Changes in NCD Management within Urban Primary Health Care System: Analysis of 2014 and 2017 National Surveys

Dr. Deepa Barua, Research Fellow, ARK Foundation

Background

Being one of the most densely populated countries in the world, Bangladesh is witnessing an evergrowing increase in the urban population. The share of the urban population in the total population increased from 33.53% in 2014 to 35.86% in 2017. Despite evidence from nationwide surveys showing an increase in NCD risk factors among Bangladeshi urban dwellers over time, there is an evident gap in the status of NCD management across urban primary health care (PHC) centres. We aimed to understand the changes in NCD management within the urban primary health care system between 2014 and 2017 from nationally representative surveys.

Methods

This was a **quantitative study** where analysis was done based on secondary data from the **Bangladesh Health Facility Survey 2014 and 2017.**

Bangladesh Health Facility Survey or BHFS is a **nationally representative health facility survey** providing information on the availability of basic and essential healthcare services and the readiness of health facilities to provide patients with quality services.

106 urban PHC centres from 1596 facilities of Bangladesh Health Facility Survey (BHFS) 2014 and 66 urban PHC centres from 1600 facilities of BHFS 2017 were included in our study

The BHFS 2014 and 2017, both surveys included two types of data collection tools below and were conducted through tablet computers:

I) Facility Inventory Questionnaire

ii) Health Care Provider Interview Questionnaire

The datasets from the two surveys were analysed in the statistical software Stata, using the framework of WHO Health Systems Building Blocks.

Results

1 Service Delivery

An **increase in availability of NCD management guidelines** (20.75% to 34.85% for diabetes and 16.98% to 21.21% for hypertension) was seen at the urban PHCs between 2014 and 2017.

2 Health Workforce

Urban PHC centres with health workforce who received **training in diabetes increased** from 31.31 in 2014 to 40.91% in 2017. In contrast, **a decrease in workforce trained in hypertension** was noticed from 25.47% in 2014 to 18.19% in 2017.

3 Access to Drugs & Equipment

Between 2014 and 2017, access to Amlodipine **decreased** from 17.92% to 13.64%, while that of Metformin **increased** from 5.66% to 21.21%. Additionally, the availability of diabetic and hypertensive equipment increased from 2014 to 2017.

4 Health Financing

In 2014, 80.19% of the urban PHCs received financial contributions from donor agencies or NGOs. This increased very little in 2017, only a 3% raise. Urban PHC centres financed through user fees **increased** from 13.21% in 2014 to 45.45% in 2017.

5 Health Information System

While availability of computers saw a small **increase** from 74% to 77%, access to internet **increased** from 66% to 79% between 2014 and 2017. However, person designated for health statistics showed a **decrease** from 74% to 42% over the same duration.

6 Leadership & Governance

More than 97% of urban PHCs reported external supervision between 2014 and 2017. However, quality assurance activities **reduced** from 92.45% in 2014 to 74.24% in 2017.

Conclusion

While most components across the health system building blocks showed some improvement, the availability of guidelines, health workforce training, access to NCD drugs and health financing need an increased focus to strengthen the urban PHC system.

CHORUS RESEARCH ON URBAN HEALTH

ark foundation