Health Systems Development Programme

Assessment of the community clinics: effects on service delivery, quality and utilization of services

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Executive Summary

Background

The Health and Population Sector Programme (1998-2003) 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) were 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 staff and supplies were provided by the government. 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 extent to which the CCs were operating efficiently and effectively, and whether they were meeting the objectives set for them in HPSP in provision of ESP services. Using a combination of quantitative and qualitative techniques the study gathered evidence from service users, local influential people, service providers, managers, planners and policy makers. 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.

Findings

The key findings of the study are given below:

1) Location of clinics: the concern was whether in general CCs are appropriately located. Appropriate in this context means good access

(meeting the criterion on travel time, but also ease of access by vehicle or on foot) and suitable type of land (especially whether the land is liable to flood). Given that the land was donated there is a risk that sites would be land not considered suitable for other uses. The findings on location show that the majority of CCs are well located, in all the senses considered. A minority are very poorly located, with flooding and very difficult access. The travel time criterion is not easy to meet in areas of relatively sparse population, but in most cases it was met or nearly met. The main message for policy is that some additional monitoring of site selection is needed to avoid the minority of cases where CCs are being poorly located. The aim had been to have significant community participation in the selection of sites, but evidence suggests that in many cases the formation of Community Groups came too late for this.

2) Construction of clinic buildings: the issue here is whether the buildings conform to the design specification in terms of size, number of rooms and facilities. The quality of construction is also a major issue. Most of the CCs in the study have the specified two rooms and are built using appropriate materials. In many cases the quality of construction is below the necessary standard, and buildings are already showing signs of dilapidation. All CCs are expected to have two operational toilets and safe drinking water. Very few met these standards, with many having only one toilet, and even these were in poor condition. Few had safe drinking water. The message for policy is that more supervision of building was needed, and in particular there is a need to focus on toilet provision and tube wells. Evidence suggests that there was little effective community supervision of the building work.

3) 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 have effects on service quality. There is a need to monitor the supply of equipment and furnishing to ensure that CCs can operate as planned.

4) 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 were set up, but few were working effectively. In some cases they do not meet, and members of the groups pointed out that they have little power, but can be blamed for the poor quality of services. Overall the evidence shows that these structures are not yet operating effectively. Members of CGs pointed out that the main factors in determining service quality are staff skills, staff availability and drugs and consumables. CGs have little control of these. Even in areas where CGs have 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.

5) 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.

6) 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 staff had 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.

7) 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 have been at best intermittent. The arrangements for supply of drugs to CCs have clearly failed to achieve even a reasonable level of availability

8) 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 were effectively closed, and were 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 immunisation were available. It is clear that the service availability falls very short of that planned.

9) 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 perceived quality of services, including behaviour of providers, is considered poor by the users.

Conclusions and Recommendations

The aim of this study is to assess the development of community clinics, their location, facilities, staffing, services and management. 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 are 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 have 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 are 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 are playing at most a limited role in the development of ESP services for those most in need.

CHAPTER I: OVERVIEW OF HEALTH AND POPULATION SECTOR PROGRAMME (HPSP)

Background

Over the last two decades, the health and family planning programmes of Bangladesh have achieved considerable progress in reducing fertility, infant mortality and under-five mortality. The immunisation coverage in this country is one of the highest among the developing countries. Despite all these successes, Bangladesh has not made much progress in reducing maternal mortality and morbidity.

The mid-term review of the Fourth Population and Health Project (FPHP) in 1995 drew attention to overall poor utilisation of public sector health and population services. The same review also raised questions regarding cost-effectiveness, sustainability, and quality of services of the government health and population programmes at that time. The Ministry of Health and Family Welfare (MOHFW) had identified the existence of two separate organisations for health and family planning programmes as primary reason for failure to respond to needs of child and maternal health and clinical contraception and limited the capability for increasing range, quality and effectiveness of services[1]. The Government of Bangladesh (GOB) also observed that it was difficult to provide all the services needed by all segments of the population because of resource constraints and priority setting was essential to ensure sustainable health services for the population. The GOB's observations were discussed during GOB-donor consultation held in Paris in September 1995. The Paris consultation endorsed GOB's observations and decided to consider them as inputs for strategy formulation for the health sector.

On the basis of experiences gained from the FPHP and the suggestions extended by various development partners, the Government agreed that there was an urgent need for reforms in health and family planning services and identified three major intervention areas; (i) Reorganisation of the Ministry of Health and Family Welfare's (MOHFW) implementation structure to eliminate duplicative systems and to maximise efficiencies; (ii) improvement of management through capacity enhancement, human resources development, and effective management information system; and (iii) development of a comprehensive national reproductive health strategy, including family planning, maternal health care, STD/AIDS control and other reproductive services. Incorporating all these reform plans, the government formulated the Health and Population Sector Strategy (HPSS) and the Executive Committee of the National Economic Council approved it on 19 August 1997. Approval of HPSS led to the preparation of an implementation plan for the approved strategies. The plan document, known as Health and Population Sector Programme (HPSP), included all the required activities and related expenditures. The HPSP was put into operation from 1st July 1998.

Objectives

HPSP aimed to reform the health and population sector to provide a package of essential health care services for the people of Bangladesh and to slow the population growth rate. It was emphasised that services should be responsive to client's needs, especially those of children, women and the poor. It was expected that the HPSP would achieve high quality care,

[1] 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.

with adequate delivery capacity and financial sustainability. HPSP represented a shift from a project driven approach to a sector wide management approach.

Through implementation of HPSP, the government expected to reduce maternal, infant and under-five child mortality rates, communicable diseases, unwanted fertility and thereby the total fertility rate. Other important objectives of HPSP were increased life expectancy, improved nutritional status and more healthy life-styles.

Major Reforms/Reorganisations Initiative

HPSP 1998-2003 incorporated eight reforms for the health and population sector of Bangladesh. The purposes were to increase maternal and child health care facilities; improve access for the poor to public health care facilities; introduce cost-effective and sustainable health services; avoid duplications in service provisions; reduce the burden of communicable diseases; and improve quality of care. The following were the reforms/reorganisation initiatives introduced in HPSP.

a. *Essential Services Package (ESP)*
   The Government realised the difficulties in providing all the services needed by all segments of the population due to resource constraints. Hence, the policy makers decided to design a health service that would achieve the greatest health impact per taka spent, could be provided in a sustained way, and would satisfy the need of the most vulnerable in the society – women, children and poor. Accordingly, the MOHFW devised an Essential Services Package (ESP) for phased implementation in Bangladesh. The major focuses of the ESP were reproductive health care, child health care, communicable disease control, limited curative care, and behavioural change communication.

b. *Reorganisation of Service Delivery*
   There were three major changes in the service delivery process in HPSP. First, the separate wings of the MOHFW, health service and family planning service, were to be integrated at Upazila level and below to provide health and family planning services in an integrated way, and from the same places. Second, the roles and job descriptions of executives in health and family planning services were redefined. Third, steps were taken for administrative decentralisation and delegation of decision-making process to the Upazila level.

c. *Strengthening of Integrated Support Services*
   Effective delivery of health care services is highly dependent on integrated and coordinated support services. Hence, HPSP took steps to intensify human resource development, facilities development, procurement and logistics, quality assurance programmes, behaviour change communication (BCC), management information systems (MIS), and research and development (R&D).

d. *Improvement in Hospital Level Services*
   Besides primary health care services, hospital services were targeted for improvement, especially equity in access and efficiency of services. The plan was to strengthen and upgrade the district level hospitals to enable them to provide full range of referral services to the primary level to complement the ESP.

e. *Sector Wide Programme Management*

The project based management system was replaced by sector wide programme management. Expected benefits of this approach were clear sector policy and a strategic framework; clear links between the sector policies and the expenditure plans for the sector; annual operational plans to identify the activities to be carried out under each strategy; clear estimates of resources required to implement plans; integrated management of activities under line managers; effective reporting on activities and results against the plan.

f. *Policy and Regulatory Framework Strengthened*
To achieve financial sustainability of health and family planning programmes, the HPSP encouraged public-private mix in provision and financing health care. The existing policies were reviewed and revised and regulatory framework was proposed to improve accessibility, affordability and quality of services, including safety and rational use of drugs.

g. *Services of Public Health Importance Strengthened*
The HPSP identified services of public health importance and recommended steps to strengthen these. Issues included were environmental health and industrial/occupational health including arsenic pollution in drinking water; health emergency preparedness; emerging and re-emerging diseases; and prevention and control of HIV/AIDS/STDs. It also emphasised inter-sectoral working to link health and population initiatives to those of other ministries whose activities influence implementation of health and population programmes.

h. *Strengthened Health and Nutrition Services*
The HPSP included a plan to strengthen the network of facility-based services through establishment/upgrading of hospitals, specialised care centres and drug testing laboratories. It had included programmes to deliver nutrition related interventions.

Establishment of 'one-stop service' delivery (Close-to-Client)

Before introduction of HPSP on 1st July 1998 the MOHFW had two separate cadres at all levels to provide and manage health and family planning services. It was argued that two separate Directorates could not adequately respond to the needs of child and maternal health and clinical contraception. Often the clients could not obtain health, reproductive health and family planning services from the same service point. The separate structures in the delivery system limited the potential for increasing the range, quality and effectiveness of services and there was duplication of effort and poor use of resources. The studies of consumer preferences conducted by some agencies showed that people in Bangladesh wanted one-stop services[2]. Moreover, the 1994 International Conference on Population and Development in Cairo and 1995 UN Fourth World Conference on Women in Beijing had clearly advocated an integrated approach, including health services, family planning and women's empowerment, as the best approach to dealing with health and population problems.

The separate service structure was an impeding factor for delivering the planned Essential Services Package (ESP) because it had integrated health and family planning services. Therefore, the government decided to reorganise services by unifying health and family planning services at upazila level and below. It decided to provide services in a three-tiered fixed facility-based one-stop delivery system, with the UHC at the upazila level, the UHFWC at the union level, and the community clinics (CC) at the ward/village level.

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

CHAPTER II: REVIEW OF THE POLICY FRAMEWORK AND EXISTING EVALUATION REPORTS

Introduction

MOHFW decided to construct one CC for every 6000 population at village/ward[3] levels to provide ESP to the rural people, particularly to the poor, free of charge. One Health Assistant (HA) and one Family Welfare Assistant (FWA) have been posted in each CC to provide health and family planning services on all working days from 9 am to 4 pm. A doctor has been assigned to supervise the activities of each CC. It was planned to supply some 23 essential drugs in each clinic to treat common illnesses such as fever, abdomen pain, diarrhoea, and cold and cough along with family planning activities.

Government decided to construct CCs on donated land. Management of CCs is to be given to a committee with 9 to 11 members taken from the local community. Representatives from the villagers, including three women, poor and landless people will form the group. Members, after consultation among themselves, nominate/elect one member as Chairman and the Union Parishad (UP) Chairman is ex-officio chief patron and supervisor.

Rationale for 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 have 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[4]. 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

[3] There are 4,442 unions in Bangladesh, each comprising a population of 27,000. A union is similar to a county. Each union is divided into 9 wards. A ward is the lowest administrative unit of local government.

[4] Sarker, S, Islam, Z, Routh, S, Saifi, R A, Begum, H A, Nasim S M A, and Mesbahuddin, M (2001), Operation Research on ESP Delivery and Community Clinics in Bangladesh Transition Plan on shift from Outreach to Community Clinic-based Service-delivery System: A Study of Perspectives of Stakeholders, ICDDR,B: Centre for Health and Population Research Mohakhali, Dhaka 1212, Bangladesh (ICDDR,B Working Paper No. 146).

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 succeed[5].

- 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 promotive services including missed-opportunities immunisation could be linked to acute curative care and counselling[6].

- In the system prior to HPSP 1998-2003, there were 3-4 HAs for each union, one Assistant Health Inspector for every 2 unions, and 2 Health Inspectors for each upazila. Family planning domiciliary services were provided by 3-5 FWAs, and one Family Planning Inspector in each union. 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[7].

- The studies on consumer preferences and the experiences of combined EPI outreach and Satellite Clinics had shown that the rural people of Bangladesh prefer one-stop provision of a package of essential services to address their basic health needs[8].

Design Criteria

1. One-stop service: as many BCC and other services as possible would be provided at one place on each working day.

2. Accessibility: half an hour travel-time to the service provision point.

3. Coverage: 80% coverage of population living within the half an hour walking distance to the service points.

4. Quality: service to be provided according to the defined standards.

5. Efficiency: providing more services for the same costs, or same services at less cost, in a more accessible way.

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[5] www. Bangla2000.com, December 20,2000.

[6] 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.

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

[8] 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. (ICDDR,B working paper, 87)

6. Community Participation: involvement and participation of community in designing, planning, monitoring and helping to implement the program. The community was to donate the land in a suitable location and assist in constructing the clinic.

7. Population based planning: services will be based on the needs of the defined population.

8. Technical competence: availability of skilled human resources with multiple skills.

9. Logistic and supply: designed to ensure availability of medicines, vaccines, cold chain and instruments according to the level of services.

Basis of Service Delivery Design

The design for ESP services of the HPSP is based on objectives, targets, available manpower, and functions to be performed at upazila level and below. It is assumed that to provide specific functions, appropriate training to the key personnel including Community Groups will be carried out to match with the new roles. The main objective is to streamline the manpower and services to be provided at CCs so that the service system becomes cost effective, easier to manage, convenient for the clients/patients to receive and provide maximum coverage (80%).

Service Design and Community Clinic

1) For ESP and BCC service delivery, a team comprising of one FWA and one HA (or their equivalents after re-organisation) are the core personnel. A FWV provides additional clinical services and supportive supervision and visits each centre at least once a month.

2) Each team has at least one female (FWA/HA) worker.

3) Services are provided from a fixed facility serving a population of approximately 6,000. Services are to be available on every working day. Depending on local arrangement, the Community Clinic may choose other opening times that suit local needs.

4) Limited domiciliary services are focused on groups or individuals who are at risk, the most neglected including the extreme poor, follow-up on drop-outs for family planning for back referred cases, surveillance, and follow-up for specific infectious diseases including Directly Observed Therapies (DOTS). These services are provided in most cases one day per week, by one of the team-members, with other maintaining the services at the CC.

5) Depending on the service needs of the catchment population, it may be necessary to provide domiciliary or outreach services for an additional half or whole day, but on most days, the two team members will be working together in the CC. The decision on use of health worker time on focused domiciliary visits will be made by the Upazila Health Manager in consultation with the UHFWC in charge and the community.

6) The function of the CC is to provide first-level services of the ESP. Performance and quality standards are based on technical standards and norms for ESP interventions.

7) Location and timing of the CCs should be based on negotiation between the upazila manager and community members with participation of UHFWC in-charge.

8) The MOHFW has criteria for selection of location and constructing Community Clinic (such as number of rooms, waiting space, washrooms etc.). The community will donate the land, assist in constructing the clinic and provide maintenance and security services for the clinic. The CC should be constructed at a central location of the population of 6000.

9) There are on average four CCs in a Union. There are at least 8 field workers per Union at present (belonging to Health and Family Planning directorates together).

10) The existing satellite clinics and outreach centres are being gradually reduced. While the one-stop services will be focussed on providing the ESP and BCC, the existing behaviour of the community will require some time to change. The following steps will be taken for gradual reduction of the satellite/outreach services. In four weeks, the team will cover different outreach clinics/centres with 6000 population in each. i.e. one for 1,500 people (instead of one for 1,000 as exists now). In a union, therefore, there will be 16 such centres (instead of present 24) in addition to the four clinics. The 16 centres (for 4 teams) may be reduced to 12 based on the experience of the piloting being done in TFIPP area. If there are 12 centres per union, each team will go to 3 outreach clinics (one per month). The remaining one-day per month may be used for attending co-ordination meetings at the upazila. At present each centre is visited by HA/FWA once a month. So, even with this suggested reduction in the number of outreach sites, the number of visits per month will remain the same. There will be community based non-salaried volunteers who will assist field workers in outreach sites and CCs.

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.
- 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.

Community Involvement

Community involvement was a central theme in the development of the HPSS, with a plan to build a partnership between government and the community to support service development, HPSP envisaged that community involvement in implementation and monitoring for the ESP would be used as an entry point for such partnership. Involvement of community in management and operation of CCs was planned to be implemented through formation of Community Groups (CGs) representing people from all walks of life in the catchment area of each CC. Some specific responsibilities have been given to the CGs by the government including land donation, site selection, supervision of construction, operational management, day to day repairs-maintenance, rehabilitation in the long-run and motivation of the community to seek health and family planning services from the CCs.

Community Clinics and Essential Service Package

The primary aim of the HPSP was to provide a package of integrated health and family planning services, the ESP, in an effective and financially sustainable way. The delivery of ESP was to be organized at different levels in a way that meets the needs of local population on cost-effective basis and in a manner easy to manage and convenient for the clients. Service delivery from fixed facilities may lead to disadvantages of longer travel time, limiting access/usages/coverage especially for poor and women[9]. To offset these potential disadvantages, strategies were undertaken to increase scope and quality of services, to encourage community participation in and contribution to the overall planning and setting up of the facilities, maintenance of a flexible mix of fixed and mobile services to ensure coverage of clients who live at a distance or whose access is limited by culture, poverty or incapacitating medical symptoms. It is planned that Family Welfare Visitors (FWV) and Assistant Health Inspectors (AHI) from Union Health and Family Welfare Centre (UHFWC) should visit CCs each week to provide additional services that HA and FWA are unable to provide. Each CC will remain under the direct supervision of an MBBS doctor posted either at union or upazila level. However, treatments available at Community Clinics are primary health and family planning services and it will screen and refer patients to higher levels health centres.

The services to be delivered by the Community Clinics are given in Table 1.

Table 1: List of services should be available in Community Clinics

Area of Service	Services	Target Population	Service Provider
Safe Motherhood	Before pregnancy health education	All married women of child bearing age	FWA & HA
	Registration	All pregnant women of the area.	FWA & HA
	Care of pregnant women	Pregnant women	FWA, HA & FWV
	Antenatal Care	Pregnant women	FWA, HA & FWV
	Referral of complicated patient	Women with complicated labour	FWA, HA & FWV
	Emergency Obstetric Care	Pregnant women	FWA & HA & FWV
	Service after delivery	Postnatal mother	FWA & HA
	Family Planning Services	All eligible couple	FWA, HA & FWV
	Reproductive Tract Infections/ Venereal Diseases	All Women	FWA, HA & FWV
	Maternal Nutrition: BCC related intervention	All population group	FWA, HA & FWV

[9] MOHFW (1998), Health and Population Sector Programme 1998-2003: Programme Implementation Plan (Part-I), Ministry of Health and Family Welfare, Government of People's Republic of Bangladesh, p.30.

	MR service	All married women	FWA, HA, FWV
	Adolescent health care	All adolescent age group	FWA, HA & FWV
	Infertility	Infertile couple	FWA, HA & FWV
	General care of neonates	Neonates	FWA, HA & FWV
Child Health Care	EPI Service	Children below 1 year of age, Women on age 15-49 years	HA
	School Health Services	Students of primary & secondary level	AHI/FWV
	Diarrhoeal diseases	All population	HA/FWA
	Management of influenza, cough, pneumonia, severe pneumonia and very severe pneumonia and health, ARI, education.	All population especially children below 5 years of age	HA, FWA
Communicable Disease Control	Malaria control	All population group	HA/FWA/AHI/FWV
	Kalazar control	All population group	HA/FWA/AHI/FWV
	Filaria control	All population especially of endemic areas	HA/FWA/AHI/FWV
	Tuberculosis control	All population group	HA/FWA/AHI/FWV
	Emerging and re-emerging diseases (Dengue fever)	All population group	HA/FWA
HIV/AIDS/STD	Counselling	Mother's receiving antenatal care Identified STD patients	HA/FWA
	Condom promotion	All population of reproductive age	HA/FWA
	Behavioural Change Communication (BCC)	STD exposed population group	HA/FWA
	Referral to higher treatment centre for STD treatment	STD exposed population group	HA/FWA
Limited Curative Care	Everyday accidents (burn, cut, injury etc.)	All population group	HA, FWA
	Emergency health services (pain, senseless, suffocation, asthma and poisoning)	All population group	HA, FWA
	Treatment of skin disease (ringworm, itching, eczema etc.)	All population group	HA, FWA
	Treatment of eye disease (conjunctivitis)	All population group	HA, FWA

	Treatment of dental problems	All population group	HA, FWA
	Treatment of ear diseases (earaches, causes of earaches)	All population group	HA, FWA

EPI Outreach Services / Domiciliary Services/Satellite Services

Providing services from a fixed-centre at the community level is a significant shift from the previous domiciliary system and represents one of the main features of HPSP. Home visits, out-reach and satellite programs would continue during the period of transition from doorsteps to fixed-centre service delivery. These are planned to be reduced by 20% each year and should be completely phased out by the end of the programme period.

Mid Term Report / Annual Performance Report / Aide Memoire on the activities of the community clinics

The Annual Performance Report (APR) findings of April-May 1999 suggested the establishment and operation of Community Clinics with full stakeholder participation as key step in addressing the needs of the poor. During the review of plans for the financial year 1999-2000, the APR mission stressed that the HPSP should avoid an excessive focus on the expansion of facilities (i.e., community clinics), without matching this with the necessary service quality.

The Working Group 1 on the Service Delivery[10] raised some important concerns. It was worried that the transition to community clinics risks further lowering EPI coverage, as outreach opportunities would be reduced. It raised some specific issues such as the role of staff; outreach versus fixed site roles; how to ensure no negative impact on EPI and TB defaulter tracing; payment for recurrent costs (as no budgets were provided and the policy is not to have user charges); choice of sites is based on geography rather than poverty or under-served area criteria; monitoring of workers' productivity; fitting of sites of NGOs to the overall framework.

It recommended a comprehensive evaluation including a focus on stakeholder participation, ownership and utilisation of critical ESP elements; careful phasing to synchronise buildings provision/trained staff etc. It also recommended that a system for ensuring provider accountability and empowering upazila managers to respond to feedback from community groups.

Mid-Term Report and Annual Performance Report 15 October – 03 November, 2000:

The Mid Term Report (MTR) and APR of November 2000 commented on the effectiveness of the Community Clinics. It considered CCs as central to provide ESP effectively. It observed that community participation of CCs were to a large extent limited to site selection and donation of land. It referred to reports and said that there

[10] Annual Programme Review April 19 May 02, 1999

was a sharp contrast between the confidence in the local village doctors and the government's own health personnel. This is a fact that should be considered when constituting the CGs. CCs are also important for BCC activities. It suggested emphasis needed to be given to BCC activities to influence health care seeking behaviour at CCs. The Aide Memoire of June 2002 said little about CCs.

Other research findings on Community Clinics

The Study on Improving Access to Health Care for the Poor and Vulnerable in Bangladesh[11] covered 93 respondents from 12 Community Clinics spread over five (5) Districts. The study found that the overall activities of CCs covered by the survey were not impressive and, as a result, the objectives of the Community Clinics were not being fulfilled as had been hoped. Most of the Clinics were found to be closed and none had any drugs when the survey was conducted. The quality of construction was also found to be poor at some of the surveyed CCs. Lack of essential drugs at the CCs has already given a bad reputation for being an unreliable source of health care.

An average of about 40 patients attended the surveyed CCs each day as long as the supplied drugs had lasted. Most of the patients were reported to be women and children and came from poor backgrounds. This suggests that CCs have the potential to be a major source of health services for the poor and vulnerable.

There were gaps of 2-14 days when services were not provided even when drugs were in stock. The reasons cited for these were weekly and national holidays and the service providers attending meetings, conducting field visits, preparing Geographical Reconnaissance and managing satellite clinics.

Nine of the 21 CC health workers interviewed did not have any training in ESP and those who had undergone the training reported the need for further training, with stress on active participation. None of the trained CC personnel had any idea about the names of instruments, their uses and the techniques of using them. All admitted the need for knowledge on diseases and their respective drugs. Service providers from the family planning (FP) sector did not know about common diseases and their management. However, since all the service providers were from the health and FP sectors, they were fairly aware of what to do should a patient need their services. During their interviews at the CCs, the service providers stressed the need for more training in the use of instruments and examining a patient. At one CC it was observed that both the service providers could not attend to patients at the same time because they had only one Daily Service Register. The FWA was sitting idle, while the HA was using the register.

Some of the community people, who attended the CCs during the survey, expressed dismay at the unreliability of the clinics. They reported that they would rather seek health service from the private sector, as it was more reliable and available, and would

[11] Study on Improving Access to Health Care for the Poor and vulnerable in Bangladesh Part I: Final Report; Population Research and Development Associates (PRADA); January 2002

not hesitate to pay for a reliable service. Most of the CCs had in place Community Groups, although the number of members required in CGs did not always conform to government guidelines. The CGs often came to the aid of service providers in consoling and convincing patients when they were disappointed at the lack of drugs. One CG was successful in keeping the CC open by raising funds for the supply of drugs.

Findings of the Service Delivery Survey: Second Round[12]

The study collected data in September and October 2000. It included interviews with 215 UP Chairmen or their deputies, 215 Community Group members and 195 local health workers i.e., Health Assistants and Family Welfare Assistants. The study did not specifically report on the state of CCs. Out of 195 HAs/FWAs, only one reported that he/she had been working in a functioning community clinic. The study did not say how many community clinics it found open and functioning. It interviewed 630 persons of various levels and found that 53% reported a CG has been formed and 44% that it was functioning. In some communities, the site for the community clinic was finalised even though there was no functioning CG. Almost a third of community based health workers said that they did not know about CGs and how they should function. Fifteen percent said that they did not know anything at all about community clinics and how they would work.

Only 10% of household respondents knew about a CG active in their community. Out of these 85% did not know anything about its activities and 10% believed it did nothing. The study did not mention the number of functioning community clinics. In communities with a functioning Community Group, 13% of the households said that they knew of a group, while 7% of households in sites without a functioning group said that they knew of one.

Findings from the Situation Analysis of the Maternal Health Care Delivery System in Bangladesh[13]

The above study was conducted in forty community clinics as a part of the situation analysis of the maternal health care delivery system in Bangladesh by the MOHFW and the London School of Hygiene & Tropical Medicine. The main objective was to see the functional status of the community clinics. It was found that out of the forty community clinics 31 (78%) were non-functioning. The study reported that out of the 9 functioning community clinics around half were functioning in a clean environment. The others did not have either water supply, or usable sanitary latrines. The study found poor physical location as a major barrier to access to these community clinics. Only six of the forty community clinics surveyed (15%) were found to be easily accessible. Almost 85% were poorly located either in terms of approachability or

[12] Ministry of Health & Family Welfare; HPSP Service Delivery Survey: Second Cycle, 2000
[13] Rahman, S.A. & Normand Charles, Situation Analysis of the Maternal Health Care Delivery System in Bangladesh: January 2002.

difficulty in access due to inappropriate site selection. Some were accessible only by boat.

As regards CGs the study reported that 71% of the CGs were not functioning or not formed at all. Supervision and monitoring of the clinics by the higher authority was not found to be in line with government policy. Most were visited only occasionally, and not as per the schedule prescribed by the government.

Most of the community clinics surveyed were found to be under performing. The use of these clinics by the local people was low. Only 19 percent of the clinics surveyed reported remaining open on all working days. Twenty-eight percent opened once a week while 38 percent clinics were reported to be open only once in a month. Fifteen percent of clinics have been reported to have opened only once since the formal opening. The mean time open per day was 2 hours (±0.5 hour). The study found that the poor performance was also due to the acute shortage of drugs and equipment. On an average, these clinics reported not more than 7-10 patients a day. Despite a very low use and attendance of patients in the clinics, the mean consultation time for the patients in these clinics were only 0.73 minutes (±0.5 minutes). This suggests a lack of motivation among the service providers of community clinics to perform their jobs. Twenty six percent of the service recipients said that the CCs lack privacy, 21% mentioned unavailability of drug and medical supplies, 20% reported rude attitudes of service providers. Inadequate clinical skills among providers were also reported.

CHAPTER III: OBJECTIVES AND METHODOLOGY OF THE STUDY

Introduction

The present study was initiated under the second phase of "Situation Analysis of Maternal Health Care Delivery System in Bangladesh" conducted jointly by the Policy Research Unit (PRU) of the Ministry of Health & Family Welfare (MOH&FW) and the London School of Hygiene and Tropical Medicine, (LSHTM), University of London.

Objectives

The main objective of this study was to provide evidence on the progress in developing Community Clinics, effects of these new health facilities on access, utilisation, quality of care provided and satisfaction and any related effects of care provided elsewhere within the health system. In addition, the study aimed to:

(i) assess the location and physical facilities of these clinics against standards outlined in the government plan;
(ii) assess the cost of establishment, management and operation of these facilities;
(iii) compare the developments and services to the model envisaged in the policy as well as in terms of absolute standards;
(iv) identify the factors that constrain CCs from meeting the health care needs of users as well as the satisfaction of clients on the quality of care provided by these health facilities;
(v) suggest appropriate public policies for making these health facilities effective and efficient for health services delivery at the village level.

Rationale for the study

Two major reforms agenda have been initiated under the HPSP. These are (i) unification of management of health and family planning services at the Upazila level and below and (ii) promoting a one-stop service delivery for the Essential Services Package - to deliver health and family planning services from a single point throughout country particularly through the Community Clinics at the village level.

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. With the development of CCs there would be a phased reduction on the outreach services and satellite clinics. Findings of a study of maternal health services carried out in 19 districts of 6 divisions in the country under Health System Development Programme showed that these Community Clinics were not fulfilling the role envisaged by the government. Other studies reported that CCs were not meeting planned requirements and raised concern about the performance and quality of these clinics. Questions are being raised as to the quality of construction of the CCs, involvement of community in their management, operation and day to

day maintenance, people's confidence and future sustainability. Power conflicts and organisation rivalry were reported. Government is on the threshold of undertaking the next Health, Nutrition and Population (HNP) Sector Program. Given this backdrop and other evidence of disappointing performance of facility-based government health services, there is a need for better evidence for policy decisions on the future development of CCs. At the request of the government, the present study was included in the second phase of "Situation Analysis of Maternal Health Care Delivery System in Bangladesh".

Research Question

The study considered two main questions. These are: a) what has been the progress in development of community clinics, including buildings and equipment, management and governance arrangement and human resource development, and b) how well are the clinics fulfilling the roles envisaged in the HPSP implementation plans.

Perspective

The perspectives in the study are those of policy makers and of the community.

Types of Data

The study used both the qualitative and quantitative data.

Study Design/Data collection techniques

The study used a range of quantitative and qualitative methods, and explored a range of dimensions of performance. The focus was on measures of service availability, access to care, quality of care and patient satisfaction. A number of methods were used to collect data. These were (i) Document analysis (including review of other studies and analysis of service use data) (ii) direct observation, (iii) case studies (iv)key informants interviews and (v) focus group discussions.

(i) Document analysis: This involved review of the government project documents and policy papers, such as Programme Implementation Plan (PIP) of HPSP, Health & Population Sector Strategy (HPSS) papers, Annual Operational Plans (AOP) of HPSP, Annual Programme Review of HPSP, government gazette notifications, minutes of various meetings of the MOH&FW, evaluation report of government's Health and Population Sector Program, aide-memoirs from project related missions, administrative databases, official reports, and correspondences issued/circulated by the MOH&FW relating to the objectives of the study.

(ii) Direct observation: A mix of direct and participatory observation techniques were followed to collect data from the CCs. The observation technique involved observing and recording by the interviewers in a log book the extent to which the government's expectation in terms of delivery of ESP services through the CCs have been fulfilled and the gaps/mismatch between the government's desired level of care and the actual level of care being provided through these CCs.

(iii) Case studies: Selected case studies were also done to collect in-depth information from the service users at various service delivery points. The case studies, descriptive and explanatory, served to document the service quality and the utilization of the CCs in the country including the performance of the CCs.

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(iv) Interviews: Key informants such as service providers, service users and the community groups were interviewed. These were carried out to collect views of stakeholders in the CCs. The interviews were administered face to face in both formal and informal settings, and the interview protocol included both closed questions with a series of possible answers and open-ended questions where broad questions were followed up with more specific questions. The interviews were conducted to understand the community's perception on the service quality of the CCs and the impacts of the Clinics on the user's perceived need for health care.

(v) Focus group discussions (FGD): Seventeen FGD with the service providers, service users, community groups and those familiar with the pertinent issues were organised. This was done to gather further insights into the performance of the clinics and the extent to which objectives were being achieved.

Study locations and sample

The study locations consisted of community clinics in 18 Upazila, from 18 districts in all the 6 division of the country. A representative sample of around 4 % of the total functioning community clinics was taken for the study. This gave a total of 120 community clinics. The sampling used a three-stage systematic random sampling procedure with probability proportionate to each division, district and upazila. The sample was designed to take into account the geographical and socio-economic differences as well as ensuring a sufficient sample to allow the results to be generalised in the whole country.

Study implementation:

a) The Core-Team: Composition and Responsibility

A team of researchers drawn from Bangladesh and the UK conducted the study.

Professor Charles Normand, Head of Epidemiology & Population Health, London School of Hygiene and Tropical Medicine, as Principal Investigator of the study headed the team. Other team members were from the Policy Research Unit (PRU), Ministry of Health & Family Welfare.

The study team used a combination of qualitative and quantitative measures. Quantitative data were used to show frequency and percentage levels of the key indicators. Qualitative data were examined for themes and explanations of the findings in the quantitative results.

The written document analysis provided evidence on the policy process as well as the dynamics of the process that influenced the government to establish a new category of health care facility at the village level. This experience from Bangladesh can be put into the context of findings elsewhere. Data from the primary sources such as interviews with the key informants, users and service providers were analysed under each of the central themes of the study. The analysis was carried out using SPSS (Statistical package for Social Science). Descriptive statistics such as frequency and percentages are presented.

The draft report was presented to stakeholders at the first week of November 2002 to allow comments to be taken on board. The findings of the study were discussed at the Health Systems Development Programme workshop held in the Birmingham, UK in September 2002.

Developing tools for data collection

Initially a draft tools for data collection were developed. Care was taken to use local vocabulary as much as possible to ease communication with the respondents. Instruments include interview schedules, observation checklists, structured and semi-structured questionnaires and inventory guidelines. Instruments were pre-tested to assess appropriateness and workability. Pre-testing took place outside the areas selected for the study. On the basis of the pre-test results, the draft instruments were modified.

Guidelines for qualitative research

Guidelines were developed based on experience from market research to ensure consistency in the qualitative work. In a FGD, people from similar backgrounds or experiences (e.g., service providers, community group member, local elites,) were brought together to discuss a specific topic of interest to the investigator(s). Homogeneous samples were preferred to get wider views on the issues under study.

Purpose of FGD

The purpose of the FGD was to:

- Explore the range of opinions/views on a topic of interest.
- Explore meanings of survey findings that could not be explained statistically.

A range of techniques, including pictures and discussion were used to introduce topics for discussion. FGDs were recorded on tape. Recording the discussion had the advantage allowing sections to be played back to pick up salient points after the discussion was over. Even then important points can be missed unless the tape recording is accompanied by detailed notes on who the participants were, the order in which they spoke, and the non-verbal language that accompanied what was said.

Suitable discussion participants were invited to a meeting at an agreed place and time. The ideal number of participants was eight to ten, but the study team was flexible about numbers and did not turn away any participants even if they had arrived at the meeting late and did not pressure people to come to the meeting. The study team arrived early to make preparations and greet the participants. They maintained a neutral attitude and appearance, and did not start talking about the topic of interest before the official opening of the group discussion. They then explained clearly that the purpose of the discussion was to find out what people think about the practices or activities depicted by the pictures. Participants were told that they were not looking for any right or wrong answer but that they wanted to learn what each participant's views were. It was made clear to all participants that their views were valued.

Data Management

Data management comprised the following activities: (a) registration of information and questionnaires received from the field; (b) data processing; and (c) computerisation of data.
As soon as the questionnaires were received from the field, they were entered into registration books to ensure that all schedules received from the field had been received at the Dhaka Office.

The data processing activities involved editing and coding of the questionnaire, and computerisation of data. A team consisting of the Investigators, Co-ordinator, the Computer Programmer, editors and edit verifiers did editing. Since many of the questions answered in the questionnaire were coded from the field, the major objectives of editing were to verify that the survey questionnaires had been correctly filled-in, correct samples had been interviewed;

that items of information recorded or responded to questions obtained were consistent with one another; and that all questions in the questionnaire had been asked.

Editors did the initial editing of schedules. The Editing Verifiers then verified edited schedules. The Investigators randomly checked edited schedules after verification, and the Programmer checked another 5 percent. This system had previously proved to be an effective one to ensure a high standard in the editing work.

In any qualitative study, open-ended questions provide broader insights. Responses to such open-ended questions were recorded `Verbatim'. In order to analyze such questions, categorization of responses was necessary. Some of the questions answered in the data collection instruments were coded from the field. There were several questions for which field coding was difficult. Answers to such questions were coded in-house and was verified by the Investigators.

The data were analysed, under the overall guidance and supervision of the Programmer, with assistance from the Investigators. Computerisation of data involved entering data onto the computer; conducting validation checks to ensure that data have been correctly entered; preparation of output tables; and ensuring that the output tables are correct. Data were entered using SPSS, which has fully integrated data entry; cleaning and editing tools with user-defined skip logic, rules, and input screens. The program had the built-in mechanism to guard against erroneous entry of data. Before generating output tables, proper range checks and checks of internal consistencies were done. The Programmer and the data entry operators were responsible for computerisation of data. The Programmer, with technical assistance from the Investigators, prepared the code-manual.

Data Analysis

Quantitative data were used to show frequency and percentage levels of the key indicators. Qualitative data were examined for themes and explanations of the findings in the quantitative results. Data from primary sources such as interviews with the key informants, users and service providers' were analysed under each of the central themes of the study. Data on providers' perceptions, as well as users' perception on the community clinics were drawn and analysed from the study on the unification of health and family planning services carried out in parallel with this study. The analysis was carried out using SPSS (Statistical Package for Social Science). Descriptive statistics such as frequency and percentages are presented.

Limitations of the study

The study team carefully designed and tested the tools for data collection and staffs were trained for data entry. In order to make the sample representative, a total of 120 community clinics were selected for the study, however, data could not be collected from all of these. The sample was 120 supposedly functional CCs from a list provided by the Construction, Maintenance and Management Unit (CMMU). The team was told by Union Health and Family Planning Officers (UH&FPOs) that 15 of these were not at all functional. In addition, the team found another 45 CCs were closed and was not able to make any contact. However, it was possible to get some information about the physical location and condition from outside and by asking local people about opening times and service availability. Therefore, full information could be collected only from 60 CCs. Great care was therefore needed in interpreting the data since the observed patterns of services was only taken from 60 CCs. Out of 128 Civil Surgeons and Deputy Directors (FP) of 64 districts contacted, replies were received only form 27 (CS – 9 & DDFP – 18).

Chapter IV: Findings

Introduction

This chapter deals with the information gathered through Focus Group Discussion (FGD), direct observations, structured questions and case studies. In addition to FGD and direct observations, field investigators also applied other techniques such as rapport building and key informant interviews. A research instrument and guidelines on FGD were used for collection of information from the service receivers, members of the Community Groups (CGs) and interested elite of the locality. In total 18 FGD were scheduled but 17 were held as one CC in Baniachang Upazila of Habiganj district was not formally opened and operational and no Community Group could be found. The sample Upazilas were selected from 18 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 9 to 11. 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 have S.S.C and H.S.C level education. A few of had a post graduate degree. By profession they were mainly service providers, businessmen, teachers, religious leaders (Imam), housewives and agricultural workers. The participants included CG Chairmen and members, village doctors, service users, UP members and persons respected in the community.

A total of 18,000 CCs are to be planned, of which 13,500 will be constructed new and the rest would be set up in cyclone shelters and buildings constructed for multipurpose uses in coastal belts. About 10,000 CCs have been constructed so far during study period. Each CC is meant to be within 30 minutes walking distance for most of the population, especially vulnerable groups. Findings of the study have been presented in this section in tables and case studies form. Pictorial view of some CC are also presented at annexure- I.

Clinic Buildings, Location, facilities, quality of structures

On receiving the letter from the government through UHFPO for establishment of Community Clinics, UP chairman discussed the issues with the representatives from all walks of life and held a meeting to exchange views. During the discussion, convenience in access to the CC has special attention. Although not all the guidelines were followed in the site selection, it was found that the clinics were generally located so as to allow good access. Most of the sites (62.1%) were in the middle of the catchment area and are easy to get to. Out of the surveyed CCs, 79.3% were near to dwelling houses in the village, 56.9% near to public institutions, but 38% were in flood prone areas, and 24% marshy and water logged land. Land had been donated voluntarily except in one (Gazipur Natunbazar Community Clinic[14] under Bhandaria Union and Upazila in Pirojpur District).

> During FGD, the land donor was present and remarked with painful laughter that “CG eto utsahi je ami bari nai athacho nizera amar jami mepe CC toeri karachhe”. The CG was so enthusiastic that in my absence my land had been taken over and CC constructed.
>
> ------*Comment from a land donor*

[14] At the time of site selection for this Clinic, the owner of the land was out of the country. In his absence, the land was selected and CC was constructed.

Tulatuli CC of Naikhonchhari Upazila under Banderban District is located in a place that is surrounded by water and hillocks making it very difficult to access. Users can only reach the CC by walking through water. The CC was opened 6 months after construction because of poor quality of works. The research team also observed that about three-quarters of Dhalbazar CC (constructed on government land) are under water. The rear is above water, but the entrance passage and stairs are submerged. These do not conform to the government site selection criteria.

The research team found that the CG had very little participation in construction of CCs. The contractors, who were mostly local people, and did everything in their own way. The study found from the direct observation of 105 CCs that 67 CCs (63.80%) were constructed on high land, 32 (31.48%) CCs on low land and 6 (5.72%) CCs on water logged low land. Table below gives the picture of the type of land used in constructing the CCs.

Table-2: Location of land of surveyed CCs by number and percentage

Location of land	No. Of CCs	Percentage (%)
High land	67	63.80
Low land	32	31.48
Low land with water logging	6	5.72
Total N=	105	100

Case study-1: Site selection was not in line with the principles and misleading activities of the providers

Dhalbazar Community Clinic:

Dhalbazar Community Clinic is in Tarol Union of Dirai Upazila under Sunamgonj District. The CC was visited on 23.08.2002 at 11.30 A.M when it was found to be closed. From Upazila Headquarters, the Dhalbazar CC is accessible only by water way (Trawler). As there is no road communication, the CC can be reached by all the surrounding villages by trawler only. The CC is situated at north-west part of the market from where it is accessible on bare-foot as the road remains muddy for about 6/7 months of the year. The Community Clinic infrastructure is a brick-built building with a floor space of 316.16 sq.ft (30'.5'' x 10'.5'') which is smaller than the government approved size (450sft). About three-fourths (3/4) of the CC was under water while it was visited. As the CC Building was closed, it was not possible for the research team to observe inside but having discussion with the local people, it was assumed that there were 3 rooms. The shopkeepers as well as general people informed the team that the CC had been constructed on the government land beside the Tehshil Office. It indicates the absence of community participation which is one of the criteria for establishment of CC. The CC opens once a week on Tuesday and works for about 4/5 hours. Some weeks it does not open at all. The investigators reported that the main reason why the CC was closed was the lack of drug supply for a long time. Some villagers also said that the HAs/FWAs have spread a wrong idea that it was the hospital for "mother and child and not for male patients", as a result, male patients do not seek health services from this CC. Again, the CC is known to the people as "CARE Hospital", because no name-plate is hung on the CC and workers of " Nirapad Ma Project" of CARE visit the CC frequently for motivational works. Thus the service providers are discouraging use of the clinic by giving the wrong impression about who should use it. Nearby shop-keepers and others were asked about the existence and activities of the Community Group (CG), but they informed the team that they had not heard of this. The HA who became available at Dirai UHC said that there was a CG on paper but no meeting had yet been held. This is evidence of reluctance of the community (Community Group) to look after the CC and keep it operational.

Out of 60 CCs 38 have a significant proportion of the catchment population living beyond 30 minutes walking distance, only about half are within 2 km distance of the nearest CCs and 62 are near graveyards. It is seldom possible to meet all criteria for site selection, but overall a little fewer than 60% can be judged to meet site selection principles. The research team found that the CG had very little involvement in the site selection and construction of CCs.

Design

It was observed from the 60 CCs that were found open that half met the specifications in terms of floor space. Each CC building was constructed on 5 decimals of donated land with two properly ventilated rooms and a veranda. One room is used for providing Health and Family Planning Services in general and the other is meant for examination and labour purposes. The veranda is used as the waiting place of the service seekers. Two separate concrete benches have been constructed at the two ends of the waiting room-one for male and another for female. In most of the cases, partition screens were not found.

Each CC should have two toilets - one for the males and the other for females. But 51 out of the 60 CCs examined were found to have with only one toilet attached to the examination/labour room. The research team also observed that 34 CCs (56.66%) had toilets that were very dirty, unusable, and lacking components. Table 3 gives details:

Table –3: Position of latrines of CCs by number and percentage*

Number and condition of latrines	No. of CCs	%
One latrine	51	85%
Two latrines	09	15%
Total N=	**60**	**100**
Clean	26	43.34
Dirty	34	56.66
Total = N	**60**	**100**

* Out of the 120 study sample the research team could not get access to 60 CCs, 45 CCs were closed on the visiting day and 15 were totally non-functioning.

According to government guidelines, every CC should have one tube well. It was found that 39 (65%) CCs had non-functioning tube well and in 6 no tube well had been installed. Water needs are meet by bringing water from nearby sources (houses or pond). One tube well was found to be arsenic contaminated thus making water unusable. 5 CCs had tube wells linked with ponds (unsafe water).

Table-4: Position of tube-wells installed in CCs by number and percentage

Position of Tube-wells	No. of CCs	%
Have and workable	15	25
Have but not workable	39	65
Have not	06	10
Total =N	**60**	**100**

Quality of Construction

It has been found from the direct observation that the CG had very little involvement and interest in the supervision of the construction of CCs. In 38% community clinics windows and doors were found broken and in 25% CCs had leaks in the roof. Seven CCs were in very bad condition within 6-12 months after construction.

Cost of construction

The land was donated. The expenditure up to May 2002 for the 10,000 clinics constructed is around Taka 275 crore.

Case study-2: Fully unsuitable location and very low quality construction

Gabtali Community Clinic:

Gabtali CC is situated at Bhaijora Union of Morrelgonj Upazila in Bageraht District. It stands by the side of Union Parishad semi pucca road on a low-lying water-logged land. It is surrounded by submerged land infested with big leeches. Service users as well as HA and FWA are afraid of these bloodsuckers. Site selection of this CC does not conform to the government guideline for site selection. External environment of the CC is also very bad. Due to lack of approach road and water logging it has become inaccessible. There is no bench for patients in the waiting space (Veranda). Patients directly go to HA/FWA's room and receive services standing by the side of the providers. Water falls from leakage of the roof and, as such, inside of the room is damp. There is no tube-well because the same had been stolen from the Chairman's house. Overall environment of the CC is bad and unsuitable for delivering services to the patients. The CC operates two days a week (Saturday and Wednesday). On the observation day there was no patient as it was not the day for delivery of services. Since opening on 17.01.2002, the CC received drugs twice.

Community involvement, formal structures and how these are working

Community Involvement is an important aspect of HPSP implementation. The government policy is to provide necessary funds for establishment of CC, supply of required MSR, equipment and furniture and employ required manpower (service providers). On the other hand, the community donates land, supervises the construction of physical infrastructure, participates in operational management; bear the cost of repair, maintenance, rehabilitation and keeping the premises neat and clean. For this purpose a Community Group for each CC is meant to be formed prior to the selection of land. The group is set up with the help of Union level service providers HI and FWV. The Community Group should have 9 – 11 members including three women members, donor of the land or his representative as life member and service providers (HA/FWA). The HA/FWA will act as the member-secretary of the Group and will provide secretarial service to the CG but will have no voting power.

The study found that in all the CCs surveyed, CGs had been formed mostly with 11 members and following other guidelines of the government. In one CC, the CG had been formed with 13 members to include one representative from each village of the catchment area of the CC.

Table-5: Formation of CG at different stages of CC construction and operations by number and percentage.

Stage of forming CG	No. of CCs	%
Before site selection and construction	38	63.34
After hand-over	18	30
No CG formed	04	6.66
Total = N	60	100

Although the government guidelines have been followed in forming the CGs, these failed to perform their initial responsibilities of site selection, land donation and supervision of construction. Some of the CG members reported that they did not know the total number of members of the groups and who they are. One of the important functions of the CGs is to monitor the regular opening and timely service provision by staff in the CCs.

The research team found that in general, the CGs are not working. The Chairman of the Union Parishad is supposed to supervise the functioning of CC once in a month and CG to look into whether the CC opens and closes at the correct times, service recipients are attended properly and also to motivate the community to seek health and family planning services as and when required. During FGD and direct observation, most of the CG members said that they had not been oriented on their roles and responsibilities.

The findings of the FGD of 17 CCs show that only 6 (33.9%) CGs were aware of their responsibilities while 11 (64.7%) CGs did not know. More than half of the UP Chairmen were not found to visit and supervise CCs and the CG did not hold any meeting, although they were meant to meet at least once a month, to review the situation for taking corrective measures. Table 6 gives details of patterns of meetings. It was reported that the time for operation of Clinics is fixed by the UH&FPO or his representatives. Visit and supervision of the activities of CCs by the UHC level officials were also reported to be very rare.

Table-6: Meeting of CG held in functional CCs by number and percentage

CG Meeting held	**No. of CCs**	**Percentage (%)**
Every month	12	20.00
Every 3 months	17	28.34
Every 6 months	03	5.00
Above 6 months	10	16.66
No meeting held	18	30.00
Total = N	**60**	**100**

Case Study-3:
Krishnapur Community Clinic: A place of unsocial activities

This community clinic is situated at Krishnapur village of Vatara Union under Sharishabari Upazila in Jamalpur District. First target of the research team was to visit "Parpara Community Clinic" and accordingly the team reached there but they found the clinic closed. Then, they waited there for a while and looked for the service providers (HA/FWA) with the help of the local people but in vain. Being disappointed the team took spot decision to visit Krisnapur CC.

Krishnapur CC is approchable by rickshaw from Sharishabari Upazila headquarters. It was reported that there were 3 staff in the CC – HA, FWA and night guard. The night guard is in addition to the staffing pattern of the Government for CC. The service providers were not available when the CC was visited. The night guard and the local people informed researchers that there was no certainty that the HA/FWA would turn up. Generally, they come once / twice a week but in last week none of the providers came. Only on EPI vaccination day both the providers attend. Since formal opening in November 2000, the CC received drugs in two occasions though not according to its need. There is no supply of drugs for more than a year. This leads to quarrels and using foul words between the service seekers and the providers. To avoid this situation, the providers do not open the CC regularly. FP materials are also not distributed in spite of being availability. The night guard told researchers that the CG was formed with 11 (eleven) members who initially met every month. But now, the CG does not hold any meeting with the remarks that " Ousad nai tai baitak kore love ki mase mase" (what is the utility of holding meeting in every month when there is no medicine).

The CG members and HA engaged the night guard with the false hope that after a year he will get about 40,000 (Forty) thousand taka at one time and government will appoint him permanently. (Tumi mon die kaj koro bachhar khaneker modhey tumi ek sathe 40,000-taka pabe, tumake sarkar sthaie niog dibe). So far, he has been paid taka fifteen thousand in four installments raising funded through collection of ticket-charge of Tk.2 per patient. The night guard lives in the room meant for examination of the patients and he uses examination table as his bed. One broken chair was found in his room. It was reported that the CG gave permission for him to live in the room exclusively.

*One **Mr. Khaju mia** of Charnandina village, who registered land in favour of the government for construction of CC, but arranged to establish the CC on another, unregistered land of his cousin. His family often sit at the front of the clinic, and their behaviour makes the CC unsuitable for service delivery, especially for female patients.*

Availability of service providers

According to the "Community Clinic Sthhapan Sankarant Nitimala" (Principles relating to Establishment of Community Clinics), the government will deploy two service providers- one Health Assistant (HA) and one Family Welfare Assistant (FWA) in each CC. They are to provide 33 listed essential Health and Family Planning Services to the clients including referral of serious cases. In addition, they are also to provide eight domiciliary services as per their job descriptions in Guidelines on Operation, Management and Functioning of Community Clinic (MOH&FW – 2000).

In the sixty (out of 120) clinics that were found to be operating, the study found that 88% of CCs had both the providers, HA/FWA) and 12% of CCs had one provider-only HA in 2 CCs (3.34%) and FWA in 5 CCs (8.34%). On the observation day out of 120 staff in 60 clinics surveyed, 87 (37 HA and 50 FWA) were found who had been posted and should be available to work in the clinics. In many cases they were not at the clinic when the researchers arrived, and given that some were eventually found at home, it is not likely that they were engaged in other clinical work. It had also been found that in many cases the two service providers were not available at a time on the same day. They prepared the duty schedule themselves in a way

that only one provider could come to the CC on any given day in a week. In 7 (12%) CC there was only one provider either HA or FWA. This limits their usefulness in meeting urgent needs.

As regards education of staff, it was reported by the providers that 72 per cent of FWA's education level was SSC and below while 65 per cent HA's had HSC and graduation. In the case of training it was found that 82 of the 87 respondents had received 21 days ESP training, 3 (HA) received EOC training. It was also found that only 3 providers (HA) got training on CC management. None of the FWA received training on EOC and UMIS. Of the 87 service providers 83 received training in 2001-2002 though the HPSP implementation started in 1998. The respondents did not think that the training had given them the necessary skills and experience. There is some support for these views given that, despite 21 days training on ESP, they could not say what the basic components of ESP were. Two thirds said that they did not know how to operate the equipment.

Case Study –4

Fakirbari Community Clinic: Unfriendly attitudes of the Providers' disappointed the clients

Fakirbari Community Clinic is situated at Fakirbari Village of Tirnaihat Union under Tetulia Upazila in Panchgarh Distinct. Distance between Upazila headquarters to CC is about 17 km. Some public and private institutions including Union Parishad Office are also situated around the CC. It is constructed on a low land which goes under water even after light rainfall. The CC is about 3 km away from Tetulia-Banglabandha pucca road, so it is accessible by van or on-foot but only on-foot during the rainy season. It takes two hours from CC to Tetulia UHC by van. The team visited the CC at 9.00 A.M. when they found it closed. Then they arranged to collect the name and address of the chairman of the CG and went to his house where three more CG members appeared. They started discussion with them and other people who were present there. The people of the community stated that the Clinic is closed for about 6 months and opens once a month for providing EPI Vaccination. The HA never comes except on EPI vaccination day. The FWA often comes but not to provide services from CC. The medicine supply stopped for a long time. The field research team talked to teachers, Community Group members, local people and service receivers. Almost all of them responded in the same line and said that the people of this area were very poor and were vulnerable to various types of diseases. So, they focussed on regular operation of the Clinic. They said that any sort of advice of service providers would be very helpful for the service seekers. The CG said that they disagreed with TH&FPO on the issue of community contribution for maintenance of CC, as the people are very poor. About service delivery and quality of service one receiver said that the CC remained closed for a long time, one female doctor (FWA) was present when it opened but she left the CC after one hour. When they sought service, she gave few antacids and asked them to meet later. Another old man informed the team that one-day he went to the doctor (HA) for treatment of fever and strong headache but the doctor told that as there was no medicine, he should come later. Then the old man asked again for medicine. But the doctor became angry and asked him to go from the CC. Since then this old man did not go to the clinic. Their statements are given below in their own version:

" Anekdin eti bandha achhe abong zodi kakhono khole akjon mahila daktar boshe abong sha 30 minit ba akghanta theke chole jai. Amra zodi jai tahole kaekti antacid amader hate dharie die bole akhon ashen pore dekha korben, akhon amader ekhane sarkar kono ousod deina".

The old man said:-

" Ami ekmash jabat zar abong matha bethar janya ei CC te ashi, akhanker daktar janai je akhane kono ousod nai apni pare asun. Tarpar ami abaro anurod kari, kintu daktar garam hoe bole apni chole jan. Ami tarpar theke aie haspatale ar kakhono ashi nai."

Effects on service delivery, especially supply system, drugs, logistics

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 were provided once at the time of formal opening of the CC. Table 7 shows in details the frequency of drug supply.

Table-7: Frequency of Drug Supply in CCs

Frequency of Drug supply	Duration of time for receiving drugs	Number of CCs	Percentage (%)
One time	19 months	25	41.63
Two times	19 months	14	23.37
Three times	20 months	03	5.00
Four times	18 months	05	8.33
Five times	18 months	03	5.00
Six times	14 months	03	5.00
Nine times	9 months	01	1.67
Eleven times	11 months	01	1.67
Twelve times	12 months	01	1.67
Fifteen times	26 months	01	1.66
No supply	Since opening	03	5.00
Total N=		60	100

Equipment:

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

Table 8 shows the intended and observed pattern of availability of equipment.

Table – 8

Sl No.	Description of equipment	Unit	Entitled	No. of CC (n=60)
1	Primary Medical Kits (Scissors, Forcep)	Kit	2*	45
2	B.P.Instrument with Stethoscope	Set	1	41
3	Tool Kits (1-gagh, 6 masks, 4 Thermometers, 2 Timer, one Sensor testing kits)	Kit	1	45
4	Insecticide Spraying Machine	No.	8	0**
5	Bathroom Scale (Child)	No.	1	45
6	Weighing Scale	No.	1	38
7	Kerosene Stove	No.	1	40
8	Hanging Scale	No.	1	40

* Only one was available in each clinic

** None were available in many clinics

None of the CCs surveyed received all the scheduled categories of equipment mentioned above. Most of the Clinics had 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 were not functioning properly and do not open for providing services. The irregular supply system of drugs and other logistics have adversely affected the overall service delivery of the CCs.

Furniture:

As per "Community Clinics Sthapan Sankrant Nitimala", a CC would get 8 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 were supplied with a delivery table, 91.7% CCs received an examination table, 98.3% steel cabinet (two compartment), 67% received bench to seat, 78.3% received mat/cushion, 90% received black board, 98.4 got wooden/plastic chair, 95% received wooden table with one drawer.

Case Study-5: ***About an abandoned facility***

Anjupara Community Clinic:

Anjupara Community Clinic is under Tiakhali Union of Kalapara Upazila in Patuakhali District. It stands by the side of a Union Parishad Kacha road running through the village. Anjupara CC is at 8 k.m. distance from Kalapara Upazila Headquarters. Of this distance 5 km is pucca (concrete) and three km. Kacha (earthen). The CC facility is a brick-built building having 2 rooms, one veranda, one tiolet and one tube-well. The veranda is used as a waiting room. There is no signboard of the CC but a different signboard like" Purbo Rajapara Begum Sufia Smriti Sangsad, Sthapito 2002" (East Rajapara Begum Sufia Memorial Sangsad, established in 2002). The research team visited the CC at 9.45 a.m. when they found it under lock and key. So, they sat in a road side shop and started discussion with the shopkeeper and other 3 or 4 local people who informed them that the CC is closed for a long time. The HA and FWA provided services for a week since its formal opening on 15.03.2002 and the people received good services in that week. The shopkeeper said that he did not know how many members are there in Community Group (CG), but he knew Mr. Mannan Ghazi, the Chairman of CG and donor of the land. The HI and HA appeared there just at the moment when some one was going to be sent to call in Mr. Mannan Ghazi. After introduction with HI&HA, they were requested to open the lock of the main gate. Then HI, HA and 3 people tried for about 25 minutes one after another but failed. On seeing this, the shopkeeper came forward with Kerosene oil to help them. After 10 minutes effort the shopkeeper succeeded to open the lock of the main gate.

In the meantime the CG Chairman reached there accompanied by 10 to 12 persons. On entering, the veranda (waiting space) was found full of dust, spiders webs everywhere and a dead-rotten rat spreading a bad smell. Of the two rooms one was open and other was locked. All the people including HI, HA, CG Chairman and members present tried one after another for 40 minutes to open the lock of the room but in vain. One observation table and one delivery table were found in the open room. The room was extremely dirty with abundance of spiders' webs and there was water on the floor. Toilet and tube well are also in this room. The toilet was very dirty and unusable. The tube well was connected with the nearest pond and the same was found non-functional. Logistics have been kept in the room which is under lock and key. The team was told by the CG Chairman that the CG had been formed with 5 members. Then, the HA objected and told that there are 12 members of the CG. The CG Chairman and the HA became involved in quarrel on this issue, It was known that no meeting of the CG was held since its opening in March, 2002. .

Services provided, range & times

Limited curative care, preventive and promotive 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. Generally, the service seekers do not to wait long time for a consultation- 83.3% patients had to wait for less than 5 minutes. The average consultation time was reported 3.1 minutes for consultation by FWA and 1.2 minutes for a consultation time with a HA.

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 are 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 were. However, the irregular opening of CCs suggested that many are 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.

Table-9: Implementation status of ESP component in CCs

Services	ESP Components	Status
Essential Services package	Reproductive Health Care	Family Planning Services i.e. distribution of temporary methods, TT vaccination when available.
	Child Health Care	EPI vaccination, distribution of ORS packets and Vit-A when available ARI, cold and cough, fever etc. if medicine is in stock.
	Communicable Disease Control	Treatment of Malaria, TB & Leprosy in those CCs, which works all weekdays having necessary drugs.
	Limited Curative Care	General hurt, fever, cold and cough, dysentery, gastric, itches, diarrhoea, Vertigo, headache, hookworm etc during availability of drugs.
	Behaviour Change Communication	Counselling on safe drinking water, sanitation, use of sanitary latrine, personal hygiene, ORS preparation and use, importance of vaccination etc. in some CCs. Most of the CCs were found without display of BCC materials.

Utilisation of facilities, particularly by the priority groups

HPSP aims that ESP to be a 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.

The two other public health facilities at upazila level and below (UHCs and UH&FWCs) had been suffering from chronic under utilisation since their commissioning. For the past decade this issue was under serious discussion. The main causes that have been identified are lack of commitment and efficiency of service providers, dearth of MSR and appropriate medical equipments, shortage of skilled technicians, physical inaccessibility as well as absence of adequate social mobilisation. The present study also found the Community Clinics to be very under utilised. The use of these Clinics by the rural people particularly by the priority groups (children, women & the poor) is low. The data presented below were taken from the record of attendance for one year, and show that on an average working day there were 22 users in each clinic.

Table 10: Average number of patients per clinic receiving treatment in one year (n=60 clinics)

Service	Sex	May2001-April 2002												Total
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
a. General Health Care received	Male	39.8	24.3	39.3	51.3	57.6	50.3	82.9	107.3	70.3	53.5	41.1	33.8	651.4
	Female	63.9	62.3	85.9	111.4	107.6	99.8	145.7	154.5	106.1	134.0	75.9	77.8	1224.9
	Children	21.8	14.2	34.3	27.8	39.9	40.3	46.2	38.3	53.0	43.8	14.6	16.2	390.1
	Sub total	125.4	100.8	159.5	190.6	205.1	190.3	274.8	300.0	229.3	231.3	131.6	127.8	2266.4
b. Maternal Health Care	ANC	7.2	7.3	10.5	7.2	8.2	11.2	17.7	23.5	17.8	29.9	24.2	36.8	201.5
	PNC	2.4	1.0	2.0	1.7	0.8	1.8	5.4	5.1	3.1	11.4	6.8	6.9	48.4
	Sub total	9.6	8.3	12.5	8.9	9.0	13.0	23.1	28.6	20.9	41.3	31.0	43.7	249.9
c. Family Planning Services	Male	2.6	4.3	4.2	4.7	5.0	4.5	16.5	10.5	8.6	32.7	27.7	20.9	142.2
	Female	76.5	95.8	102.5	102.5	99.8	107.2	162.1	162.2	166.6	184.8	181.0	171.5	1612.5
	Sub total	79.2	100.1	106.6	107.2	104.8	111.6	178.5	172.6	175.3	217.5	208.7	192.4	1754.6
d. Child Health														
e. EPI		31.5	46.3	53.8	33.8	32.3	28.8	54.8	46.3	26.8	100.8	66.3	53.8	574.8
f. ARI		2.9	12.3	11.9	13.9	13.4	22.6	57.9	73.9	60.6	46.7	42.3	55.1	413.5
g. Diarrhoea		3.3	6.3	7.5	8.7	10.5	11.2	8.0	17.9	10.0	9.6	11.0	17.2	121.1
h. Common cold/fever		10.3	5.0	13.9	10.8	14.5	16.5	18.2	21.2	25.8	16.4	15.8	13.4	181.6
	Sub total	48.0	69.9	87.0	67.1	70.6	79.0	138.8	159.2	123.1	173.5	135.3	139.4	1290.9
Others	Male	10.4	10.8	24.4	11.6	12.6	41.6	27.8	39.5	21.8	13.6	7.8	9.3	231.0
	Female	213.0	85.0	101.0	99.0	86.0	145.0	115.0	0.0	103.0	0.0	107.0	109.0	1163.0
	Sub total	223.4	95.8	125.4	110.6	98.6	186.6	142.8	39.5	124.8	13.6	114.8	118.3	1394.0
TOTAL														**6956**
Average per working day														**22.3**

The research team also took a census on the day of the visit, and the results of this are given in table 11, showing only an average of 13.6 attendances per day.

Table 11: Average number of patients/ persons received treatment/service on the day of survey.

Indicator	Patients/Users			
	Male	Female	Children	Total
Average No.of patients received treatment on the day of survey	3.6	4.95	3.5	12.2
Average No.of patients received F.P.services on the day of survey	0.0	1.366	0.0	1.4
TOTAL				**13.6**

Assuming a five-hour working day (in terms of time available to see patients), the daily capacity of two health workers in a fixed clinic should be around 60 (assuming 5 minutes per patient). Some duties take the staff out of the clinic, but the current workload represents only between one quarter and one third of a full time service.

The study found that all the participants in the FGD and respondents of direct observation expressed their dissatisfaction with the overall operation of the CCs. Even the members of the Community Groups were dissatisfied. FGD findings show that out of 17 studied CCs, only 2 (11.76%) were found to be working satisfactorily, while 10 (58.82%) were found to be unsatisfactory and 5 (29.42%) partly satisfactory. People said they had expected that there would be a hospital in their vicinity from where all sorts of services for treatment of common ailments would be provided by the MBBS doctor in association with HA/FWA and nurses, where free medicines would be available. While part of the expectation could not be met, the key source of discontent is the poor availability of drugs, which also sometimes leads to the clinic being closed. There was also dissatisfaction that clinics were often closed. Those that donated land are angry that this has not led to high quality services available without travelling long distance. Table 12 gives more details of the comments from FGD on services and their quality.

Table 12

FGD Respondents' views about service delivery at CCs (FGD No-17)

Respondents' views about service delivery	No of CCs	Percentage (%)
Satisfactory	2	11.76%
Partly Satisfactory	5	29.42%
Not Satisfactory	10	58.82%
Total=N	17	100%

Total participants of the FGD – 183 (Male – 147, Female – 36)

Lack of medicine is critical issue for creating dissatisfaction among the people. Almost all CCs open once or twice per week only to provide EPI and FP services. Respondents of FGD arranged at Dhankunia CC of Chatmohor Upazila in Pabna district complained " Kono osud nai, thik moto Khole na, Ekhanae Ese Ki hobe". (There is no medicine in the CC, it also does not open properly, so what is the point in coming here). They also said that "Ebhabe cholte thakle bhaban venge felbo, panch shatak jami chashe Anbo, Ebhaban dia Kichhu hobe na" (If the CC operates in this way, then we will demolish the building and bring the land under cultivation, this building will come to no use). The land donor of Syedpur CC under Kalapara Upazila in Patuakhali district expressed his great dismay and said " Shunechhilam Abong Asha Karechhilam Akjon MBBS Dakter thakbe, thikmoto oushod pabe janagon. Alakar gorib o mahilara Kashta Kori doore na gie gharer nikat hote chikitsha pabe, kintu tar kechhuui holo na". (I heard and expected that an MBBS doctor would be posted in the CC who would provide services rightly. The poor people of the community particularly, women, children and the poor would get treatment and thus avoid hardship of travel to go to FWC or UHC. But nothing in that line happened). There is no medicine and HA/FWA are not available. This situation compels him to think that he had donated land in vain. Table 13 shows the per day working hour/time.

Table –13: Per day working hours of CCs by number and percentage

Working hours of CCs	No. of CCs	%
5-6 hours per day	39	65%
3-4 hours per day	17	28.34
Less than 3 hours per day	04	6.66
Total =N	60	100

(Of the 120 sample CCs, 45 were found closed and 15 were not formally open and functioning. Hence, data on 60 CCs have been shown in the above table.)

Other aspects of quality of services

Sustainability is a big issue closely related to any community based programme or intervention. In the past it had been experienced in many cases that such social sector interventions oriented to community empowerment did not sustain with the withdrawal of support from national level or development partners. The main reasons for this failure were attributed to the lack of involvement and ownership of the community.

It has been observed by the study team that many CGs were formed after construction or formal opening of the CCs instead of being formed before site selection. These CGs failed to perform their initial responsibilities of site selection, land donation and supervision of construction. Almost all the CGs do not hold regular meetings, in some cases, not for more than a year, while as per guidelines of the Government, CG should meet once in a month. Some of the CG members reported that they do not know the total number of members of the groups and who they are. This indicates pessimism from the CGs about their ability to keep the CCs operating and providing quality services. One of the important functions of the CGs is to look after regular opening and timely service providing of the Providers in the CCs. But it has found that most of the CCs remained open ranging 1-4 days in a week. Some of them open once or twice in a week and some once a month for holding EPI session or distributing FP method.

Table-14: Number of CCs showing working days/week

Working days	No. of CCs	%
6 days per week	24	40
4-5 days per week	11	18.34
2-3 days per week	15	25
Once in a week	05	8.33
Once in a month	05	8.33
Total =N	**60**	**100**

Accessibility is a very important factor, which contributes to increase utilisation and sustainability of the facilities. The study shows that of the 105 CCs (60 functional and found open and 45 functional but not open on visiting day) 61 CCs (58.09%) are easily accessible while 44 (41.91%) are difficult to access.

Table below shows the accessible situation clearly

Table-15: Accessibility of surveyed CCs by number and percentage

Accessibility	No. of CCs	Percentage (%)
Easy access	61	58.09
Difficult to access	44	41.91
Total =N	**105**	**100**

Overall implementation status of the ESP components are given below in table 16

Table 16 :

Indicators/Overall Situation	**Govt. Guidelines**	**Findings/Implementation status**
Service providers	Two in each CC- HA (1) and FWA (1)	53 CCs were found both HA and FWA posted, while on the visiting day in 27 CCs both of them were present- 7 CCs were posted only one provider either HA or FWA.
Working days and opening hours	6 days a week. At least 40 hours a week ie. About 7 hours daily.	24 (40%) CCs open 6 days week but work far less hours than indicated in the guidelines.
Drugs Supply	23 categories of drugs. All CCs to get on monthly basis	Excepting few (4 CCs) almost all CCs got drugs only one time when formally opened. 3 CCs received no medicine at all)

Equipment and other logistics supply	43 items of equipments and other logistics.	All CCs had equipments and other logistics though not in full.
Furniture	8 types of furniture to be supplied by the contractors who contracts the CC.	All CCs got furniture but not in full.
Registers and report book	10 different types of registers are to be maintained for specific purposes	No CC found to have all Registers. Almost all CCs had 7/8 types of Registers.
Community groups	To be formed in all CCs with 9 – 11 members	No CG had been formed in 4 CCs. Others have CG but not functional.
Training in ESP (21) days	Service providers are to be trained in ESP prior to posting at the CCs.	Service providers of about 65% CCs did not receive training on ESP and do not have knowledge about ESP
BCC Materials	Not specified but to be displayed to disseminate	Most of the CCs had no BCC Materials and Health Education.

Availability of resources for –

(a) Service delivery and operational management:
As shown above, the main problems are in limited opening and poor supply of drugs.
(b) Maintenance of CCs:
Maintenance budget for CCs has not been kept in the HPSP as this part has been planned to be borne by the community. So far about 10,000 CCs have been constructed at a cost of Tk. 275 crore. The standard per-annum maintenance cost is 2.5% of the construction cost.
So an amount of about Tk. 6.88 crore will be required annually to maintain CCs already constructed. This amount is supposed to be arranged by the community, but this seems to be highly ambitious in the context of the socio-economic conditions of the community people. The findings of the study indicate that resources from outside may be needed.

Effects on FP Services:
From direct observation, FGD and exit interviews it appears that the establishment of CCs has affected Family Planning Services. After opening of CCs, the plan is to reduce the number of home visits. There is a belief that the FP services motivational work has been reduced. Because of socio-economic, religious and family barriers, as well as lack of privacy and geographical inaccessibility, some rural women are reluctant to seek FP services from the CCs. They do not want to come to CCs walking 1-2 km and they feel shy to tell their problems in presence of elders at the CCs. They prefer to get FP services as before through home visit and satellite clinics. It will be important to monitor the uptake of FP services as these changes take effect.

Expectations of the Community:
It is clear from the focus groups that people in the community had high and currently impossible expectations. They hoped for:
1. A Hospital will be established for treatment of all types of diseases
2. One MBBS doctor will be posted to provide required services

3. One Nurse will be in the hospital to work with the doctors
4. Free medicine will be dispensed as per need
5. HA and FWA will also work in the hospital
6. Necessary equipment and logistics will be provided according to the schedule
7. Women, children and the poor will get health care from the clinic near to their houses.

Actually what they have got:

1) A small clinic to provide preventive, promotive and limited curative care
2) No qualified doctor has been in place
3) The untrained and unskilled HA and FWA are the providers
4) Very irregular or no supply of drugs and other logistics
5) Clinics remain closed most of the days of the week
6) Providers are not fully posted and available
7) Attitude of the providers are not co-operative and client friendly
8) Environment of most of the CCs are not suitable for delivery of health care.

Opinions of the Civil Surgeons, Deputy Directors (FP) and UHC Level Officers on Community Clinics.

The sections above report the findings of the parts of the study that assessed impact on development of services, access, and quality of care. This section reports the opinions and ideas of those with managerial responsibility - the Civil Surgeons and Deputy Directors of Family Planning.

Views of the District level officers of the Health and Family Planning Services (CSs & DDs) were collected by post through sending a questionnaire to them. About one third of the total CSs and DDs responded. Views of the UHC level officers were gathered through interviewing them by the research team. Their opinions have been represented under the following clusters:

a) Physical facility and quality of construction:

The Civil Surgeons said that the conditions of CCs were not at all satisfactory and the quality of construction was poor. Plastering of the building had not been done properly and the floors were in bad condition. Doors, windows and furniture had been made with poor quality materials. Deputy Directors gave the same views as those of the CSs. They pointed out that location of some CCs was very difficult to access by women, children and the poor.

As regards justification and appropriateness of establishment of CCs, some of the Civil Surgeons stated that there should have been a pilot scheme to test the concept before going ahead with developments across the country. They think that it is a good step to provide health and family planning services close to rural people from one service delivery point. The field staff (HA/FWA), who had to provide services through home visit, satellite clinic and outreach centres, have got a place to sit and can give services smoothly and effectively without wastage of time that used to be needed for home visits. As the CCs have been established nearer to the community people, they are in a position to demand services from the health providers.

There are also opposite views from some CSs who think that while UHFWC (one in each Union) is not functioning properly, the establishment of CCs was not justified and appropriate. There is lack of medicine, medical and surgical requisites and other logistics. The health

workers of CCs are not also trained and skilled to deliver quality services. Some DDs expressed similar opinions about the appropriateness of establishing CCs.

(b) ESP service delivery and quality of care:

Civil Surgeons said that it was difficult to comment at this stage about service delivery and quality of care. The CCs are not yet functioning fully. The specified services are not yet being provided and they believe that the quality has not improved.

Deputy Directors drew attention to the fact that CCs are usually closed and there is lack of drugs and trained providers. They also pointed out that there was little accountability and an unclear chain of command. With reduced home visits, satellite clinics and outreach centres, drop out rates had increased, and there was some evidence that BCC, FP and nutrition related activities had decreased. Shortages of drugs, MSR and skilled providers were hampering the development of quality care. The DDs also suggested that use of UH&FWCs has also decreased. As pointed out above, there were already well-understood problems with the performance of the union level facilities.

(c) Sustainability:

CSs suggested that in the present situation it was difficult to comment about sustainability of CCs. However, it can be said that to make the CCs sustainable, regular supply of drugs, MSR and other logistics, improving the skills of the health workers, strengthening supervision and monitoring and enhancing the capacity of the CGs are essential. Similar views were given by the DDs.

Chapter V: 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 are 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 have 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 are well located, and in this respect the government policy has been carried out in the development of clinics. In a few cases there are 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 are 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 were 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 is designed to be through formation of Community Groups of local people.

The overall picture is of limited community involvement. CGs were set up late, and it is clear that they have responsibility but feel that they have too little power. CGs have not been effective in monitoring service delivery and quality, and (probably correctly) see themselves 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 staff 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 are 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 are they see patients only for short consultations. There is evidence that most staff have received some ESP relevant training, but also that this is not really 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 have 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 17 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.

SECTION VI: CONCLUSIONS AND RECOMMENDATIONS

The HPSP aims 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 are 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 are 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 HPSP emphasises 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 have too little effective authority and they are unable to fulfil their responsibilities. Several comments were 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 are 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 are to be put in place. The role of health workers in the clinics requires a wide range of skills and their job descriptions are currently beyond the skill levels of most staff. There are 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 had not yet been achieved. Community expectations have 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 will be undermined by failure to deliver services of reasonable quality and services that meet legitimate expectations of the community.

Annexure-1

Pictorial view of some Community Clinics

Figure-1: Clinic constructed on water logged site making access difficult

Figure-2: Unhygienic environment around a community clinic

Figure – 3: Community Clinic: Yet to open the door for the people

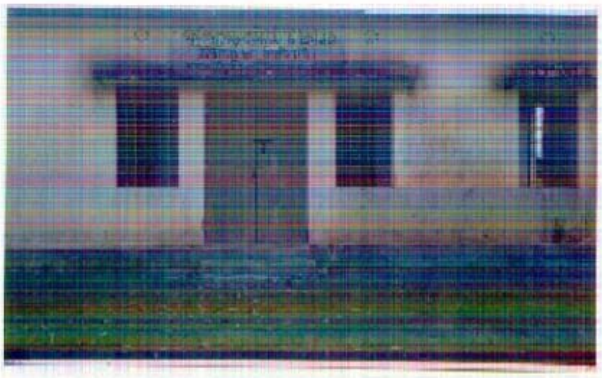

Figure-4: A family taking shelter beside a non-functioning Community Clinic

Figure-5: A view of FGD session conducted by the Principal Investigator

Figure – 6: Another view of FGD session

Figure – 7: People make their own way to get into the Community Clinic

Figure-8: Principal Investigator along with the research team discussing various issues on CC with community leaders

List of Acronyms

AHI	= Assistant Health Inspector
AIDS	= Acquired Immune Deficiency Syndrome
AOP	= Annual operational plan
ARI	= Acute Respiratory infection
BCC	= Behaviour 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 Immunisation
ESP	= Essential Services Package
FDG	= 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
LSHTM	= London School of Hygiene and Tropical Medicine.
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
PIP	= Programme implementation plan
PRO	= Policy and Research units
R&D	= Research and Development
RCC	= Rod and Cement Concrete
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