/body fluid counts	28.8	50.0	1.1	31.8	0.0	0.0	0.0	0.0	0.0	29.0	51.7	3.6	10.3
TB culture	8.4	22.6	0.0	8.2	0.0	0.0	0.0	0.0	0.0	0.7	6.2	0.4	1.3
TB rapid diagnostic test	20.5	37.1	0.0	22.5	0.0	0.0	0.0	0.0	0.0	3.1	18.4	1.2	3.5
Equipment for diagnostic imaging													
X-ray machine (linked with TB)	23.7	67.7	1.1	22.1	0.0	0.0	0.0	0.0	0.0	1.5	51.5	2.0	5.7
X-ray machine	24.2	72.6	1.1	22.1	0.0	0.0	0.0	0.0	0.0	1.5	62.0	2.2	6.5
Ultrasonogram	10.2	62.9	1.1	4.4	0.0	0.0	0.0	0.0	0.0	15.9	65.8	2.7	7.7
CT scan	1.0	3.2	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	10.2	0.3	0.8
Number of facilities	47	5	8	35	374	149	117	106	1,010	81	36	1,548	538

Note: The basic test indicators presented in this table comprise the diagnostic capacity domain for assessing general service readiness within the health facility assessment methodology proposed by WHO and USAID (WHO 2012).
CSF = cerebrospinal fluid; CT = computed tomography

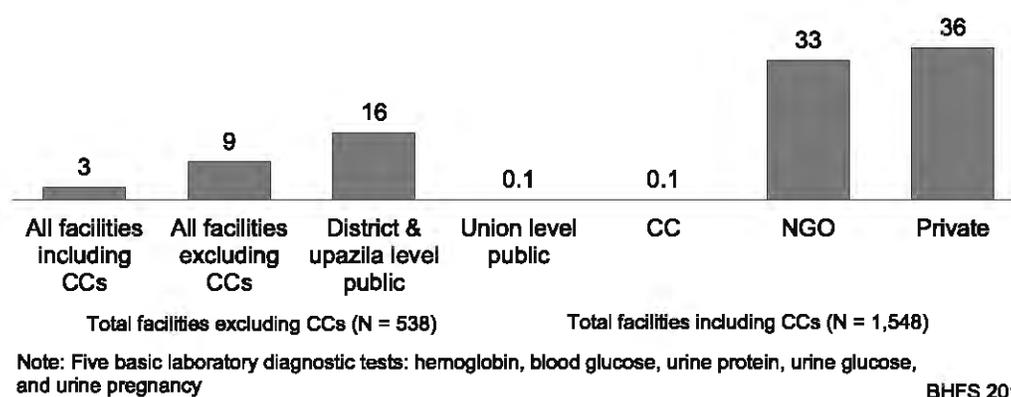
Figure 3.9 Capacity to conduct basic laboratory diagnostic tests in health facilities



BHFS 2014

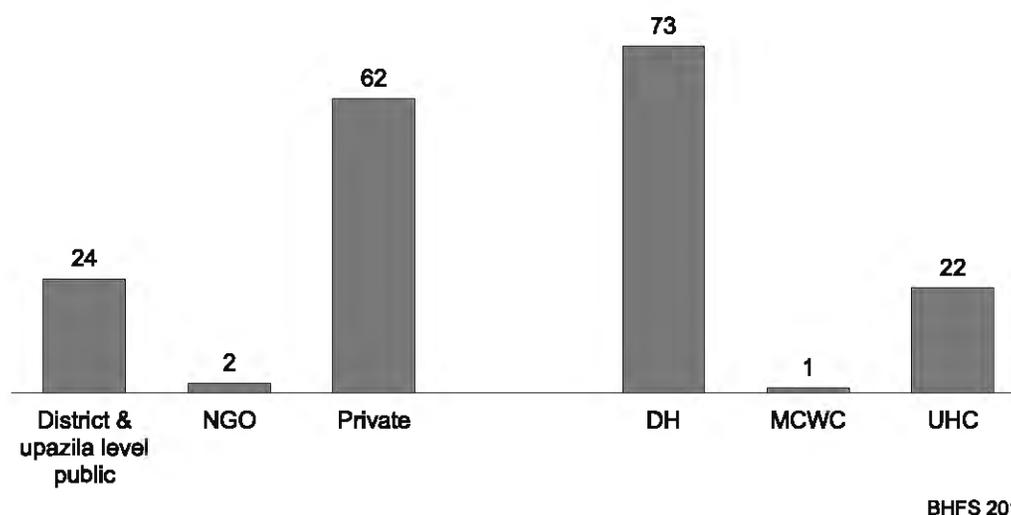
The 2014 BHFS also examined availability of the following five basic laboratory tests: hemoglobin, blood glucose, urine protein, urine glucose, and urine pregnancy. Only 3 percent of all facilities, including CCs (9 percent, excluding CCs), provide all five tests (Figure 3.10). About one-third of private hospitals and NGO facilities provide these five basic laboratory tests in their facilities. Among the public facilities, only 16 percent of district and upazila-level facilities provide all tests. As expected, only a negligible proportion of union-level facilities and CCs provide all five basic laboratory tests in their facilities.

Figure 3.10 Availability of all five basic laboratory diagnostic tests in health facilities, by facility type



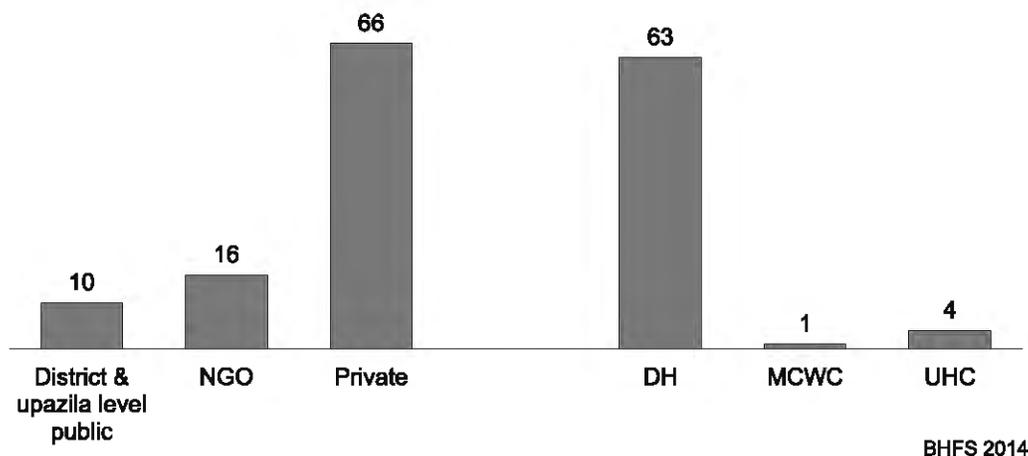
The survey assessed the availability of a functional x-ray machine. In the public sector x-ray machines are available in only district and upazila-level facilities (Table 3.5 and Figure 3.11). A majority of DHs (73 percent) have functional x-ray machines. Six in 10 private hospitals and 1 in 5 UHCs have functional x-ray machines. Availability of this imaging equipment is very low in MCWCs and in NGO facilities (1 percent and 2 percent, respectively).

Figure 3.11 Availability of functional x-ray machine in health facilities, by facility type



The survey also obtained information on the availability of functional ultrasound machines at the facilities. The machine is available in district and upazila-level public facilities, and in NGO and private facilities. Over 60 percent of DHs and private hospitals have a functional ultrasound machine; however, only 16 percent of NGO facilities have ultrasound machines. Only 4 percent of UHCs and 1 percent of MCWCs have this imaging machine (Table 3.5 and Figure 3.12).

Figure 3.12 Availability of functional ultrasound machine in health facilities, by facility type



3.1.5 Availability of Essential Medicine

Consistent availability of essential medicines is critical to the delivery of quality health services. The 2014 BHFS assessed the availability of 14 essential medicines, in keeping with the service readiness indicators proposed by the WHO and USAID. Table 3.6 presents information on the availability of essential medicine in Bangladesh health facilities.

On average, Amoxicillin tablets/capsules were the most widely available of these essential medicines, found in 87 percent of all facilities on the day of the survey. District and upazila-level public facilities (95 percent) were more likely than NGO facilities (76 percent) and private hospitals (62 percent) to have Amoxicillin tablets/capsules. Paracetamol oral suspension was the next most widely available of the essential medicines, available in 86 percent of all facilities (83 percent, excluding CCs). Public facilities (district and upazila-level facilities, union-level facilities, and community clinics), each at over 80 percent, were slightly more likely than either NGO facilities (78 percent) or private hospitals (71 percent) to have paracetamol oral suspension. Other medicines are much less widely available; for example, amitriptyline tablets, atenolol tablets, captopril tablets, ceftriaxone injections, glibenclamide tablets, salbutamol inhaler, and simvastatin tablets are each available, on average, in 6 percent or less of facilities. It is important to note that most of these other medicines are not expected to be available in lower level facilities. For example, only 5 percent of all facilities had atenolol tablets, but the proportion increases slightly to 14 percent after exclusion of CCs from analysis. About 73 percent of DHs, 55 percent of UHCs, and 60 percent of private hospitals had atenolol tablets available on the day of the survey.

Table 3.6 Availability of essential medicines

Percentages of facilities having the 14 essential medicines available, by background characteristics, Bangladesh HFS 2014

Essential medicines	Facility type												Total	Total excluding CCs
	District and upazilla public facilities	DH	MCWC	UHC	Union level public facilities	UHFWC	UHFWC (up-graded)	USC/RD	Public community clinic	NGO clinic/hospital	Private hospital			
Essential medicines														
Amitriptyline tablets/capsules ¹	9.6	19.4	3.3	9.6	0.3	0.1	0.2	0.7	0.0	8.2	53.1	2.0	5.8	
Amoxicillin tablets/capsules ²	95.1	95.2	94.6	95.2	91.4	94.3	93.7	84.9	86.4	76.2	61.6	86.8	87.5	
Atenolol tablets/capsules ³	48.8	72.6	5.4	54.8	3.4	3.7	0.5	6.2	0.7	23.1	59.6	5.4	14.1	
Captopril tablets/capsules ⁴	9.2	12.9	1.1	10.5	0.6	0.6	1.1	0.0	0.3	5.5	29.6	1.8	4.0	
Ceftriaxone injectable ⁵	58.7	87.7	22.8	82.4	2.0	3.6	1.2	0.9	0.4	36.0	73.2	6.1	16.7	
Ciprofloxacin tablets/capsules ⁶	83.7	87.1	80.4	83.9	66.1	70.2	70.8	55.2	14.3	69.4	71.5	33.1	68.5	
Co-trimoxazole oral suspension ⁷	73.1	75.8	76.1	72.1	71.3	73.5	78.1	60.9	34.1	43.8	33.3	44.7	64.8	
Diazepam tablets/capsules ⁸	77.3	85.5	85.9	74.2	58.5	69.0	72.1	29.0	16.4	61.7	76.9	32.2	61.8	
Diclofenac tablets/capsules ⁹	60.8	79.0	31.5	84.5	18.4	15.4	12.1	29.5	6.3	59.2	65.9	15.0	31.5	
Glibenclamide tablets/capsules ¹⁰	17.8	27.4	3.3	19.8	0.7	0.9	0.0	1.2	0.0	2.7	32.2	1.8	4.6	
Omeprazole/Cimetidine tablets/capsules ¹¹	66.1	83.9	23.9	72.7	18.1	12.6	7.7	37.1	2.0	79.1	69.5	13.4	34.8	
Paracetamol oral suspension ¹²	82.7	91.9	91.3	79.5	86.0	91.3	90.8	73.3	86.6	77.7	70.5	85.5	83.4	
Salbutamol inhaler ¹³	20.5	36.7	15.2	19.0	4.5	4.2	5.3	3.9	2.9	18.4	53.5	5.8	17.2	
Simvastatin/Atovastatin tablet/capsule ¹⁴	4.0	8.1	3.3	3.5	0.6	0.2	1.5	0.8	0.4	1.6	25.3	1.2	2.8	
Number of facilities	47	5	6	35	374	149	117	108	1,010	81	36	1,548	538	

Note: The indicators presented in this table comprise the essential medicines domain for assessing general service readiness within the health facility assessment methodology proposed by WHO and USAID (WHO 2012).

¹ For the management of depression in adults

² First-line antibiotics for adults

³ Beta-blocker for management of angina/hypertension

⁴ Vasodilator for management of hypertension

⁵ Second-line injectable antibiotic

⁶ Second-line oral antibiotic

⁷ Oral antibiotic for children

⁸ Muscle relaxant for management of anxiety, seizures

⁹ Oral analgesic

¹⁰ For management of type 2 diabetes

¹¹ Proton pump inhibitor, for the treatment of peptic ulcer disease, dyspepsia, and gastro-esophageal reflux disease

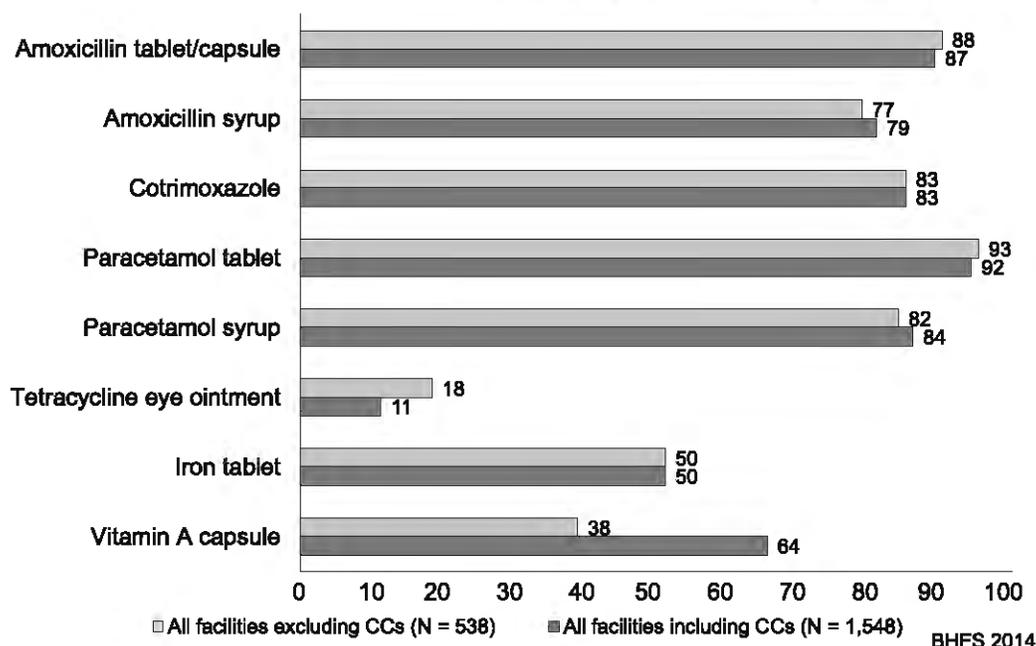
¹² Fever-reduction and analgesic for children

¹³ For the management and relief of bronchospasm in conditions such as asthma and chronic obstructive pulmonary disease

¹⁴ For the control of elevated cholesterol

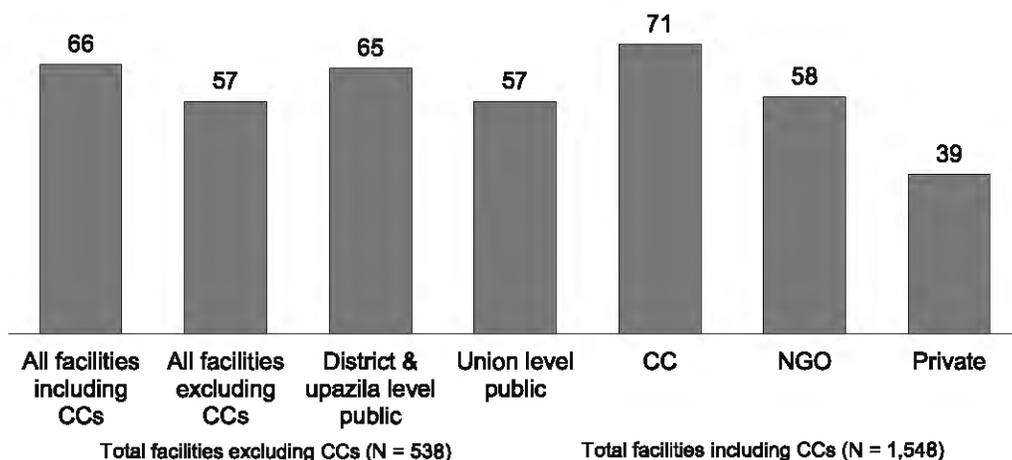
The survey obtained information on the availability of eight essential medicines of a drug and dietary supply (DDS) kit: amoxicillin tablet/capsule, amoxicillin syrup, co-trimoxazole, paracetamol tablet, paracetamol syrup, tetracycline eye ointment, iron tablet, and vitamin A capsule. Paracetamol tablets were the most widely available medicine in all facilities followed by amoxicillin tablet/capsule and paracetamol syrup. There is little difference in availability of these medicines even when CCs are excluded from the analysis. Tetracycline eye ointment was found in 11 percent of all facilities, with the proportion increasing slightly to 18 percent after exclusion of CCs. Vitamin A capsules were available in 64 percent of all facilities, with the proportion decreasing to 38 percent after exclusion of CCs from the analysis (Figure 3.13).

Figure 3.13 Availability of eight essential medicines of a DDS kit in health facilities



The survey also examined the availability of at least six essential medicines of a DDS kit (out of eight specific DDS kit medicines) in health facilities. Two-thirds of all facilities (57 percent, excluding CCs) have at least six essential medicines of a DDS kit (Figure 3.14). Among the public facilities, CCs (71 percent) were more likely to have at least six essential medicines than district and upazila-level (65 percent) and union-level (57 percent) facilities. About six in ten NGO facilities have at least six essential medicines while four out of ten private hospitals have these medicines.

Figure 3.14 Availability of at least six essential medicines of a DDS kit in health facilities, by facility type



Note: At least six of eight essential medicines of a DDS kit: amoxicillin tablet/capsule, amoxicillin syrup, cotrimoxazole, paracetamol tablet, paracetamol syrup, tetracycline eye ointment, iron tablet, and vitamin A capsule.

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3.1.6 Quality Assurance

Quality assurance (QA) refers to a system for monitoring the quality of care, identifying problems, and instituting changes to resolve those problems. QA systems require an established standard against which quality is measured. There must be systematic methods to assess results and develop interventions.

Overall, only 10 percent of all health facilities (14 percent, excluding CCs) report that they have regular QA activities and have evidence of such activities (Table 3.7). District and upazila-level public facilities (46 percent) are more likely than NGO facilities (29 percent) and private hospitals (21 percent) to report QA activities and have documentation. Among public facilities, 63 percent of DHs, 47 percent of UHCs, and 32 percent of MCWCs reported QA activities and had documentation available.

3.1.7 Client Feedback

Obtaining client feedback on health service delivery provides an opportunity for management to undertake remedial actions and to increase the satisfaction of health service users. It is critical to providing health services that meets people's expectations. The 2014 BHFS ascertained whether facilities have a system to elicit and review client opinion.

Overall only 26 percent of all facilities (35 percent, excluding CCs) have systems to elicit and review client opinion (Table 3.7). NGO facilities (81 percent), district and upazila-level facilities (61 percent), and private hospitals (53 percent) are more likely than union-level public facilities (20 percent) and CCs (22 percent) to have such a system in place. Among public facilities, however, 86 percent of DHs, 61 percent of UHCs, and 46 percent of MCWCs have such a system in place.

3.1.8 Human Resources for Health

The health workforce is an integral part of the health system. WHO considers the health workforce to be one of the key building blocks of the health system. Table 3.8 and Figures 3.15, 3.16, and 3.17 report the percentages of sanctioned health provider posts filled in the surveyed facilities, by type of facility.

Physicians: The survey obtained information on filled posts of physicians categorized as 'Specialist' and 'General practitioner.' Among public facilities, specialists are expected and available only in DHs and UHCs, where 70 percent and 55 percent of specialist posts are filled. In NGO and private

Table 3.7 Quality assurance and client opinion

Among all facilities, the percentages with quality assurance activities and having documentation of quality assurance activities, and the percentages of facilities with a system for eliciting client opinion, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities with		Number of facilities
	Regular quality assurance activities with observed documentation of quality assurance activity ¹	System for determining client opinion, procedure for reviewing client opinion ²	
Facility type			
District and upazila public facilities	46.2	61.3	47
DH	62.9	85.5	5
MCWC	31.5	45.7	8
UHC	46.9	61.2	35
Union level public facilities	5.9	20.0	374
UHFWC	6.3	21.3	149
UHFWC (upgraded)	4.4	23.3	117
USC/RD	7.0	14.6	108
Public community clinic	7.9	21.6	1,010
NGO clinic/hospital	29.2	81.3	81
Private hospital	20.5	53.1	36
Location			
Urban	30.9	69.4	130
Rural	8.1	22.3	1,418
Division			
Barisal	9.2	18.1	116
Chittagong	8.4	19.6	287
Dhaka	9.1	31.5	421
Khulna	6.6	28.7	197
Rajshahi	6.6	21.1	224
Rangpur	20.9	27.4	205
Sylhet	10.8	37.5	87
Total	10.0	26.3	1,548
Total excluding CCs	13.9	35.1	538

¹ Facility reports that it routinely carries out quality assurance activities and had documentation of a recent quality assurance activity. This could be a report or minutes of a quality assurance meeting, a supervisory checklist, a mortality review, or an audit of records or registers.

² Systems asked in the survey for determining client opinion are suggestion box, client survey form, client interview form, official meeting with community leaders, informal discussion with clients or the community, email, facility's website, letters from clients/community, and text/SMS messages. (Documentation of system not observed)

facilities 85 percent and 71 percent of specialist posts respectively are filled. In General Practitioner category ninety percent of the sanctioned posts are filled in private hospitals, 83 percent in NGO facilities, 66 percent in district and upazila public facilities and 22 percent in union level public facilities (Table 3.8 and Figure 3.15).

The survey also examined the overall status of filled physician posts by combining *specialist* and *general practitioner* categories and observed that the percentage of sanctioned physician posts filled at union-level public facilities is low (22 percent). Comparatively, 62 percent of sanctioned physician posts are filled in district and upazila-level facilities, and over 80 percent in NGO facilities and private hospitals (Table 3.8 and Figure 3.15).

Table 3.8 Staffing pattern in surveyed facilities

Percent of filled posts by provider category and type of facility, Bangladesh HFS 2014

Facility type	Specialist ¹	General practitioner ²	Specialist and general practitioner	Paramedic ³	Nurse/midwife ⁴	Field supervisors ⁵	Medical and pharmaceutical technicians ⁶	Other health providers ⁷	Others ⁸	Number of facilities
Facility type										
District and upazila public facilities	58.5	66.4	62.2	99.5	80.7	84.7	78.8	86.1	78.6	47
DH	70.1	70.5	70.3	-	88.8	100.0	83.9	71.8	62.9	5
MCWC	-	84.4	84.4	132.3	88.8	100.0	74.5	66.7	117.8	7
UHC	54.7	64.0	58.8	97.5	75.8	84.7	78.0	88.4	81.9	35
Union level public facilities	-	21.6	21.6	86.9	-	83.4	43.7	93.5	78.7	370
UHFWC	-	16.1	18.1	90.0	-	97.4	36.3	95.4	68.4	147
UHFWC (upgraded)	-	8.0	8.0	80.2	-	71.4	37.0	91.7	89.4	117
USC/RD	-	37.8	37.8	91.2	-	-	58.3	91.8	74.2	105
Public community clinic	-	-	-	-	-	-	-	95.3	86.7	952
NGO clinic/hospital	84.5	82.6	83.7	103.3	83.3	93.4	102.9	102.1	97.0	81
Private hospital	70.8	89.6	81.9	90.0	102.5	100.0	93.8	87.7	92.8	36
Total	67.9	70.7	69.5	92.9	92.2	84.8	72.2	94.6	89.2	1,486
Total excluding CCs	67.9	70.7	69.5	92.9	92.2	84.7	72.2	92.9	89.2	533

Note: Numbers provided by facility in-charge

Note: "-" means both sanctioned and filled posts reported none.

¹ Superintendent, director/manager/coordinator, UH&FPO, consultant (Medicine), consultant (Surgery), consultant (OBS/GYN), consultant (Pediatrics), consultant (Orthopedic), consultant (Eye), consultant (Anesthesia), consultant (Radiology and Imaging), consultant (Pathologist), consultant (ENT), consultant (Skin & VD), consultant (Cardiology), assistant registrar (Medicine), assistant registrar (Surgery), assistant registrar (OBS/GYN), assistant registrar (Pediatric)

² Residential medical officer (RMO), medical officer (MO)/physician, radiologist, pathologist, anesthetist, emergency medical officer (EMO), indoor medical officer (IMO), medical officer (MO) -Blood Transfusion), dental surgeon, MO - Homeopath/Unani/Ayurvedic, MO- Clinic, MO - MCH-FP

³ Senior FWV, SACMO, family welfare visitor (FWV), paramedic

⁴ Matron, nursing supervisor, senior staff nurse, staff nurse, assistant nurse, midwife

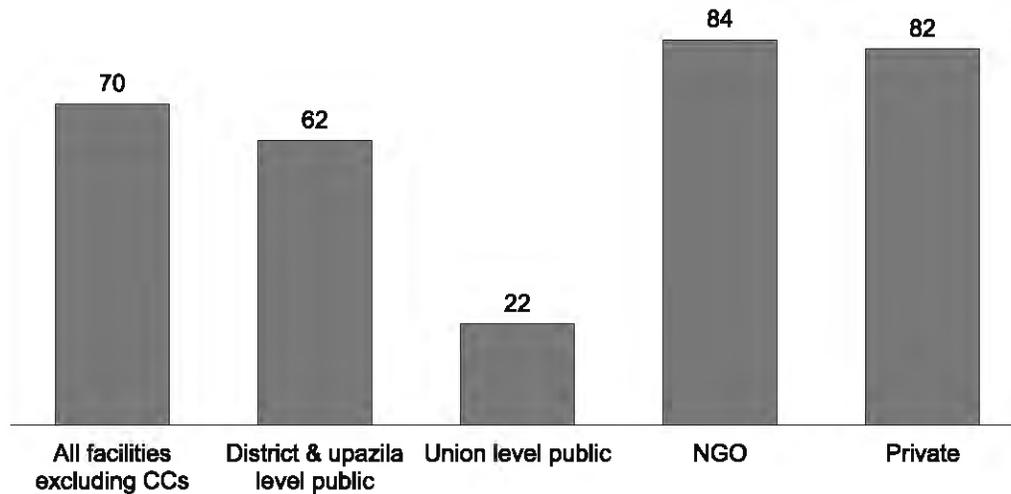
⁵ Upazila family planning officer (UFPO), assistant FP officer (AUFPO), family planning inspector (FPI), TB leprosy control administrator, health inspectors, assistant health inspectors.

⁶ Pharmacist, medical technologist - laboratory, medical technologist - blood transfusion, medical technologist - radiology, medical technologist - physiotherapy, medical technologist - dental, EPI technician.

⁷ Nutritionist/dietician, health educator, sanitary inspector, community health care provider, health assistant, family welfare assistant (FWA), counselor, community mobilizer/service promoter, outreach worker

⁸ Female medical attendant, ward master, attendant (OT/LAB/Dispensary/Ward Boy), store keeper, statistician/statistical assistant, other providers

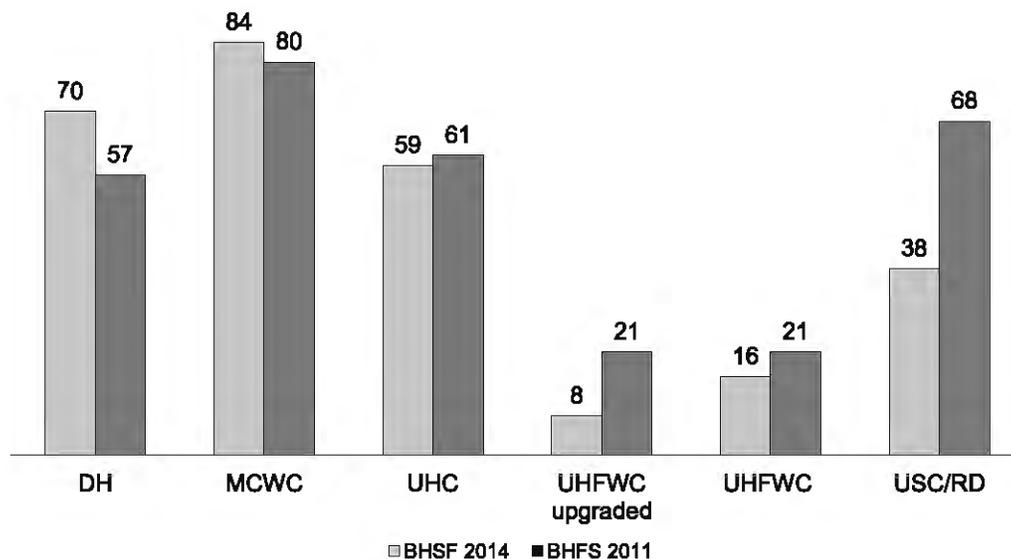
Figure 3.15 Percentage of physician positions filled in different facilities



BHFS 2014

Compared with finding from the 2011 BHFS, physician staffing has improved in DHs and MCWCs, remained the same in UHCs, and drastically declined in union-level facilities (Figure 3.16). Because of the timing of the survey, the 2014 BHFS did not capture the current vacancy rate after appointment of 6,000 physicians through the 33rd BCS. However, the staffing pattern indicates that HR planning and deployment for lower level facilities remains an issue to be addressed urgently.

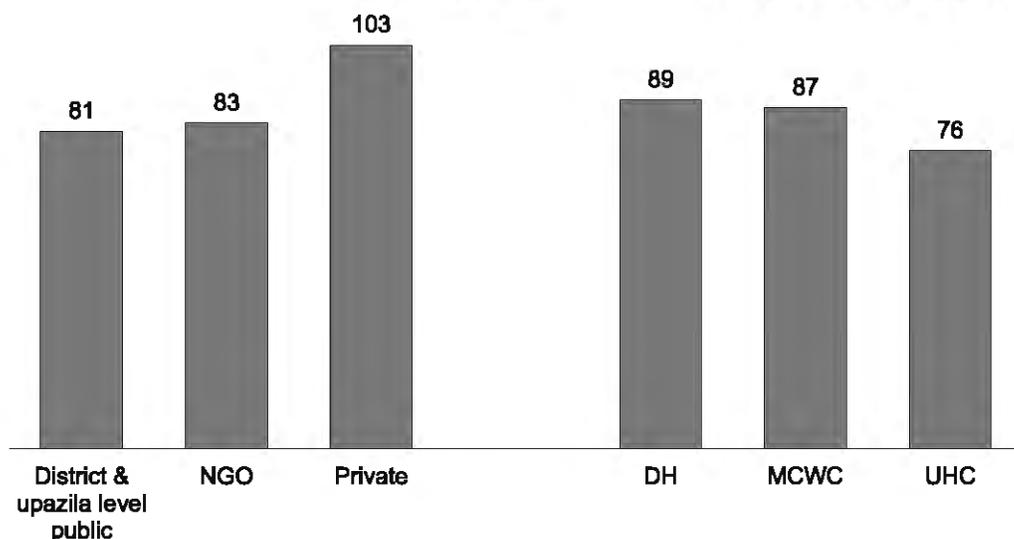
Figure 3.16 Trend in physician positions filled in public health facilities, by facility type



Nurse/midwife category: Over 100 percent (103 percent) of the sanctioned posts in private hospitals, 83 percent in NGO facilities, and 81 percent in district and upazila-level public facilities are filled (Table 3.8 and Figure 3.17). There are no sanctioned nurse/midwife posts in UHFWCs, upgraded UHFWCs, USC/RDs, or community clinics.

Recent recruitment of more than 4,000 nurses has made a positive change in filling nurse/midwives posts in the public sector. It is important to note that, the sanctioned positions for nurses in Bangladesh are much lower than the WHO recommended level. Currently, in terms of sanctioned positions, there are 1.2 nurses for every one physician, whereas the WHO-recommended level is 4 nurses for every one physician. These findings indicate that the sanctioned positions for nurses need to be increased in the public sector to ensure quality service provision.

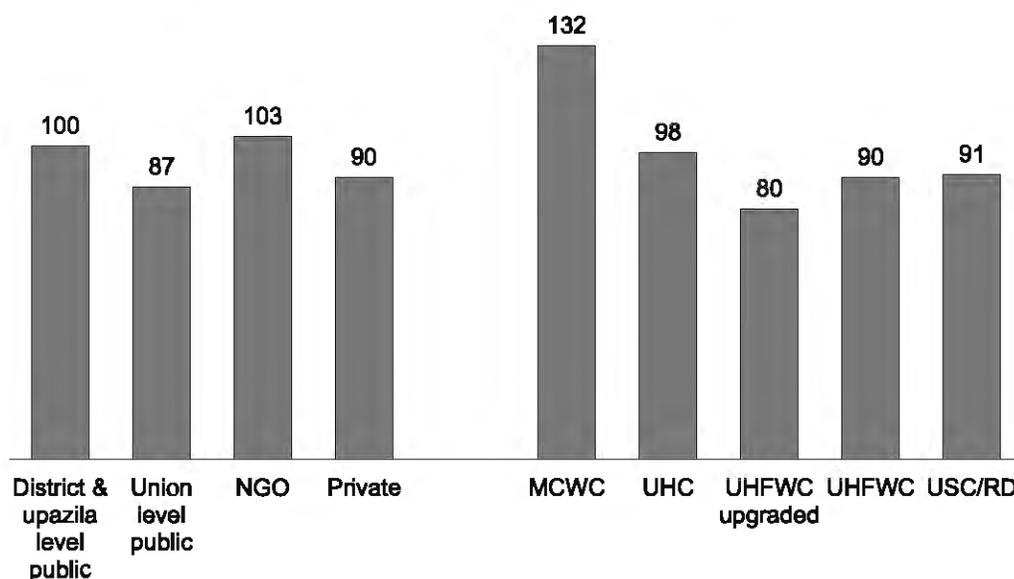
Figure 3.17 Percentage of nurse/midwife position filled in different facilities



BHFS 2014

Paramedic category: Staffing patterns and distribution of paramedics' positions are more equitable across the sectors. All the paramedic positions at district and upazila-level public facilities as well as in NGO facilities are currently filled, and 90 percent of paramedic positions in private hospitals are filled. Vacancies in paramedic positions are highest in upgraded UHFWCs, where paramedics (FWVs and SACMOs) are the main service-providers (Table 3.8 and Figure 3.18).

Figure 3.18 Percentage of paramedic positions filled, by facility type



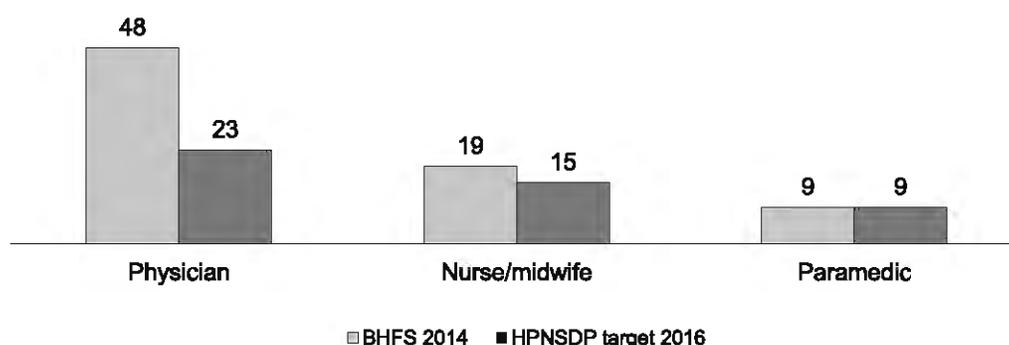
Note: Paramedics include SACMO, FWV, and NGO/private paramedics

BHFS 2014

Field supervisor category: All (100 percent) sanctioned posts in DHs, MCWCs and private hospitals are filled for this category. Eighty percent or more of field supervisor posts are filled in UHCs, UHFWCs, and NGO facilities (Table 3.8).

The HPNSDP Result Framework indicator on Human Resources for Health (HRH) requires periodic updating on “Proportion of service provider positions functionally vacant at upazila and district level and below, by category (of providers)”. The target of this indicator was to halve the 2009 vacancy rate (of 48 percent) by 2016. The 2014 BHFS findings indicate that despite the target of 23 percent, the overall vacancy for physician positions in 2014 remains at 48 percent. It is to be noted here that the 2014 estimate represents the national figure based on a sample survey. Despite notable improvement in the staffing pattern in DHs and MCWCs, the vacancy rate increased at union-level facilities and this negatively affected the overall level. If one wants to calculate the vacancy rate the way MOHFW does, i.e., by dividing total filled positions by total sanctioned positions, the vacancy rate among physicians comes down to 30 percent. If one compares the 2014 vacancy status among nurses’ positions with the 2016 target, progress can be considered satisfactory. Finally, the findings show that the results framework target for paramedic positions has been achieved well ahead of time (Figure 3.19). Filling 2,100 vacant FWV positions during the first three years of HPNSDP have made this possible.

Figure 3.19 Proportion of service provider (physician, nurse, paramedic) positions functionally vacant in public facilities in 2014 and HPNSDP targets for 2016



3.2 CHILD HEALTH SERVICES

The 2014 BHFS used the Integrated Management of Childhood Illnesses (IMCI) guidelines as the basis for assessing the provision of child health services. These guidelines are based on two major principles: (1) that all sick children should be routinely assessed for *major symptoms* (fever, cough, or difficult breathing; diarrhea; ear pain or discharge; nutrition and immunization status; feeding problems; and other potential problems) and (2) that all children should be examined for *general danger signs* that indicate the need for immediate referral or admission to a hospital. The 2014 BHFS assessed the availability of child health services, particularly the availability of curative care services for sick children, child growth monitoring services, and child vaccination services.

3.2.1 Outpatient Curative Care, Child Growth Monitoring, and Child Vaccination

Table 3.9 and Figure 3.20 provide information on availability of various types of basic child health services. Outpatient curative care for sick children is available in over 90 percent of all facilities. Child vaccination (78 percent) and growth monitoring (62 percent) are less widely available. When CCs are excluded from the analysis one important change in availability of child health service is observed—the percentage of facilities with child vaccination services declines from 78 percent to 65 percent.

There is little variation in availability of outpatient curative care for sick children among public sector facilities, where 93 percent and more provide the service; however, curative care services for sick children are less available in NGO facilities (83 percent) and private hospitals (68 percent).

Availability of child growth monitoring and child vaccination services follow a somewhat similar pattern, albeit these two services are available in slightly lower percentages than curative care services for sick children. For example, only 16 percent of private hospitals provide child vaccination services compared with 92 percent of DHs.

Child health services are not well integrated, with only one-half of all facilities (52 percent) providing all three basic child services. Among the various managing authorities, public sector facilities (35 percent of USCs/RDs to 78 percent of UHCs) and NGO facilities (51 percent) are much more likely to provide all three basic child health services than private hospitals (9 percent).

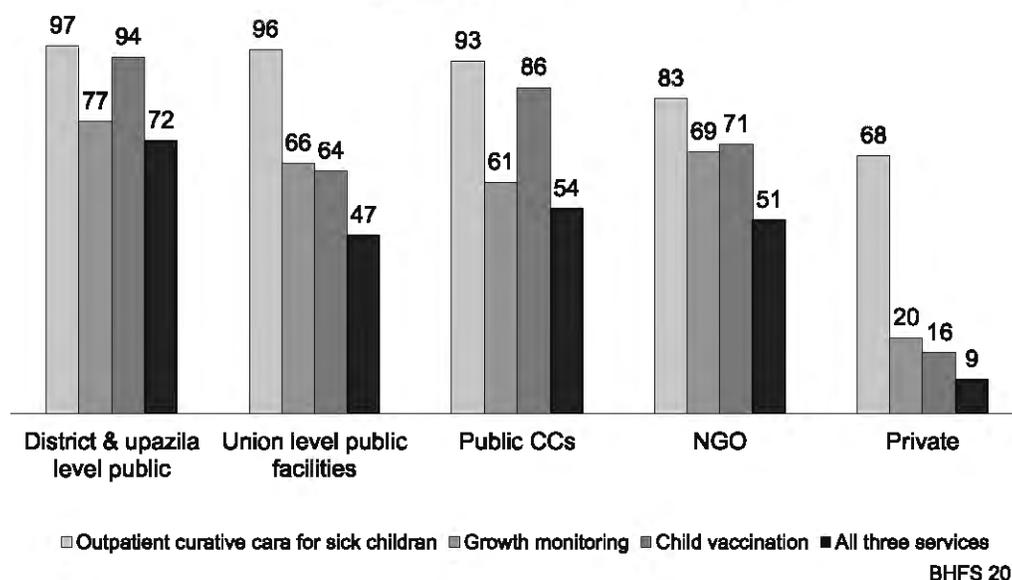
Table 3.9 Availability of child health services

Among all facilities, the percentages offering specific child health services at the facility, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities that offer:					Number of facilities
	Outpatient curative care for sick children	Growth monitoring	Child vaccination ¹	All three basic child health services	Routine vitamin A supplementation	
Facility type						
District and upazila public facilities	96.6	76.9	93.7	72.0	76.0	47
DH	100.0	74.2	91.9	69.4	86.7	5
MCWC	93.5	73.9	66.3	46.7	52.2	8
UHC	96.7	78.0	100.0	76.0	79.3	35
Union level public facilities	96.1	66.3	64.1	46.7	42.2	374
UHFWC	97.0	70.6	64.7	51.6	44.5	149
UHFWC (upgraded)	96.6	71.4	65.7	51.0	35.4	117
USC/RD	94.4	55.0	61.7	35.1	46.3	108
Public community clinic	92.7	60.9	85.7	53.9	80.1	1,010
NGO clinic/hospital	82.9	68.7	71.0	50.9	62.9	81
Private hospital	68.2	19.5	15.6	9.3	37.3	36
Location						
Urban	61.6	55.2	63.7	45.1	60.8	130
Rural	93.6	62.8	79.7	52.1	69.6	1,418
Division						
Barisal	96.0	60.1	64.7	53.6	69.6	116
Chittagong	92.1	58.6	76.8	45.2	63.2	287
Dhaka	90.0	60.7	66.1	45.8	64.7	421
Khulna	98.6	66.5	82.3	58.7	77.7	197
Rajshahi	85.0	53.6	82.3	43.2	64.6	224
Rangpur	95.5	77.3	85.7	69.6	83.7	205
Syhet	99.8	65.6	87.2	58.6	64.0	97
Total	92.6	62.1	78.4	51.5	68.9	1,548
Total excluding CCs	92.3	64.5	64.6	47.1	47.9	538

¹ Routine provision of DPT/pentavalent, polio, and measles vaccination in the facility to children

Figure 3.20 Availability of child health services in health facilities, by facility type



3.2.2 Vitamin A Supplementation

The 2014 BHFS also assessed routine provision of vitamin A supplementation to children less than age 1. Overall, close to 70 percent of all health facilities (48 percent, excluding CCs) provide vitamin A supplementation to children less than age 1. District and upazila-level facilities (76 percent) and CCs (80 percent) are more likely to provide vitamin A supplementation than union-level public facilities (42 percent), NGO facilities (63 percent), and private hospitals (37 percent) (Table 3.9).

3.2.3 Availability of Guidelines, Trained Staff, and Basic Equipment for Child Curative Care Services

The availability of treatment guidelines for easy reference contributes to the overall quality of services that clients receive. Trained staff, medicine, and basic equipment are also necessary to assess and examine sick children properly.

3.2.4 Guidelines for Sick Childcare

Table 3.10 presents information on availability of relevant guidelines and basic equipment for sick childcare. Availability of guidelines and equipment varies by facility type. Overall, 51 percent of all facilities (56 percent, excluding CCs) have IMCI guidelines. District and upazila-level public facilities (77 percent), NGO facilities (57 percent), and union-level public facilities (55 percent) are more likely to have IMCI guidelines than private hospitals (26 percent). As seen in Table 3.9, private hospitals are also less likely to offer curative care for sick children compared with public sector and NGO facilities. Guidelines for growth monitoring are available in fewer facilities. Overall, three out of 10 have guidelines for growth monitoring, about the same as when CCs are excluded from the analysis. However, availability of guidelines for growth monitoring varies by type of facility. NGO facilities (47 percent) and district and upazila-level public facilities (42 percent) are more likely than private hospitals (8 percent), CCs (30 percent), and union-level public facilities (30 percent) to have guidelines on growth monitoring.

3.2.5 Equipment for Sick Childcare

Bangladesh health facilities are better in terms of equipment for sick childcare. Thermometers and stethoscopes are the most widely available equipment, each available in over 90 percent of facilities that offer outpatient curative care for sick children. Little over 60 percent of facilities that offer outpatient curative care for sick children had a child scale; a similar proportion had a length/height board (Table 3.10). However,

altogether, only 42 percent of facilities (44 percent excluding CCs) that offer curative care for sick children had all four items of equipment available on the day of the survey.

Table 3.10 Guidelines and equipment for child curative care services

Among all facilities offering outpatient curative care for sick children, the percentages having indicated guidelines and equipment, by background characteristics, Bangladesh HSF 2014

Background characteristics	Guidelines			Equipment							Number of facilities offering outpatient curative care for sick children
	IMCI	Growth monitoring	Child scale ¹	Length or height board	Thermometer	Stethoscope	All four equipment items (child scale, height board, thermometer, stethoscope) available	Infant scale ²	Growth chart	Timer	
Facility type											
District and upazila public facilities											
DH	77.1	41.9	86.5	68.6	97.7	99.6	66.3	75.1	68.1	92.2	46
MCWC	75.8	41.9	98.4	80.8	96.8	100.0	79.0	88.7	58.1	96.8	5
UHC	57.0	40.7	86.0	70.9	95.3	97.7	66.3	76.7	65.1	89.5	7
	81.5	42.1	84.8	66.3	98.3	100.0	64.4	72.7	70.2	92.0	34
Union level public facilities											
UHFWC	54.8	29.2	65.3	48.6	84.3	93.4	36.3	41.0	48.9	76.3	359
UHFWC (upgraded)	56.4	37.2	64.2	44.6	82.3	93.6	33.5	38.1	50.8	80.1	144
USC/RD	45.4	24.4	79.5	62.3	83.3	91.1	48.0	53.3	52.8	73.3	113
	63.0	23.1	51.0	39.1	88.1	95.8	27.1	31.2	34.9	74.4	102
Public community clinic											
	47.8	30.0	55.9	66.9	96.8	93.3	40.8	25.3	40.6	70.4	936
NGO clinic/hospital											
	56.9	47.3	84.8	73.8	100.0	100.0	66.4	74.9	63.2	91.9	67
Private hospital											
	26.4	8.4	89.9	46.4	97.7	97.7	44.1	82.6	24.4	89.7	24
Location											
Urban	54.9	35.9	86.3	67.7	98.2	99.5	61.2	76.2	53.8	91.2	106
Rural	50.2	30.2	59.2	61.9	93.5	93.5	40.2	30.7	43.0	72.5	1,327
Division											
Barisal	66.5	35.0	62.5	65.7	92.5	90.2	38.2	35.6	51.2	75.4	112
Chittagong	42.8	27.5	59.1	62.3	94.5	90.1	36.4	32.9	41.9	82.2	265
Dhaka	38.0	24.8	50.1	54.2	92.3	93.5	31.6	29.9	30.3	68.9	379
Khulna	50.9	34.9	61.3	61.8	92.5	98.9	42.8	31.5	48.3	77.8	195
Rajshahi	45.7	25.1	57.8	61.9	94.0	92.9	43.0	29.5	35.5	70.6	190
Rangpur	77.1	52.4	83.7	72.4	98.5	99.6	64.4	47.5	71.9	75.0	196
Sylhet	57.9	14.5	70.0	72.1	92.4	90.4	50.0	39.4	44.0	65.4	96
Total	50.6	30.6	61.2	62.3	93.8	93.9	41.8	34.1	43.8	73.9	1,433
<i>Total, excluding CCs</i>	<i>55.8</i>	<i>31.8</i>	<i>71.1</i>	<i>53.8</i>	<i>88.3</i>	<i>95.1</i>	<i>43.5</i>	<i>50.7</i>	<i>50.0</i>	<i>80.5</i>	<i>497</i>

3.2.6 Trained Staff for Sick Childcare

Table 3.11 presents information on relevant training in IMCI and growth monitoring. The 2014 BHFS obtained information on any in-service training ever received as well as recent training (defined as training received in the past 24 months). Over 50 percent of facilities that offer curative care for sick children have at least one provider of child care services who reported ever receiving in-service training in IMCI, whereas 44 percent of facilities have at least provider who had ever received in-service training on growth monitoring. These percentages do not change much when CCs are excluded from the analysis. Private facilities and NGO facilities are less likely to have ever trained providers on IMCI than all level of public facilities. For growth monitoring, district and upazila-level facilities are much more likely than other facility types to have providers with in-service training.

A much lower proportion of facilities that offer curative care for sick children have providers with recent (during the past 24 months) in-service training on IMCI (29 percent) or growth monitoring (27 percent).

Table 3.11 Trained staff for child curative care services

Among all facilities offering outpatient curative care for sick children, the percentages having indicated trained staff, by background characteristics, Bangladesh HSF 2014

Background characteristics	Trained staff				Number of facilities offering outpatient curative care for sick children
	IMCI (during the past 24 months)	IMCI (at any time)	Growth monitoring (during the past 24 months)	Growth monitoring (at any time)	
Facility type					
District and upazila public facilities	37.9	78.2	32.9	66.9	46
DH	35.5	72.8	27.4	62.9	5
MCWC	22.1	67.4	17.4	62.8	7
UHC	41.6	61.3	37.1	66.4	34
Union level public facilities	14.8	53.2	11.8	39.5	359
UHFWC	10.8	52.2	8.5	38.8	144
UHFWC (upgraded)	14.9	47.3	13.9	39.0	113
USC/RD	20.3	61.3	14.1	40.9	102
Public community clinic	36.3	54.7	33.7	45.6	936
NGO clinic/hospital	10.6	46.4	11.4	44.4	67
Private hospital	18.8	30.4	18.2	27.9	24
Location					
Urban	20.7	52.0	17.9	45.9	106
Rural	30.1	54.4	27.6	44.3	1,327
Division					
Barisal	44.1	66.9	31.9	50.7	112
Chittagong	25.4	48.7	28.0	36.7	265
Dhaka	34.7	57.0	26.1	46.4	379
Khulna	17.5	44.5	26.3	44.6	195
Rajshahi	26.8	54.0	24.6	40.8	190
Rangpur	27.2	57.0	26.1	46.3	196
Sylhet	36.4	58.6	34.0	52.8	96
Total	29.4	54.3	26.9	44.4	1,433
Total excluding CCs	18.5	53.5	14.0	42.1	497

3.2.7 Availability of Medicine and Commodities for Sick Childcare

A range of medicines and commodities are needed to provide curative care for sick children. WHO and USAID proposed a set of essential and priority medicines and commodities that facilities must have available to support the provision of child health services. Overall, essential medicines are in better supply than priority medicines in facilities that offer curative care for sick children (Table 3.12.1). Six of the seven essential medicines were in stock on the day of the survey visit in 64 percent and above of facilities that offer curative care for sick children: oral rehydration salts, amoxicillin syrup, paracetamol syrup/suspension, vitamin A capsules, mebendazole/albendazole, and zinc tablets. However, there is some variability in the availability of each of these essential medicines. For example, while 81 percent of facilities, on average, had amoxicillin syrup/suspension/dispersible, NGO facilities (70 percent), and private hospitals (54 percent) are less likely than public sector facilities to have the medicine available on the day of the survey. Among public sector facilities, however, USCs/RDs are the least likely, at around 70 percent, to have this essential medicine, compared with 92 percent of MCWCs for example.

Each of the four priority medicines (ampicillin powder for injection, ceftriaxone powder for injection, gentamycin injection, and benzathine benzyl-penicillin injection) was available on the day of the survey in less than 10 percent of facilities that offer curative care for sick children. But excluding CCs from the analysis, the percentages improved for three priority medicines. Even in higher level facilities such as hospitals where these priority medicines are expected to be available, survey findings are not that encouraging. For example, only a quarter of DHs (26 percent), and a similar proportion of UHCs (24 percent) had ampicillin powder for injection available on the day of the visit; half of private hospitals had them. About two-thirds (68 percent) of DHs had ceftriaxone powder for injection, while a slightly smaller proportion of UHCs (62 percent) had them; about three quarters of private hospitals (77 percent) had them.

Figure 3.21 presents information on the availability of the 10 items that are required for facilities to be considered ready to provide child curative care. The majority of facilities that offer child curative care have the five basic medicines: mebendazole/albendazole (88 percent), paracetamol syrup/suspension (86 percent), amoxicillin syrup/suspension (81 percent) ORS (79 percent), and zinc tablets (64 percent). Among other items, a growth chart is least likely to be available (44 percent), followed by IMCI guidelines (51 percent) and IMCI trained staff (54 percent). The low availability of a growth chart is a concern because more than one third of children under age 5 in Bangladesh, according to a recent BDHS, are stunted. Functioning child scales were available at 61 percent of health facilities on the day of survey. However, a thermometer is widely available (94 percent) in all health facilities. When CCs are excluded from the analysis, the percentage of facilities having ORS or zinc tablets/syrup decreases substantially, while the percentage of facilities with a child scale increases.

Figure 3.21 Availability of items (tracer indicators) in health facilities for readiness to provide child curative care

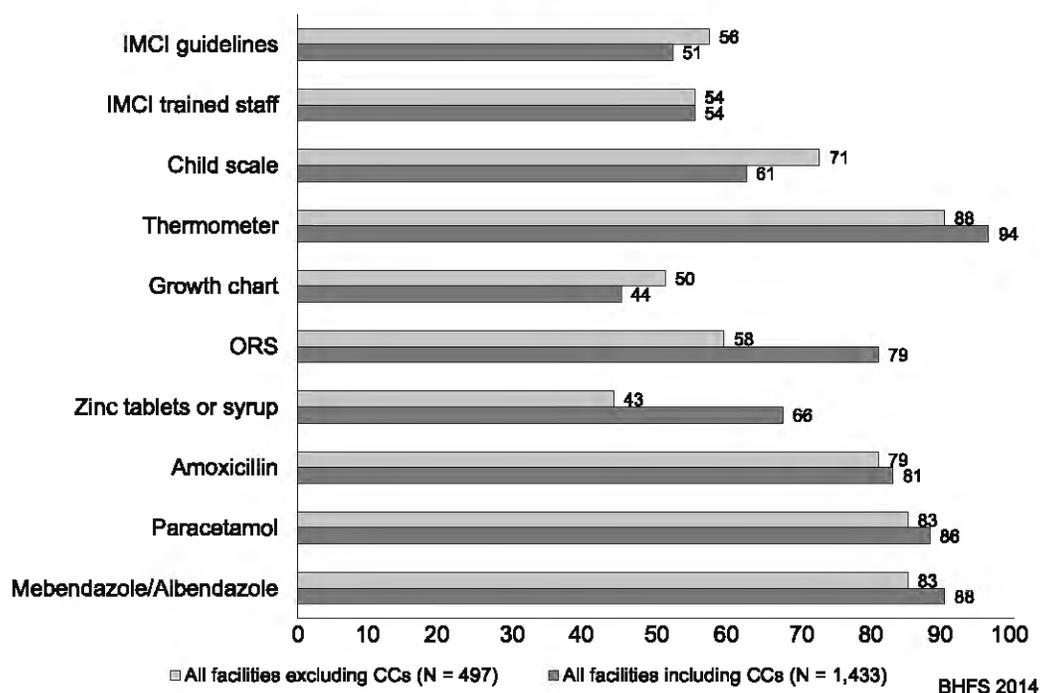
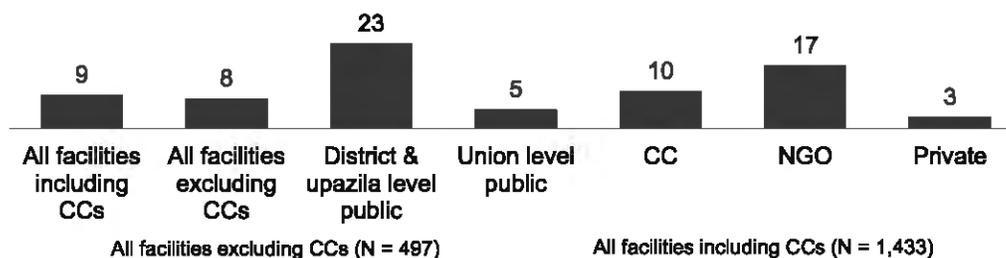


Figure 3.22 and Table 3.12.2 present information on facilities that have all the 10 readiness items to provide child curative care services. Overall, only 9 percent of facilities offering child curative care have all the 10 service readiness items to be considered as ready to provide child curative care. District and upazila-levels public facilities are comparatively more ready than other facilities to provide child curative care. For example, while over 80 percent of NGO facilities and 68 percent of private hospitals offer child curative care services only 17 percent of NGO facilities and three percent of private hospitals that offer child curative care services can be considered ready to provide quality services. Given the MOHFW's focus on maternal and child care services under HPNSDP, the study indicates a major gap in child care service readiness.

Figure 3.22 Readiness of health facilities to provide child curative care, by facility type



Note: Readiness of facilities to provide child curative care: IMCI trained staff (at least one provider ever receiving in-service training on at least some components of IMCI), IMCI guidelines, equipment (child scale, thermometer, growth chart), and medicines (ORS, zinc dispersible tablets/syrup, amoxicillin syrup/suspension, paracetamol syrup/suspension, and mebendazole/albendazole)

BHFS 2014

Table 3.12.2 Readiness of health facilities to provide child curative care services

Among all facilities offering outpatient curative care for sick children, the percentages having indicated IMCI guideline, IMCI trained staff at any time, basic equipment and essential medicines available on the day of the survey and percentage having all 10 items, by background characteristics, Bangladesh HSF 2014

Background characteristics	IMCI guideline	IMCI (trained at any time)	Child scale	Thermometer	Growth chart	Zinc tablets or syrup	ORS	Amoxicillin syrup, suspension or dispersible	Paracetamol syrup or suspension	Mebendazole/albendazole	Having all 10 items	Number of facilities offering outpatient curative care for sick children
Facility type												
District and upazila public facilities	77.1	78.2	86.5	97.7	68.1	65.4	87.7	80.4	82.4	75.5	22.6	46
DH	75.8	72.6	98.4	96.8	58.1	75.8	98.4	75.8	88.7	83.9	22.6	5
MCWC	57.0	67.4	86.0	95.3	65.1	27.9	46.5	91.9	91.9	84.2	8.1	7
UHC	81.5	81.3	84.8	98.3	70.2	71.7	94.8	78.6	79.5	70.2	25.7	34
Union level public facilities	54.8	53.2	85.3	84.3	46.9	33.9	47.5	81.7	84.4	84.8	4.7	359
UHFWC	56.4	52.2	84.2	82.3	50.8	33.1	39.4	86.4	89.8	91.8	4.2	144
UHFWC (upgraded)	45.4	47.3	79.5	83.3	52.8	26.5	24.3	87.1	90.3	91.7	3.9	113
USC/RD	63.0	61.3	51.0	88.1	34.9	43.2	84.8	69.1	69.9	67.1	6.2	102
Public community clinic	47.8	54.7	55.9	96.8	40.8	77.2	89.3	81.6	86.9	91.3	10.0	936
NGO clinic/hospital	56.9	46.4	84.8	100.0	63.2	70.6	89.8	69.8	81.7	82.0	17.0	67
Private hospital	26.4	30.4	89.9	97.7	24.4	67.7	76.3	53.7	72.0	71.7	3.1	24
Location												
Urban	54.9	52.0	86.3	98.2	53.8	67.1	86.5	70.4	78.4	78.3	16.0	106
Rural	50.2	54.4	59.2	93.5	43.0	65.3	77.9	81.3	86.2	89.2	8.8	1,327
Division												
Barisal	86.5	88.9	82.5	92.5	51.2	78.5	84.7	85.4	92.1	92.2	13.5	112
Chittagong	42.8	48.7	59.1	94.5	41.9	53.6	72.7	80.0	87.3	85.0	6.0	265
Dhaka	38.0	57.0	50.1	92.3	30.3	67.8	75.4	80.2	80.7	84.5	5.1	379
Khulna	50.9	44.5	81.3	92.5	48.3	81.8	73.8	78.6	88.3	87.3	6.5	195
Rajshahi	45.7	54.0	57.6	94.0	35.5	66.9	85.0	78.8	82.8	87.7	12.0	190
Rangpur	77.1	57.0	83.7	98.5	71.9	75.6	90.5	80.6	91.4	86.8	21.3	196
Sylhet	57.9	58.6	70.0	92.4	44.0	80.5	72.7	85.1	85.1	94.9	5.8	96
Total	50.6	54.3	81.2	93.8	43.8	65.5	78.6	80.5	85.6	86.4	9.3	1,433
Total without CC	55.8	53.5	71.1	88.3	50.0	43.4	58.4	78.8	83.2	82.9	7.9	497

3.3 FAMILY PLANNING SERVICES

3.3.1 Availability of Family Planning Services

The 2014 BHFS obtained information on availability of family planning services from all the sampled public, private, and NGO health facilities. Family planning services are considered available if a facility provides, prescribes, or counsels about family planning. Table 3.13 and Figure 3.23 provide information on the availability of family planning services in Bangladesh health facilities.

Modern methods of family planning: Eight in ten facilities (81 percent) offer at least one type of temporary modern family planning method; this percentage remains the same when CCs are excluded from the analysis. On average, district and upazila-level public facilities (94 percent), union-level public facilities (83 percent), CCs (82 percent), and NGO facilities (88 percent) are much more likely than private hospitals (21 percent) to offer modern family planning. Among the public facilities, however, DHs (60 percent) and USCs/RDs (61 percent) are less likely to offer modern methods of family planning compared with other public facilities. Rural facilities (82 percent) are slightly more likely than urban facilities (72 percent) to offer a modern method of family planning. Facilities in Dhaka, at 67 percent, are much less likely than facilities in other divisions (from 75 percent in Rajshahi to 94 percent in Khulna, Rangpur, and Sylhet) to offer modern methods of family planning.

Long-acting and permanent methods of family planning: Long-acting and permanent methods are less widely available in Bangladesh health facilities. Overall, only about half (48 percent) of all health facilities offer any long-acting or permanent family planning methods, i.e., IUCDs, implants, or male or female sterilization. However, as expected, the percentage of facilities that offer long-acting or permanent family planning increases (to 69 percent) when CCs are excluded from the analysis. Among district and upazila-level public facilities, as many as 98 percent of UHCs and 96 percent of MCWCs offer long-acting or permanent methods of family planning; however, only 57 percent of DHs offer any of these methods. Almost 8 in 10 NGO facilities offer long-acting or permanent methods of family planning. Urban facilities (68 percent) are more likely than rural facilities (46 percent) to offer a long-acting or permanent method. Facilities in Barisal, at 36 percent, are less likely than facilities in other divisions (from 41 percent in Dhaka to 63 percent in Rangpur) to offer long-acting or permanent methods.

Twenty-nine percent of health facilities (36 percent, excluding CCs) offer male or female sterilization services, that is, health workers in these facilities can actually perform the procedure in the facility, or else they discuss this option with clients and then refer clients elsewhere to obtain the service. Generally district and upazila-level public facilities (87 percent) and NGO facilities (51 percent) are more likely than union-level public facilities (28 percent), CCs (26 percent), or private hospitals (14 percent) to offer male or female sterilization services. Urban facilities (52 percent) are more likely than rural facilities (27 percent) to offer male or female sterilization services.

Table 3.13 Availability of family planning services

Among all facilities, the percentages offering methods of family planning by background characteristics, Bangladesh HFS 2014

Background characteristics	Methods of family planning (FP)				Number of facilities
	Percentage offering any FP ¹ (including emergency contraceptive)	Percentage offering any modern FP ² (including emergency contraceptive)	Percentage offering any long-acting and permanent methods ³	Percentage offering male or female sterilization ⁴	
Facility type					
District and upazila public facilities	94.3	94.2	92.7	87.1	47
DH	59.7	59.7	58.5	48.4	5
MCWC	97.8	96.7	95.7	82.8	8
UHC	98.7	98.7	97.5	93.9	35
Union level public facilities	85.1	83.4	69.6	27.6	374
UHFWC	94.3	93.1	77.1	26.4	149
UHFWC (upgraded)	93.7	91.8	78.9	31.8	117
USC/RD	63.0	60.7	49.1	24.9	108
Public community clinic	82.9	81.8	36.8	25.5	1,010
NGO clinic/hospital	90.3	88.3	77.1	51.3	81
Private hospital	20.7	20.5	18.9	14.3	36
Location					
Urban	73.8	72.4	67.9	51.8	130
Rural	83.6	82.2	46.2	26.9	1,418
Division					
Barisal	88.7	88.0	35.8	13.0	118
Chittagong	83.5	82.9	49.0	39.5	287
Dhaka	70.4	66.9	40.8	22.3	421
Khulna	94.6	93.5	52.7	30.8	197
Rajshahi	75.9	75.4	51.8	25.3	224
Rangpur	94.4	94.1	63.0	48.4	205
Sylhet	94.1	94.1	41.7	13.8	97
Total	82.7	81.4	48.0	29.0	1,548
Total excluding CCs	82.5	80.9	69.4	35.5	538

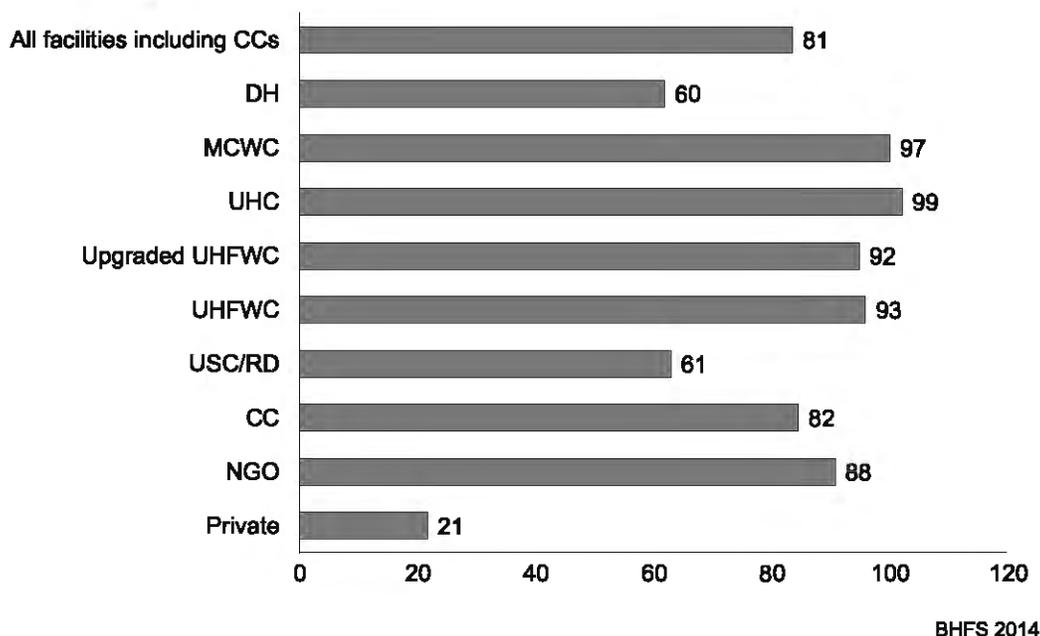
¹ Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, IUCDs, male condoms, female sterilization (tubal ligation) or male sterilization (vasectomy), emergency contraceptive, or periodic abstinence.

² Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), implants, IUCDs, male condoms, female sterilization (tubal ligation), or male sterilization (vasectomy), emergency contraceptive.

³ Facility provides, prescribes, or counsels clients on any of the following long-term and permanent methods of family planning: implants, intrauterine contraceptive devices (IUCDs), female sterilization (tubal ligation), or male sterilization (vasectomy).

⁴ Providers in the facility perform male or female sterilization or counsel clients on male or female sterilization.

Figure 3.23 Percentage of facilities offering counseling, prescribing, or providing any type of modern family planning methods, by facility type



3.3.2 Availability of Family Planning Methods on the Day of the Survey

Stock-outs of family planning methods can put a woman at risk of unintended pregnancy. The 2014 BHFS assessed the availability of contraceptive methods on the day of the assessment among facilities that report providing these methods. During data collection in each facility, the survey interviewers observed whether the family planning commodities were available or in stock on that day.

As Table 3.14 and Figure 3.24 show, the majority of facilities providing the most popular methods had them in stock on the day of the assessment. Nationwide, 84 percent of facilities (81 percent, excluding CCs) that report providing any family planning methods actually had every method that they provide available in the facility on the day of the visit. These findings indicate that there are gaps in the availability of contraceptive methods in facilities that provide them. For example, among facilities that provide the intrauterine contraceptive device (IUCD), 87 percent had the device in stock, meaning that 13 percent did not. Similarly 78 percent of facilities that provide implants had the method on the day of the assessment, and 22 percent did not. Overall, private facilities were least likely to have family planning commodities in stock—about half did not have the relevant family planning commodities.

Table 3.14 Availability of family planning commodities

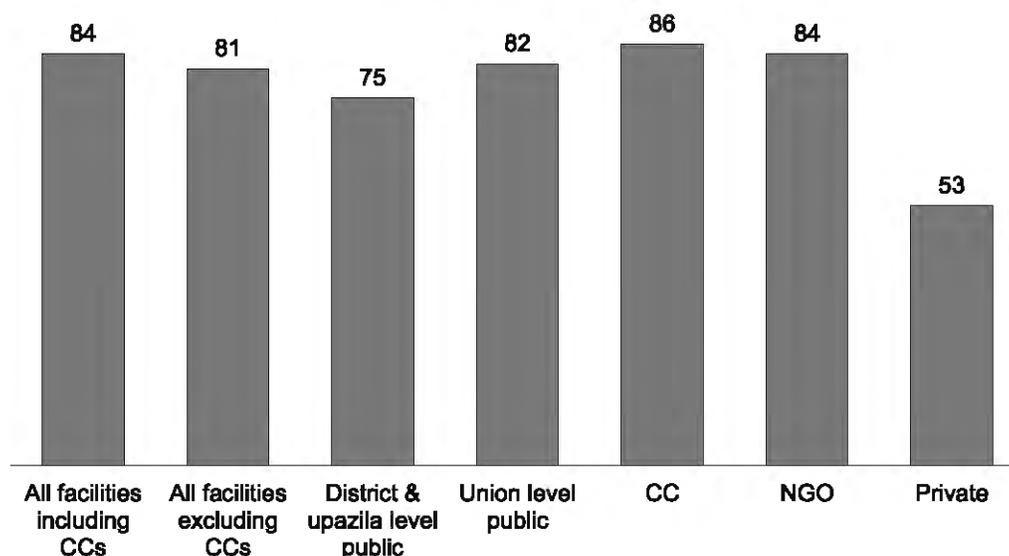
Among facilities that provide¹ the indicated modern family planning method, the percentages where the commodity was observed to be available on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Combined or progestin only oral pills	Combined or progestin only injectable	Male condom	Intrauterine contraceptive device	Implant	Emergency contraception	Every method provided by facility was available on day of survey
Facility type							
District and upazila public facilities							
DH	97.2	97.1	97.1	89.7	79.2	85.7	77.8
MCWC	100.0	98.6	98.9	96.1	95.9	60.0	80.9
UHC	99.5	94.9	98.4	93.6	93.2	51.6	73.9
Union level public facilities							
UHFWC	97.6	95.6	97.2	93.8	55.7	55.6	82.3
UHFWC (upgraded)	94.8	97.0	97.4	91.1	72.9	68.4	80.0
USC/RD	95.9	90.8	93.2	86.0	67.4	82.6	83.3
Public community clinic							
	97.5	90.5	95.3	77.2	59.5	72.7	86.2
NGO clinic/hospital							
	97.1	97.1	98.1	91.8	91.5	90.8	84.1
Private hospital							
	80.1	63.0	63.0	40.3	31.9	47.9	53.2
Location							
Urban	98.9	95.3	97.2	90.1	90.6	79.8	79.0
Rural	97.2	92.0	95.7	86.8	67.9	69.5	84.9
Division							
Barisal	98.2	92.4	94.4	93.4	90.3	60.8	88.8
Chittagong	97.2	93.1	94.8	97.2	85.6	72.3	88.4
Dhaka	93.9	84.5	92.1	89.1	79.2	65.1	77.0
Khulna	97.9	92.5	93.3	71.0	79.2	41.5	77.0
Rajshahi	97.1	91.2	100.0	70.1	87.9	63.9	78.6
Rangpur	99.2	97.7	100.0	98.1	90.6	98.3	95.5
Sylhet	99.6	98.6	99.8	86.6	51.3	87.2	93.3
Total	97.2	92.3	95.8	87.4	77.9	71.9	84.4
Total excluding CCs	96.6	95.2	96.8	91.3	81.1	71.5	81.2

Note: The denominators for each characteristic/method combination are different and are not shown in the table. The combined oral contraceptive pills, injectable contraceptives, and male condom measure presented in the table comprise the medicines and commodities domain for assessing readiness to provide family planning services within the health facility assessment methodology proposed by WHO and USAID (2012). Each commodity or method shown in this table was observed to be available in the service area or location where commodities are stored, and at least one of the observed commodities or methods was valid, i.e., within expiration data.

¹ The facility reports that it stocks the method in the facility and makes it available to clients without clients having to go elsewhere to obtain it.

Figure 3.24 Percentage of facilities with family planning commodities (pill, injectables, condom, IUCD, implants, ECP) available on day of survey



BHFS 2014

3.3.3 Availability of Guidelines, Trained Staff, and Equipment

To provide family planning services to clients, facilities should have family planning guidelines, appropriately trained providers, and certain supplies and equipment in place to ensure that clients get the best possible service. Table 3.15.1 and Figure 3.25 provide details on availability of service guidelines, trained staff, and equipment for provision of family planning services.

Table 3.15.1 Guidelines, trained staff, and basic equipment for family planning services

Among facilities offering any modern family planning methods, the percentage having family planning guidelines, the percentage having at least one staff member recently trained on family planning service delivery, and the percentage with the indicated equipment observed to be available on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering any modern family planning and having:			Equipment							Number of facilities offering any modern family planning methods
	Guidelines on family planning ¹	Staff trained in family planning during past 24 months ²	Staff trained in family planning at any time ²	Blood pressure apparatus ³	Examination light	Examination bed or couch	Samples of family planning methods	Pelvic model for IUCD ⁴	Model for showing condom use	Other family planning-specific visual aid ⁶	
Facility type											
District and upazila public facilities											
DH	75.2	35.8	82.1	96.8	78.2	94.7	90.5	60.4	69.8	87.9	45
MCWC	83.8	45.9	73.0	94.6	78.4	94.6	89.2	59.5	67.6	88.5	3
UHC	76.4	46.1	93.3	94.4	84.3	96.6	89.9	67.4	73.0	86.5	7
	74.2	32.4	80.5	97.5	76.8	94.3	90.7	59.0	69.3	86.3	34
Union level public facilities											
UHFWC	58.5	27.3	68.5	85.2	52.4	79.6	71.9	36.9	44.9	75.8	312
UHFWC (upgraded)	60.0	31.3	71.6	83.2	49.4	76.9	73.1	35.0	44.1	78.1	139
USC/RD	58.3	28.4	71.1	86.3	56.3	86.6	71.9	41.0	44.8	76.6	108
	55.5	20.3	57.7	87.8	52.1	74.0	69.7	34.4	46.5	69.7	65
Public community clinic	49.2	33.5	50.4	83.4	40.1	73.0	61.6	11.9	28.1	63.8	825
NGO clinic/hospital	78.0	39.0	76.9	97.4	84.2	92.2	88.9	51.8	69.9	82.8	72
Private hospital	36.4	13.7	26.8	84.4	84.4	74.5	53.1	39.2	31.4	50.1	7
Location											
Urban	71.3	33.9	73.7	95.8	82.4	90.4	87.3	54.4	67.7	78.4	94
Rural	52.6	32.1	56.1	84.3	44.4	75.4	65.0	19.7	33.5	67.8	1,186

(Continued...)

Table 3.15.1—Continued

Background characteristics	Percentage of facilities offering any modern family planning and having:			Equipment							Number of facilities offering any modern family planning methods
	Guidelines on family planning ¹	Staff trained in family planning during past 24 months ²	Staff trained in family planning at any time ²	Blood pressure apparatus ³	Examination light	Examination bed or couch	Samples of family planning methods	Pelvic model for IUCD ⁴	Model for showing condom use	Other family planning-specific visual aid ⁵	
Division											
Barisal	57.8	35.5	55.3	78.3	42.4	65.1	69.5	14.8	31.3	75.1	103
Chittagong	50.4	34.2	61.0	85.4	36.0	70.7	56.1	12.1	26.3	60.7	238
Dhaka	50.8	39.3	70.2	77.9	44.6	64.7	59.4	20.1	26.7	52.9	282
Khulna	49.9	27.9	49.7	90.9	51.6	89.1	69.0	17.2	37.7	67.2	185
Rajshahi	53.6	17.3	45.9	84.9	44.9	79.5	65.7	17.1	35.2	64.8	169
Rangpur	68.1	27.6	49.8	95.9	66.7	86.7	81.0	52.7	64.6	94.7	193
Sylhat	52.5	47.8	63.7	80.9	40.3	89.1	80.1	19.3	34.2	85.4	91
Total	54.0	32.2	57.4	85.1	47.2	76.5	66.7	22.3	36.1	68.6	1,260
Total excluding CCs	63.0	29.8	70.6	88.4	60.8	83.2	76.3	41.8	51.3	77.8	435

Note: The measures presented in the table concerning guidelines for family planning and staff trained in FP comprise the staff and training domains, and blood pressure apparatus comprises the equipment domain, for assessing readiness to provide family planning services within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ National guidelines or any other guidelines on family planning

² The facility had at least one interviewed staff member providing the service who reports receiving in-service training in some aspect of family planning. The training must involve structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

³ A functioning digital blood pressure apparatus or else a manual sphygmomanometer with a stethoscope

⁴ IUCD = Intrauterine contraceptive device

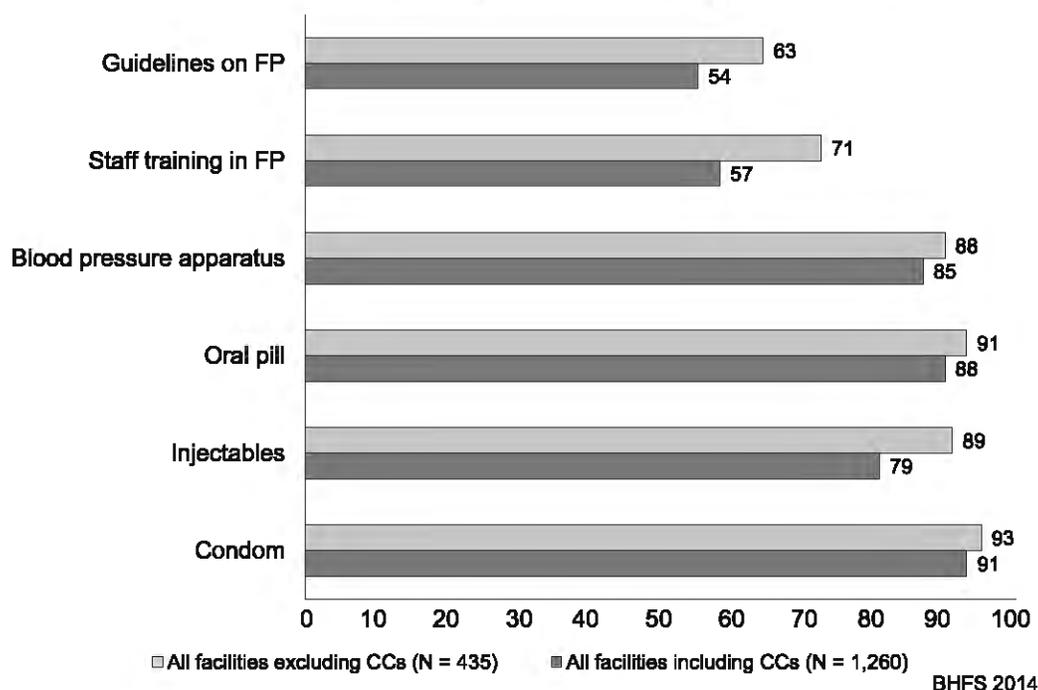
⁵ Flip charts or leaflets

Over half of facilities (54 percent) that offer any modern family planning methods have family planning guidelines available at the service site; this proportion increased to 63 percent when CCs were excluded from the analysis. Among public facilities, CCs are least likely (49 percent) to have guidelines on family planning, and among all facilities, private hospitals are least likely, at 36 percent, to have family planning guidelines. Urban facilities, at 71 percent, are more likely than rural facilities (53 percent) to have family planning guidelines.

Fifty-seven percent of all health facilities (71 percent, excluding CCs) that offer any modern family planning methods reported having at least one staff member who had ever received in-service training in family planning. District and upazila-level public facilities (82 percent) and NGO facilities (77 percent) are more likely to have a trained staff than CCs (50 percent) and private hospitals (29 percent). These percentages drop quite drastically when assessing for providers with recent in-service training in family planning, i.e., training in the past 24 months. For example, 93 percent MCWCs have at least one staff who had received in-service training in family planning; however, only 46 percent had a provider who had received training in the past 24 months.

With the exception of a few items, facilities that offer family planning services are likely to have equipment that supports and enhances the provision of such services. For example, over 8 of every 10 health facilities (85 percent) have a blood pressure apparatus available at the service site. Three-quarters (77 percent) of all facilities have an examination bed; two-thirds (67 percent) have samples of different family planning methods available at the service site. However, an examination light is not widely available; only about half of the facilities have one (47 percent). About one-third (36 percent) of facilities have a model for demonstrating condom use. When CCs are excluded from the analysis, in most cases the proportion of facilities with equipment available improves.

Figure 3.25 Availability of items (tracer indicators) in health facilities for readiness to provide family planning services



3.3.4 Readiness of Health facilities to Provide Family Planning Services

The 2014 BHFS measures readiness of health facilities to provide family planning services. The WHO specifies items or tracer indicators that facilities must have to be considered ready to offer the service. WHO recommends that facilities offering any family planning service must have all of the following to be considered ready:

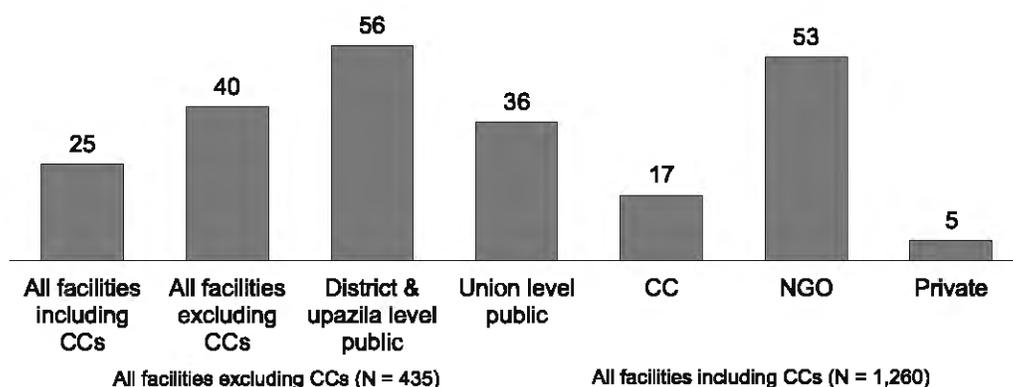
- **Trained staff:** At least one staff person who received in-service training in family planning in the last 24 months. In this report, this requirement is modified to consider that a facility has trained staff if it has any staff who ever received in-service training on FP.
- **Guidelines:** National or any other guidelines on family planning available at the facility
- **Equipment:** Blood pressure apparatus
- **Commodities:**
 - Oral pill
 - Injectables
 - Condom

While around 80 percent of facilities in Bangladesh offer family planning services, only one in four of these facilities can be considered ready to provide quality family planning services, i.e., having all six items available at the facility on the day of the survey. Readiness to provide family planning services increases from 25 percent to 40 percent when CCs are excluded from the analysis. The primary reasons for low readiness are low availability of trained staff and family planning guidelines in general and low availability of commodities such as condoms and injectables in CCs.

Examining service readiness by facility type shows that, while over 90 percent of district and upazila-level public facilities and almost 90 percent of NGO facilities offer family planning services, little more than half of these facilities can be considered ready to provide quality family planning services (Figure 3.26 and Table 3.15.2). In the public sector, CCs are least likely to be ready to provide family planning services, mainly because they are less likely to have trained staff, guidelines, and commodities available compared with other public facilities. Private hospitals are least engaged in providing family planning

services, and they are least ready to provide quality services—only 5 percent of private facilities offering family planning can be considered ready to provide quality family planning service.

Figure 3.26 Readiness of health facilities to provide family planning services, by facility type



Note: Readiness of facilities to provide family planning services: Trained staff (at least one staff who ever received in-service training on FP), guidelines (national or any other guidelines on FP), equipment (blood pressure apparatus), commodities (oral pill, injectables, condom)

BHFS 2014

Table 3.15.2 Readiness of health facilities to provide family planning services

Among facilities offering any modern family planning methods, the percentage having family planning guidelines, blood pressure apparatus, the percentage having at least one staff member trained on family planning service delivery at any time, the percentage with the indicated contraceptive commodities available on the day of the survey, and the percentage having all 6 items, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering any modern family planning and having:						All 6 items available	Number of facilities offering any modern family planning methods
	Guidelines on family planning ¹	Staff trained in family planning any time ²	Blood pressure apparatus ³	Combined or progestin only oral pills	Combined or progestin only injectable	Male condom		
Facility type								
District and upazila public facilities								
DH	75.2	82.1	98.8	97.4	94.2	98.5	58.0	45
MCWC	83.8	73.0	94.6	94.8	91.9	94.6	51.4	3
UHC	76.4	93.3	94.4	97.8	95.5	98.9	64.0	7
Union level public facilities								
UHFWC	74.2	80.5	97.5	97.5	94.2	98.2	54.6	34
UHFWC (upgraded)	58.5	68.5	85.2	91.2	90.5	94.5	35.8	312
USC/RD	60.0	71.6	83.2	90.7	91.2	95.3	35.1	139
Public community clinic	58.3	71.1	86.3	92.6	92.7	98.2	37.4	108
NGO clinic/hospital	55.5	57.7	87.8	90.0	85.3	90.1	33.7	65
Private hospital	49.2	50.4	83.4	88.9	73.2	89.7	17.3	825
Location								
Urban	78.0	78.9	97.4	91.3	88.8	91.9	53.2	72
Rural	36.4	28.8	84.4	44.0	42.1	34.3	5.0	7
Division								
Barisal	71.3	73.7	95.8	90.7	90.1	90.9	50.4	94
Chittagong	52.6	56.1	84.3	88.1	77.9	90.9	23.1	1,166
Dhaka	57.8	55.3	78.3	93.4	86.1	92.6	23.8	103
Khulna	50.4	61.0	85.4	88.7	81.3	87.5	27.4	238
Rajshahi	50.8	70.2	77.9	84.0	61.6	84.3	24.6	282
Rangpur	49.9	49.7	90.9	88.9	77.8	91.2	19.1	165
Sylhet	53.6	45.9	84.9	89.5	79.2	94.8	18.8	189
Total	66.1	49.8	95.9	88.3	95.3	98.5	35.0	193
Total without CC	52.5	63.7	80.9	92.1	83.5	92.3	25.6	91
Total	54.0	57.4	85.1	88.3	78.8	90.9	25.1	1,260
Total without CC	63.0	70.6	88.4	91.1	89.4	93.3	40.1	435

Note: The measures presented in the table concerning guidelines for family planning and staff trained in FP comprise the staff and training domains, and blood pressure apparatus comprises the equipment domain, for assessing readiness to provide family planning services within the health facility assessment methodology proposed by WHO and USAID (2012).

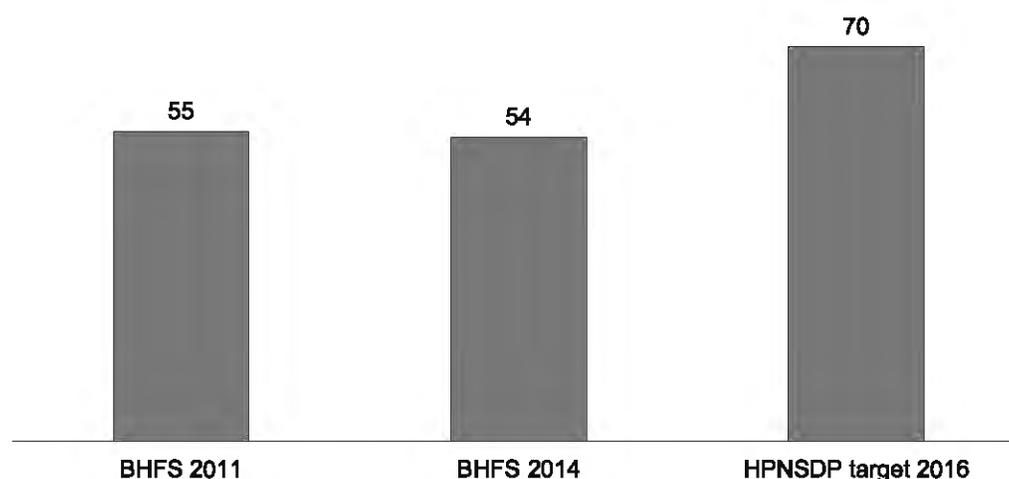
¹ National guidelines or any other guidelines on family planning

² The facility had at least one interviewed staff member providing the service who reports receiving in-service training in some aspect of family planning. The training must involve structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

³ A functioning digital blood pressure apparatus or else a manual sphygmomanometer with a stethoscope

The HPNSDP result framework developed an indicator to examine availability of four family planning commodities—pills, condoms, injectables, and IUCDs in public sector facilities, excluding the CCs and irrespective of whether the facility reported providing services related to the four specific methods. The assumption was that all public facilities (excluding CCs) are supposed to be providing services related to the four specified family planning methods. The results show that only 54 percent of public facilities (excluding CCs) had all four commodities available at the facility on the day of survey. The HPNSDP target for 2016 for this indicator is 70 percent (Figure 3.27).

Figure 3.27 HPNSDP Results Framework Indicator: Availability of contraceptives in public facilities: Percent of all public facilities except CCs with contraceptives (condom, pill, DMPA, IUCD) available on the day of the survey



3.4 ANTENATAL CARE SERVICES

3.4.1 Availability of ANC services

Antenatal care is the gateway towards many of the critical maternal, newborn, and child health care services. In most cases this is the first opportunity for a woman and a family to interact with the health system. Table 3.16 and Figure 3.28 show the availability of antenatal care (ANC) services by facility type. The table also provides information on how often these services are offered in Bangladesh health facilities and the availability of tetanus toxoid (TT) vaccine in facilities that offer ANC services.

Almost all facilities in Bangladesh (97 percent) offer ANC services (95 percent, excluding CCs). There is no variation in availability of ANC among the different facility types and managing authorities. Even at the lower level of availability, about 8 out of 10 private hospitals (79 percent) offer ANC services. Among facilities that offer ANC, 84 percent (83 percent, excluding CCs) do so five or more days per week.

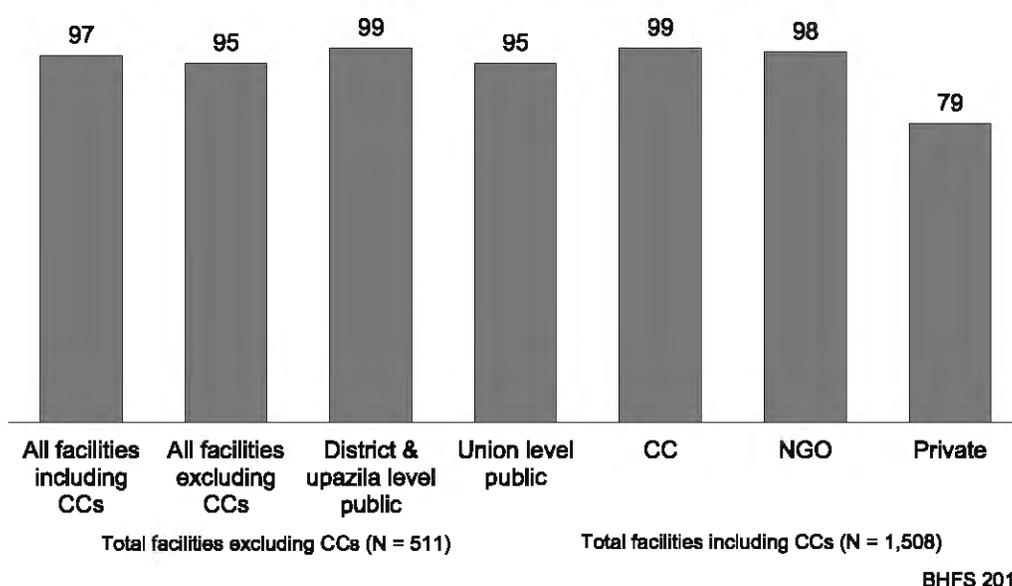
Table 3.16 Availability of antenatal care services

Among all facilities, the percentage offering antenatal care (ANC) services and, among facilities offering ANC services, the percentages offering the service on the indicated number of days per week, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities that offer ANC	Number of facilities	Percentage of facilities offering ANC where ANC services are offered the indicated number of days per week ¹			Tetanus toxoid vaccine every day ANC is offered	Offers tetanus toxoid vaccine	Number of facilities offering ANC
			1-2	3-4	5+			
Facility type								
District and upazila public facilities								
DH	99.1	47	2.3	2.2	95.0	42.4	62.7	47
MCWC	98.4	5	1.8	0.0	96.7	55.7	75.4	5
UHC	100.0	8	4.3	5.4	88.0	22.8	41.3	8
	99.0	35	2.0	1.8	98.2	44.7	65.5	34
Union level public facilities								
UHFWC	95.3	374	8.1	12.3	79.0	11.4	25.6	356
UHFWC (upgraded)	98.2	149	7.3	14.5	77.7	15.7	26.4	146
USC/RD	99.0	117	6.0	12.2	80.7	7.8	29.2	116
	87.3	108	12.0	9.1	78.9	9.1	19.8	94
Public community clinic	98.8	1,010	5.6	7.8	84.7	15.2	33.6	997
NGO clinic/hospital	97.9	81	3.0	2.9	93.5	36.3	62.6	79
Private hospital	78.5	36	6.2	5.6	86.2	22.3	43.2	28
Location								
Urban	92.7	130	4.0	3.8	92.0	36.5	59.2	121
Rural	97.8	1,418	6.2	8.8	83.5	14.7	32.1	1,387
Division								
Barisal	98.8	116	2.7	8.3	87.2	22.6	33.8	115
Chittagong	97.4	287	2.0	10.4	88.1	16.6	33.2	280
Dhaka	97.9	421	7.6	8.4	82.5	12.5	38.1	412
Khulna	98.7	197	6.5	10.1	79.6	28.4	49.3	191
Rajshahi	94.5	224	9.0	6.9	81.7	15.5	24.1	212
Rangpur	98.9	205	3.4	5.2	91.3	16.6	27.3	203
Sylhet	98.8	97	8.8	9.3	81.2	2.8	28.9	96
Total	97.4	1,548	6.0	8.4	84.1	16.4	34.3	1,508
Total excluding CCs	94.9	538	6.6	9.6	83.1	18.7	35.7	511

¹ Some facilities offer ANC services less often than one day per week, so the total percentage may be less than 100 percent.

Figure 3.28 Availability of ANC services in health facilities, by facility type



Among facilities offering ANC services, one-third (34 percent) report that they offer tetanus toxoid (TT) vaccination services. District and upazila-level public facilities and NGO facilities (each at 63 percent) are more likely than union-level public facilities (26 percent), CCs (34 percent), or private hospitals (43 percent) to offer TT vaccine. Among district and upazila-level public facilities, 75 percent of DHs and 66

percent of UHCs that offer ANC services also offer TT vaccine. MCWCs are less likely to offer TT vaccine than other district and upazila level facilities.

While about a third of ANC facilities offer TT vaccination services, only 16 percent offer TT vaccine every day that ANC is offered. Furthermore, 56 percent of DHs and 45 percent of UHCs that offer ANC provide TT vaccination services every day that ANC is offered.

3.4.2 Availability of Guidelines, Trained Staff, and Equipment

Availability of ANC service guidelines, appropriately trained providers, and certain supplies and equipment, including those for infection control, all contribute to the provision of quality services. In addition, the capacity to perform basic diagnostic tests and offer routinely dispensed medicines enhances the service. Fifty percent of facilities that offer ANC services (53 percent, excluding CCs) had guidelines on ANC available at the ANC service site on the day of the survey (Table 3.17). Among the different facility types, district and upazila-level public facilities (70 percent) and NGO facilities (73 percent) are more likely to have ANC guidelines compared with either union-level public facilities or CCs (each at 48 percent). Availability of ANC guidelines is lowest in private hospitals (25 percent). Urban facilities (61 percent) are more likely than rural facilities (49 percent) to have ANC guidelines. Facilities in Dhaka and Chittagong (around 40 percent each) are comparatively less likely than those in other divisions to have ANC guidelines, most likely because of a higher concentration of private facilities in these divisions.

Table 3.17 Guidelines, trained staff, and basic equipment for antenatal care services

Among facilities offering antenatal care (ANC) services, the percentage having guidelines, at least one staff member recently trained on ANC service delivery, and the indicated equipment observed to be available on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering ANC that have:				Equipment					Number of facilities offering ANC
	Guidelines on ANC ¹	Staff trained for ANC during the past 24 months ²	Staff trained for ANC at anytime ²	Blood pressure apparatus ³	Stethoscope	Adult weighing scale	Fetal stethoscope	Measuring tape ⁴	Examination bed or couch	
Facility type										
District and upazila public facilities	70.3	38.1	83.6	97.7	98.9	88.5	48.0	60.8	95.0	47
DH	72.1	54.1	85.2	98.4	98.4	91.8	50.8	72.1	96.7	5
MCWC	70.7	39.1	83.7	92.4	94.8	89.1	50.0	64.1	96.7	8
UHC	70.0	35.6	83.4	98.8	100.0	87.9	44.4	58.3	94.4	34
Union level public facilities	47.8	15.3	50.0	85.4	91.0	78.8	19.0	35.4	79.3	356
UHFWC	52.5	16.5	53.6	86.6	91.2	76.3	16.7	35.1	81.2	146
UHFWC (upgraded)	47.8	15.8	53.7	81.3	88.0	85.8	23.2	41.3	88.1	116
USC/RD	40.8	13.1	40.0	88.7	94.4	65.8	17.3	28.5	67.9	94
Public community clinic	48.2	31.3	48.3	85.5	91.2	84.2	8.5	32.7	74.1	997
NGO clinic/hospital	72.9	24.1	60.4	98.3	99.1	84.1	44.3	63.3	95.4	79
Private hospital	24.7	12.1	27.5	94.7	98.0	83.8	43.3	52.6	95.2	28
Location										
Urban	61.4	23.4	55.9	96.9	98.2	90.0	46.4	59.4	94.3	121
Rural	48.6	27.3	48.1	85.8	91.4	82.4	11.9	34.2	78.1	1,387
Division										
Barisal	56.3	22.9	38.5	83.0	89.8	86.7	11.6	41.2	72.5	115
Chittagong	38.5	38.5	57.2	84.1	86.3	86.1	7.0	27.5	74.2	280
Dhaka	39.9	30.4	57.8	84.3	92.1	70.5	15.7	33.4	70.1	412
Khulna	58.5	18.4	44.3	93.8	96.7	90.3	12.0	40.8	85.2	191
Rajshahi	48.9	16.0	35.9	83.8	93.7	84.2	8.1	32.4	77.7	212
Rangpur	70.7	20.9	39.5	96.1	98.1	91.1	29.1	50.4	88.1	203
Sylhet	60.1	38.4	54.3	81.7	88.0	89.5	25.9	36.3	91.4	96
Total	49.6	27.0	48.7	86.7	91.9	83.0	14.7	36.2	77.5	1,508
Total excluding CCs	52.5	18.6	53.5	89.1	93.4	80.8	26.7	43.0	84.1	511

Notes: The guidelines for ANC and staff trained in ANC comprise the training domain, and the blood pressure apparatus indicator comprises the equipment domain, for assessing readiness to provide ANC services within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ National ANC guidelines or other guidelines relevant to antenatal care

² Facility has at least one interviewed staff member providing ANC services who reports receiving in-service training in some aspect of antenatal care. The training must have involved structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

³ Functioning digital blood pressure apparatus or else a functioning manual sphygmomanometer and a stethoscope

⁴ For measuring fundal height

The survey also obtained information on whether facilities have a provider who received in-service training on antenatal care. Results show that about 50 percent of ANC facilities have at least one staff person who has received in-service ANC training. District and upazila-level public facilities (84 percent) and NGO facilities (60 percent) are more likely to have providers who have ever received ANC-related in-service training than union-level public facilities (50 percent), CCs (46 percent), and private hospitals (28 percent) (Table 3.17). If we consider whether facilities have staff with recent in-service training (in-service training in the last 24 months), then only one-fourth of facilities (27 percent) of ANC had at least one staff member with recent ANC-related in-service training.

As for equipment that might be used during physical examination, the great majority of facilities had a stethoscope (92 percent), blood pressure apparatus (87 percent), adult weighing scale (83 percent), and an examination bed or couch (78 percent), but fewer had measuring tape (36 percent) or fetal stethoscope (15 percent). When CCs are excluded from the analysis, the proportions change only slightly. For the equipment that is less widely available (for example, measuring tape), NGO facilities (63 percent) and district and upazila-level public facilities (61 percent) appear to be better equipped than other facilities. Looking more closely at district and upazila-level public facilities, DHs are comparatively better equipped (72 percent) than MCWCs (64 percent) and UHCs (58 percent) (Table 3.17).

3.4.3 Availability of Laboratory Tests

Having the capacity to perform basic laboratory tests on-site saves time for both the client and the provider. It also makes it much more likely that the client receives the test results and the provider can act on them. In general, the basic laboratory tests important to ANC are lacking in most facilities that offer ANC, ranging from a low of 1 percent having capacity to do blood grouping and Rhesus factor, to a high of 19 percent having the capacity for urine protein testing (Table 3.18). The number of CCs offering ANC services is large compared with other public sector facilities; however, only a few CCs have the capacity for laboratory testing. Thus, when CCs are excluded from the analysis, the percentage of facilities that offer hemoglobin, urine protein, urine glucose, or syphilis tests increases by 1.6 to 2.5 times. Looking a little more closely, in almost all cases, DHs, UHCs, NGO facilities, and private hospitals that offer ANC are much more likely than lower level public facilities to have the capacity for any of these basic tests. Also, urban facilities are much more likely than rural facilities to have the capacity to do these basic tests.

Table 3.18 Diagnostic capacity

Among facilities offering antenatal care (ANC) services, the percentages having the capacity to conduct the indicated tests in the facility, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering ANC that have the indicated tests					Number of facilities offering ANC
	Hemoglobin ¹	Urine protein ²	Urine glucose ³	Blood grouping and Rhesus factor ⁴	Syphilis ⁵	
Facility type						
District and upazila public facilities	70.2	68.1	66.4	6.6	41.5	47
DH	96.7	86.9	88.5	18.0	80.3	5
MCWC	28.3	33.7	32.6	0.0	7.6	8
UHC	75.6	73.0	70.6	6.4	43.3	34
Union level public facilities	7.9	12.0	7.8	0.0	1.4	356
UHFWC	10.7	13.2	9.5	0.0	2.4	146
UHFWC (upgraded)	3.6	10.1	4.7	0.0	0.0	116
USC/RD	6.6	12.5	9.0	0.0	1.5	94
Public community clinic	3.6	12.3	12.9	0.0	0.7	997
NGO clinic/hospital	69.3	75.1	76.3	6.0	40.3	79
Private hospital	87.2	78.5	80.5	6.6	72.7	28
Location						
Urban	72.5	73.4	73.3	5.1	47.7	121
Rural	6.4	13.8	13.1	0.3	1.9	1,387
Division						
Barisal	7.6	6.5	9.7	0.1	1.5	115
Chittagong	10.5	16.8	20.0	0.9	5.4	280
Dhaka	13.5	21.0	16.7	1.3	8.2	412
Khulna	5.1	12.4	12.6	0.5	3.1	191
Rajshahi	9.6	18.6	15.5	0.2	4.3	212
Rangpur	19.9	27.0	30.5	0.2	6.6	203
Sylhet	13.1	16.9	16.9	0.0	4.3	96
Total	11.7	18.5	17.9	0.6	5.5	1,508
Total excluding CCs	27.5	30.6	27.9	1.9	15.0	511

Note: The hemoglobin and urine protein measures presented in the table comprise the diagnostics domain for assessing readiness to provide ANC services within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ Capacity to conduct any hemoglobin test in the facility

² Dip sticks for urine protein

³ Dip sticks for urine glucose

⁴ Anti-A, anti-B, and anti-D reagents, plus an incubator, Coomb's reagent, and glass slides all present

⁵ Rapid test for syphilis or Venereal Disease Research Laboratory (VDRL) test or polymerase chain reaction (PCR) or rapid plasma reagin (RPR)

3.4.4 Availability of Medicines for Routine ANC

Some pregnant women should take iron supplements and/or folic acid to combat anemia and improve pregnancy outcomes; they should receive TT vaccine, if they are not yet covered. Table 3.19.1 reports on the availability of medicines and supplies essential for the provision of routine ANC services. As evident from the table, medicines for the provision of routine ANC are widely available in facilities that offer ANC services. With the exception of TT vaccines (available in 19 percent of facilities), medicines such as iron tablets (96 percent) and folic acid (94 percent) are almost universally available in all facilities that offers ANC. Private hospitals are slightly less likely to have indicated medicines for ANC than public sector and NGO facilities.

Table 3.19.1 Availability of medicines for routine antenatal care

Among facilities offering antenatal care (ANC) services, percentages with essential medicines and tetanus toxoid vaccine for ANC observed to be available on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering ANC that have indicated medicines					Number of facilities offering ANC
	Iron tablets	Folic acid tablets	Combined iron and folic acid	Iron or folic acid tablets	Tetanus toxoid vaccine	
Facility type						
District and upazilla public facilities	99.1	98.6	95.2	99.1	60.0	47
DH	100.0	95.1	95.1	100.0	75.4	5
MCWC	96.7	96.7	94.6	96.7	30.4	8
UHC	99.5	99.5	95.4	99.5	64.3	34
Union level public facilities	97.3	95.8	90.5	97.3	12.0	356
UHFWC	97.7	96.1	92.7	97.7	14.9	146
UHFWC (upgraded)	95.7	94.5	91.7	95.7	7.6	116
USC/RD	98.5	96.7	85.4	98.5	12.9	94
Public community clinic	95.4	93.5	87.5	95.4	16.5	997
NGO clinic/hospital	94.8	94.8	90.6	94.8	46.0	79
Private hospital	79.7	80.4	78.4	81.7	52.7	28
Location						
Urban	92.1	92.1	88.5	92.6	52.4	121
Rural	96.0	94.2	88.4	96.0	16.1	1,387
Division						
Barisal	98.4	96.4	97.0	98.4	20.2	115
Chittagong	93.2	92.0	64.9	93.2	14.8	280
Dhaka	95.7	92.8	64.3	95.9	24.1	412
Khulna	91.5	90.5	87.7	91.5	35.8	191
Rajshahi	97.2	96.8	92.8	97.2	11.6	212
Rangpur	100.0	100.0	93.6	100.0	13.0	203
Sylhet	94.7	88.0	86.8	94.7	3.3	96
Total	95.7	94.0	88.4	95.7	19.0	1,508
Total excluding CCs	96.1	95.0	90.3	96.2	23.9	511

Note: The medicines and vaccines presented in the table comprise the medicines and commodities domain for assessing readiness to provide ANC services within the health facility assessment methodology proposed by WHO and USAID (2012).

3.4.5 Readiness of Health Facilities to provide ANC Services

The 2014 BHFS obtained information to assess readiness of health facilities to provide ANC services. Readiness is measured based on the availability of WHO recommended items/tracer indicators that are necessary to offer quality ANC services. In estimating ANC service readiness for this report, the survey adopted a slightly less restrictive and Bangladesh-context-appropriate version of tracer indicators. The following six items/tracer indicators must be available at health facilities for ANC service:

- **Trained staff:** At least one provider of ANC ever receiving in-service training on ANC
- **Guidelines:** National or other ANC guidelines at the facility
- **Equipment:** Blood pressure apparatus
- **Diagnostic capacity:**
 - Hemoglobin test
 - Urine protein test
- **Medicines:** Iron or folic acid tablet

Table 3.19.2 and Figure 3.29 show how Bangladesh health facilities are doing in terms of readiness to provide quality ANC services. Bangladesh health facilities are doing pretty well in terms of availability of iron or folic acid tablets and blood pressure apparatus. However, only half of the facilities had staff with in-service training focused on ANC. While the staff might have been oriented on ANC during their basic training, in-service training is still important, to keep providers up-to-date. Moreover, ANC guidelines are available in half of the facilities for the use of ANC service providers. A very small percentage of facilities have the capacity to provide a hemoglobin or urine protein test, 12 percent and 19 percent respectively. However, when CCs are excluded from the analysis, the percentage of facilities with the capacity to provide

these two tests increases to 28 and 31 percent. Mothers in Bangladesh are suffering from anemia, and it is estimated that one in five maternal deaths are due to pre-eclampsia/eclampsia. To detect these conditions, hemoglobin and urine protein testing are extremely useful. The facilities providing antenatal care are not adequately prepared to detect these pregnancy-related risk conditions.

Table 3.19.2 Readiness items of facilities for providing ANC services

Among facilities offering antenatal care (ANC) services, the percentages having the indicated items considered important for the provision of quality ANC services, by background characteristics, Bangladesh HFS 2014

Background characteristics	Guidelines on ANC ¹	Staff trained for ANC any time ²	Blood pressure apparatus ³	Hemoglobin testing capacity	Urine protein testing capacity	Iron or folic acid tablets	All six items	Number of facilities offering ANC
Facility type								
District and upazila public facilities								
DH	70.3	83.6	97.7	70.2	68.1	99.1	41.5	47
MCWC	72.1	85.2	98.4	98.7	86.9	100.0	55.7	5
UHC	70.7	83.7	92.4	28.3	33.7	96.7	15.2	8
	70.0	83.4	98.8	75.6	73.0	99.5	45.3	34
Union level public facilities								
UHFWC	47.8	50.0	85.4	7.9	12.0	97.3	3.3	356
UHFWC (upgraded)	52.5	53.6	86.6	10.7	13.2	97.7	3.5	146
USC/RD	47.8	53.7	81.3	3.6	10.1	95.7	1.6	116
	40.8	40.0	88.7	8.8	12.5	98.5	5.1	94
Public community clinic								
	48.2	48.3	85.5	3.6	12.3	95.4	0.6	997
NGO clinic/hospital								
	72.9	60.4	98.3	69.3	75.1	94.8	32.6	79
Private hospital								
	24.7	27.5	94.7	87.2	78.5	81.7	8.1	28
Location								
Urban	61.4	55.9	98.9	72.5	73.4	92.6	28.8	121
Rural	48.6	48.1	85.8	6.4	13.8	96.0	2.2	1,387
Division								
Barisal	56.3	38.5	83.0	7.6	8.5	98.4	2.2	115
Chittagong	38.5	57.2	84.1	10.5	18.8	93.2	3.9	280
Dhaka	39.9	57.8	84.3	13.5	21.0	95.9	5.4	412
Khulna	58.5	44.3	93.8	5.1	12.4	91.5	1.7	191
Rajshahi	46.9	35.9	83.8	9.8	18.6	97.2	5.1	212
Rangpur	70.7	39.5	96.1	19.9	27.0	100.0	5.2	203
Sylhet	60.1	54.3	81.7	13.1	18.9	94.7	5.9	98
Total	49.6	48.7	88.7	11.7	18.5	95.7	4.3	1,508
Total excluding CCs	52.5	53.5	89.1	27.5	30.6	96.2	11.6	511

Note: The guidelines for ANC and staff trained in ANC comprise the training domain, and the blood pressure apparatus indicator comprises the equipment domain, for assessing readiness to provide ANC services within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ National ANC guidelines or other guidelines relevant to antenatal care

² Facility has at least one interviewed staff member providing ANC services who reports receiving in-service training in some aspect of antenatal care. The training must have involved structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

³ Functioning digital blood pressure apparatus or else a functioning manual sphygmomanometer and a stethoscope

As evident in the table, the percentages of facilities providing the individual services are quite good; however, only a few facilities are able to provide all the services. While 95 percent of facilities provide ANC services, among them only 4 percent can be considered ready to provide quality ANC in terms of having all the six items. There is only a marginal increase to 12 percent when CCs are excluded from the analysis. This very low level of service readiness is due to health facilities' lack of capacity to test for hemoglobin or urine protein. District and upazila-level public health facilities and NGO facilities are most likely to be ready to provide ANC services. Surprisingly, only 8 percent of private facilities can be considered ready to provide quality ANC services (Table 3.19.2 and Figure 3.30).

Figure 3.29 Availability of items/tracer indicators in health facilities for readiness to provide ANC services

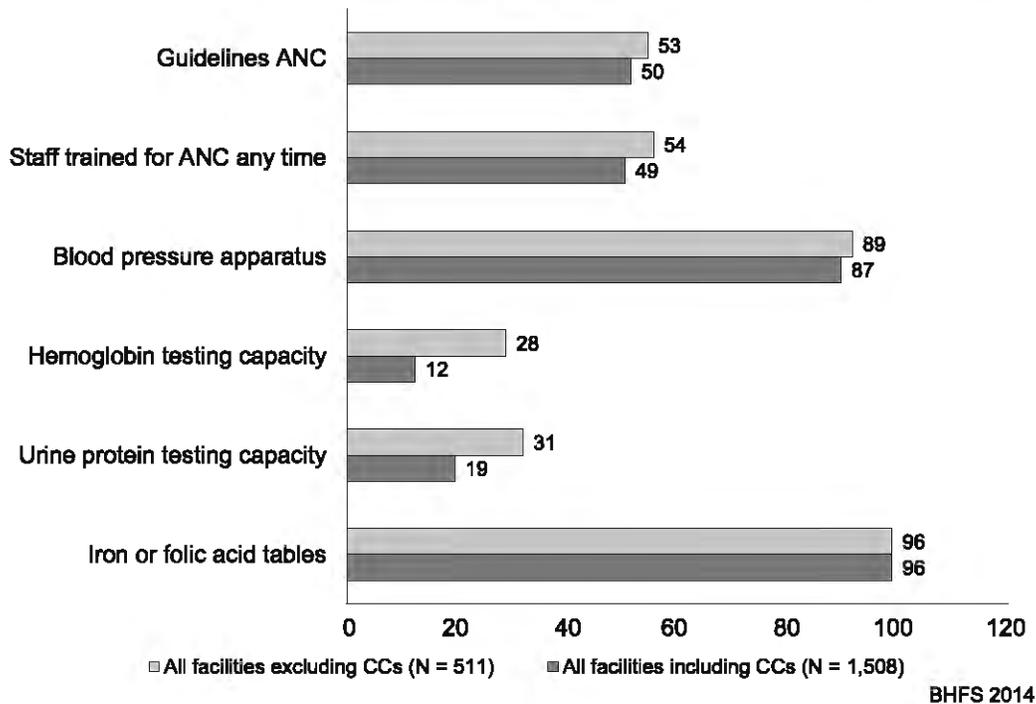
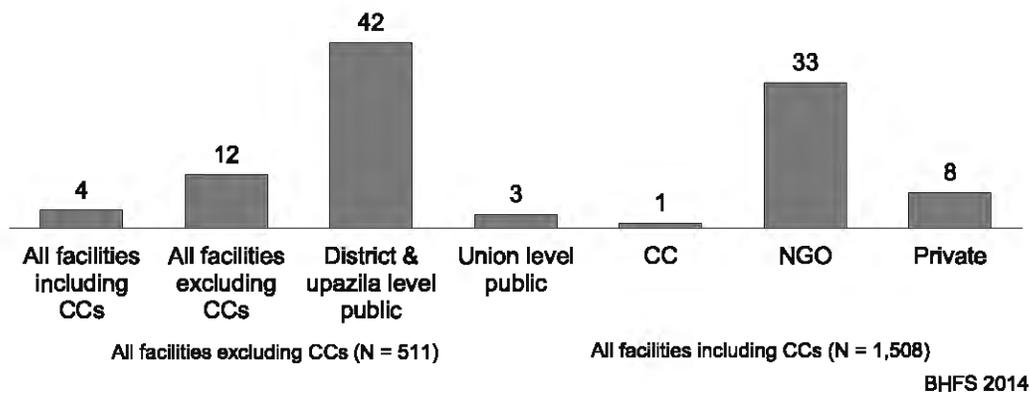


Figure 3.30 Readiness of health facilities to provide ANC services, by facility type



3.5 DELIVERY AND NEWBORN CARE SERVICES

Table 3.20 and Figure 3.31 provide information on the availability of various maternal health services. Overall, normal delivery services are available in one out of five (18 percent) health facilities, increasing to 39 percent when CCs are excluded from the analysis. These services are almost exclusively available in DHs (98 percent), UHCs (97 percent), private hospitals (93 percent), and MCWCs (90 percent). Less than 50 percent of upgraded union level facilities are offering normal delivery, while 7 percent of CCs are providing this service. Only 3 out of 10 NGO facilities offer normal delivery services. Urban facilities (63 percent), as one might expect, are much more likely than rural facilities (14 percent) to offer normal delivery services.

Table 3.20 Availability of maternal health services

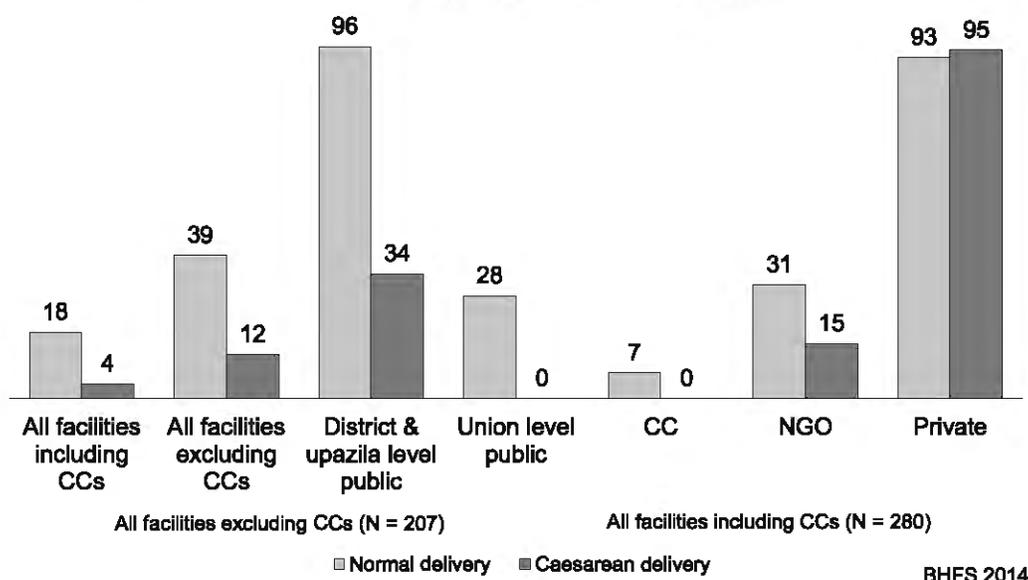
Among all facilities, the percentages offering specific maternity services and the full range of maternity services and, among facilities that offer normal delivery services, the percentages having a skilled provider available on-site or on-call 24 hours a day to conduct deliveries, with or without an observed duty schedule, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering:					Number of facilities	Percentage of facilities offering normal delivery services that have:		
	Antenatal care (ANC)	Normal delivery service	Cesarean delivery	ANC and normal delivery service	ANC, normal delivery, and cesarean delivery		Provider of delivery care available on-site or on-call 24 hours/day, with observed duty schedule	Provider of delivery care available on-site or on-call 24 hours/day, with or without observed duty schedule	Number of facilities offering normal delivery services
Facility type									
District and upazila public facilities	99.1	95.7	33.8	95.6	33.4	47	88.7	96.3	45
DH	98.4	98.4	98.4	96.8	95.2	5	93.4	96.7	5
MCWC	100.0	90.2	55.4	90.2	55.4	8	77.1	90.4	7
UHC	99.0	98.6	19.5	96.6	19.5	35	90.3	97.5	34
Union level public facilities	95.3	27.7	0.0	27.7	0.0	374	7.1	40.1	103
UHFWC	98.2	24.5	0.0	24.5	0.0	149	5.8	34.9	36
UHFWC (upgraded)	99.0	47.2	0.0	47.2	0.0	117	9.1	43.5	55
USC/RD	87.3	10.9	0.0	10.9	0.0	108	2.0	40.7	12
Public community clinic	98.8	7.2	0.0	7.2	0.0	1,010	6.2	29.3	73
NGO clinic/hospital	97.9	30.8	14.9	30.8	14.9	81	61.6	79.7	25
Private hospital	78.5	93.2	95.2	76.2	75.0	36	54.5	98.6	33
Location									
Urban	92.7	63.1	44.8	58.4	39.1	130	72.8	94.8	82
Rural	97.8	14.0	0.3	14.0	0.3	1,418	13.1	41.1	198
Division									
Barisal	98.8	13.0	1.8	13.0	1.7	116	39.5	67.4	15
Chittagong	97.4	20.0	4.6	19.5	4.0	287	28.7	52.9	58
Dhaka	97.9	23.0	6.3	22.2	5.3	421	28.3	70.5	97
Khulna	96.7	12.6	3.6	12.4	3.2	197	34.0	46.4	25
Rajshahi	94.5	15.7	2.0	15.7	2.0	224	20.6	35.1	35
Rangpur	98.9	18.1	2.0	16.1	2.0	205	44.9	58.1	33
Sylhet	98.8	16.1	4.9	17.3	4.0	97	30.3	42.4	18
Total	97.4	18.1	4.0	17.7	3.5	1,548	30.6	56.9	280
Total excluding CCs	94.9	38.5	11.5	37.4	10.2	538	39.2	66.6	207

As expected, only a very small proportion of facilities (4 percent) provide Cesarean delivery services. When CCs are excluded from the analysis, still only 1 in 10 facilities provides Cesarean delivery. One-third of district and upazila-level public facilities compared with 15 percent of NGO facilities and 95 percent of private hospitals offer Cesarean delivery services. At public facilities Cesarean deliveries are not provided at facilities below the upazila level. Among public facilities, 98 percent of DHs, 55 percent of MCWCs, and 20 percent of UHCs offer Cesarean delivery services (Table 3.20). A notable proportion of private facilities provide delivery services but not antenatal care.

Among facilities that offer normal delivery services, a little over half (57 percent) reported that they have a provider of delivery care available on-site or on-call 24 hours/day (Table 3.20). However, when a duty schedule is also assessed, only 31 percent of facilities that offer normal delivery had a provider of delivery care available, either on-site or on-call, and also had a duty schedule available. DHs (93 percent) and UHCs (90 percent) are more likely than other facilities to have providers on-site or on-call and also more likely to have a 24-hour duty schedule (Table 3.20).

Figure 3.31 Availability of maternal health service in health facilities, by facility type



3.5.1 Availability of Guidelines, Trained Staff, and Equipment for Delivery Services

The quality of delivery services depends partly on the availability of guidelines, staff with up-to-date training, and certain basic equipment. Table 3.21 reports the extent to which these items were available on the day of the survey in facilities that offer normal delivery services. Availability of guidelines related to delivery is generally low (27 percent) in facilities that offer normal delivery services. However, DHs (41 percent), MCWCs (39 percent), and UHCs (41 percent), are slightly more likely than other facility types to have guidelines.

Only 1 in 10 facilities that offer normal delivery have providers who had received in-service training in IMPAC during the past 24 months (recent), while 4 in 10 facilities that offer normal delivery have at least one provider who ever received in-service training in IMPAC. Among all facilities, district and upazila-level public facilities and NGO facilities are more likely to have a provider who had ever received in-service training than union-level public facilities, CCs, and private facilities.

About one-third of facilities (33 percent) have emergency transport, with the percentage increasing to 41 percent when CCs are excluded from the analysis. DHs (93 percent), UHCs (85 percent), MCWCs (68 percent), and private hospitals (69 percent) are more likely to have emergency transport compared with NGO facilities (58 percent).

Also, about 6 in 10 facilities had a delivery pack available on the day of the survey visit. That is either the facility had a sterile delivery pack available at the delivery site, or else all the following individual equipment were present: cord clamp, episiotomy scissors, scissors or blade to cut cord, suture material, and needle holder. Eighty percent or more of DHs, MCWCs, UHCs, and private hospitals that offer normal delivery services had a delivery pack available. NGO facilities are only slightly less likely to have one, at 74 percent.

A suction apparatus (mucus extractor) was less widely available, with only 48 percent of facilities that offer delivery services having one available at the service site on the day of visit. DHs (95 percent) are more likely than all other facility types to have a suction apparatus.

A neonatal bag and mask were available in 46 percent of facilities. Availability across facility types is similar to availability of suction apparatus, with DHs being more likely than other facility types to have them.

Table 3.21 Guidelines, trained staff, and equipment for delivery services

Among facilities offering normal delivery services, the percentages having guidelines, at least one staff member recently trained in delivery care, and basic equipment for routine delivery available in the facility on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering normal delivery service that have:					Equipment							Number of facilities offering normal delivery services
	Guidelines on IMPAC ¹	Staff trained in IMPAC during the past 24 months ²	Staff trained in IMPAC at anytime ²	Emergency transport ³	Examination light ⁴	Delivery pack ⁵	Suction apparatus (mucus extractor)	Manual vacuum extractor	Vacuum aspirator or D&C kit ⁶	Neonatal bag and mask	Partograph ⁷	Gloves ⁸	
Facility type													
District and upazila public facilities	40.5	18.4	55.0	83.4	82.1	80.5	75.7	51.9	56.8	79.5	47.3	87.8	45
DH	41.0	23.0	60.7	93.4	95.1	83.6	95.1	80.7	73.8	90.2	59.0	88.5	5
MCWC	38.6	20.5	69.9	67.5	86.7	81.9	74.7	48.2	65.1	71.1	59.0	83.1	7
UHC	40.8	17.3	51.0	85.2	79.1	79.7	73.0	51.4	52.6	79.6	43.1	88.6	34
Union level public facilities	28.1	7.3	35.6	8.5	47.6	49.9	38.7	15.2	15.5	34.7	17.1	69.9	103
UHFWC	34.2	10.1	38.5	13.8	51.9	60.9	33.5	12.6	18.4	31.5	14.3	67.6	36
UHFWC (upgraded)	19.9	6.6	30.7	8.8	43.5	48.5	38.5	16.4	13.4	37.8	19.0	73.5	55
USC/RD	30.0	1.7	49.6	0.0	54.3	32.2	56.2	17.8	15.8	29.9	16.4	59.7	12
Public community clinic	27.4	1.3	30.2	10.2	60.2	45.3	22.6	7.7	12.7	22.2	15.4	56.5	73
NGO clinic/hospital	27.9	27.8	58.2	57.6	90.4	74.2	73.5	35.9	43.2	71.0	39.9	87.4	25
Private hospital	11.3	7.9	20.3	69.2	88.2	80.8	74.0	44.5	55.2	71.3	30.5	74.1	33
Location													
Urban	24.1	16.5	41.6	76.2	87.3	76.8	77.7	45.6	54.0	74.9	40.3	81.6	82
Rural	28.4	6.5	35.9	14.6	55.9	52.3	35.4	15.8	18.1	34.4	18.9	67.1	198
Division													
Barisal	32.7	15.2	29.2	32.3	43.7	54.8	41.6	23.1	28.8	48.9	26.7	83.2	15
Chittagong	28.0	14.9	37.2	32.6	55.0	49.5	49.1	30.2	36.2	43.6	17.8	68.2	58
Dhaka	25.8	8.0	45.4	37.2	67.9	60.8	55.1	19.0	22.1	47.2	29.6	59.2	97
Khulna	21.2	13.8	44.2	45.4	74.0	47.1	56.2	21.8	34.9	51.3	29.2	82.0	25
Rajshahi	10.8	2.6	14.8	17.4	48.8	58.3	28.2	16.4	12.5	28.7	13.6	63.2	35
Rangpur	56.2	4.8	39.6	22.2	93.5	89.8	49.8	41.1	48.4	62.9	35.1	98.2	33
Sylhet	20.5	11.1	34.9	40.5	72.2	52.1	32.4	26.1	29.4	44.2	22.1	96.1	18
Total	27.2	9.4	37.5	32.7	65.1	59.5	47.8	24.5	28.6	46.3	25.2	71.4	280
Total excluding CCs	27.1	12.3	40.1	40.6	66.8	64.5	56.7	30.5	34.2	54.8	28.6	76.6	207

Note: The indicators presented in this table comprise the staff and training and equipment domains for assessing readiness to provide delivery care within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ IMPAC (integrated management of pregnancy and childbirth) guidelines, or BEmOC (basic emergency obstetric care) guidelines, or CEmOC (comprehensive emergency obstetric care) guidelines

² Facility has at least one interviewed staff member providing the service who reports receiving in-service training in IMPAC or CEmOC. The training must have involved structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

³ Facility had a functioning ambulance or other vehicle for emergency transport stationed at the facility and had fuel available on the day of the survey, or facility has access to an ambulance or other vehicle for emergency transport that is stationed at another facility or that operates from another facility.

⁴ A functioning flashlight is acceptable.

⁵ Either the facility had a sterile delivery pack available at the delivery site or else all the following individual equipment must be present: cord clamp, episiotomy scissors, scissors (or blade) to cut cord, suture material with needle, and needle holder.

⁶ Facility had a functioning vacuum aspirator or else a dilation and curettage (D&C) kit available.

⁷ A blank partograph at the service site

⁸ Disposable latex gloves or equivalent available at the service site

3.5.2 Availability of Medicines and Commodities for Normal Delivery Services

Table 3.22 provides information on the availability of essential medicines and commodities for delivery care. Overall, these essential medicines are available in only 22 percent to 36 percent of facilities that offer normal delivery services. However, the availability of essential medicines improves slightly when CCs are excluded from the analysis. For example, among the essential medicines for delivery care, injectable uterotonic (oxytocin) was available in only one-third (34 percent) of facilities that offer normal delivery services. Looking at individual facility types, availability of an injectable uterotonic is similar in DHs and private hospitals, each at over 80 percent. Availability is also similar in MCWCs, UHCs, and NGO facilities, each at around 62 percent. Availability is much lower in the other facility types.

Injectable magnesium sulphate and injectable diazepam were available on the day of the survey in 22 and 28 percent, respectively, of all facilities offering normal delivery care. Availability is similar to that of oxytocin, whereby DHs and private hospitals (at 59 percent and 64 percent, respectively) are more likely than MCWCs (31 percent), UHCs (37 percent) and NGO facilities (48 percent) to have injectable magnesium sulphate available. The other facility types are much less likely to have them.

Injectable antibiotics were available in 33 percent of facilities. Injectable antibiotics are much more likely to be available in DHs (82 percent) and private hospitals (76 percent) than in other facility types. Looking individually at the availability of essential medicines, when CCs are excluded from analysis, the percentages increase for all essentials medicines.

Table 3.22 Medicines and commodities for delivery

Among facilities offering normal delivery services, the percentages with essential medicines and commodities for delivery care, and priority medicines for mothers observed to be available on the day of the survey, by background characteristics, Bangladesh HFS 2014

Medicines	Facility type											Total	Total excluding CCs
	District and upazila public facilities	DH	MCWC	UHC	Union level public facilities	UHF WC (up-graded)	USC/RD	Public community clinic	NGO clinic/hospital	Private hospital	Total		
Essential medicines for delivery¹													
Injectable uterotonic (oxytocin) ²	64.1	83.6	62.7	61.5	11.4	16.8	6.8	16.3	17.1	61.7	81.6	34.2	40.3
Injectable antibiotic ³	69.3	82.0	44.6	72.4	8.5	18.6	0.2	16.4	13.0	64.2	76.3	32.5	39.4
Injectable magnesium sulphate ²	38.7	59.0	31.3	37.1	6.8	8.8	5.7	6.1	5.3	47.5	63.9	22.0	27.9
Injectable diazepam	60.9	83.6	59.0	57.9	1.9	5.1	0.0	1.2	5.3	68.5	83.7	28.0	36.0
Skin disinfectant	47.1	59.0	49.4	44.8	14.9	16.2	15.5	6.2	0.9	64.9	63.6	26.7	35.8
Intravenous fluids with infusion set ⁴	74.9	78.7	66.3	76.1	5.1	7.4	2.0	12.5	17.9	70.1	89.8	35.6	41.8
Priority medicines for mothers⁵													
Sodium chloride injectable solution	72.3	86.9	51.8	74.3	11.9	17.4	5.6	24.7	26.5	64.4	76.8	39.6	44.3
Injectable calcium gluconate	13.0	19.7	9.6	12.6	5.5	12.3	2.2	0.0	5.0	33.9	60.6	15.6	19.4
Ampicillin powder for Injection	22.0	24.6	8.4	24.4	5.3	12.4	1.8	0.0	5.3	21.9	45.2	14.2	17.3
Injectable metronidazole	38.2	65.6	28.9	35.9	0.1	0.3	0.0	0.0	0.0	53.9	72.2	19.6	26.5
Misoprostol capsules or tablets	32.8	44.3	54.2	26.7	20.5	30.2	12.4	29.2	14.4	54.2	59.0	26.5	33.4
Azithromycin capsules or tablets or oral liquid	61.2	80.3	20.5	66.7	9.8	17.1	3.2	18.2	5.3	83.0	74.4	31.1	40.3
Cefixime capsules or tablets	40.9	72.1	16.9	41.2	4.6	6.3	2.3	10.1	7.7	79.8	70.6	25.8	32.2
Benzathine benzyl penicillin powder for Injection	13.9	16.4	8.4	14.6	5.4	6.3	3.1	7.4	6.1	16.1	36.8	11.7	13.6
Injectable bethamethasone/dexamethasone	41.3	55.7	18.1	43.9	0.0	0.0	0.0	0.0	0.0	56.7	72.6	20.4	27.5
Nifedipine capsules or tablets	13.3	32.8	4.8	12.2	0.0	0.0	0.0	0.0	0.0	20.9	62.4	11.4	15.5
Number of facilities offering normal delivery services	45	5	7	34	103	36	55	12	73	25	33	280	207

Notes: The essential medicines presented in this table comprise the medicines domain for assessing readiness to provide basic obstetric care within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ All essential medicines for delivery were assessed and must be available at the service delivery site.

² Injectable uterotonic (e.g., oxytocin) and injectable magnesium sulphate are also classified as priority medicines for mothers.

³ Injectable penicillin, injectable gentamycin, injectable ampicillin, or injectable ceftriaxone

⁴ Normal saline solution, lactated Ringer's solution, or 5% dextrose solution

⁵ The priority medicines for mothers are defined by WHO; the list is published at <http://www.who.int/medicines/publications/A4prioritymedicines.pdf>

3.5.3 Availability of Priority Medicines for Mothers

Table 3.22 also provides information on availability of priority medicines for mothers, as defined by WHO. As with essential medicines, these priority medicines are in general not widely available, and they are much more likely to be available in higher level facilities than in lower level facilities.

3.5.4 Availability of items for Infection Control during provision of delivery care

Infection control is vital during delivery care. Among facilities that offer normal delivery services, three-quarters (77 percent) had soap and running water or else alcohol-based hand disinfectant available at the service site, with the percentages increasing to 84 percent when CCs are excluded from the analysis (Table 3.23). These items are almost universally available in district and upazila-level public facilities, NGO facilities, and private hospitals that offer normal delivery services (94 percent, 95 percent, and 98 percent, respectively) compared with 72 percent of union-level public facilities. Among public facilities, DHs, MCWCs, and UHCs are almost equally likely to have soap and running water or else alcohol-based hand disinfectant (95 percent).

Latex gloves were available, in general, in 7 out of 10 facilities. District and upazila-level public facilities and NGO facilities are slightly more likely than either private hospitals or union level public facilities (88 percent and 87 percent vs. 74 percent and 70 percent, respectively) to have latex gloves. DHs, MCWCs, and UHCs compare favorably with NGO facilities in availability of latex gloves.

Two-thirds of facilities (66 percent) had a sharp container available at the service site on the day of the survey. Half of the facilities (48 percent) had a waste receptacle with plastic bin liner. Availability of a waste receptacle with a plastic bin liner varies across all types of facilities.

Table 3.23 Items for infection control during provision of delivery care

Among facilities offering normal delivery services, the percentages with indicated items for infection control observed to be available at the service site on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities offering normal delivery services that have items for infection control								Number of facilities offering normal delivery services
	Soap	Running water ¹	Soap and running water	Alcohol-based hand disinfectant	Soap and running water or else alcohol-based and disinfectant	Latex gloves ²	Sharps container	Waste receptacle ³	
Facility type									
District and upazila public facilities	94.8	92.3	90.5	63.8	93.5	87.8	73.5	62.6	45
DH	96.7	96.7	93.4	65.6	95.1	88.5	80.3	83.6	5
MCWC	97.6	92.8	92.8	83.9	95.2	83.1	77.1	50.6	7
UHC	93.9	91.6	89.5	83.5	92.9	88.6	71.8	61.9	34
Union level public facilities	88.4	67.4	62.0	39.9	72.2	69.9	60.2	36.1	103
UHFWC	89.1	62.6	62.6	40.1	70.6	67.6	69.2	35.6	36
UHFWC (upgraded)	87.2	69.4	80.4	38.0	71.9	73.5	53.0	35.6	55
USC/RD	91.9	72.8	67.6	48.2	78.8	59.7	66.4	40.0	12
Public community clinic	82.4	48.1	48.1	36.1	56.0	56.5	65.6	43.6	73
NGO clinic/hospital	95.4	92.6	90.4	70.4	95.4	87.4	72.2	60.4	25
Private hospital	97.6	94.9	94.9	73.8	97.6	74.1	70.9	68.0	33
Location									
Urban	95.3	93.5	91.4	69.6	95.4	81.6	73.0	65.1	82
Rural	87.2	63.0	60.3	41.9	68.7	67.1	63.3	41.3	198
Division									
Barisal	94.8	63.5	63.5	41.4	70.5	83.2	61.0	41.7	15
Chittagong	80.6	63.5	60.8	38.4	71.4	66.2	67.7	37.9	58
Dhaka	89.5	73.6	70.6	45.9	75.9	59.2	65.7	63.3	97
Khulna	65.8	61.5	71.0	47.6	74.7	82.0	58.7	38.6	25
Rajshahi	95.8	65.5	65.5	61.6	70.1	83.2	57.4	34.8	35
Rangpur	94.8	64.5	64.5	66.9	84.8	96.2	82.2	55.3	33
Sylhet	98.8	73.4	73.4	32.3	83.3	96.1	65.6	33.1	18
Total	69.8	71.9	69.4	50.0	76.5	71.4	66.1	48.3	280
Total excluding CCs	92.1	80.3	76.9	54.2	83.7	76.6	66.3	50.0	207

¹ Piped water, water in bucket with specially fitted tap, or water in pour pitcher

² Non-latex equivalent gloves are acceptable.

³ Waste receptacle with plastic bin liner

3.5.5 Signal Functions for Emergency Obstetric Care

Complications of labor and delivery can be expected to occur in a certain percentage of deliveries. It is said that approximately 15 percent of mothers develop life-threatening complications at the time of delivery, even if they are otherwise normal during the antenatal period. In such situations, special care is needed; that care is called Emergency Obstetric and Neonatal Care (EmONC). EmONC comprises nine signal functions layered in three levels: obstetric first aid, Basic EmONC, and Comprehensive EmONC. It is usually not possible to predict which women will experience complications, however. Therefore, facilities that offer normal delivery care should be prepared to provide the most important interventions—EmONC signal function—to manage complications when they occur. These signal functions reflect the responsiveness of the health services to the main obstetric complications at basic and comprehensive levels, which correspond roughly to the health center level and the level of the first-referral hospital. Table 3.24 and Figure 3.32 report on the performance of the signal functions in facilities that offer normal delivery services. Facilities are considered Basic Emergency Obstetric and Neonatal care (BEmONC) facilities if they provide the first seven signal functions over a designated three-month period and are considered Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) facilities if they provide all nine signal functions over a designated three-month period.

Each of the facilities that provide normal delivery care was asked whether they had performed any number of the nine signal functions at least once during the three months preceding the survey. More than half of the facilities administered parental oxytocin in the three months preceding the survey while 45 percent of facilities administered antibiotics and 30 percent of facilities administered parenteral anticonvulsants in the three months preceding the survey. For each of these signal functions, DHs, MCWCs, UHCs, NGO facilities, and private hospitals are more likely to have administered the signal function than other facility types.

Blood transfusion and cesarean delivery, as expected, are rare. Among facility types, DHs (90 percent) and private hospitals (57 percent) that offer normal delivery services transfused blood in an obstetric context during the three months preceding the survey.

Thirteen percent of facilities offering normal delivery performed all seven signal functions in the three months prior to the survey and can be considered BEmONC facilities. Excluding CCs from the analysis, still less than 20 percent (17 percent) of facilities in Bangladesh that offer normal delivery services are BEmONC facilities. One third of district and upazila level public facilities (including 53 percent of district hospitals) and private hospitals performed all seven signal functions for emergency obstetric care. A slightly lower proportion (28 percent) of NGO facilities offering normal delivery can be considered BEmONC facilities. Urban areas are eight times more likely to have BEmONC facilities than rural areas.

The percentage of health facilities that offer normal delivery and that are CEmONC facilities (that is, they perform all nine signal functions for emergency obstetric care) is very low—only 4 percent. Excluding the CCs, this percentage barely improves to 6 percent only. Half (49 percent) of DHs offering normal delivery can be considered CEmONC facilities, but only 6 percent and 5 percent of MCWCs and UHCs, respectively, can be considered so. Very few private hospitals and NGO facilities offering normal delivery are CEmONC facilities (16 percent and 9 percent, respectively).

Table 3.24 Signal functions for emergency obstetric care

Among facilities offering normal delivery services, percentages reporting that they performed the signal functions for emergency obstetric care at least once during the three months before the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities that applied parenteral:				Percentage of facilities that carried out:						Number of facilities offering normal delivery services		
	Antibiotics	Oxytocic	Anticonvulsant	Assisted vaginal delivery	Manual removal of placenta	Removal of retained products of conception (MVA)	Neonatal resuscitation	Blood transfusion	Caesarean delivery	Percentage having 3 signal functions ¹		Percentage having 7 signal functions ²	Percentage having all 9 signal functions ³
Facility type													
District and upazilla public facilities	87.1	84.8	58.3	82.1	78.7	66.2	71.5	24.5	34.4	54.3	36.0	9.8	45
DH	95.1	90.2	78.7	85.2	93.4	80.3	78.7	90.2	96.7	75.4	52.5	49.2	5
MCWC	79.5	85.5	48.2	74.7	72.3	55.4	66.3	9.6	60.2	42.2	22.9	6.0	7
UHC	87.4	83.9	57.3	83.1	77.8	66.3	71.5	17.8	19.7	53.8	36.3	4.7	34
Union level public facilities	31.1	38.5	13.5	38.8	27.7	18.4	30.8	0.0	0.0	10.4	1.4	0.0	103
UHFWC	32.8	36.8	13.7	26.6	23.0	18.8	22.3	0.0	0.0	11.4	0.0	0.0	36
UHFWC (upgraded)	29.0	38.1	14.3	43.2	24.8	18.2	33.5	0.0	0.0	10.1	0.9	0.0	55
USC/RD	36.2	45.7	9.0	53.9	56.0	33.5	44.5	0.0	0.0	9.0	7.9	0.0	12
Public community clinic	9.6	24.1	18.5	27.4	20.9	11.5	26.0	0.0	0.0	8.6	0.0	0.0	73
NGO clinic/hospital	72.4	66.9	39.0	58.5	65.3	52.2	58.7	14.5	44.6	38.6	27.6	9.3	25
Private hospital	86.9	86.4	80.6	67.5	67.2	59.9	65.8	56.8	96.4	57.1	32.1	16.4	33
Location													
Urban	84.1	81.2	55.6	71.2	73.5	63.2	68.1	38.3	68.1	51.6	33.0	14.1	82
Rural	28.8	37.7	19.3	38.3	29.3	19.4	32.2	1.1	1.4	13.8	4.2	0.3	198
Division													
Barisal	47.6	46.4	19.5	41.7	45.4	29.8	31.7	6.4	11.6	17.6	8.1	2.7	15
Chittagong	53.0	51.9	27.0	47.3	48.3	32.8	39.2	13.7	22.8	25.1	16.9	7.6	58
Dhaka	49.3	51.0	27.5	48.8	39.0	29.6	47.1	15.9	26.6	28.8	11.3	4.5	97
Khulna	41.5	57.6	34.4	42.7	37.5	29.0	57.7	18.8	27.0	27.2	10.8	4.4	25
Rajshahi	31.0	30.3	20.8	48.2	42.0	32.3	29.8	8.8	11.8	19.6	13.7	3.8	35
Rengpur	38.2	69.2	53.8	44.8	46.3	44.5	49.8	2.7	12.4	27.9	11.6	1.6	33
Sylhet	38.7	41.8	29.0	63.3	43.9	29.0	31.8	4.3	18.8	22.1	12.0	0.9	18
Total	44.8	50.5	29.9	47.9	42.3	32.3	42.8	12.0	21.0	24.9	12.6	4.4	280
Total excluding CCs	57.3	59.8	34.0	55.2	49.8	39.6	48.7	16.2	28.4	30.7	17.1	5.9	207

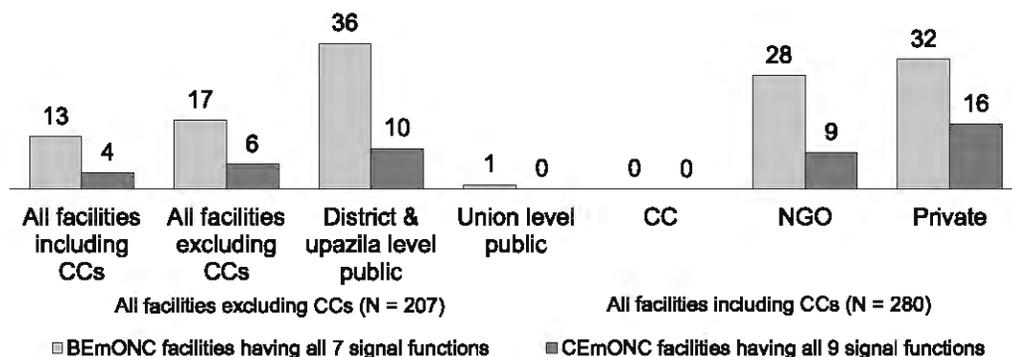
MVA = Manual vacuum aspiration

¹ Antibiotics, oxytocin, anticonvulsant

² Antibiotics, oxytocin, anticonvulsant, assisted vaginal delivery, manual removal of placenta, removal of retained product of conception, neonatal resuscitation

³ Antibiotics, oxytocin, anticonvulsant, assisted vaginal delivery, manual removal of placenta, removal of retained product of conception, neonatal resuscitation, blood transfusion, and caesarean delivery

Figure 3.32 Signal functions for emergency obstetric care, by facility type



Note: Seven signal functions are antibiotics, oxytocin, anticonvulsant, assisted vaginal delivery, manual removal of placenta, removal of retained product of conception, neonatal resuscitation. Nine signal functions are antibiotics, oxytocin, anticonvulsant, assisted vaginal delivery, manual removal of placenta, removal of retained product of conception, neonatal resuscitation, blood transfusion, and caesarean delivery.

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3.5.6 Specific Training on Maternal and Newborn Health

In-service training in maternal and newborn health care services not only improves the knowledge of skilled birth attendants but also improves their skills. Table 3.25 presents information on specific in-service training that interviewed providers of delivery care reported that they ever received, or received within 24 months of the survey. Overall, the proportions of providers reporting that they received any of the specific trainings was low; the proportions reporting they received any of the trainings during the 24 months preceding the survey are even lower. For example, while 43 percent of interviewed providers had received in-service training in active management of the third stage of labor, only 11 percent reported that the most recent training was during the 24 months preceding the survey.

Forty-five percent of interviewed providers had received in-service training in neonatal resuscitation at some time, but 21 percent had received in-service training in neonatal resuscitation during the 24 months before the survey (Table 3.25). Training in post-abortion care was reported by fewer providers. About 3 out of 10 providers received in-service training in post-abortion care, while less than 10 percent reported that they received such training during the 24 months preceding the survey.

Table 3.25 Training for providers of normal delivery services: Delivery care

Among facilities offering normal delivery services, the percentages having trained staff on specific topics related to delivery and newborn care, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities having normal delivery or newborn care services and having at least one staff who has received in-service training on:												
	IMPAC during the past 24 months	IMPAC at anytime	Routine care for labor and delivery during the past 24 months	Routine care for labor and delivery at anytime	Active management of third stage of labor (AMTSL) during the past 24 months	Active management of third stage of labor (AMTSL) at anytime	Emergency obstetric care/life-saving skills during the past 24 months	Emergency obstetric care/life-saving skills at anytime	Post-abortion care during the past 24 months	Post-abortion care at anytime	Neonatal resuscitation during the past 24 months	Neonatal resuscitation at anytime	Number of facilities offering normal delivery services
Facility type													
District and upazila public facilities													
DH	18.9	56.0	25.0	72.1	19.5	67.2	15.3	45.9	18.5	57.7	43.3	72.2	45
MCWC	19.7	57.4	27.9	72.1	24.6	83.9	23.0	52.5	19.7	59.0	50.8	80.3	5
UHC	18.1	65.1	19.3	78.3	19.3	71.1	15.7	55.4	14.5	65.1	36.1	74.7	7
UHC	18.9	53.9	25.7	70.8	18.8	66.9	14.1	42.9	19.2	56.0	43.6	70.5	34
Union level public facilities													
UHFWC	5.9	31.7	7.0	57.8	10.0	43.6	2.7	24.0	2.1	25.9	20.3	43.5	103
UHFWC (upgraded)	9.3	35.8	5.4	50.5	5.8	35.6	3.0	24.8	1.6	27.9	23.4	51.7	36
USC/RD	3.5	28.8	8.0	61.3	13.3	48.4	2.8	23.8	2.9	27.8	20.5	38.8	55
USC/RD	6.9	33.2	6.9	63.8	6.9	45.6	1.7	22.9	0.0	11.0	9.9	40.7	12
Public community clinic													
Public community clinic	1.3	40.7	1.3	43.1	1.3	30.2	1.3	20.1	0.0	17.9	8.0	37.1	73
NGO clinic/hospital													
NGO clinic/hospital	27.8	52.8	41.4	74.6	35.9	67.7	24.0	42.9	19.8	46.0	33.0	64.0	25
Private hospital													
Private hospital	8.5	22.0	7.1	21.8	6.8	19.7	6.8	19.7	6.8	15.4	8.5	16.9	33
Location													
Urban	16.9	42.0	21.9	51.3	18.6	46.8	14.5	34.1	13.3	36.7	28.7	49.8	82
Rural	5.8	37.4	7.2	54.4	8.1	41.8	3.6	25.0	3.5	26.6	17.2	43.2	198
Division													
Barisal	11.7	23.7	19.0	46.1	17.5	43.9	10.6	19.6	3.8	19.6	20.9	41.0	15
Chittagong	14.8	33.0	15.8	47.2	18.1	42.9	12.9	31.8	12.3	30.0	24.1	48.7	58
Dhaka	7.5	45.0	8.2	64.6	8.1	45.0	4.6	29.8	4.2	27.8	12.9	48.9	97
Khulna	11.1	37.0	21.2	47.6	25.7	48.7	11.6	19.4	9.3	24.6	48.7	62.1	25
Rajshahi	2.3	35.9	3.5	35.9	1.2	18.7	1.2	24.8	2.1	28.8	7.4	12.9	35
Rangpur	7.3	43.9	7.8	61.3	8.8	59.0	3.6	34.8	3.8	44.2	17.6	45.5	33
Sylhet	11.0	34.2	18.1	48.9	15.4	45.5	5.6	13.9	10.0	27.0	43.5	56.4	18
Total	9.1	38.7	11.5	53.5	11.2	43.2	6.8	27.7	6.4	29.5	20.6	45.2	280
Total excluding CCs	11.8	38.0	15.1	57.2	14.7	47.8	8.7	30.4	8.6	33.6	25.0	48.0	207

Note: Training here refers only to in-service training. The training must have involved structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

IMPAC = Integrated management of pregnancy and childbirth

3.5.7 Readiness of Health Facilities to Provide Normal Delivery

Following WHO guidelines, the 2014 BHFS assessed service readiness for normal delivery based on availability of specific items/tracer indicators in health facilities. It is to be noted that the list of items assessed in this report has been adapted to Bangladesh context and made shorter, and the definition used for trained staff is less restrictive than the WHO specifications.

- **Trained staff:** At least one provider ever trained in IMPAC
- **Guidelines:** National or other IMPAC guideline available at the facility

- **Equipment:**
 - Examination light
 - Delivery pack
 - Suction apparatus
 - Neonatal bag and mask
 - Partograph
 - Gloves
- **Medicines and commodities**
 - Injectable oxytocin
 - Injectable antibiotic
 - Magnesium sulphate
 - Skin disinfectant
 - Intravenous solution with infusion set

Table 3.26 and Figure 3.33 summarize the availability of items/tracer indicators for assessing health facilities' readiness for normal delivery. Availability of guidelines and trained staff on IMPAC is generally low (27 percent and 38 percent, respectively). Also, about 6 in 10 facilities had a delivery pack available on the day of the survey visit, i.e., either the facility had a sterile delivery pack available at the delivery site, or else all the following individual items of equipment were present: cord clamp, episiotomy scissors, scissors or blade to cut cord, suture material, and needle holder. The essential medicines are available in only 22 percent to 36 percent of facilities that offer normal delivery services. When CCs are excluded from the analysis, the availability of all items /tracer indicators improves only slightly.

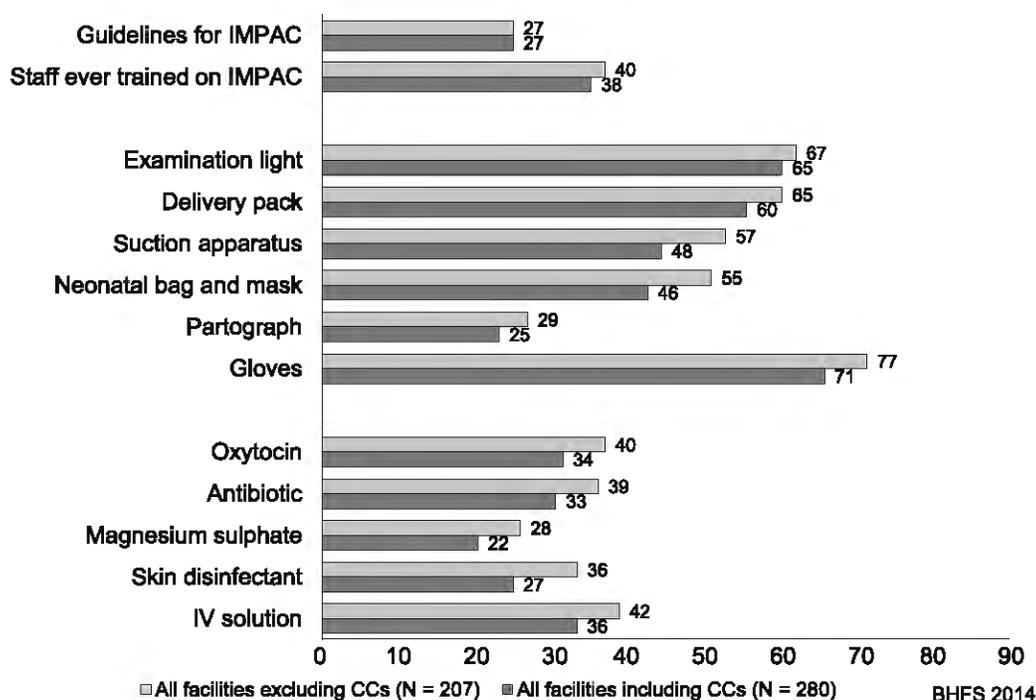
Table 3.26 Readiness of health facilities for normal delivery services

Among facilities offering normal delivery services, the percentages having items/tracer indicators for readiness for normal delivery service, by background characteristics, Bangladesh HFS 2014

Background characteristics	Guidelines on IMPAC	Staff trained in IMPAC at anytime	Examination light	Delivery pack	Suction apparatus	Neonatal bag and mask	Partograph	Gloves	Injectable uterotonic oxytocin	Injectable antibiotic	Magnesium sulphate	Skin disinfectant	Intravenous fluids with infusion set	Percentage having 13 items ¹	Number of facilities offering normal delivery services
Facility type															
District and upazilla public facilities	40.5	55.0	82.1	80.5	75.7	79.5	47.3	87.8	64.1	69.3	38.7	47.1	74.9	6.8	45
DH	41.0	60.7	95.1	83.6	95.1	90.2	59.0	88.5	83.6	82.0	59.0	59.0	78.7	11.5	5
MCWC	38.8	69.9	86.7	81.9	74.7	71.1	59.0	83.1	62.7	44.6	31.3	49.4	68.3	8.4	7
UHC	40.8	51.0	79.1	79.7	73.0	79.6	43.1	88.6	81.5	72.4	37.1	44.8	76.1	5.8	34
Union level public facilities	28.1	35.6	47.6	49.9	38.7	34.7	17.1	69.9	11.4	8.5	6.8	14.9	5.1	0.0	103
UHFWC	34.2	38.5	51.9	60.9	33.5	31.5	14.3	67.6	16.8	18.6	8.8	16.2	7.4	0.0	38
UHFWC (upgraded)	19.9	30.7	43.5	46.5	38.5	37.8	19.0	73.5	6.8	0.2	5.7	15.5	2.0	0.0	55
USC/RD	30.0	49.6	54.3	32.2	56.2	29.9	16.4	59.7	16.3	16.4	6.1	8.2	12.5	0.0	12
Public community clinic	27.4	30.2	60.2	45.3	22.6	22.2	15.4	56.5	17.1	13.0	5.3	0.9	17.9	0.0	73
NGO clinic/hospital	27.9	58.2	90.4	74.2	73.5	71.0	39.9	87.4	61.7	64.2	47.5	64.9	70.1	10.0	25
Private hospital	11.3	20.3	88.2	80.8	74.0	71.3	30.5	74.1	81.6	76.3	63.9	63.6	89.8	0.0	33
Location															
Urban	24.1	41.6	87.3	76.8	77.7	74.9	40.3	81.6	68.8	70.7	51.4	58.6	80.5	3.2	82
Rural	28.4	35.9	55.9	52.3	35.4	34.4	18.9	67.1	19.9	16.7	9.8	13.4	17.0	1.5	198
Division															
Barisal	32.7	29.2	43.7	54.8	41.6	48.9	26.7	83.2	21.0	21.2	5.6	20.6	24.1	1.1	15
Chittagong	26.0	37.2	55.0	49.5	49.1	43.6	17.8	66.2	29.7	33.1	17.3	30.4	31.7	3.1	58
Dhaka	25.8	45.4	67.9	60.8	55.1	47.2	29.6	59.2	36.3	41.5	27.2	25.7	40.2	2.1	97
Khulna	21.2	44.2	74.0	47.1	56.2	51.3	29.2	82.0	33.2	20.8	17.5	37.7	33.2	1.9	25
Rajshahi	10.8	14.6	46.8	58.3	28.2	28.7	13.6	63.2	30.4	28.9	24.5	15.8	33.9	1.2	35
Rangpur	56.2	39.6	93.5	89.8	49.8	62.9	35.1	98.2	46.8	24.3	20.8	28.7	37.1	2.3	33
Sylhet	20.5	34.9	72.2	52.1	32.4	44.2	22.1	96.1	34.0	30.6	26.4	27.9	36.9	0.0	18
Total	27.2	37.5	65.1	59.5	47.8	46.3	25.2	71.4	34.2	32.5	22.0	26.7	35.6	2.0	280
Total excluding CCs	27.1	40.1	66.8	64.5	56.7	54.8	28.6	76.6	40.3	38.4	27.9	35.8	41.8	2.7	207

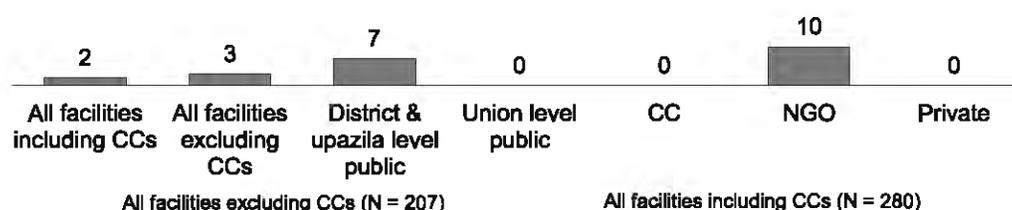
¹ 1. Guideline on IMPAC. 2. At least one staff ever trained in IMPAC. 3. Examination light. 4. Delivery pack. 5. Suction apparatus. 6. Neonatal bag and mask. 7. Partograph. 8. Gloves. 9. Injectable uterotonic oxytocin. 10. Injectable antibiotic. 11. Magnesium sulphate. 12. Skin disinfectant. 13. Intravenous fluids with infusion set.

Figure 3.33 Availability of items/tracer indicators in health facilities for readiness to provide normal delivery



Only 2 percent of all facilities (3 percent, excluding CCs) offering normal delivery can be considered ready to provide this service. District and upazila-level public facilities (7 percent) and NGO facilities (10 percent) are more likely to be ready than other facilities. Surprisingly none of the private hospitals can be considered ready to offer quality normal delivery; the same is true for union-level public facilities and CCs (Figure 3.34).

Figure 3.34 Readiness of health facilities to provide normal delivery services, by facility type



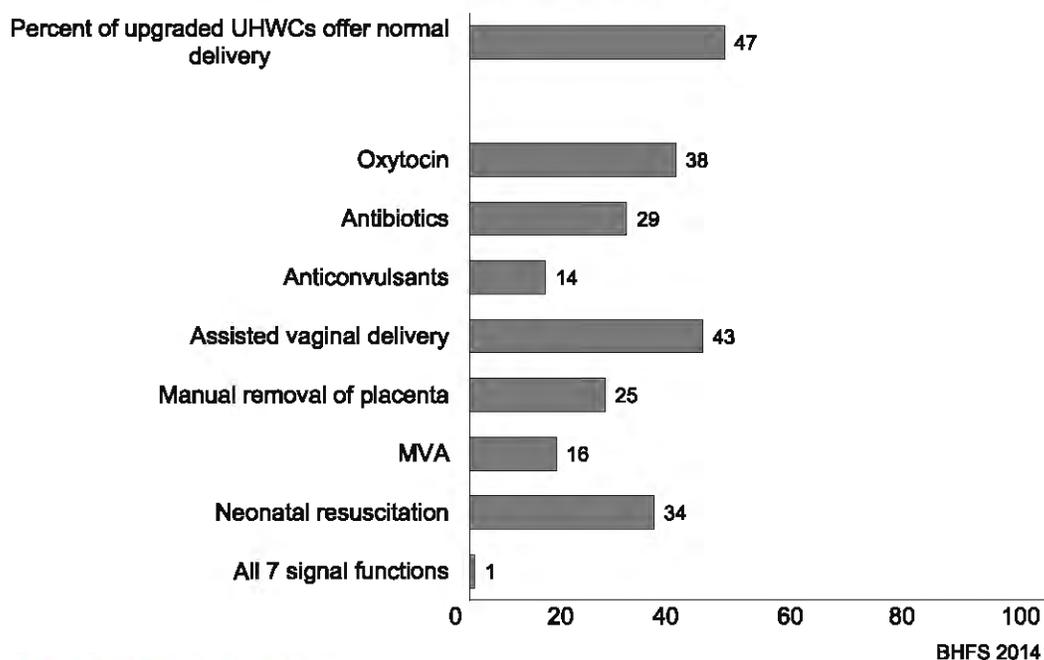
Note: Items for readiness of delivery services are: Ever trained staff in IMPAC, guidelines on IMPAC, equipment (examination light, delivery pack, suction apparatus, neonatal bag and mask, partograph, gloves), medicines and commodities (injectable oxytocin, injectable antibiotic, magnesium sulphate, skin disinfectant, intravenous solution with infusion set).

BHFS 2014

3.5.8 HPNSDP Results Framework Indicator: Provision of Basic EmONC Services in Upgraded UHFWC Facilities

Among 3,800 UHFWCs in Bangladesh, over 1,500 are scheduled for an upgrade. The HPNSDP target is for 50 percent of these to be Basic EmONC facilities. The 2014 BHFS findings show that only 47 percent of upgraded UHFWCs are providing normal delivery care (see Table 3.20); among these upgraded UHFWCs, the seven signal functions are each available in only 14 percent to 43 percent. In terms of overall preparedness, the progress is very low. Only 1 percent of upgraded UHFWCs are providing all seven signal functions.

Figure 3.35 HPNSDP Results Framework Indicator: Percentage of upgraded UHFWCs able to provide basic EmONC services



3.6 TUBERCULOSIS (TB)

3.6.1 Availability of TB Services

Achieving effective TB control requires concerted efforts at all levels. As shown in Table 3.27, only 9 percent of all facilities (17 percent, excluding CCs) offer any TB diagnostic services. As expected, TB diagnostic services are more likely to be available in district and upazila-level public facilities (78 percent) compared with union-level facilities (5 percent). Among public sector facilities, district hospitals (94 percent) and UHCs (92 percent) are more likely than any other facility types to provide TB diagnostic services. Six out of ten private hospitals and two out of ten NGO facilities provide TB diagnostic services.

Only 5 percent of health facilities (11 percent, excluding CCs) offer TB treatment and/or TB treatment follow-up services. As with TB diagnostic services, these services are almost exclusively available in district and upazila-level public facilities (70 percent); only 3 percent of union-level facilities provide these services. TB treatment and/or TB treatment follow-up services are more likely to be available in UHCs (86 percent) and DHs (63 percent) than any other facility types. Only 6 percent of private hospitals and 12 percent of NGO facilities provide TB treatment and/or TB treatment follow-up services.

Only 10 percent of all facilities (18 percent, excluding CCs) offer some form of TB services, i.e., TB diagnosis, treatment, or treatment follow-up services (Table 3.27 and Figure 3.36). A large proportion of DHs (94 percent) and UHCs (93 percent) offer TB diagnosis, treatment, and/or follow-up services. In

contrast, and as expected, only 5 percent of USCs/RDs and CCs do so. Six out of 10 private hospitals and 2 out of 10 NGO facilities provide TB diagnosis, treatment, and/or TB treatment follow-up services.

Table 3.27 Availability of tuberculosis services, guidelines, and trained staff for tuberculosis services

Among all facilities, the percentages offering any tuberculosis (TB) diagnostic services or any treatment and/or treatment follow-up services and, among facilities offering any TB services, the percentages having TB guidelines and at least one staff member recently trained in TB services, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of all facilities offering:				Number of facilities	Percentage of facilities offering any TB services that have guidelines for:				Number of facilities offering any TB diagnostic, treatment, and/or treatment follow-up services	
	Screening and referral for TB diagnosis ¹	Any TB diagnostic services ²	Any TB treatment and/or treatment follow-up services ³	Any TB diagnostic, treatment, and/or treatment follow-up services		Diagnosis and treatment of TB	Diagnosis and treatment of MDR-TB	Management of HIV and TB co-infection	TB infection control		Trained staff ⁴
Facility type											
District and upazila facilities	47.8	77.8	70.0	78.8	47	76.9	49.4	17.8	38.2	37.8	37
DH	48.4	93.5	62.9	93.5	5	60.3	31.0	25.9	39.7	37.9	5
MCWC	0.0	3.3	1.1	3.3	8	0.0	0.0	0.0	33.3	33.3	0
UHC	58.0	91.8	86.1	93.1	35	79.9	52.5	16.5	38.1	37.8	32
Union level facilities	1.7	4.8	3.1	5.2	374	55.4	28.6	10.7	33.1	0.0	19
UHFWC	1.2	3.6	1.2	3.6	149	56.0	0.0	13.2	69.8	0.0	5
UHFWC (upgraded)	1.2	6.8	3.9	7.3	117	46.7	46.7	16.0	22.5	0.0	9
USC/RC	2.9	4.4	4.9	5.0	108	68.5	28.3	0.0	13.6	0.0	5
Community clinic	3.7	5.0	1.7	5.3	1,010	16.5	10.5	0.0	18.8	39.3	53
NGO clinic/hospital	10.3	19.2	12.0	19.9	81	34.4	29.3	17.7	30.3	43.3	16
Private hospital	7.7	61.5	5.8	61.5	36	5.2	5.2	5.2	10.4	21.0	22
Location											
Urban	19.2	47.0	26.3	47.4	130	40.8	28.1	14.1	26.7	31.5	62
Rural	3.7	5.8	2.8	6.1	1,418	34.4	21.0	4.5	24.8	31.5	86
Division											
Barisal	2.6	8.5	5.0	11.2	116	29.4	12.8	3.2	55.4	8.6	13
Chittagong	5.0	10.6	5.8	10.9	287	31.6	16.2	5.2	14.9	19.7	31
Dhaka	7.8	11.9	5.6	11.9	421	34.5	36.9	10.4	24.1	59.1	50
Khulna	5.6	9.9	3.6	10.4	197	30.1	10.9	5.1	9.5	13.0	20
Rajshahi	1.6	5.9	2.8	5.9	224	35.5	15.3	10.4	50.4	23.8	13
Rangpur	3.9	6.1	5.1	6.1	205	83.5	34.0	19.5	33.8	2.4	13
Sylhet	4.0	7.8	3.5	7.8	97	34.8	23.3	7.0	14.1	48.1	8
Total	5.0	9.3	4.8	9.6	1,548	37.1	23.9	8.5	25.6	31.5	148
Total without CCs	7.4	17.2	10.5	17.6	538	48.7	31.5	13.3	29.4	27.1	95

Note: The guidelines and trained staff indicators presented in this table comprise the staff and training domain for assessing readiness to provide TB services within the health facility assessment methodology proposed by WHO and USAID (2012).

MDR-TB = Multi-drug resistance tuberculosis

¹ Facility reports that it refers clients outside the facility for TB diagnosis, and there is documentation on the day of the survey visit to support the contention.

² Facility reports that providers in the facility make a diagnosis of TB by using any of the following methods: sputum smear only, x-ray only, either sputum or x-ray, both sputum and x-ray, or based on clinical symptoms only; or else the facility reports that they refer clients outside the facility for TB diagnosis, and a register was observed indicating clients who had been referred for TB diagnosis.

³ Facility reports that they follow one of the following TB treatment regimens or approaches:

Directly observe for two months and follow up for four months

Directly observe for six months

Follow up clients only after the first two months of direct observation elsewhere

Diagnose and treat clients while in the facility as inpatients, and then discharge elsewhere for follow-up

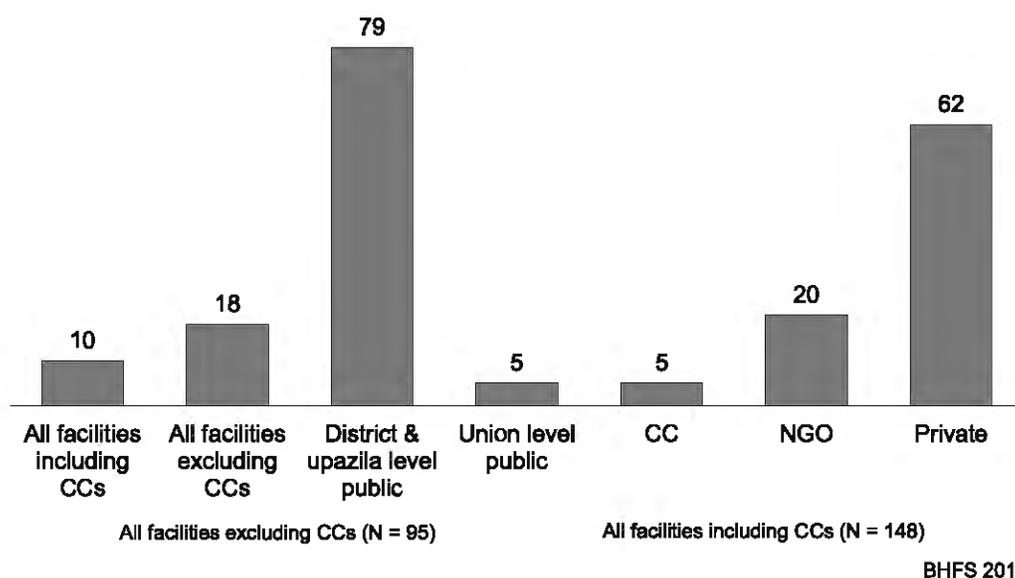
Provide clients with the full treatment with no routine direct observation phase

Diagnose, prescribe, or provide medicines with no follow-up

Diagnose only, no treatment

⁴ At least one interviewed provider of any one of the following TB services reported receiving in-service training relevant to the particular TB service during the 24 months preceding the survey: TB diagnosis and treatment; management of HIV and TB co-infection; multi-drug-resistant (MDR)-TB treatment, identification of need for referral; DOTS treatment; or TB infection control. The training must have involved structured sessions; it does not include individual instruction that a provider might have received during routine supervision.

Figure 3.36 Availability of TB diagnostic, treatment and/or TB follow up services in health facilities



3.6.2 Availability of Guidelines and Trained Staff

3.6.2.1 Guidelines

Guidelines for the diagnosis and treatment of TB are expected to be available at the respective TB diagnosis and treatment sites. However, most did not have them on the day of the survey visit. Guidelines for the diagnosis and treatment of TB were present in 37 percent of health facilities that offer any TB diagnostic, treatment, and/or treatment follow-up services (Table 3.27). Guidelines for the diagnosis and treatment of multi-drug-resistant (MDR)-TB were available in 24 percent of facilities, while one of every ten facilities that offer any TB services had guidelines for the management of HIV-TB co-infection. In all cases, district and upazila-level facilities were more likely to have these guidelines compared with other facility types.

About one in four facilities that offer any TB services had guidelines for TB infection control available on the day of survey visit (Table 3.27). Among district and upazila-level facilities offering TB services, 38 percent had such guidelines compared with 33 percent of union-level facilities offering TB services. Among all facilities, UHFWCs, at 70 percent, were the most likely to have TB infection control guidelines.

3.6.2.2 Trained Staff

Three out of ten facilities that offer TB services had at least one provider of that service who had received in-service training in that service in the 24 months before the survey (Table 3.27). Among public facilities, district and upazila-level facilities are most likely to have a provider with recent in-service training (38 percent), while union level facilities do not have recently trained staff on TB service (zero percent).

3.6.3 Diagnostic Capacity

Early case detection and diagnosis are critical for TB control. Sputum microscopy remains the mainstay of diagnosis for pulmonary tuberculosis. The 2014 BHFS assessed availability of TB diagnostic capacity in facilities that offer any TB diagnostic, treatment, and/or follow-up services.

Few TB facilities had the supplies and equipment for any method of TB diagnosis on the day of the survey visit (Table 3.28). The most common systems for TB diagnosis seen were x-ray (available in 21 percent of facilities offering any TB diagnostic, treatment, and/or follow-up services, 33 percent, excluding CCs) and TB smear microscopy (available in 17 percent of facilities offering any TB diagnostic, treatment, and/or follow-up services, 27 percent, excluding CCs). Overall, 13 percent of facilities (20 percent, excluding CCs) have TB rapid diagnostic test kits, and only 5 percent of facilities (7 percent, excluding CCs) have culture medium for diagnosing TB.

3.6.4 Treatment and Availability of Medicines

On the day of the visit, 36 percent of all facilities (53 percent excluding CCs) that offer TB treatment and/or treatment follow-up services had first-line medicines for treating TB (any combination of pyrazinamide, rifampicin, ethambutol, and isoniazid); 22 percent had injectable streptomycin, and 16 percent had isoniazid and thiacetazone tablets (Table 3.28). Districts and upazila-level facilities were supplied with more medicines than union level and NGO facilities, while almost no private hospital had medicines.

Table 3.28 Diagnostic capacity and availability of medicines for tuberculosis treatment

Among facilities offering any tuberculosis (TB) diagnostic, treatment, and/or treatment follow-up services, the percentages that have TB and HIV diagnostic capacity and medicines for TB treatment available in the facility on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Percentage of facilities that have the following TB diagnostic capacity:				Percentage of facilities that have:		Percentage of facilities that have the following medicines for treating TB:			Number of facilities offering any TB diagnostic, treatment, and/or treatment follow-up services
	TB smear microscopy ¹	Culture medium ²	TB rapid diagnostic test kits	TB x-ray	HIV diagnostic capacity ³	System for diagnosing HIV among TB clients ⁴	First-line treatment for TB ⁵	Injectable streptomycin	Isoniazid and thiacetazone tablets	
Facility type										
District and upazila facilities	36.0	10.7	26.0	30.1	7.0	8.9	83.8	57.5	39.7	37
DH	41.4	24.1	39.7	72.4	10.3	8.9	60.3	38.2	39.7	5
MCWC	0.0	0.0	0.0	33.3	0.0	0.0	33.3	0.0	0.0	0
UHC	35.4	8.8	24.2	23.8	6.8	9.3	87.7	61.1	40.0	32
Union level facilities	0.0	0.0	0.0	0.0	0.5	0.0	52.7	23.6	20.5	19
UHFWC	0.0	0.0	0.0	0.0	2.0	0.0	32.7	17.5	19.5	5
UHFWC (upgraded)	0.0	0.0	0.0	0.0	0.0	0.0	46.7	16.0	0.0	9
US/RD	0.0	0.0	0.0	0.0	0.0	0.0	81.9	41.7	53.6	5
Community clinic	0.0	0.0	0.0	0.0	0.0	0.0	6.8	0.0	0.0	53
NGO clinic/hospital	20.7	3.5	15.8	7.3	8.1	7.6	52.4	40.9	26.2	16
Private hospital	38.4	10.1	29.8	83.7	12.8	6.9	1.7	0.0	0.0	22
Location										
Urban	31.9	8.9	23.9	46.4	9.8	7.4	48.6	35.6	26.9	62
Rural	6.4	1.5	4.7	2.5	0.9	1.7	27.6	12.3	7.4	86
Division										
Barisal	11.1	2.7	11.2	8.3	1.4	0.6	19.6	5.8	2.7	13
Chittagong	11.2	3.9	12.1	19.6	0.0	0.3	33.8	16.7	14.4	31
Dhaka	24.6	5.0	12.7	28.0	6.3	6.0	31.7	29.7	16.2	50
Khulna	16.7	6.4	11.3	22.1	6.8	4.7	23.7	7.6	6.2	20
Rajshahi	17.4	0.0	10.4	17.2	4.9	4.9	45.2	31.8	25.6	13
Rangpur	12.8	9.7	24.5	7.8	11.4	10.1	88.2	28.3	33.3	13
Syhet	6.0	2.4	5.7	23.3	0.0	0.0	40.6	36.1	16.1	6
Total	17.0	4.6	12.7	20.8	4.6	4.1	36.4	22.0	15.5	148
Total without CCs	26.6	7.2	19.8	32.5	7.2	6.4	53.1	34.4	24.3	95

Note: The indicators presented in this table comprise the diagnostics and medicines and commodities domains for assessing readiness to provide services for TB within the health facility assessment methodology proposed by WHO and USAID (2012).

¹ Functioning microscope, slides, and all stains for Ziehl-Neelsen test (carbol-fuchsin, sulphuric acid and methyl blue) all were available in the facility on the day of the survey visit.

² Solid or liquid culture medium, e.g., MGIT 960

³ HIV rapid diagnostic test kits available in TB service area

⁴ Record or register indicating TB clients who had been tested for HIV

⁵ Four-drug fixed-dose combination (4FDC) available, or else isoniazid, pyrazinamide, rifampicin, and ethambutol are all available, or a combination of these medicines, to provide first-line treatment

3.6.5 Readiness of Health Facilities to Provide TB Services

The 2014 BHFS obtained information to assess readiness of health facilities to provide TB services. Readiness is measured based on the availability of WHO recommended items/tracer indicators that are necessary to offer quality TB services. The 2014 BHFS adopted a slightly less restrictive and Bangladesh-context-appropriate version of tracer indicators to assess TB service readiness, whereby the following four items/tracer indicators must be available at health facilities to be considered ready to provide TB services:

- **Trained staff:** At least one provider ever receiving in-service training on TB
- **Guidelines:** Any guideline for TB
- **Diagnostic capacity:** TB microscopy
- **Medicines:** First-line TB medicines

Table 3.29 and Figures 3.37 and 3.38 show information on indicators used to assess the readiness of health facilities to provide TB services. Forty three percent of facilities (52 percent excluding CCS) providing TB services have any type of TB guidelines. Eight in ten district and upazila level public facilities have any type of TB guidelines. In comparison, availability of TB guidelines in CCs (27 percent), NGO facilities (34 percent) and private facilities (10 percent) is substantially lower. Less than half of all facilities have at least one provider who ever received in-service training on TB. The rest of the two tracer indicators, namely availability of TB microscopy and first line TB medication have been described before. Overall, among facilities offering any TB service only 7 percent (11 percent excluding CCs) have all four service readiness indicators and therefore can be considered ready to provide TB services. Not surprisingly, DHs (26 percent) and UHCs (21 percent), and to a lesser extent NGO facilities (15 percent) can be considered ready to provide TB services. There is little variation at the divisional level; however, facilities in Rajshahi (12 percent) and Dhaka (11 percent) are better than facilities in other divisions.

Table 3.29 Readiness of health facilities for tuberculosis services

Among facilities offering any tuberculosis (TB) diagnostic, treatment, and/or treatment follow-up services, the percentages that have the indicated items available in the facility on the day of the survey, by background characteristics, Bangladesh HFS 2014

Background characteristics	Any guideline for TB ¹	Trained staff at any time ²	TB microscopy ³	First-line TB medications ⁴	Having all 4 items	Number of facilities offering any TB diagnostic, treatment, and/or treatment follow-up services
Facility type						
District and upazila facilities	81.0	67.5	36.0	83.8	21.4	37
DH	65.5	69.0	41.4	60.3	25.9	5
MCWC	0.0	33.3	0.0	33.3	0.0	0
UHC	83.9	67.5	35.4	87.7	20.9	32
Union level facilities	55.4	11.1	0.0	52.7	0.0	19
UHFWC	56.0	2.0	0.0	32.7	0.0	5
UHFWC (upgraded)	46.7	0.0	0.0	46.7	0.0	9
US/RD	68.5	37.5	0.0	81.9	0.0	5
Community clinic	27.0	46.6	0.0	6.8	0.0	53
NGO clinic/hospital	34.4	51.9	20.7	52.4	15.2	16
Private hospital	10.4	33.9	38.4	1.7	0.0	22
Location						
Urban	44.6	50.6	31.9	48.6	10.4	62
Rural	41.3	42.5	6.4	27.8	4.6	86
Division						
Barisal	31.1	17.1	11.1	19.6	4.3	13
Chittagong	31.9	31.4	11.2	33.8	3.7	31
Dhaka	49.0	75.1	24.6	31.7	10.5	50
Khulna	32.9	33.6	16.7	23.7	3.7	20
Rajshahi	35.5	31.8	17.4	45.2	12.2	13
Rangpur	84.1	21.6	12.8	88.2	5.4	13
Sylhet	35.9	60.5	8.0	40.8	5.7	8

(Continued...)

Table 3.29—Continued

Background characteristics	Any guideline for TB ¹	Trained staff at any time ²	TB microscopy ³	First-line TB medications ⁴	Having all 4 items	Number of facilities offering any TB diagnostic, treatment, and/or treatment follow-up services
Total	42.7	45.9	17.0	36.4	7.1	148
Total without CCs	51.5	45.5	26.6	53.1	11.0	95

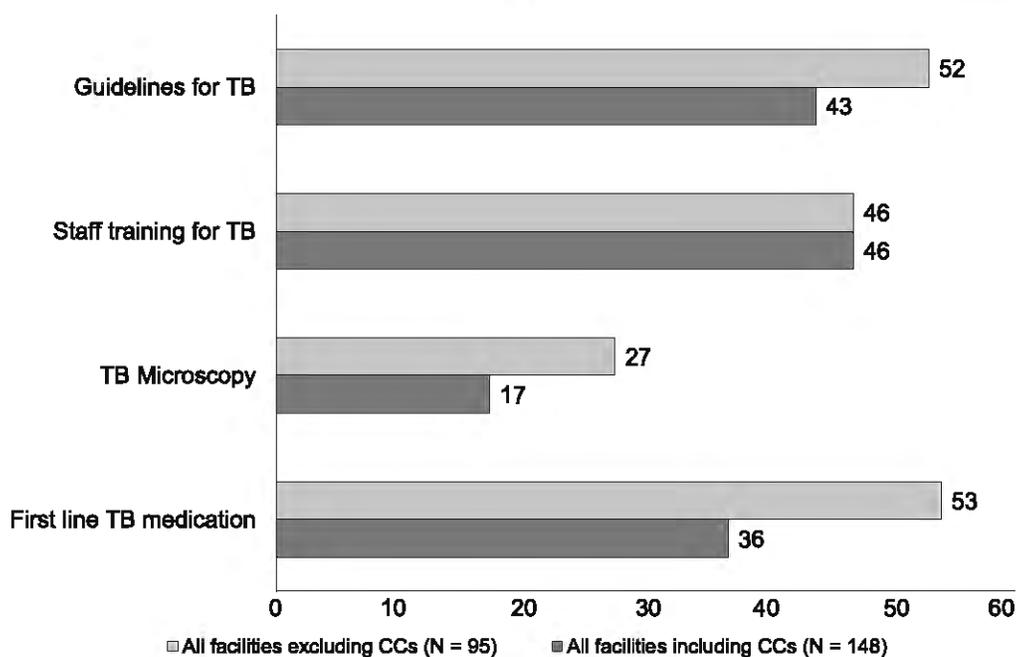
¹ National guidelines for the diagnosis and treatment of TB, guidelines for the management of HIV and TB co-infection, or any guideline related to MDR-TB treatment.

² At least one interviewed provider of any one of the following TB services reported receiving in-service training relevant to the particular TB service: TB diagnosis and treatment; management of HIV and TB co-infection; MDR-TB treatment, identification of need for referral; DOTS treatment; or TB infection control. The training must have involved structured sessions; it cannot include individual instruction that a provider might have received during routine supervision.

³ Functioning microscope, slides, and all stains for Ziehl-Neelson test (carbol-fuchsin, sulphuric acid, and methyl blue) all were available in the facility on the day of the survey visit.

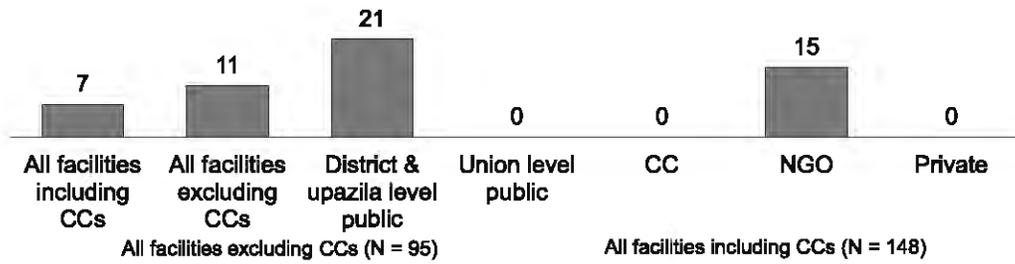
⁴ Four-drug fixed-dose combination (4FDC) available, or else isoniazid, pyrazinamide, rifampicin, and ethambutol are all available, or a combination of these medicines, to provide first-line treatment.

Figure 3.37 Availability of items/tracer indicators in health facilities for readiness to provide TB services



BHFS 2014

Figure 3.38 Readiness of health facilities to provide TB services, by facility type



BHFS 2014

APPENDIX

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Project Director, Urban Primary Health Care Service Delivery Project	Member
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Deputy Chief (Health), Ministry of Health & Family Welfare	Member
Director (PHC), Directorate General of Health Services	Member
Director (Hospital), Directorate General of Health Services	Member
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