Effective coverage of Primary Care Services amongst the urban poor in Bangladesh: Challenges and Solutions

The realities of urbanization in Bangladesh - from traffic congestion to the rapid growth of urban slums due to rural in-migration exceeding 1000 people per day - challenge health service delivery systems, particularly for the poor. Despite a greater density of service providers in urban areas, adequate health care remains out of reach for many of the poor because of high costs, lack of information and the absence of an organized primary health care delivery system equivalent to that found in rural areas. Beyond the operation of a few small to medium hospitals and outdoor facilities, human resource constraints have required Local Government Division (LGD) to coordinate Urban Primary Health Care Services including Maternal, Newborn and Child Health, on a project basis through contracts with NGOs. This has been supplemented by independent NGO efforts focused on providing basic services to urban disadvantaged populations. The extent to which these services are sufficient or effective in reaching the urban poor, has not been established.

In this context, Dr. Alayne Adams, Senior Social Scientist, ICDDR,B and Professor at JPGSPH, presented findings from a DFID funded study that used the Tanahashi framework (Tanahashi 1978) as a conceptual tool to identify shortcomings and promising service delivery practices in reaching the urban poor in Dhaka, Bangladesh. Each model is comparatively assessed with respect to the coverage dimensions of availability, accessibility, acceptability and utilization, and their relative strengths and weaknesses in each dimension are examined. The framework usefully disaggregates challenges to effective service coverage - helping identify what, where and why bottlenecks exist. The Tanahashi framework identified four dimensions that facilitate or inhibit effective coverage – or the part of population in need who receive effective services.

1. Availability of resources necessary to provide services - manpower, facilities and its adequacy relative to the size of the population needing these services.
2. Accessibility of these services to those who need them: i.e. How proximate services are and how much they cost.

Dr. Alayne Adams was the key note presenter at the session

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3. The acceptability of services to the target population which is often a function of culture, religion, gender
4. Utilization coverage, which measures the actual use of or contact with these services relative to the target population

The models investigated were BRAC’s urban Manoshi project, Urban Primary Health Care Programme (UPHCP), Smiling Sun Franchise and Marie Stopes. Analysis was based on a desk review of grey and published literature, and qualitative data collected by means of 20 key informant interviews, 15 site visits, 3 stakeholder meetings and 13 Focus Group Discussions with community members. Each model was assessed conceptually according to Tanahashi’s coverage dimensions of availability, accessibility, acceptability and utilization.

Objectives of the Presentation
1. To examine 4 models of PHC delivery for the urban poor using the Tanahashi framework
2. To identify lessons to inform scale-up of equity-oriented delivery systems for the urban poor
3. To reflect on the value of the Tanahashi framework in thinking about implementation challenges.

The Models
Manoshi is a MNCH programme run by BRAC in seven city corporations and 15 metropolitan areas in Bangladesh. Initially supported by Gates Foundation, it focuses on the provision of health and referral services to pregnant and lactating women, newborns and under-five children by means of trained community health workers. Comparative analysis using Tanahashi Framework revealed Manoshi’s particular strength in designing services that are accessible and acceptable to slum residents. Strategies range from the engagement of community workers as health promoters, an emphasis on creating social networks around pregnancy and delivery, providing a comfortable non-institutional setting for a safe delivery and placing referral programme officers in tertiary facilities to help women navigate the referral process. Relative to the other models examined, the availability of services was much lower in Manoshi given its almost exclusive focus on maternal and newborn health, and the absence of anything but the most basic supplies and equipment. Demand for a wider range of services, however, was evident in the frequent mention of using Marie Stopes for ultrasound and post-natal care among Manoshi beneficiaries. Evidence suggests that overall utilization by the poor is quite good, but its services are less attractive to wealthier households. The model is also distinguished by its commitment to continual evaluation to inform improvements in service design and delivery.

UPHCP: In the absence of local government capacity to deliver primary health care, UPHCP contracts NGOs to increase access to essential health services, and improve health outcomes among the urban poor.
Managed by the Local Government Division of the Ministry of Local Government and Rural Development and Cooperatives (MoLGRDC), and financed by ADB and several bilateral donors, the model operates in six City Corporations and a number of Municipalities across the country. Comparative analysis indicates reasonable levels of availability in terms of the location and range of services on offer, however, low levels of accessibility and acceptability were identified due to lack of proximity to where poor settlements, limited opening hours, ad-hoc pro-poor targeting, limited outreach by service providers and the perception amongst communities that services are ‘second rate’. Utilization is high amongst non-working women and infants, but low among the rest of the working population who overwhelmingly rely on the informal private sector.

Smiling Sun Franchise is the most recent urban iteration of long-term USAID investment in NGO health delivery. It aims to create and market a brand of quality MNCH services which are provided by partnering NGOs, and to attract a loyal fee-paying clientele and private sector support to help underwrite subsidized services for the urban poor. Smiling Sun did comparatively well on the dimensions of availability of services, as evidenced by well-provisioned facilities and the presence of qualified personnel. Accessibility by the poor, however, was comparatively low, due to the failure of the service to effectively subsidize costs and the tendency to locate near their middle class clientele.

The timing and infrequency of satellite clinics, and lack of strong outreach, has also undermined the accessibility and acceptability of services, and ultimately, is contributing to declining utilization and market share in urban areas, particularly among the poor.

Marie Stopes is a well-respected provider of reproductive health services known for its commitment to quality and innovative delivery strategies for disadvantaged and marginalized groups. Availability is comparatively high, due to well-equipped and run clinics providing high quality sexual and reproductive health services. By contrast, accessibility is relatively low due to inadequate numbers of slum-based mini-clinics, the high cost of even subsidized services, and the fact that services they provide under UPHCP, are over subscribed and clearly insufficient relative to demand. On acceptability, Marie Stopes innovations in specialized service delivery strategies for specific poor and disadvantaged populations warrant particular mention. This is also reflected in good utilization among specific disadvantaged populations, and by better off clients who can afford clinic services, however, the needful poor do not benefit to the same extent.
Lessons learning across the four urban PHC models

**Availability**
- Additional PHC and EmOC facilities are needed closer to poor settlements
- Contracting with NGOs increases availability however hampers innovation
- More attention to LAPM, nutrition, NCDs and newborn care is required
- Positive experiences of LGD and MoHFW partnerships around EPI, TB & FP could be replicated
- There is a need for national-local coordination around HHR salaries and professional development
- Potential of task shifting PHC functions to trained paramedics, nurses and midwives
- Mapping location of health facilities relative to poor settlements is critical to planning

**Accessibility**
- Extend hours of service for working poor
- Greater effort to coordinate static and satellite coverage and services is required to avoid duplication
- Community-based outreach could be strengthened by using locally recruited workers
- Pay as you go cross-subsidized services is neither equitable nor efficient
- Multiple targeting criteria and multiple cards are messy and inefficient
- Over reliance on payment at point of service i.e. no pre-payment systems and individuals are further driven into impoverishment to mitigate health costs

**Acceptability**
- The urban poor want quality, choice and convenience in services
- Social networks encourage use of health facilities
- Engage slum-based non-formal providers (i.e. pharmacists) around referral & safe practices

Development and application of standardized quality standards can simplify care-seeking
Supportive supervision should be introduced to ensure respectful, quality care
Specialized delivery approaches improve services for hard-to-reach populations

**Utilization**
- Linkages between PHC, community mobilization and poverty reduction activities will strengthen demand for effective MNCH-FP health services
- Outreach has a critical role in health services
- Referral POs based at tertiary facilities assist the poor in navigating the care system
- Mobile technology has proven effectiveness in referral
- Electronic records that travel with women facilitate consistent and appropriate care
- Regular population-based surveys are needed to find out who doesn’t present for services and why
- Provider harmonization around HMIS is a priority with data feedback to local-level managers.

**Conclusion**
Dr. Adams concluded her remarks by discussing the extent to which the Tanahashi framework successfully identified challenges and solutions to effective coverage of PHC services to the urban poor. She noted that efforts to achieve effective coverage must cover the full spectrum of recognizing health needs, ensuring availability of services to address those needs, making these accessible in term of location, cost, and acceptable such that service contact, adherence and follow-up are enhanced. As revealed in her comparative analysis, in urban areas, many obstacles and barriers are apparent along the path to effective coverage, with the health needs of many people left behind at each stage. Used as a conceptual tool for comparative analysis, the Tanahashi framework proved useful in identifying where and why these bottlenecks occur, and in considering what innovations were particularly effective in addressing them. At the same time, the original framework was limited in not embracing the broader social-structural context and health systems factors that are also known to influence effective coverage. Some of the areas left out include governance, considerations of public-private mix, levels of government and information systems.

As shown in Figure 1, this broader context is reflected in a revised version of the framework adapted by Frenz and Vega (2011). Health systems can ease or obstruct access, especially for groups with fewer resources or capabilities according to its specific architecture and features. These include issues of: physical, financial and informational resources; organizational features ranging from governance to private-public, and formal-informal provision; outreach, or the ability to the health system to identify and target the most vulnerable, and the extent to which the system permits the participation of
Likewise, it is important for services to take into account the broader social context, and the many determinants of vulnerability to ill health that are associated with unhealthy urban environments. These encompass: 1) Improvements in the urban health environment (water, sanitation, occupational and food safety among others) that fall beyond the direct purview of the health sector, but are essential to its success; 2) Social determinants of health like urban livelihoods, and women’s empowerment; and 3) The need to develop the health literacy of the poorest and most disadvantaged so that they can recognize need, and have the confidence and skills to navigate a complex urban health system.

A final amendment to the model is to integrate an indicator of UHC with equity which disaggregates effective coverage achieved by different social groups with different health needs. Minimally effective coverage should be equal for all socioeconomic groups, however, ideally, the system should place greater priority on the needs of the most.

**Concluding questions and comments**

Several comments and questions were made regarding the presentation:

- Health systems and institutional structures are vastly different in rural compared to urban areas, resulting in the need to approach health provision differently.
- How do we start to quantitatively define target populations, measure trends and service utilization in Bangladesh with such a dynamic and shifting population? Ideas proposed included measuring the coverage of a particular disease (for example pneumonia) by different service providers.
- It is critically important for a denominator to be established in order to measure what our target population is. One opportunity to do this is looking at a system of unique identifiers, such as assigning birth registration and population registration numbers combined with electronic health records across services.
- There is so little known about how effectively services are reaching populations in terms of population groups and specific diseases/conditions.
- In urban areas, financial accessibility appears to be an important determinant of utilization, as illustrated by this analysis. This raises the potential need for social insurance or pre-payment systems to reduce barriers around cost or the process of subsidization assessment.
- Contractual arrangements (such as the UPHCP model) do not encourage innovation amongst its service providers, as they have been forced to ‘bid low’ for the contract and therefore have limited resources.
- Bottleneck analysis may also assist in considering some of the structural and contextual factors surrounding service utilization.
- The Tanahashi model is linear in nature and therefore has limitations, as not every situation can be represented and analyzed in this manner. It does not take into account enabling environmental factors such as policy frameworks.

*Megacity traffic congestion in Dhaka impedes ambulance service.*
that influence service provision and effective coverage.

- What is an ‘effective’ intervention? This would allow the determination of ‘effective coverage.’ The following scenario was proposed: If availability is low however utilization is high, it begs the question – what is this utilization of?
- Sharing experiences and looking at varied scenarios and applications of the Tanahashi model is useful in promoting critical thinking among professionals in different sectors and projects. It was suggested that stakeholders from these four projects engage around the framework and share experiences regarding challenges and successes, with the goal of making service delivery strategies more effective in reaching the urban poor.