EC BANGLADESH

Assessment of Essential Service Delivery (ESD) Program in NGO Clinic and UPHCP

National Institute of Population Research and Training (NIPORT)
MINISTRY OF HEALTH AND FAMILY WELFARE

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Content

Acknowledgement

The research study on "Assessment of the Essential Service Delivery (ESD) Program in NGO Clinic and UPHCP" played a massive role to investigate type of providers and their experience in EDS, capacity to provide service, community people's perception as well as client's satisfaction to the NGO Clinic and UPHCP which will help to further improvement of the service and initiative for future intervention of NGO Clinic and UPHCP.

The study is conducted in 14 district comprising Dhaka, Chitagong, Rajshahi, Barishal, Bogra, Mynensingh, Shirajgonj, Comilla, Noakhali, Bagerhat, Nilphamari, Jhenaidah, Khulna and sylhet with a view to cover seven divisions of Bangladesh considering NGO clinic working areas and 6 City Corporation and 5 Municipalities as the area of UPHCP.

However, the whole assignment has been commenced and completed according to the designed plan and guidance of NIPORT representatives from central to district level. We are very much thankful and indebted to them for their cordial and professional participation with this study.

The Project Management Unit (PMU) of UPHCP under the Ministry of Local Government and Rural Development and Cooperatives (MoLGRDC), Project Implementation Unit (PIU) of City Corporation and municipalities, local administration of the district alongside CS and officials of other departments of Govt. and PA NGOs have provided remarkable support by making available information and other assistance to the study team. We are grateful to them for their all-out cooperation to complete the study.

Last but not the least; we wish to express our profound gratitude to the research team for their sincere and hard working during data collection and other related works. EC Bangladesh is also grateful to local influential, teachers Community People, service providers and service receivers and all others involved in Key Informer Interview (KII), Focus Group Discussion (FGD) and individual interviews for giving us their invaluable information, data and co-operation during this study.

Arif Sikder
Executive Director
EC Bangladesh

Foreword

The study report may be measured as comprehensive one which shows that the present status of NGO clinic and UPHCP that included the role of providers and their experience, capacity, community people's opinion as well as client's satisfaction to the Essential Service Delivery program which will help to further improvement of capacity, quality in order to ensuring better services.

The study has been conducted through an integrated approach combining qualitative and quantitative methods. Sample from different segments of the population such as managerial service providers, mid-level service providers and service recipients from the various service delivery points of UPHCP and NGO clinics has been collected.

This study team has gained multi-disciplinary opinion about the services through direct observation, Focus Group Discussions, Key Informer Interviews in participation of government representatives, community influential, and community people that has been incorporated with this study report.

The research team including of team leader, demographer, statistician, public health specialist, sociologist, computer programmer has been involved full time basis in conducting of this survey. The study team is confident that the findings from this study will represent the general status to improve Essential Services Deliver Program in UPHCP and NGO clinic in Bangladesh.

Representative from relevant government officials such as Civil Surgeon, Thana Nirbahi Officer, City Corporation and municipalities has also been interviewed as the key informer and gained a lot of data information as well as specific recommendations which has been included in this report.

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DG, NIPORT

National Institute of Population Research and Training (NIPORT)

Preface

The study on Assessment of Essential Service Deliver Program in NGO clinic and UPHCP has been conducted by EC Bangladesh with the purpose of investigating type of providers and their experience in EDS, capacity to provide service, community people's perception as well as client's satisfaction which will help to review the program in order to further improvement of the essential service package in NGO Clinic and UPHCP.

In order to improve the health status of the urban population by ensuring quality Essential Service Delivery that included multi disciplinary services through Public-Private Partnership approach, Government and NGOs have been implementing Urban Primary Health Care Program and on the other hand different individual NGOs have been implementing health program through clinics in urban and rural areas in Bangladesh especially for the poor, particularly focusing on women and children. But still there are some limitations in facilities, capacity of service providers due to lack of training and different types of problem. This study helped to investigate the real status of these clinics and capacity of service providers as well as their requirements on training to provide ESD program in Bangladesh.

"Training Research and Development" Operational Plan, Health Population and Nutrition Sector Development Program (HPNSDP), National Institute of Population Research and Training (NIPORT) under the Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh has allocated public fund and procured services in order to conduct the research to Environment Council Bangladesh.

The report of this study comprised the present insight of the service receiver and community people and capacity of service providers as well as various recommendations to increase the quality of Essential Service Package and improve the capability of provider through NGO clinic and UPHCP in Bangladesh.

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Director (Research)

National Institute of Population Research and Training (NIPORT)

Acronyms

AHI	Assistant Health Inspector
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual operational plan
ARI	Acute Respiratory infection
BCC	Behavior Change Communication
CBD	Community Based Distributions
CMMU	Construction, Maintenance and Management Unit
CS	Civil Surgeon
DOTS	Directly Observed Therapies
ECNEC	Executive Committee of National Economic Council
EPI	Expanded Program on Immunization
ESP	Essential Services Package
ESD	Essential Service Delivery
FGD	Focus group discussion
FP	Family Planning
FPHP	Fourth Population and Health Project
FP-MCH	Family Practice–Maternal and Child Health
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HA	Health Assistant
HPSP	Health and Population Section Program
HNPSP	Health Nutrition and Population Sector Programme
HPNSDP	Health Population and Nutrition Sector Development Program
HPSS	Health and Population Sector Strategy
HSC	Higher Secondary Certification
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
KII	Key Informer Interview
MCH	Maternal and Child Health
MDT	Multi-Drug Therapy
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MSR	Medical and Surgical Requisite
MTR	Mid-Term Review

NGO	Non-Government Organization
ORS	Oral Rehydration Salt
PMU	Project Management Unit
PIU	Program Implementation Unit
PIA	Program Implementation Area
PA	Partner Area
PRO	Policy and Research units
R&D	Research and Development
SSC	Secondary School Certificate
STD	Sexually Transmitted Disease
STI	Sexual Transmitted Infection
SWM	Sector Wide Management
TB	Tuberculosis
TT	Tetanus Toxide
UH&FPO	Upazila Health and Family Planning Office
UHC	Upazila Health Complex
UHFWC	Upazila Health and Family Welfare Centre

Executive Summary

About 26% of the population of Bangladesh live in urban areas out of them a large proportion of are living in slum areas. Due to lack of knowledge and information on health most of the urban slum dwellers cannot able the access to essential basic health services. Children those are living in urban slums are deprived of education and health care. Women folk who are also the most neglected group existing in the slum to meet their basic health needs and ensuring their rights as a result there are high rate of mortality and morbidity is existed among slum dwelling.

The Government of Bangladesh is committed to address the issues of improving the health status of the urban population. This is to be done through improved access to and utilization of efficient, effective and sustainable Primary Health Care Services. The provision of public health services in urban areas is the responsibility of Local Government Bodies as mandated by the Local Government (City Corporation) Ordinance 2008 and the Local Govt (Pourashava) Ordinance 2008.

For primary health care services delivery, the public sector works in partnership with NGOs and the local government institutions such as the City Corporations and Pouroshova UPHCP has been implementing. The health service delivery mechanism in urban areas involves diverse roles of the government (MOLGRD&C and MOH&FW), NGOs and the private sector. On the other hand, to ensure health care service including maternal health and child care, reproductive health care, clinical and non-clinical family planning services, communicable disease, tuberculosis, post-abortion care safe delivery including first aid emergency obstetric care. These NGO's works through 346 urban and rural clinics, nearly 8000 satellite clinics and almost 7000 female storehouse holders nationwide is serving approximately 17% of the national population. Over 1.5 million customers are getting services each month.

The aim of the study was to investigate type of providers involved with this service and their experience in EDS, capacity to provide service, community influential's opinion as well as client's satisfaction to the services of NGO clinic and UPHCP. Using a combination of quantitative and qualitative techniques, the study gathered data and evidence from service providers, service receiver and local influential people. The study also drew on policy and

management documents, routine statistics, and previous studies and reports that included information on NGO clinic and UPHCP. The sample of clinics covered all areas of the country and included a wide range of setting. The study team is, therefore, confident that the findings represent the general state of development of NGO clinic and UPHCP.

The key findings of the study are given below:

- **Type of Service Providers Involved in the Service**

Different type of staffs are involved according to the range and type of service like Doctor cum Clinic Manager, Field Supervisor, Medical Assistant, Nurse, Counsellor, Health Worker, Pharmacist, Office Assistant, Lab Technician, MLSS, Aya, Night Guard, Driver etc. Type of service provider is enough to carry on the center properly but less number of staff or service provider is a fact. Most of the centres have the physicians who are designated as Clinic Manager which is a barrier to ensure quality servicer and cause of work load to a doctor playing the role at the same time. So it is needed to recruit individual staff for both of the position of Clinic Manager and Physician. In some cases, existing field level workers cannot complete his planned activities within the time frame due to large scale of area and population.

- **Staff's experience and training to provide ESP:**

The level of staffs experience is mixed. Some of staffs are very experienced on essential service delivery because they have gained practical knowledge and participated in different types of training during their working period and some are recruited newly who are less experienced because they didn't have much training on Essential Service Delivery (ESD) for their individual position and responsibilities. One thing is remarkable that the technology, process and methodology is varied due to effect of modernization and for this why doctors who got different training previously cannot deserve the new technology. So training is needed as the continuous activity for the staff especially for the doctors and health assistant or paramedics. Multi-disciplinary training on ESP is also needed for the staff. It is needed to arrange Child Health Care related training for the Physician.

- **Capacity of Staff to provide services:**

In order to ensure quality ESP it is essential to become enough capable in individual working field and multi-sectoral approach. Evidence shows that in case of capability of staffs involved

in ESD there was remarkable variation one to one. Some staff has 5-8 years working experience and some have 6 months to 1 year working experience on the field of ESD Programme. Less experienced staff has received limited number of training and there was a limitation of follow up and refresher training in the next time. Except basic training on ESD there were expectations from the staff to arrange multi-dimensional training such as social motivation, mobilization, communication, planning, area based development approach, rapport building, centre management, monitoring and evaluation, follow up supervision, reporting, documentation, presentation, application of modern tools and techniques relevant to the health, one to one communication, case study writing etc.

- **Facilities :**

Different types of services are provided in the NGO clinic and UPHP such as Child Health Care, Reproductive Health Care, Communicable Disease Control, Limited Curative Care, Management and Prevention/Control of RTIs/STIs, VCCT for HIV/AIDS, Management of Violence against Women, Primary Eye Care, TB Control & Treatment, Behaviour Change Communication, Diagnostic Service etc. Here it is mentionable that most of the centers have diagnostic service but some of them have limited number of diagnostic facilities. If all types of diagnostic service is included under each NGO clinic and UPHCH (CRHCC and PHCC). Satellite service is needed to enlarge in terms of wide range of location and areas. There are limited types of drug is provided to the clients.

- **Community level influential's opinion about the capacity of the service providers**

Though there were limited involvement of community level influential is seen during this study. But someone who is aware on this service and committed to develop the service for poor people has told that staffs capacity in ESD is needed to develop and for this regular training and follow up activity, refresher training, monitoring is very essential. They have given the opinion that capacity of a staff can ensure the quality service.

- **Client's satisfaction and opinion in development of service of NGO clinic and UPHCP:**

Client's satisfaction is good to the service because they can get health service with no cost and low cost. But they have the expectation for more medicine supply as per need of various diseases. Sometime clients cannot reach the physician due to his /her absence or late presence

in the clinic. Proper monitoring is very essential for the center so that they can get the service when they need. Sometime due to lack of continuous electricity supplies they cannot feel comport to wait in the clinic. So it is important to ensure generator facility for the clinic.

Many of the problems found in other health services are appeared here–shortages of drugs and consumables, insufficient skills in some staff, staff not available when needed, and generally services considered being of a poor standard by users. There were also risks in that some previously successful outreach services are to be replaced, and there is a need to ensure that the benefits of these are retained.

It is needed to strengthen Clinical Contraceptive Services, increase utilization of long-term clinical contraceptive services, include voluntary sterilization, increase engender Health, aims to improve knowledge, awareness and demand for clinical contraceptive services; strengthen counselling and quality of services including infection prevention, include more training of providers; strengthen BCC activities; develop logistic support and management information system.

It is essential to increase training and education in Reproductive Health to strengthen the capacity of service providers, enhance on the job performance of service providers, development of training on MIS that will encourages follow-up of training and monitors quality, improve prevention and management of sexually transmitted diseases; improve program monitoring and evaluation; developed a series of television spots and videos in order to influence behaviour through educational entertainment to the client in NGO clinic and UPHCP.

Chapter One: Introduction and Rational

Background

The Health and Population Sector Programme (HPSP): 1998-2003 of the Government of Bangladesh and the USAID-funded National Integrated Population and Health Programme (NIPHP): 1997-2002 are aimed at providing a range of health and family planning services through an effective and financially sustainable system capable of delivering an Essential Services Package (ESP) to be responsive to clients' needs, especially to that of vulnerable groups, i.e., women, children, and the poor. The ESP delivery involves reorganization and restructuring of the existing service-delivery strategy from the home-visitation approach to a static centre service-delivery (Programme Implementation Plan, Part I, HPSP). The HPSP has also focused on sector-wide management within a sectoral policy framework, instead of a multiple project-driven approach, with a view to addressing a range of structural inefficiencies and inconsistencies in the health and family planning sector where separate vertical and duplicative services, including support systems, exist. Implementation of a client-oriented cost-effective service-delivery system for the ESP has evolved as the most critical concern of the HPSP.

The urban areas and their health dynamics are different from those of the rural part of the country. The urban population is growing fast with high intra-urban mobility of inhabitants, creating excess of demand for healthcare and becoming problem for any kind of estimations. The municipalities and city corporations are constitutionally mandated to providing primary healthcare to their inhabitants. But usually they are under-staffed and under-equipped to meet the demand for healthcare and are obviously unable to meet the extra demand, especially when the government has adopted a health sector reform to provide her citizens with a broader range of services (ESP) at a minimum cost.

The HPSP defines the Essential Services Package as a package of health and family planning services responsive to clients' needs, especially of women, children, and the poor, and includes high-impact quality services that are financially sustainable to be delivered through a one-stop service. The main purpose of ESP delivery in HPSP is to organize services,

provided at different levels, in a way that they meet the needs of the population, and are cost-effective, easier to manage and convenient for the clients/patients.

UPHCP and NGO Clinic

The Government of Bangladesh is committed to put in place strategies to address the issues of improving the health status of the urban population. This is to be done through improved access to and utilization of efficient, effective and sustainable Primary Health Care Services. The provision of public health services in urban areas is the responsibility of Local Government Bodies as mandated by the Local Government (City Corporation) Ordinance 2008 and the Local Govt (Pourashava) Ordinance 2008.

For primary health care services delivery, the public sector works in partnership with NGOs and the local government institutions such as the City Corporations and Pouroshovas. The health service delivery mechanism in urban areas involves diverse roles of the government (MOLGRD&C and MOH&FW), NGOs and the private sector.

Urban Primary Health Care Project, a Public-Private Partnership is an innovative initiative with the goal to improve the health status of the urban population, specially the poor, particularly focusing on women and children. These population segments are usually underserved by the health care facilities due to many reasons. UPHCP is committed to provide all essential health and reproductive health services to them for improvement of their livelihood. With the aim at contributing to achieve the national goals and targets of the Millennium Development Goals (MDGs), the First Urban Primary Health Care Project (UPHCP) and Second Urban Primary Health Care Project (UPHCP-II) were initiated in 1998 and 2005 respectively which are milestones in urban health care services.

On the other hand, in order to improve the health status of the urban and rural population, specially the poor, particularly focusing on women and children of Bangladesh different NGOs have been implementing ESD programme through 346 urban and rural clinics, nearly 8000 satellite clinics and almost 7000 female depot holders nationwide, serving approximately 17% of the national population. Over 1.5 million customers are served each month. Major objectives of the program include expanding the range and quality of services;

increase access to services by the poor; NGO institutional and financial capacity building; and influencing policy to expand the role of NGOs as health care providers in Bangladesh.

Components of Essential Services Delivery Program

Within the overall context of the HPSP, the elements of the ESD are grouped into the following five areas:

a. Reproductive Health Care
b. Child Health Care
c. Communicable Disease Control
d. Limited Curative Care
e. Behaviour Change Communication (BCC)

Rationale for the study

The Government of Bangladesh (GoB) is committed to ensuring the nationwide availability of the Essential Services Package (ESP). Its main aim is to make available key preventive and curative services and information, addressing the major causes of mortality and morbidity among children, women, and the poor in general. In Bangladesh, although the health and family-planning infrastructure has been developed to provide a range of services through a tiered system, in practice, most services are not linked to other services, especially at the urban primary care level, resulting in limited effectiveness. Despite the availability of the considerable infrastructure for service-delivery, services still remain largely fragmented, and are not organized to meet the basic health needs of customers adequately. By ensuring a one-stop provision of integrated package of essential services from a fixed site and by adopting a customer-oriented approach, the basic health needs of customers could be better addressed. To assess the overall scenario, this study is designed into the Urban Primary Health Care Project (UNHCP) Clinic and NGO Clinics in Bangladesh.

Chapter Two: Literature Review

The lowest tier of the urban primary healthcare-delivery system comprises Satellite Clinics organized by NGOs. The next tier of service-delivery includes fixed clinics/dispensaries, managed by the GoB/NGOs. Several government agencies, such as, city corporation (or municipal) health department, DGHS and Directorate of Family Planning (DFP) together with a large number of commercial and voluntary organizations, provide ESD services in urban areas. At the government dispensary level, the delivery of basic health and family-planning services is fragmented: Directorate of Health Services supervises the medical officers and provides limited curative cure; DFP supervises the paramedics (FWVs), and provides family-planning methods, antenatal care (ANC), postnatal care (PNC) etc., and the Dhaka City Corporation supervises the vaccinators who provide child immunization. The source of supplies is also multiple and different from each other.

Although these facilities are expected to provide essential services, individual facilities usually offer a limited range of services, and many of these have become single-purpose clinics, i.e. providing only immunization, or only family-planning, or only curative services, etc. The consequences of fragmentation of services not only increase the cost of providing these services, but also limit access to these services as inconvenience and opportunity costs for the clients increase. The staffs of these facilities are either medical doctors or paramedics who could be trained further to provide a broader range of services and supervised by a common management structure to overcome their limitations.

Operations research on urban ESP delivery

To improve the health and well-being of the rapidly growing urban population, the ORP had embarked on a collaborative research with a number of government agencies. The experience was built on working in the slums of Dhaka and with the GOB and NGO stakeholders involved in the delivery of health and family-planning services [1], the government agencies involved in the partnership include: MOHFW, MOLGRDC, DGHS, DFP, and DCC. The purpose of this collaborative endeavour was to operationalize an integrated ESP delivery system in the public sector clinic at primary level for the urban population, with special focus on the slum and non-slum poor.

The ESP Intervention

A clinic-level needs-assessment study completed in September 1998 identified the following weaknesses for further improvement and strengthening [9]:

1. Absence of a proper physical facility and logistics, including insufficient seating arrangements, absence of an exclusive consultation area with privacy of clients, non-availability of a number of basic tools (vaginal speculum, spot light, gloves, etc.) and drugs.
2. Absence of job-aids (service-delivery protocols) for providers and training of providers on the corresponding national guidelines, poor use and inappropriate management of RTIs/STIs, and some childhood illnesses.
3. Poor supervision and absence of supervisory mechanism with little coordination among providers.
4. Overlapping of responsibilities and absence of clear-cut job descriptions of staff.
5. Inappropriate client appraisal, lack of history-taking and physical examination, and other aspects of client care.
6. Absence of any screening procedure for identifying need(s) of additional service(s) of clients.
7. Absence of any system of counselling and health education for attending clients.

Based on the above findings, the key research issues were defined, and the intervention was designed. A Model ESP Clinic was defined to be characterized by:

- Appropriate physical facility
- Appropriate staffing
- Availability of essential health and family-planning services of acceptable quality
- Linkage of services and providers
- Appropriate counselling and health education to clients
- Identification of needs of the clients for additional service(s) and tapping of missed opportunities
- Improved satisfaction of clients with awareness on the services available

The operations research was conducted during October 1998-March 2001, and the following activities were undertaken either consecutively or simultaneously. Each of these activities was properly monitored, and the related processes and effects were documented.

Chapter Three: Research Objectives and Methodology

Aim of the Research

The general objective of the study is to assess the capacity and utilization of the NGO Clinic and UPHCP for implementation of Essential Service Delivery (ESD).

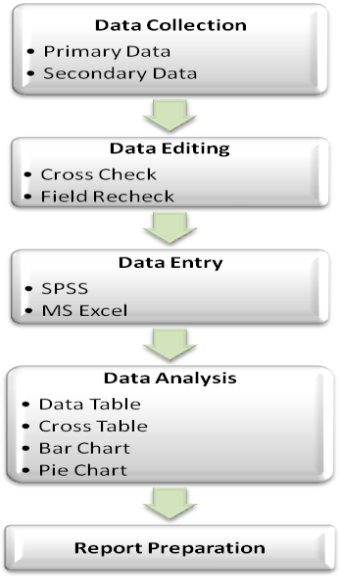
Specific Objectives

Several specific objectives were set to achieve the ultimate goal of the research. The specific objectives of this research were as follows:

- To investigate type of providers involved in the service of the NGO Clinic and UPHCP
- To investigate their experience and training to provide ESP
- To investigate their capacity to provide services at the NGO Clinic and UPHCP level
- Investigate facilities
- To investigate the exit clients of the NGO Clinic and UPHCP to assess their opinions about their service
- To investigate the opinions of the community level influential's about the capacity of the service providers

Specific Tasks

With a view to achieving the goal and objectives of the research, there were many specific tasks to be accomplished under the research. Specific tasks as outlined in the ToR and to be carried out by the consultant were as follows:



Methodology for Carrying Out the Activities and Obtaining Expected Output

In order to achieve the set goal and objectives of the assignment, following steps had been completed during the study:

- Recruitment of data collector and other staffs
- Inception Report Preparation and Submission
- Research materials development
- Existing literature review
- Orientation Training for the staff
- Team composition and placement:
- Sample Questionnaire Interview
- Focus Group Discussion (FGD)
- Observation
- Interview of Key informant
- Opinion sharing meeting
- Data input and interpretation
- Workshop on draft report sharing

- Draft Report Submission:
- Inspection, Monitoring and Evaluation
- Final Report preparation and Submission

The following section provides illustration of major designed activities:

Recruitment of data collector and other staffs
After awarding the assignment and signing the contract, recruit of necessary number of qualified and experienced data collector and staff to accomplish the project activities have been completed. Standard process has been followed to select the best candidate. A total number of 12 data collector and 6 supervisors have been recruited for the field.

Inception Report Preparation and Submission
An incretion report has been prepared mentioning that the assignment work has been started and the activities are going on well. The inception report included the reviewed action plan. The inception report produced 5 copies according to the requirement of ToR. The report has been submitted maintaining the quality and dead line.

Research materials development
The expert professional team recruited for this study prepared more effective and qualitative questionnaire for proper data and information collection. Other logistic materials like clip board, pen, pencil, poster paper, computer, printer etc also developed in time.

Existing literature review
The research team reviewed existing literatures related to this assessment in order to identify recent status and collected existing data and information those helped to conduct this study effectively.

Orientation Training for the staff
The required project staff has been given orientation training to equip them with the theme, goal, objectives, methodology, working strategies, expected results and impact of the assignment. The training module and schedule has been developed by incorporating the training methods, equipments and ground rules to be used. A standard Terms of Reference (ToR) in this regard also has been developed.

Team composition and placement:

After completion of training and considering concerned factors a well team has been composed and placed in respective working station within the project areas. Psycho-social factors have been considered in team composition and placement of staff so that the team could work with satisfaction. It helped the team timely accomplishment of assignment activities both quantitatively and qualitatively.

Sample Questionnaire Interview

In Bangladesh there are 185 UNHCP centers and 24 of them are Comprehensive Reproductive Health Care Centre (CRHCC) and rests 161 are Primary Health Care Centre (PHCC) in nine City Corporations and Municipalities. There are 35 well known NGOs who are providing essential health services through clinics to different communities in Bangladesh. Nearly 346 urban and rural clinics, 8000 satellite clinics and almost 7000 female depot holders nationwide and serving approximately 17% of the national population. Over 1.5 million customers are served each month. Major objectives of the program include expanding the range and quality of services; increase access to services by the poor.

Under this research a total number of 40 NGO clinics and 80 UNHCP centres (6 Nos CRHCC and 74 Nos PHCC) have been selected for data collection.

About 200 service recipients from those selected NGO Clinic and UPHCP centers have been surveyed and 25 Manager who are top level of responsible person of those institutions and 60 service providers who are directly involved to ESP also have been surveyed. Thus a total number of 285 persons have been interviewed during this study through following simple sampling method. Supervisors followed up and provided all kinds of support and facilities to the data collectors. Supervisors' submitted individual reports to team leader and provided information time to time. All professionals have gone to the field according to their personal plan and visited the field activities.

Focus Group Discussion (FGD)

A total no of 12 Focus Group Discussions have been conducted under 12 NGO Clinic and UPHCP centres areas. Focus Group Discussions have been conducted to understand the views and opinions of service providers; community influential's and service receivers

Photo-2: Participants are attentive to Focus Group Discussion

concerning the ESD Program in NGO Clinic and UPHCP operation. The participants for the FGD have been considered (i) clients, (ii) community influential, (iii) two types of service providers both mid and top level staff, and (iv) Thana officials. In each focus group 10 to 12 participants have participated for discussion. Focus Group Discussion (FGD) have created the scope to participate collectively all types of individual who are directly or indirectly involved with this ESD Program in NGO clinic and UPHCP centers.

Observation

The research team followed up observation method to identify the actual situation of the ESD Program in NGO Clinic and UPHCP centers considering low, medium and high performance. The team has visited about good number of Clinic during the service period. The observer prepared an in-depth report after completion the observation. This observation method helped to reach the data accumulation.

Opinion sharing meeting

An opinion sharing meeting has been conducted where health and family planning representative, national and international level researcher, different level of service providers involved in ESD program of NGO clinics and UPHCP centers, service recipient, doctors have participated. In the meeting an environment has been created to share the goal, objectives and tasks of the study as well as suggestions.

Data input and interpretation

After completion of all types of data and information collection, the expert computer programmer completed the data input. He prepared a data base with all types of data collected from the field during this study. The research team analyzed data for making the draft report after collection of all data and designed assessment activities.

Workshop on draft report sharing

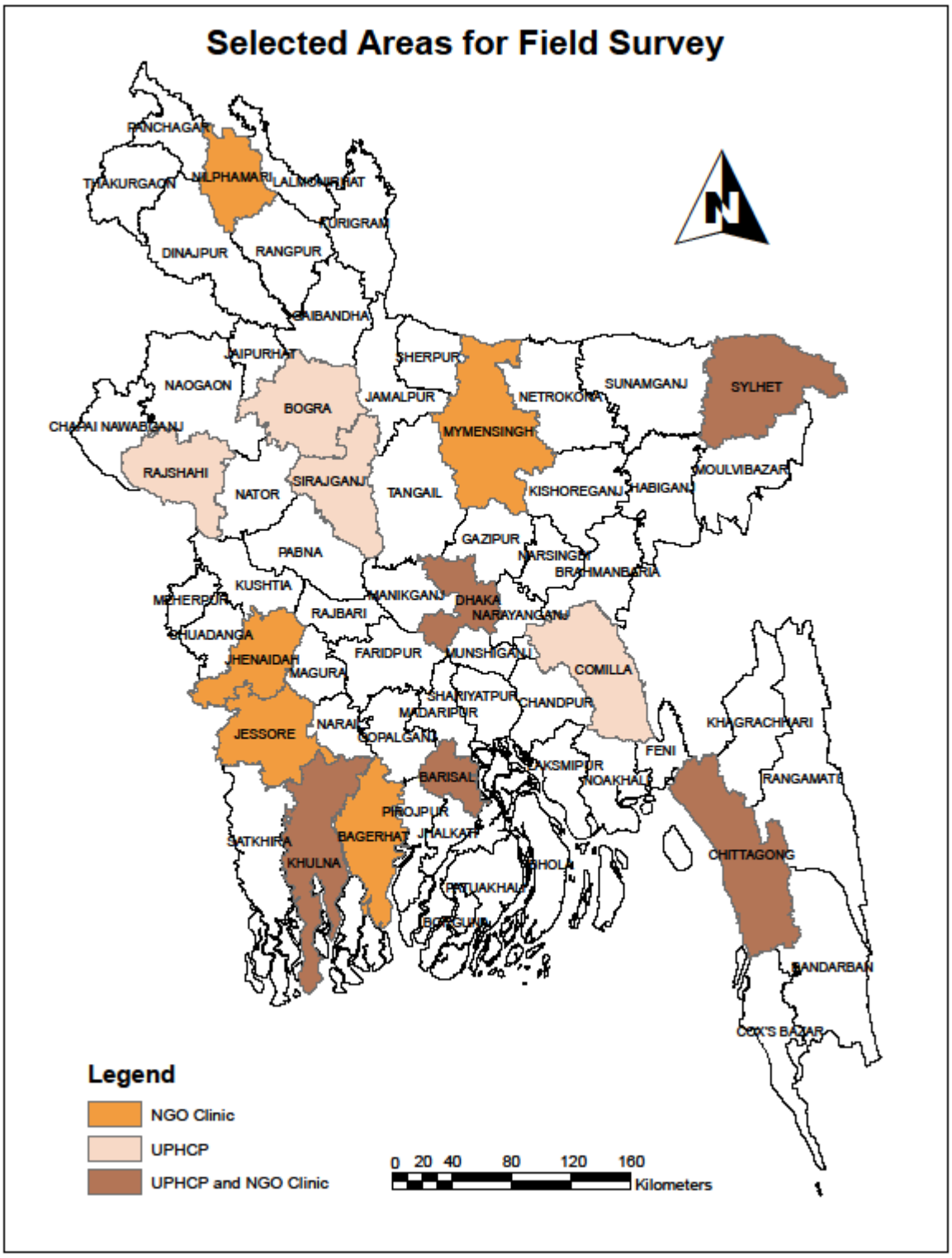
A national level day long workshop has been conducted in the final stage of this assessment in participation with different level of stakeholders such as representatives of health service providing institutions, representatives from research firms, government representatives, NGO representatives, doctor, service providers, recipients in order to share the draft report. The research team presented the draft report in this workshop and recorded all types of recommendations from the participants.

Draft Report Submission:

A draft report has been submitted to the authority of NIPORT within the expected dated mentioned in the TOR. A total 5 copies of draft report to get approval for finalizing and printing the final report have been submitted.

Inspection, Monitoring and Evaluation

The client officials and officials from NIPORT have visited the field regularly and intensively monitored the assignment activities.



Map: Study areas for data collection

Chapter Four: Findings and analysis

Table 1: Trainings that Mid Level Worker have had

Training	Number of Mid Level Worker
DOT	8
Eye Care	2
Breast Feeding	3
Puberty Age Problems	1
HIV/AIDS	30
BCC	15
Other Necessary	1
EPI	15
Maternity/Safe Delivery	3
Store Management/Database Management	2
Administration	1
Family Planning	3
First Aid	20
IMCI/CIMCI	8
ORH	1
CMT	3
RTI	11
STI	15
TB	6
IOD/IUD	3
ANC/PNC	2
PLTM	2
MR	2
Counselling	8
Child Care	3
Code of Conduct	2
Medicine	2
Nursing	2
IPCC	1
Lab Training	1
Medical Emergency	1
Monitoring & Evaluation	1
Social Motivation	1
Follow up & Supervision	7
Reporting	1
Violence Against Women	12
Social Mapping	0
Rapport Building	0

The above table shows the training that the Mid Level Workers already have had. From the table it can be seen that among 50 Mid Level Workers 30 already have taken training on HIV/AIDS which is highest in number, 20 Mid Level Workers already have taken training on first aid, 15 Mid Level Workers already have taken EPI training, DOT training have been taken by 8 Mid Level Workers, IMCI/CIMCI training have been taken by 8 Mid Level Workers, counseling training have been taken by 8 Mid Level Workers, 6 Mid Level Workers already have taken TB training and 4 Mid Level Workers already have taken BCC training. The details are shown in Table 1.

Table 2: Trainings that Mid Level Workers think they need

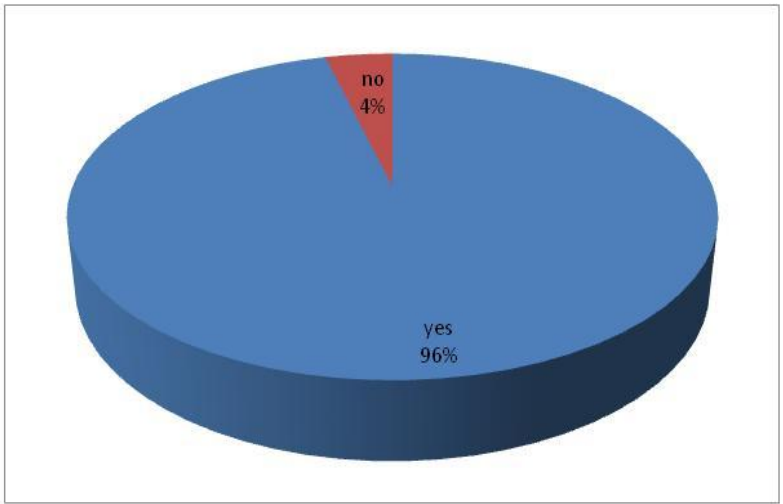
Training	Number of Mid Level Worker
ANC/PNC/DNC	5
BCC	5
Pneumonia	1
Diarrhea	1
HIV/AIDS	8
First Aid	15
Marketing/Management	12
Accounting	15
Maternal & Child Care	16
Family Planning	6
Counselling	15
EPI	5
TB	7
Advocacy	11
Monitoring & Evaluation	9
IUD/IP	5
Delivery/Sigerian	7
DOT	1
Nutrition	2
RTI/STD	7
Lab Training	8
Nursing	10
NCC	1
MR	2
Office Management	9
Administration/Reporting	9
Refreshers Training	12
Social Motivation	15
Follow up & Supervision	16
Reporting	14
Violence Against Women	7
Social Mapping	13
Rapport Building	14

The above table shows the training that the Mid Level Workers think they need. From the table it can be seen that Mid Level Workers 16 think that they need maternal & child care training, 8 Mid Level Workers think that they need HIV/AIDS training, 7 Mid Level Workers think that they need TB training, 15 Mid Level Workers think that they need First Aid training, 6 Mid Level Workers think that they need family planning training, 15 Mid Level Workers think that they need counseling training, 5 Mid Level Workers think that they need ANC/PNC/DNC/BCC a7 EPI training and 5 Mid Level Workers think that they need IUD/IP training; 11 Mid Level Workers think that they need advocacy training; 7 Mid Level Workers think that they need monitoring & evaluation; 5 Mid Level Workers think that they need RTI/STD; 8 Mid Level Workers think that they need lab training; 10 Mid Level Workers think that they need nursing; 14 Mid Level Workers think that they need reporting. The details are shown in Table 2.

Table 3: Designation of the Mid Level Worker (in percentage)

Designation	Percentage of Mid Level Worker
Admin cum Accounts Officer	4
Doctor	4
Program Coordinator	8
Counsellor	28
Outreach /Field Supervisor	8
Lab Technologist	2
Office Representative & Accountant	4
Paramedic	38
TB program officer	2
Service Promoter	2
Total	**100**

The above table shows the designation of Mid Level Workers. The table reveals that among the Mid Level Workers 38% are Paramedic, 28% Mid Level Workers are Counselor, 8% Mid Level Workers are Program Coordinator, 8% Mid Level Workers are Outreach /Field Supervisor , 4% Mid Level Workers are Admin cum Accounts Officer, 8% Mid Level Workers are Doctor and 8% Mid Level Workers are Office



Representative & Accountant . The details are shown in Table 3.

Figure 1: Have the Mid Level Workers ever heard about ESD.

Figure 1 expresses that 96% Mid Level Workers heard about ESD and 4% Mid Level Workers never heard about ESD at all.

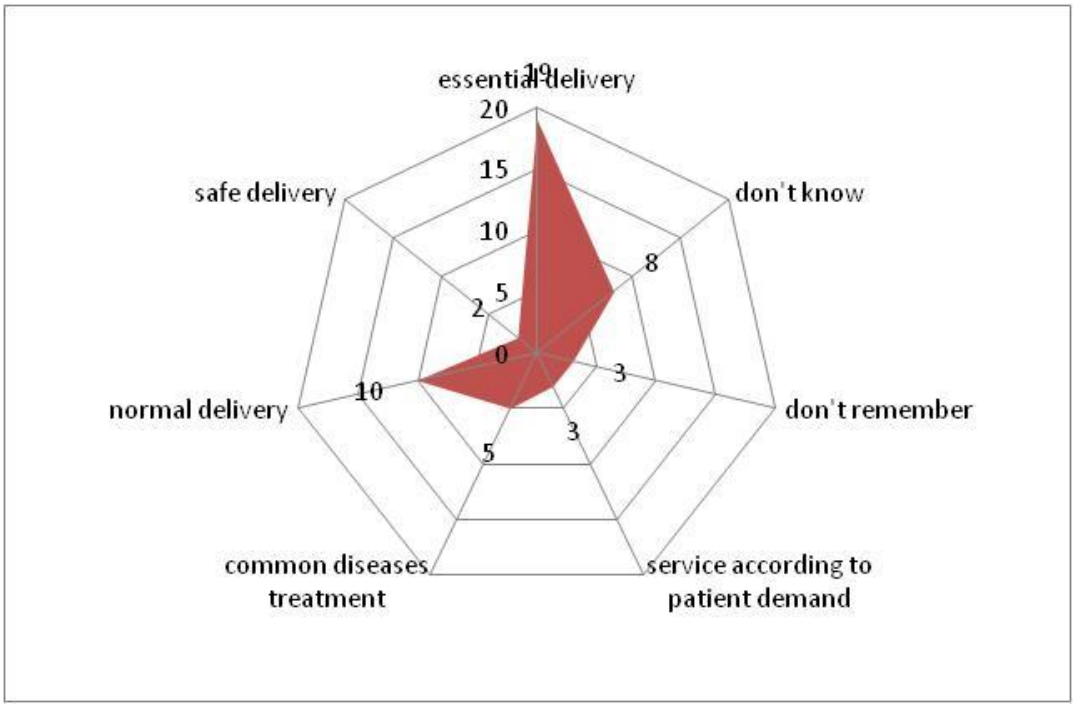


Figure 2: Meaning of ESD according to Mid Level Workers

Figure 2 expresses the extent of knowledge of Mid Level Workers about ESD. Among 50 Mid Level Workers 19 think that ESD means essential service delivery, 10 Mid level Workers think that ESD means normal delivery, 3 Mid level Workers think that ESD means service according to patient demand, 5 Mid level Workers think that ESD means common diseases treatment, 2 Mid level Workers think that ESD means safe delivery, 8 Mid level Workers don’t know about ESD and 3 Mid level Workers don’t remember what is ESD.

Table 4: Involvement of Mid Level Worker in ESD

Involvement	Number	Percentage
Not Involved	**4**	**8%**
Involved	**46**	**92%**
1 year	10	20
2 year	7	14
3 year	9	18
4 year	7	14
7 year	8	16
14 year	3	6
15 year	2	4
Total	**46**	**92**

From the above table it is seen that 8% of the Mid Level Worker has never been involved in ESD program and 92% Mid Level Worker is involved with ESD now. Among them 20% Mid Level Worker has been involved with ESD for 1 year, 14% Mid Level Worker has been involved with ESD for 2 year, 18% Mid Level Worker has been involved with ESD for 3 year, 14% Mid Level Worker has been involved with ESD for 4 year and 16% Mid Level Worker has been involved with ESD for 7 year. The details are shown in Table 4.

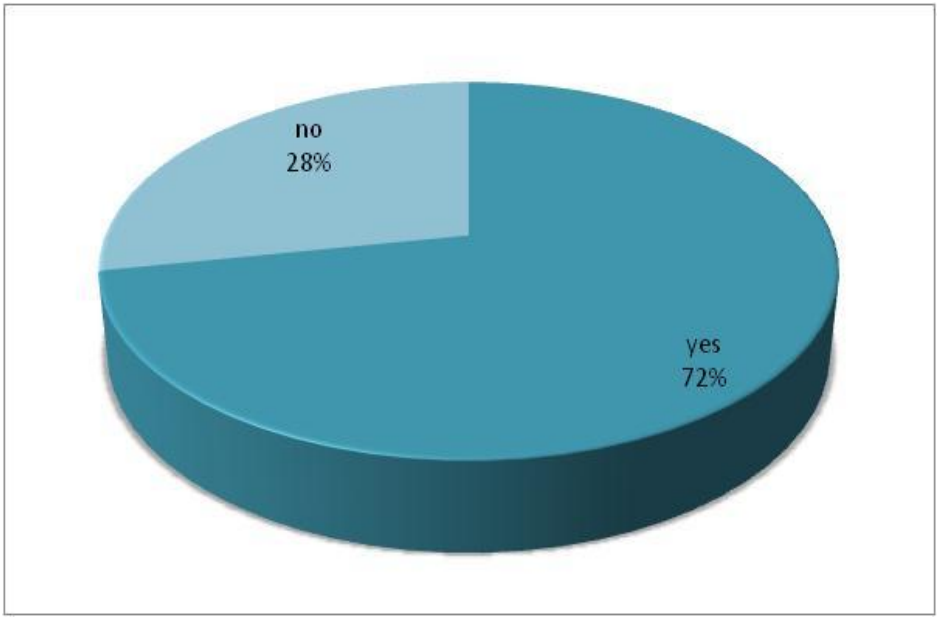


Figure 3: Have the Mid Level Workers had any training related to ESD

Figure 2 shows the acknowledgement of training related to ESD of Mid Level Worker. 72% mid level worker says that they have received training related to ESD and 28% mid level worker says that they have not received training related to ESD.

Table 5: Training related to Mid Level Workers job

Designation	Training Related to Their Job	
	Yes	No
Admin cum Account officer	50.00	50.00
Co-coordinator	50.00	50.00
Counsellor	92.86	7.14
Doctor	50.00	50.00
Lab Technician	100.00	0.00
Office Representative & Accountant	100.00	0.00
Paramedic	78.95	21.05
Service Promoter	0.00	100.00
Supervisor	100.00	0.00
TB program officer	100.00	0.00
Total	**80.00**	**20.00**

The above table reveals that 50% Admin cum Account officer had their job related training and 50% had not, 50% Co-coordinator had their job related training and 50% had not, 92.86% Counselor had their job related training and 7.14% had not, 50% Doctor had their job related training and 50% had not, 100% Lab Technician had their job related training, 78.95% Paramedic had their job related training and 21.05% had not and 100% Supervisor had their job related training. The details are shown in Table 5.

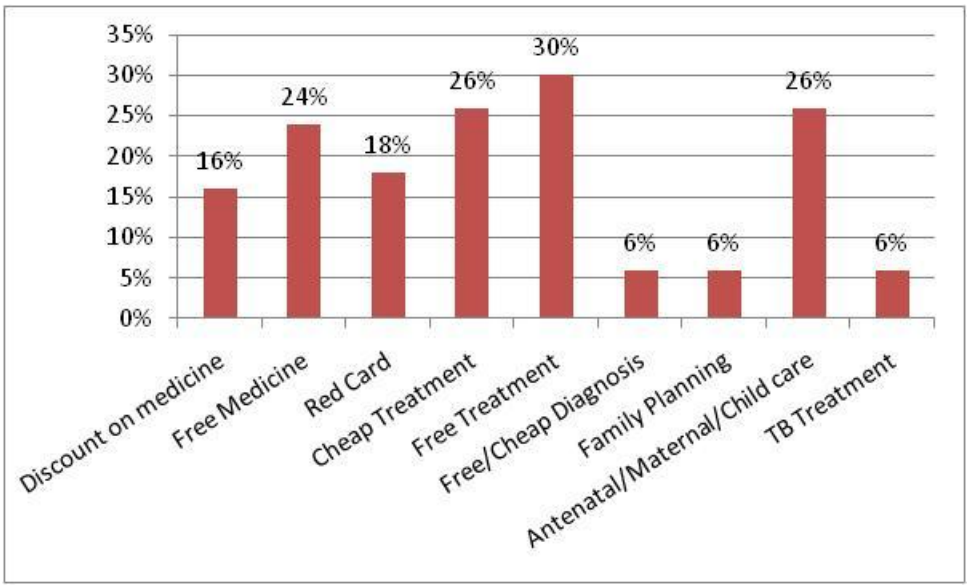


Figure 4:

Fundamental services available in the clinics

The above figure shows that 16% clinic provides discount on medicine, 24% clinic provides free medicine, 18% clinic provides Red Card service, 26% clinic provides cheap rate treatment, 30% clinic provides free treatment, 6% clinic provides free/cheap rate diagnosis, 6% clinic provides family planning advice and service, 26% clinic provides antenatal/maternal/child and 16% clinic provides TB treatment.

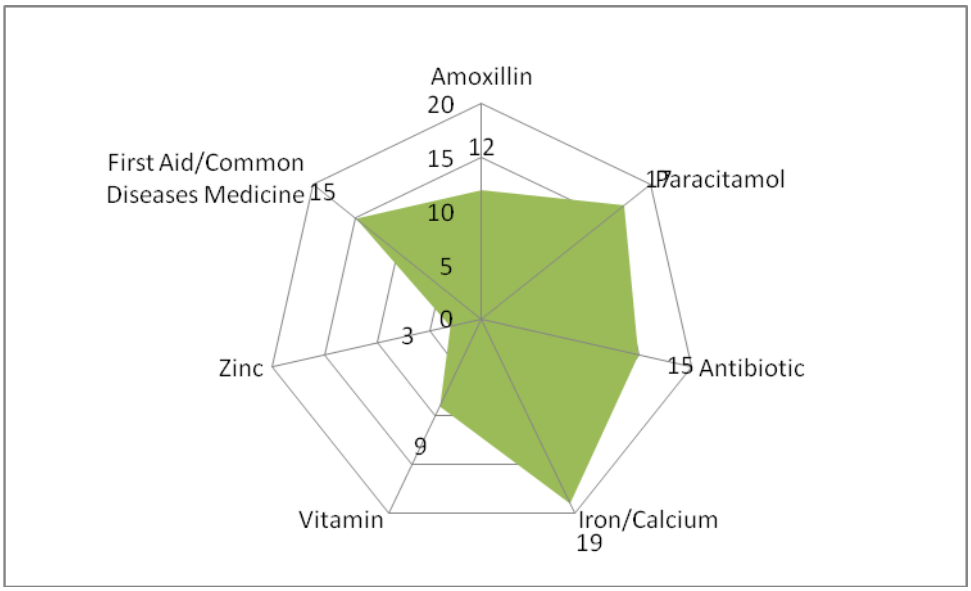


Figure 5:

Medicine provided from clinic

The above figure shows the basic medicines provided by the clinic. 12 clinic provides Amoxicillin to the service recipient, 17 clinic provides Paracitamol to the service recipient, 15 clinic provides Antibiotic to the service recipient, 19 clinic provides Iron/Calcium tablet to the service recipient, 9 clinic provides Vitamin to the service recipient, 3 clinic provides Zinc tablet to the service recipient and 15 clinic provides first aid/common diseases medicine to the service recipient. Besides Sepradin, Histacin, Cipro, Antacid, Ciproxcin are provided in some clinics.

Table 6: Opinion of Senior Managers/Mid Level Workers about medicine and emergency service

Post	Enough Medicine		Provision of Emergency Service	
	Yes	No	Yes	No
Senior Manager	72.5	27.5	35.0	65.0
Mid Level Worker	70.0	30.0	38.0	62.0

The Table 6 shows that 72% Senior Manager thinks that there are enough medicine and 35% Senior Manager Thinks that there are adequate provisions of emergency service in the clinic. 70% Mid Level Worker thinks that there are enough medicine and 38% Mid Level Worker Thinks that there are adequate provisions of emergency service in the clinic.

Table 7: Provision of emergency facilities according to Mid Level Worker

Service	Opinion	
	Yes	No
Ambulance	30.0	70.0
Skilled Manpower	42.0	58.0
First Aid	34.0	66.0
Oxygen Supply	32.0	68.0

The above table reveals that 30% Mid Level Workers think that ambulance is needed for the provision of emergency service, 42% Mid Level Workers think that skilled manpower is needed for the provision of emergency service, 34% Mid Level Workers think that first aid service is needed for the provision of emergency service and 32% Mid Level Workers think that oxygen supply is needed for the provision of emergency service.

Table 8: Necessities to improve quality of service according to Mid Level Worker

Service	Percentage of Mid Level Worker
Ambulance	52
OT/Delivery centre/Maternity Center/Sigerian	22
Ultra sonogram/Other Equipment	18
Generator	10
X-ray Machine	4

The above table shows that 52% Mid Level Workers think that ambulance is needed to improve the quality of service, 22% Mid Level Workers think that OT/Delivery center/Maternity Center/Sigerian is needed to improve the quality of service, 18% Mid Level Workers think that Ultra sonogram/Other Equipment is needed to improve the quality of service, 10% Mid Level Workers think that Generator is needed to improve the quality of service, and 4% Mid Level Workers think that X-ray Machine is needed to improve the quality of service.

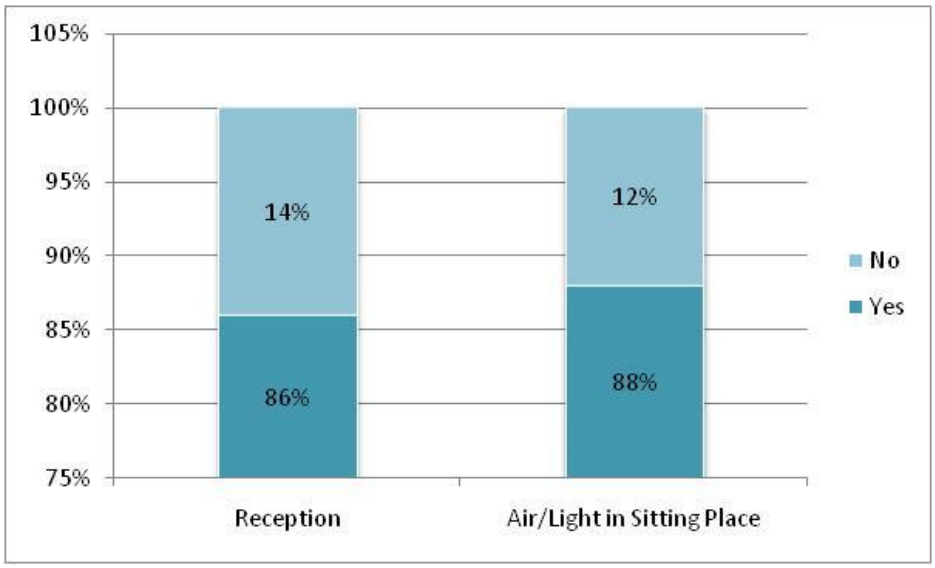


Figure 6:

Reception for patient and Air/Light circulation in the sitting place

From the above figure it can be revealed that there is reception for patient in 86% clinic and there is not in 14% clinic. There is enough light/air circulation in sitting place in 88% clinic and there is not in 12% clinic.

Table 9: Average number of patient served by clinics per day

Number	Percentage of Clinic
15-25	20
26-35	12
36-45	38
46-55	8
56-65	4
66-75	12
76-85	6
Total	100

Table 9 shows that 20% clinic give service to 15-25 patients per day, 12% clinic give service to 26-35 patients per day, 38% clinic give service to 36-45 patients per day, 8% clinic give service to 46-55 patients per day, 4% clinic give service to 56-65 patients per day, 12% clinic give service to 66-75 patients per day and 6% clinic give service to 76-85 patients per day.

Table 10: Necessary steps to improve service according to Mid Level Worker

Necessary Steps	Opinion	
	Yes	No
Training to improve skill	80.0	20.0
Increase skilled manpower	76.0	24.0

Increase necessary equipment	82.0	18.0
Training for updated information	34.0	66.0
Lab facility	26.0	74.0
Ambulance	14.0	86.0
Generator	28.0	72.0
Ultra sonogram	30.0	70.0

From the above table it can be seen that 80% Mid Level Workers identified ” Training to improve skill” as a necessary step to improve service, 76% Mid Level Workers identified ” Increase skilled manpower” as a necessary step to improve service, 82% Mid Level Workers identified” Increase necessary equipment” as a necessary step to improve service, 34% Mid Level Workers identified ” Training for updated information” as a necessary step to improve service, 26% Mid Level Workers identified ” Lab facility as a necessary step to improve service and 14% Mid Level Workers identified ” Ambulance” as a necessary step to improve service. The details are shown in Table 10.

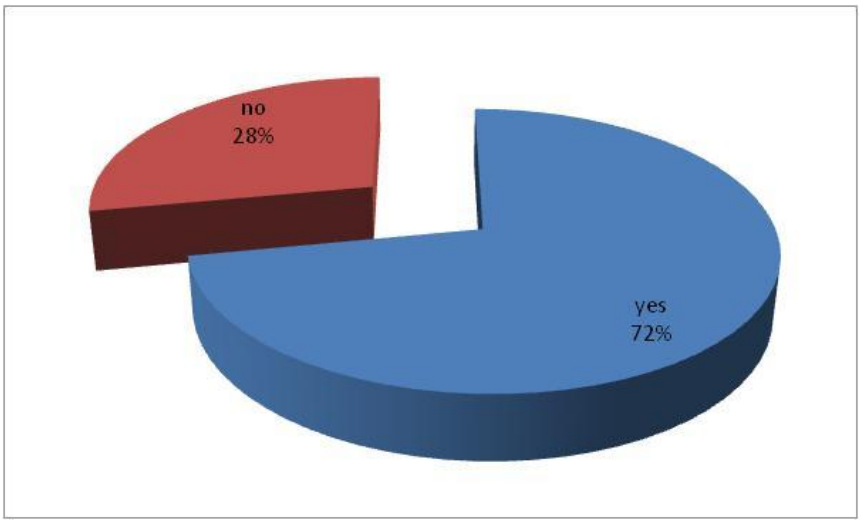


Figure 7: Necessity to increase manpower according to Med Level Worker

72% Mid Level Workers think that it is necessary to increase manpower in the clinic and 28% Mid Level Workers disagree with them.

Table 11: Type of manpower to increase

Type of Manpower	Percentage
BCC worker	12
Doctor	16

Type of Manpower	Percentage
Receptionist	4
Skilled Manpower	8
Field Worker	16
Service Promoter	4
Nurse	4
Paramedic	8
Store Keeper	2
Technician	2

12% Mid Level Workers think that it is necessary to increase BCC worker in the clinic, 16% Mid Level Workers think that it is necessary to increase Doctor r in the clinic, 4% Mid Level Workers think that it is necessary to increase Receptionist in the clinic, 8% Mid Level Workers think that it is necessary to increase Skilled Manpower in the clinic, 16% Mid Level Workers think that it is necessary to increase Field Worker in the clinic and 8% Mid Level Workers think that it is necessary to increase Paramedic in the clinic. The details are shown in Table 11.

Table 12: Response of Senior Manager/Mid Level Worker/Service Recipient to the service availability

Service	Senior Manager		Mid Level Worker		Service Recipient	
	Yes	No	Yes	No	Yes	No
ANC/PNC	97.5	2.5	100.0	0.0	17.5	82.5
Delivery/EOC	38.0	62.0	38.0	62.0	40.0	60.0
New born child care	60.0	40.0	60.0	40.0	77.5	22.5
MR	97.5	2.5	100.0	0.0	17.5	82.5
Sigerian	97.5	2.5	100.0	0.0	45.5	55.5
Vaccination	97.5	2.5	100.0	0.0	95.0	5.0
MRI	95.0	5.0	92.0	8.0	45.5	55.5
Diarrhea and other child diseases	100.0	0.0	100.0	0.0	75.0	25.0
Measles	87.5	12.5	92.0	8.0	40.0	60.0
Nutrition advice	92.5	7.5	100.0	0.0	72.5	27.5
Family planning	100.0	0.0	100.0	100.0	75.0	25.0
RTI/STD	97.5	2.5	100.0	0.0	7.5	92.5
HIV/AIDS advice	97.5	2.5	100.0	0.0	47.5	52.5
Communicable diseases	80.0	20.0	70.0	30.0	60.0	40.0
TB test	80.0	20.0	82.0	18.0	40.0	60.0
DOT	87.5	12.5	82.0	18.0	20.0	80.0
Leprosy	17.5	82.5	12.0	88.0	2.5	97.5
Women persecution	72.5	27.5	68.0	32.0	45.0	55.0

Service	Senior Manager		Mid Level Worker		Service Recipient	
	Yes	No	Yes	No	Yes	No
prevention service						
Juvenile health care	95.0	5.0	94.0	6.0	40.0	60.0
Eye care service	97.5	2.5	100.0	0.0	27.5	72.5
Ambulance	38.0	62.0	38.0	62.0	15.0	85.0
Limited common diseases treatment	77.5	22.5	72.0	28.0	40.0	60.0
BCC	97.5	2.5	100.0	0.0	7.5	92.5
Free medicine	93.0	7.0	80.0	10.0	60.0	40.0
Cheap rate medicine	-	-	-	-	50.0	50.0
Referral	100.0	0.0	100.0	0.0	75.0	25.0
first aid	100.0	0.0	100.0	0.0	75.0	25.0
Emergency obstetric care,	38.0	62.0	38.0	62.0	60.0	40.0
Others	12.5	87.5	6.0	94.0	5.0	95.0

The above table shows the opinion of Senior Manager, Mid Level Worker and Service Recipient about the existence of different types of services in the clinic. In case of ANC/PNC 97.5% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 17.5% Service Recipient says that it exists. In case of Delivery/EOC 38% Senior Manager says that it exists, 38% Mid Level Worker says that it exists and 40% Service Recipient says that it exists. In case of New born child care 38% Senior Manager says that it exists, 38% Mid Level Worker says that it exists and 77.5% Service Recipient says that it exists. In case of Diarrhea and other child diseases 100% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 75% Service Recipient says that it exists. In case of Nutrition advice 92.5% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 72.5% Service Recipient says that it exists. In case of Communicable diseases 80% Senior Manager says that it exists, 70% Mid Level Worker says that it exists and 60% Service Recipient says that it exists. The details are given in the Table 12.

Table 13: Number of officer and other employee in the clinic

Officer		Other Employee	
Range	Percentage	Range	Percentage
≤3	70.0	≤5	17.5
4-6	20.0	6-10	25.0
7-10	7.5	11-15	17.5
11-15	0.0	16-20	20.0
≥16	2.5	21-25	15.0
Total	100.0	26-30	5.0

Officer		Other Employee	
		Total	100.0

In 70% clinic there is 3 or less than 3 officer, in 20% clinic there is 4-6 officer, in 7.5% clinic there is 7-10 officer, in 2.5% clinic there is 16 or more than 16 officer. In 17.5% clinic there is 5 or less than 5 other employee, in 25% clinic there is 6-10 other employee, in 17.5% clinic there is 11-15 other employee, in 20% clinic there is 16-20 other employee and in 15% clinic there is 21-25 other employee. The details are given in the Table 13.

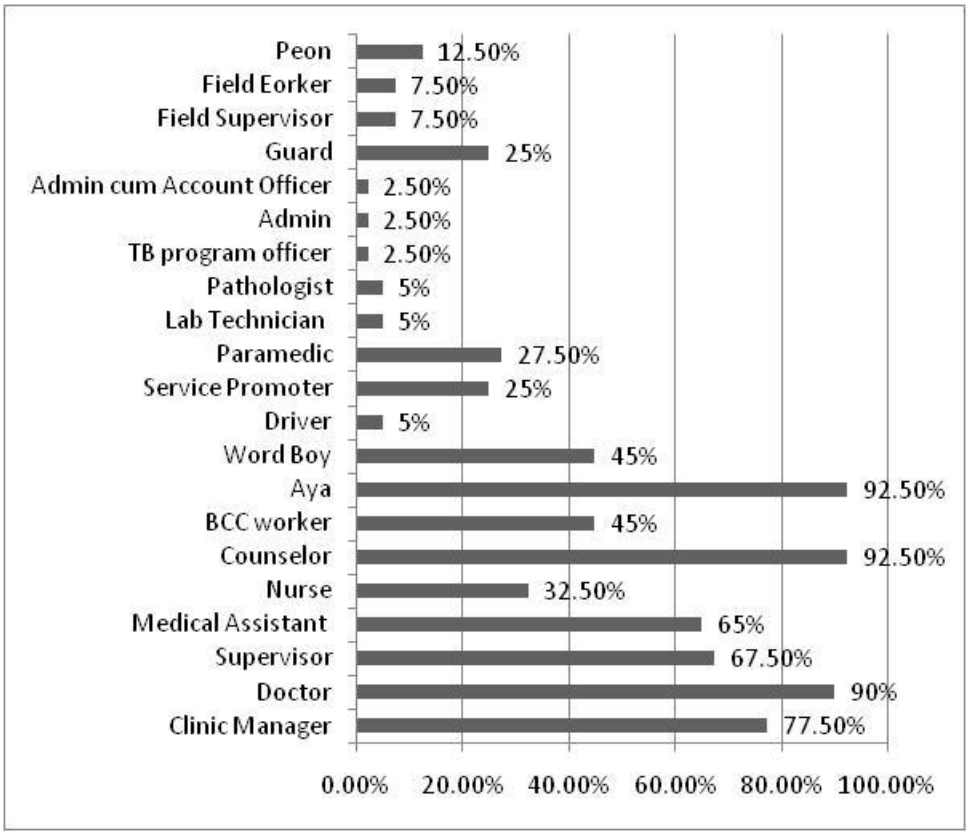


Figure 8:

Manpower distribution among the clinics

From Figure 7 it is seen that in most of the clinics (92.5%) there are aya and counselor, in 77.5% clinic there is clinic manager, in 90% clinic there is doctor, in 67.5% clinic there is supervisor, in 65% clinic there is medical assistant, in 32.5% clinic there is nurse, in 45% clinic there is BCC worker, in 45% clinic there is word boy, in 5% clinic there is driver, in 25% clinic there is service promoter, in 27.5% clinic there is paramedic and in 12.5% clinic there is peon. Detailed can be seen at Figure 7.

Table 14: Method of monitoring of the clinics

Monitoring Method	Percentage
Attendance Checking	10

Monitoring Method	Percentage
Register Review	20
Weekly/Fortnightly/ Monthly	25
Checklist	5
Work Plan	17.5
Staff Meeting/Group Discussion/Courtyard Meeting	7.5

The above table reveals that 10% clinic is monitors by Attendance Checking, 20% clinic is monitors by Register Review, 25% clinic is monitors by Weekly/Fortnightly/ Monthly, 5% clinic is monitors by Checklist, 17.5% clinic is monitors by Work Plan and 7.5% clinic is monitors by Staff Meeting/Group Discussion/Courtyard Meeting. Besides, some clinics are monitored by room to room investigation. Personal query, regular contact and day closing audit etc. And one clinic responded that their monitoring method is confidential.

Table 15: Status of training related to monitoring of Senior Manager

Status	Opinion	
	Yes	NO
Training already received	52.5	47.5
Need to receive	97.5	2.5

52.5% Senior Manger says that they received training related to monitoring and 97.5% Senior Manger says that they need to receive training related to monitoring.

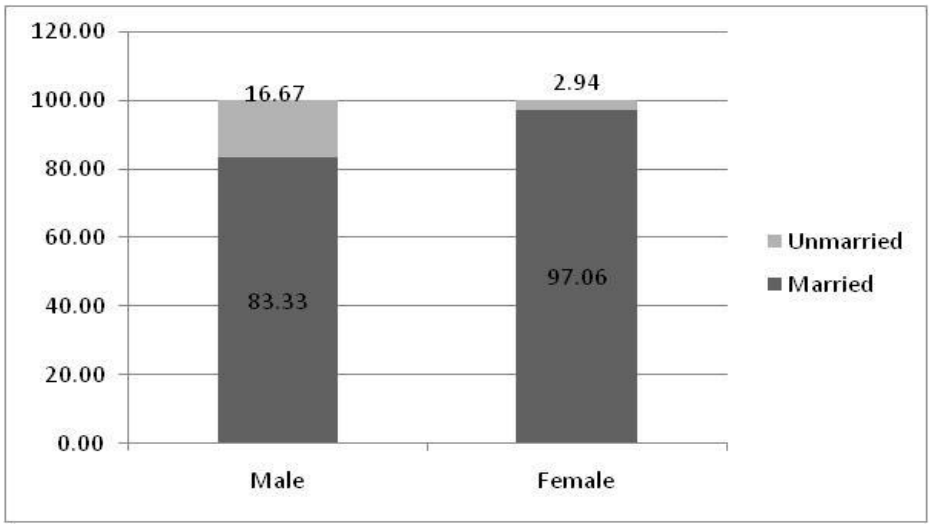


Figure 9: Sex and marital status of the service recipient

From the above figure it can be seen that 83.33% male service recipient is married and 16.67% male service recipient is unmarried. 97.06% female service recipient is married and 2.94% female service recipient is unmarried.

Table 16: Income range of the service recipient

Income Range	Percentage
≤5000	7.5
5001-10000	42.5
10001-15000	20.0
15001-25000	25.0
>25000	5.0
Total	100.0

From the above table it is seen that 7.5% service recipient belongs to ≤5000 income group, 42.5% service recipient belongs to 5001-10000 income group, 20% service recipient belongs to 10001-15000 income group, 25% service recipient belongs to 15001-25000 income group and 5% service recipient belongs to >25000income group.

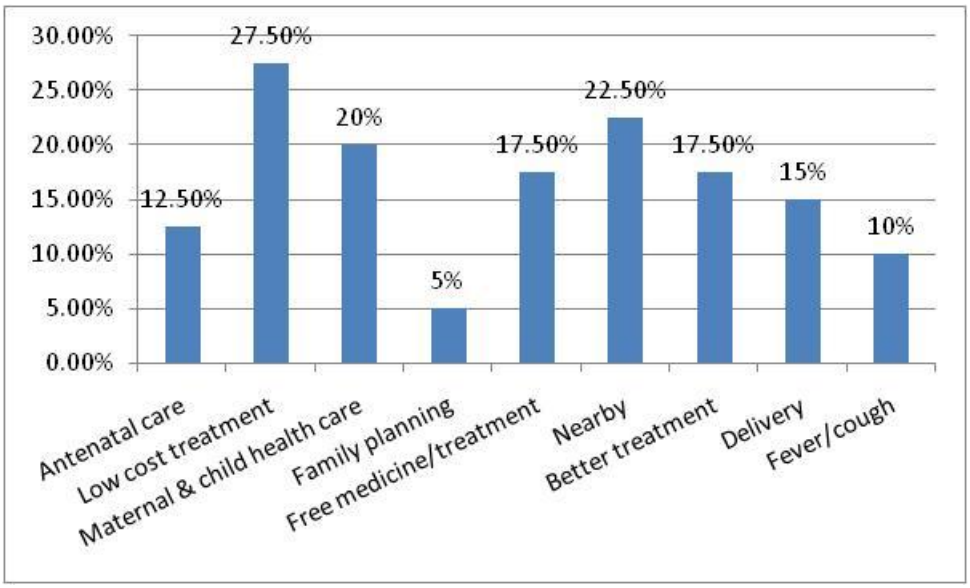


Figure 10: Reason of coming of the patient

12.5% patient comes to the clinic for antenatal care, 27.5% patient comes to the clinic for low cost treatment, 20% patient comes to the clinic for maternal & child health care, 5% patient comes to the clinic for family planning, 17.50% patient comes to the clinic for free medicine/treatment, 22.5% patient comes to the clinic because it is nearby, 17.5% patient comes to the clinic for better treatment, 15% patient comes to the clinic for delivery and 10% patient comes to the clinic for fever/caugh.

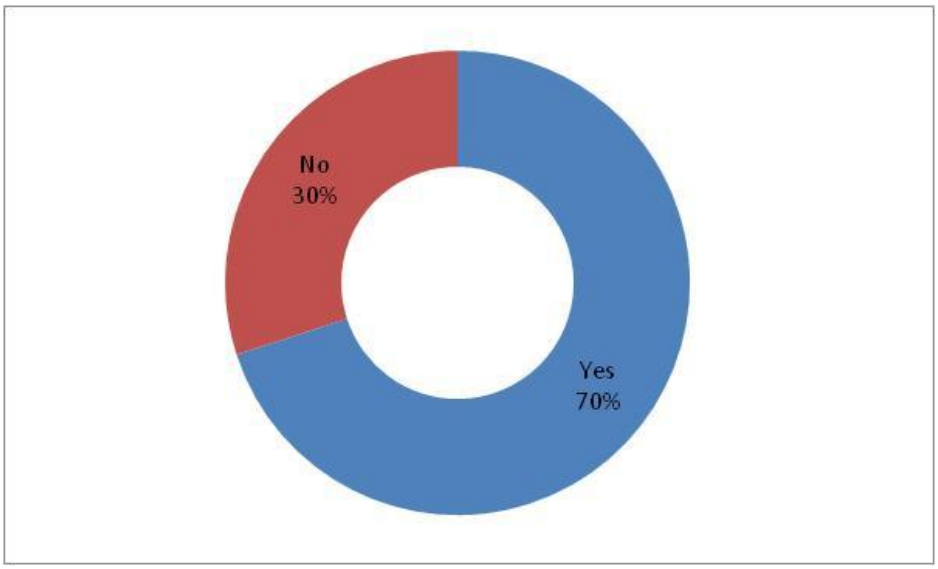


Figure 11: Opinion of service recipient about getting expected service

70% service recipient says that they get expected service from the clinic and 30% service recipient says that they don't get expected service from the clinic.

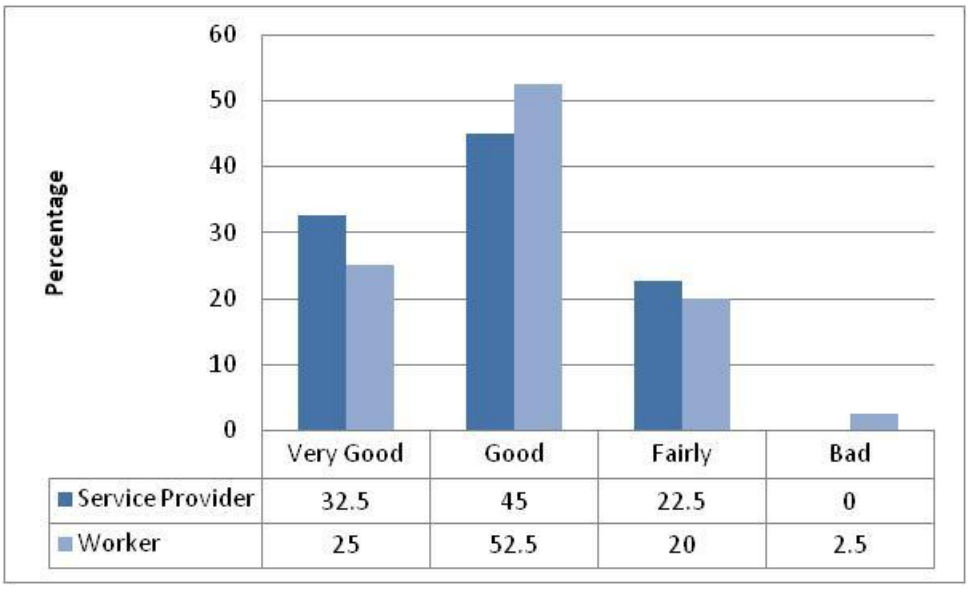


Figure 12: Opinion of service recipient about attitude of service providers and worker

From the above figure it can be said that 32.5% service recipient thinks that attitude of service provider is very good, 45% service recipient thinks that attitude of service provider is good, 22.5% service recipient thinks that attitude of service provider is fairly. 25% service recipient thinks that attitude of worker is very good, 52.5% service recipient thinks that attitude of worker is good, 20% service recipient thinks that attitude of worker is fairly, 2.5% service recipient thinks that attitude of worker is bad.

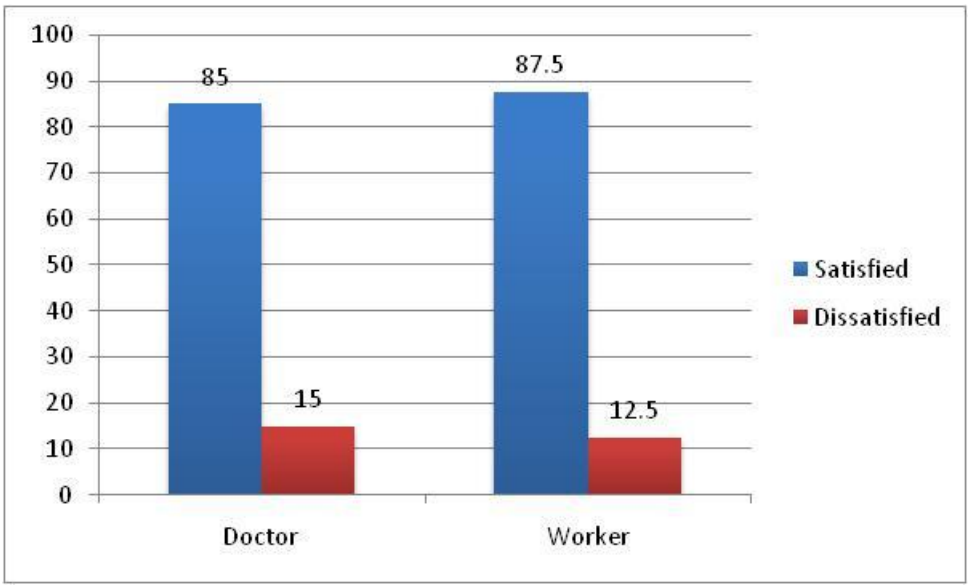


Figure 13: Satisfaction with the behaviour of doctor and worker

85% service recipient is satisfied with the behaviour of doctor and 15% service recipient is dissatisfied with the behaviour of doctor. 87.5% service recipient is satisfied with the behavior of worker and 12.5% service recipient is dissatisfied with the behavior of worker.

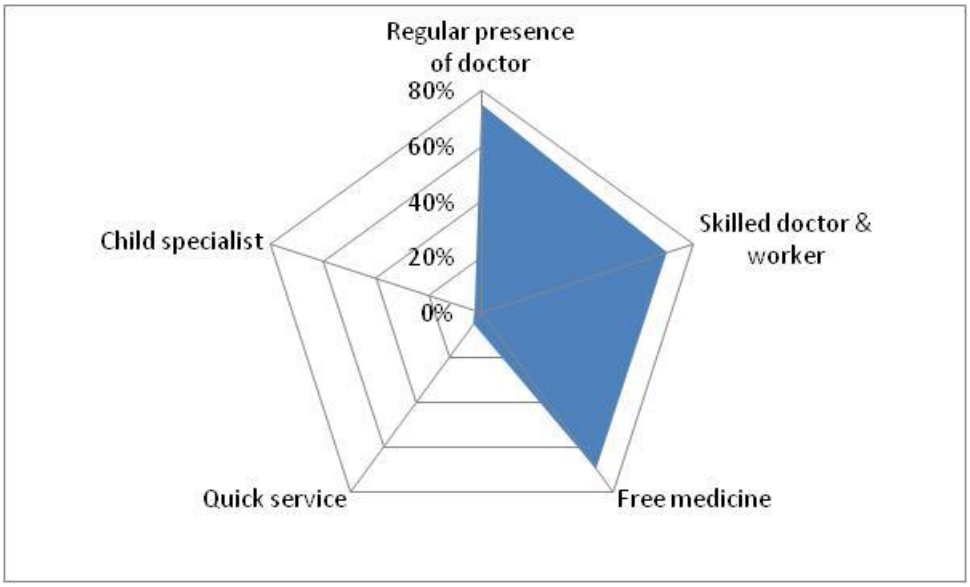


Figure 14: Patient demand of other services

From the above figure it can be revealed that 75% service recipient demand regular presence of doctor, 70% service recipient demand skilled doctor, 70% service recipient demand free medicine, 5% service recipient demand quick service and 2.5% service recipient demand child specialist other than existing services.

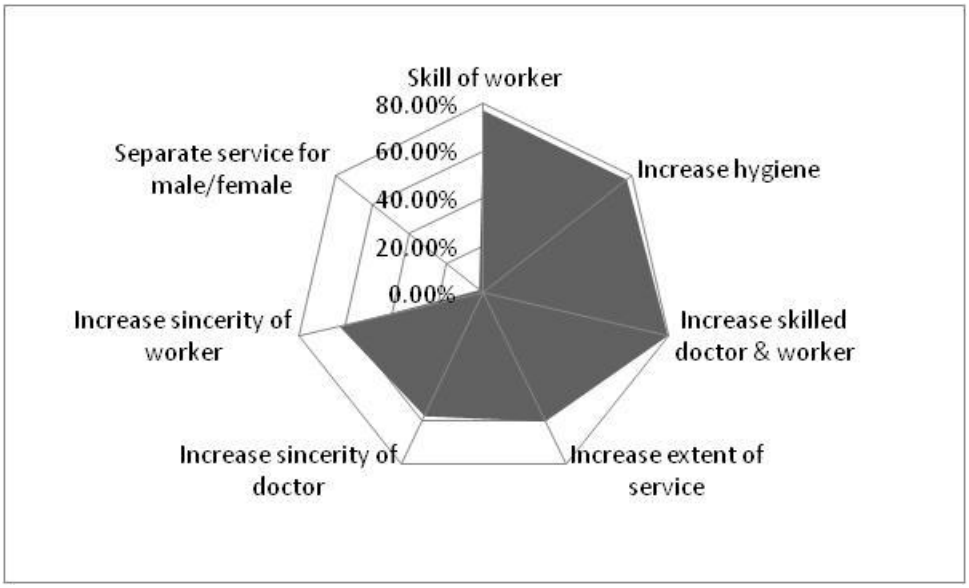


Figure 15: Suggestion of service recipient to improve quality of service of the clinic

Figure 14 reveals that 77.5% service recipient suggests "skill of worker" to improve the quality of service, 77.5% service recipient suggests "Increase hygiene" to improve the quality of service, 80% service recipient suggests "Increase skilled doctor & worker" to improve the quality of service, 60% service recipient suggests "Increase extent of service" to improve the quality of service, 57.5% service recipient suggests "Increase sincerity of doctor" to improve the quality of service, 62.5% service recipient suggests "Increase sincerity of worker" to improve the quality of service and 2.5% service recipient suggests "Separate service for male/female" to improve the quality of service.

Observation

The research team will make the plan to observe actual situation of the ESD Program in NGO Clinic and UPHCP centers considering low, medium and high performance. The team will visit about 6 no of NGO Clinic and 6 no of UPHCP centers during their service period. The observer will prepare an in-depth report after completion the observation. This observation method will help to reach the data accumulation.

Interview of Key informant

The study included some interviews of key informant. Through this interview a good number of data and information have been collected. This interview has been conducted with PIU of City Corporation and Civil Surgeon etc. A total 48 no of Key Informant have been Interviewed. This type of interview helped to ensure check and balance of the study.

Senior Monitoring & Evaluation Officer of Chittagong City Corporation, Chittagong, UNO of Khadim Nagar Upazilla under Sylhet district said, "*NGO and UPHCP clinics within its jurisdiction were in well infrastructure condition. Most of the clinics were in good condition. But proper monitoring is nessential to ensure good health service. Old staff's are experienced and their capability in ESD program is also good level but those staffs who are newly appointed in place of droped out are very much poor in capability and they need to have training"*

Following are the problems to run the clinics had been found out from the key informer interviews:

- Shortage of adequate manpower
- Inadequate medicine supply
- Inadequate trained nurse and other staff
- Lack of modern health facilities

According to the aforementioned problems key informers gave their various opinion those are as follows:

- The building environment of maximum clinics is satisfactory.
- The services provided in the NGO clinic and UPHCP is also satisfactory
- Lack of electricity and modern instruments is the main problems of maximum NGO clinics and PHCC clinic under UPHCP program of different areas.
- Recruitment of necessary eligible manpower to improve service quality and area coverage is essential.
- Regular training and refresher training, follow up activity is very essential.
- Sufficient medicine supply is needed to ensure coverage of more poor client
- Monitoring and supervision should be developed.
- More budgets were necessary to ensure quality medicine and other facilities.
- Budget flow should be continuous

- ❖ Staff salary and other facilities also should be increase to develop their commitment

Focus Group Discussion (FGD)

A total no of 12 Focus Group Discussions have been conducted under 12 NGO Clinic and UPHCP centres areas. Focus Group Discussions have been conducted to understand the views and opinions of service providers; community influential's and service receivers concerning the ESD Program in NGO Clinic and UPHCP operation. The participants for the FGD have been considered (i) service receiver, (ii) community influential, (iii) two types of service providers both mid and top level staff and (iv) Thana officials. In each focus group 10 to 12 participants have participated for discussion. Focus Group Discussion (FGD) have created the scope to participate collectively all types of individual who are directly or indirectly involved with this ESD Program in NGO clinic and UPHCP centers. Several FGD had conducted to know the peoples' opinion about the services in GNO clinic and UPHCP. The major findings are discussed below:

- ❖ The NGO clinic and UPHCP is playing a great role to ensure essential service delivery to doorsteps of the community people.
- ❖ NGO clinic and UPHCP is providing low cost health service and free medicine and service to the people.
- ❖ The clinics are very much useful for pregnant women, children and old people who cannot go far for health services.
- ❖ People can come at the clinics when they needs without any hesitation.

However, there were some problems. They are:

- ❖ Shortage of adequate manpower
- ❖ Inadequate medicine supply
- ❖ Inadequate trained staff
- ❖ Lack of modern health facilities
- ❖ Do not serve for whole day
- ❖ Lack of electricity and water supply

Some necessary steps should be taken for improving the quality of service. They are:

- ❖ Ensuring enough manpower qualified staff
- ❖ Ensuring good quality and enough medicine
- ❖ More publicity to disseminate information about the service
- ❖ Take more BCC activities
- ❖ Providing more equipment

- Provide more lab facilities and training to lab technician
- Ensure efficient administrative officer
- Monitoring should be improved

Chapter Five: Discussion

UPHCP, an innovative project for the delivery of a package of preventive, promotive and curative health services to the urban poor, was started with a loan from the Asian Development Bank (ADB) in 1998. Other donors (DFID, Nordic Development Fund) also contributed through ADB. The project was supposed to be implemented in phases, with five years in each phase. The main objective of the health project is to provide ESP services and curative care with a focus on women, children and on reproductive health. The targeted geographical areas are slums of Rajshahi, Khulna, Chittagong, sylhet, Barishal, Bogra Municipality, Shirajgonj Municipality, Comilla Municipality, Madhobdi Municipality, Savar Municipality and divisional towns and cities.

NGO Service Delivery Program (NSDP) supports 41 local NGOs to deliver an essential package of health services (ESP) including child health, maternal health care, reproductive health care, clinical and non-clinical family planning services, communicable disease control, tuberculosis, safe delivery including first aid emergency obstetric care, post-abortion care, and limited curative care. This network of NGO's works through 346 urban and rural clinics, nearly 8000 satellite clinics and almost 7000 female depot holders nationwide, serving approximately 17% of the national population. Over 1.5 million customers are served each month.

The study was conduted with the aim to investigate type of providers involved in the service of the NGO Clinic and UPHCP; to investigate their experience and training to provide ESP; their capacity to provide services; to investigate facilities; io investigate the exit clients of the NGO Clinic and UPHCP to assess the exit clients opinions about their service and the opinions of the community level influential's about the capacity of the service providers etc.

It was found that in case of ANC/PNC 97.5% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 17.5% Service Recipient says that it exists. In case of Delivery/EOC 38% Senior Manager says that it exists, 38% Mid Level Worker says that it exists and 40% Service Recipient says that it exists. In case of New born child care 38%

Senior Manager says that it exists, 38% Mid Level Worker says that it exists and 77.5% Service Recipient says that it exists. In case of Diarrhea and other child diseases 100% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 75% Service Recipient says that it exists. In case of Nutrition advice 92.5% Senior Manager says that it exists, 100% Mid Level Worker says that it exists and 72.5% Service Recipient says that it exists. In case of Communicable diseases 80% Senior Manager says that it exists, 70% Mid Level Worker says that it exists and 60% Service Recipient says that it exists. Under this research a total number of 40 NGO clinics and 80 UNHCP centers (6 Nos CRHCC and 74 Nos PHCC) have been selected for data collection. So it is mentionable that in case of CRHCC and PHCC under UPHCP, some service is varied. CRHCC is included some extra service such as Delivery, New Born Child Care, Segerian, Ambulance etc and other services like ANC/PNC, MR, Vaccination, MRI, Diarrhea and other child diseases, Measles, Nutrition advice, Family planning, RTI/STD, HIV/AIDS advice, Communicable diseases, TB test, DOT, Leprosy, Women persecution prevention service, Juvenile health care, Eye care service, Limited common diseases treatment, BCC, Free medicine, Cheap rate medicine, Referral, First Aid, Emergency obstetric care and others.

The findings revealed that the 16% Mid Level Workers think they need. maternal & child care training, 8 Mid Level Workers think that they need HIV/AIDS training, 7 Mid Level Workers think that they need TB training, 15 Mid Level Workers think that they need First Aid training, 6 Mid Level Workers think that they need family planning training, 15 Mid Level Workers think that they need counseling training, 5 Mid Level Workers think that they need ANC/PNC/DNC/BCC a7 EPI training and 5 Mid Level Workers think that they need IUD/IP training; 11 Mid Level Workers think that they need advocacy training; 7 Mid Level Workers think that they need monitoring & evaluation; 5 Mid Level Workers think that they need RTI/STD; 8 Mid Level Workers think that they need lab training; 10 Mid Level Workers think that they need nursing; 14 Mid Level Workers think that they need reporting.

The findings showed that 75% service recipient demand regular presence of doctor, 70% service recipient demand skilled doctor, 70% service recipient demand free medicine, 5% service recipient demand quick service and 2.5% service recipient demand child specialist other than existing services.

The findings of the study suggest a trend towards increased use of selected ESP in the NGO clinics. It appeared that, over time, the quality of services of clinics improved resulting in

increased use of ESP. But at the same time, it was also found that there were substantial unmet reproductive and child-health needs among the clients NGO clinics. So, there is still a scope to increase the use of ESP more through addressing missed opportunities. BCC also needs to be ensured at the community to address the unmet needs of clients who do not visit the clinics.

There is evidence that most staff had received some ESP relevant training, but also that this is not adequate. Many have only limited knowledge of ESP and what is included. It became clear from the discussion with the respondents that lack of drugs and modern equipment/medical and lab instruments is need to increase in the clinic.

The study found that there are satisfaction with the overall performance of the NGO clinic and UPHCP. But it is essential to arrange more training and follow up activity after training; increase staff facilities like salary, bonus, increment etc in order to make them committed to the service; increase management capacity of centre manager who will be only responsible for center management; increase lab facility; ensure generator support for continuous electricity supply to ensure more quality service.

Chapter Six: Lessons Learned and Recommendations

Introduction

The findings of the study have several implications for the overall improvement of the service provider's capacity in ESD programme; coverage of ESP in NGO clinic and UPHCP and suggest that:

Most of the centres under UPHCP have the physicians who are designated as Clinic Manager which is a barrier to ensure quality service and cause of work load to a doctor playing the role at the same time. However, to supervise and monitor the center activity a senior person who will be Clinic Manager and in some cases, existing field level workers cannot complete his planned activities within the time frame due to large scale of area and population.

- Need to recruit individual staff for both of the position of Clinic Manager and Physician.
- Recruit more skilled field worker for according to the accurate area and population.

In some cases it was followed that lack of experience of service provider's service can be lower. Even lack of commitment and attention to the service is also the cause of barrier of service quality of service provider. So the suggestion:

- Organize basic and regular refresher training and follow up activity for the 6 month to 1 year working experienced staff
- Review training for the doctors, paramedics and health Assistant who are directly involved with service
- Increase facilities for the Service providers
- Organize training locally so that trainer can use local resources and examples as well as staff can participate densely and can manage time more effectively.

Lack of awareness of clients about the availability of specific ESP and specific health needs beyond their desired services is the contributing factor for unmet health needs suggesting:

- Introduction of behaviour change communication (BCC) at clinics and in the community to provide more information to clients about the availability of a broader range of services and their own health needs.
- Field workers, Peers/neighbours can assist as motivators.

There were some shortages of modern equipment and furnishings, but the main problem is the inadequate and intermittent supply of drugs. Irregular fund flow is one of the causes of irregular drug supply. Unless this is addressed effectively, it is unlikely that NGO clinic and UPHCP will gain widespread acceptance in the community.

- Ensure regular and timely budget flow
- Inadequate and intermittent supply of drugs

The study has given the various recommendation which might be increased the service quality and acceptance of NGO clinic and UPHCP those implications has been described briefly in the following section:

Type of Service Providers Involved in the Service

There are various types of service provider involved with NGO clinic and UPHCP such as Doctor cum Clinic Manager, Field Supervisor, Medical Assistant, Nurse, Counsellor, Health Worker, Pharmacist, Office Assistant, Lab Technician, MLSS, Aya, Night Guard and Driver etc. Type of service provider is enough to carry on the center properly but less number of staff or service provider is a fact. It is needed to recruit individual staff for both of the position of Clinic Manager and Physician. In some cases, existing field level workers cannot complete his planned activities within the time frame due to large scale of area and population.

Staff's experience and training to provide ESP:

One thing is remarkable that the technology, process and methodology is varied due to effect of modernization and for this why doctors who got different training previously cannot deserve the new technology method and information. Newly appointed staffs who need to get more training as refresher training and follow up activity the continuous activity and especially doctors and health assistant or paramedics need to have. Multi-disciplinary training

on ESP is also needed for the staff. It is needed to arrange more Child Health Care related training for the Physician.

Capacity of Staff to provide services:

Some staff has 5-8 years working experience and some have 6 months to 1 year working experience on the field of ESD Programme. Less experienced staff has received limited number of training. On the other hand, old staff who received different training needed to have follow up and refresher training in the next time. ESD there were expectations from the staff to arrange multi-dimensional training such as:

Name of Position	Training	Remark
Clinic Manager	➢ Clinic Management & Administration ➢ Rights & Advocacy training ➢ BCC ➢ HIV/AIDs ➢ Quality Service Promotion ➢ Social Motivation and Mobilization ➢ Effective Communication ➢ Plan & Implementation ➢ Monitoring and Evaluation ➢ Follow up Supervision ➢ Reporting, Documentation ➢ Presentation ➢ Gender mainstreaming ➢ Violence Against Women ➢ Case Study Writing etc.	
Doctor/Physician	➢ Reproductive Health Care ➢ Child Health Care	

Name of Position	Training	Remark
	➢ Clinic Management & Administration ➢ TBA ➢ HIV/AIDs, STD/STI Management ➢ Quality Assurance ➢ Service to Pregnant Women ➢ BCC ➢ Quality Service Promotion ➢ Tuberculosis ➢ Application of modern tools and techniques relevant to the health ➢ Gender mainstreaming	
Mid Level Worker	➢ Reproductive Health Care ➢ Child Health Care ➢ HIV/AIDs, STD/STI Management ➢ Quality Assurance ➢ Service to Pregnant Women ➢ BCC ➢ Quality Service Promotion ➢ Social Motivation and Mobilization ➢ Effective Communication ➢ Plan & Implementation ➢ Monitoring and Evaluation ➢ Follow up Supervision ➢ Reporting, Documentation	

Name of Position	Training	Remark
	➢ Presentation ➢ Gender mainstreaming ➢ Violence Against Women ➢ Case Study Writing etc.	
Field Staff	➢ Social Motivation and Mobilization ➢ Effective Communication ➢ Plan & Implementation ➢ Advocacy & Area Based Development Approach ➢ Rapport Building ➢ Follow up Supervision ➢ Reporting, Documentation ➢ Presentation ➢ One to one Communication ➢ Case Study Writing etc.	

Facilities

Different types of services are provided in the NGO clinic and UPHP such as Child Health Care, Reproductive Health Care, Communicable Disease Control, Limited Curative Care, Management and Prevention/Control of RTIs/STIs, VCCT for HIV/AIDS, Management of Violence against Women, Primary Eye Care, TB Control & Treatment, Behaviour Change Communication, Diagnostic Service etc. Here it is mentionable that most of the centers have diagnostic service but some of them have limited number of diagnostic facilities. If all types of diagnostic service is included under each NGO clinic and UPHCH (CRHCC and PHCC). Satellite service is needed to enlarge in terms of wide range of location and areas. There are limited types of drug is provided to the clients.

Community level influential's opinion about the capacity of the service providers

Though there were limited involvement of community level influential is seen during this study. But someone who is aware on this service and committed to develop the service for poor people has told that staffs capacity in ESD is needed to develop and for this regular training and follow up activity, refresher training, monitoring is very essential. They have given the opinion that capacity of a staff can ensure the quality service.

Client's satisfaction and opinion in development of service of NGO clinic and UPHCP

Client's satisfaction is good to the service because they can get health service with no cost and low cost. But they have the expectation for more medicine supply as per need of various diseases. Sometime clients cannot reach the physician due to his /her absence or late presence in the clinic. Proper monitoring is very essential for the center so that they can get the service when they need. Sometime due to lack of continuous electricity supplies they cannot feel comport to wait in the clinic. So it is important to ensure generator facility for the clinic.

Many of the problems found in other health services are appeared here–shortages of drugs and consumables, insufficient skills in some staff, staff not available when needed, and generally services considered being of a poor standard by users. There were also risks in that some previously successful outreach services are to be replaced, and there is a need to ensure that the benefits of these are retained.

It is needed to strengthen Clinical Contraceptive Services, increase utilization of long-term clinical contraceptive services, include voluntary sterilization, increase engender Health, aims to improve knowledge, awareness and demand for clinical contraceptive services; strengthen counselling and quality of services including infection prevention, include more training of providers; strengthen BCC activities; develop logistic support and management information system.

It is needed to increase training and education in Reproductive Health to strengthen the capacity of service providers, enhance on the job performance of service providers, development of training on MIS that will encourages follow-up of training and monitors quality, improve prevention and management of sexually transmitted diseases; improve program monitoring and evaluation; developed a series of television spots and videos in order to influence behaviour through educational entertainment to the client in NGO clinic and UPHCP.

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Appendix-A:

Questionnaire for Service Provider

Appendix-B:

Questionnaire for Service Receiver

Appendix-C:

Discussion topics of Key Informer Interview

Appendix-D:

Discussion topics of Focus Group Discussion (FGD)