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Sources for Sick Child Care in Bangladesh

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The private sector is the primary source of care in Bangladesh; however, care-seeking patterns vary by socioeconomic status. Understanding if and where sick children are taken for care is critical to improve case management interventions. This brief presents a secondary analysis of the 2014 Bangladesh Demographic and Health Survey to examine where treatment or advice is sought for sick children who experienced at least one of three treatable illnesses: fever, acute respiratory infection, or diarrhea. These illnesses represent some of the leading causes of death in children under five years old.

Key Findings

- 40% of Bangladeshi children experienced fever, acute respiratory infection symptoms, or diarrhea in the past two weeks.
- 84% of Bangladeshi caregivers seek treatment or advice outside the home, across all three illnesses.
- Among caregivers who seek sick child care, 55% use the private sector, 15% use the public sector, and 30% use other sources (unqualified doctors).
- Many more caregivers from the wealthiest quintile (73%) seek care from the private sector than the poorest caregivers (45%).
- 98% of public sector care seekers access a clinical facility; 54% of private sector care seekers access a non-clinical source (nongovernmental field workers and pharmacies).
- The substantial use of other sources of care in Bangladesh is an important finding that should inform programs to improve child survival.

This is one in a series of briefs that examines care seeking in USAID maternal and child survival priority countries.

Illness prevalence

According to mothers interviewed across the country for the Bangladesh Demographic and Health Survey, 40 percent of Bangladeshi children under five experienced one or more of the following illnesses: fever (37 percent), symptoms of acute respiratory infection (ARI)—a proxy for pneumonia—(5 percent), and/or diarrhea (6 percent) in the two weeks prior to the survey.[1]

Out-of-home care seeking

When children fall ill, most caregivers in Bangladesh (84 percent) seek advice or treatment outside the home.[2] For children with ARI symptoms, 89 percent of caregivers seek care outside the home. Comparatively, 77 percent of caregivers seek advice or treatment for children with diarrhea. The high ARI burden in Bangladesh and the fact that diarrhea can often be effectively managed at home could contribute to the differential care-seeking levels between these two illnesses. The overall care-seeking level in Bangladesh is somewhat higher than the average level (78 percent) across Asian maternal and child survival priority countries ("USAID priority countries").[3]

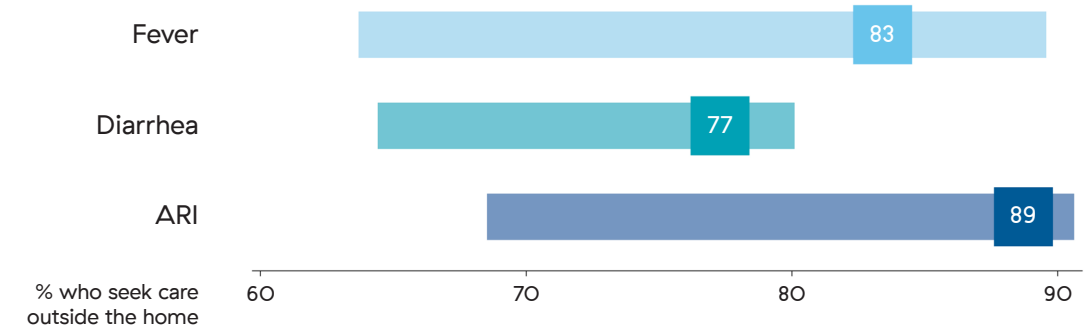
2 out of 5 children in Bangladesh experienced fever, ARI symptoms, or diarrhea in the last 2 weeks.

Sources of care

The private sector is the primary source of sick child care in Bangladesh. Among caregivers who seek treatment or advice outside of their homes, 55 percent use private sector sources, 15 percent use public sector sources, and 30 percent seek treatment from other sources, typically unqualified doctors. Compared to other USAID priority countries, Bangladesh has the highest care-seeking level from other sources, which likely has implications regarding the quality of care sick children receive. Among public sector care seekers, almost all (98 percent) go to a clinical facility like a hospital or a clinic, rather than seeking care from a family welfare assistant. In contrast, 46 percent of private sector care seekers use clinical facilities, while the remainder use non-clinical sources such as pharmacies. This analysis shows where caregivers go for treatment, regardless of their level of access to different sources of care. It does not reflect where caregivers might choose to go if they had access to all sources of care.

Figure 1. Compared to its neighbors, Bangladesh has high levels of out-of-home care seeking

The bars indicate the care-seeking range in the region. Squares show the care-seeking rates in Bangladesh.

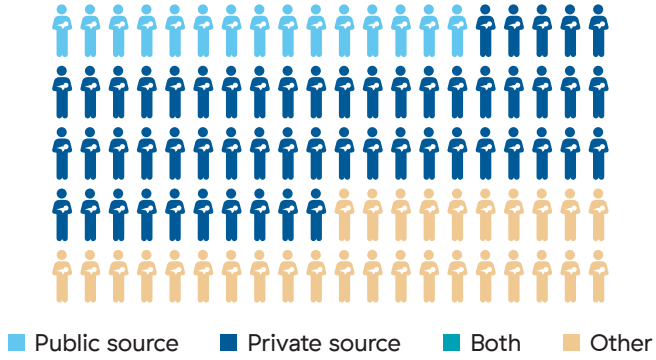


[1] All Demographic and Health Survey data used in this analysis are reported by mothers who were asked if their children under age five experienced fever, ARI symptoms, or diarrhea in the two weeks before the interview. These data do not report whether children recently had pneumonia or malaria because both illnesses must be confirmed in a laboratory. Instead, the Demographic and Health Survey reports whether or not children had recent symptoms of ARI as a proxy for pneumonia, and fever as a proxy for malaria. ARI is defined as a reported cough with chest-related rapid or difficult breathing.

[2] In this analysis, out-of-home sources of care comprise public sources (hospitals, Upazila health complexes, Upazila health and family welfare centers, maternal and child welfare centers, community clinics, satellite clinics, and family welfare assistants), private sources (private clinics, hospitals, and doctors; nongovernmental organizations, nongovernmental static and satellite clinics, and nongovernmental field workers; pharmacies), and other sources (unqualified doctors). This brief focuses on sources of care outside the home, not whether or not the child received proper care, which could include at-home use of oral rehydration salts for diarrhea.

[3] The USAID priority countries in Asia are Afghanistan, Bangladesh, India, Indonesia, Myanmar, Nepal, and Pakistan.

Among caregivers who seek sick child care outside the home, 15% seek treatment or advice from public sector sources, 55% from private sector sources, and 30% from other sources.



Equity in illness prevalence and care seeking

In Bangladesh, the burden of fever, ARI symptoms, and/or diarrhea in the poorest households is slightly greater than it is in the wealthiest households (42 percent versus 36 percent, respectively). The poorest and wealthiest children in Bangladesh who experience one of these illnesses are equally likely to receive treatment (83 percent and 86 percent, respectively). The magnitude of the disparity in care seeking between the poorest and wealthiest quintiles in Bangladesh is the smallest among the USAID priority countries in Asia.

Figure 2. Regionally, Bangladesh has the lowest wealth disparity in care seeking

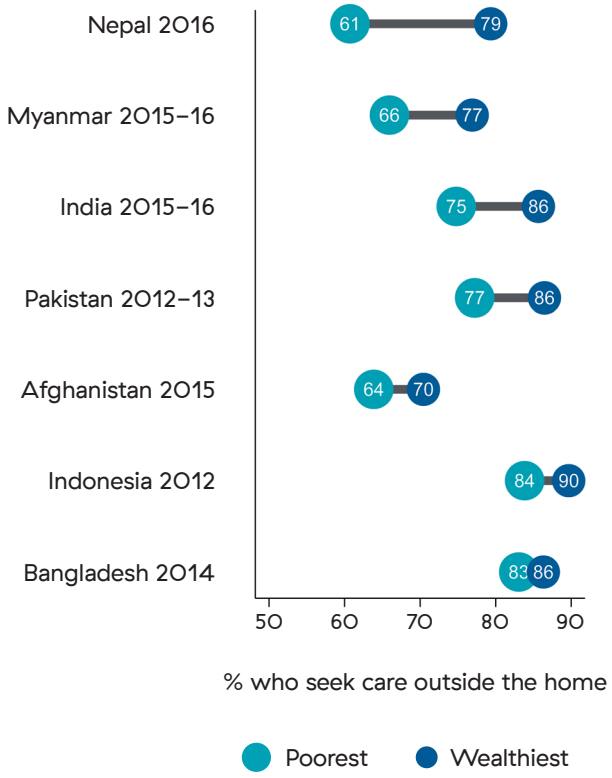
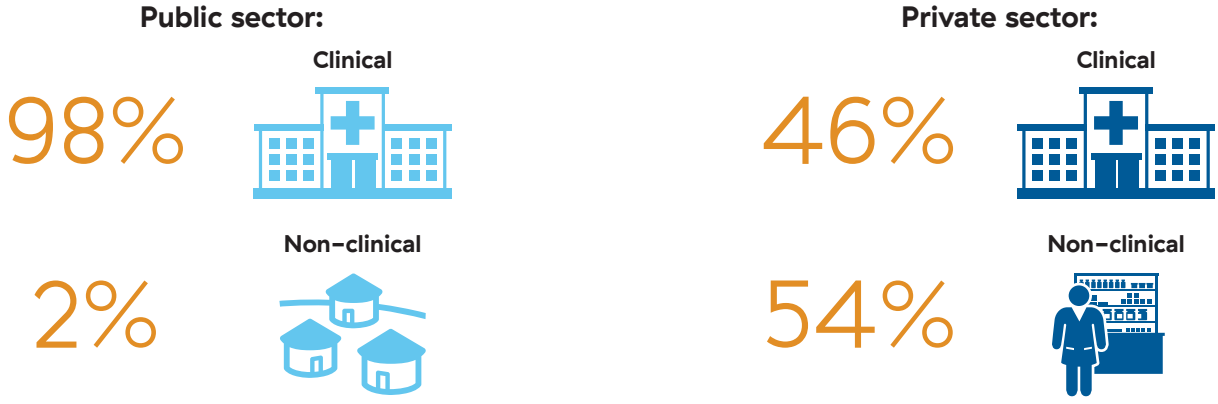


Figure 3. Public sector clients use clinical sources while private sector clients use non-clinical sources

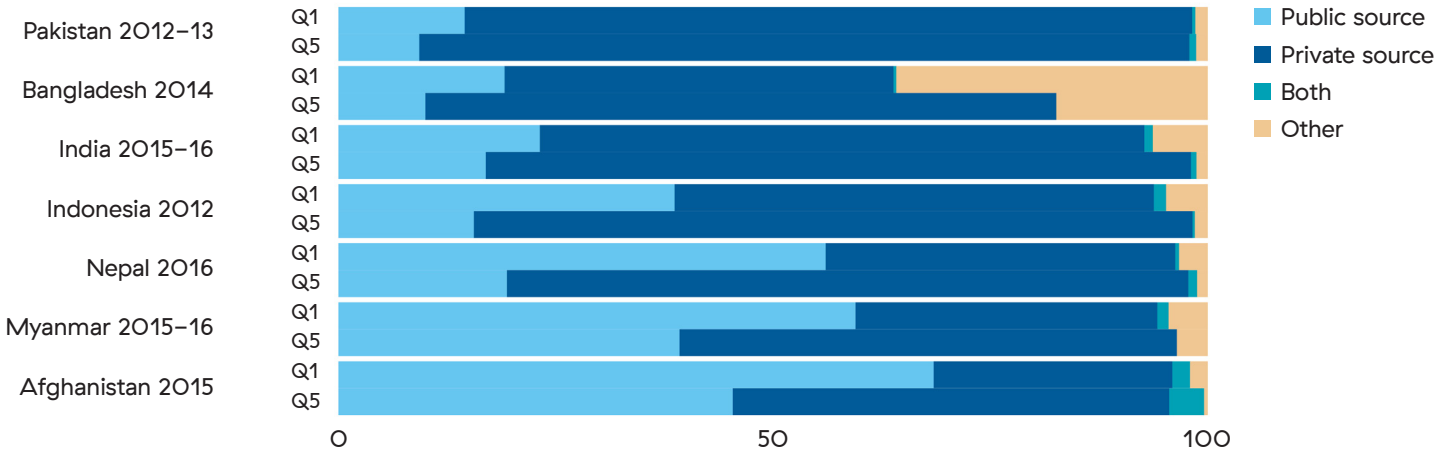


Sources of care categories

Public sector: Hospitals, Upazila health complexes, Upazila health and family welfare centers, maternal and child welfare centers, community clinics, satellite clinics, family welfare assistants
Private sector: Private clinics, hospitals, and doctors; nongovernmental organizations, nongovernmental static and satellite clinics, and nongovernmental field workers; pharmacies
Other: Unqualified doctors

The majority of care outside the home for sick children is accessed from the private sector across socioeconomic statuses. However, the wealthiest caregivers are more likely than the poorest to seek care from a private sector source (73 percent versus 45 percent, respectively) and are less likely to seek care from the public sector (10 percent versus 19 percent, respectively). In addition, the poorest families are much more likely to use other sources of care than the wealthiest families (36 percent versus 17 percent, respectively). Compared to all other USAID priority countries, caregivers in Bangladesh are much more likely to seek care from other sources. The substantial use of unqualified doctors and the large socioeconomic disparity in reliance on these informal providers are important findings that should inform Bangladeshi programs to improve child survival.

Figure 4. Use of other sources of care is high in Bangladesh, particularly among the poorest



Q1: Poorest, Q5: Wealthiest

Conclusion

Fever, ARI symptoms, and diarrhea are common illnesses in Bangladesh, affecting 40 percent of all children. The majority of caregivers seek advice or treatment outside the home for their sick children across all socioeconomic statuses. The private sector is the primary source of out-of-home care for both the poorest and wealthiest sick children. The level of private sector care seeking among the wealthiest Bangladeshis is higher than the level among the poorest. Bangladesh has the highest reliance on other sources of sick child care, primarily unqualified doctors, among all USAID priority countries. While this holds true for both the poorest and the wealthiest, poorer caregivers are more likely than their wealthier counterparts to rely on other sources of care. The substantial use of other sources of care and the socioeconomic differences in care seeking patterns should be considered when designing programs to improve child survival in Bangladesh.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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