Utilization of Community Clinic

National Institute of Population Research and Training (NIPORT)

MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF PEOPLES REPUBLIC OF BANGLADESH

Conducted by:

EC Bangladesh

Environment Council Bangladesh

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Contents

List of Chart

List of Table

Foreword

The study report may be considered as comprehensive one which shows that the present real status of the community clinic services and in order to ensuring better services what types of changes are needed in the infrastructure of the community clinic are also has been included.

The study has been conducted through an integrated approach combining qualitative and quantitative methods. Sample from different segments of the population such as service providers, service recipients from the various service delivery points of the health and family planning services has been collected. Focus group discussion in participation of community people, social leaders, and government representatives has been conducted and gained multi-disciplinary opinion about the services that also has been included in this report.

Interview from local relevant government representative such as Health and Family Planning Officer, Civil Surgeon, Thana Nirbahi Officer, Upazila Chairman as the key informer has been conducted and according to their interview specific recommendations also has been included in this report.

An expert research team including of demographer, statistician, public health specialist, sociologist, team leader, computer expert has been involved full time basis in conducting of this survey. The study team is, therefore, confident that the findings represent the general state of development of Community Clinics in Bangladesh.

Mr. K.C Mondal

DG, NIPORT

National Institute of Population Research and Training (NIPORT)

Preface

This report on utilization of community clinic is the outcome of a study that has been conducted by EC Bangladesh. The aim of the study was to investigate status of community clinic utilization and the factors influencing the utilization of community clinic in order to provide data for increasing acceptance of Community Clinic service.

To provide the Essential Service Package through 18,000 community clinics is an addition to the health and family planning services infrastructure for rural areas in Bangladesh. The other purposes of establishing Community Clinics were to ensure (i) wider coverage, especially for women, children and the poor, (ii) appropriate skill mix of health and family planning personnel, (iii) availability of services close-to-client, (iv) involvement of the community at all possible areas starting from site selection, construction, management, operation and maintenance of the CCs, (v) establishment of a referral system, (vi) ensuring equity and accessibility. But still there are some limitations in utilization of those community clinics due to different types of problem. This study helped to investigate the real status of community clinic utilization and ensure proper and satisfactory utilization of services at community clinic in Bangladesh.

National Institute of Population Research and Training (NIPORT) under the Ministry of Health and Family Welfare (MOHFW) has been allocated public fund under the “Research and Development” component of the Operational Plan “Training Research and Development” of Health Nutrition and Population Sector Program (HNPSP)’ and it procured services in order to conduct the research to Environment Council Bangladesh.

The report of the study included the present perception of the service receiver and providers of the community clinic as well as various recommendations from different to increase the Essential Service Package through the community clinics in Bangladesh.

Dr. A.M.M. Anisul Awwal, PHD

Director (Research)

National Institute of Population Research and Training (NIPORT)

Acknowledgement

The research study will play an enormous role to investigate the status of community clinic utilization and the factors influencing the utilization of community clinic in order to provide data for increasing acceptance of Community Clinic services.

The study is conducted in 12 district comprising Munshiganj, Noagaon, Shirajgonj, Sunamganj, Moulivibazar, Kustia, Brahmmanbaria, Bagerhat, Bogra , Bhola and Chittagonj with a view to cover seven division of Bangladesh by EC Bangladesh. Through the study, it has been possible to successfully identify the actual status of community clinic utilization as well as the way to improve the acceptance of Community Clinic services in Bangladesh

However, the whole assignment were undertaken and completed according to the designed plan and monitoring by the NIPORT officials right from central to district level. We are thankful and indebted to them.

EC Bangladesh is also grateful to the local administration of the district, upazilas, alongside CS and H&FP officials and officials of other departments of GoB who have provided their all-out cooperation to complete the study.

We wish to express our profound gratitude to the research team for their sincere and hard working during data collection and other related work.

Last but not the least; EC Bangladesh are also grateful to local elite, teachers Community Clinic 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 all-out co-operation throughout the data collection process.

Arif Sikder
Executive Director
EC Bangladesh

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
CC	Community Clinic
CG	Community group
CMMU	Construction, Maintenance and Management Unit
DOTS	Directly Observed Therapies
ECNEC	Executive Committee of National Economic Council
EPI	Expanded Program on Immunization
ESP	Essential Services Package
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
HPSS	Health and Population Sector Strategy
HSC	Higher Secondary Certification
ICPD	International Conference on Population and Development
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
ORS	Oral Rehydration Salt
PRO	Policy and Research units
R&D	Research and Development

SSC	Secondary School Certificate
STD	Sexually Transmitted Disease
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
UP	Union Parisad

Executive Summary

The Health Nutrition and Population Sector Programme (HNPSP) aimed to bring important changes to health and family planning services in Bangladesh. The introduction of a sector wide approach brought a series of changes in the planning, financing and delivery of services. A key component was the development of the new Essential Services Package (ESP) to meet the needs of the poor, especially in rural areas and particularly women and children. Village level facilities were to be developed as a focus for the provision of ESP. These Community Clinics were to bring family planning, preventive health services and limited curative services closer to the population, and to improve the efficiency of service provision, partly by replacing outreach services with services provided from a fixed point.

Community Clinics (CC) are to provide services for around 6000 people, and it was envisaged that their location would make them accessible for 80% of the population within less than 30 minutes walking distance. The design was to be simple – two rooms with drinking water and lavatory facilities, and a covered waiting area. Funds for building the clinics were provided centrally, but communities had to donate land. This was designed to increase the feeling of ownership of the developments. In a similar way, each community was required to set up a group to support and assist with the management of the CC, although the government provided the staff and supplies. Each clinic should have two staff, one health assistant and one family Welfare assistant. There is a specified allocation of equipment and a range of drugs necessary to deliver the ESP services. Staff from the CCs would continue to provide a limited range of outreach services, especially in the early period after opening, and staff from higher levels in the system would visit on a regular basis to provide additional services and to supervise the CC staff. The development included a training programme for CC staff.

At the time when this study was planned around ten thousand CCs had been built, although some were not commissioned. The aim of the study was to assess the utilization of and whether they were meeting the objectives set for them in HNPSP in provision of ESP services. Using a combination of quantitative and qualitative techniques, the study gathered evidence from service users, local influential people and service providers. The study also drew on policy and management documents, routine statistics, and previous studies and reports that included information on CCs. The sample of clinics covered all parts of the country and included a wide mixture of types of setting.

The study team is, therefore, confident that the findings represent the general state of development of CCs.

The key findings of the study are given below:

1) Furniture and equipment: the government guidance sets out required furniture and equipment. The picture here was mixed. Most CCs were found to have some items, but few were found to have all the specified furniture, and almost none had all the specified equipment. Deficiencies were sufficiently serious to had effects on service quality. There is a need to monitor the supply of equipment and furnishing to ensure that CCs can operate as planned.

2) Community participation in development and operation of CCs: the policy is for representative community groups (CGs) to be formed, and these should take part in site selection, supervise construction and provide some management and supervision of services. In most cases CGs are set up, but few were working effectively. In some cases they do not meet, and members of the groups pointed out that they had little power, but can be blamed for the poor quality of services. Overall, the evidence shows that these structures were not yet operating effectively. Members of CGs pointed out that the main factors in determining service quality were staff skills, staff availability, drugs, and consumables. CGs has little control of these. Even in areas where CGs has potential control such as in, building security and maintenance there is little encouraging evidence. Previous experience in Bangladesh suggests that there is a need for effective mechanisms to allow more 'ownership' by local communities, but this is not yet happening in CCs.

3) Staff posting to CCs: the successful operation of CCs depends on people with the required skills being posted to the CCs. Again, here the picture is mixed. Some CCs had the two staff, many had one and in some cases, there were no staffs posted. However, even when staff was posted to CCs it was often difficult to find them and productivity seems low.

4) Skills of staff: staff in CCs should have the skills to provide the ESP services designated for provision at the village level. Evidence showed that staffs have been provided with training, and some of this training is good. However, it was also clear that much more is needed to equip CC staff for the full range of ESP services for which they require skills.

5) Supply of drugs: the policy specifies the 23 drugs that should be available at CCs. In most cases, most of these had been available at the time of opening, but supplies were limited, and had been at best intermittent. The arrangements for supply of drugs to CCs had clearly failed to achieve even a reasonable level of availability

6) Opening hours: policy suggests that CCs should be open during normal working hours six days per week. There is local discretion to allow variation to meet local circumstances. The study found that around half the CCs are effectively closed, and are providing little or no service. In a quarter of the clinics, the services were often available, but did not conform to the designated level. In other cases opening was erratic, and often only limited services such as immunization were available. It is clear that the service availability falls very short of that planned.

7) Service quality: previous evidence shows that the perceived low quality of public health services in Bangladesh has been a disincentive to their use. Evidence from this study suggests that the users consider the perceived quality of services, including behaviour of providers, poor.

There are some reasons to be optimistic – the developments have put in place facilities of broadly the planned specification in broadly the right locations. Causes for concern were the poor quality of some of the construction, some deficiencies in the facilities, furnishing and equipment and poor maintenance. However, in terms of operation and service development the picture is less encouraging. Many of the problems found in other government health services are appeared here – shortages of drugs and consumables, insufficient skills in some staff, staff not available when needed, and generally, services considered to be 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 clear that at present the community clinics were playing at most a limited role in the development of ESP services for those most in need.

Chapter One: Introduction and Rational

Background

Over the last two decades, the health programmes of Bangladesh have achieved considerable progress in reducing fertility, infant mortality and under-five mortality. The immunization coverage in this country is one of the highest among the developing countries.

Health Nutrition and Population Sector Research (HNSPSP) is the mainstream public sector health research in the country. This sector research will run through 2011. The funding mechanism for HNPSP is results based.

National Institute of Population Research and Training (NIPORT) under the Ministry of Health and Family Welfare (MOHFW) has been allocated public fund under the "Research and Development" component of the Operational Plan "Training Research and Development" of Health Nutrition and Population Sector Research (HNPSP)' and it intends to procure services in order to conduct the research studies or study related activities (e.g. (data collection, data editing, data entry, data analysis and report printing) under the Package "NAS-2 : Utilization of community clinic".

This project aims at fulfilling certain objectives that will help to investigate the real status of community clinic utilization and ensure proper and satisfactory utilization of services at community clinic in Bangladesh. Certainly, these works incorporate a large variety and huge volume of tasks for which a well-defined technical approach and a structured methodology is required. In the following section technical approach with understanding of the objectives, scope of work and methodology to be adopted in this project has been illustrated in the next subsequent pages.

There were 18000 Community Clinic in the different locality of Bangladesh. Community Clinic has been established with a view to serve different types of health service to the community people. For ensuring the quality services and strengthening the structure of the community clinic it is required to investigate the present situation.

Rationale for the study

To provide the ESP from a fixed point at the village level, about 18,000 community clinics were planned of which about 10000 were completed by May 2002 (CMMU, LGRD). This is an addition to the health and family planning services infrastructure for rural areas in

Bangladesh. The other purposes of establishing Community Clinics were to ensure (a) wider coverage, especially for women, children and the poor, (b) appropriate skill mix of health and family planning personnel, (c) availability of services close-to-client, (d) involvement of the community at all possible areas starting from site selection, construction, management, operation and maintenance of the CCs, (e) establishment of a referral system, (f) ensuring equity and accessibility. Still there are some problems in utilization of those community clinics due to different types of problem. By this study, it is try to find out the real scenario of utilization of community clinics in Bangladesh.

Chapter Two: Literature Review

It is essential to review existing literature for gaining different types of information and the status in order to conduct any research work. To conduct the study different types of literature relevant to this study has been taken in reviewed during the study.

History of establishing community clinics

The Government is establishing CCs to deliver local primary health care and family planning services in rural areas. They replace the home-based and other outreach services at the community level. The UHFWCs and UHCs had complementary functions to a CC for the adjacent 6,000 people, while serving as the facilities for referral and support for the CCs of the respective unions and upazila.

The establishment of CCs was based on the experience of a pilot project at Abhoynagar in Jessore and Mirersarai in Chittagong. The group exercise at Mirersarai in Chittagong demonstrated that 71% and 67% respectively of the existing outreach sites may be phased out. The participants from Mirersarai emphasized that even the female clients would be able to reach CC located within 10-15 minute walking distance. In the workshop at Abhoynagar it was shown that 46% of the existing outreach sites might be phased out. However, the participants suggested that the Expanded Programme on Immunisation (EPI) sites/ Satellite Clinics, located further away (beyond 15-minute walking distance) from the CCs, should be continued for some period after construction of CC. However, in both areas people said that intensive mass campaigns must be undertaken to make the community aware of the change of the service-delivery points. In addition to the success of pilot projects, Government had the following view for establishing CCs:

- The public sector health services were unsuccessful in providing health and family planning care according to expectation of people. The government adopted the strategy to build a partnership of public-sector facilities and providers with the community to address the health needs of the local population efficiently and effectively and to ensure long-term sustainability of the essential healthcare provision. It was expected that where the community is involved, the programme would succeed1.
- The CCs would provide ‘one-stop’ community-level ESP services in a consistent location designed for easy access at the time of need and thus a much more comprehensive range of services could be provided. Preventive and primitive

[1] www.bangla2000.com, June 5, 2011.

services including missed-opportunities immunisation could be linked to acute curative care and counselling[2].

- In the system prior to HPSP 1998-2003, there were 3-4 HAs for each union, one Assistant Health Inspector for every two unions, and two Health Inspectors for each Upazila. 3-5 FWAs and one Family Planning Inspector in each union provided family planning domiciliary services. The Family Welfare Visitor (FWV) from the UH&FWC attended the Satellite Clinics on the scheduled session days. There was also provision of one Senior Family Welfare Visitor in each Upazila to oversee and support the FP-MCH activities. That service-delivery system at the grassroots level was both labour-intensive and costly, and has a limited range of services to offer at any one time. The frequency of field worker's visit per household could not adequately meet the need of a family for healthcare, especially reproductive healthcare. CCs would replace labour intensive and costly health care services with cost-effective extensive health and family planning services at one location[3].
- The studies on consumer preferences and the experiences of combined EPI outreach and Satellite Clinics have shown that the rural people of Bangladesh prefer one-stop provision of a package of essential services to address their basic health needs[4].

The specific functions of CCs are:

- Registration of pregnant women
- BCC: hygiene, diet, immunisation, intestinal, breast-feeding etc.
- Informing pregnant women in advance to attend the clinic for FWV services and ensuring that pregnant women come for antenatal services.
- Maintaining the expected date of delivery information to provide assistance if danger signals appear.

[2] MOHFW (1998), Health and Population Sector Programme 1998-2003: Programme Implementation Plan (Part-I), Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.

[3] Routh S, Arifeen SE, Jahan SA, Begum A, Thwin AA, Baqui AA (1997), Developing alternative service delivery strategies for MCH-FP services in urban wereas: findings from an experiment, Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1997. (ICDDR,B working paper, 106).

[4] Hasan Y, Barkat-e-Khuda, Levin A. Strengthening outreach sites through an approach combining satellite clinics with EPI. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1997. (ICDDRB working paper, 87)

- Referral to higher levels
- Providing FP methods: pills and condoms
- EPI: informing families in advance about outreach clinics and ensuring that children are immunised at the correct times.
- Minor treatment: ORS, Vit. A, anti helminthic's, ARI, DOTS for TB, MDT for Leprosy, anti malaria etc.

Chapter Three: Research Objectives and Methodology

Aim of the Research

The aim of the study is to investigate status of community clinic utilization and the factors influencing the utilization of community clinic in order to provide data for increasing acceptance of Community Clinic service.

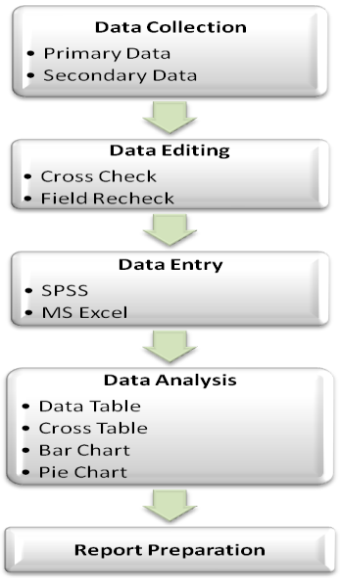
Objectives

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

1. Record the types of services available in Community Clinic
2. Observed the numbers of clients received different services per day
3. Determine the socio-economic, demographic and cultural factors that influence the utilization of Community Clinic
4. Observed existing facilities, stock of contraceptives, medicine and manpower
5. Assess clients' perception and satisfaction about the services of Community Clinic
6. Obtain clients and providers opinion on how the utilization of services at Community Clinic can be increased

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

Following steps had been identified to be accomplished in order to achieve the set goal and objectives of the research.

1) Advertisement and recruitment of data collector and other staffs
2) Inception Report preparation and submission
3) Research materials development
4) Training Orientation for the staff
5) Team composition and placement
6) Questionnaire Interview
7) Key Informer Interview (KII)
8) Focus Group Discussion (FGD)
9) Observation
10) Opinion sharing meeting
11) Data input and interpretation
12) Workshop on draft report sharing
13) Existing documents review
14) Final Report preparation
15) Monitoring by the Implementing Organization

The following section provides illustration of these designed activities:

Advertisement and recruitment of data collector and other staffs

After awarding the assignment and signing the contract, the 1st task was to advertise and recruit necessary number of qualified and experienced data collector and staff to accomplish the project activities. Advertisement was widely circulated and the standard processes were followed to select the best candidate. A total number of 12 data collector and 6 supervisors were recruited for the field.

Inception Report Preparation and Submission

After signing the contract, an incretion report was prepared mentioning that the assignment work had been started and the activities were going on well. The inception

report included the reviewed action plan. The inception report was produced 5 copies according to the requirement of ToR. The reports were submitted maintaining the quality and dead line.

Research materials development

The expert professional team recruited for this study to prepare the more effective and qualitative questionnaire so that proper data and information can be collected. Other logistic materials like clipboard, pen, pencil, poster paper, computer, printer etc. A total package of materials will developed at a time for the assignment duration.

Orientation Training for the staff

The required project staffs were 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 were developed by incorporating the training methods, equipments and ground rules to be used. Number of key resource persons and facilitators will also be stated in the training module. A standard Terms of Reference (ToR) in this regard were developed.

Photo 01: Orientation training for the Staff

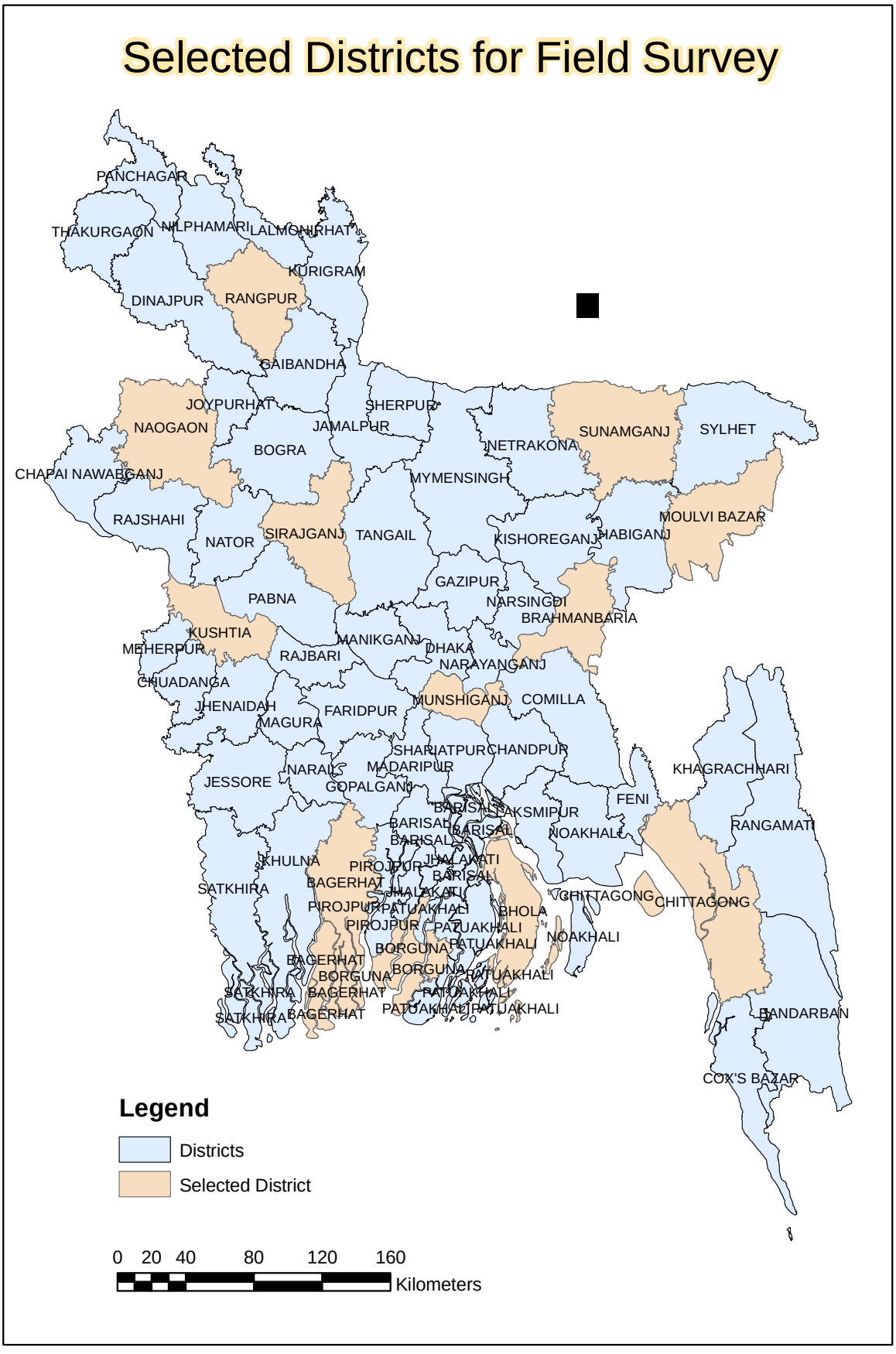
Team composition and placement

After completion of training and considering concerned factors, a well team were composed and placed in respective working station within the project areas. Psychosocial factors were considered in team composition and placement of staff so that the team could work with satisfaction. This will help to timely accomplishment of assignment activities both quantitatively and qualitatively.

Sample Questionnaire Interview

A number of 10 community people from each of the selected 12 community clinic catchment areas under 12 districts (sample basis selected) of 6 divisions were

interviewed through the sample questionnaire. Thus, a total number of 120 community people were interviewed during this study. The data collectors will collect data through sample questionnaire (Annex 1 & 2). Each recruited divisional supervisors prepared the Individual report. Through this interview community peoples were informed about the services and their participation were ensured. Checklists of questionnaire interview were provided to the Interviewer.



Map: Surveyed district during data collection

Key Informer Interview (KII)

An interview of Key informer like Upazila Nirbahi Officer (UNO), Upazila Health and Family Planning Officer (UH&FPO), Upazila Chairman from selected district were conducted. About 8 persons from each of 12 districts were in-depth interviewed. A total 96 Key Informer were selected for the Interview who can provide more potential and reliable information. This type of interview was helpful to ensure check and balance of the study. A checklist of activity and process for conducting the KII was provided to the interviewer so that they can complete their assessment.

Focus Group Discussion (FGD)

The focus group discussions were conducted in Community Clinic areas designated as low, medium and high performing. The objectives of the focus group discussions were to understand the views and opinions of service providers, community leaders and clients concerning the community clinic operation. The designated areas were selected based on report of the Management Information System (MIS) unit of the Health and Family Planning Directorate. Considering one focus group for each category of stakeholders and one focus group from each of the low, medium and high performing areas, about 12 focus group discussions were conducted under 12 selected districts. The stakeholders for the FGD were considered (i) clients, (ii) community leaders, (iii) service providers, and (iv) Upazila officials. In each focus group, 6 to 8 participants were included for discussion. Many localized NGOs were providing health and family planning services in different areas in Bangladesh who were also involved with this process. Community people's participation was ensured through this FGD.

Observation

The study followed the observation method for collecting the real information from the community. The research team made the plan for observing the actual situation of the community clinic considering low, medium and high performance. The team will visit 10 community clinics when service is going on. Some success and failure case study also were observed during this assignment period. The staff presented a report after completion the observation.

Opinion sharing meeting

After gaining the assignment and contact signing to conduct the study, a opinion sharing meeting with the participation of service recipient, service providers, health and family planning representative and other health service providing agencies on behalf of sharing

the goal, objective and our tasks of this assignment. The meeting was conducted consisting of 40 representatives as the participants. The meeting will create the environment for Interactive session and group work so that our team can gain multi-disciplinary recommendation for achieving a output oriented study.

Existing literature review

The existing literatures were reviewed related to issues to gain status of Community Clinic generally as well as prospects and challenges in Bangladesh. It will help to identify primary data regarding the present status of the community clinic.

Data input and interpretation

After completion of all types of data and information collection, the expert computer programmer input the data. Data base software was purchased for this study. Then the data were analysed according to the plan and schedule for making the final report.

Workshop on draft report sharing

A daylong workshop on final report sharing was conducted at national level with the participation different level health service providing institutions representatives, doctor, government representatives, NGO representative who were proving related service as well as some service recipient. In the workshop, the draft report was presented and floor was opened to all for any recommendation. Through this workshop, participants also informed about the real status of the community clinic.

Final Report preparation

Finally, a report was prepared for submission to client maintaining quality and dead line. A soft copy and 200 (two hundred) printed copies of the final report on “NAS-2: Utilization of Community Clinic” were submitted by June 20011.

Chapter Four: Findings and analysis

This chapter deals with the information gathered through Focus Group Discussion (FGD), direct observations, structured questions and Key Informer interview. In addition to FGD and direct observations, field investigators also applied other techniques such as rapport building and key informant interviews.

Findings from service receiver

Sex Structure

Sex structure is important to categorize patients who take health services from the CC. From the study, it has been found that female person's are more interested to take health services from the community clinics. From the field survey, 87% patients have been found female while only 13% is male only (Figure-01).

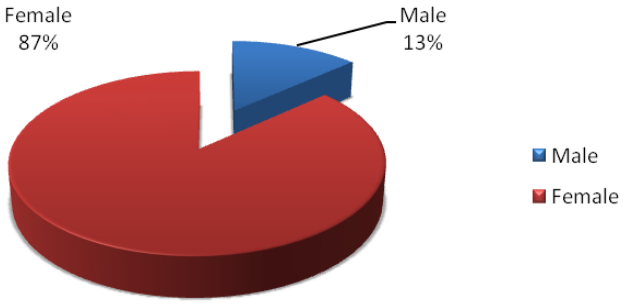


Figure 01: Patients according to sex

Source: Field Survey, 2011

Age Structure

Age structure is also another important factor. Because people of different ages need different health facilities. Therefore, categories according to age had been given priority for this study. Among the respondents, the age range of 15 years to 25 years, 26 years to 35 years and 36 years to 45 years had the major share. These three groups cover about 73%. That means most of the service recipients has been found at a range of 15 years to 45 years (Figure 02).

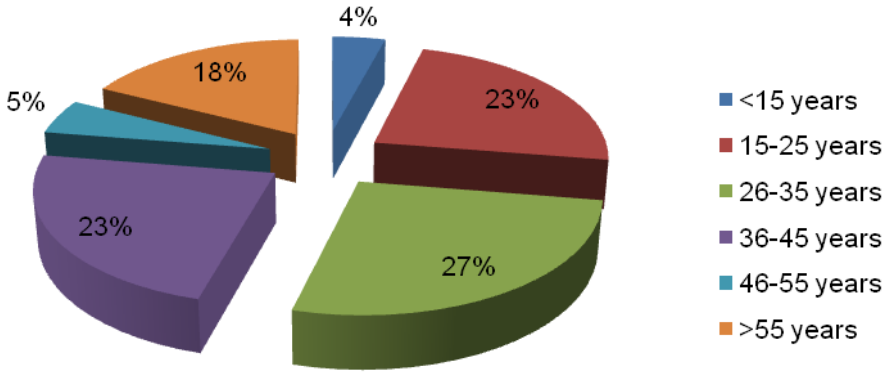


Figure 02: Age Structure of Respondents

Source: Field Survey, 2011

Marital status

According to the field survey, 85% respondents are married and only 15% are unmarried (Table 01). A table showing the marital status of the service recipients is given below:

Table 01: Marital status of the service recipients

Marital status	Frequency	Percentage (%)
Married	102	85.0
Not Married	18	15.0
Total	**120**	**100.0**

Source: Field Survey, 2011

Occupation Structure

To justify the choice of different types of patients of different ages, occupation structure is necessary. In this study, occupation structure of respondents and occupation structure of household head of the respondents are considered.

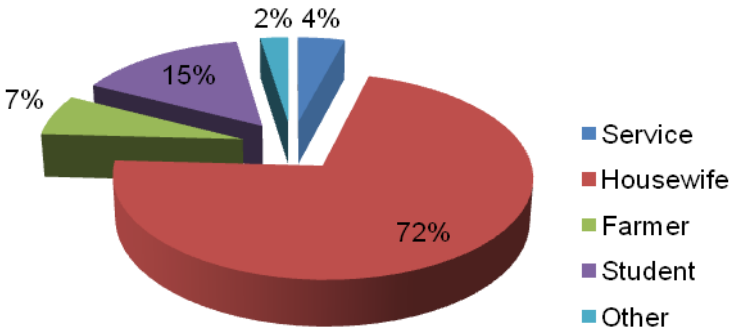


Figure 03: Occupation Structure of Respondents

Source: Field Survey, 2011

As most of the respondents are female (Figure 01), housewife is the most dominant occupation among the respondents.

On the other hand, farming and the business had the major share of the occupation of the household head occupation. Farmers contain 41% while businesspersons are 28% (Figure 04). Service as an occupation category has 16% share. There are other some occupations like, students, rickshaw pullers etc. are found from the study.

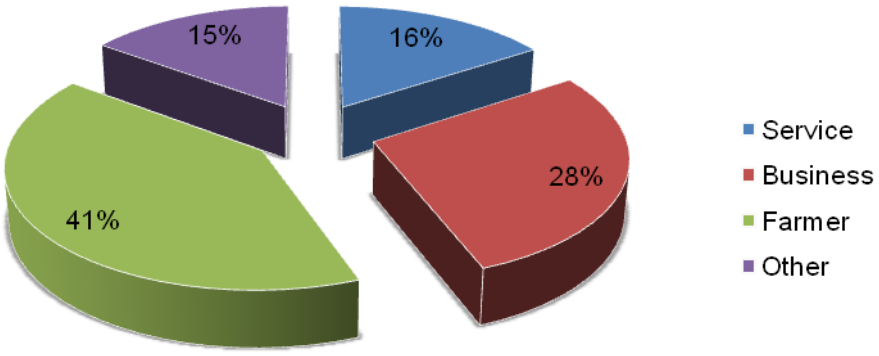


Figure 04: Household Head Occupation of the Respondents

Source: Field Survey, 2011

Income Structure

From the study, it has been found that most of the time respondents chose community clinics for free medicine and health service at no cost or free of cost. A table showing the income status of the respondents is given below:

Table 02: Total household income of the respondents

Monthly Total Income (Tk)	Frequency	Percentage (%)
3000-5000	49	40.8
6000-10000	48	39.2
11000-15000	19	18.8
>15000	5	1.2
Total	**120**	**100.0**

Source: Field Survey, 2011

Table 02 shows that at 80% cases total household income of the respondents are in a range of 3000 to 10000 BDT. Among them, respondents with income range 3000-5000BDT is about 41% and respondents with income range 6000-10000 is 39% of the total. Only 1.2% respondents have total household income of more than 15000BDT.

Household Type

Household type is another important dimension to identify economic status of service recipients. Most of the times, among the people who receive the health service from the community clinics live in katcha, semi-pacca and tin-shade houses. These types of structures are generally considered as in low cost housing category. Only about 16% service recipients live in pacca houses (Table o3). A table representing the housing status of the respondents is given below:

Table 03: Housing status of the respondents

Household Type	Frequency	Percentage (%)
Pacca	19	15.8
Semi-Pacca	36	30.0
Katcha	23	19.2
Tin-shade	42	35.0
Total	**120**	**100.0**

Source: Field Survey, 2011

The ratio of different household types of respondents is shown in Figure 05.

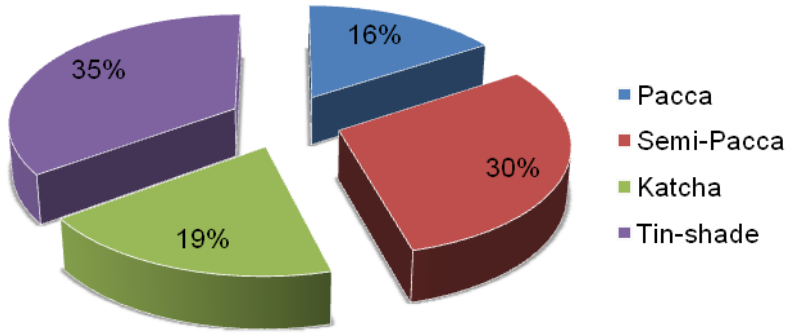


Figure 05: Household type of the Respondents
Source: Field Survey, 2011

Service Delivery Factors

Facilities

Community clinics were established to ensure health facilities at community level. People come to community clinics to get free medicine and low cost health service. Sometimes patients had not to pay any money to get service. From the study, it is found that 53% respondents said that they do not pay for health service (Figure: 07). Moreover, the payment for health service- who has to pay- is only 10 BDT (Source: Field Survey, 2011).

Therefore, cost is the main reason to choose community clinics. From the study it is found that, a large number of people come to community clinic to get low cost health facilities. A question has been asked to everyone about the factors to choose community clinics for health service. It can be noticed that the question is open ended and not exclusive in nature. From the field survey, 73 persons among 120 have been found who prefer community clinics for free medicine (Figure 06). Nevertheless, the maximum number

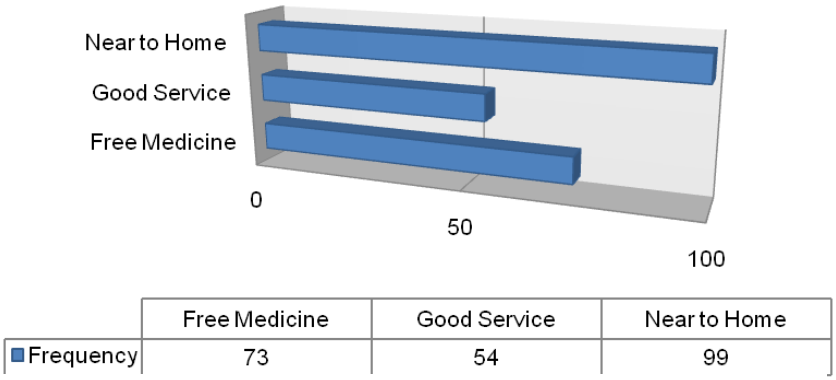


Figure 06: Reasons for coming to the Community Clinic
Source: Field Survey, 2011

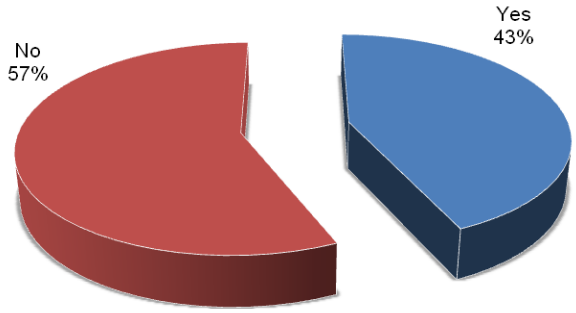


Figure 07: Payment Status of Community Clinic
Source: Field Survey, 2011

patients (99 persons) consider distance as the first reason to come to community clinics (Figure 06). Another important reason as they said do the health service providers provide good service.

Only 2% people had to travel more than 1 kilometre to get health services from

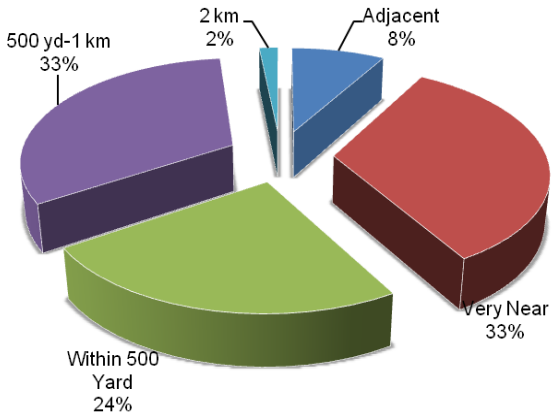


Figure 08: Distance to get service from Community Clinic
Source: Field Survey, 2011

community clinics (Figure 08). This is an important factor for choosing community clinics by people. 41% respondents had the opportunity to get services almost without travelling (Figure 08). In addition, 57% respondents have the opportunity to get services with travelling only up to 1 kilometre. The main objective of establishing community clinics is to ensure health services at community level. Lower distance plays important role to execute the objective.

On the other hand, patients of common diseases are the most the major stakeholder of all types of patients. 70% of total respondents said that they come to community clinics for some common syndromes like fever, cold infection, physical pain, diarrhoea etc. (Table 04).

Table 04: Types of patients come to community clinics

Service Taken	Frequency	Percentage (%)
Common Disease	84	70.0
Injured	8	6.7
Pregnancy Service	12	10.0
Family Planning	16	13.3
Total	**120**	**100.0**

Source: Field Survey, 2011

Family planning services and some services for pregnant women are also available at community clinics. 28% respondents came to community clinics for pregnancy services and family planning services (Table 04).

People come several times to get health services. Maximum number (36%) of respondents said that they came to the certain clinic twice within 1 week. Moreover, 46% respondents said they came 1-4 weeks ago at the certain clinic before the time of interview. In addition, 31% said they came before one month (table: 05).

Table 05: Interval to come to certain community clinics by patients

Interval to come at CC	Frequency	Percentage (%)
within 1 week	43	35.8
1-3 week	31	25.8
3-4 week	15	12.5
before 1 month	31	25.8
Total	**120**	**100.0**

Source: Field Survey, 2011

Frequency to come to community clinics is a major determinant of utilizing community clinics or symbol that people had belief on provided facilities of community clinics. From the study it is found that only 1% respondents said that they generally didn't come to community clinic to get health services (Figure: 09). It seems that community clinics are reliable to most of the respondents.

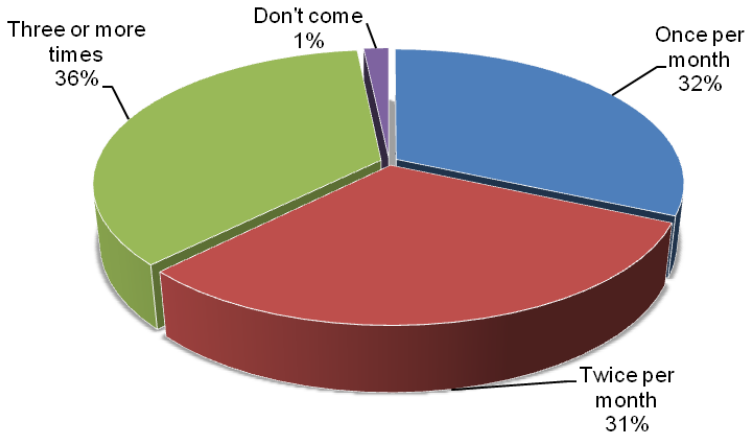


Figure 09: Frequency to come at Community Clinic
Source: Field Survey, 2011

Quality of Service

There are some factors to determine the quality of services considered in this study. The factors are duration of staying to get service, service delivery time, time spend by doctors

to a patient, cordiality of service providers and last of all satisfaction of service recipients. The factors are described below:

Duration of Staying to Get Service

Duration of staying to get health services depends on different factors. In maximum cases, patients get service within 10 minutes. About 51% respondents said that they got services within 10 minutes. Sometimes patients had to wait for 1 hour or more to get service.

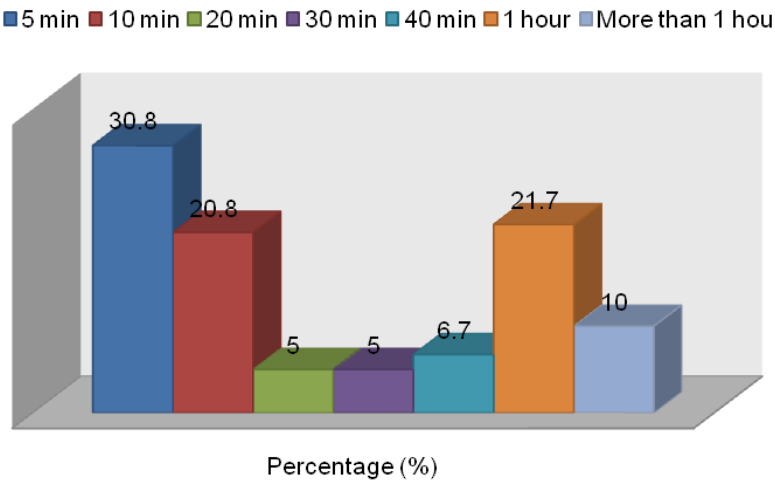


Figure 09: Duration of staying to get service at Community Clinic
Source: Field Survey, 2011

Service Delivery Time

Community clinics do not provide health services for whole day. People can get services from 9 am to 4 pm in a day. 44% respondents said that they are able to get health services for 6 to 7 hours in a day (Table 06). In addition, for other cases the service delivery time is lower.

Table 06: Service delivery time of community clinics

Time	Duration (hour)	Frequency	Percentage (%)
10am-1pm	3	20	16.7
10am-2pm	4	10	8.3
10am-3pm	5	10	8.3
10 am -4 pm	6	16	13.3
9 am -1 pm	4	8	6.7
9 am -2 pm	5	12	10.0
9 am -3 pm	6	10	8.3

9 am -4 pm	7	34	28.3
Total		**120**	**100.0**

Source: Field Survey, 2011

On the other hand, time spent for patient by doctors is another factor. In 38% cases respondents said that doctors do not want to spend enough time for them which is not a good sign at all (Figure 10).

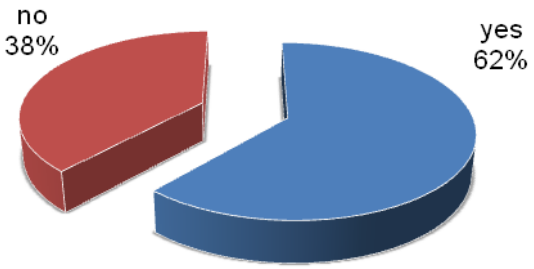


Figure 10: Time spent to provide health services

Source: Field Survey, 2011

Peoples' Satisfaction

Peoples' satisfaction on health services depends on cordiality of doctors and nurses and other staffs of the concern clinic. In this study, it is found that at 85% cases respondents had said they are satisfied to the cordiality of doctors (Table 07).

Table 07: Type of cordiality of service providers

Type of cordiality	**Satisfied to Doctors**		**Satisfied to Nurses & Staffs**	
	Frequency	**Percentage (%)**	**Frequency**	**Percentage (%)**
Very good	52	43.3	50	41.7
Good	50	41.7	26	21.7
Moderate	16	13.3	42	35.0
Bad	2	1.7	2	1.7
Total	120	100.0	120	100.0

Source: Field Survey, 2011

On the other hand, about 64% respondents said that they are satisfied with the service of nurses and other staffs and 35% said they are moderately satisfied (Table 07).

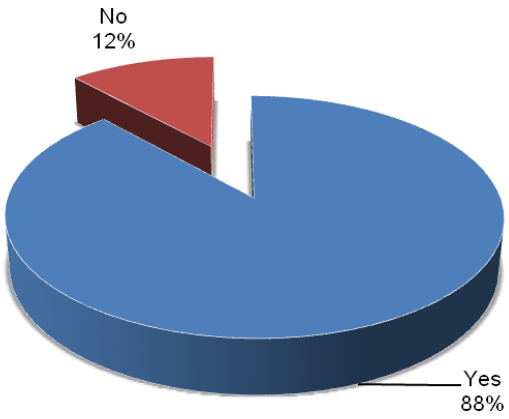


Figure 11: Satisfaction to provided services

Source: Field Survey, 2011

During the interview, respondents have been asked if they are satisfied or not for getting services from the certain community health clinic. About 88% respondents said they are satisfied with and 12% said they are not satisfied (Figure 11). Lack of doctors and medicine and delay to get service are the major reasons for the dissatisfaction.

Expectation of People

Respondents were asked about their expectations from the community clinics. Maximum number of respondents said that they expect improved services from the community clinics. About 109 respondents among the 120 had demanded improved services (Figure 12). 69 respondents said that doctors that are more qualified are necessary and 74

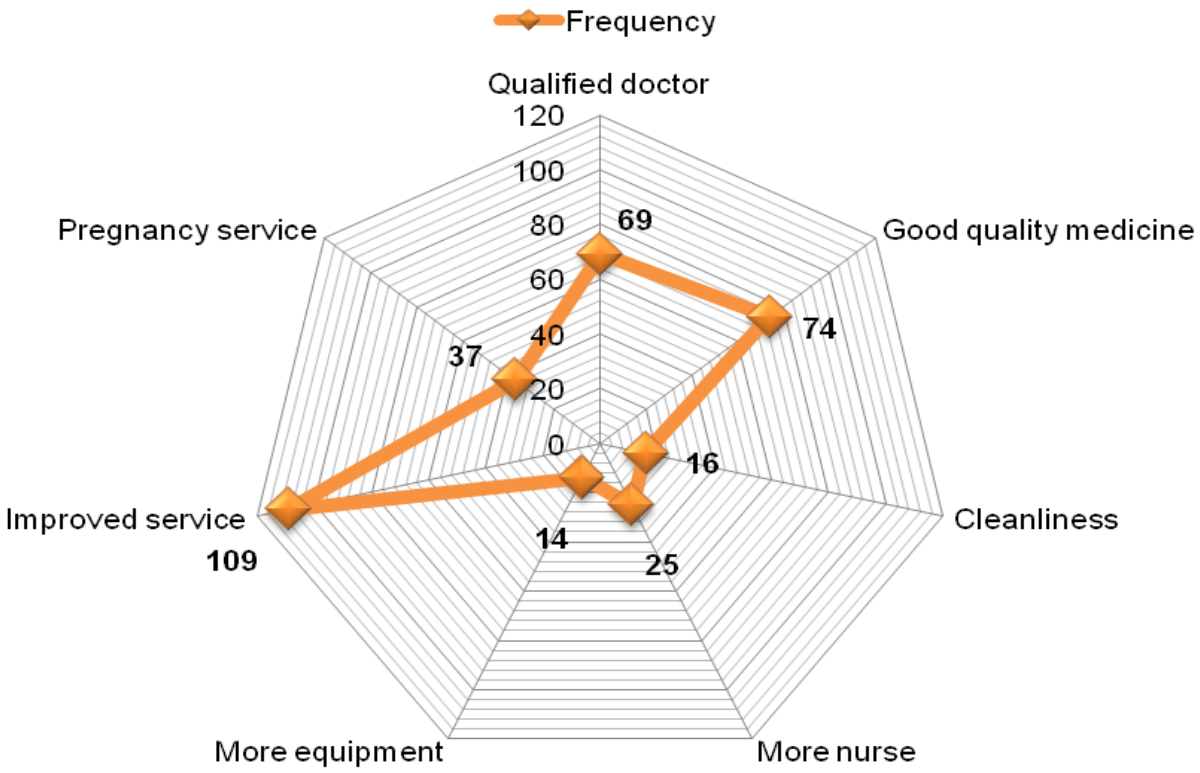


Figure 12: Expectation of people from Community Clinic

Source: Field Survey, 2011

respondents said good quality medicine is necessary (Figure 12). According to different respondents other expectations are sufficient health facilities for pregnant women, cleanliness, more trained nurses and more equipments are necessary.

Respondent's Opinion to Improve Health Services

Respondents asked to give some opinion to improve the health service of the community clinics. Maximum number of respondents had given emphasize on increasing availability of qualified doctors and sufficient number of good quality medicine (Figure 13).

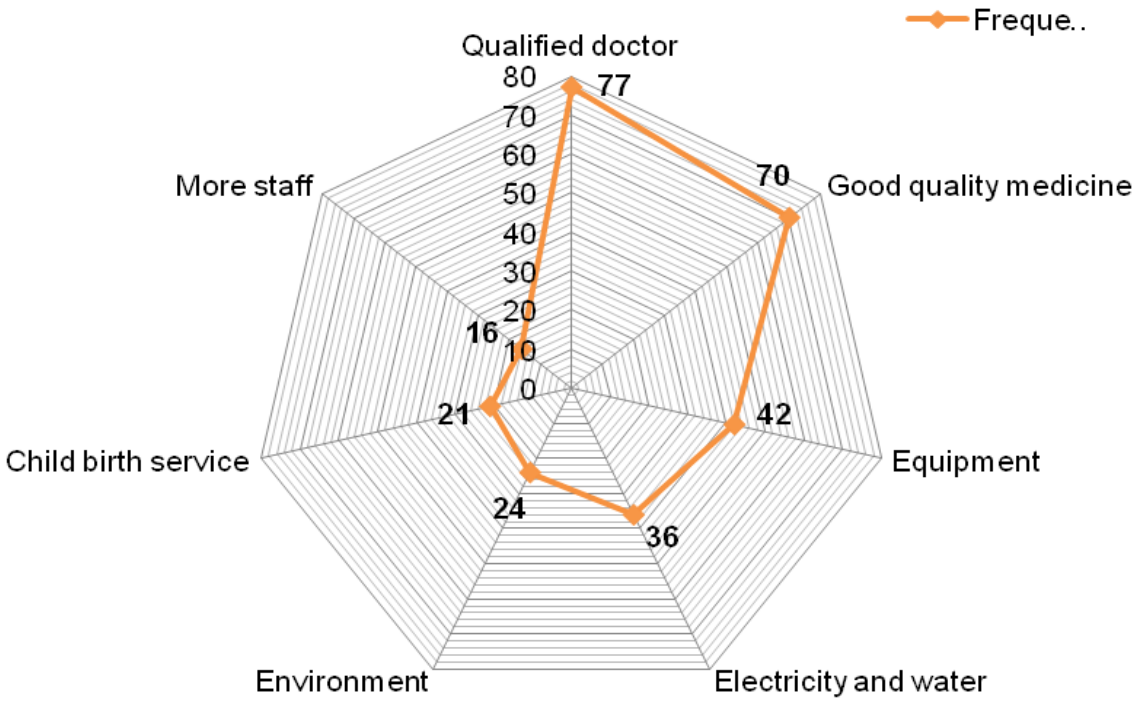


Figure 13: Respondent's Opinion to Improve Health Services Community Clinic

Source: Field Survey, 2011

Other important factors emphasized by the respondents are modern equipments, sufficient electricity and water supply, suitable environment, childbirth service and sufficient numbers of staffs.

Service Providers Point of View

Drug supply:

The availability of drugs, equipment and medical instruments, are very important factors for creating demands for health care services of the target population. The government guidelines on Community Clinics make provision for 23 categories of medicines to be supplied to the CC. According to the guidelines, each Community Clinic would maintain a

monthly stock of those medicines. The study shows that generally, medicines are provided once at the time of formal opening of the CC.

Equipment:

"Community Clinic Sthapan Sankrant Nitimala" maintains that each Community Clinic would keep eight categories of equipment.

Sl No.	Description of Equipment	Unit	Entitled
1	Primary Medical Kits (Scissors, Forceps)	Kit	2
2	B.P Instrument with Stethoscope	Set	1
3	Tool Kits (1-gagh, 6 masks, 4 thermometers, 2 Timer, one sensor testing kits)	Kit	8
4	Insecticide Spraying Machine	No.	1
5	Bathroom Scale (Child)	No.	1
6	Weighting Scale	No.	1
7	Kerosene Stove	No.	1
8	Hanging Scale	No.	1

None of the CCs surveyed received all the scheduled categories of equipment mentioned above. Most of the Clinics have been found to function with the equipment and medical instruments such as BP machine, thermometer, stethoscope, weighing machine and primary medical kits. It became clear from the discussion with the respondents that the lack of regular supply of drugs and equipment/medical instruments was the main reason why most of the Community Clinic are not functioning properly and do not open for providing services. The irregular supply system of drugs and other logistics had adversely affected the overall service delivery of the CCs.

Furniture:

As per "Community Clinics Sthapan Sankrant Nitimala", a CC would get eight categories of furniture at the time of its hand-over and formal opening. These are one labour table/examination table, one investigation table, one steel almira (two compartment), two back-rest bench (for 4-5 persons), two mat/cushion bed for service receiver, one black board with stand, 6 wooden/plastic chair and one table with one-drawer. All CCs are supplied with a delivery table, 81.2% CCs received an examination table, 98.3% steel cabinet (two compartments), 77% received bench to seat, 72.1% received mat/cushion,

90% received black board, 94% got wooden/plastic chair, 95% received wooden table with one drawer.

Services provided, range & times

Limited curative care, preventive and primitive services together with counselling are planned to be provided at the Community Clinics. From the survey report, it is found that limited clinical treatment was provided to the clients for minor illness, general health care, ANC, PNC care, FP services, TT vaccination, ARI, Diarrhoea, common cold and fever.

As per the government guidelines the service providers (HA/FWA) are to provide 33 listed health and family planning services. In addition, eight types of domiciliary services were also included in their job descriptions (MOH&FW/2000). These include EPI activities, Family Planning Services (distribution of temporary methods) and limited curative services for some common ailments like fever, cold & cough, dysentery, headache, vertigo, diarrhoea, itches, minor cuts & snatches of skin, intestinal parasite, gastric illness, asthma and uncomplicated delivery (see table 8). It was difficult to identify clearly, to what extent the ESP components are covered in part because the service providers did not know what those all are. However, the irregular opening of CCs suggested that many were only sometimes available.

The study shows that 40% of the functioning and surveyed CCs remain open 6 days per week, 18.34% open 4-5 days per week, 25% open 2-3 days per week and 8.33% open once in a week another 8.33% once in a month. Few are open for the intended 7 hours per day.

Main features of the community clinics according to service provider's point of view are discussed below:

- The doctors are not very much qualified. Most of them are educated in paramedical. Some of them are HSC passed and had LMAFP. None of them is equivalent to MBBC degree.

- Most of the community clinics have one nurse, one doctor and one staff. A large number of posts are vacant.

- According to the health assistants, more manpower is needed for all of the community clinics for the betterment of the service.

- The minimum number of patient for community clinics is 25-30 and the maximum is 130-140.
- Most of the time they come for common diseases, family planning advices and for pregnancy services.
- Community clinics provide free medicine to the patients.

The common medicines provided to the patients were:

1. Medicine for common diseases
2. Vaccine
3. Vitamin
4. Medicine for pregnant women
5. Birth control equipments

- The community clinics provide health services for 4 to 7 hours in a day.
- Different types of equipments like stethoscope, stressor are needed for different clinics.
- Most of the time people behave cordially with service providers of community clinics.

Service providers of the community clinics think that the clinics can be more effective if more facilities can be provided and more publicity may be helpful.

Key Informer Interview

Interviews had been conducted with Upazila Nirbahi Officer, Upazila Family Planning Officer and Upazila Chairman. Different potential and reliable information had been obtained from those interviews. The findings from the key informer interview are discussed below:

Upazila Nirbahi Officer (UNO)

UNO of Khadim Nagar Upazilla under Sylhet district said that community clinics within his jurisdiction were in well infrastructure condition. Most of the community clinics were in good condition. However, some clinics were not good condition also. Md. Ataul Gani, UNO of Dhunat Upazila of Bogra district said that most of the clinics in his area were not in good condition and they were in a somehow tolerable situation.

Proper monitoring is necessary to ensure good health service. Community clinics of Khadim Nagar were monitored regularly as government rules according to Md. Enamul Habib UNO of Khadim Nagar Upazilla under Sylhet district. Nevertheless, in most of the cases UNO is not the mostly responsible person for monitoring. As Md. Ataul Gani said, "basically UH & FPO monitors and supervises the community clinics." It is the most common scenario found in the study.

Different problems to run community clinics had been found out from the key informer interview with the UNOs. The problems are:

- Lack of financial budget
- Shortage of adequate manpower
- Inadequate medicine supply
- Inadequate trained nurse and doctors
- Lack of modern health facilities

According to their opinion adequate budget, adequate manpower including trained nurses and doctors and modern equipments were necessary to improve the service of the community clinics.

According to UNO of Dhunat Upazila of Bogra district, "discussion on activities of community in the monthly meeting of upazila parishad and conduction of motivational work get emphasize". On the other hand, recommendation to Ministry of Health for equipments has found as a major responsibility from different UNOs.

There were different problems, but all the UNOs of different areas had the opinion that community clinics were necessary for ensuring health facilities at community level. If necessary steps from the government can be taken, these clinics were more effective.

Upazila Health and Family Planning Officer (UHFPO)

According to different Upazila Health and Family Planning Officer the main features of community clinics are described below:

- The building conditions of maximum community clinics were satisfactory and they are being repaired regularly by the Department of Health Engineering.
- Health workers of the community clinics provide primary health services of community people.
- The community clinics are supervised and monitored by Health Inspectors, Assistant Health Inspectors and UH&FPO
- Lack of eligible manpower, electricity, and instruments etc. are the main problems of community clinics of different areas.
- Recruitment of eligible manpower, instruments and electricity is necessary to improve service quality and area coverage.
- The community clinics are monitored and supervised properly by health officers to improve the service quality.

Last of all if the community clinics were maintained properly the people of the remote areas would get health service easily.

Upazila Chairman

Different ideas had been provided by different Upazila chairmen. These are described below:

- The community clinics provide primary health facilities for general diseases and family planning supports. However, the facilities should be improved.
- Monitoring and supervising should be developed.
- Qualified doctors, trained nurses and trained staffs should be appointed.
- More budgets were necessary to ensure quality medicine and other facilities.
- More people should be encouraged to take health service from community clinics.

Focus Group Discussion

A research instrument and guidelines on FGD was used for collection of information from the service receivers, members of the Community Groups (CGs) and interested elite of the locality. The sample CCs were selected from 12 districts covering six Divisions. This was done to give proper representative character of samples of surveyed CCs. The number of participants in the FGD varied from nine to eleven. The respondents were aged between 19 and 75, most being in the age group 30-55. Their education level ranges from the 5th class to degree level; most had S.S.C and H.S.C level education. A few of had a postgraduate degree. By profession, they were mainly service providers, businessmen, teachers, religious leaders (Imam), housewives and farmers. The participants included CG Chairmen and members, village doctors, service users, UP members and persons respected in the community.

Several FGD had conducted to know the peoples' opinion about community clinics. The major findings are discussed below:

According to the participants, the community clinics are important for:

- The community clinics ensure primary health service to the doorsteps of the community people.
- The Community clinics provide low cost health service and free medicine 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:

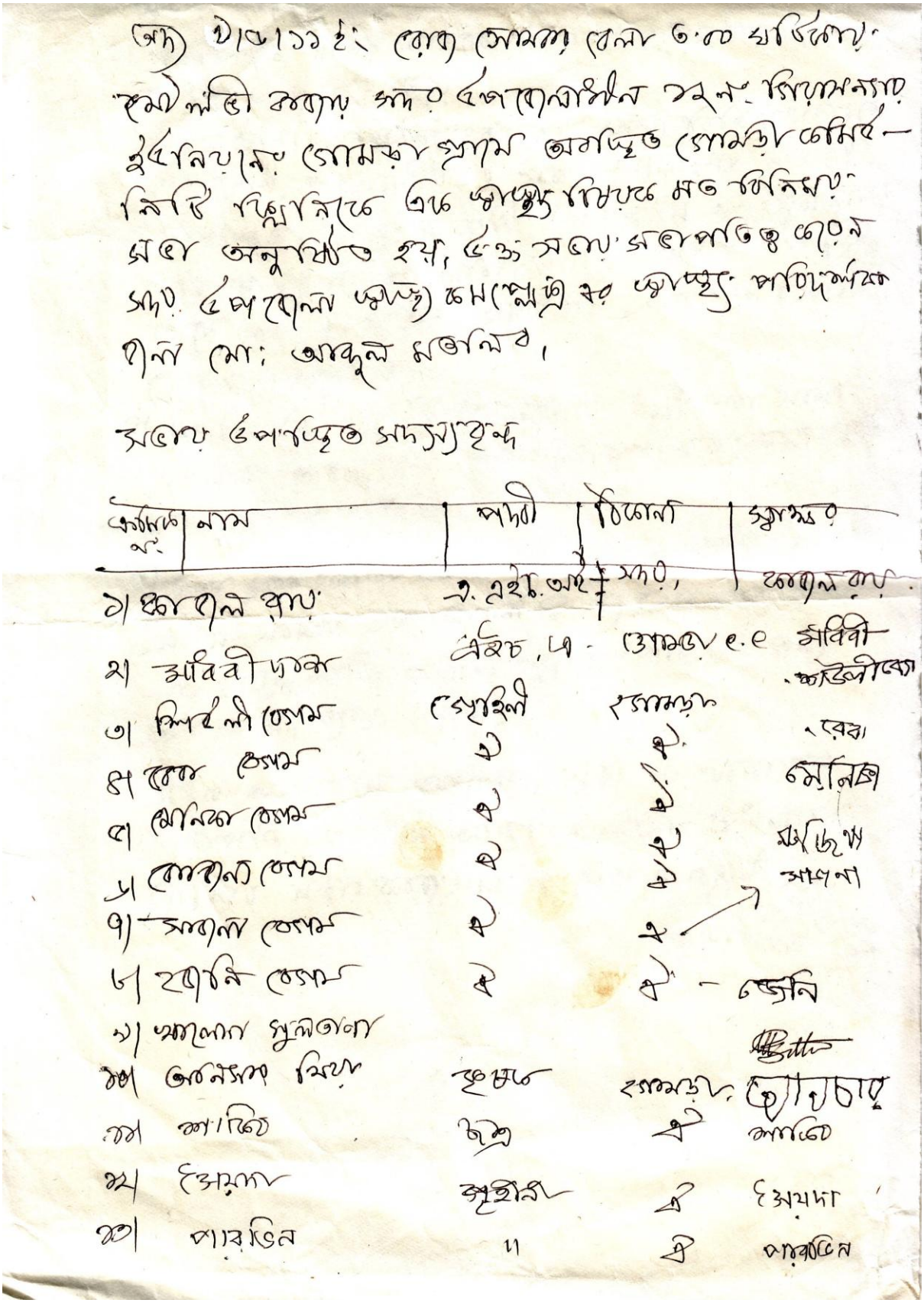
- Service is limited to some primary health care facilities only.
- Shortage of adequate manpower
- Inadequate medicine supply
- Inadequate trained nurse and doctors
- Lack of modern health facilities

- 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
- Ensuring qualified doctors and nurses
- Ensuring good quality medicine
- Ensuring good environment
- More publicity
- Providing more equipment

Most of the participants of the discussion think that the community clinics can be more effective if the necessary facilities can be provided.



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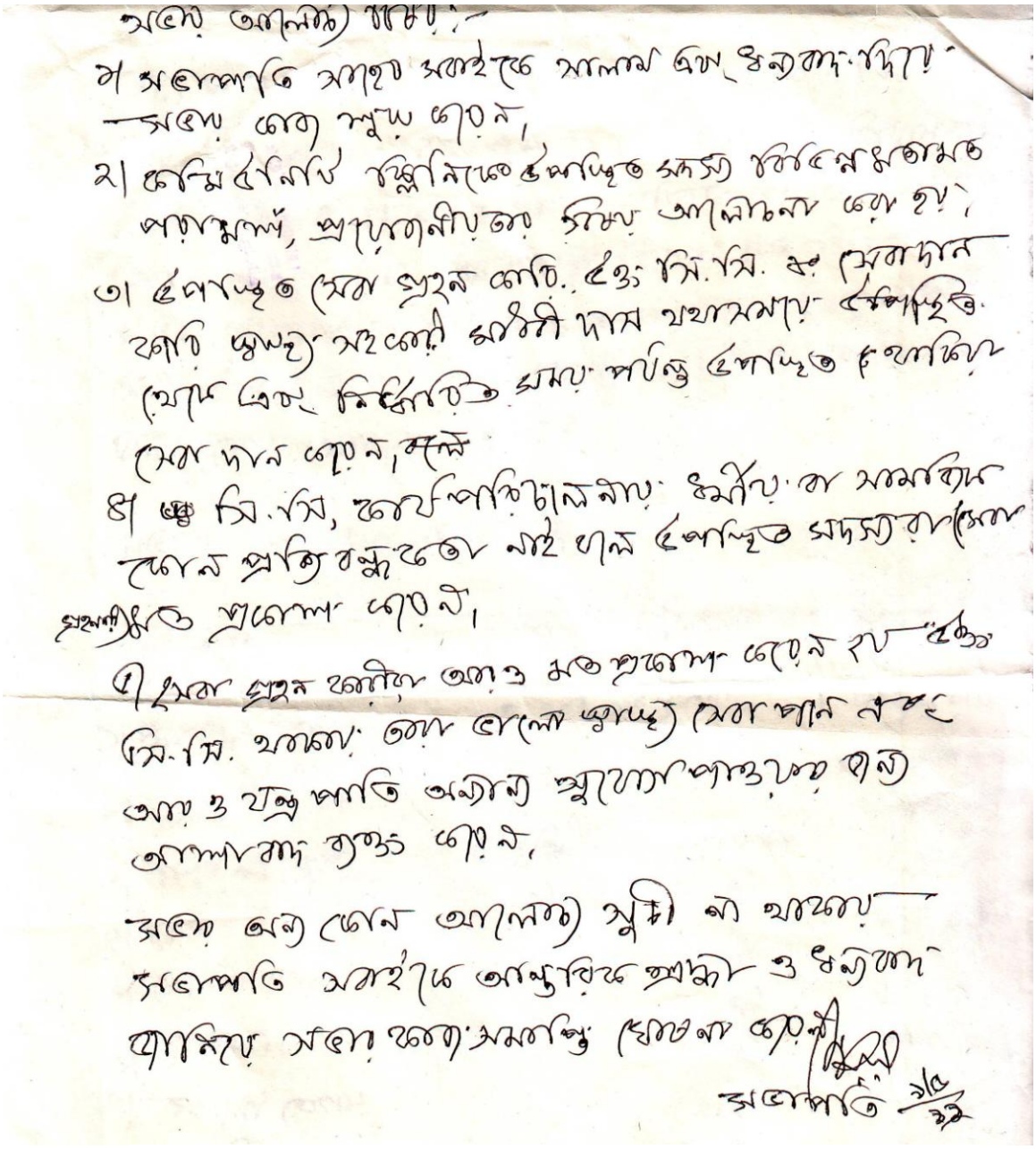

Figure: Meeting Minute's of a Focus Group Discussion (FGD)

Figure: Focus Group Discussion (FGD)

Chapter Five: Discussion

Introduction

The primary aim of the HPSP was to provide a package of integrated Health and Family Planning services, namely, the Essential Service Package (ESP), in an effective, easy and financially sustainable manner. With this end in view, the Government of Bangladesh has set up Community Clinics to deliver primary health care and family planning services near to the homes of people in rural areas. The Community Clinics were the lowest tier of three-tiered ESP delivery mechanism planned in the Health and Population Sector Programme 1998 – 2003.

The Clinics replaced the home based and other out-reach services at the community level. The delivery of ESP had been organised at different levels to meet the needs of the local population in a cost-effective manner, in a way that is easy to manage and convenient for the clients. Community Clinics were planned to be one–stop static service points for a community of about 6000 people in the rural areas.

Location, facilities and condition of buildings

Most clinics were well located, and in this respect, the government policy has been carried out in the development of clinics. In a few cases, there were major problems that show that the land donated was of little value, and is not suitable for the provision of health and population services, but overall this is not a major problem.

Evidence shows that the quality of the buildings is not at the desired and required standard. In general, the shape and configuration is satisfactory, but the quality of construction is typically poor, and the basic facilities and equipment were not satisfactory. Perhaps more seriously the condition of the buildings is already deteriorating, suggesting both that the initial work was poor, and that the maintenance is not happening.

Some of the furniture was available, but in many cases, there are items missing, and the condition of much of the furniture is poor. This all contributes to a poor impression, and is likely to discourage use by the target population.

Community involvement

HPSP has envisaged that community involvement in planning; implementation and monitoring for the ESP would be used as an entry point for partnership between

government and communities. Involvement of Community in the field of management and operation of CCs are designed to be through formation of Community Groups of local people.

The overall picture is of limited community involvement. CGs was set up late, and it is clear that they had responsibility but feel that they had too little power. CGs had not been effective in monitoring service delivery and quality, and (probably correctly) sees them as being at risk of blame from the local population for problems not of their making. The lack of knowledge of their membership, roles and powers suggests limited engagement from the communities with this attempt at participation.

In general, CCs received medicines only once at the time of formal opening. Overall, the problems of logistics and supplies contribute to the limited ability to deliver services, and the poor motivation of staff. Without drugs, staffs see little point in being open but being able to provide only very limited services. There is a vicious circle of public alienation due to poor drug supply and very limited opening times, and this alienation is in part leading to a lack of local participation in the governance and support of the CCs.

Range and availability of services – staffing, drugs, incentives

As per the government guidelines, CCs should provide 33 listed health and family planning services, in addition to, eight types of domiciliary services. It is difficult to measure exactly what proportion of this is being provided, but it is clear that only a part of this range of services is provided at all, much is of poor quality and the experiences of users were not good. There is clear evidence of posts not being filled, but more worrying, of people in posts but not working.

Clinics are not open when they should be, staff are not there and when they see patients only for short consultations. 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. None of the CCs surveyed received all of the categories of equipment, which can also limit the quality of services. It became clear from the discussion with the respondents that lack of drugs and equipment/medical instruments supply was a major reason why most of the Community Clinics were not functioning properly and do not open.

Utilisation of services, especially by target group

The strategy for increasing demand and utilisation of services include a move to (a) client-oriented one-stop services, and (b) communication with and involvement of communities in health services delivery. HPSP states that ESP should be client-oriented service, which would be provided on a one-stop basis at different levels of facilities: CCs, UH&FWCs and UHCs.

Client orientation would require change in attitude of service providers, which would be achieved through BCC activities component of the program. To gain the confidence of clients, communities would be involved in planning and managing services at CCs. The scope and quality of services would had to be sufficient to attract clients, who would also need to be informed about the range of services available at the CCs and other service delivery facilities. The evidence is that behaviour of staff is no better than in other tiers of the services, and this has been already identified as a cause in the low utilisation of services at union and Upazila levels.

Overall performance of the clinics

The study found widespread dissatisfaction with the overall performance of the CCs. Even the members of the Community Groups expressed their dissatisfaction. From the FGD findings from 12 CCs reveal that out of studied CCs only a tenth were working well, a third were partly satisfactory, and more than half were not really functioning. Whilst there is some good service delivery, overall people are not satisfied, and this is justified by the physical facilities, lack of timely service delivery, shortages of drugs and equipment, poor skills of staff and low morale in the service. Disillusion with the performance of clinics is made worse by the mistaken expectations in the population, who expected a doctor led service locally with a wider range of services and high quality.

Chapter Six: Conclusion and Recommendations

The community clinics are intended to provide health and family planning services to the rural people through one-stop service delivery with particular emphasis on vulnerable groups and the poor. Putting the right buildings in the right places is a key part of the implementation. The findings of this study suggest that most were well located in terms of access, but there remains a serious concern that one third is on boggy ground that is subjected to flooding. The objective of all people being within 30 minutes walk has not been fully achieved, but overall, the locations were not a serious problem. Most of the buildings conform to the guidance except in the provision of toilets and safe water. The quality of the building varied, and about one-quarter show serious signs of poor workmanship. It is clear that there has not been adequate supervision of some of the development and construction. To some extent, this is probably due to the late and unsatisfactory degree of community participation.

Community participation is widely seen as a key to the improvement of services, and the CCs emphasise this dimension. Whilst accepting that it takes time to set up stable and effective participation structures, the evidence in this study is not encouraging. The involvement of community at every stage was inadequate, CGs had too little effective authority and they were unable to fulfil their responsibilities. Several comments are made that the members do not want to appear too active for fear of being blamed for problems they cannot avoid or solve. The problems of staff availability and skills, and the limited availability of services and drugs are really the responsibility of officials at Union and Upazila levels. However, the poor cleanliness and maintenance of buildings does suggest little effective leadership by the CGs.

Before commenting on the detailed findings on service availability, it is important to note that only half of the CCs in the study sample were working to any important degree. The detailed findings therefore relate to the more successful half that were providing some services. Staffing for the operational clinics is a little below the planned levels, but more seriously the skill levels observed (and that reported by the staff themselves) is too low to allow high quality services to be provided. There is a clearly stated commitment from the Government to human resource development in the health sector, and this is likely to be a priority if the necessary skills for community clinics were to be put in place. The role of health workers in the clinics requires a wide range of skills and their job descriptions were currently beyond the skill levels of most staff.

There were some shortages of equipment and furnishings, but the main problem is the inadequate and intermittent supply of drugs. Unless this is addressed effectively, it is unlikely that the CCs will gain widespread acceptance in the community.

Utilisation of CC services remains low, and our one-day census suggests that the routine figures may overstate the level of use. Immunisation services are being provided, but overall the child health and maternal health care are particularly low. These figures are supported by the qualitative data that show that to some extent the former outreach immunisation services are being provided in the CCs, but that the maternal health and curative care developments are slow to take place.

Perhaps the most interesting finding on user satisfaction is the extraordinarily high expectations of many of those interviewed and those that took part in focus groups. For whatever reason they expected doctor led services and a major change in the availability of drugs; the former was never intended, and the latter not achieved. Participants in the FGD and other respondents, including members of Community Groups expressed their dissatisfaction with the overall operation of the CCs. A serious problem that must now be tackled if the development is to continue and succeed is the scepticism in the population about the possibility of high quality services being developed.

Under HPSP, the government planned to provide basic health care to the rural population close to their homes through CCs. This study found that these objectives are not yet been achieved. Community expectations had been raised but not met. If the policy is to be implemented effectively it is important to give at least as much attention to the working of CCs as it is to build facilities across the whole country. There is a real risk that the policy of introducing facility based village level services were undermined by failure to deliver services of reasonable quality and services that meet legitimate expectations of the community. Some specific recommendations on this study have been given bellow:

Furniture and equipment

The government guidance sets out required furniture and equipment. The picture here was mixed. Most CCs were found to have some items, but few were found to have all the specified furniture, and almost none had all the specified equipment. Deficiencies were sufficiently serious to had effects on service quality. There is a need to monitor the supply of equipment and furnishing to ensure that CCs can operate as planned.

Community participation in development and operation of CCs

The policy is for representative community groups (CGs) to be formed, and these should take part in site selection, supervise construction and provide some management and supervision of services. In most cases CGs are set up, but few were working effectively. In some cases they do not meet, and members of the groups pointed out that they had little power, but can be blamed for the poor quality of services. Overall, the evidence shows that these structures were not yet operating effectively. Members of CGs pointed out that the main factors in determining service quality were staff skills, staff availability, drugs, and consumables. CGs has little control of these. Even in areas where CGs has potential control such as in, building security and maintenance there is little encouraging evidence. Previous experience in Bangladesh suggests that there is a need for effective mechanisms to allow more 'ownership' by local communities, but this is not yet happening in CCs.

Staff posting to CCs

The successful operation of CCs depends on people with the required skills being posted to the CCs. Again, here the picture is mixed. Some CCs had the two staff, many had one and in some cases, there were no staffs posted. However, even when staff was posted to CCs it was often difficult to find them and productivity seems low.

Skills of staff

Staff in CCs should have the skills to provide the ESP services designated for provision at the village level. Evidence showed that staffs have been provided with training, and some of this training is good. However, it was also clear that much more is needed to equip CC staff for the full range of ESP services for which they require skills.

Supply of drugs

The policy specifies the 23 drugs that should be available at CCs. In most cases, most of these had been available at the time of opening, but supplies were limited, and had been at best intermittent. The arrangements for supply of drugs to CCs had clearly failed to achieve even a reasonable level of availability

Opening hours

Policy suggests that CCs should be open during normal working hours six days per week. There is local discretion to allow variation to meet local circumstances. The study found that around half the CCs are effectively closed, and are providing little or no service. In a

quarter of the clinics, the services were often available, but did not conform to the designated level. In other cases opening was erratic, and often only limited services such as immunization were available. It is clear that the service availability falls very short of that planned.

Service quality

Previous evidence shows that the perceived low quality of public health services in Bangladesh has been a disincentive to their use. Evidence from this study suggests that the users consider the perceived quality of services, including behaviour of providers, poor.

There are some reasons to be optimistic – the developments have put in place facilities of broadly the planned specification in broadly the right locations. Causes for concern were the poor quality of some of the construction, some deficiencies in the facilities, furnishing and equipment and poor maintenance. However, in terms of operation and service development the picture is less encouraging. Many of the problems found in other government health services are appeared here – shortages of drugs and consumables, insufficient skills in some staff, staff not available when needed, and generally, services considered to be 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 clear that at present the community clinics were playing at most a limited role in the development of ESP services for those most in need.

Appendix-A

Questionnaire for service providers

এনভারনমেন্ট কাউন্সিল বাংলাদেশ (ইসি বাংলাদেশ)

বাড়ী নং ৬৭, ব্লক-ক, পিসিকালচার হাউজিং সোসাাইটি, শ্যামলী, ঢাকা-১২০৭

(স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রনালয়-এর অধীন নিপোর্ট কর্তৃক বাস্তবায়নাধীন গবেষনার সাথে সংশ্লিষ্ঠ একটি সহযোগী প্রতিষ্ঠান)

Title of the Research:

Utilization of Community Clinic

কমিউনিটি ক্লিনিকের তথ্যের ফরম

(কমিউনিটি ক্লিনিকের স্বাস্থ্যসেবা প্রদানকারীর সাথে সাক্ষৎকার ফরম)

সম্মতি পত্র

আমরা এসেছি ইসি বাংলাদেশ-এর পক্ষ থেকে। আমরা স্বাস্থ্য ও পরিবার কল্যান মন্ত্রনালয়-এর অধীন নিপোর্ট-এর সহায়তা ও অর্থায়নে " বাংলাদেশে কমিউনিটি ক্লিনিকের ব্যবহার" সম্পর্কিত গবেষনা কাজে আপনার দৃষ্টিভঙ্গি, অভিজ্ঞতা ও মতামত সম্পর্কে জানার জন্য আপনার নিকট কিছু প্রশ্ন করতে চাই। আপনার দেয়া মূল্যবান তথ্যগুলো বাংলাদেশের জাতীয় পর্যায়ে স্বাস্থ্য পরিকল্পনায় নতুন নীতি সম্পৃক্তকরনে গুরুত্বপূর্ণ ভূমিকা রাখবে। গবেষণা কাজে আপনার অংশগ্রহণ স্বেচ্ছাসেবা মূলক এবং এ ব্যাপারে আপনি পুরোপুরি স্বাধীন। এ প্রশ্নোত্তর পর্বে আপনি চাইলে যে কোন নির্দিষ্ট প্রশ্নের উত্তর নাও দিতে পারেন। আপনার পরিচয় এবং ব্যক্তিগত তথ্য সম্পূর্ণরুপে গোপন রাখা হবে। আপনার দেয়া সকল তথ্য শুধুমাত্র গবেষণা কাজে ব্যবহার করা হবে। আপনি সাক্ষাৎকার দিতে রাজী আছেন কি?

☐ হ্যাঁ ☐ না

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর	তত্ত্বাবধায়কের নাম ও স্বাক্ষর

তারিখঃ

ফরম নং

কমিউনিটি ক্লিনিকের তথ্যের ফরম

(কমিউনিটি ক্লিনিকের স্বাস্থ্যসেবা প্রদানকারীর সাথে সাক্ষৎকার ফরম)

ক্লিনিকের নামঃ

যে এলাকায়/পাড়ায় অবস্থিতঃ | গ্রাম/ওয়ার্ড নং | ইউনিয়ন/পৌরসভাঃ

থানাঃ | জেলাঃ | বিভাগঃ

উওরদাতার নামঃ

পদবীঃ

কমিউনিটি ক্লিনিকের তথ্যঃ

১. বর্তমানে কর্মরত কর্মকর্তা/ কর্মচারীর সংখ্যাঃ

২. মোট পদের সংখ্যাঃ

৩. শূন্য পদের সংখ্যাঃ

৪. স্বাস্থ্যসেবা প্রদানকারীর সংখ্যাঃ

৫. স্বাস্থ্যসেবা প্রদানকারীর যোগ্যতাঃ

৬. স্বাস্থ্যসেবা প্রদানকারীর পদবীঃ

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

৭. দৈনিক মোট রোগীর সংখ্যা (রেজিষ্টার অনুযায়ী)ঃ

৮. কি কি সমস্যা নিয়ে রুগীরা এখানে আসেন?

ক. জ্বর

খ. পাতলা পায়খানা

গ. পেটে ব্যথা

ঘ. চুলকানী

ঙ. ঘা-পাঁচড়া

চ. প্রশব ব্যথা

ছ. শ্বাস কষ্ট

জ. উচ্চ রক্তচাপ

ঝ. আহত/আঘাত প্রাপ্ত

ঞ. হাড় ভাঙ্গা

ট. অন্যান্য (.....)

৯. ক্লিনিকে যে সকল মৌলিক সুযোগ সুবিধা বিদ্যমান (দেখে ও জিজ্ঞেস করে লিখতে হবে) ঃ

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

চ. .....

ছ. .....

কি কি সেবা এই ক্লিনিক থেকে প্রদান করা হয় ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

চ. .....

ছ. .....

১০. কি কি ঔষধ এই ক্লিনিক থেকে প্রদান করা হয় ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

চ. .....

১১. এখানে কি পর্যাপ্ত ঔষধ আছে ?

ক. হ্যাঁ খ. না

এখানে ঔষধ কোথা থেকে আসে ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

১২. সেবা প্রদানের সময় অর্থাৎ কমিউনিটি ক্লিনিক কতক্ষণ খোলা থাকে?

সকাল ..... থেকে বিকাল ..... পর্যন্ত (মোট ..... ঘন্টা)

১৩. জরুরী অবস্থায় সেবা প্রদানের ব্যবস্থা আছে কি ?

ক. হ্যাঁ খ. না

১৪. সেবা প্রদান করতে গিয়ে সাধারনত কি কি সমস্যার সম্মুখীন হন ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

১৫. আর কি কি প্রয়োজনীয় সুবিধা থাকলে আরো ভালো সেবা প্রদান করা সম্ভব ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

১৬. আর কি কি প্রয়োজনীয় আসবাব হলে আরো ভালো সেবা প্রদান করা সম্ভব ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

১৭. আর কি কি প্রয়োজনীয় যন্ত্রপাতি হলে আরো ভালো সেবা প্রদান করা সম্ভব তার তালিকাঃ

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

১৭. জনবল আরো বাড়ানো প্রয়োজন বলে মনে করেন কি?

ক. হ্যাঁ খ. না

১৮. উত্তর হ্যাঁ হলে, কোন ধরনের জনবল?

ক. .....

খ. .....

গ. .....

১৯. এই ক্লিনিকটি কি যেখানে অবস্থিত হলে ভাল হত সেখানেই আছে?

ক. হ্যাঁ খ. না

২০. স্থানীয় জনগনের সহায়তা কেমন পাচ্ছেন?

ক. খুব ভাল খ. ভাল গ. মোটামুটি ঘ. ভাল না

২১. ক্লিনিকের সাথে জনগনকে সম্পৃক্ত করার জন্য আর কি করা যেতে পারে?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

ধন্যবাদ

_____

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর ও তারিখ

Appendix-B

Questionnaire for service Receivers

এনভারনমেন্ট কাউন্সিল বাংলাদেশ (ইসি বাংলাদেশ)

বাড়ী নং ৬৭, ব্লক-ক, পিসিকালচার হাউজিং সোসাাইটি, শ্যামলী, ঢাকা-১২০৭

(স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রনালয়-এর অধীন নিপোর্ট কর্তৃক বাস্তবায়নাধীন গবেষনার সাথে সংশ্লিষ্ঠ একটি সহযোগী প্রতিষ্ঠান)

Title of the Research:

Utilization of Community Clinic

কমিউনিটি ক্লিনিকের সেবা গ্রহনকারীর তথ্যের ফরম

(কমিউনিটি ক্লিনিকের স্বাস্থ্যসেবা গ্রহনকারীর সাথে সাক্ষৎকার ফরম)

সম্মতি পত্র

আমরা এসেছি ইসি বাংলাদেশ-এর পক্ষথেকে। আমরা স্বাস্থ্য ও পরিবার কল্যান মন্ত্রনালয়-এর অধীন নিপোর্ট-এর সহায়তা ও অর্থায়নে " বাংলাদেশে কমিউনিটি ক্লিনিকের ব্যবহার" সম্পর্কিত গবেষনা কাজে আপনার দৃষ্টিভঙ্গি, অভিজ্ঞতা ও মতামত সম্পর্কে জানার জন্য আপনার নিকট কিছু প্রশ্ন করতে চাই। আপনার দেয়া মূল্যবান তথ্যগুলো বাংলাদেশের জাতীয় পর্যায়ে স্বাস্থ্য পরিকল্পনায় নতুন নীতি সম্পৃক্তকরনে গুরুত্বপূর্ণ ভূমিকা রাখবে। গবেষণা কাজে আপনার অংশগ্রহণ স্বেচ্ছাসেবা মূলক এবং এ ব্যাপারে আপনি পুরোপুরি স্বাধীন। এ প্রশ্নোত্তর পর্বে আপনি চাইলে যে কোন নির্দিষ্ট প্রশ্নের উত্তর নাও দিতে পারেন। আপনার পরিচয় এবং ব্যক্তিগত তথ্য সম্পূর্ণরুপে গোপন রাখা হবে। আপনার দেয়া সকল তথ্য শুধুমাত্র গবেষণা কাজে ব্যবহার করা হবে। আপনি সাক্ষাৎকার দিতে রাজী আছেন কি?

☐ হ্যাঁ ☐ না

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর

তত্ত্বাবধায়কের নাম ও স্বাক্ষর

তারিখঃ

ফরম নং

কমিউনিটি ক্লিনিকের সেবা গ্রহনকারীর তথ্যের ফরম

(কমিউনিটি ক্লিনিকের স্বাস্থ্যসেবা গ্রহনকারীর সাথে সাক্ষৎকার ফরম)

সেবা গ্রহনকারীর নামঃ

এলাকা/পাড়ার নামঃ গ্রাম/ওয়ার্ড নং ইউনিয়ন/পৌরসভাঃ

থানাঃ জেলাঃ বিভাগঃ

লিঙ্গঃ ক. পুরুষ/ছেলে খ. মহিলা /মেয়ে

বয়সঃ

পেশাঃ

ধর্মঃ

বৈবাহিক অবস্থাঃ ক. বিবাহিত খ. অবিবাহিত

খানার ধরনঃ ক. একক খ. যৌথ

খানার সদস্য সংখ্যা ঃ

খানার উপার্যনক্ষম সদস্যের সংখ্যা ঃ

খানার প্রধানের পেশাঃ ক. চাকুরী খ. ব্যবস্যা গ. কৃষিকাজ ঘ. অন্যান্য (.....)

খানার মাসিক আয় (টাকা)ঃ

বাসস্থানের ধরনঃ ক. নিজস্ব বাড়ী খ.ভাড়া বাড়ী গ. আশ্রয় ঘ.সরকারী ঙ. অন্যান্য(.....)

বাসস্থানের প্রকৃতিঃ ক. পাকা খ. আধাপাকা গ. কাঁচা ঘ. টিন ঙ. ছন চ. অন্যান্য(.....)

কমিউনিটি ক্লিনিকে সেবা সংক্রান্ত তথ্যঃ

১. কি কি সুবিধার কারনে আপনি এই কমিউনিটি ক্লিনিকে আসেন?

ক. .....

খ. .....

গ. .....

২. কি কি সেবা নেওয়ার জন্য ক্লিনিকে এসেছেন?

ক. .....

খ.....

গ. .....

৩. কতদিন আগে আপনি শেষ এই ক্লিনিকে এসেছেন?

ক. ১ সপ্তাহের মধ্যে খ. ১-৩ সপ্তাহের মধ্যে গ. ৩-৪ সপ্তাহের মধ্যে ঘ. ১ মাসের আগে

৪. মাসে কতবার আসেন?

ক. ১ বার খ. ২ বার গ. ৩ বা তার অধিক বার ঘ. আসেন না

৫. ক্লিনিকে সেবা পেতে কতক্ষন অপেক্ষা করতে হয়?

ক. ৫ মিনিট খ. ১০ মিনিট গ. ২০ মিনিট ঘ. ৩০ মিনিট

ঙ. ৪০ মিনিট চ. ১ ঘন্টা ছ. ১ ঘন্টার বেশি

৬. ক্লিনিক থেকে বাড়ীর দূরত্ব কত?

ক. লাগানো খ. খুব কাছে গ. ৫০০ গজের মধ্যে ঘ. ৫০০ গজ থেকে ১ কি.মি.

ঙ. ২ কি.মি. চ. ২ কি.মি. এর বেশি

৭. এই ক্লিনিক থেকে কি কি সেবা পান?

ক. .....

খ. .....

গ. .....

ঘ. .....

৮. সেবা প্রদানের জন্য টাকা প্রদান করতে হয় কি?

ক. হ্যাঁ খ. না

৯. উত্তর "হ্যাঁ" হলে কি পরিমান টাকা প্রদান করতে হয়?

..... টাকা

১০. ক্লিনিক থেকে কোন ঔষধ দেওয়া হয় কি?

ক. হ্যাঁ খ. না

১১. উত্তর "হ্যাঁ" হলে ঔষধের জন্য টাকা প্রদান করতে হয় কি?

ক. হ্যাঁ খ. না

১২. উত্তর "হ্যাঁ" হলে কি পরিমান টাকা প্রদান করতে হয়?

..... টাকা

১৩. ক্লিনিক থেকে সর্বক্ষন সেবা পান কি?

ক. হ্যাঁ খ. না

১৪. উত্তর "না" হলে কখন থেকে কখন সেবা পেয়ে থাকেন?

সকাল ..... থেকে বিকাল ..... পর্যন্ত (মোট ..... ঘন্টা)

১৫. ডাক্তার/স্বাস্থ্যসেবা প্রদানকারী কি রোগীদের যথেষ্ঠ সময় দেন?

ক. হ্যাঁ খ. না

১৬. স্বাস্থ্যসেবা প্রদানকারীদের ব্যবহার অথবা আন্তরিকতা কেমন?

ক. খুব ভাল খ. ভাল গ. মোটামুটি ঘ. খারাপ

১৭. কর্মীদের ব্যবহার অথবা আন্তরিকতা কেমন?

ক. খুব ভাল খ. ভাল গ. মোটামুটি ঘ. খারাপ

১৮. স্বাস্থ্যসেবা প্রদানকারীদের ব্যবহারে আপনি কি সন্তুষ্ঠ?

ক. হ্যাঁ খ. না

১৯. উত্তর "না" হলে আপনি কি কারনে অসন্তুষ্ঠ?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

২০. কর্মীদের ব্যবহারে আপনি কি সন্তুষ্ঠ?

ক. হ্যাঁ খ. না

২১. উত্তর "না" হলে আপনি কি কারনে অসন্তুষ্ঠ?

ক. .....

খ. .....

গ. .....

ঘ. .....

২২. পরিবারের অন্য সদস্যরা এই ক্লিনিক থেকে সেবা গ্রহন করেন কি?

ক. হ্যাঁ খ. না

২৩. উত্তর "না" হলে কি কারনে তারা উক্ত সেবা গ্রহন করছেন না?

ক. .....

খ. .....

গ. .....

ঘ. .....

২৪. এই ক্লিনিক থেকে আপনি আর কি কি সেবা/সুবিধা আশা করেন?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

২৫. আর কি কি সেবা/সুবিধা প্রদান করলে কমিউনিটি ক্লিনিকের সেবা গ্রহনকারীর সংখ্যা বাড়বে?

ক. .....

খ. .....

গ. .....

ঘ. .....

ঙ. .....

ধন্যবাদ

_____

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর ও তারিখ

Appendix-C

Discussion Topics in Key Informer Interview

EC Bangladesh

House-67, Block - KA
Piciculture Housing Society, Shyamoli
Dhaka – 1207

Key Informer Interview (Administration-UNO)

1. Name of Informer:

   Designation: Upazilla:

   District: Division:

2. The condition of those community clinics (Infrastructure and Service)

3. Monitoring and supervision procedures of those community clinics

4. Problems to provide service

5. Requirement to improve the service quality and area coverage

6. Initiatives from UNO Office

7. Opinions on those community clinic

8. Documents on Community Clinic of the Upazila in UNO office

Signature of the Surveyor and Date

EC Bangladesh

House-67, Block - KA
Piciculture Housing Society, Shyamoli
Dhaka – 1207

Key Informer Interview (Health)

1. Name of Informer:
   Designation: Upazila:
   District: Division:
2. Number of community clinics in the Thana (Open and Closed)
   Total: Open: Closed:
3. The served population under the Community Clinic
4. The condition of those community clinics (Infrastructure and Service)
5. The basic services are provided by those community clinics
6. Monitoring and supervision procedures of those community clinics
7. Problems to provide service
8. Requirement to improve the service quality and area coverage
9. Initiatives from Health Office
10. Opinions on those community clinic
11. Documents on Community Clinic of the Thana

Signature of the Surveyor and Date

EC Bangladesh

House-67, Block - KA
Piciculture Housing Society, Shyamoli
Dhaka – 1207

Key Informer Interview (Chairman)

1. Name of Informer:
   Designation: Thana:
   District: Division:
2. Number of community clinics in the Union (Open and Closed)
   Total: Open: Closed:
3. The served population under the Community Clinic
4. The condition of those community clinics (Infrastructure and Service)
5. The basic services are provided by those community clinics
6. Monitoring and supervision procedures of those community clinics
7. Problems to provide service
8. Requirement to improve the service quality and area coverage
9. Initiatives from UP Office
10. Opinions on those community clinic
11. Documents on Community Clinic of the Thana

Signature of the Surveyor and Date

Appendix-D

Discussion Issues in Focus Group Discussion (FGD)

EC Bangladesh

House-67, Block - KA
Piciculture Housing Society, Shyamoli
Dhaka – 1207

Focus Group Discussion (FGD)

1. Information about Community Clinic
2. Area Covered
3. Provided Service
4. Service Quality
5. Involvement
6. Satisfaction
7. Experience
8. Opinions