SUSTAINABLE AGRICULTURE AND PRODUCTION LINKED TO IMPROVED NUTRITION STATUS, RESILIENCE, AND GENDER EQUITY (SAPLING)

HEALTH SERVICES ASSESSMENT IN THE CHITTAGONG HILL TRACTS: RESULTS FROM 70 COMMUNITY CLINICS IN BANDARAN DISTRICT

The Sustainable Agriculture and Production Linked to Improved Nutrition Status, Resilience, and Gender Equity (SAPLING) program, a six-year USAID-funded Resilience Food Security Activity in partnership with the Ministry of Chittagong Hill Tracts Affairs (MOCHTA), worked with over 54,000 poor and extreme poor households across five sub-districts (upazilas) in Bandarban District of the remote Chittagong Hill Tracts (CHT) region of Bangladesh to apply a multi-sectoral integrated approach to improve gender-equitable food security, nutrition, and resilience. Seventy (70) community clinics in SAPLING's catchment area are responsible for delivering the government's "Essential Service Package" consisting of maternal and neonatal health services, integrated management of childhood illness, reproductive health and family planning services, immunizations, nutritional education, micronutrient supplementation, health education and counseling, screening of chronic non communicable diseases, treatment of minor ailments, and establishing referral linkage with other facilities. SAPLING assessed clinic operations in December 2019 to identify gaps and challenges in accessing services. Findings were shared with the Bandarban Civil Surgeon and other development partners to enable targeted, focused interventions to ensure an effective health care system in Bandarban.

KEY FINDINGS

Results from the assessment identified gaps in staffing, health service provider training, service delivery, and availability of equipment and medicines. These gaps likely impact the quality of services provided to communities living in SAPLING's implementation area of Bandarban District.

STAFFING

Nearly all clinics are fully staffed with a Community Health Care Provider (CHCP), Family Welfare Assistant (FWA), and a Health Assistant (HA), except for eight clinics in Ruma upazila with no FWV/FWA or HA. While there is a provision for a quota of ethnic minority hiring in the Ministry of Family Planning, guidance is not provided for ensuring that staff ethnicity and language match the patient population. Staff with an ethnicity which matched the clinic population varied by subdistrict.

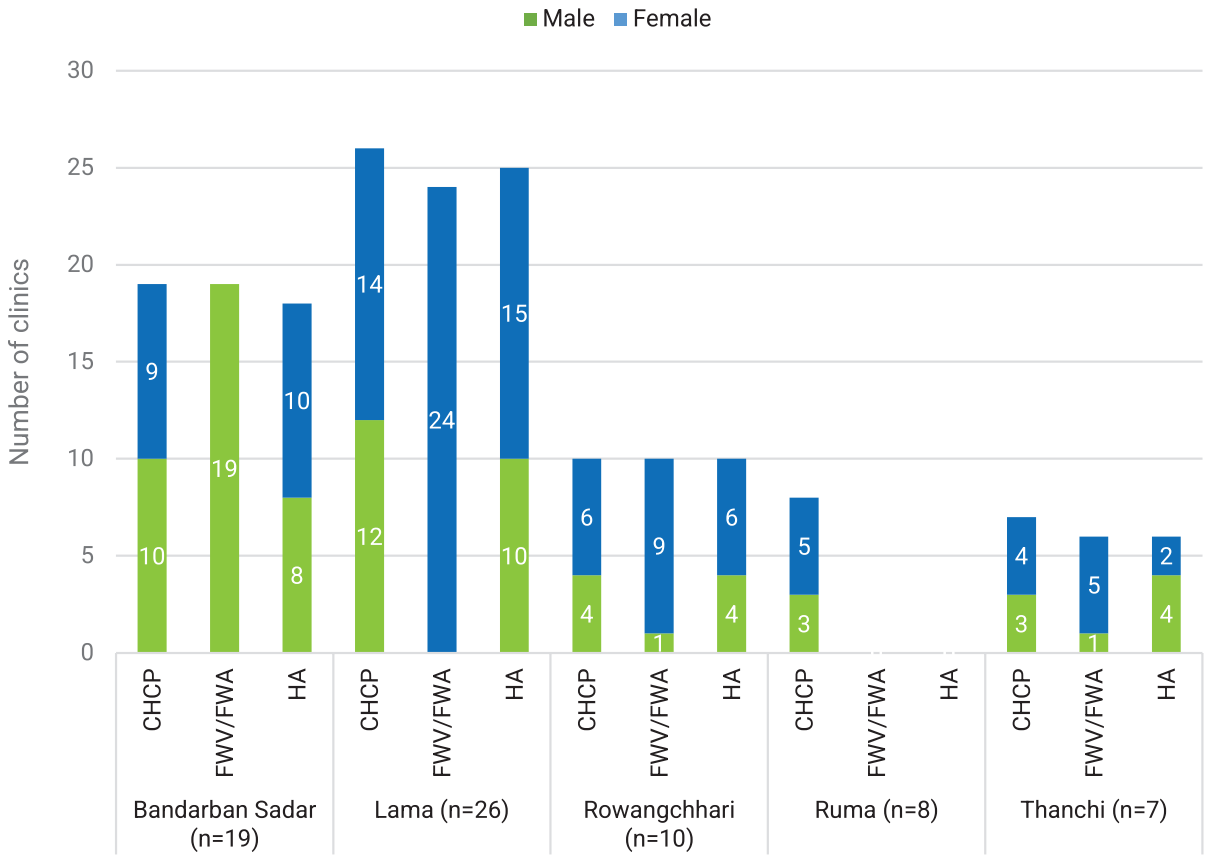

FIGURE 1: Number of clinics staffed with CHCP, FWA/FWV, and HA by sex and upazila.

TRAINING OF COMMUNITY CLINIC HEALTH CADRES

Staff training varied considerably by staff type, training content, and upazila. Nearly all staff had received any type of refresher training: 91% of CHCP, 97% of FWV/FWA, and 97% of HAs. However, training content was inconsistent across the respondents, with no one type of training consistently administered across the sample. Inconsistent training content across the sample means staff may not be skilled in important procedures.

GOVERNANCE AND MANAGEMENT

Community groups (CG) and community support groups (CSG) are responsible for community clinic daily operations, monitoring of clinic functions, fundraising for improvements in each clinic, promoting the use of community clinic services, and increasing community awareness about health issues. Findings from the assessment indicate that all clinics across all upazilas have a CG and all meet the expected male:female ratio, but only ¾ of CGs are fully operational. Most CGs which are operational are in Bandarban Sadar, Lama,

and Rowangchari sub-districts, while most in Thanchi are only partially operational. For CSGs, no upazila had all CSGs fully operational, defined as meeting four or more times in the past year. Levels of training for the CSGs were lower overall than CGs, with the exception of Ruma where CSGs had received all training except for workplan training; more than 50% of CSG groups received training more than three years ago or had received no training at all.

TRAVEL TIME

Clinic staff were asked to report on how most patients travelled to the clinic and their transport times. More than 98% of clinics (n=69) said they are accessed only by walking. The majority of clinics say the longest commute for patients is over 1 hour. In Rowangchari and Ruma upazilas, the mean longest transit time is 1.5 hours, followed by Bandarban Sadar and Lama (1.8-2.0 hours), and in Thanchi, a mean of over four hours.

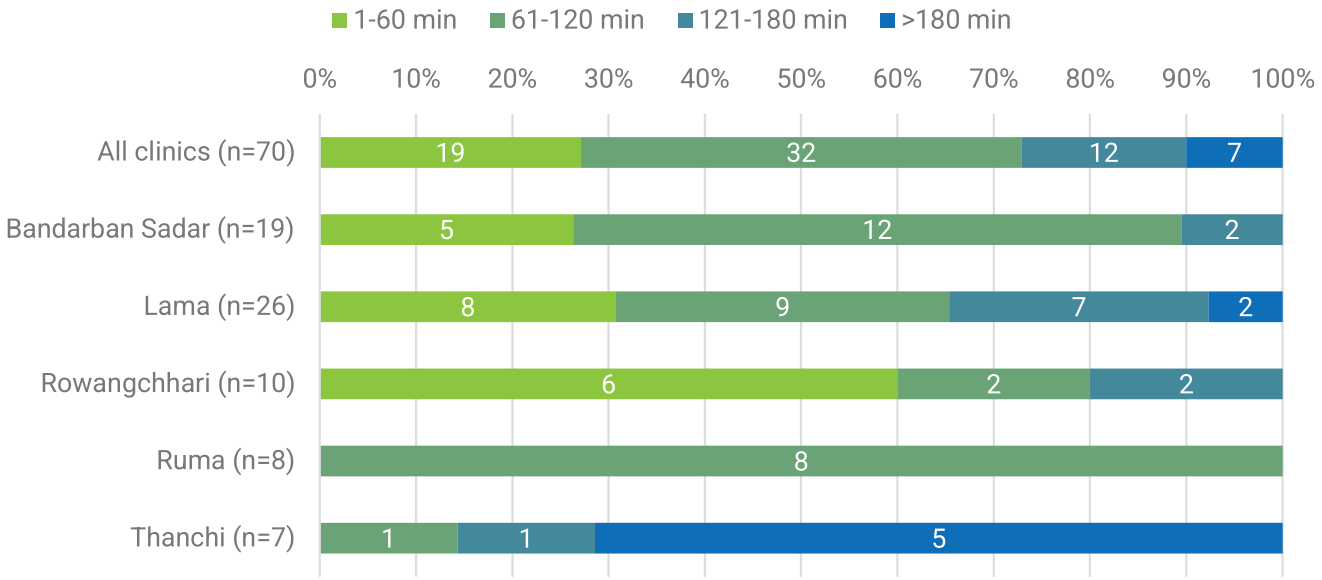

FIGURE 2: Longest reported transit/travel time to clinic, by upazila

SERVICE DELIVERY

Nearly all clinics in all five upazilas provide antenatal, delivery, and postnatal services as well as growth monitoring and vaccinations. While most clinics (n=68) provide iron-folic acid (IFA) supplementation during antenatal (ANC) and postnatal (PNC) check-ups, only 16 clinics across three upazilas provide IFA and Vitamin A supplementation (VAS) during delivery services. All eight clinics in Ruma said they do not offer IFA and VAS at delivery nor general vaccinations.

COMMODITIES AND EQUIPMENT

Almost all (69) clinics reported having operational stethoscopes, blood pressure machines, register books, and ANC and GMP cards. However, less than half (44%) of all clinics had any of the 27 essential medicines assessed and more than ¾ of clinics had 'insufficient' quantities—50% or less of the required amount—in their clinics. Additionally, deficiencies in basic equipment included growth monitoring equipment (e.g., salter scales and height and length boards; 15-24% didn't have, depending on the equipment), missing or unusable EPI cards (37%), and 74% did not have useable delivery kits, despite 97% of clinics reporting they offer delivery services. This absence of kits was seen across all sub-districts. Thirteen percent of clinics did not have functioning latrines and water facilities in eight clinics were observed to be non-operational by survey enumerators (11%).

DISCUSSION

All 70 community clinics serve diverse ethnic groups living in the catchment areas. However, with service providers who are not the same ethnicity as the catchment population, communication can be a major barrier to receiving health care. This may also limit some ethnic groups to seek care. Nearly all clinics are accessed by walking, often for long periods, also a barrier to accessing health services. All clinics reported they are open six days a week, six hours per day, with staff available every day, however, anecdotal information suggests that staff availability is not as universal as reported. Clinics almost universally report providing maternal and child health services, most community clinics do not have childbirth facilities and most are missing delivery kits. Notable gaps in clinic services include vitamin A supplementation and iron folic acid supplementation at delivery and wound stitching. Many medications are also not available in sufficient supply. These findings reveal a disconnect between advertised available services and ability to deliver those services, with a lack of equipment and medicines.

RECOMMENDATIONS

Key recommendations from the assessment include:

- Revitalization of CGs and CSGs to enhance the overall oversight and functioning of clinics.
- Build capacity of CGs and CSGs for self-financing mechanisms (e.g., savings groups or user fees) to provide a sustained source of capital to finance clinic maintenance and group operations.
- Establish a feedback mechanism, such as participatory community health score cards, to strengthen communication and relationships between CGs/CSGs and clinic staff, help identify gaps and needs, and motivate provider performance.
- Standards for refresher training requirements and content should be established to maintain quality of provider care and ensure consistency of treatment and clinic management.
- Availability and sufficient supplies of stocks, including medicine and delivery kits, should be assured in all areas.
- Equipment needs should be filled, and non-operational equipment fixed or replaced.
- Health facilities require potable water and sanitation facilities for both staff and patients to provide services and reduce the spread of infectious diseases. All non-operational water and toilet facilities should be fixed and access to both for staff and clients is essential.
- Provision of equipment, staffing, training, and supplies should be consistent across all clinics in the district.
- Greater attempts to match the ethnicity of the service provider with the ethnic groups in the catchment area would enhance service provision and potentially increase the number of people seeking health services.
- Provision of equipped, trained, and available birth services at the community clinic are needed for safe pregnancy outcomes.