Pattern and Effect of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach

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Declaration

This thesis entitled as **"Pattern and Effect of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach"** is submitted to the Faculty of Postgraduate Medical Science and Research of the University of Dhaka in partial fulfillment of the requirements for the Doctor of Philosophy (PhD) degree. This is an original study done by the researcher himself under the guidance of the supervisors. Neither the study nor any part of it is submitted to any other institute for any other degree.

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Certificate of the Supervisor

This is to certify that the thesis entitled as **"Pattern and Effect of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach''** submitted by Prof. Dr. Baizid Khoorshid Riaz, for Doctor of Philosophy (PhD) degree, to the Faculty of Postgraduate Medical Science and Research, University of Dhaka, as a record of research work. He carried out the thesis work under my direct supervision and guidance. The results embodied in this thesis have not been submitted elsewhere for the award of any other degree.

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Certificate of Approval by the Examiners

The undersigned examiners certified that we have carefully read and recommended to the Faculty of Postgraduate Medical Science and Research of the University of Dhaka, for acceptance of this thesis entitled **'Pattern and Effect of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach'** submitted by Prof. Dr. Baizid Khoorshid Riaz for Doctor of Philosophy (PhD) degree.

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List of Abbreviations

ANC	Ante-natal Care
ARI	Acute Respiratory Tract Infection
BCC	Behavior Change Communication
BUHS	Bangladesh University of Health Sciences
CBHC	Community Based Health Care
CHCP	Community Health Care Provider
CC	Community Clinic
CDD	Communicable Disease Control
CG	Community Group
CMSD	Central Medical Store Depot
CSBA	Community Skill Birth Attendant
CSG	Community Support Group
CS	Civil Surgeon
CMAM	Community Management of Acute Malnutrition
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
EDCL	Essential Drug Company Limited
EPI	Expanded Program on Immunization
ESP	Essential Service Package
ECNEC	Executive Committee of the National Economic Council
FP	Family Planning
FWA	Family Welfare Assistant
GAVI	Global Alliance for Vaccine & Immunization
Gavi-HSS	Gavi Health System Strengthening
GOB	Government of Bangladesh
GO	Government Organization
HA	Health Assistant
HED	Health Economic Directorate
HFA	Health For All
HNPSP	Health Nutrition and Population Sector Programme
HPNSDP	Health, Population, Nutrition Sector Development Program
HPSP	Health and Population Sector Program

JICA	Japan International Cooperation Agency
KI I	Key Informant Interview
MDGs	Millennium Development Goals
MOH&FW	Ministry of Health and Family Welfare
MO	Medical Officer
MOU	Memorandum of Understanding
MP	Member of Parliament
ND	Normal Delivery
NID	National Immunization Day
NGO	Non-government Organization
NIPSOM	National Institute of Preventive and Social Medicine
NNS	National Nutrition Services
NRR	Net Reproduction Rate
OP	Operation Plan
PHC	Primary Health Care
PhD	Doctor of Philosophy
RCHCIB	Revitalization of Community Health Care Initiatives in Bangladesh
SDGs	Sustainable Development Goals
SACMO	Sub-assistant Community Medical Officer
Tdh	Terre des hommes Foundation
TOT	Training of Trainers
TIKA	Turkish Cooperation and Coordination Agency
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Upazila Health and Family Welfare Centre
UNICEF	United Nations Children's Fund
UN	United Nations
UP	Union Parishad
USAID	United States Agency for International Development
WHO	World Health Organization

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Prof. Dr. Baizid Khoorshid Riaz

Dated:

Abstract

Introduction: Community Clinics (CC) have played a crucial role in the remarkable achievements of health sector of Bangladesh and community participation is regarded as the key to this triumph. Comprehensive study on implementation, utilization and management of community clinic services is a time honoured issue.

Objective: This cross-sectional study was designed to conduct in mixed method to assess the patterns and effects of community participation in health care delivery in rural Bangladesh through the community clinic approach.

Methodology: Quantitative part of the study was concerned with pattern of community participation through community clinic approach while qualitative part dealt with key informant's interview to determine the effects of community participation on health of rural communities. The study was conducted among 32 randomly selected community clinics, 63 health care providers, 2238 service users, 3285 community people and 597 key informants.

Results: Most (96.9%) of the CCs were located in easy to reach area of the community. Lands of CCs were donated exclusively by the community members. Almost all the CCs had good infrastructure and security in most (93.7%) was maintained by community people and members of community groups. Availability of equipment was not encouraging as only 12.5% CCs were in the 'Good' while supply service was 'Good' in 40.6% CCs. Availability of logistics and furniture was 'Good' in 62.5% CCs. Provision of health care delivery was 'Good' in more than three fourth while health education services was 'Good' in 96.7% CCs. All the CCs showed increased trend of heath care utilization and normal delivery conduction in last five years. All the CCs performed referral service and 98.4% provided referral form to the referred patients. Community Groups (CG) of 88.9% and Community Support Group (CSG) of 96.8% CCs were active. UP chairman was the chief patron in more than half (58.7%) CCs. Most (92.1%) of the CG members were trained on training manual & trainer's guide and 85.7% met once in a month. CC service users were predominantly female (71.2%) followed by male (20.0%) and children (8.9%). Most (99.2%) of the users knew about services available at the CCs. Users perceived benefits of CCs included free drugs (82.1%), free treatment (81.2%), easy access (76.3%), need based health services (75.0%) and immunization services (68.6%). More than three fourth of the users were satisfied with the services of CCs. Most (88.3%) of community people opined that CCs are located within the vicinity of their residing area. About 96.0% regarded that CCs remained open every working day and almost all (99.0%) opined that CGs were concerned about benefits of CCs and community participation in decision making for construction, further improvement, problem solving, local fund

collection and referral services. Most (91.2%) of the key informants (KI) addressed that committees of CC were functional and 86.8% opined that the members of the committees were included following eligibility criteria. KI also mentioned that CG was involved in supervision of construction works (49.2%), management & maintenance (79.2%), cleanliness of premises (88.4%) and collection of money locally (22.9%). Collected money was spent to treat poor patients (59.5%), to treat children (49.2%), to repair infrastructure (43.7%) and to treat women (37.5%). More than three fourth (86.8%) of the KIs regarded the management of CCs as satisfactory. Average number of patients treated in CCs was significantly different by divisions (ANOVA, $p<0.01$). Availability of furniture/logistics was significantly different among the CCs ($p<0.05$) by division. Level of satisfaction about waiting room (χ^2, $p<0.01$), waiting time ($p<0.01$), quality of the service providers ($p<0.01$) was significantly varied by sex and occupation of the users. Knowledge about CC ($p<0.05$), CG ($p<0.01$), CSG ($p<0.01$) significantly varied by sex and occupation of the community members. Perceived impacts of community participation through community clinic approach included raised health awareness of the community, effective utilization of essential health care, reduction of communicable diseases, maternal and child morbidity and mortality. Major constraints noticed lack of specialist doctors (30.3%), inadequate service provider (30.9%), inadequate equipments (51.8%) and drug supply (51.8%), insufficient logistics supply (38.2%), financial constraint (34.3%), poor patronization of Government (20.1%) and lack of electricity supply (8.0%).

Conclusion: Community clinics need more campaign and promotional activities through organizing more meetings with community people, expansion of space, resource mobilization, digital communication and easy transportation to ensure effective access to services. In order to improve community health, access of the community people to comprehensive health services and must be ensured. For this, the government, stakeholders and communities must extend their participation through community clinic approach to improve the health status of the people.

1.1 Introduction

"Community Clinic" is a unique concept adopted by the Government of Bangladesh in order to successfully establish the link between community people and the caregivers in the hospital settings for successful attainment of community health. As a result, people are getting the benefits of healthcare up to the grass-root level. But in that succession, the role of effective community participation is yet to be fully anticipated.

"Community participation" is an important connote of changing people's attitude and actions towards promoting a sense of responsibility. It is viewed as a reaffirmation of the role of people in managing their own health. In case of receiving healthcare services people need behavioural change as well as more active involvement of community people in health care delivery programme. This can make behavioural changes more acceptable and maintain a consistency with community norms (1).

Community participation is one of the main principles of Primary Health Care (PHC), which is the strategy proposed in Alma Ata in 1978 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and adopted by 150 member states of the two organizations. It is meant to revolutionize the practice of health care and health development, leading to health for all by the year 2000 (2). The concept is not fully new rather it was used within health programs and healthcare in social practice and development in 1950's and early 1960's. Later, the concept was adopted in a new form and revolutionize according to the recent demand. Effective community participation is a broad term and it involves a wide range of activities taking into account the active contribution of each and every member of the community. But often the uniformity is not maintained. Only a part of the community actively takes part in attaining successful community health & in the management of community clinics. But every member should contribute and become aware about their own health so that no one is left behind and the concept of universality is achieved.

A study conducted in South Australia determined the levels of participation in social and civic community life in a metropolitan region, and assessed different levels of participation according to demographic, socioeconomic and health status. It was found that the response rate to the survey was 63.6% and levels of participation were

highest in the informal social activities index (46.7–83.7% for individual items), and lowest in the index of civic activities of a collective nature (2.4–5.9% for individual items). Low levels of involvement in social and civic activities were reported more frequently by people of low income and low education levels (3).

Another study was conducted in China to present an urban community in Beijing and to identify factors that have affected community mobilization in urban China. The result revealed that the rise of community participation is premised on perceived benefits that participation brings to community programs in terms of added efficiency, sustainability, and the collective community power (4).

Similar study was carried out in Bangladesh regarding Essential Services Package (ESP) and to assess the behavior change communication (BCC) needs for the community clinics-based service-delivery of essential health and family planning services package. The study suggested that development of an appropriate BCC Program, incorporating interpersonal communication, print, demonstration and electronic media, as well as advocacy workshops, is essential for the effective operation of the community clinics through community participation and community resource mobilization (5).

Government of the Peoples' Republic of Bangladesh undertook the first sector wide program entitled 'The Health and Population Sector Program (HPSP)', for a period of five years from 1998 to 2003 and then extended it to 2010 under second sector wide program in the name of 'Health Nutrition and Population Sector Programme (HNPSP)' throughout the country, at all levels of service delivery, namely community, union, upazila and district collaboration with GO-NGO partnership. Then the third sector wide program entitled "Health, Population, Nutrition Sector Development Program (HPNSDP) was launched in 2011 and it continued till 2016. All these sector wide programs are designed to ensure access of all people to basic health care services with special emphasis to the rural people through community participation (6). Recently, 4th sector wide program has been launched from January 2017 named "Health, Population and Nutrition Sector Program (HPNSP)" which aims to gradually move the country towards universal health coverage by successful attainment of health-related SDGs.

At the community level in the rural areas, the Essential Services Package (ESP) has been planned to be offered from Community Clinics to meet the needs of the poor, especially in rural areas and particularly women, children and poor. The ESP has been launched with the plan of delivering healthcare at three tier of the district, i.e. starting from Upazila Health Complex (UHC) at the upazila (sub-district) level, Union Health and Family Welfare Centre (UH&FWC) at the union level, and upto Community Clinic at the ward/village and grass root level (6).

One of the main strategies of sector wide program is to establish Community Clinics (CCs) at the village level to provide one-stop health and family welfare services. The main philosophy of this initiative is to involve rural communities in the planning, implementing, maintenance and ensuring safety and security of these clinics, and to create mass awareness among rural populations about the utility of health and family planning services. These CCs 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 (6).

In 1998 government planned to establish 13500 Community Clinics (CC), one CC for around 6000 population in rural Bangladesh. From the very beginning of this unprecedented initiative community participation was ensured as Community Clinics were constructed on community donated land. During 1998-2001 period 10,723 Community Clinics were constructed and majority were made functional. But in 2001 due to the change of government these clinics were closed just after the beginning of its journey and this situation continued till 2008. Due to long closure for more than 7 years, people were disappointed as they were deprived of CC's services. The current govt. after getting responsibility in 2009 started revitalization of Community Clinic as flag-ship program through the project "Revitalization of Community Health Care Initiatives in Bangladesh", with project duration of 5 years. Under this project CCs built during 1998-2001 have been made functional after necessary repair, deployment of service providers, supply of medicine & other logistics support. Besides these, new CCs constructed under the project have also been made functional. Later on Project duration has been extended for 1 year with an additional 361 CCs for very difficult to reach and isolated areas with new target of 13,861 (7).

Community Clinic is a unique example of Public Private Partnership (PPP) as all CCs are constructed on community donated lands; construction, medicine and all necessary logistics, service providers are from government but the management is done by the Community. Community Health Care Provider (CHCP) is the chief of community clinic who renders service 6 days per week. Health Assistant (HA) and Family Welfare Assistant (FWA) work there alternatively 3 days in a week. Community Group is the pivotal element of Community Clinic. For each CC there is a community Group (CG) consisting of 13-17 members, headed by local UP member. Besides this, in the catchments area of each CC there are 3 Community Support Groups (CSG) comprising of 13-17 members (7).

Bangladesh has achieved remarkable success in health sector and awarded international awards in respect of reduction of child mortality and improvement of maternal health. In addition to those, life expectancy, access to safe water and sanitation has increased. Poverty and malnutrition has reduced and health related quality of life has improved remarkably (7).

It is evident that behind all these success and achievements, community clinics has played a crucial role by rendering need based basic health care services to the rural people and it has been established by effective utilization and participation by the rural communities of the country. So it is imperative to assess the pattern and effects of community participation through community clinics approach in the rural context of the country. But relevant study is very scarce in Bangladesh. So, comprehensive study on the community clinics in respect of implementation, utilization and maintenance of community clinic services along with pattern and effects of community participation is a time honoured issue in Bangladesh.

The present study assessed the pattern of community participation and its effect on service utilization and on different dimensions of health of the rural communities. The study also unveiled the opinions of the rural people and diverse community leaders regarding planning, implementation, utilization and maintenance of community clinic services. The study provided more emphasis on ways and means of community participation and the strength, constraints and opportunities associated with community clinics.

The study aimed to determine the obstacles present in the way of successful accomplishment of the concept of community participation in Bangladesh so that the community clinics are made more effective for community people and they can get full benefit of the setting. It has given an overall scenario of the country on active community participation and its effects in achieving community health.

In the aforementioned study, an attempt has been made to explore the factors that make barriers to community participation in health care delivery by the community clinics. The study also explored the expectations of the community people regarding their health needs to be meet by the community clinics. Thus the study findings provide a comprehensive picture about pattern and effects of community participation in rural communities, which will guide health service planners and policy makers for taking appropriate measures to improve the quality of health services of the community clinics. Ultimately it can be said, this study will contribute to the sustainable health development of community and country.

1.2 Rationale

Since her inception, the government of Bangladesh has taken different initiatives for decentralization of health services through establishment of Upazila Health Complex with a vision to extend health services to the grass root level in phases. Bangladesh was one of the signatories in WHO's "Alma-Ata Declaration" in 1978 with a pledge to ensure Health for All (HFA) by 2000 through Primary Health Care (8, 9).

It was observed in 1996 that Bangladesh is quite behind the target in different parameters towards achieving Health for All (HFA). The notable reasons were unavailability of resources & inaccessibility of PHC to the vast rural community which comprises of three quarters of population. Community participation was not also satisfactory. But these were the important principles of PHC. In this context in 1996 Govt. of Bangladesh planned to establish Community Clinics to extend Essential Service Package of PHC to the door steps of rural community (7, 10).

On 26 April 2000 the then Hon'ble Prime Minister Sheikh Hasina inaugurated Gimadanga Community Clinic of Patgati union at Tungipara upazila under Gopalgonj district. 26th April is being observed every year as the CC establishment day. Community Clinic is the lowest tier one-stop service outlet for health, population and nutrition services at the grass root level. It offers services in respect of health education, health promotion, treatment of minor ailments, first aid for minor injuries, and identification of emergency and complicated cases with referral to higher facilities for proper management (7).

Community Clinics are constructed on community donated lands; construction, medicine and all necessary logistics, service providers are from government but the management is done by the Community. Government renders only the technical support. So community participation, engagement and ownership are the vital factors for smooth & effective functioning and monitoring of CC in addition to its sustainability.

Present Govt. has taken initiatives for Revitalization of CC as the top-most priority project in Health Sector. The Project was approved by ECNEC on Sept. 2009 titled as "Revitalization of Community Health Care Initiatives in Bangladesh" (RCHCIB). Several documentaries have been made on CC & shown in different forums at home

and abroad. A nationwide mass campaign on different aspects of CC has been conducted through miking, leaflet distribution, TV shows, documentary, songs of eminent artists and speeches of local govt. representatives & district and Upazila managers (7).

Monitoring is important but more difficult compared to the facilities of Union, Upazila and other levels nearer to head quarters as the CCs are located in remote areas. In spite of this, monitoring of the CCs is being done regularly by using specific checklists. The activities of CCs are being supervised and monitored from different levels - National, Division, District and Upazila levels. Under WHO support 7 Field Monitors (1 in each district) are also supervising and monitoring CC activities in a rotating manner (3 months in 1 district) where performance is low. Monitoring is also being done through mobile tracking of CCs from project office, analyzing the monthly report and monthly meeting of different levels.

Government of Bangladesh has been working to make digital Bangladesh with "Vision 2021". In accordance with this, RCHCIB is also working. All the CCs have been provided with Lap Top & Modem. At present 85% CCs are reporting on line. E-learning for CHCPs was inaugurated by Hon'ble Prime Minister in 2015. In near future E health program will be started encompassing CC. Community Clinic has now become an "Information Hub" for health, family planning, nutrition and general information.

Community clinic is an integral part of Bangladesh Health System particularly of Upazila Health services. The journey of community clinic to ensure primary health care services for the rural community will remain uninterrupted but active community participation and commitment of all stakeholders are the best drivers to make this journey safe and successful. Bangladesh will achieve 'Health for All' in true sense when the country will be able to achieve the MDGs and ensure SDGs within the stipulated time.

Considering the realities, the country needs to assess the pattern and effects of community participation in rural communities through community clinic approach to find out the realities associated with its functioning, service delivery, constraints and sustainability. Very few studies on CC have been done by different organizations independently and their findings were concentrated on client satisfaction on CC

services. But study on community participation through community clinic approach is not available in the country.

This current study intends to assess the pattern of community participation in terms of establishment and maintenance of community clinics along with identification of community health problems, decision making, implementation and utilization of community clinic services. The study findings will help the policy makers, stakeholders and health care providers to formulate effective measures to overcome the constraints associated with community clinics. It will also contribute to improve the quality of community clinic services to meet the community needs for health. The study will also create the opportunity to devise innovative strategies for community participation through community clinic initiatives to ensure community health development.

Although because of revitalization of community clinic initiative, CCs all over the country are running to their full extent successfully, yet the determinants behind the successful running of the clinics need to be documented. Researches need to be carried out to check whether it is active community participation and involvement which is causing the success or only the initiatives of the local government that is contributing. Because, if the latter is the case, the success won't last longer and the main intend of the concept of community based healthcare will be hindered. So, this study was carried out in need to detect the ins and outs of the existing situation.

Bangladesh is a riverine country with varied geographical location. There are many hard to reach areas where the community clinics are yet to function to their full potential. Those vulnerable communities need to be addressed and the gaps need to be filled. Hence comes the need for the mentioned study which proceeded to look details in the matter by detecting the determinants, patterns and effects of active community participation.

In a resource poor country like Bangladesh, success of community based healthcare depends on successful contribution of community people in the activities of community clinic. That is the reason why the role of community participation needed to be thoroughly assessed and the study proceeded to much extent to do that for the betterment of the people of the country. Any deviation from the expected scenario was carefully recorded to divulge fruitful results.

1.3 Research Questions

- What are the patterns of community participation in rural Bangladesh through community clinic approach?
- What are the effects of community participation on different aspects of community health through community clinic approach?

1.4 Objectives

1.4.1 General objective:

- To assess the patterns and effects of community participation in rural Bangladesh through the community clinic approach.

1.4.2 Specific objectives:

- To assess community participation in respect of establishment and maintenance of community clinics (CCs) in rural Bangladesh.
- To ascertain community participation in respect of problem identification, decision making and implementation with the community clinics.
- To assess the quality of health care facilities and services of the CCs.
- To assess utilization and satisfaction of the patients regarding CC services.
- To determine the effects of community participation on different aspects of community health through CC approach.
- To ascertain socio-demographic, economic, political and administrative determinants for community participation through CC approach.

1.5 Variables of the Study

A. Dependent Variable:

Effects of community participation in terms of

- **Management of CC:** Sense of responsibility of ownership, community involvement, strengthening management, financial support.
- **Access to CC:** Information communication, access to health services, utilization of services, ante natal care utilization, quality of CC services
- **Community health:** Awareness on CC, healthy lifestyle of the community, water and sanitation condition, personal habit, morbidity and mortality improvement of the community.

B. Independent Variables

1. Variables related to pattern of community participation

- Establishment of CC
- Management of CC
- Decision making process
- Implementation
- Utilization of CC services
- Supervision and monitoring

2. Variables related to quality of physical facilities of CC

- Location, Nature of land
- Size, quality of construction
- Accessibility to CC
- Waiting space and accommodation for staff
- Availability, skill, training of service providers and supporting staff
- Water and sanitation facilities
- Electricity supply
- Sufficiency of logistics and furniture
- Availability of necessary equipments
- IT facilities (Telephone, Hotline, Laptop, Internet)

3. Variables related to types of services of CC

- Types of health care services (General, Maternal, Neonatal)

- Family planning services
- Drug supply service
- Information communication services
- Health education services
- Number of patients served
- Normal delivery conducted
- Referral services
- Functions of CGs and CSGs
- Security services

4. Variables related satisfaction of the clients

- Availability of need based services
- Types of benefits of CC
- Cooperation of supporting staff
- Attitudes of service providers
- Quality of CC services
- Waiting arrangement and time
- Cleanliness of CC
- Privacy and response

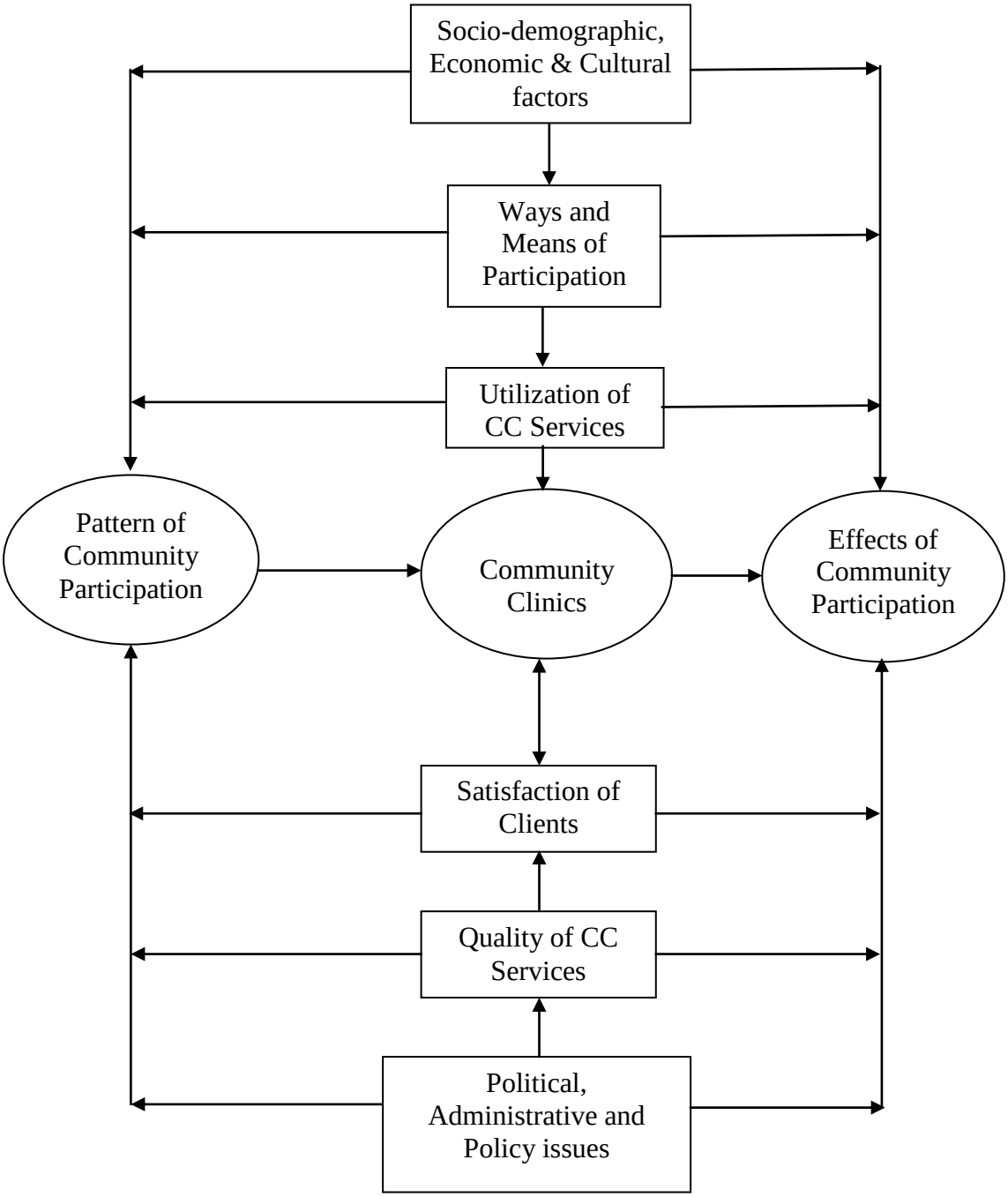
5. Variables related to socio-demographic, economic and cultural features

- Socio-demographic characteristics of the participants (Age, sex, education, occupation, income etc)
- Economic solvency

6. Variables related to political and administrative issues

- Local political support, power pressure
- Administrative problems

1.6 Conceptual Framework



1.7 Operational Definitions

1.7.1 Pattern of community participation: In this study, pattern of community participation is defined as the involvement of community people in different activities of community clinic including establishment of CC, management of CC, decision making process, implementation, supervision, monitoring and utilization of CC services.

1.7.2 Effects of community participation: In this study, effect of community participation is defined as the end products or results of community participation through community clinic approach on community health and management of community clinics. It includes following aspects

- ✓ **Management of CC:** Sense of responsibility of ownership, community involvement, strengthening management, financial support.
- ✓ **Access to CC:** Information communication, access to health services, utilization of services, ante natal care utilization, quality of CC services
- ✓ **Community health:** Awareness on CC, healthy lifestyle of the community, water and sanitation condition, personal habit, morbidity and mortality improvement of the community.

1.7.3 Quality of physical facilities of CC: In this study, assessment of quality of physical facilities of community clinic considered location, nature of land, size, and quality of construction, accessibility to CC, waiting space, availability, skill and training of service providers. It also included water and sanitation facilities, electricity supply, sufficiency of logistics and furniture, availability of necessary equipments and IT facilities like telephone, hotline, laptop, internet etc.

1.7.4 Types of services of CC: In this study, types of services were types of health care services like general, maternal, neonatal and family planning services, drug supply service, information communication services, health education services. The study considered some indicators to assess CC services like number of patients served, normal delivery conducted, referral services conducted, functions of CGs and CSGs and security services.

1.7.5 Satisfaction of the clients: The study assessed satisfaction of the clients of community clinic services in terms of availability of need based services, types of benefits of CC, cooperation of supporting staff, attitudes of service providers, quality of CC services, waiting arrangement and time, cleanliness of CC and privacy and response.

2. Literature Review

Concept of Community Clinics:

In 1971 we achieved independent & sovereign Bangladesh through our great liberation war under the leadership of Father of the Nation, the greatest Bangalee of thousand years, Bangabandhu Sheikh Mujibur Rahman, at the cost of three million martyrs. Since independence, Bangladesh took different pragmatic steps to rebuild the war-torn country including the health sector. Bangabandhu's government took initiative for decentralization of health services through establishment of Thana (Upazila) Health Complex with a vision to extend health services to the grass root level in phases. Accordingly Bangladesh was moving forward with its own strategy to achieve HFA. But an important principle of PHC, community participation was not satisfactory.

In this context Community Clinic (CC) is the new innovation to extend Primary Health Care to the doorsteps of rural people all over rural Bangladesh. Thousands of people are getting services from the CCs & it has become an integral part of health system. It is an unique example of Public-Private partnership as, all the CCs have been constructed on community donated land while construction, medicine, service providers, logistics & all other inputs are from Govt. but management is both by community and Govt. through Community Group (CG). Community owns CC & plays active role for its improvement in all regards. People are satisfied with the services of CC as it is the one stop service outlet in respect of Health, Family Planning and Nutrition.

It is the flagship program of present Govt. At present 13,136 CCs are on board as June 2016 and number is gradually increasing. In many cases Medical Officers & SACMOs are visiting CCs periodically and providing services to the complicated cases. All the CCs have been provided with Laptop & internet connection and have been reporting on line. E-health from CC to UHC has been introduced in some places. We hope that in near future E-heath will be scaled up all over the country. It is believed that CC will be able to contribute substantially in achieving SDGs like MDGs & health for all will be ensured.

Establishment History of Community Clinics:

Bangladesh was one of the countries who signed the "Alma-Ata Declaration" in 1978 with a pledge to ensure "Health for All" (HFA) by 2000 through Primary Health Care (PHC). But in 1996 it has been observed that we were far behind the destination as per the set indicators. Unavailability & inaccessibility of PHC to the rural community of Bangladesh (about three fourths of national population) with lacking in community participation were the important reasons.

To address those shortfalls, the then Government of Bangladesh in 1996 planned to establish Community Clinic (CC) (1 CC for about 6000 population) to extend PHC at the door steps of the villagers all over the country. Community Clinic is the brain child of Hon'ble Prime Minister Sheikh Hasina. Construction started in 1998. During 1998-2001, 10723 CCs were constructed & about 8000 started functioning. HA & FWA were service providers in addition to their domiciliary services. They had been trained on ESP (Essential Service Package) under HPSP (1st Sector Program).For management of CC activities, there was 1 Community Group (CG) for each CC having 9-11 members headed by Land Donor/his or her representative. In CG there was no distinct provision for adequate women's representation & scope for empowerment and adolescent participation. Even, the roles & responsibilities of local govt. representatives for smooth functioning and effective management of CC was not considered with due importance.

The CCs were on board for a short time as CCs were closed in 2001 after the change of govt. & remained as such till 2008. General people of the community couldn't realize the benefits from CCs. They became very much disappointed. Due to closure and abandonment for years together, many CCs had been occupied by unauthorized occupants, became centers of unsocial activities e.g. addiction, gambling & others. As there was none to look after, the condition of most of the CCs (the low cost infrastructure in rural setup) became very poor and a substantial number of CC demolished due to river erosion. In 2009 the existing number of CC stands at 10624 (11).

Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB):

In this context in 2009, Govt. planned to revitalize CCs through a project "Revitalization of Community Health Care Initiatives in Bangladesh" (RCHCIB) as priority as it was in their election manifesto. It was a project of 5 years duration from 2009-2014. There after the span of the project has been extended for 1 year more i.e. up to 30.06.2015 in 2 phases.

a) **Community Group (CG)**:

Management body of CC, has been formed for all the functional CCs with some major changes. CG members' number has been increased from 9-11 to 13-17 with at least one third women members and adolescent girl/boy. The group is headed by elected UP member of that locality instead of land donor/his or her representative. Land donor/his or her representative is life member & senior vice president of CG. Out of president & vice presidents at least one is female. CHCP is the member secretary in place HA/FWA.

b) **Community Support Group (CSG):**

It is new & an addition for better community engagement under Revitalization of Community Health Care Initiatives (RCHCIB) project as there was no such provision with CC during 1998-2001. In the catchment area of each CC, there will be 3 CSGs comprising of 13-17 members with at least one third women members. For all functional CCs, CSGs have been formed. The CSGs help CG in CC management along with making community aware regarding the services available at CC and common health messages.

c) **Community Health Care Provider (CHCP**):

New category of service provider (1 for each CC) has been recruited in phases following all the necessary steps. After the last phase of recruitment the existing number of CHCPs becomes 13822. As their job is in developmental head, a significant number of CHCPs have quitted their job, getting better option otherwise. The latest working CHCPs' number stands at 13622 & it is decreasing gradually, causing a substantial number of vacancies.

d) **Community Based Health Care (CBHC):**

From the beginning of RCHCIB, mainstreaming of the project had been thought of & implemented through the existing health system from the national to sub district level. For this one Operational Plan (OP) titled "Community Based Health Care" (CBHC), housed at DGHS under 3rd sector program (HPNSDP) is being implemented since July, 2011 complementary to RCHCIB .During the first 3 years mainly different types of local & overseas training and in the fourth year, pay & allowances of the manpower transferred from RCHCIB to CBHC along with local training have been accomplished out of CBHC. After the expiry of RCHCIB, all the activities of Community Clinics are being implemented through CBHC (11).

Rehabilitation of Community Clinics:

Support from: Terre des hommes Foundation

Terre des Hommes Foundation (Tdh) is one the partners of Community Clinic (previously was of RCHCIB & now is of CBHC). They have been supporting in 2 districts- Kurigram & Barguna under the partnership. They were supposed to support nutritional issues for the improvement of Maternal & Child Health. But they came forward with more support- Rehabilitation (repair & renovation) of Community Clinic building, providing training to the Service Providers and collaborating daily at field level in the mentioned 2 districts.

Community Groups & Community Support Groups are also supported by Tdh with training to understand their roles & responsibilities, to be fully involved with CC rehabilitation work for sustainability and accountability of their respective clinics. The rehabilitation of CC allows access to safe drinking water, sanitation facilities, extension of one shed to have space for counseling session and deliver appropriate care from CCs.

In order to strengthen public health & nutrition services, Govt.& Tdh resource persons jointly imparted training to 147 govt. health staff (CHCP, HA, FWA,1st line supervisors) to run the clinics effectively. Training was on Basic nutrition including maternal services, Community Management of Acute Malnutrition (CMAM) that prioritized under National Nutrition Services (NNS).

Till December, 2015 Tdh already facilitated the rehabilitation of 86 CCs & 5783 CG and CSG members were trained. The nutritional services are now in place in all 121 CCs, ultimately targeted for rehabilitation work. As of December 2015, Tdh has spent TK.2, 84, 18,703 from its own for the rehabilitation works including shed construction as well as to ensure water & sanitation facilities there. People of the remote areas now can avail better health, nutrition & family planning services from the CCs at their door steps in a better environment even during disaster (11).

Infrastructure:

a) **Construction**

- Initial target for construction of CC under RCHCIB was 2876 but there after 361 for very hard reaching, hill, remote & isolated areas has been added to it, resulting the target 3237. At the same time land required for construction of CC has also been increased to 8 decimals instead of 5 decimals. Within the project period 2719 CCs have been constructed, 33 are ongoing & 485 will remain beyond construction.
- Out of these 485 CCs, 300 CCs will be constructed out of JICA support, 10 through TIKA support, 80 through PPD & rest will be constructed under 4th sector program.

b) **Repair**

- As the CCs were left unused for more than 7 years, repair was urgently needed prior to making those functional in 2009. This was done by HED with block allocated fund of MOHFW. But in most of the cases the repair was not at all up to the standard. There after 1080 CCs have been repaired under RCHCIB in phases.

c) **Electric line installation & connection**

- There was no provision for electric supply in the CCs constructed during 1998-2001. The CCs constructed under RCHCIB have the provision for electric line installation.

d) **Installation of solar panel for electricity**

- In a substantial number of CCs, solar panel has been installed with the support of some organizations/institutes under different programs e.g. Disaster management, Upazila parishad, Hon'ble MPs, individuals. Specific information in respect of CCs' number & donors is being collected (11).

Manpower:

CBHC head office is running with 43 sanctioned manpower

- Out of 13,861 CHCP (1 for each CC) 13,822 have been appointed in phases, among them in the mean time 200 CHCP have quitted their job getting better option somewhere else.
- Existing number of CHCP is 13622, among them 53% female and 47% male (11).

Activities of Community Clinic:

At present 13,136 CCs are on board & the number is increasing gradually. From 2009-2015, 460.88 million visits were made to CCs for services of which 9.071 million emergency & complicated cases were referred to higher facilities for proper management. Among the service seekers about 80% are women and children. On average 9.5-10 million visits are in CCs per month & 38 visits per day per CC.

CC is the lowest tier health facility for quality PHC. It is one stop service outlet for (11).

- Maternal and neonatal health care service
- Integrated management of childhood illness
- Reproductive health and FP service
- EPI, ARI and CDD
- National education and micronutrient supplementation
- Health and family planning education and counseling
- Identification of emergencies and complicated cases with referral to higher
- facilities for better management
- Screening of non communicable disease with upwards referral
- Treatment of minor ailments and first aid of simple injuries
- Any other services identified by GOB under HPNSDP to be provided
- Establishing effective referral linkage with higher facilities
- All the CCs are outreach sites for routine Immunization & NID. It addition it provides (11).

Table: Status of important services of CC from 2009-March, 2016

Sl No	Service	Number	Remark
1	PHC (Health, FP, Nutrition)	483.20 million visits	On average 39 visit/CC/day
2	Referred from CC	11 million emergency & complicated patients	Most of the cases have been referred to UHC
3	Normal Delivery (ND)	28160	Normal Delivery is going on in 1008 CC & is increasing
4	Supply of Medicine	Medicine worth TK. 8270.50 million	Medicine Supplied by EDCL & CMSD

Source: Community Based Health Care, DGHS, Bangladesh (12)

Medicine supply from CCs:

Name of Medicine	Name of Medicine
1. Oral Rehydration Solution	17. Chlorhexidine and Cetrimide Solution
2. Paracetamol tab 500mg	18. Gention Violate 2% Topical solution
3. Metronidazole tab 400mg	19. Cotrimoxazole Tablet 120mg
4. Amoxycillin cap 250mg	20. Cotrimoxazole Tablet 960mg
5. Amoxycilin syrup 100ml	21. Hyoscine Butyle Bromide Tablet 10 mg
6. Amoxicillin Pediatric drop-10 ml	22. Neomycin and Bacitracin skin ointment
7. Antacid chewable tablet 650 mg	23. Vitamin B Complex tab
8. Albendazole chewable tablet 400 mg	24. Penicillin V tab 250mg
9. Paracetamol susp 60ml	25. Ferrous Fumerate & Folic acid tablet 200mg
10. Benzoic & Salicylic ointment	26. Doxycycline cap 100mg
11. Benzyle Benzoate	27. Sulbutamol Tablet 4mg
12. Calciam Lactate Tablet 300 mg	28. Sulbutamol Syrup 100ml
13. Chlorpheniramin Malate tabler 4 mg	29. Vitamin –A Capsul (2 Lac IU)
14. Chlorpheniramin syrup100 ml	30. Zink Tablet 20 mg
15. Chloramphencol Eye Ointment 1%	31. Condom
16. Chloramphenicol Eye Drop 0.5%	32. Contraceptive Pill
	33. Misoprostol Tablet 200 micro gram

Training:

a) **Community Health Care Provider (CHCP):**

- Training manual for CHCPs' basic training of 12 weeks (6 weeks theoretical + 6 weeks hands on) & trainer's guide have been developed though a series of meetings, workshops with the participation of GO-NGO experts and specialists of UN Agencies. It was finalized through a national workshop with participation of MOHFW, DGHS, DGFP, UN Agencies, field managers & other stakeholders.
- The training was cascade in type. First master trainers have been developed – there after they conducted TOT for District & Upazila managers and then the TOT holders conducted the basic training for the CHCPs.
- 10353 CHCPs have been provided Basic Training, 13114 CHCPs have provided refresher training.

b) **Community Group (CG)**

- Training manual for CG members & trainer's guide have been developed though a series of meetings, workshops with the contribution of GO-NGO experts and specialists of UN Agencies. It was finalized in a national workshop with the participation of MOHFW, DGHS, DGFP, UN Agencies, field managers & other stakeholders.
- **170,799** CG members have been provided training.

c) **Community Support Group (CSG):**

- Training manual for CSG members & trainer's guide have been developed though a series of meetings, workshops with the participation of GO-NGO program experts. It was finalized in a national workshop with the participation of MOHFW, DGHS, DGFP, UN Agencies & other stakeholders.
- 56,0388 CSG members have been provided orientation.

d) **Statisticians' training**

- All the statisticians of different levels (Division, District & Upazila) have been trained on the reporting formats & on line reporting.
- 552 statisticians have been provided training on Community Clinic MIS (Management Information System)

e) **1st line supervisor**

- For the training of 1st line supervisors of both Health & Family planning, draft manual has been developed through a series of meetings and workshop with the participation of GO-NGO stakeholders. It has been piloted. With the findings of the pilot the draft has been further tuned & will be finalized through a national workshop. The training will be organized in 2016-2017.

f) **Local Govt. representative**

- 19154 Local Govt. Representatives have been provided training.

g) **Overseas training**

- Overseas training for experience sharing & learning on PHC has been organized for the relevant & good performing managers of different levels (majority from the field). This was an incentive so that others might be inspired for sincere efforts & better performance through a healthy competition. Overseas training has been offered to 10 managers.
- 205 Officials of different levels have been offered overseas training.

h) **CSBA training for female CHCPs:**

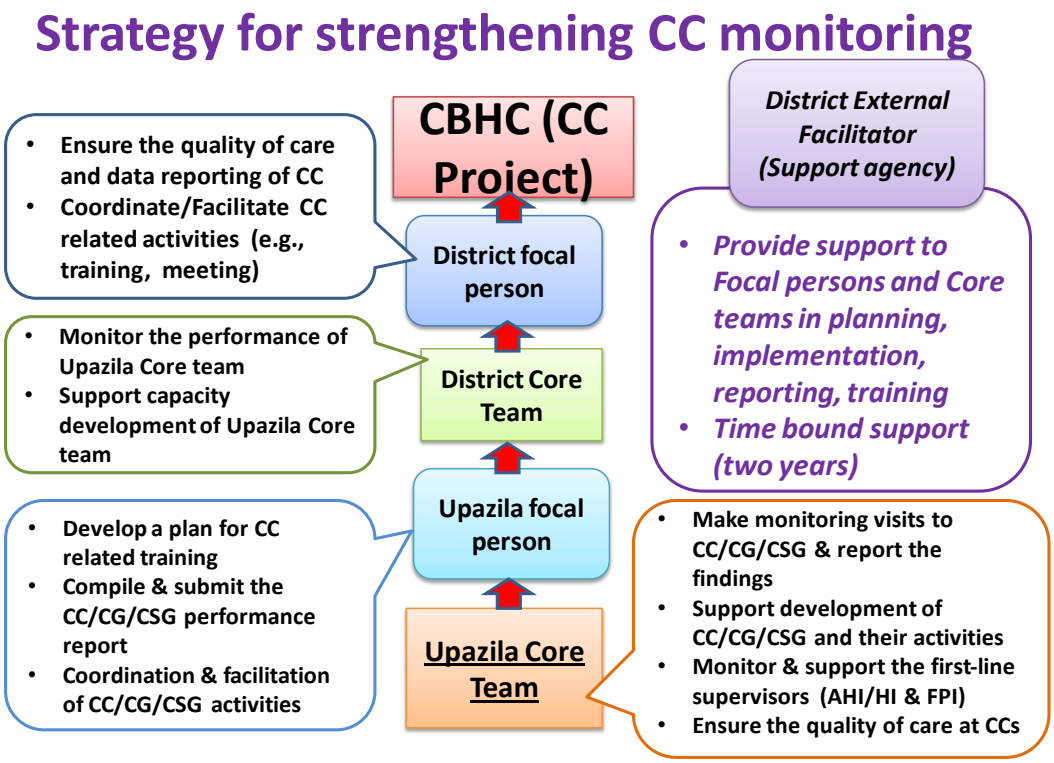
- 1517 female CHCPs have been trained as CSBA (11).

Monitoring:

It is being done routinely by the supervisors of different level. The supervisors have been using the specific checklist. WHO supported for 3 years by providing a few field monitors. Some of our partners are supporting supervision & Monitoring by providing external facilitators. The external facilitators supported in the formation of district & Upazila core teams, capacitated them with remarkable improvement in supervision and monitoring of CC. It is being implemented in 5 districts. The DMCH&IO of GAVI-HSS & District Nutrition officers under UNICEF have been supporting supervision & monitoring of CC activities. Monitoring is also being done from CBHC head office through mobile tracking & analyzing online report with necessary feedback (11).

Conceptual Framework of Community Clinics Monitoring Strategy

It is recognized that one of challenges of Community Clinic (CC) is monitoring. The Community Clinic Project started a trial of new CC monitoring strategy in 5 districts in 2014. The new monitoring strategy is depicted as below:



District CORE Team

District Focal Person (CC): Deputy Civil Surgeon (DCS) / Medical Officer Civil Surgeon (MO-CS) / Senior Health Education Officer (Sr. HEO)

Members:

- MO-CS
- Sr./Jr. HEO
- EPI Sup.
- DSI
- Public Health Nurse
- Statistician (12)

Upazila CORE Team

Upazila Focal Person (CC): - MO (CC) / MO (DC)

Members:

- Health Inspector (HI) (Selective)
- Assistant Health Inspector (AHI) (Selective)
- FPI (Selective)
- Sanitary Inspector (SI)
- Medical Technologist EPI (MT-EPI)
- Statistician (12)

Role of Community Clinics:

a) **Role in MDGs and SDGs:**

Bangladesh is one of the successful countries to achieve the goals of MDGs and now on the track of SDGs. To fulfill the rest of the works of MDGs and sustain them, implementation of Primary Health Care (PHC) will play vital role. And CCs are the key option to achieve PHC through community participation. If we can ensure the community participation at every stages and every level of society rest of the goals will be achieved within 2030 AD.

b) **Role in Family Planning:**

Though we consider the population as resource but we desire to achieve Net Reproduction Rate (NNR) will be 1. Which means 60% couple should use family planning methods. With this view CCs are providing family planning advices as well as family planning materials free of cost.

c) **Role in Immunization**

CCs are the centre from where EPI vaccines are given to the children and female of reproductive age. They also participate in NIDs program and provide Viamin-A capsule, thus contributing immunization.

d) **Role in Health Education:**

Education about personal health care is provided from CCs. as well as education about sanitation, importance of safe drinking water, avoiding risk factors etc are given regularly.

e) **Others Role:**

- It is first conduct point for any disease and act as an effective referral system by which many lives are saved.
- They provide ANC
- Conduct home delivery by SBAs
- Normal delivery is done in CCs
- People of the remote areas now can avail better health, nutrition & family planning services from the CCs at their door steps in a better environment even during disaster (12).

Community Participation and Community Clinics

In the modern form, the concepts of community participation took shape in the 1950s (Chowdhury, 1996). From the situation in the 1950s, when community development was perceived to be synonymous with community participation, the situation has now changed to one in which there appears to be no clear understanding of the relationship between the two (Abbott, 1995). Clearly, this impacts or changes perception of what constitutes community participation and development.

Definition and meaning of community participation

Participation is a rich concept that varies with its application and definition. The way participation is defined also depends on the context in which it occurs. For some, it is a matter of principle; for others, practice; for still others, an end in itself. Indeed, there is merit in all these interpretations as Rahnema (1992).

Participation is a stereotype word like children use Lego pieces. Like Lego pieces the words fit arbitrarily together and support the most fanciful constructions. They have no content, but do serve a function. As these words are separate from any context, they are ideal for manipulative purposes. 'Participation' belongs to this category of word (13).

Often the term participation is modified with adjectives, resulting in terms such as community participation, citizen participation, people's participation, public participation, and popular participation. The Oxford English Dictionary defines participation as "to have a share in" or "to take part in," thereby emphasizing the rights of individuals and the choices that they make in order to participate.

Arnstein (1969) states that the idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you. But there has been little analysis of the content of citizen participation, its definition, and its relationship to social imperatives such as social structure, social interaction, and the social context where it takes place. Brager, Specht, and Torczyner (1987) defined participation as a means to educate citizens and to increase their competence. It is a vehicle for influencing decisions that affect the lives of citizens and an avenue for transferring political power. However, it can also be a method to co- opt dissent, a mechanism for ensuring the receptivity, sensitivity, and even accountability of social services to the consumers. Armitage (1988) defined 'citizen participation as a process by which citizen's act in response to public concerns, voice their opinions about decisions that affect them, and take responsibility for changes to their community' (14).

Pran Manga and Wendy Muckle (1997) suggest that citizen participation may also be a response to the traditional sense of powerlessness felt by the general public when it comes to infl uencing government decisions: "people often feel that health and social services are beyond their control because the decisions are made outside their community by unknown bureaucrats and technocrats". Westergaard (1986) defined participation as "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control". This definition points toward a mechanism for ensuring community participation. The World Bank's Learning Group on Participatory Development (1995) defines participation as "a process through which stakeholders influence and share control over development initiatives, and the decisions and resources which affect them" (15).

A descriptive definition of participation programs would imply the involvement of a significant number of persons in situations or actions that enhance their well- being, for example, their income, security, or self- esteem (Chowdhury, 1996). Chowdhury states that the ideal conditions contributing towards meaningful participation can be discussed from three aspects:

1. What kind of participation is under consideration?
2. Who participates in it?
3. How does participation occur?

Evens (1974) also points out the importance of the following issues in order to assess the extent of community participation:

1. Who participates?
2. What do people participate in?
3. Why do people participate?

   There are:

   a) Cultural explanations (values, norms, and roles, etc.)
   b) Cognitive explanations (verbal skills and knowledge about the organizations)
   c) Structural explanations (alternatives, resources available, and the nature of benefit sought).
   d) Implications (how the benefit contributes to the ends or principles they value).

Oakley and Marsden (1987) defined community participation as the process by which individuals, families, or communities assume responsibility for their own welfare and develop a capacity to contribute to their own and the community's development. In the context of development, community participation refers to an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receive a share of project benefits (16).

Paul's five objectives to which community participation might contribute are:

1. Sharing project costs: participants are asked to contribute money or labor (and occasionally goods) during the project's implementation or operational stages.
2. Increasing project efficiency: beneficiary consultation during project planning or beneficiary involvement in the management of project implementation or operation.
3. Increasing project effectiveness: greater beneficiary involvement to help ensure that the project achieves its objectives and those benefits go to the intended groups.

4. Building beneficiary capacity: either through ensuring that participants are actively involved in project planning and implementation or through formal or informal training and consciousness- raising activities.
5. Increasing empowerment: defined as seeking to increase the control of the underprivileged sectors of society over the resources and decisions affecting their lives and their participation in the benefits produced by the society in which they live.

Objectives and organization of project- level activities are different from those of programs at the national or regional levels. The level or scope of the activity must be taken into consideration when defining objectives. According to Bamberger, three distinct kinds of local participation included the following:

1. Beneficiary involvement in the planning and implementation of externally initiated projects or community participation.
2. External help to strengthen or create local organizations, but without reference to a particular project, or local organizational development.
3. Spontaneous activities of local organizations that have not resulted from outside assistance or indigenous local participation (17).

The first two are externally promoted participatory approaches used by governments, donors, or NGOs, while the third is the kind of social organization that has evolved independently of (or despite) outside interventions. At a community level, there is a separation of community participation into two distinct approaches:

1. The community development movement and
2. Community involvement through conscientization

The basis of conscientization, according to De Kadt, started from "the existence of socioeconomic inequalities, the generation of these by the economic system, and their underpinning by the state" (18).

Community Development and Community Clinics

In the modern form, the concepts of community development took shape in the 1950s. The word development is fraught with ideological, political, and historical connotations that can greatly change its meaning depending on the perspective being

discussed. The following three definitions of development are most helpful and suitable in relation to this research project.

The first definition is provided by Korten (1990):

> Development is a process by which the members of a society increase their personal and institutional capacities to mobilize and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations.

Korten's definition emphasizes the process of development and its primary focus on personal and institutional capacity. It also touches on justice, equity, quality of life, and participation. The second definition is from Robinson, Hoare, and Levy's (1993) work. He adds the dimension of empowerment to Korten's idea of development (19).

Empowerment is a social action process that promotes participation of people, organisations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of life, and social justice. Finally, it emphasize that development must promote economic growth, but not at any cost (20).

The encouragement of economic growth must take account of and be restrained by three other equally important objectives: 1. Protection of the environment and consideration of the ecological impact of industrialization and commercialization. 2. Fair and equitable distribution as well as redistribution of goods and services to enable poorer people to get a fairer share of society's wealth and to participate fully in the economy. 3. Creation of opportunities for everyone to increasingly participate in the political, artistic and other activities of society.

Zachariah and Sooryamoorthy's criteria for development recognize the environmental and ecological facets of communities going through the process of development. The environment is considered an integral part of development, since any impacts on a person's environment also influence the state of well- being or welfare. Environment and development are thus linked so intricately that separate approaches to either environmental or developmental problems are piecemeal at best (20).

Community Participation vs. Community Development

The community development approach emphasizes self- help, the democratic process, and local leadership in community revitalization. Most community development work involves the participation of the communities or beneficiaries involved (21). Thus, community participation is an important component of community development and reflects a grassroots or bottom-u p approach to problem solving. In social work, community participation refers to ". the active voluntary engagement of individuals and groups to change problematic conditions and to influence policies and programs that affect the quality of their lives or the lives of others" (22).

One of the major aims of community development is to encourage participation of the community as a whole. Indeed, community development has been defined as a social process resulting from citizen participation (21). Through citizen participation, a broad cross-section of the community is encouraged to identify and articulate their own goals, design their own methods of change, and pool their resources in the problem-solving process. It is widely recognized that participation in government schemes often means no more than using the service offered or providing inputs to support the project (21).

This is contrasted with stronger forms of participation, involving control over decisions, priorities, plans, and implementation; or the spontaneous, induced, or assisted formation of groups to achieve collective goals. The most important and complicated issue bearing on local level planning and development is community participation. (21).

Effective community participation may lead to social and personal empowerment, economic development, and sociopolitical transformation (23). Yet there are obstacles: the power of central bureaucracies, the lack of local skills and organizational experience, social divisions, and the impact of national and transnational structures (23). There is no clear-cut agreement in the literature of community development on the nature of community participation or on a prescription to ensure it. The need for community participation in development and management is nonetheless accepted and recognized in the professional literature.

Future Plan:

Though there are many limitations but Prime Minister Sheikh Hasina trying hard and sole to establish the system, and providing the health care services to doorstep of every family. For achieving her dream some plans are taken:

- For every 6000 population there will be one CC
- MBBS doctors will appoint in every CCs
- Mini OT will establish in every CC so that CS can be performed
- All the CC will be digitalized
- A national database will established where every patients will be registered by service provider from root level
- A massive engineering project is already taken to built up infrastructure of CCs

Finance and Support:

1. GO-NGO:

From the beginning of RCHCIB, GO-NGO collaboration and partnership has been considered important for successful implementation of CC activities. The NGOs who were interested to work, signed MOU with RCHCIB. During the tenure of RCHCIB, 16 NGOs were partners. Most of the NGOs supported in community engagement through CG,CSG & local govt. representatives, some in operational research & others in nutritional activities. They accomplished the agreed tasks out of their own budget. Most of the NGOs & Institutes who have signed MOU with RCHCIB have been working with CBHC. Some other NGOs are coming forward to support CBHC (12).

2. Support from UN Agencies:

i. **WHO:** Rapid Assessment on CC; TA & Financial support for development of CHCP's training manual, trainer's guide, TOT, Financial support for Supervision & Monitoring; Development of documentary, Technical & financial support for best CC award, E-learning

ii. **JICA:** Financial support for CHCP, CG, CSG & Local Govt. representative training

iii. **Gavi The vaccine alliance:** Capacity development of CG, CSG in 20 low performing districts; Construction of 162 birthing rooms in 162 CCs of 162

Upazila, furniture & normal delivery equipments to 154 CCs; establishment of signboard of services & EPI schedule at CC in 21districts.

iv. **UNICEF:** Support for Water & Sanitation in some selected areas; Communication materials for improvement of MCH services & logistics for nutrition services through NNS

v. **USAID:** Support for supervision of CC as a follow up of training in some areas; Communication materials for improvement of MCH services.

vi. **TIKA:** Financial support for construction of 10 Community Clinics.

vii. **OMRON:** (Medical equipments manufacturing company, JAPAN) has donated 2000 Digital Blood Pressure Monitor & 1000 Glucometer to CCs.

i. **Save the children:** Support for follow up of training through supervision of CC (12).

3. Methods

3.1 Study Design: The proposed study was a cross-sectional study used mixed methods containing both quantitative and qualitative part.

- ❖ Quantitative part of the study was a cross-sectional study to collect data in respect of ways and means of community participation, quality of facilities and services of the community clinics and effects of community participation through CC approach.
- ❖ On the other hand, qualitative part of the study was conducted to disclose the opinions of opinion leaders in the communities through Key Informant Interview (KII) to determine the effects of community participation on specific areas of community health in rural Bangladesh.

3.2 Study Period: The study was conducted during the period of 2011-2018.

3.3 Study Places: The study was conducted in the randomly selected rural areas of the eight divisions of the country. The study was conducted in 32 randomly selected community clinics and its catchment communities.

3.4 Study Population:

- ❖ Community clinic
- ❖ Patients attending community clinics
- ❖ Household members (Adults ≥18 years)
- ❖ Key informants were opinion leaders of different sectors or dimensions.

Category of Key Informants:

Health authority, union parishad chairman & members, teachers (primary and high school), religious leaders (Imams/Muezzins), community leaders, social activists and members of CG and CSG.

3.5 Selection Criteria:

3.5.1 Inclusion Criteria

- ❖ The community clinics were selected randomly and administrative permission was obtained from the Directorate General Health Services and informing respective Civil Surgeon and Upazila Health and Family Planning Officer.

- ❖ Participants were included by taking informed written consent of each participant.
- ❖ Adult community participants who were aged ≥18 years were included in the study
- ❖ Participants were included in the study irrespective of sex.

3.5.2 Exclusion Criteria

- ❖ Participants who were severely ill both physically and mentally were excluded from the study.
- ❖ Visitors or tourists were excluded from the study.

3.6 Sample Size:

Sample size was calculated for the House hold survey by using the formula:

$n = z^2pq/d^2$; Where: n = desired sample size

p = 0.5 (as there was no estimate of any community participation prevalence rate for house hold survey, we were assuming 50% level of Community Participation for this survey).

q = 1 - p = 1- 0.5 = 50%

d = degree of error (absolute precision of the study assumed 0.05).

z = the reliability co efficient at the 95% C.I= 1.96.

$n = z^2pq/d^2 = (1.96)^2 \times 0.5 \times 0.5 \div (0.05)^2$

n = 384. Considering 5% non-response rate and rounding the sample size was (384 + 5%) = 404. Thus, the sample size was 404 from each district.

Total 16 districts were selected randomly from eight divisions (2 districts from each division). Total 6,464 (404 participants from each district) participants from 16 districts were included in the study. From each community, 202 participants were supposed to be included in the study. Out of 202 participants in each community, CHCP/HA/FWA (2), patients (73), household members (107) and key informants as opinion leaders (20) were intended to include. But the response rates were as follows:

Participants Account	Participants form Each Community	Total Sample Size (32 Communities)	Responded Sample Size	Response Rate
CHC / HA / FWA	02	02 X 32 = 64	63	98.4%
Patients	73	73 X 32= 2336	2238	95.8%
Household members	107	107 X 32= 3424	3285	95.9%
Key informants	20	20 X 32= 640	597	93.3%
Total	202	202 X 32= 6464	6183	95.7%

Considering non-response rate finally the sample size was 6,183 and overall response rate was 95.7% and non-response rate was 4.3% which was within expected range. At the community level from each household, one participant was included in the study randomly. On the other hand, total 32 community clinics (2 CC from each district) were chosen for data collection. Therefore, total sample size was 6183 participants and 32 community clinics.

3.7 Sampling Technique:

- The study was conducted using multistage sampling technique. Multistage sampling technique was used as follows:
- At first, 16 districts (2 from each division) were selected randomly from 8 administrative divisions of Bangladesh. Secondly, 32 community clinics (2 from each district) were selected randomly from those districts.
- The patients were selected randomly using systematic random sampling technique at the community clinic during weekly visits. On the basis of number patients attending in each day and number of patients to be included in study on that respective day, sampling interval was calculated and accordingly patients were included randomly following that sampling interval.
- The household members were selected randomly using systematic random sampling technique at the community kevel. In this case, household number (GR number) was used. In each community total households was the population and required sample 107 was the sample of the community. The sampling interval was calculated by dividing the population with the sample size in each community. Following that sampling interval households were selected and only one participant was selected randomly from each household.
- Key informants were selected conveniently from the community clinics, community, union parishad office, mosque etc.

3.8 Data Collection Instruments:

- Under the quantitative study design, data were collected with the help of a semi-structured questionnaire and checklist. The questionnaire was developed consisting of socio-economic status such as age, sex, education, employment status, household possession, utilization of local health care quality of cc facilities and services, reasons behind non utilization of health care facilities,

patterns of utilization in respect of type and patterns of health problem, pattern of community participation in different dimensions of community of clinics.

- Under the qualitative study design, data were collected by key informant interview (KII) with the help of an interview schedule.
- All the instruments were developed as draft followed by pre-test was done in two community clinics and in its catchment area other than study place. Finally the data collection instruments were finalized for data collection by necessary corrections and modifications following the findings of pretest.

3.9 Pre-testing: All the data collection instruments were pre-tested in two community clinics and related catchment areas of Gazipur district. One CC was obtained from Sripur upazila and another CC was obtained from Kaliakair upazila of the district.

3.10 Data Collection Technique

- **Descriptive Survey:** Data regarding logistics & physical facilities, human resources, political & administrative services of the community clinics were collected by face-to-face interview under the cross-sectional study design.
- **Patients Survey:** Data were collected from the patients by face-to-face interview at the community clinic during weekly visits under the cross-sectional study design.
- **Providers Survey:** Data were collected from the health care providers by face-to-face interview at the community clinic under the cross-sectional study design.
- **Household Survey:** Data was collected from the household members by face-to-face interview at the community level under the cross-sectional study design.
- **Key Informants Survey**: Data were collected from the key informants by Key Informants Interview (KII) at the community level or at the CC under the qualitative design.

3.11 Data Processing:

The collected data were checked, verified, categorized, coded and then entered into the computer for analysis with the help of SPSS software program. Any inconsistency and irrelevancy with data were checked carefully and corrected accordingly.

3.12 Data Analysis:

- **Quantitative data** were analyzed with the help of SPSS software. Both descriptive and inferential analysis was done to relate the participation with selected characteristics. Non-response of the patient was not replaced and that was excluded from the final analysis. The data analysis and data gathering were done simultaneously. Descriptive statistics included mean, standard deviation, frequency, percentage while inferential statistics included chi square test, 't' test and ANOVA. Statistical significance was tested at 5 per cent probability level at 95% confidence interval.
- **Qualitative data** were collected from key informants were analyzed by triangulation and summarizing.
- **Scoring of data on equipments**
  - ✓ Each equipment was assigned a score in the following way:
  - ✓ Score=2 if supply was sufficient and condition was perfect;
  - ✓ Score=1 if supply was insufficient and condition was perfect; Or Supply was sufficient and condition was not good;
  - ✓ Score=0 if supply was insufficient and condition was not good.
  - ✓ Then the total score for availability of equipments for each CC was calculated. CCs were then graded as Poor, Average and Good according to the given criteria.
- **Scoring of data on furniture/logistics**
  - ✓ Each furniture/logistics was assigned a score in the following way:
  - ✓ Score=2 if supply was sufficient and condition was good;
  - ✓ Score=1 if (supply was insufficient and condition was good)
  - ✓ Or (supply was sufficient and condition was not good);
  - ✓ Score=0 if supply was insufficient and condition was not good.
  - ✓ Then the total score for availability of furniture/ logistics for each CC was calculated and accordingly the CCs were graded as 'Poor', 'Average' and 'Good'.
- **Scoring of data on health services of CCs**
  - ✓ Each service was given a score 1 if it was provided, and score 0, if it was not provided. Then the total score for each CC regarding health services was calculated.
  - ✓ Finally the CCs were graded as per given criteria based on the total score.

❖ **Scoring of data on Health education service**

- ✓ Each issue was given a score 1 if it was covered, and score 0, if it was not covered.
- ✓ Then the total score for each CC regarding health education was calculated and accordingly the CCs were graded as per given criteria based on the total score.

❖ **Scoring of data on ppatients' satisfaction**

- ✓ Attempt was made to quantify the level of satisfaction by assigning score to different levels of satisfaction about each service in the following way:
- ✓ Score=2 if satisfied, Score=1 if partially satisfied, Score=0 if not satisfied
- ✓ So the total score for all 11 services given by a patient ranged from 22 to 0.
- ✓ Level of patient satisfaction about CC services was graded as 18-22: Good, 11-17: Average, ≤10= Poor

3.13 Ethical Implications:

There was no risk on study population as there was no hazardous procedure involved in the study. All the participants were informed about the purpose of the study. There was no loss of working hours of the studied population. There was no physical invasive procedure with the participants. Initially the ethical clearance for the study was obtained from Bangladesh Medical Research Council (BMRC). Before interviewing, an informed written consent was obtained from each participant. Before interview, they were also be briefed about the objectives and detailed procedure of the study and their voluntary participation in the study was sought.

3.14 Limitations of the study:

During this study following constrains were faced

- As a cross-sectional design, the study could have limitations in finding the patterns and effects of community participation.
- Data were collected from different hard to reach areas so sometimes it was difficult to reach the user of those areas.
- Sometimes it was difficult to interview all the members of CG & CSG due to their busy work schedule.
- Service users and community people were use to their local language so it took more times for data collection.
- Relevant literatures were insufficient for comparison of the study findings.

4.0 Results

Secion-1: Findings Related to Community Clinics

1.1 Geographical location and communication of community clinics (CCs)

Location and communication facilities are important for the Community Clinics to serve the local community. The study reveals the geographical location and communication of the community clinics.

1.1.1 Geographical location and communication of CCs

Table-1.1 provides the information related to location and communication facility of the Community Clinics (CC) surveyed. Out of 32 CCs, 23 (71.9%) were located in the middle of the catchments area and were easy to reach, 8 (25.0%) were near to residing area of the village and only 1 (3.1%) was located near to flood prone area. No CC was located either out of the surveyed village or in marshy and water logged land. More than two-thirds of the CCs (68.8%) were located in high land and the remaining CCs were located either in low land (28.1%) or low land with water logging (3.1%). Almost all the CCs (93.8%) were easy to access and only 2 (6.3%) were difficult to access.

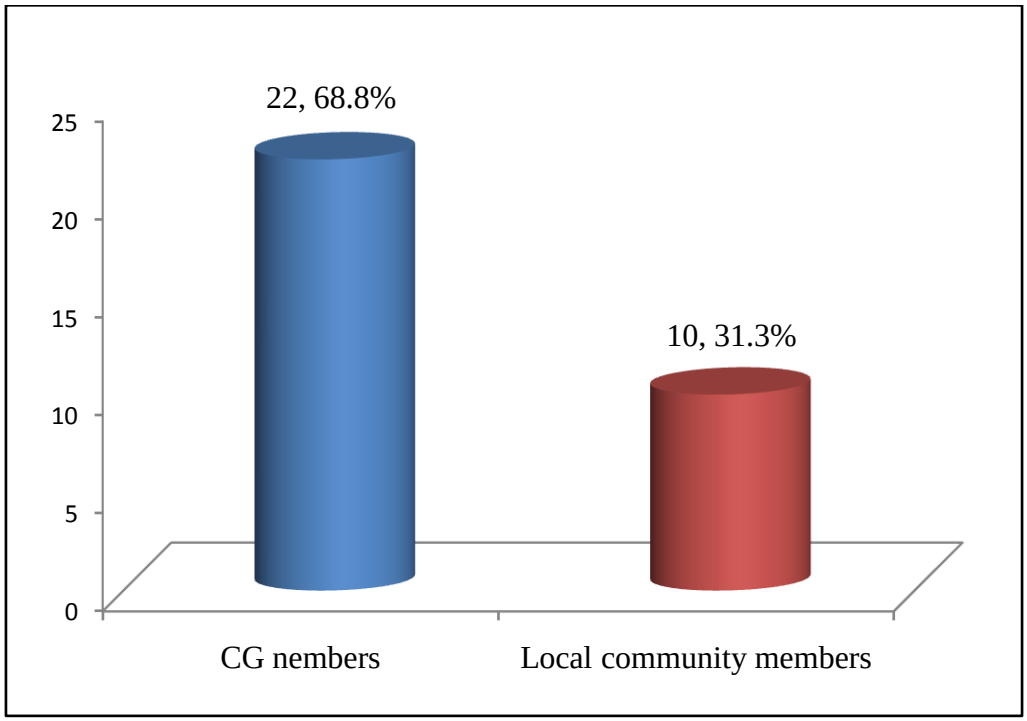
Table-1.1: Location and Communication [n=32]

Attributes	Frequency	Percentage
Accessibility to the community clinic		
Easy to access	30	93.8
Difficult to access	02	6.3
Location of the CC		
Middle of the catchments area and easy to reach	23	71.9
Near to residing area of the village	08	25.0
Near to flood prone area	01	3.1
Level of land where the CC is located		
High land	22	68.8
Low land	09	28.1
Low land with water logging	01	3.1

1.1.2 Distribution of CCs by land provider

Figure-1.1 shows the land where CCs were located was donated exclusively by the community members. In 22 CCs (68.8%), CG members donated land and in the remaining 10 CCs (31.3%), local members of community donated it. Government did not donate any land for the sample CCs.

Figure-1.1: Distribution of CCs by land provider



1.2 Infrastructure of Community Clinics (CCs)

1.2.1 Physical facilities of CC

The table-1.2a & 1.2.b shows the infrastructural facilities of the sample CCs. Of all, 31 CCs had govt. approved (450 sq. ft) size, only 1 CC was smaller than Govt. approved size. Quality of construction of the CCs, on an average was good. Door's quality was good in almost all the CCs (96.9%), Window's quality was good in slightly more than four-fifths of the CCs (81.3%); but Roof's quality was good in less than two-third of the CCs (62.5%). Among all 81.3% CCs consisted of two rooms and the rest 18.8% had three rooms.

Regarding toilet facilities is important more than two-thirds (68.8%) of the CCs had only one toilet while 31.3% had two toilets. Very much alarming fact as reviewed by the study that half of the toilets were dirty which were found a threat for healthy environment of the facilities.

Regarding safe drinking water supply, only 10 (31.3%) had tube-wells in functioning condition. 20 (62.5%) CCs had tube-wells installed but not functioning. 2 (6.3%) CCs did not have any tube-well.

In respect of waiting facility for the patients, almost all the CCs (30) had waiting space for patients well equipped with bench and other facilities. In only 2 CCs patients had to remain standing.

Regarding electricity for proper functioning of a CC, only 18 (56.3%) CCs had electric connection.

In respect of sufficiency of chair/table for health worker, presence of hotline number at the CC, for providing services, 27 CCs (84.4%) had sufficient number of chair/table, only 8 CCs (25.0%) had hotline of which 1 was inactive. With regards to providers, availability of HA (59.40%) and FWA (46.90%) were rather low. On the other hand CHCP was available in most (90.60%) of the CCs.

Regarding security of the CCs, only 2 CCs had night guards, 16 were kept under lock and key and security of the remaining 14 were maintained either by CG and neighboring household or by local people

Table-1.2a: Physical facilities of CC [n=32]

Attribute	Frequency	Percentage
Size of the community clinic		
Govt. approved (450 sqft)	31	96.9
Smaller than Govt. approved size	1	3.1
Quality of construction of the CC		
Good door's quality	31	96.9
Good window's quality	26	81.3
Good roof's quality	20	62.5
Number of Rooms in the CC		
Two	26	81.3
Three	6	18.8
Number of latrine		
One	22	68.8
Two	10	31.3
Condition of latrine		
Clean	16	50.0
Dirty	16	50.0
Condition of tube-wells installed at CCs		
Have and functioning	10	31.3
Have but not functioning	20	62.5
Do not have	2	6.3
Waiting space for patients		
Well equipped with bench and others	30	93.8
Not equipped (Patients remain standing)	2	6.3

Table-1.2b: Physical facilities of CC [n=32]

Attribute	Frequency	Percentage
Electricity supply at the CC		
Present	18	56.3
Sufficiency of chair/table for providing services		
Sufficient	27	84.4
Any hotline number at the CC		
Present	8	25.0
Whether the hotline is active (n=8)		
Yes	7	87.5
Presence of night guard at the CC		
Yes	2	06.3
No	30	93.7
Maintenance of security of the CC		
Yes	20	62.5
No	12	37.5
Security of the CC is maintained by		
Guard	2	6.3
Lock and key	16	50.0
CG and neighboring household take care	8	25.0
Local people	6	18.8

1.3 Availability of Equipments in Community Clinics (CCs)

The study assessed sufficiency of equipment including (i) Primary medical kits (scissors, forceps) (ii) BP instrument with stethoscope, (iii) Tool kits (1-gauge, 6 masks, 4 thermometers, 2 timers, one sensor kits) (iv) Insecticide spraying machine (v) Bathroom scale (vi) Kerosene stove (vii) Hanging scale (viii) Umbo bag and penguin sucker (ix) Urinary catheter (x) Syringe (xi) Vaginscope (xii) Flash cards titled "Sonali Alo" (xiii) Others were available in the CCs.

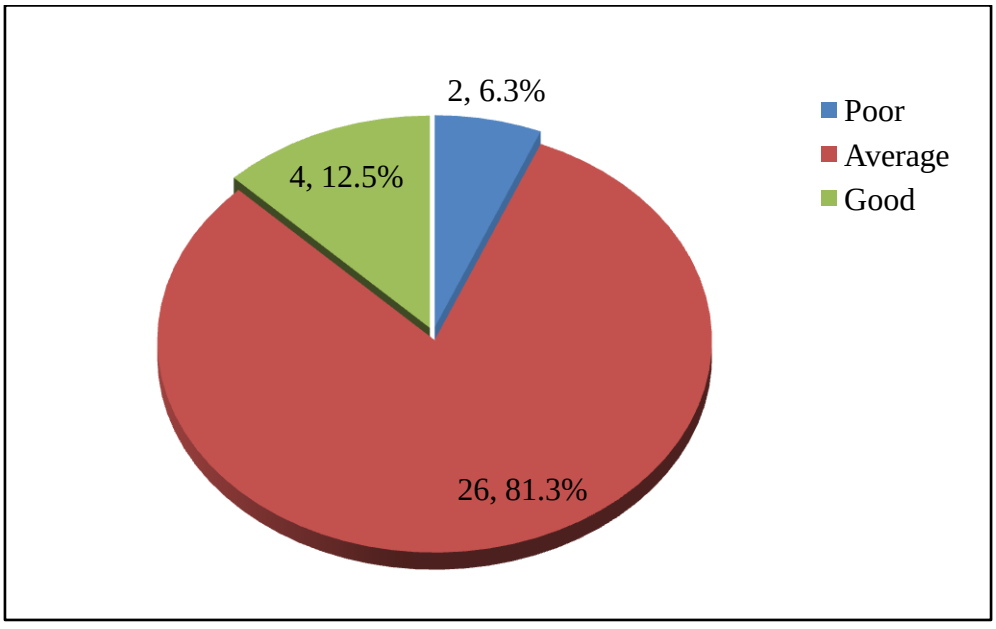
Each equipment was assigned a score in the following way:

Score=2 if supply was sufficient and condition was perfect; Score=1 if supply was insufficient and condition was perfect; Or Supply was sufficient and condition was not good; Score=0 if supply was insufficient and condition was not good. Then the total score for availability of equipments for each CC was calculated. CCs were then graded as Poor, Average and Good according to the given criteria.

1.3.1 Availability of equipments

Figure-1.2 shows the distribution of the CCs by availability of equipment. The overall picture of availability of equipment was not encouraging. Only 4 CCs (12.5%) were in the 'Good' category, more than four-fifths (81.3%) were 'Average' and 6.3% were 'Poor' category.

Figure-1.2: Availability of equipments (n=32)



1.3.2 Availability of equipments in CCs by different divisions

Table-1.3 shows that availability of equipments was average in all four CCs in Dhaka, Khulna and Barisal division while Sylhet, Rajshahi, Chittagong & Mymensingh division had 3(75.0%) CCs with average availability of equipments and 2(50.0%) average, 1(25.0%) good and 1(25.5%) CC had poor availability of equipments in Rangpur division. This difference was not statistically significant (Fisher's Exact, p>0.05)

Table-1.3 Association between availability of equipments in different division

Division	Availability of equipments in CC			Total f(%)	Significance (Fisher's Exact)
	Poor f(%)	Average f(%)	Good f(%)		
Dhaka	0(0.0)	4(100.0)	0(0.0)	4(100.0)	df= 14 p = 0.873
Sylhet	0(0.0)	3(75.0)	1(25.0)	4(100.0)	
Rajshahi	0(0.0)	3(75.0)	1(25.0)	4(100.0)	
Chittagong	0(0.0)	3(75.0)	1(25.0)	4(100.0)	
Khulna	0(0.0)	4(100.0)	0(0.0)	4(100.0)	
Rangpur	1(25.0)	2(50.0)	1(25.0)	4(100.0)	
Mymensingh	1(25.0)	3(75.0)	0(0.0)	4(100.0)	
Barisal	0(0.0)	4(100.0)	0(0.0)	4(100.0)	
Total	2(6.3)	26(81.3)	4(12.5)	32(100.0)	

1.3.3 Reasons of inadequacy of equipment in CCs

Table-1.4 shows the reasons of inadequacy of equipments are varied: more than two-thirds reported non-availability of equipments, 37.50% reported that equipments were out of order, 3.1% reported that equipments were lost or stolen and quite a few (12.50%) did not know about sufficiency of equipments in the CCs.

Table-1.4: Reasons of inadequacy of equipment (Multiple Responses)

Reasons	Frequency	Percentage
Out of order	12	37.5
Lost / Stolen	01	3.1
Not available	22	68.8
Don't Know	04	12.5

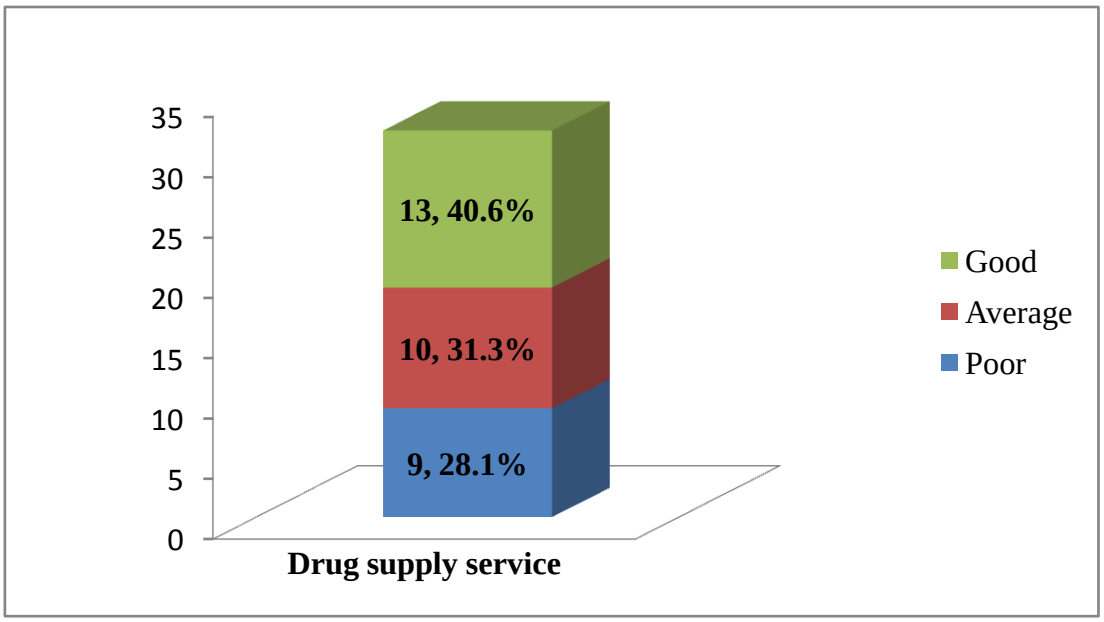
1.4 Drug Supply Services at Community Clinics (CCs)

In order to find the state of drug supply services, attributes such as (i) Availability of all essential drugs (30), (ii) Supply of essential drugs in due time, (iii) Sufficiency of Quantity of essential drugs supplied, (iv) Sufficiency of Quantity of essential drug dispensed, (v) Dispensing of essential drugs by assigned person were considered. Each attribute was given a score 1 if it was satisfied, and score 0, if the attribute was not satisfied. Then the total score for each CC regarding drug supply services was calculated. Finally the CCs were graded as per given criteria based on the total score.

1.4.1 Level of drug supply services at CCs

Figure-1.3 provides the distribution of the sample CCs as per grading based on drug supply services score. It is found that as far as drug supply services concerned, the situation was rather discouraging as only 40.6% CCs were graded as 'Good' where as about one-third (31.3%) were just 'Average' and as high as about one-third (28.1%) were 'Poor'.

Figure-1.3: Level drug supply services (n=32)



1.4.2 Drug supply services at CCs by different divisions

Table-1.5 shows that 3(75.0%) CCs in Rangpur division had poor drug supply service while 4(100.0%) had good drug supply service in Dhaka division and this difference was not statistically significant (Fisher's Exact, p>0.05)

Table-1.5: Drug supply services at CCs by different divisions

Division	Drug supply services in CCs			Total f(%)	Significance (Fisher's Exact)
	Poor f(%)	Average f(%)	Good f(%)		
Dhaka	0(0.0)	0(0.0)	4(100.0)	4(100.0)	
Sylhet	2(50.0)	2(50.0)	0(0.0)	4(100.0)	
Rajshahi	1(25.0)	2(50.0)	1(25.0)	4(100.0)	
Chittagong	0(0.0)	1(25.0)	3(75.0)	4(100.0)	
Khulna	0(0.0)	1(25.0)	3(75.0)	4(100.0)	df= 14
Rangpur	3(75.0)	1(25.0)	0(0.0)	4(100.0)	p = 0.110
Mymensing	1(25.0)	2(50.0)	1(25.0)	4(100.0)	
Barisal	2(50.0)	1(25.0)	1(25.0)	4(100.0)	
Total	9(28.1)	10(31.3)	13(40.6)	32(100.0)	

1.5 Furniture and logistics at the Community Clinics (CCs)

A stock of furniture /logistics including (i) Labor table, (ii) Investigation table, (iii) One steel almirah with two compartments (iv) Two back rest bench (for 4-5 person), (v) Two mat/cushion bed for service receiver, (vi) One black board with stand, (vii) Wooden/plastic chair, (viii) One table with one-drawer, (ix) Patient's register book, (x) Report card, (xi) Provider's attendance book, (xii) Laptop, (xiii) Internet facility (Modem) were considered.

Each Furniture/Logistics was assigned a score in the following way:

Score=2 if supply was sufficient and condition was good;

Score=1 if (supply was insufficient and condition was good)

Or (supply was sufficient and condition was not good);

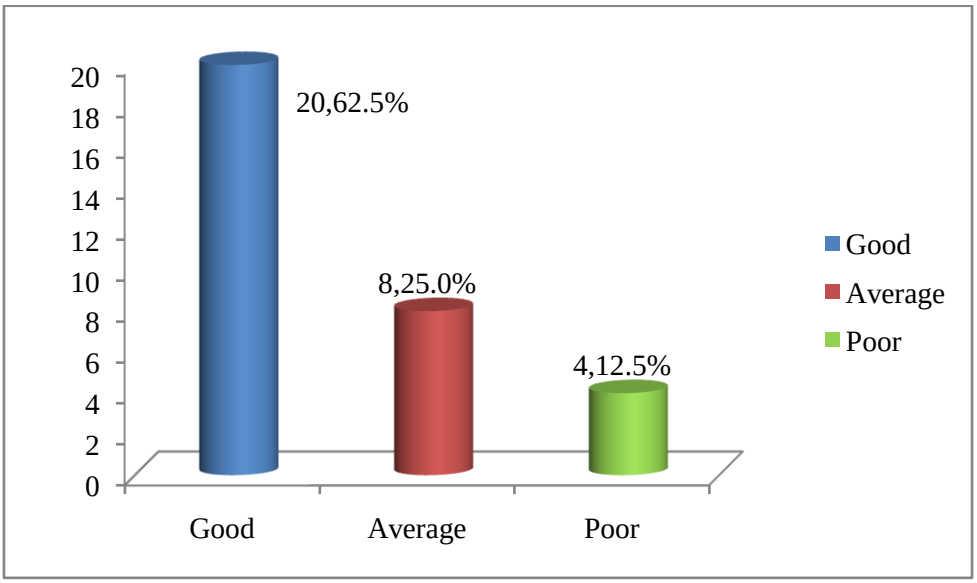
Score=0 if supply was insufficient and condition was not good.

Then the total score for availability of furniture/ logistics for each CC was calculated and accordingly the CCs were graded as 'Poor', 'Average' and 'Good'.

1.5.1 Availability of furniture and logistics

Figure-1.4 shows the distribution of the CCs by availability of furniture/ logistics. The overall picture could not be termed as encouraging. Less than two-third CCs (62.5%) was in the 'good' category, 25.0% were 'average' and 12.5% were in 'poor' category.

Figure-1.4: Availability of furniture and logistics



1.5.2 Availability of Furniture and Logistics by Division

Table-1.7 shows that in Khulna division 4(100.0%) and in Sylhet division 4(100.0%) CCs had good level of availability of furniture whereas Barisal 2(50.0%) had poor and Rangpur 4(100.0%) had average level of availability of furniture/logistics. This differences was statistically significant (Fisher's Exact, $p<0.05$).

Table-1.6: Availability of furniture in CCs by different divisions

Divisions	Availability of furniture/logistics in CC			Total f(%)	Significance (Fisher's Exact)
	Poor f(%)	Average f(%)	Good f(%)		
Dhaka	1(25.0)	1(25.0)	2(50.0)	4(100.0)	df= 14 p = 0.031
Sylhet	0(0.0)	0(0.0)	4(100.0)	4(100.0)	
Rajshahi	0(0.0)	1(25.0)	3(75.0)	4(100.0)	
Chittagong	0(0.0)	1(25.0)	3(75.0)	4(100.0)	
Khulna	0(0.0)	0(0.0)	4(100.0)	4(100.0)	
Rangpur	0(0.0)	4(100.0)	0(0.0)	4(100.0)	
Mymensing	1(25.0)	1(25.0)	2(50.0)	4(100.0)	
Barisal	2(50.0)	0(0.0)	2(50.0)	4(100.0)	
Total	4(12.5)	8(25.0)	20(62.5)	32(100.0)	

1.5.3 Reasons of insufficiency of furniture/logistics

Reasons of insufficiency of furniture/logistics were either these were not supplied (59.4%) or these were damaged (40.6%) which is shown in table-1.8.

Table-1.7: Reasons of insufficiency of furniture/logistics

Reasons of insufficiency	Frequency	Percentage
Not supplied	19	59.4
Damaged	13	40.6

1.6 Health services provided by the Community Clinics

Community Clinics provide various health services including preventive care like health education, drug supply, diagnostic services and clinical care like treatment to patients including antenatal and delivery care.

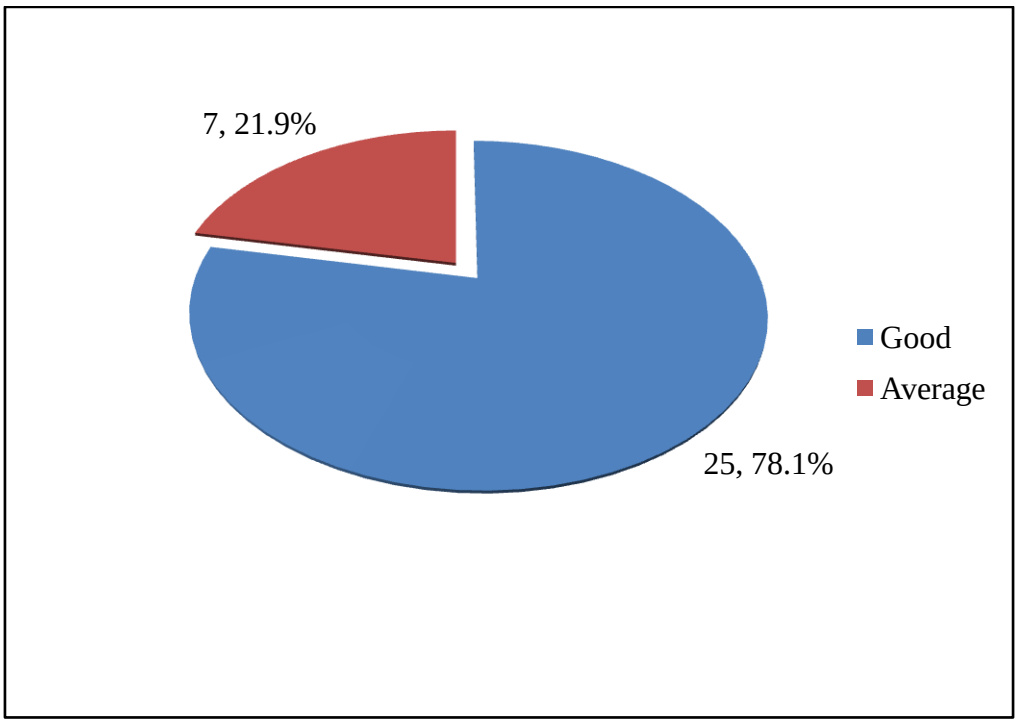
In order to assess the state of health services provided by the CCs, serviceslike(i) Reproductive and FP services, (ii) Integrated management of childhood illness (IMCI), (iii) Maternal and neonatal health care, (iv) EPI, ARI, (v) Nutritional education and micro-nutrient supplements, (vi) Health and Family Planning Education & counseling, (vii) Communicable disease control, (viii) Identification of emergency & complicated cases with referral to higher facilities for better manage, (ix) Screening of Non Communicable diseases like- Hypertension, Diabetes, Arsenicosis, Cancer, Heart diseases, Autism etc& referral, (x) Conduction of normal delivery, (xi) Treatment of minor ailments & first aid of simple injuries and handling of emergency cases like Poisoning, Snake bite, burn etc, (xii) Establishing effective referral linkage with higher Facilities, (xiii) Establishing an effective MIS and database of Community, (xiv) Other services identified by GOB under ESP to be Provided were considered.

Each service was given a score 1 if it was provided, and score 0, if it was not provided. Then the total score for each CC regarding health services was calculated. Finally the CCs were graded as per given criteria based on the total score.

1.6.1 State of health services of the Community Clinics

Figure-1.5 shows that majority (78.1%) of the CCs were graded as 'Good' in respect of health services provision as requirements of the people while 21.9% CCs were graded as 'Average'.

Figure-1.5: State of Health Care Provision by the Community Clinics



1.6.2 State of health services of the CCs by division

Table-1.9 shows that state of health care provision was good in 100% CCs of Sylhet, Chittagong, Khulna & Mymensingh division whereas average in Dhaka (50.0%) & Rangpur (75.0%) division. This difference was not statistically significant (Fisher's Exact, p>0.05).

Table-1.8: State of healthcare provision in CC by Division

Division	State of healthcare provision in CCs		Total f(%)	Significance (Fisher's Exact)
	Average f(%)	Good f(%)		
Dhaka	2(50.0)	2(50.0)	4(100.0)	df = 14 p = 0.114
Sylhet	0(0.0)	4(100.0)	4(100.0)	
Rajshahi	1(25.0)	3(75.0)	4(100.0)	
Chittagong	0(0.0)	4(100.0)	4(100.0)	
Khulna	0(0.0)	4(100.0)	4(100.0)	
Rangpur	3(75.0)	1(25.0)	4(100.0)	
Mymensingh	0(0.0)	4(100.0)	4(100.0)	
Barisal	1(25.0)	3(75.0)	4(100.0)	
Total	7(21.9)	25(78.1)	32(100.0)	

1.6.3 Health education services of the Community Clinics

All the community clinics are concerned about provision of health education services to the community members on important health issues like(i) Ante-natal care (ANC), (ii) Delivery plan, (iii) Post natal care (PNC), (iv) Child Health and Nutrition, (v) Growth monitoring of children, (vi) Common health problems, (vii) Family planning and (viii) Nutrition.

Each issue was given a score 1 if it was covered, and score 0, if it was not covered. Then the total score for each CC regarding health education was calculated and accordingly the CCs were graded as per given criteria based on the total score.

Table 1.9 shows the distribution of CCs by health issues included in health education. Almost all (96.9%) of the CCs were graded as 'Good' as far as providing health education was concerned and only 1 CC (3.1%) was graded as 'Average'.

Table-1.9: State of Health Education Services

State of Health Education	Frequency	Percentage
Average	01	3.1
Good	31	96.9
Total	32	100.0

1.6.4 State of health education services of the CC by division

Table-1.11 revealed that state of health education services in CCs was good (100.0%) almost all except Dhaka (75.0%) division. This difference was not statistically significant (Fisher's Exact, p>0.05).

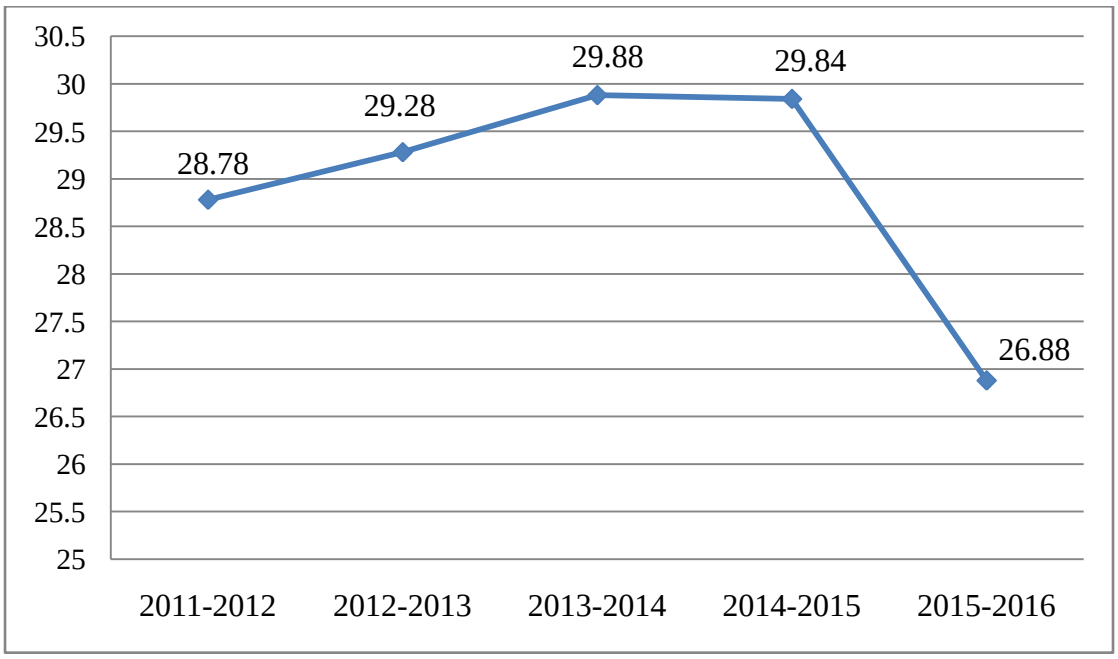
Table-1.10: State of Health education services in CCs by division

Division	State of Health Education Services in CCs		Total f(%)	Significance (Fisher's Exact)
	Average f(%)	Good f(%)		
Dhaka	1(25.0)	3(75.0)	4(100.0)	df = 14 p = 1.000
Sylhet	0(0.0)	4(100.0)	4(100.0)	
Rajshahi	0(0.0)	4(100.0)	4(100.0)	
Chittagong	0(0.0)	4(100.0)	4(100.0)	
Khulna	0(0.0)	4(100.0)	4(100.0)	
Rangpur	0(0.0)	4(100.0)	4(100.0)	
Mymensingh	0(0.0)	4(100.0)	4(100.0)	
Barisal	0(0.0)	4(100.0)	4(100.0)	
Total	1(3.1)	31(96.9)	32(100.0)	

1.7 Trends of essential drugs supply at the Community Clinics

Figure-1.6 shows the number of types of essential drugs supplied at the CC during the last five financial years preceding the survey year. It was found that the average number of types of drugs supplied did not vary remarkably during the period under consideration; it varied from 26.88 in 2015-2016 to 29.88 in 2013-2014. During the period 2011-2012 to 2014-2015 the average was almost the same; but during 2015-2016 it dropped by about 3 items.

Figure-1.6: Trends of drug supply at the CC during the last five financial years



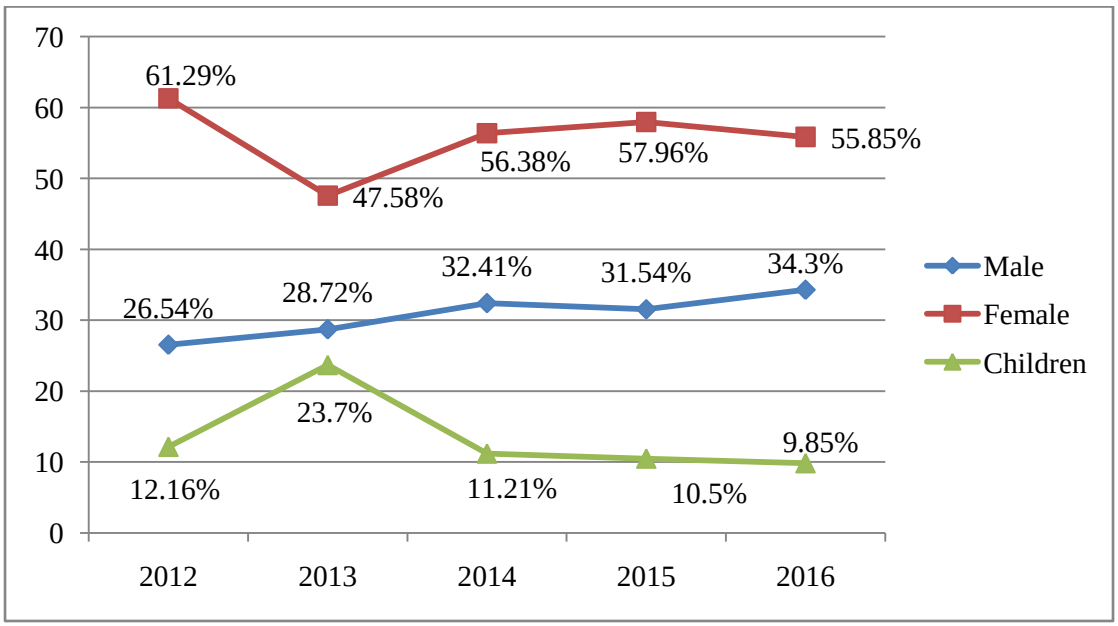
1.8 Trends of services utilization at the Community Clinics

1.8.1 Number of patients utilizing CC services during the last five years

Figure-1.7 shows the number of patient utilized CC services during the last five years. It was found that the number of patient utilizing CC services increased over the years. Female formed the majority of the service users followed by male and the by children.

In 2012 total number of patients was 213422 of whom 26.54% were male, 61.29% were female and 12.16% were children.
In 2013 total number of patients was 225754 of whom 28.72% were male, 47.58% were female and 23.70% were children.
In 2014 total number of patients was 232839 of whom 32.41% were male, 56.38% were female and 11.21% were children.
In 2015 total number of patients was 244810 of whom 31.54% were male, 57.96% were female and 10.50% were children.
In 2016 total number of patients was 252700of whom 34.30% were male, 55.85% were female and 9.85% were children.
During the last five years, total number of patients was 1169525 of whom 30.85 % were male, 55.79% were female and 13.35% were children.

Figure-1.7: Number of patients utilizing CC services during the last five years



1.8.2 Comparison of average number of patient treated at CCs by division

Table- 1.12 shows that average 45549.75 (±7392.799) patients were treated in CCs of Sylhet division was higher whereas average 26053.00 (±5722.494) patients were treated in CCs of Dhaka division was lower and this difference was statistically significant (ANOVA, p<0,01).

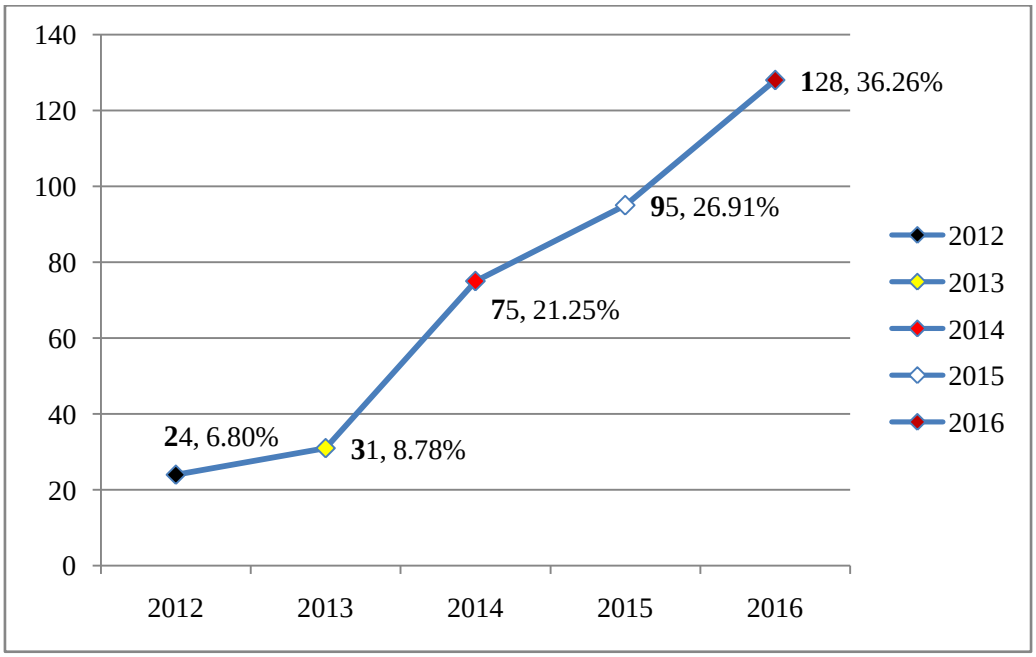
Table-1.11: Comparison of average number of patient treated by division

Divisions	Average patients treated	Significance (ANOVA)
Dhaka	26053.00 (±5722.494)	
Sylhet	45549.75 (±7392.799)	
Rajshahi	43482.25 (±2602.921)	
Chittagong	34078.25 (±5584.428)	F = 4.231
Khulna	39726.25 (±5467.104)	df = 7
Rangpur	36597.75 (±7755.359)	p = 0.004
Mymensingh	32093.00 (±3379.639)	
Barisal	34801.00 (±8597.865)	
Total	36547.66 (±8063.609)	

1.8.3 Number of normal delivery conducted at the CC during the last five years

Figure-1.8 reveals the information regarding the number of normal delivery conducted at the CC during the last five years. It was found that the number of normal delivery conducted at the CC was increased over time – from 24 in 2012 to 128 in 2016.

Figure-1.8: Number of normal delivery conducted at the CC during the last five years



Section-2: Findings Related to CC Service Providers

2.1 Background information of the CC service providers

2.1.1 Socio-demographic characteristics of service providers

Table 2.1 shows the findings related to socio-demographic characteristics of service providers of the CCs. Out of 63 Providers, 29 (46.0%) were CHCP, 19 (30.2%) were HA and 15 (23.8%) were FWA. Gender mix of the providers was almost equal: females (52.4%) slightly outnumbering the males (47.6%). More than half of the providers (58.7%) were aged 25 – 34 years, about one-fifth (20.6%) belonged to age group 35 – 44 years and remaining (20.6%) were aged 45 years or above. Thus the providers consisted mostly of young people; about four-fifths (79.3%) were aged 25 – 45 years. Mean age of the providers was 35.2 years with SD 10.03 years. Educational status of the providers was quite high: each 30.2% were graduates and masters followed by 31.7% had HSC and only 7.9% had SSC kevel education.

Table 2.1: Socio-demographic characteristics of providers [n=63]

Socio-demographic attribute	Frequency	Percentage
Designation		
CHCP	29	46.0
HA	19	30.2
FWA	15	23.8
Age (in years)		
25 – 34	37	58.7
35 – 44	13	20.6
45 – 54	13	20.6
Mean ± SD	35.2±10.03	
Gender		
Male	30	47.6
Female	33	52.4
Educational status		
SSC	05	7.9
HSC	20	31.7
Graduation	19	30.2
Masters	19	30.2

2.1.2 Type of service providers by sex

Table-2.2 shows that males were higher (55.9%) among CHCP and females were higher (100.0%) among FWAs. On the other hand among HAs males (50.0%) and females (50.0%) were equally distributed and it was statistically significant (Fisher's Exact, $p<0.05$).

Table-2.2: Type of service provider by sex

Service providers	Sex		Total f(%)	Significance (Fisher's Exact)
	Male f(%)	Female f(%)		
CHCP	19(55.9)	15(44.1)	34(100.0)	
HA	11(50.0)	11(50.0)	22(100.0)	df= 2
FWA	0(0.0)	7(100.0)	7(100.0)	p = 0.022
Total	30(47.6)	33(52.4)	63(100.0)	

2.1.3 Service providers by their educational status

Table-2.3 revealed that majority i.e. 73.6% CHCP had graduate and above level of education whereas majority i.e. 50.0% HA had HSC level of education and 57.1% FWA had SSC level of education. This difference was statistically significant (Fisher's Exact, $p<0.01$).

Table-2.3: Service providers by their educational status

Service providers	Educational status				Total f(%)	Significance (Fisher's Exact)
	S.S.C f(%)	HSC f(%)	Graduation f(%)	Masters f(%)		
CHCP	1(2.9)	8(23.5)	11(32.4)	14(41.2)	34(100.0)	
HA	0(0.0)	11(50.0)	7(31.8)	4(18.2)	22(100.0)	df= 6
FWA	4(57.1)	1(14.3)	1(14.3)	1(14.3)	7(100.0)	p = 0.002
Total	5(7.9)	20(31.7)	19(30.2)	19(30.2)	63(100.0)	

2.2 Professional Training

2.2.1. Service providers by professional training

Professional training is very important for improving skills and keeping up-to-date with emerging knowledge. All of the 63 providers (100.0%) received professional training in one or more selected health issues. Considering the individual issue, the percentage of providers received training was not at all encouraging. Only on two health issues, more than three-fourths of the providers received training while other health issues included Nutrition (87.30%) and Arsenicosis (77.80%). Well below two-thirds (60.3%) received training on two issues including CC management and Autism. Around half of the providers received training on Tuberculosis (57.10%), Computer (57.10%), Basic training of CHCP (54.00%) and Refresher training of CHCP (49.20%). In respect of the remaining health issues, percentage of the providers received training were very discouraging; it was lowest in SBA training for female CHCP (15.90%) followed by EOC training (20.60%), ESP training (28.60%), Training on NCDs (38.10%) and training on MIS (44.40%). This scenario emphasizes that much has yet to be done for training the service providers of the CCs (Table 2.4**)**.

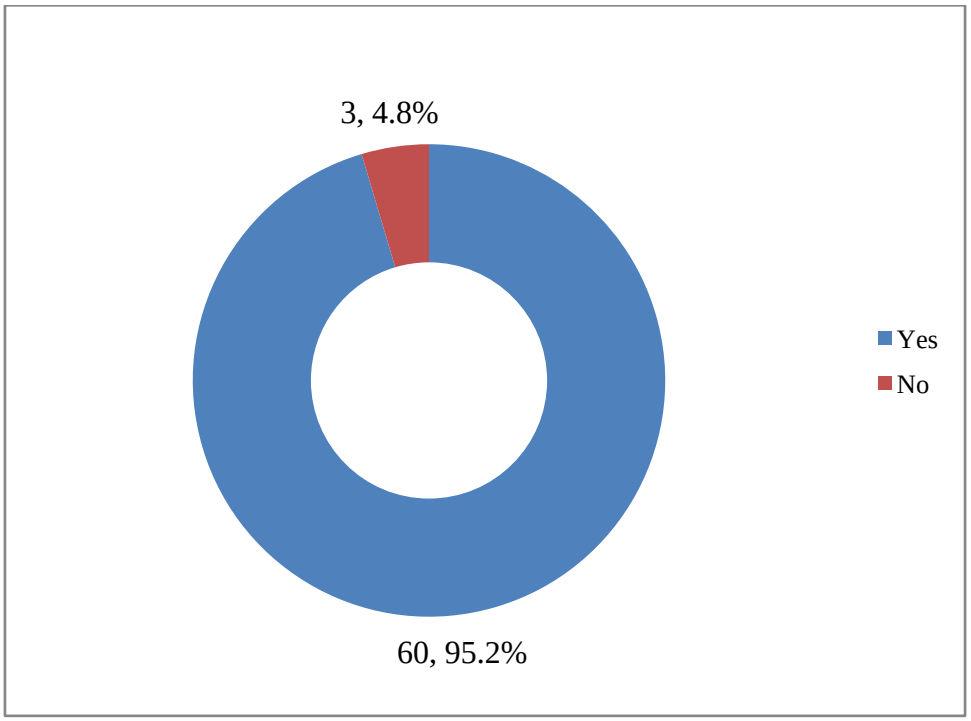
Table 2.4: Distribution of the Service Providers by Professional Training [n=63]

Attribute	Frequency	Percentage
Received any professional training		
Yes	63	100.0
Type of training received		
ESP training	18	28.6
EOC training	13	20.6
CC management	38	60.3
Basic training of CHCP	34	54.0
Refresher training of CHCP	31	49.2
SBA training for female CHCP	10	15.9
Training on Nutrition	55	87.3
Training on computer	36	57.1
Training on autism	38	60.3
Training on arsenicosis	49	77.8
Training on tuberculosis	36	57.1
Training on NCDs	24	38.1
Training on MIS	28	44.4

2.2.2 Opinion on necessity of training to improve skills

Almost all (95.2%) of the providers opined about the necessity of relevant professional training to improve skills.

Figure-2.1: Opinion on necessity of training to improve skills



2.3 Workload of the health service providers at Community Clinics

2.3.1 Workload of the health workers at the CCs

Table 2.5 shows about the workload of the CC service providers. Regular attendance is necessary for providing service to the patients and attendance rate of the service providers was found very high and almost all the providers (96.8%) attended the clinics in time every day. Most (90.5%) of the providers worked 5–6 hours per day while less than 10% worked only 3–4 hours per day. Two-thirds worked 6 days per week and the remaining one-third worked only 2-3 days per week. 96.8% maintained Register book / Report card regularly.

Table 2.5: Workload of the health workers at the CCs [n=63]

Attribute	Frequency	Percentage
Duration of work per day (Hours)		
3-4 hours	06	09.5
5-6 hours	57	90.5
Number of working days		
6 days per week	42	66.7
2-3 days per week	21	33.3
Maintain Register book / Report card regularly		
Yes	61	96.8
No	01	01.6
Sometimes	01	01.6

2.3.2 Duration of work per day and designation of service providers

Table-2.6 revealed that all 34(100.0%) CHCP were worked for 5-6 hours per day while 4(18.2%) HA and 2(28.6%) FWA worked for 3-4 hours per day. This difference was statistically significant (Fisher's Exact, $p<0.01$)

Table-2.6: Association between duration of work per day and designation of service providers

Service providers	Duration of work per day (Hrs)		Total f(%)	Significance (Fisher's Exact)
	3-4 f(%)	5-6 f(%)		
CHCP	0(0.0)	34(100.0)	34(100.0)	
HA	4(18.2)	18(81.8)	22(100.0)	df= 2
FWA	2(28.6)	5(71.4)	07(100.0)	p = 0.005
Total	6(9.5)	57(90.5)	63(100.0)	

2.4 Service coverage at the Community Clinics

2.4.1 Service coverage at the CCs

Table 2.7 shows the services covered by the providers of the CCs. On average they treated 36 patients per day of which 11 were male, 20 were female and only 5 were children. Number of females treated per day was almost twice the number of males and number of children consisted of one-fourth of the females. Number of patients provided FP services was low – on an average only 6 females, 2 males and 1 child received FP services per day. All 63 CCs had referral system and 98.4% maintained referral slip. Most CCs referred the patients to Primary level facility UHC (71.4%). Very few patients were referred to Secondary level facility like District hospital (25.4%) or Tertiary level facilities like Medical college hospital (14.3%). In 19.0% cases patients were referred to USC (Union Sub-center). Regular visit to CCs is necessary for delivering service to the patients. Most FWAs (95.2%) visited the CC every week but only 55.6% of them made home visit regularly. 74.3% of providers who made home visits did it 2-3 days per week, 14.3% made home visit more than 3 days per week. 11.4% made home visits less than 2 days per week. FWAs making home visit mostly provided EPI (Vaccination) services (86.1%), more than half (58.3%) provided FP (Contraceptive) services and, only one-third provided DOTS (TB).

Table-2.7: Service Coverage at the CCs [n=63]

Attribute	Frequency	Average
Average number of patients treated on the day of survey		
Male	685	10.87
Female	1252	19.87
Child	341	05.41
Total	2278	36.16
Average number of patients provided FP and MCH services on the day of survey		
Male	132	02.1
Female	392	6.22
Child	83	1.32
Total	607	9.63
Does FWA visit the CC every week		
Yes	60	95.2
No	3	4.8
Make home visit regularly		
Yes	35	55.6
No	28	44.4
Number of days for home visit per week (n=35)		
<2 days	4	11.4
2-3 days	26	74.3
>3 days	5	14.3
Service(s) provided during home visit		
DOTS (TB)	12	33.3
FP (Contraceptive) services	21	58.3
EPI (Vaccination) services	31	86.1

Note: Figures within parenthesis indicate average per CC

2.4.2 Average number of patients treated by Service providers

Table-2.8 revealed that on the day of survey average 13.09±7.92 male patients were treated by HA whereas average 6.57±3.05 male patients were treated by FWA. This difference was not statistically significant (ANOVA, p>0.05).

Among female patients, average 20.88±12.30 were treated by CHCP while average 11.57±4.43 were treated by FWA on the day of survey. This difference was not statistically significant (ANOVA, p>0.05).

Among children, average 6.12±5.67 were treated by CHCP on the other hand average 1.43±1.27 were treated by FWA. This difference was not statistically significant (ANOVA, p>0.05).

Table-2.8: Comparison of average number of patients treated by Service provider

Service provider	Average number of patients treated on the day of survey	Significance (ANOVA)
	Male patients	
CHCP	10.32(±6.10)	F = 2.863 df = 2 p = 0.065
HA	13.09(±7.92)	
FWA	6.57(±3.05)	
Total	10.87(±6.78)	
	Female patients	
CHCP	20.88(±12.30)	F = 1.675 df = 2 p = 0.196
HA	20.95(±14.82)	
FWA	11.57(±4.43)	
Total	19.87(±12.87)	
	Children	
CHCP	6.12(±5.67)	F = 2.218 df = 2 p = 0.118
HA	5.59(±5.65)	
FWA	1.43(±1.27)	
Total	5.41(±5.49)	

2.4.3 Referral system in CCs

Table-2.9 shows, all 63(100.0%) health care providers said that every CC had referral system from where higher (71.4%) patients referred to UHC, 25.4% referred to district hospital and19.0% referred to union sub center

Table-2.9: Referral system in CCs

Attribute	Frequency	Percentage
CC have referral system		
Yes	63	100.0
If yes, then where the patients referred to		
USC (Union Sub-center)	12	19.0
UHC (Primary level)	45	71.4
District hospital (Secondary level)	16	25.4
Medical college hospital (Tertiary level)	9	14.3
Availability of referral slip		
Available	62	98.4

2.5 Facilities for the service providers

2.5.1 Satisfaction of service providers with salary and other allowances

Attractive salary and other incentive structure of any organization work as a catalyst in delivery of improved service. Among all of the providers, 38.1% were not satisfied with their salary and other allowances while96.8% reported that they got inadequate festival bonus which is shown in table-2.10.

Table-2.10: Satisfaction of service providers with salary and other allowances [n=63]

Attribute	Frequency	Percentage
Satisfied with your salary and other allowances		
Yes	39	61.9
No	24	38.1
Get any festival bonus		
Yes	61	96.8
No	2	3.2

2.5.2 Satisfaction with salary and other allowances and service provider

Table-2.11 shows that 52.9% CHCP were satisfied with salary and other allowances whereas 68.2% HA and 85.7% FWA were satisfied with salary and other allowances and this difference was not statistically significant (Fisher's Exact, p>0.05).

Table-2.11: Satisfaction with salary and other allowances by service provider

Service provider	Satisfied with salary and other allowances		Total f(%)	Significance (Fisher's Exact)
	Yes f(%)	No f(%)		
CHCP	18(52.9)	16(47.1)	34(100.0)	
HA	15(68.2)	7(31.8)	22(100.0)	df= 2
FWA	6(85.7)	1(14.3)	7(100.0)	p = 0.216
Total	39(61.9)	24(38.1)	63(100.0)	

2.5.3 Satisfaction with salary and other allowances by sex of service provider

Table-2.12 revealed that higher (63.6%) numbers of females were satisfied with salary and other allowances than males (60.0%). This difference was not statistically significant (χ^2, p>0.05).

Table-2.12: Satisfaction with salary and other allowances by sex of service provider

Sex	Satisfied with salary and other allowances		Total f(%)	Significance
	Yes f(%)	No f(%)		
Male	18(60)	12(40)	30(100.0)	$\chi^2 = 0.09$
Female	21(63.6)	12(36.4)	33(100.0)	df = 1
Total	39(61.9)	24(38.1)	63(100.0)	p = 0.77

2.6 Management of the Community Clinics

Following tables portray the structure and role of the Community Group (CG) and the Community Support Group (CSG) in the management of community clinics in respect of its functioning, monitoring and quality of services.

2.6.1 Community groups for management of the CC

Table 2.13a & 2.13b shows the structure and role of the Community Group (CG). Quite a large number of the CCs (88.9%) had effective and functioning Community Group (CG) for management of the CC while 11.1% CGs were inactive. In the CCs with inactive CG, 28.6% reported that it was not formed properly, and 71.4% did not know the reason. Off all, 98.2% providers thought that numbers of members of the CG were adequate and 92.1% thought that number of female members of the CG were adequate. The posts of member secretary and chief patron of the CG were regarded very important. In most cases (96.8%), CHCP was the member secretary of CG and in more than half of cases (58.7%), UP chairman was the chief patron of the CG. Most (92.1%) of the CG members were trained following training manual & trainer's guide. The CG members met mostly once in a month (85.7%); in one case the CG members met once in a year.

Table-2.13a: Community Group (CG) and management of community clinics

Attribute	Frequency	Percentage
Community Group (CG) for Management of the CC		
Active	56	88.9
Inactive	07	11.1
Reasons for inactivity		
Improperly formed	02	28.6
Did not know	05	71.4
Adequacy of the members of the CG		
Adequate	55	98.2
Inadequate	01	1.8
Adequacy of female members of the CG		
Adequate	58	92.1
Inadequate	05	7.9

Table-2.13b: Community Group (CG) and management of community clinics

Attribute	Frequency	Percentage
Member Secretary of CG		
CHCP	61	96.8
Other member	02	3.2
Patron of the CG		
UP chairman	37	58.7
Other member	26	41.3
Training of CG members based on training manual & guide		
Yes	58	92.1
No	05	7.9
How often the CG members meet		
Once in week	07	11.1
Once in a month	54	85.7
Every 3 months	01	1.6
Once in a year	01	1.6

2.6.2 Community support groups for management of the CCs

Table 2.14a & 2.14b below shows that 96.8% CCs had Community Support Group (CSG) to support CG. Around 98% thought that the number of the members of the CSG was adequate, 92.1% opined that the number of female members of the CSG was adequate. In 96.8% cases, CHCP were member secretary of CSG and in 58.7% cases, UP chairman was the chief patron of the CG. About 83% opined that CSG members were trained following training manual & trainer's guide.

It was revealed that in the CCs, cleanliness was ensured mostly by aya (41.3%) and Cleaners (38.1%). In 33.3% cases, CG/CSG supervised the cleanliness activities.
In 63.5% cases, the FWA/HA came to the CC for providing services thrice in a day, 3.2% never came and 11.1% and 22.2% came once in a week and twice in a week respectively.

Table 2.14a: Community Support Group (CSG) and management of Community Clinics

Attribute	Frequency	Percentage
Community Support Group (CSG) to support CG		
Active	61	96.8
Inactive	02	3.2
Reason of inactivity		
Not formed properly	04	66.7
No one is interested	02	33.3
Adequacy of the members of the CSG		
Adequate	55	98.2
Inadequate	01	1.8
Adequacy Female members of the CSG adequate		
Adequate	58	92.1
Inadequate	05	7.9
Member Secretary of CSG		
CHCP	61	96.8
Other member	02	3.2

Table 2.14b: Community Support Group (CSG) and management of community clinics

Attribute	Frequency	Percentage
Training of CSG members based on training manual & guide		
Yes	52	82.5
No	11	17.5
Chief patron of the CSG		
UP chairman	37	58.7
Other	26	41.3
Cleanliness of the CC is ensured by		
Cleaners clean the clinic	24	38.1
CG/CSG supervises the cleanliness	21	33.3
Aya cleans the CC	26	41.3
Don’t know	1	1.6
Frequency of visits of the FWA/HA to the CC		
Never	2	3.2
Once in a week	7	11.1
Twice in a week	14	22.2
Thrice in a day	40	63.5

2.7 Monitoring of Community Clinics

Table 2.15a & 2.15b shows that monitoring of the CC was done mostly by monthly report analysis (98.4%) and online communication through internet (90.5%). Other methods of monitoring such as Monthly meeting at division, district, upazila and union level taking CC issue as top most prioritized agenda (85.7%), Mobile tracking of service providers from HQ (84.1%), and Routine CC visit by GO, NGOs & DPs of different tiers with specific checklist (82.5%). Service reports mostly used for reporting included maternal health (96.8%), child health (88.9%), and family planning (82.5%), general health (81.0%), nutrition (74.6%) and referral (65.1%). Service reports used for neonate care (92.1%), infant care (87.3%) and under five health care (84.1%). Service reports also used for maternal health were including antenatal care (95.2%), postnatal care (92.1%) and normal delivery (58.7%). In case of any complication, pregnant women were referred to UHC (Primary level-69.8% cases), district hospital (Secondary level-15.9% cases), medical college hospital (Tertiary level-9.5% cases), USC (Union Sub-center-4.8% cases). (Table 6c)

Table 2.15a: Monitoring of Community Clinics

Way of monitoring	Frequency	Percentage
Monthly report analysis	62	98.4
Routine CC visit by G0, NGOs & DPs of different tiers with specific checklist	52	82.5
Mobile tracking of service providers from HQ	53	84.1
Monthly meeting at division, district, Upazila, union level taking CC issue as top most prioritized agenda	54	85.7
Online report communication through internet	57	90.5

Table 2.15b: Monitoring of Community Clinics

Way of monitoring	Frequency	Percentage
Service reports used for reporting (Multiple Responses)		
Child health	56	88.9
Maternal health	61	96.8
General health	51	81.0
Family planning	52	82.5
Nutrition	47	74.6
Referral	41	65.1
Service reports used for child health services (Multiple Responses)		
Neonate care	58	92.1
Infant care	55	87.3
Under five health care	53	84.1
Service reports used for maternal health services (Multiple Responses)		
Antenatal care	60	95.2
Normal delivery	37	58.7
Postnatal care	58	92.1
Referral health facility to refer pregnant women		
USC (Union Sub-center)	3	4.8
UHC (Primary level)	44	69.8
District hospital (Secondary level)	10	15.9
Medical college hospital (Tertiary level)	6	9.5

Section-3: Findings Related to CC Service Users (Patients)

3.1 Socio-demographic profile of the health service users

Health care users were predominantly female (71.2%). More than half of the patients were aged 19-44 years, 21.4% were in the age group 45-59 years, and 10.3% were aged 60 years or more. Children (aged 10- 18 years) comprised only 8.9% of the patients. Majority of the patients were housewife (59.6%) which is expected as most of the patients were female. Farmers, Student and Businessmen comprised only 15.7%, 9.4% and 6.0%, respectively. Unemployment was low, only 2.0%. Occupations like Service (2.5%), Day labor (3.2%) and others (1.6%) together accounted for only 7.3% of the patients. A formidable number of patients never went to school (29.3%), more than one-third had Primary (1-5 years of education) level education, about one-fourth had Secondary (6-10 years of education) level education (24.2%), and the remaining 11.0% had SSC and above level of education (Table-3. 1)

Table 3.1: Socio-demographic profile of the health service users [n=2238]

Attribute	Frequency	Percentage
Gender		
Male	644	28.8
Female	1594	71.2
Age (Years)		
Child (10 – 18)	200	8.9
19 – 44	1328	59.3
45 – 59	479	21.4
60 or more	231	10.3
Mean ± SD	37.63 ± 14.90	
Occupation		
Business	135	6.0
Farmer	352	15.7
Service	57	2.5
Housewife	1333	59.6
Student	210	9.4
Day laborer	71	3.2
Unemployed	45	2.0
Others (Beggar, Domestic worker, Rickshaw driver)	35	1.6
Education		
Never gone to school	656	29.3
Primary (1-5 years of education)	793	35.4
Secondary (6-10 years of education)	542	24.2
SSC and above	247	11.0

3.2 Knowledge of the patients on health services available at CC

Table 3.2 provides findings regarding patients' knowledge about services available at CC. Almost all the patients (99.2%) knew about the about services available at CC. Most of the patients knew about availability of Maternal and Neonatal services (91.8%) followed by EPI/Vaccination services (86.4%) and Treatment of common diseases and problems & first aid for the minor injuries (71.8%). Around half of the patients knew that services like Reproductive Health services and Family Planning (54.3%), Nutritional education and micronutrient supplementation (49.8%) and Health, Nutrition and FP education & counseling (48.7%) were available at the CC. Around only one-third knew about Integrated management of childhood illness (IMCI) (38.2%), Screening of Diabetes, Hypertension, Autism, Club feet and referral to higher facilities (36.8%) and Registration of newly married couple, pregnant mothers, birth and death; preservation of EDD (31.7%). Very few people knew about availability of vital services like providing Essential Service Package (ESP) (3.9%), Normal delivery with the availability of trained manpower & other facilities (7.9%), establishing an effective referral linkage (15.7%) and Identification of emergency and complicated cases with referral to higher facilities (21.8%).

Table 3.2: Knowledge of the patients on health services available at CC [n=2238]

Attribute	Frequency	Percentage
Whether know about the services available in the CC		
Yes	2220	99.2
No	18	0.8
Services available at the CC (Multiple Responses)		
Maternal and Neonatal services	2039	91.8
Integrated management of childhood illness (IMCI)	849	38.2
Reproductive Health services and Family Planning	1205	54.3
EPI (Vaccination) services	1918	86.4
Registration of newly married couple, pregnant mothers, birth and death; preservation of EDD	704	31.7
Nutritional education and micronutrient supplementation	1105	49.8
Health, Nutrition and FP education & counseling	1082	48.7
Treatment of common diseases and problems & first aid for the minor injuries	1595	71.8
Screening of Diabetes, Hypertension, Autism, Club feet and referral to higher facilities	816	36.8
Normal delivery with the availability of trained manpower & other facilities	175	7.9
Identification of emergency and complicated cases with referral to higher facilities	485	21.8
Establishing an effective referral linkage.	348	15.7
Provide Essential Service Package (ESP)	86	3.9

3.3 Benefits of the CC obtained by the patients

Out of 2238 patients, 2236 (99.9%) obtained benefits from the CC in various ways. Benefits included free drugs (82.1%), free treatment (81.2%), easy access (76.3%), need based health services (75.0%) and immunization services (68.6%). Proportion of patients receiving counseling about CHCP, FWA and HA was rather low as it was 33.2% only (Table 3.3).

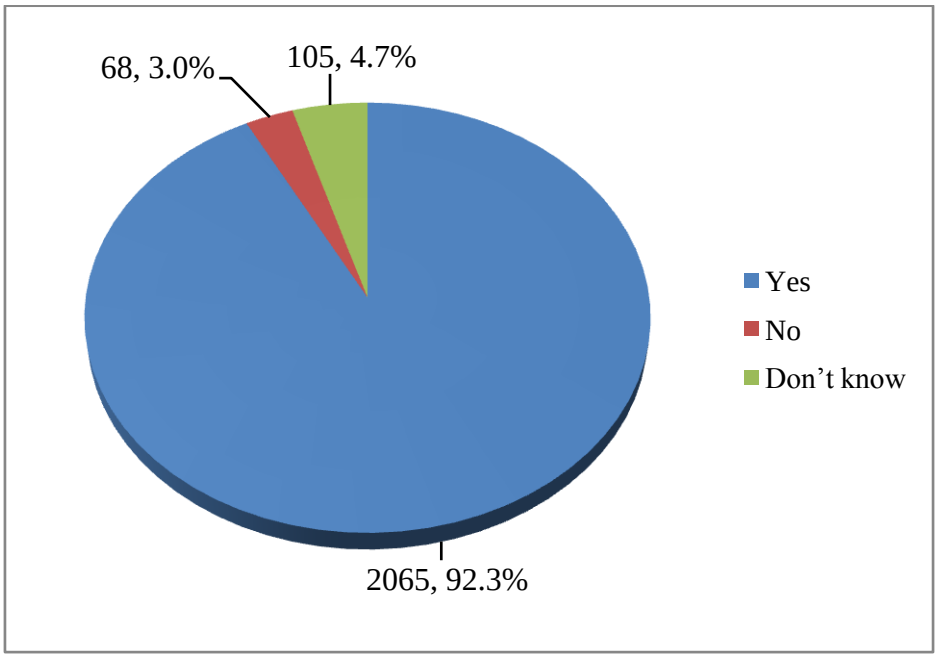
Table 3.3: Benefits of the CC obtained by the patients [n=2238]

Attribute	Frequency	Percentage
Benefits obtained		
Yes	2236	99.9
No	02	0.1
Types of benefits obtained (Multiple Responses)		
Need base health services	1673	75.0
Free drugs	1833	82.1
Free treatment	1812	81.2
Easy to access to the CCs	1704	76.3
Immunization services	1531	68.6
Counseling of CHCP, FWA and HA	742	33.2

3.4 Need based training of the staffs

Figure-3.1 shows that most (92.3%) of the patients opined that the staff was trained enough as they got need based training to provide designated services.

Figure-3.1: Opinion of service user about need based training of the staff [n=2238]



3.5 Reasons for selecting the CC for treatment

About four-fifths of the patients selected CC for treatment because of 'less distance' (79.3%), around two-thirds selected CC for 'providers' good behavior' (69.4%), 'availability of drugs' (67.3%), cleanliness (63.9%), and less waiting time (60.0%). Around half (49.2%)of the patients mentioned reasons as 'experienced and qualified provider', 'better waiting arrangement' (47.5%), 'one stop service' (38.8%), 'convenient clinic hour' (25.6%), and 'provider is known' (24.3%). (Table-3.4)

Table-3.4: Reasons of selecting the CC for treatment [n=2238]

Reasons (Multiple Responses)	Frequency	Percentage
Less distance	1775	79.3
Better waiting arrangement	1062	47.5
Less waiting time	1343	60.0
Experienced and qualified provider	1101	49.2
Providers good behavior	1554	69.4
Cleanliness	1431	63.9
Availability of drugs	1507	67.3
One stop service	869	38.8
Convenient clinic hour	573	25.6
Provider is known	544	24.3

3.6 Level of satisfaction of the patients about the CC services and facilities

Patients stated their satisfaction regarding existing CC services and facilities in respect of waiting arrangement, waiting time, cleanliness of the CC, maintenance of privacy of patients, interaction and behavior of provider, perceived quality of services, availability of medicine, whether qualified person provided service, access to enough information, if received prompt service, and quality of health education. Out of 11 service categories, more than 80% ranging from 80.3% (Cleanliness of the CC) to 85.7% (both Waiting arrangement and Received prompt service) patients were satisfied with 7 services. Among the remaining 4 service categories, patients' satisfaction level ranged from 72.9% (Privacy maintained) to 76.8% (Waiting time). Attempt was made to quantify the level of satisfaction by assigning score to different levels of satisfaction about each service in the following way:

Score=2 if satisfied, Score=1 if partially satisfied, Score=0 if not satisfied

Level of patient satisfaction about CC services

18-22: Good, 11-17: Average, ≤10= Poor

So the total score for all 11 services given by a patient ranged from 22 to 0.

3.6.1 Level of satisfaction of patients and services/ facilities of the CC

The overall mean score of 19.7(±2.59) bears testimony to the fact that the patients were, on an average, users were satisfied with the services provided by the CC (Table-3.5).

Table 3.5: Level of satisfaction about the services and facilities of the CC [n=2238]

Services and facilities	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)
Waiting arrangement	1918(85.7)	297(13.3)	23(1.0)
Waiting time	1719(76.8)	486(21.7)	33(1.5)
Cleanliness of the CC	1798(80.3)	410(18.3)	30(1.3)
Privacy maintained	1631(72.9)	535(23.9)	72(3.2)
Interaction and behavior of provider	1908(85.3)	320(14.3)	10(0.4)
Perceived quality of services	1805(80.7)	401(17.9)	32(1.4)
Availability of medicine	1707 (76.3)	477(21.3)	54(2.4)
Qualified person provide service	1916(85.6)	285(12.7)	37(1.7)
Enough information was given	1714(76.6)	475(21.2)	49(2.2)
Received prompt service	1919(85.7)	268(12)	51(2.3)
Quality of health education	1889(84.4)	276(12.3)	73(3.3)

3.6.2 Level of satisfaction about waiting arrangement and occupation of the patients

Table-3.6 shows that 55(96.5%) service holders were satisfied while 218(16.4%) housewives were partially satisfied about waiting arrangement on the other hand 5(1.4%) farmers were not satisfied about waiting arrangement and this difference was statistically significant (χ^2, $p<0.01$)

Table-3.6: Association between level of satisfaction about waiting arrangement and occupation of the patients

Occupation	Waiting arrangement			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	125(92.6)	9(6.7)	1(0.7)	135(100.0)	
Farmer	319(90.6)	28(8.0)	5(1.4)	352(100.0)	
Service	55(96.5)	2(3.5)	0(0.0)	57(100.0)	
Housewife	1100(82.5)	218(16.4)	15(1.1)	1333(100.0)	$\chi^2 = 40.523$
Student	184(87.6)	25(11.9)	1(0.5)	210(100.0)	df = 14
Day laborer	65(91.5)	6(8.5)	0(0.0)	71(100.0)	p = 0.000
Unemployed	43(95.6)	2(4.4)	0(0.0)	45(100.0)	
Others	27(77.1)	7(20.0)	1(2.9)	35(100.0)	
Total	1918(85.7)	297(13.3)	23(1.0)	2238(100.0)	

3.6.3 Level of satisfaction about waiting time and occupation of the patients

Table-3.7 revealed that 39(86.7%) unemployed were satisfied while 308(23.1%) housewives were partially satisfied about waiting time. On the other hand 15(4.3%) farmers were not satisfied about waiting time and this difference was statistically significant (χ^2, $p<0.01$).

Table-3.7: Association between level of satisfaction about waiting time and occupation of the patients

Occupation	Level of satisfaction about waiting time			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	106(78.5)	26(19.3)	3(2.2)	135(100.0)	
Farmer	262(74.4)	75(21.3)	15(4.3)	352(100.0)	
Service	46(80.7)	10(17.5)	1(1.8)	57(100.0)	
Housewife	1013(76.0)	308(23.1)	12(0.9)	1333(100.0)	$\chi^2 = 32.754$
Student	167(79.5)	43(20.5)	0(0.0)	210(100.0)	df = 14
Day laborer	58(81.7)	12(16.9)	1(1.4)	71(100.0)	p = 0.003
Unemployed	39(86.7)	5(11.1)	1(2.2)	45(100.0)	
Others	28(80.0)	7(20.0)	0(0.0)	35(100.0)	
Total	1719(76.8)	486(21.7)	33(1.5)	2238(100.0)	

3.6.4 Level of satisfaction about quality of service provider and occupation of patients

Table-3.8 shows that 51(89.5%) service holders were satisfied whereas 47(13.4%) farmers were partially satisfied about qualified service providers and 4(5.6%) day laborers were not satisfied about qualified service provider which was statistically significant (χ^2, $p<0.01$).

Table-3.8: Association between level of satisfaction about quality of service provider and occupation of patients

Occupation	Level of satisfaction about quality of service provider			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	115(85.2)	18(13.3)	2(1.5)	135(100.0)	
Farmer	292(83.0)	47(13.4)	13(3.7)	352(100.0)	
Service	51(89.5)	4(7.0)	2(3.5)	57(100.0)	
Housewife	1147(86.0)	176(13.2)	10(0.8)	1333(100.0)	$\chi^2 = 31.514$
Student	184(87.6)	20(9.5)	6(2.9)	210(100.0)	df = 14
Day laborer	58(81.7)	9(12.7)	4(5.6)	71(100.0)	p = 0.005
Unemployed	40(88.9)	5(11.1)	0(0.0)	45(100.0)	
Others	29(82.9)	6(17.1)	0(0.0)	35(100.0)	
Total	1916(85.6)	285(12.7)	37(1.7)	2238(100.0)	

3.6.5 Level of satisfaction about cleanliness of the CCs and occupation of patients

Table-3.9 shows that 50(87.7%) service holders were satisfied whereas 17(23.9) day laborers were partially satisfied about cleanliness of the CCs and 3(4.2%) day laborers were not satisfied about cleanliness of the CCs which was not statistically significant (χ^2, p>0.05).

Table-3.9: Association between level of satisfaction about cleanliness of the CCs and occupation of patients

Occupation	Cleanliness of the CCs			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	108(80.0)	24(17.8)	3(2.2)	135(100.0)	
Farmer	269(76.4)	76(21.6)	7(2.0)	352(100.0)	
Service	50(87.7)	7(12.3)	0(0.0)	57(100.0)	
Housewife	1078(80.9)	239(17.9)	16(1.2)	1333(100.0)	χ^2 = 22.550
Student	178(84.8)	32(15.2)	0(0.0)	210(100.0)	df = 14
Day laborer	51(71.8)	17(23.9)	3(4.2)	71(100.0)	p = 0.068
Unemployed	39(86.7)	5(11.1)	1(2.2)	45(100.0)	
Others	25(71.4)	10(28.6)	0(0.0)	35(100.0)	
Total	1798(80.3)	410(18.3)	30(1.3)	2238(100.0)	

3.6.6 Level of satisfaction about privacy in the CCs and occupation of patients

Table-3.10 shows that 169(80.5%) students were satisfied whereas 21(29.6%) day laborers were partially satisfied about Privacy of the CCs and 16(4.5%) farmers were not satisfied about cleanliness of the CCs which was not statistically significant (χ^2, $p>0.05$).

Table-3.10: Level of satisfaction about privacy in the CCs and occupation of patients

Occupation	Privacy maintained			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	104(77.0)	27(20.0)	4(3.0)	135(100.0)	
Farmer	237(67.3)	99(28.1)	16(4.5)	352(100.0)	
Service	40(70.2)	12(21.1)	5(8.8)	57(100.0)	
Housewife	977(73.3)	321(24.1)	35(2.6)	1333(100.0)	$\chi^2 = 23.118$
Student	169(80.5)	35(16.7)	6(2.9)	210(100.0)	df = 14
Day laborer	47(66.2)	21(29.6)	3(4.2)	71(100.0)	p = 0.058
Unemployed	33(73.3)	10(22.2)	2(4.4)	45(100.0)	
Others	24(68.6)	10(28.6)	1(2.9)	35(100.0)	
Total	1631(72.9)	535(23.9)	72(3.2)	2238(100.0)	

3.6.7 Availability of medicine in the CCs and occupation of the patients

Table-3.11 shows that 59(83.1%) day laborers were satisfied whereas 36(26.7%) businessmen were partially satisfied about availability of medicine and 10(2.8%) farmers were not satisfied about availability of medicine in the CCs which was not statistically significant (χ^2, p>0.05).

Table-3.11: Level of satisfaction about availability of medicine and occupation of the patients

Occupation	Availability of medicine			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	97(71.9)	36(26.7)	2(1.5)	135(100.0)	
Farmer	267(75.9	75(21.3)	10(2.8)	352(100.0)	
Service	43(75.4)	12(21.1)	2(3.5)	57(100.0)	
Housewife	1002(75.2)	298(22.4)	33(2.5)	1333(100.0)	χ^2 = 14.251
Student	173(82.4)	34(16.2)	3(1.4)	210(100.0)	df = 14
Day laborer	59(83.1)	10(14.1)	2(2.8)	71(100.0)	p = 0.431
Unemployed	35(77.8)	9(20.0)	1(2.2)	45(100.0)	
Others	31(88.6)	3(8.6)	1(2.9)	35(100.0)	
Total	1707(76.3)	477(21.3)	54(2.4)	2238(100.0)	

3.7 Advantages of the Community Clinics

Table-3.12 shows the advantages of the CCS as stated by the patient. More than 90% patients mentioned 'Close location of CC to the inhabitation' (97.2%), 'One stop outlet for Health, FP & Nutrition' (95.2%), 'Free Service' (97.7%), 'Easy communication'(90.5%), 'Availability of necessary advice' (96.8%), 'Referral service for emergency & complicated cases' (97.3%), 'Good knowledge, skill & behavior of providers' (97.2%), and 'Involvement of community in management CC' (92.8%). About 80.0% patients told that they were benefitted as the Service provider was from same locality.

Table 3.12: Advantages of the CCs [n=2238]

Advantages	Frequency	Percentage
CC is located close to the inhabitation	2171	97.2
One stop outlet for Health, FP & Nutrition	2130	95.2
Service is free of cost	2187	97.7
Easy communication to the CC	2026	90.5
Necessary advice is available	2167	96.8
Referral services for emergency & complicated cases	2177	97.3
Knowledge, skill & behavior of provider are good	2175	97.2
Service provider is from same locality	1789	79.9
Involvement of community in management of CC	2076	92.8

3.8 Quality of health education in the CCs and occupation of the patients

Table-3.13 shows that 182(86.7%) students were satisfied whereas 24(17.8%) businessmen were partially satisfied about quality of health education and 4(5.6) day laborer were not satisfied about quality of health education in the CCs which was not statistically significant (χ^2, p>0.05).

Table-3.13: Quality of health education in the CCs and occupation of the patients

Occupation	Quality of health education			Total f(%)	Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)		
Business	105(77.8)	24(17.8)	6(4.4)	135(100.0)	
Farmer	291(82.7)	45(12.8)	16(4.5)	352(100.0)	
Service	45(78.9)	7(12.3)	5(8.8)	57(100.0)	
Housewife	1137(85.3)	163(12.2)	33(2.5)	1333(100.0)	$\chi^2 = 19.015$
Student	182(86.7)	21(10.0)	7(3.3)	210(100.0)	df = 14
Day laborer	59(83.1)	8(11.3)	4(5.6)	71(100.0)	p = 0.164
Unemployed	38(84.4)	5(11.1)	2(4.4)	45(100.0)	
Others	32(91.4)	3(8.6)	0(0.0)	35(100.0)	
Total	1889(84.4)	276(12.3)	73(3.3)	2238(100.0)	

3.9 Different aspect of management in Community Clinics

3.9.1 Level of satisfaction in different aspect of management in CCs by sex of the patients

Table- 3.14a & 3.14b shows that in respect of waiting arrangement more males (90.7%) were satisfied than females (83.7%) whereas more females (15.2%) were partially satisfied than males (8.4%). This difference was statistically significant (χ^2, $p<0.01$).

In respect of waiting time, more males (76.9%) were satisfied than females (76.8%) whereas more females (22.4%) were partially satisfied than males (20.0%). This difference was statistically significant (χ^2, $p<0.01$).

Regarding cleanliness, more females (81.4%) were satisfied than males (77.8%) whereas more males (20.3%) were partially satisfied than females (17.5%). This difference was not statistically significant (χ^2, $p>0.05$).

In respect of privacy maintenance, more females (73.8%) were satisfied than males (70.5%) whereas more males (25.3%) were partially satisfied than females (23.3%). This difference was not statistically significant (χ^2, $p>0.05$).

Regarding interaction and behavior of the service provider, more females (85.8%) were satisfied than males (84.0%) whereas more males (15.8%) were partially satisfied than females (13.7%). This difference was not statistically significant (χ^2, $p>0.05$).

In respect of perceived quality of services, more females (81.4%) were satisfied than males (78.7%) whereas more males (19.4%) were partially satisfied than males (17.3%). This difference was statistically significant (χ^2, $p<0.01$).

On the basis of availability of medicine, more females (76.9%) were satisfied than males (74.7%) whereas more males (22.8%) were partially satisfied than females (20.7%). This difference was not statistically significant (χ^2, $p>0.05$).

Regarding qualified service provider, more females (86.1%) were satisfied than males (84.5%) whereas more males (3.1%) were not satisfied than females (1.1%). This difference was statistically significant (χ^2, $p<0.01$).

In respect of information obtained from providers, more females (76.8%) were satisfied than males (76.1%) whereas more males (21.6%) were partially satisfied than females (21.1%). This difference was not statistically significant (χ^2, p>0.05).

On the basis of receiving prompt service, more females (86.1%) were satisfied than males (84.9%) whereas more males (3.3%) were not satisfied than females (1.9%). This difference was not statistically significant (χ^2, p>0.05).

Regarding quality of health education, more females (85.8%) were satisfied than males (81.1%) whereas more males (14.6%) were partially satisfied than females (11.1%). This difference was statistically significant (χ^2, p<0.05).

Table-3.14a: Level of satisfaction in different aspect of management in CCs by sex of the patients

Sex	Level of satisfaction				Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)	Total f(%)	
	Waiting arrangement				
Male	584(90.7)	54(8.4)	6(0.9)	644(100.0)	χ^2 = 18.963
Female	1334(83.7)	243(15.2)	17(1.1)	1594(100.0)	df = 2
Total	1918(85.7)	297(13.3)	23(1.0)	2238(100.0)	p = 0.000
	Waiting time				
Male	495(76.9)	129(20.0)	20(3.1)	644(100.0)	χ^2 = 17.496
Female	1224(76.8)	357(22.4)	13(0.8)	1594(100.0)	df = 2
Total	1719(76.8)	486(21.7)	33(1.5)	2238(100.0)	p = 0.000
	Cleanliness of the CC				
Male	501(77.8)	131(20.3)	12(1.9)	644(100.0)	χ^2 = 4.590
Female	1297(81.4)	279(17.5)	18(1.1)	1594(100.0)	df = 2
Total	1798(80.3)	410(18.3)	30(1.3)	2238(100.0)	p = 0.101
	Privacy maintained				
Male	454(70.5)	163(25.3)	27(4.2)	644(100.0)	χ^2 = 4.124
Female	1177(73.8)	372(23.3)	45(2.8)	1594(100.0)	df = 2
Total	1631(72.9)	535(23.9)	72(3.2)	2238(100.0)	p = 0.127
	Interaction and behavior of provider				
Male	541(84.0)	102(15.8)	1(0.2)	644(100.0)	χ^2 = 3.385
Female	1367(85.8)	218(13.7)	9(0.6)	1594(100.0)	df = 2
Total	1908(85.3)	320(14.3)	10(0.4)	2238(100.0)	p = 0.184

Table-3.14b: Level of satisfaction in different aspect of management in CCs by sex of the patients

Sex	Level of satisfaction				Significance
	Satisfied f(%)	Partially satisfied f(%)	Not satisfied f(%)	Total f(%)	
	Perceived quality of services				
Male	507(78.7)	125(19.4)	12(1.9)	644(100.0)	$\chi^2 = 2.728$
Female	1298(81.4)	276(17.3)	20(1.3)	1594(100.0)	df = 2
Total	1805(80.7)	401(17.9)	32(1.4)	2238(100.0)	p = 0.256
	Availability of medicine				
Male	481(74.7)	147(22.8)	16(2.5)	644(100.0)	$\chi^2 = 1.287$
Female	1226(76.9)	330(20.7)	38(2.4)	1594(100.0)	df = 2
Total	1707(76.3)	477(21.3)	54(2.4)	2238(100.0)	p = 0.525
	Qualified person provide service				
Male	544(84.5)	80(12.4)	20(3.1)	644(100.0)	$\chi^2 = 11.742$
Female	1372(86.1)	205(12.9)	17(1.1)	1594(100.0)	df = 2
Total	1916(85.6)	285(12.7)	37(1.7)	2238(100.0)	p = 0.003
	Information obtained from providers				
Male	490(76.1)	139(21.6)	15(2.3)	644(100.0)	$\chi^2 = 0.165$
Female	1224(76.8)	336(21.1)	34(2.1)	1594(100.0)	df = 2
Total	1714(76.6)	475(21.2)	49(2.2)	2238(100.0)	p = 0.921
	Received prompt service				
Male	547(84.9)	76(11.8)	21(3.3)	644(100.0)	$\chi^2 = 3.918$
Female	1372(86.1)	192(12.0)	30(1.9)	1594(100.0)	df = 2
Total	1919(85.7)	268(12.0)	51(2.3)	2238(100.0)	p = 0.141
	Quality of health education				
Male	522(81.1)	94(14.6)	28(4.3)	644(100.0)	$\chi^2 = 8.229$
Female	1367(85.8)	182(11.4)	45(2.8)	1594(100.0)	df = 2
Total	1889(84.4)	276(12.3)	73(3.3)	2238(100.0)	p = 0.016

Section-4: Findings Related to Opinions of Community Member

4.1 Socio-demographic profile of the community members

Majority of the community members surveyed were female (60.3%). More than two-thirds (74.3%) of the respondents were aged 19-44 years, 19.1% were in the age group 45-59 years, 6.5% were aged 60 years or more. Half of the respondents were Housewife. Farmers and Businessmen comprised of 19.5% and 10.0%, respectively. Number of respondents having other occupations such as Student, Day laborer, Retired and unemployed were very low, ranging from 1.2% (Unemployed) to 7.2% (Student). Slightly less than one-fourth of respondents never went to school (22.7%), more than one-third had Primary (1-5 years of education) level education (36.2%), one-fourth had Secondary (6-10 years of education) level education (25.2%) and the remaining 15.9% had either SSC or HSC level of education (Table 4.1).

Table 4.1: Socio-demographic profile of the community members [n=3285]

Attribute	Frequency	Percentage
Gender		
Male	1305	39.7
Female	1980	60.3
Age (Years)		
19 -44	2445	74.3
45 – 59	626	19.1
≥60	214	6.5
Mean ± SD	35.75±10.02	
Occupation		
Business	328	10.0
Farmer	642	19.5
Service	131	4.0
Housewife	1658	50.5
Student	236	7.2
Day laborer	153	4.7
Retired	48	1.5
Unemployed	38	1.2
Others	51	1.6
Education		
Never gone to school	746	22.7
Primary (1-5 years of education)	1188	36.2
Secondary (6-10 years of education)	828	25.2
SSC	227	6.9
HSC	296	9.0

4.2 Knowledge of the community members about CC services [n=3285]

Out of 3285 respondents, 3229 (98.3%) knew about the services available at CC; only 56 did not know about it. Their main source of information was Neighbors/ relatives (57.0%) who used CC services. Role of Health Workers, Public representatives, and Radio/TV/Newspapers to help the people know about the services available at CC was not remarkable; number of people who came to know from these sources were 23.6%, 14.4%, and 3.8%, respectively only.

According to the respondents, the distance of the CC was not far-off. A vast majority (88.3%) reported that it was not too far from home, they could go on foot and it was within half a mile walk. The farthest CC could be reached in 10 minutes by rickshaw/van (9.6%) or in 30 minutes walk (2.1%).

About 96% respondents said that the CC opened every day. Well over half (55.8%) reported that the working hours of the CC was 5 hours or more. More than one-fourth (26.4%) reported that working hours of the CC was 4-5 hours and according to 13.1% the working hour was less than 4 hours. 4.7% of peopled did not have any idea about the working hours of the CC.

Most of the people (62.1%) mentioned CHCP as the service providers in the CC. HA and FWA were mentioned, respectively, by 22.2% and 12.4% people. Only 0.5% mentioned MBBS Doctor as the provider. A large number (36.7%) did not know who the providers were. An alarmingly large number of people (46.8%) reported that the CC suffered from shortage of medicine. About 40.0% did not know about the CG. Almost 99.0% of the people who knew about the CG were of the opinion that CG's participation had benefited the community. A large proportion (63.8%) of respondents did not know about the CSG. 98.0% of the people who knew about the CSG were of the opinion that CSG's participation had benefited the community. Around 31% respondents did not know about the clinic hours.

Major constraints associated with the CC, as reported by the people were, unavailability of medicine (including antibiotic) (32.8%), lack of specialist doctors such as gynecologist, diabetes specialist, eye specialist (30.3%), and inadequate number of health care provider (30.9%). Other constraints reported were long distance of CCs (about 11.0%), lack of electricity (about 8.0%), unfriendly behavior of providers (4.2%), and badly constructed building (3.0%).(Table 4.2a & 4.2b).

Table 4.2a: Knowledge of the community members about CC services [n=3285]

Attribute	Frequency	Percentage
Whether know about the CC		
Yes	3229	98.3
Source of information about the community clinic		
Health Workers	763	23.6
Public representatives	466	14.4
Neighbors/ relatives	1839	57.0
Radio/ TV/ Newspapers	124	3.8
Others	37	1.1
Distance of the CC from your residence		
Can go on foot, not too far from home, within half a mile walk	2900	88.3
Can reach in 30 minutes walk	70	2.1
Can reach in 10 minutes by rickshaw/van	315	9.6
Whether CCs open every day		
Yes	3143	95.7
Working hours of the CC		
<4 hours	429	13.1
4-5 hours	867	26.4
>5 hours	1835	55.8
Don't know	154	4.7
Service providers of the CC (Multiple Responses)		
CHCP	2041	62.1
HA	728	22.2
FWA	407	12.4
MBBS Doctor	17	0.5
Don't know	1207	36.7

Table 4.2b: Knowledge of the community members about CC services [n=3285]

Attribute	Frequency	Percentage
Drug supply shortage at the CCs		
Yes	1538	46.8
Whether know about the CG		
Yes	1989	60.5
No	1296	39.5
Whether know about the CSG		
Yes	1190	36.2
No	2095	63.8
CSG's participation has benefited the community [n=1190]		
Yes	1166	98.0
Do you know about the clinic hour		
Yes	2275	69.3
No	1010	30.7
Constraints associated with the CC		
Medicine (including antibiotic) is not available	1078	32.8
Long distance	354	10.8
Unfriendly behavior of the providers	137	4.2
Inadequate health care provider	1015	30.9
Lack of Specialist Doctors-Gynecologist, Diabetes, Eye	995	30.3
No electricity	260	7.9
Badly constructed building	100	3.0

4.3 Knowledge of community members about CC, CG & CSG by different socio-demographic attributes

4.3.1 Knowledge of community members about CCs, CGs & CSGs by sex

Table-4.3 shows that In respect of knowledge about CC, 98.2% males and 98.4% females were known about CC. This difference was not statistically significant (χ^2, $p>0.05$).

Regarding knowledge about CG, 69.7% males and 54.5% females were known about CG. This difference was statistically significant (χ^2, $p<0.01$).

On the basis of knowledge about CSG, 52.5% males and 71.2% females were not known about CSG. This difference was statistically significant (χ^2, $p<0.01$).

Table- 4.3: Knowledge of community members about CCs, CGs & CSGs by sex

Sex	Knowledge of community members			Significance
	Yes f(%)	No f(%)	Total f(%)	
	Know about the CC			
Male	1281(98.2)	24(1.8)	1305(100.0)	$\chi^2 = 0.233$
Female	1948(98.4)	32(1.6)	1980(100.0)	df = 1
Total	3229(98.3)	56(1.7)	3285(100.0)	p = 0.63
	Know about the CG			
Male	909(69.7)	396(30.3)	1305(100.0)	$\chi^2 = 75.177$
Female	1080(54.5)	900(45.5)	1980(100.0)	df = 1
Total	1989(60.5)	1296(39.5)	3285(100.0)	p = 0.000
	Know about the CSG			
Male	620(47.5)	685(52.5)	1305(100.0)	$\chi^2 = 119.336$
Female	570(28.8)	1410(71.2)	1980(100.0)	df = 1
Total	1190(36.2)	2095(63.8)	3285(100.0)	p = 0.000

4.3.2 Knowledge of community members about CCs, CGs & CSGs by occupation

Table-4.4 shows that In respect of knowledge about CC, service holders (100.0%), retired person (100.0%), unemployed (100.0%) were known about CC whereas farmers (3.1%), day laborer (2.6%) & housewives (1.7%) were not known about it. This difference was statistically significant (χ^2, $p<0.05$).

Regarding knowledge about CG, retired person (75.0%), businessmen (73.2%), farmers (71.7%) were known about CG while housewives (46.7%), day laborer (45.1%) & students (39.8%) were not known about it. This difference was statistically significant (χ^2, $p<0.01$).

On the basis of knowledge about CSG, unemployed (76.3%), students (74.6%), housewives (72.9%) were not known about CSG while retired person (62.5%), farmers (54.7%) & day laborer (47.7%) were known about it. This difference was statistically significant (χ^2, $p<0.01$).

Table- 4.4: Knowledge of community members about CCs, CGs & CSGs by occupation

Occupation	Whether known about the CC		Total f(%)	Significance
	Yes f(%)	No f(%)		
Business	327(99.7)	1(0.3)	328(100.0)	$\chi^2 = 18.328$ df = 8 p = 0.019
Farmer	622(96.9)	20(3.1)	642(100.0)	
Service	131(100.0)	0(0.0)	131(100.0)	
Housewife	1629(98.3)	29(1.7)	1658(100.0)	
Student	235(99.6)	1(0.4)	236(100.0)	
Day laborer	149(97.4)	4(2.6)	153(100.0)	
Retired	48(100.0)	0(0.0)	48(100.0)	
Unemployed	38(100.0)	0(0.0)	38(100.0)	
Others	50(98.0)	1(2.0)	51(100.0)	
Total	3229(98.3)	56(1.7)	3285(100.0)	
	Whether known about the CG?			
Business	240(73.2)	88(26.8)	328(100.0)	$\chi^2 = 100.065$ df = 8 p = 0.000
Farmer	460(71.7)	182(28.3)	642(100.0)	
Service	88(67.2)	43(32.8)	131(100.0)	
Housewife	884(53.3)	774(46.7)	1658(100.0)	
Student	142(60.2)	94(39.8)	236(100.0)	
Day laborer	84(54.9)	69(45.1)	153(100.0)	
Retired	36(75.0)	12(25.0)	48(100.0)	
Unemployed	23(60.5)	15(39.5)	38(100.0)	
Others	32(62.7)	19(37.3)	51(100.0)	
Total	1989(60.5)	1296(39.5)	3285(100.0)	
	Whether known about the CSG			
Business	153(46.6)	175(53.4)	328(100.0)	$\chi^2 = 211.041$ df = 8 p = 0.000
Farmer	351(54.7)	291(45.3)	642(100.0)	
Service	52(39.7)	79(60.3)	131(100.0)	
Housewife	450(27.1)	1208(72.9)	1658(100.0)	
Student	60(25.4)	176(74.6)	236(100.0)	
Day laborer	73(47.7)	80(52.3)	153(100.0)	
Retired	30(62.5)	18(37.5)	48(100.0)	
Unemployed	9(23.7)	29(76.3)	38(100.0)	
Others	12(23.5)	39(76.5)	51(100.0)	
Total	1190(36.2)	2095(63.8)	3285(100.0)	

Section-5: Findings Related to Opinions of Key Informants (KI)

5.1 Socio-demographic profile of the key informants

About 80.0% of the key informants were male, a little less than half of the KIs (47.2%) belonged to the age group 30–44 years, a little over one-third (35.5%) were aged 45–59 years and more than 17% were aged 60 years or more. Key informants interviewed belonged to various occupations including teachers and mosque imam who formed one-fifth (20.1%) of the KIs. Proportion of service holders was almost same (19.3%) followed by upazila and union parishad chairman and members comprised 16.1% and community elites and political leaders were 15.1% while doctors and health workers were 13.6%, Businessmen were 13.4% and only 2.5% were journalists. Educational profile of the KIs showed that all them had formal education including 21.3% were graduate and above, proportion of HSC and SSC were 19.1% and 20.1% respectively, and about two-fifths (39.5%) had primary or below SSC level education (Table 5.1).

Table 5.1: Socio-demographic profile of the key informants [n=597]

Attribute	Frequency	Percentage
Gender		
Male	474	79.4
Female	123	20.6
Age (Years)		
30 – 44	282	47.2
45 – 59	212	35.5
60 or more	103	17.3
Mean ± SD	45.92 ± 13.271	
Occupation		
Business	80	13.4
Service	115	19.3
Teachers and Mosque Imam	120	20.1
Doctors and Health workers	81	13.6
Community elites and political leaders	90	15.1
Upazila and Union Chairman / Members	96	16.1
Journalist	15	2.5
Education		
Primary and below SSC	236	39.5
SSC	120	20.1
HSC	114	19.1
Graduate and above	127	21.3

5.2 Opinions of the KI regarding management of the CCs

Table 5.2a, 5.2b & 5.2c below shows that almost all the KIs (94.6%) were aware of the existence of management committee for the CC. About three-fourths of them (74.0%) mentioned CG, 9.9% mentioned CSG and remaining 16.1% mentioned other bodies as management committee for the CC. Most of these people (91.2%) reported that the committees were functional. 86.8% of the KIs were of the opinion that the members of the committees were included as per eligibility criteria.

About two-thirds (65.2%) reported that the CC had three CSGs, 18.1% reported that there were only two CSGs. A significant proportion (16.8%) said that there was only one CSG.

Most reported problems faced by the committees were Scarcity of equipments (51.8%) and inadequate drug supply (51.8%). About two-fifths(38.2%) reported Insufficient logistics supply (38.2%), and slightly more than one-third (34.3%)reported Financial constraint as problems faced by the committees. Comparatively fewer KIs reported problems like Poor patronization of Government (20.1%), No public support (19.8%). Surprisingly only 1.5% reported Pressure of power groups as problem. Most KIs (94.3%) reported that land on which the CC was located was donated by the community.

More than 60.0% reported that the CG was consisted of 17 members. Others said that the CG consisted of 10 to 16 members. 84.4% KI were aware of the presence of female embers in the CG and, according to two-thirds of them number of female members in the CG were 4–6, according to about 22.0%, it was up to 3 members while 11.1% reported that there were 7–9 female members. About 15% of the KI were not aware of the presence of female members in the CG. According to 79.6% respondents and donor was a member of the CG and according to 81.9% respondents, service provider (CHCP) was also included in the CG, and 79.7% reported that the service provider (CHCP) acted as the member-secretary of CG.

Regarding stages of CG formation, majority (61.0%) told that it was formed after hand over, 10.7% and 5.2% reported that it was formed before site selection and before construction, respectively. About one-fourth KIs had no idea about how the CG was formed. 76.7% reported that the CG members were oriented about their roles and responsibilities. According to 60.8% KIs, the CG members met every month,

18.4% reported that the members met every three months. 1.3% reported that no meeting was held at all and 14.4% did not know about how often the CG members met. About two-thirds (64.8%) KI reported that the UP Chairman supervised functioning of the CC.

66.5% KI reported that the committee members had training, and almost all of them **(**98.2%) thought that the training was useful.

Table 5.2a: Opinions of the KI regarding management of CCs [n=597]

Attribute	Frequency	Percentage
Whether know about management committee for the CC		
Yes	565	94.6
No	32	4.4
Name of the management committee (n=565)		
CG	418	74.0
CSG	56	9.9
Others	91	16.1
Whether the committees are functional		
Yes	515	91.2
No	20	3.5
Do not know	30	5.3
Whether eligibility criteria of the members maintained		
Yes	518	86.8
No	14	2.3
Do not know	65	10.9
Number of CSGs for this CCs		
One	100	16.8
Two	108	18.1
Three	389	65.2

Table 5.2b: Opinions of the KI regarding management of CCs [n=597]

Attribute	Frequency	Percentage
Problems faced by the committees		
Poor patronization of Government	120	20.1
Financial constraint	205	34.3
Insufficient logistics supply	228	38.2
No public support	118	19.8
Scarcity of equipments	309	51.8
Inadequate drug supply	309	51.8
Pressure of power groups	9	1.5
Others	57	9.5
Whether the land of CC is donated by the community		
Yes	563	94.3
No	11	1.8
Do not know	23	3.9
Number of members in the CG		
10 – 16	237	39.7
17	360	60.3
Presence of female member in the CG		
Yes	504	84.4
No	4	0.7
Do not know	89	14.9
Number of female member in the CG		
1 – 3	110	21.8
4 – 6	338	67.1
7 – 9	56	11.1
Whether the land donor included in this CG		
Yes	475	79.6
No	19	3.2
Do not know	103	17.3
Whether service provider (CHCP) included in this CG		
Yes	489	81.9
No	6	1
Do not know	102	17.1

Table 5.2c: Opinions of the KI regarding management of CCs [n=597]

Attribute	Frequency	Percentage
Whether the service provider (CHCP) act as the member-secretary of CG		
Yes	476	79.7
No	10	1.7
Do not know	111	18.6
Stages of CG formation		
Before site selection	64	10.7
Before construction	31	5.2
After hand over	364	61.0
Do not know	138	23.1
Supervision of UP chairman in functioning of CC		
Yes	387	64.8
No	131	21.9
Do not know	79	13.2
Whether the CG members are oriented about their roles and responsibilities		
Yes	458	76.7
No	31	5.2
Do not know	108	18.1
How often the CG members meet		
Every month	363	60.8
Every 3 months	110	18.4
Every 6 months	29	4.9
Every 12 months	1	0.2
No meeting held	8	1.3
Do not know	86	14.4
Provision of training for the committee members		
Yes	397	66.5
No	55	9.2
Do not know	145	24.3
Whether the training was useful		
Yes	390	98.2
No	7	1.8

5.3 Opinions of the KI regarding responsibilities of CG and CSG

Ensuring cleanliness at the CC (96.6%), Ensuring security of the CC (95.8%) and Day to day operation of the CC (90.8%) were the mostly reported responsibilities of the CG. More than three-quarters of the KIs mentioned Monitoring and evaluation of community participation, Monitoring and evaluation of CC performance, and Coordination with other providers and stakeholders as responsibilities of the CG. Local fund generation and transparent utilization was mentioned by little over half of the KIs.

KIs reported Keeping close contact with the CG (92.6%), Helping the poor, marginalized & vulnerable in getting services (83.1%), Making the community aware of the CC services (82.4%), Helping the community to get emergency services (81.4%), Disseminating Health, Nutrition & FP messages (79.9%), Helping CG in fund generation (79.7%), and Helping the poor in referral (75.4%) as responsibilities of the CSG (Table-5.3).

Table 5.3: Opinions of the KI regarding responsibilities of CG and CSG [n=597]

Attribute	Frequency	Percentage
Responsibilities of the CG		
Ensure security of the CC	572	95.8
Ensure cleanliness at the CC	577	96.6
Day to day operation of the CC	542	90.8
Local fund generation and transparent utilization	320	53.6
Coordination with other providers and stakeholders	452	75.7
Monitoring and evaluation of CC performance	453	75.9
Monitoring and evaluation of community participation	460	77.1
Responsibilities of the CSG		
Keep close contact with the CG	553	92.6
Help CG in fund generation	476	79.7
Make the community aware of the CC services	492	82.4
Help the poor, marginalized & vulnerable in getting services	496	83.1
Help the community to get emergency services	486	81.4
Help the poor in referral	450	75.4
Disseminate Health, Nutrition & FP messages	477	79.9

5.4 Opinions of the KI regarding management of CGs

49.2% reported that the CG was involved in supervision of the construction of infrastructure, 79.2% reported that the CG involved in operational management & maintenance the CC, and according to 88.4% of the KIs the CG assisted in keeping the premises neat and clean. Only 22.9% reported that committee collected money locally; but in the past the figure was even lower, only 17.9%. Money collected locally was spent mostly to treat poor patients (59.5%), to treat children (49.2%), to prepare infrastructure (43.7%), to treat women (37.5%), and other purpose (3.0%). A large proportion of KIs (28.3%) did not know how the money was spent. Most (86.8%) of the KIs regarded the overall management satisfactory. (Table-5.4)

Table 5.4: Opinions of the KI regarding management of CGs [n=597]

Attribute	Frequency	Percentage
Collection of by the committee locally		
Yes	137	22.9
No	346	58.0
Do not know	114	19.1
Having previous collected money		
Yes	107	17.9
No	327	54.8
Do not know	163	27.3
Way of spending collected money		
To treat poor patients	355	59.50
To treat women	224	37.50
To treat children	294	49.20
To prepare infrastructure	261	43.70
Others	18	3.00
Do not know	169	28.30
Involvement of CG in supervision of the construction of CC		
Yes	294	49.2
No	169	28.3
Do not know	134	22.4
Involvement of CG in management & maintenance of CC		
Yes	473	79.2
No	35	5.9
Do not know	89	14.9
Assistance of CG assist in keeping cleanliness of the premises		
Yes	528	88.4
No	9	1.5
Do not know	60	10.1
Opinion about the overall operation/services of CC		
Satisfactory	518	86.8
Partly satisfactory	74	12.4
Not satisfactory	5	0.8

5.5 Level of satisfaction about CC services by occupation of KI

Table-5.5 shows that 82.5% businessmen and 83.5% service holders were satisfied regarding CC services. On the other hand, 88.9% doctors and health care workers, 84.4% community elites and political leaders, 81.3% upazila/union parishad chairman and members, and 80.0% journalists were satisfied with CC services. This difference was not statistically significant (χ^2, p>0.05)

Table-5.5: Association between satisfaction of CCs services and occupation of KI

Occupation	Level of satisfaction			Total f(%)	Significance
	Satisfied f(%)	Partly satisfied f(%)	Not satisfied f(%)		
Business	66(82.5)	14(17.5)	0(0.0)	80(100.0)	
Service	96(83.5)	16(13.9)	3(2.6)	115(100.0)	
Teacher and Mosque Imam	96(80.0)	14(11.7)	10(8.3)	120(100.0)	
Doctor and health workers	72(88.9)	9(11.1)	0(0.0)	81(100.0)	$\chi^2 = 13.577$
Community elites and political leaders	76(84.4)	14(16.3)	0(0.0)	90(100.0)	df = 14
Upazila and Union Parishad Chairman / Members	78(81.3)	18(18.7)	0(0.0)	96(100.0)	p = 0.482
Journalist	12(80.0)	3(20.0)	0(0.0)	15(100.0)	
Total	496(83.1)	88(14.7)	13(2.2)	597(100.0)	

5.6 Findings Related to Pattern and Effects of Community Participation (Based on In-depth Interview of Key Informants)

5.6.1 Pattern of community participation in rural Bangladesh through CC

In the qualitative exploration the study explored the patterns of community involvement in rural Bangladesh through the community base health care center. In this part the study tried to understand how the community was involved with the community based health intervention and initiatives, and how effectively things are working around the implementation. The research also tried to reveal the gaps of the community participation and exposed the recommendation how to involve community more efficiently in further.

As of now, community clinics have a provision of a group where service provider should be included as a group member, ideally 13-17 people from community leaders, local government members. All community groups have also a support group who are responsible for helping to running the community clinics maintenance and ensure the optimal health services to the community people. Nevertheless, a few community clinics do not have the community groups and some of respondents didn't know about community groups which are being established for betterment of CC services.

5.6.2 How effective of community participation on Community clinic

The principles and objectives of CC based interventions were to involve community and the idea was that community will help the services provision of community clinics and improve the quality. The study interviewed community clinic service providers, community people and leaders. Majority of the research participants informed that community contribution is essential and key element for community clinic, as community people could help and support for providing the health facilities. They informed community participation could help on in many occasions

5.6.3 Suggestions can help

Most of the respondents suggested that community can participate in management of community clinics for further improvements and they could also help the committee and management in any adverse situations. Most of the respondents perceived that community people are the best persons who know the problems of their community and they can show the ways of solution also.

5.6.4 Establishing more infrastructures:

Some of the informants told that community participation can contribute to establish infrastructure for community clinics, as their active donation and other management related assistance can also help to build up more infrastructures.

5.6.5 Donation

The respondents also opined that community people have more scope to donate for the community clinic's establishment. Community participation can also provide financial help to improve and sustain the community clinic services.

5.6.6 How to improve the community participation with Community clinics activities

Most of the participants informed that community involvement with the health center (CCs) is vital, nevertheless many of them informed that community participation is still not satisfactory. Their opinion in this regard was community participants need to be improved along with the community health services. They forwarded a lots of suggestion particularly on the following issues:

- Most of the participants perceived that more awareness campaign needs to be taken place in the community, especially on community gatherings. Through the campaign, community people can be sensitized about the community health clinics and it will enhance community participation.
- Most of the participants informed that free medicine is the most attractive package to the community people. Medicine More sufficient medicine from community clinic will engage more community participation
- More doctors and service providers in community clinic could ensure more participation of local people, thus many of the respondents expressed their idea.
- Several participants informed that of some community clinics were running with short some doctors and other health services staffs, hence respondents of this research perceived that if doctors' number increase then community people would be involved more and effectively with this health centers.
- Some participants informed that different sort of training can also increase community participations. They suggested that need based and community oriented training could grow more interest about the community clinics among the participants.

- Some participants perceived the need to establish more communication from the service providers to all levels of community people. Services providers can go to the door to door of the community to involve them with the programs.

5.6.7 Perceived impact of Community Clinic in community lives:

"We usually got free treatment from the center (Community Clinic), the center is in our village, we did not need to go outside of the area, it saves both ways" (Community leader)

In the qualitative exploration, the study tried to understand how community clinics made impact among community inhabitant's life. In responses most of the participants informed that their health outcome improved significantly for the facilities of community clinics.

5.6.7.1 Perception on health outcomes

Most of the participants informed that they get free and less expensive primary health treatment from community clinics and that reduced their treatment cost then previous. Majority of participants informed that prior community clinic establishment, diarrhea was an epidemic into the community. They stated that diarrhea costs lots of lives in those communities, however and now with health services of community clinics diarrhea has been reduced gradually into those communities. Majority of respondents informed diarrheal treatment is very prompt and effective and they got free oral saline from the clinics and some of them informed they got prescriptions from the clinics and purchased medicine from outside local drug seller.

Apart from the free and less expensive treatment, majority portion of the respondents perceived that community clinics reduced children and mother mortality. They reportedly informed that community clinics provided their services especially on mother and infant on the priority basis, on the consequences of the community clinic's services infant and mother mortality rate has been lessen pointedly.

Some respondents informed that children immunization and pregnant women health check are at-best services which made an impact to the community. Some of the informants told that pregnant women's treatment is now easier and less time consuming in comparing with previous time when community clinic health facilities

were not established in community. In addition, nutrition programs for children from the clinics were also an efficient service which improved children health.

"*I had some breathing problem since ages, however I did not know the reasons for that, after coming here I came to know that I have asthma*" (Community leader, Male)

Many of the participants informed that, beforehand they did not know about the reasons of diseases and some of them did not take any treatment for that. Now they informed that they can know from the community clinics the reasons of the diseases. Some of them also reported that community clinics is a perfect place for primary health care, they frequently go to the community clinics for injury, any accidents, fevers, dysentery, gastric and other minors (perceived by the informants).On top of that some community clinics have some medical test like blood test, that is very helpful for them.

Most of the participants informed that community clinic's services and facilities enhance the medical knowledge level. Many of the people perceived that they were aware of some health conscious like primary health care, diarrhea, immunizations, family planning, safe water and hygiene.

In contrast, some respondents informed that they could not figure out any change after the facilities they had been received by the community. They could not able to provide any example of impact of health services provided by the community clinics.

5.6.7.2 Community perception on other impacts

Despite of health outcomes, many of the community leaders informed that community clinic's services made some positive impacts throughout the community. Majority respondents stated that because of community clinic, now they can get treatment within their community, they do not have to go outside for treatment and that saved their huge transportation cost. They also thought that community clinics have reduced a huge amount of treatment cost.

Some of the respondents informed that community people have tendency to visit doctors which is mostly improbable among community people previously. Many community people were reluctant to take treatment as they had to go outside of the

village, whenever they got treatment facilities nearby their home and consequently community health has been improved than any other times.

Some of the research participants stated that free and effective treatment could enhance their economic solvency and working skill, at that time they had less disease and they could work more with the treatment of community clinics.

"*We did not know about TIKA (immunization vaccine) and its important, now they (doctors) wrote down the date of the TIKA and told us if we do not maintain these, our children will be in trouble. Nothing is important than our children" (Community People)*

Apart from these impacts, some respondents perceived that they were getting some medical suggestions, like how to keep safe pregnant women and community people perceived that they got suggestion regarding infant treatment and dealing among them those were new to many of the participants.

Some of participants informed that, now they can avail any emergency treatment facilities from community clinics. Before the community clinics, there were no emergency treatment facilities into their community, they had to go Upazila for treatment and transportation arrangement on the night time was very difficult for them, some community clinics has emergency services which was excessive impact to some other people.

Another facility received by the community people was the medical referral system, some of the treatment facilities had no effective referral system and thus some patients needed to visit some specialist physicians or some diagnostics tests. In this regard, community clinics staffs suggested that comprehensive referral activities which could produce immense impact to fulfill the health needs of the patients.

Some respondents informed that some community clinics staffs visited their house and that was a good help for them, as they did not need to go to the clinics. Those field staffs were skill and very helpful, they perceived.

5.6.8 Perceived Barriers of getting health care from Community clinics

Participants from our research identified some of the constraints that really hinder to getting health services smoothly

5.6.8.1 Lack of easy access for all

Some of the participants informed that they had no easy access into their community clinics, as the roads on the way were not convenient for some of the beneficiaries. Some also informed that there were no transportations to attend the community clinics. Some informant told that, location of the community clinics was not convenient for them as some CCs were established in the hard to reach areas.

5.6.8.2 Lack of electricity and water supply into the clinic

Many of the participants informed that community clinics were not well equipped in terms of utilities and facilities. They complained that some of the community clinics had no electricity and water supplies. Hence it was difficult to provide and receive service from both sides from clines and providers' perspectives.

5.6.8.3 Lack of experienced doctors in clinics

Many of the participated informed that sometimes they did not find the doctors when they had visited to the community clinics. Sometimes community clinics facilities were not available for the community people**.** Some of them stated that some of the service providers were not experienced and skill enough and participants were not satisfied with their treatment.

5.6.8.4 There are no diagnosis facilities for the community people

Some of our research respondents informed that the community clinics had no diagnosis facilities, such as blood tests, X-rays, eyes test and others. They had to go to long distance from their home for undergo the diagnosis test, and usually they went to upazila and sometimes it costs a lot, they opined.

5.6.8.5 Lack of sufficient medicine and medicine equipment

Many of the respondents informed that some of the community clinics faced some problems with the medicine. Community clinics had no the sufficient amount of medicine to serve entire clients. Sometimes they had to buy medicine from outside of the community. In that situation, most of the participants informed that community

clinics should increase their medicine stock. As they were also running short of some medical equipment likely testing kits, bandages and others.

5.6.8.6 Community clinic has lack campaign into the community

Some of the participants informed that many of the people did not know about the community clinics and their services, the reasons behind that is lack of awareness and campaign about the community clinics.

5.6.8.7 Lack of coordination with community and community involvement:

Lack of coordination with community people was one kind of barriers of the getting effective health services. Some respondents informed that sometimes community clinic management had taken some decisions without taking the concern of the community and sometimes they were not involving community into their task and the main reason behind that they thought that the lack of coordination from the both sites.

5.6.9 Suggestions to improve the community clinic and Conclusion

- Most of the of the participants informed that community clinics need more campaign and promotional activities among the community
- CCs need to arrange more meetings with community people to more get in involve with them.
- Many of the participants informed that most of the clinics had no suffice space both in indoor, sometimes patients and caregivers find difficulties to get on it. Therefore, participants thought clinics need to expand the spaces.
- Some of the respondents informed that community clinics have to be a sustainable plan. In this regards some participants informed that need to establish a donation system where community people can participate and donate for community clinics.
- There was no specific caretaker in community clinic currently; however someone needed to maintain the cleanliness of the facilities for the health seekers and caretaker will also be responsible to maintain the security which was unavailable at that time.
- Roads and communication was identified as one of the major barrier to access into the community clinics for general population. Therefore, participants suggested to improve the communication and roads on the way of CCs.

- People must be aware through various methods about the impact of getting involvement with community clinic, and need to aware more about the benefits of the community clinic.

In this research, majority respondents were expressed their satisfactory impression to us. They thought community clinics have made a tremendous positive impact throughout the community. They thought that these not only had improved their health condition, they could now combat the unwanted death and diabilities. Apart from health benefits, majority of the research respondents informed that community clinics supports also saved their money, time and also increased their health awareness level. Most of the participants addressed community participation as a key factor for driven the community clinics health services facilities as they can improve the services by providing suggestions, mutual the social dispute, and establishing essential infrastructure for community clinics. Although community have positive involvement with community clinics coverage however it has also scope to improve the situation by more awareness campaign, training and empowering community.

Some barriers identified by the research participants, likely lack of medicine and equipment, lack easy access, insufficient diagnostic services. All of the participants informed that community clinics program can be improved significantly through more community involvement and enhancing some facilities through overcoming the existing barriers.

5.0 Discussion

Previous chapter, 'Results', provided the findings of 'Pattern and Effects of Community Participation in Rural Bangladesh through the Community Clinic Approach'. Current chapter attempts a critical discussion of these findings and compares, whenever possible, these with findings obtained from similar studies.

CCs were designed to provide services for around 6000 people each 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.

5.1 Physical Facilities of CC

Location of Community Clinics: Appropriate location ensuring less travel time, ease of access by vehicle or on foot and suitable type of land (especially whether the land is liable to flood) is a very important factor, which contributes to increased utilization and sustainability of a health care facilities. If the CC is located in a flood prone or marshy and water-logged land, or if it is not easily accessible by vehicle or on foot, or it takes much time to reach it, patients, particularly the children, women and the elders, will not be interested to visit it. The findings on location of the sample CCs show that the majority of CCs are well located, in almost all the senses considered. Out of the 32 sample CCs, 31 (96.88%) were located in the middle of the catchments area (71.9%) or near to residing area of the village (25.0%) and were easy to reach as these were within a maximum of 30-minute walking distance (90.3%) or 10-minute travelling distance by rickshaw (9.7%). 31 CCs (96.88%) were located either in high land (68.8%) or in flood free low land (28.1%) and only 1 CC (3.1%) was located in low land with water logging. Since the land was donated by the community there was a possibility that, in some cases at least, land unsuitable for other uses was donated to the CC. Hence the risk of poor location in terms travel time, flooding and very difficult access could not be avoided. Almost similar findings were obtained from Normand, Iftekar & Rahman who found tha Most of the sites (62.1%) were in the middle of the catchment area and are easy to get to. 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.

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. It is found that most of the sample CCs (96.88%) had govt. approved (450 sq. ft) size, only 1 CC was smaller than Govt. approved size. More than four-fifths of the CCs in the study had the specified two rooms and the rest 18.8% had one additional room i.e. three rooms. Quality of construction of the CCs, on an average was good. Door's quality was good in almost all the CCs (96.9%), Window's quality was good in slightly more than four-fifths of the CCs (81.3%); but Roof's quality was good in less than two-third of the CCs (62.5%). Similar results were also obtained from Normand, Iftekar and Rahman. According to the study 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. 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.

According to government guidelines, every CC should have two toilets - one for the males and the other for females and one tube well for safe drinking water. Very few of the sample CCs met these standards, with many (68.8%) having only one toilet; also half of the toilets were in poor condition (dirty). Less than one-third (31.3%) had tube well for safe drinking water. Findings from Normand, Iftekar and Rahman shows that as high as 85% CCs had only one toilet and more than half (56.66%) had toilets that were very dirty, unusable. Few (25%) had tube well for safe drinking water. 65% CCs had non-functioning tube well and in 10% no tube well had been installed.

In respect of waiting facility for the patients, almost all the CCs (93.75%) had waiting space for patients well equipped with bench and other facilities. In only 2 CCs patients had to remain standing. Level of satisfaction about waiting time was significant (χ^2, $p<0.01$) with occupation of the patients.
Most of the CCs (84.4%) had sufficient number of chair/table for health worker.

Availability of electricity is very important for proper functioning of a CC; but is found that only 18 (56.3%) CCs had electric connection.

No healthcare facility can function properly without active phones. The study shows that very few CCs (21.88%) had active hotline.

5.2 Availability of Equipments

Availability of adequate and good equipment is a pre-requisite for running a CC efficiently and effectively. "Community Clinic Sthapan Sankrant Nitimala" maintains that each Community Clinic would keep eight categories of equipment. Deficiencies in the supply of these equipment will have adverse effects on service quality. The present study assessed sufficiency and condition (damaged or good) of equipment including (i) Primary medical kits (scissors, forceps), (ii) BP instrument with stethoscope, (iii) Tool kits (1-gauge, 6 masks, 4 thermometers, 2 timers, one sensor kits), (iv) Insecticide spraying machine, (v) Bathroom scale, (vi) Kerosene stove, (vii) Hanging scale, (viii) Umbo bag and penguin sucker, (ix) Urinary catheter, (x) Syringe, (xi) Vaginscope, (xii) Flash cards titled "Sonali Alo", (xiii) Others available in the CCs. It was found that none of the CCs surveyed received all the scheduled categories of equipment mentioned above. More than four-fifths of the CCs were found to function with adequate number of Primary medical kits (87.5%), tool kits including thermometers, timers and sensor kits (81.3%), bathroom scale (90.6%) which were in good condition. Hanging scale and BP instrument with stethoscope was found in 75.0% and 65.6% CCs, respectively in adequate number and good condition. Very few CCs had equipment like urinary catheter (37.5%), Umbo bag and penguin sucker (34.4%) and Insecticide spraying machine (6.3%) in adequate number and good condition. Vaginscope received by the CCs were found either inadequate or/and damaged. When categorized in terms of adequacy and condition (good or bad), the aggregate picture of availability of equipment in sufficient quantity and good condition was not encouraging. Only 4 CCs (12.5%) were in the 'Good' category, more than four-fifths (81.3%) were 'Average' and 6.3% were 'Poor' category. This differences were not significant (χ^2, $p>0.05$).

Reasons of inadequacy of equipments are varied: more than two-thirds reported non-availability of equipments, 37.50% reported that equipments were out of order, 3.1% reported that equipments were lost or stolen and quite a few (12.50%) did not know about sufficiency of equipments in the CCs.

Findings from Normand, Iftekar and Rahman shows that 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 (75.0%), thermometer (75.0%), stethoscope (68.3%), weighing machine (63.3%), hanging scale (66.7%) and primary medical kits (75.0%). 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.)

5.3 Availability of Furniture/Logistics: 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 backrest 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. Deficiencies were sufficiently serious to have effects on service quality. The present study assessed sufficiency and condition (damaged or good) of these and some other furniture/logistics available. It was found that none of the CCs surveyed received all the scheduled categories of above mentioned furniture/logistics. At the time of survey more than three-fourths of the CCs were found to have one table with one-drawer (84.4%), one steel almirah with two compartment (81.3%) and Wooden/plastic chair (81.3%) in sufficient number and good condition. Labor table (65.6%), Two back rest bench (65.6%), Laptop (68.8%), Internet facility (Modem) (71.9%) were found in sufficient quantity and good condition in about two-thirds of the CCs. Two mat/cushion bed for service receiver (53.1%) and one black board with stand (43.8%) were also found in sufficient quantity and good condition. Some logistics like Patient's register book (84.4%), Report card (75.0%) and Provider's attendance book were also found. When categorized in terms of adequacy and condition (good or bad), the aggregate picture of availability of furniture/logistics could not be termed as encouraging. Less than two-thirds CCs (62.5%) was in the 'good' category, 81.3% were 'average' and 12.5% were in 'poor' category. Availability of furniture/logistics in CCs had significant difference (χ^2, $p<0.05$) in different divisions.

Reasons of insufficiency of furniture/logistics were either these were not supplied (59.4%) or these were damaged (40.6%).

Results obtained from Normand, Iftekar and Rahman shows that the picture here was mixed. Most CCs were found to have some items, but few were found to have all the specified furniture. All CCs were supplied with a delivery table, 91.7% CCs received an examination table, 98.3% steel cabinet (two compartments), 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.

Security of the CC is important for the service users as well as the facility itself. The study shows that out of 32 CCs only 2 CCs had night guards, 16 were kept under lock and key and security of the remaining 14 were maintained either by CG and neighboring household or by local people.

5.4 Availability of Service Providers

Successful operation of CCs depends on people with the required skills being posted to the CCs. 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).

The sample of CC service providers consisted of 46.0% CHCP, 30.2% HA and 23.8% FWA. Gender mix of the providers was almost equal: females (52.4%) slightly outnumbering the males (47.6%). Males were significantly higher (55.9%) among CHCP while females were higher (100.0%) among FWAs (Fisher's Exact, $p<0.05$). Providers consisted mostly of young people; about four-fifths (79.3%) were aged 25 – 45 years. Mean age of the providers was 35.2 years with SD 10.03 years. Educational status of the providers was quite high: each 30.2% were graduates and masters followed by 31.7% had HSC and only 7.9% had SSC kevel education. CHCP had graduate and

above level of education whereas majority i.e. 50.0% HA had HSC level of education and 57.1% FWA had SSC level of education. This difference was statistically significant (Fisher's Exact, $p<0.01$).

Professional training is very important for improving skills and keeping up-to-date with emerging knowledge. All of the 63 providers (100.0%) received professional training in one or more selected health issues. Considering the individual issue, the percentage of providers receiving training was not at all encouraging. More than three-fourths of the providers received training only on two health issues including Nutrition (87.30%) and Arsenicosis (77.80%). Below two-thirds (60.3%) received training on two issues including CC management and Autism. Around half of the providers received training on Tuberculosis (57.10%), Computer (57.10%), Basic training of CHCP (54.00%) and Refresher training of CHCP (49.20%). In respect of the remaining health issues, percentage of the providers received training were very discouraging; it was lowest in SBA training for female CHCP (15.90%) followed by EOC training (20.60%), ESP training (28.60%), Training on NCDs (38.10%) and training on MIS (44.40%). This scenario emphasizes that much has yet to be done for training the service providers of the CCs. Almost all (95.2%) of the providers opined about the necessity of relevant professional training to improve skills.

It is found that most (92.3%) of the service users were of the opinion that the staff was trained enough as they got need based training to provide designated services.

According to the findings of Normand, Iftekar and Rahman 88% of CCs had both the providers, HA/FWA) and 12% of CCs had one provider only - HA in 3.34% CCs and FWA in 8.34% CCs. As regards education of staff, it was reported by the providers that 72.0 per cent of FWA's education level was SSC and below while 65.0 per cent HA's had HSC and graduation.

Findings from Normand, Iftekar and Rahman shows 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.

5.5 Health Care Services of the Community Clinics

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.

Present study assessed the state of health services provided by the CCs which includes (i) Reproductive and FP services, (ii) Integrated management of childhood illness (IMCI), (iii) Maternal and neonatal health care, (iv) EPI, ARI, (v) Nutritional education and micro-nutrient supplements, (vi) Health and Family Planning Education & counseling, (vii) Communicable disease control, (viii) Identification of emergency & complicated cases with referral to higher facilities for better manage, (ix) Screening of Non Communicable diseases like- Hypertension, Diabetes, Arsenicosis, Cancer, Heart diseases, Autism etc& referral, (x) Conduction of normal delivery, (xi) Treatment of minor ailments & first aid of simple injuries and handling of emergency cases like Poisoning, Snake bite, burn etc, (xii) Establishing effective referral linkage with higher Facilities, (xiii) Establishing an effective MIS and database of Community, (xiv) Other services identified by GOB under ESP to be provided. Excepting Conduction of normal delivery, coverage of other services were moderate to good. Services like EPI, ARI/Provision, Nutritional education and micro-nutrient supplements/Provision; Health and Family Planning Education & counseling/Provision and establishing effective referral linkage with higher facilities/Provision were provided by all the CCs. More than 90% of the CCs provided services like Integrated management of childhood illness (IMCI)/Provision, Maternal and neonatal health care/Provision, Communicable disease control/Provision, Identification of emergency & complicated cases with referral to higher facilities for better manage/Provision, and Treatment of minor ailments & first aid of simple

injuries and handling of emergency cases like Poisoning, Snake bite, burn et/Provision. Quite a large number of CCs provided services like Diabetes, Arsenicosis, Cancer, Heart diseases, Autism etc & referral/Provision, Establishing an effective MIS and database of communit/Provision and Other services identified by GOB under ESP to be provided/Provision. Comparatively fewer CCs provided the vital service - conduction of normal delivery.

When categorized in terms of availability of the service, the aggregate picture was not bad. Majority (78.1%) of the CCs were graded as 'Good' in respect of health services provision as requirements of the people while 21.9% CCs were graded as 'Average'. This study shows that state of health care provision was good in 100% CCs of Sylhet, Chittagong, Khulna & Mymensingh division whereas average in Dhaka (50.0%) & Rangpur (75.0%) division. This difference was not statistically significant (Fisher's Exact, $p>0.05$).

5.6 Knowledge of the Community People on CC Services

Almost all the community members surveyed were aware about the services available at CC. Out of 3285 respondents, 3229 (98.3%) knew about the services available at CC; only 56 did not know about it. Their main source of information was Neighbors/ relatives (57.0%) who used CC services. Role of Health Workers, Public representatives, and Radio/TV/Newspapers to help the people know about the services available at CC was not remarkable; number of people who came to know from these sources were 23.6%, 14.4%, and 3.8%, respectively only.

This study showed that in respect of knowledge about CC, 98.2% males and 98.4% females were known about CC. This difference was not statistically significant (χ^2, $p>0.05$) on the other hand knowledge about CG & CSG by sex of the community members were statistically significant (χ^2, $p<0.01$). By occupation knowledge about CC (χ^2, $p<0.05$), CG (χ^2, $p<0.01$) & CSG (χ^2, $p<0.01$) were also significantly different among the community members.

5.7 Knowledge of the Service Users on CC Services

Almost all the patients (99.2%) knew about the about services available at CC. Most of the patients knew about availability of Maternal and Neonatal services (91.8%) followed by EPI/Vaccination services (86.4%) and Treatment of common diseases

and problems & first aid for the minor injuries (71.8%). Around half of the patients knew that services like Reproductive Health services and Family Planning (54.3%), Nutritional education and micronutrient supplementation (49.8%) and Health, Nutrition and FP education & counseling (48.7%) were available at the CC. Around only one-third knew about Integrated management of childhood illness (IMCI) (38.2%), Screening of Diabetes, Hypertension, Autism, Club feet and referral to higher facilities (36.8%) and Registration of newly married couple, pregnant mothers, birth and death; preservation of EDD (31.7%). Very few people knew about availability of vital services like providing Essential Service Package (ESP) (3.9%), Normal delivery with the availability of trained manpower & other facilities (7.9%), establishing an effective referral linkage (15.7%) and Identification of emergency and complicated cases with referral to higher facilities (21.8%).

5.8 Drug Supply Services

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 33 categories of medicines to be supplied to the CC. According to the guidelines, each Community Clinic would maintain a monthly stock of those medicines.

In order to find the state of drug supply services, attributes such as (i) Availability of all essential drugs (33), (ii) Supply of essential drugs in due time, (iii) Sufficiency of Quantity of essential drugs supplied, (iv) Sufficiency of Quantity of essential drug dispensed, (v) Dispensing of essential drugs by assigned person were considered. The overall scenario is discouraging; all 33 essential drugs were available in less than two-thirds of the CCs (62.5%) only, drugs were supplied in time in 87.5% CCs, only 43.8% CCs received essential drugs in sufficient quantity, quantity of essential drug dispensed was sufficient in 40.6% CCs only. As regards dispensing of essential drugs by assigned personnel picture is bright – in 96.9% CCs essential drugs dispensed by assigned personnel. An alarmingly large number of participants in the Community Survey (46.8%) reported that the CC suffered from shortage of medicine.

When categorized in terms of an attribute being satisfactory, the aggregate picture of drug supply services was rather discouraging as only 40.6% CCs were graded as

'Good' where as about one-third (31.3%) were just 'Average' and as high as about one-third (28.1%) were 'Poor'. This study shows that 3(75.0%) CCs in Rangpur division had poor drug supply service while 4(100.0%) had good drug supply service in Dhaka division and this difference was not statistically significant (Fisher's Exact, $p>0.05$).

Results obtained from the sample service receivers show that 76.3% of them were satisfied, 21.3% were partially satisfied and remaining 2.4% were unsatisfied about availability of medicine.

Trends of Essential Drugs Supply at the CCs

The study shows that the average number of essential drugs supplied to the CCs did not vary remarkably during the last five financial years preceding the survey year; it varied from the minimum 26.88 in 2015-2016 to the maximum 29.88 in 2013-2014.

Normand et. Al. found that in most cases most of drugs 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. 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. The key source of dissatisfaction is the poor availability of drugs, which also sometimes leads to the clinic being closed. There was also dissatisfaction that clinics were often closed. Almost all CCs open once or twice per week only to provide EPI and FP services. 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.

5.9 Health Education Services of the CCs

All the community clinics are concerned about providing of health education services to the community members on important health issues like (i) Ante-natal care (ANC), (ii) Delivery plan, (iii) Post natal care (PNC), (iv) Child Health and Nutrition, (v) Growth monitoring of children, (vi) Common health problems, (vii) Family planning and (viii) Nutrition. Overall performance of the CC as far as providing *Health*

Education Services is very satisfactory. All the 32 sample CCs conducted health education programs like *Ante-natal care (ANC), Child Health and Nutrition, Common health problems,* and *Nutrition.* Almost all the CCs (96.9%) provided education services like *Delivery plan, Post natal care (PNC),* and *Growth monitoring of children.* Education program on *Family planning* was provided by (93.8%) CCs.

When categorized in terms of an issue being included in health education, the aggregate picture of Health Education Services services was encouraging as almost all (96.9%) of the CCs were graded as 'Good' as far as providing health education was concerned and only 1 CC (3.1%) was graded as 'Average'. This study revealed that state of health education services in CCs was good (100.0%) almost all divisions except Dhaka (75.0%). This difference was not statistically significant (Fisher's Exact, $p>0.05$).

5.10 Trends of CC Services Utilization

The study tried to find the number of patients utilizing CC services during the last five years preceding the survey year. It was found that the number of patient utilizing CC services increased over the years. Female formed the majority of the service users followed by male and the by children. During the last five years, total number of patients was 1169525 of whom 30.85 % were male, 55.79% were female and 13.35% were children.

The number of normal delivery conducted at the CC during the last five years was also determined. It was found that the number of normal delivery conducted at the CC increased over time – from 24 in 2012 to 128 in 2016.

5.11 Satisfaction of the Service Users Regarding CC Services and Facilities

The present study attempted to find the service users level of satisfaction about the quality of CC services and facilities. Overall it was good; out of 11 criteria more than 80% users were satisfied with 7 criteria: waiting arrangement, cleanliness of the CC, perceived quality of services, interaction and behavior of provider, qualified person providing service, receiving prompt service, and, quality of health education. About 75.0% users were satisfied the remaining 4 service quality categories – waiting time, maintaining privacy, Availability of medicine, and, access to information.

Among the service users there were significant difference in level of satisfaction about waiting arrangement (χ^2, $p<0.01$), waiting time (χ^2, $p<0.01$) and qualified service providers (χ^2, $p<0.01$) by occupation of the users whereas cleanliness of the CCs, privacy of the CCs, availability of medicine and quality of health education were not significantly different.

In respect of sex of the user, there were significant difference in level of satisfaction about waiting arrangement (χ^2, $p<0.01$), waiting time (χ^2, $p<0.01$), perceived quality of services (χ^2, $p<0.01$) and quality of health education (χ^2, $p<0.05$). On the other hand cleanliness, privacy maintenance, interaction and behavior of the service provider, availability of medicine, information obtained from providers, receiving prompt service and qualified service providers were not significantly different.

Findings from Normand *et al*. shows 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. 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.

5.12 Workload of the Health Service Providers

Regular attendance is necessary for providing service to the patients and attendance rate of the service providers was found very high and almost all the providers (96.8%) attended the clinics in time every day. Most (90.5%) of the providers worked 5–6 hours per day while less than 10% worked only 3–4 hours per day. Two-thirds worked 6 days per week and the remaining one-third worked only 2-3 days per week. 96.8% maintained Register book / Report card regularly. Duration of work per day was significantly (χ^2, $p<0.01$) associated with designation of service providers.

Normand et. Al. 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.

5.13 Management of CC and Community Participation

In rural Bangladesh, Community Clinics (CCs) are the closest health facilities to the community people. It is a unique example of Public-Private partnership; the government policy is to provide necessary funds for establishment of CC, supply of required MSR, medicine, equipment, furniture and all other logistics and inputs and employ required manpower (service providers), and, 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. But management is both by community and Govt. through Community Group (CG) and Community Support Group (CSG). Community Involvement is an important aspect of CC implementation. Community owns CC & plays active role for its improvement in all regards.

Community Group (CG): For proper management, a Community Group for each CC is meant to be formed prior to the selection of land. The Community Group should have 9 – 17 members including three women members, elected Union Parishad1 (UP) member as the president, donor of the land or his representative as life member, service providers (HA/FWA) and members from different sectors i.e. social workers, religious leaders, adolescents, retired government officials and others. CHCP is the member secretary without voting right. Each CG holds a monthly meeting to discuss health issues in the community. It also manages Community fund that is saved by local people to cope well with community problems.

60.0% of the Key Informants reported that the CG consisted of 17 members. Others said that the CG consisted of 10 to 16 members. 84.4% KI were aware of the presence of female embers in the CG and, according to two-thirds of them number of female members in the CG were 4–6, according to about 22.0%, it was up to 3 members while 11.1% reported that there were 7–9 female members. About 15% of the KI were not aware of the presence of female embers in the CG. According to 79.6% respondents, land donor was a member of the CG and according to 81.9% respondents, service provider (CHCP) was also included in the CG, and 79.7% reported that the service provider (CHCP) acted as the member-secretary of CG.

The study shows that quite a large number of the CCs (88.9%) had effective and functioning Community Group (CG) for management of the CC while 11.1% CGs

were inactive. In the CCs with inactive CG, 28.6% reported that it was not formed properly, and 71.4% did not know the reason. Off all, 98.2% providers thought that numbers of members of the CG were adequate and 92.1% thought that number of female members of the CG were adequate. The posts of member secretary and chief patron of the CG were regarded very important. In most cases (96.8%), CHCP was the member secretary of CG and in more than half of cases (58.7%), UP chairman was the chief patron of the CG. Most (92.1%) of the CG members were trained following training manual & trainer's guide. The CG members met mostly once in a month (85.7%); in one case the CG members met once in a year.

Community Support Group (CSG): Besides, in the catchment area of each CC, there will be 3 Community Support Groups (CSGs) comprising of 13-17 members with at least one third women members. Community Support Group is a community-based organization to help CG in CC management and facilitate utilisation of CCs by mobilizing the community and making them aware regarding the services available at CC and common health messages, contributing local resource mobilization for CCs and strengthening referral linkage. Every CC has three CSGs. CSG members make a social map to identify pregnant women's houses and visit their houses regularly to follow-up the course of their pregnancy in time. They share the updated status of pregnant women at bi-monthly meetings.

It is found that 96.8% CCs had Community Support Group (CSG) to support CG. Around 98% thought that the number of the members of the CSG was adequate, 92.1% opined that the number of female members of the CSG was adequate. In 96.8% cases, CHCP were member secretary of CSG and in 58.7% cases, UP chairman was the chief patron of the CG. About 83% opined that CSG members were trained following training manual & trainer's guide.

About 40.0% community members did not know about the CG. Almost 99.0% of the people who knew about the CG were of the opinion that CG's participation had benefited the community. A large proportion (63.8%) of community members did not know about the CSG. 98.0% of the people who knew about the CSG were of the opinion that CSG's participation had benefited the community. There was significant association (χ^2, $p<0.01$) between knowledge of community members about CG and their occupation. It was revealed that in the CCs, cleanliness was ensured mostly by Aya (41.3%) and Cleaners (38.1%). In 33.3% cases, CG/CSG supervised the

cleanliness activities. In 63.5% cases, the FWA/HA came to the CC for providing services thrice in a day, 3.2% never came and 11.1% and 22.2% came once in a week and twice in a week respectively.

Formation of CG: Opinions of the Key Informants (KI)

Majority (61.0%) told that it was formed after hand over, 10.7% and 5.2% reported that it was formed before site selection and before construction, respectively. About one-fourth KIs had no idea about how the CG was formed. 76.7% reported that the CG members were oriented about their roles and responsibilities. According to 60.8% KIs, the CG members met every month, 18.4% reported that the members met every three months. 1.3% reported that no meeting was held at all and 14.4% did not know about how often the CG members met. About two-thirds (64.8%) KI reported that the UP Chairman supervised functioning of the CC.

Responsibilities of CG and CSG: Opinions of the Key Informants (KI)

Ensuring cleanliness at the CC (96.6%), Ensuring security of the CC (95.8%) and Day to day operation of the CC (90.8%) were the mostly reported responsibilities of the CG. More than three-quarters of the KIs mentioned Monitoring and evaluation of community participation, Monitoring and evaluation of CC performance, and Coordination with other providers and stakeholders as responsibilities of the CG. Local fund generation and transparent utilization was mentioned by little over half of the KIs.

KIs reported Keeping close contact with the CG (92.6%), Helping the poor, marginalized & vulnerable in getting services (83.1%), Making the community aware of the CC services (82.4%), Helping the community to get emergency services (81.4%), Disseminating Health, Nutrition & FP messages (79.9%), Helping CG in fund generation (79.7%), and Helping the poor in referral (75.4%) as responsibilities of the CSG.

Problems faced by the Committees: Opinions of the Key Informants (KI)

Most reported problems faced by the committees were Scarcity of equipments (51.8%) and inadequate drug supply (51.8%). About two-fifths (38.2%) reported Insufficient logistics supply (38.2%), and slightly more than one-third (34.3%) reported Financial constraint as problems faced by the committees. Comparatively fewer KIs reported problems like Poor patronization of Government (20.1%), No

public support (19.8%). Surprisingly only 1.5% reported Pressure of power groups as problem. Most KIs (94.3%) reported that land on which the CC was located was donated by the community.

Management of CCs: Opinions of the KIs

49.2% reported that the CG was involved in supervision of the construction of infrastructure, 79.2% reported that the CG involved in operational management & maintenance the CC, and according to 88.4% of the KIs the CG assisted in keeping the premises neat and clean. Only 22.9% reported that committee collected money locally; but in the past the figure was even lower, only 17.9%. Money collected locally was spent mostly to treat poor patients (59.5%), to treat children (49.2%), to prepare infrastructure (43.7%), to treat women (37.5%), and other purpose (3.0%). A large proportion of KIs (28.3%) did not know how the money was spent. Most (86.8%) of the KIs regarded the overall management satisfactory.

5.14 Major Constraints with the CCs

Major constraints associated with the CC, as reported by the community members were, *unavailability of medicine (including antibiotic)* (32.8%), *lack of specialist doctors such as gynecologist, diabetes specialist, eye specialist* (30.3%), and, *inadequate number of health care provider* (30.9%). Other constraints reported were *long distance of CCs* (about 11.0%), *lack of electricity* (about 8.0%), *unfriendly behavior of providers* (4.2%), and *badly constructed building* (3.0%).

5.15 Improvement of CC Management

Effective Community Participation The overall picture is of limited community involvement. CGs were set up late, and it is clear that they have responsibility. CGs have not been effective in monitoring service delivery and quality. The lack of knowledge of their membership and roles suggests limited engagement from the communities.

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.

Strengthening Activities of Management Committees

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.

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.

CG members 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. In the context of Bangladesh relevant literatures were very scarce to compare with the study findings. This study is the pioneer one to assess the patterns and effects of community participation health care delivery in rural Bangladesh through community clinic approach.

6.1 Conclusion

Since the establishment community clinics have shown effectiveness in provision of health care services at primary level in Bangladesh. Comprehensive study on effect of community participation is a time bound task. This cross-sectional study was designed to assess the pattern and effects of community participation in health care delivery in rural Bangladesh through the community clinic approach. Data were collected by mixed methods including face-to-face and key informant's interview from health care providers, service users, community people and key informants. Most of the CCs were located in easy to reach area and lands of CCs were donated exclusively by the community members. Almost all the facilities had good infrastructure and security was maintained by community people and members of community groups. Availability of equipments was not encouraging as it was 'Good' in only half of a quarter of CCs while supply service was 'Good' in two-fifth of CCs. Availability of logistics and furniture was 'Good' in less than two-thirds CCs. Provision of health care delivery was 'Good' in more than three fourth facilities and most had 'Good' health education services. All the CCs had increased trend of heath care utilization and normal delivery conduction in last five years. Almost all the health care providers got professional training and most of them were used to work 5-6 hours per day. All the CCs performed referral service and almost all maintained referral slip for patient referral. More than four-fifth of the CCs had active Community Group (CG) and almost all CCs had active Community Support Group (CSG). In almost all CCs, CHCP was the member secretary of CG and in more than half CC, UP chairman was the chief patron. CC service users were predominantly female and almost all knew about services available at the CCs. Users perceived benefits of CCs included free drugs, free treatment, easy access, need based health services and immunization service. More than three fourth of the users were satisfied with the services of CCs. Almost all of the people opined that the community people were concerned about the benefits of CCs through their participation by different ways and means like participation in decision making for further improvement, problem solving, local fund collection, assisting referral services. Most of the key informants (KI) addressed that the committees of CC were functional and more than four-fifth opined that the members of the committees were included as per eligibility criteria. It was revealed that the CG was involved in supervision, management and maintenance of the CCs. Collected money was spent to treat poor patients and repair infrastructure. Average

number of patients treated in CCs and availability of furniture/logistics were significantly different by divisions. Level of satisfaction about waiting room, waiting time and quality of the service providers were significantly varied with sex and occupation of the patients. Knowledge about CG, CSG was discriminated by sex and occupation of the community members. Management of CCs was regarded as satisfactory. Perceived impacts of community participation through community clinic approach included effective utilization of essential health care, healthy lifestyle, improved water and sanitation, increased access to vaccination and ante-natal care, reduction of communicable diseases and maternal & child mortality, raised health awareness of the community people. Major constraints included lack of specialist doctors, inadequate service provider, scarcity of equipments, inadequate drug supply, insufficient logistics supply, financial constraint, poor patronization of Government and lack of electricity supply. More campaign and promotional activities for CCs are essential through organizing more meetings with community people, expansion of space, donation of community, digital communication and easy transportation to ensure effective access to the its services. Government, stakeholders and communities must extend their participation through community clinic approach in diverse ways and means throughout the country.

6.2 Recommendations

On the basis of the findings of this study, some recommendations for effective community participation are portrayed as follows:

- Cleanliness and security of the community clinics should be ensured by appointing permanent cleaner and night guard through innovative initiatives of the government and mobilizing community resources.
- To ensure safe drinking water at the CCs, non-functional tube-wells should be repaired to make them functional and new tube-well should be provided.
- Electricity supply should be ensured where it is not available and alternative source of power supply should be made available to render need based services.
- To improve quality of health services, availability of necessary equipments should be ensured by repairing or replacing the out of order instruments and providing modern instruments.
- To ensure need based distribution of essential drugs, all types of essential drugs should be supplied in required quantity and in right time at the CCs. Effective monitoring of dug supply chain should be established.
- To improve the satisfaction of service users, hospitality, availability and maintenance of furniture and logistics should be improved.
- To improve the skill of the service providers, training program on professional skill including behavior, attitude and cooperation with clients should be organized.
- To ensure need based treatment of the complicated patients, structural referral system should established and service provider should be trained accordingly. For this, effective initiatives in respect of transportation, communication and revolving fund generation may be taken.
- To ensure effective management and maintenance of the CCs, inactive CG and CSG should be activated through training, strengthening, upgrading and reforming as required by the respective CCs.

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Annexure-1

Ethical Clearnce

Annexure-2

Work Schedule (Sequence of Tasks with Time Frame)

(January 2016–December 2017)

Task	Months											
	1 to 2	**3 to 4**	**5 to 6**	**7 to 8**	**9 to 10**	**1 to 12**	**13 to 14**	**15 to 16**	**17 to 18**	**19 to 20**	**21 to 22**	**23 To 24**
Literature review												
Development of project proposal												
Preparation of data collection instruments												
Recruitment of personnel, pre-testing & finalization of instruments												
Training of the field staff												
Data collection												
Data processing & quality control												
Data entry												
Data analysis												
Report writing												
Printing, binding & submission of final report												

Annexure-3

Pattern and Effects of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach

Informed Consent Form (English)

Background of the study:

In the rural Bangladesh, essential services are provided from a static centre, namely the Community Clinic, especially to meet the needs of the poor, women, children and elderly. Community Clinic is a unique means of community participation as are constructed with direct involvement of community members. Health sector of Bangladesh has achieved remarkable success and community clinics have played pivotal role behind it. Community participation is evidenced as the mainstreaming force for effective management and utilization community clinics and improvement community health. For this, it is inevitable to find out the pattern of community participation and unveil its effects on different dimensions of community health in rural Bangladesh.

Purpose of the study:

This study intends to assess the pattern and effects community participation in rural Bangladesh through the community clinic approach.

Types of participation in the study:

As you are a conscious member of this community and eligible for the information required for this study. For this, you are invited to take part in this research. Your participation in this study is completely voluntary.

Duration, procedures of the study and participant's involvement:

If you give consent to participate in the study, you will be interviewed with some questions will be asked to you related to your socioeconomic condition, health problems, pattern and effects of participation through community clinics and its services. All of this might take approximately 45 minutes.

Benefits, reimbursement, risk, hazards and discomforts:

For participation and information you will not have any physical, mental, social or economic loss or hazard. Since only an interview will take place, there is no risk for participation in this study. You will not have any reimbursement for participating in

this study but your participation will be beneficial in determination of pattern and effects community participation in rural Bangladesh through the community clinic approach. The study findings will contribute to take effective measures to improve community health through efficient community participation in the rural Bangladesh.

Confidentiality of information:

Information provided by you will remain confidential. We shall not disclose this information to any other person or organization. Your name or identity will not be published anywhere.

Termination of study participation / Rights to withdraw from participation:

Participation in this study is completely voluntary. If you desire you may refrain from participating in this study. If you take part, you have the right to withdraw your consent at any time and stage of this study.

Consent for participating in the study:

I am invited to participate in the research titled **"**Pattern and Effects of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach". Purpose of research, type of participation, duration and procedure of the study, benefit, risk, discomfort and reimbursement issues are informed to me in details. I have got satisfactory answer to all my questions related to the study and I am authorized that I could withdraw my consent for participation at any time or stage of the study.

I willfully give consent to take part in the research.

……	……	…….
Name of the participant	Signature of the participant/ thumb impression	Date
……	……	…….
Name of the witness	Signature of the witness/ thumb impression	Date

Thanking you for your sincere participation and valuable information for the study.

……	……	…….
Name of the interviewer	Signature of the interviewer	Date

Annexure-
Informed Consent Form (Bangla)

Pattern And Effects Of Community Participation In Health Care Delivery in Rural Bangladesh Through The Community Clinic Approach

অবহিতকরণ সম্মতি

গবেষণার প্রেক্ষাপটঃ

বাংলাদেশের গ্রামাঞ্চলে কমিউনিটি ক্লিনিক স্বাস্থ্য কেন্দ্র থেকে অত্যাবশ্যকীয় স্বাস্থ্যসেবা প্রদান করা হয় বিশেষ করে দরিদ্র জনগোষ্ঠি, নারী, শিশু ও বয়স্কদের চাহিদা পূরণের জন্য। কমিউনিটি ক্লিনিকগুলো স্থানীয় জনসাধারণের সরাসরি সম্পৃক্ততায় প্রতিষ্ঠিত হওয়ায় এগুলো জনসাধারণের অংশগ্রহনের একটি অনন্য মাধ্যম। বাংলাদেশের স্বাস্থ্যখাতের উল্লেখযোগ্য সাফল্য অর্জনের পেছনে কমিউনিটি ক্লিনিক মূখ্য ভূমিকা পালন করেছে। জনসাধারণের অংশগ্রহনের ফলশ্রুতিতেই কমিউনিটি ক্লিনিকের কার্যকর ব্যবস্থাপনা এবং স্থানীয় জনগনের স্বাস্থেও উন্নয়ন সম্ভব হয়েছে। এই প্রেক্ষিতে গ্রামবাংলায় কমিউনিটি ক্লিনিকে জনসাধারণের অংশগ্রহনের ধরণ এবং স্বাস্থ্য খাতের বিভিন্ন দিকে এর কার্যকারীতার বিষয়গুলো উন্মোচন করা অপরিহার্য।

গবেষণার উদ্দেশ্যঃ

বাংলাদেশের গ্রামাঞ্চলে কমিউনিটি ক্লিনিক কার্যক্রমে জনসাধারণের অংশগ্রহনের ধরণ ও এর কার্যকারীতা মূল্যায়ন করা।

গবেষণায় অংশগ্রহনের আমন্ত্রনের কারনঃ

যেহেতু আপনি এই এলাকায় একজন সচেতন নাগরিক এবং এই গবেষণার জন্য প্রয়োজনীয় তথ্য প্রদানের জন্য উপযোগী সেই কারণে গবেষণায় অংশ গ্রহনের জন্য আপনি আমন্ত্রিত। এ গবেষণায় আপনার অংশগ্রহন সম্পূর্ণ ঐচ্ছিক।

গবেষণার পদ্ধতি, অংশ্রগহণকারীর সম্পৃক্ততা এবং ব্যাপ্তিকালঃ

আপনি যদি এই গবেষণায় অংশগ্রহণ করার জন্য সম্মতি দেন তাহলে আপনার আর্থসামাজিক অবস্থা, স্বাস্থ্য সমস্যা, কমিউনিটি ক্লিনিকের কার্যক্রমে আপনার অংশগ্রহনের ধরণ এবং কমিউনিটি ক্লিনিকের কার্যকারীতা ইত্যাদি বিষয়ে প্রশ্ন করার মাধ্যমে আপনার একটি সাক্ষাতকার গ্রহণ করা হবে। এই সাক্ষাৎকার সম্পন্ন করতে প্রায় ৪৫ মিনিট সময় প্রয়োজন হতে পারে।

এই গবেষণায় অংশগ্রহনে উপকার, আর্থিক পূনর্ভরণ, ঝুঁকি এবং অস্বস্তিবোধঃ

এই গবেষণায় অংশগ্রহনে এবং তথ্য প্রদানে কোনপ্রকার শারীরিক, মানসিক, সামাজিক বা অর্থনৈতিক ক্ষতি হবে না। যেহেতু শুধুমাত্র একটি সাক্ষাতকার গ্রহণ করা হবে, কাজেই এই গবেষণায় অংশগ্রহণ করলে আপনার স্বাস্থ্যের কোন ঝুঁকির সম্ভাবনা নেই। এই গবেষণায় অংশগ্রহনের জন্য আপনাকে কোন ধরণের আর্থিক পুনর্ভরণ প্রদান করা হবে না কিন্তু আপনার অংশগ্রহন বাংলাদেশের গ্রামঞ্চলে কমিউনিটি

ক্লিনিক কার্যক্রমে জনসাধারণের অংশগ্রহনের ধরণ এবং কার্যকারীতা নির্ণয়ের ক্ষেত্রে অনেক উপকারী হবে। এই গবেষণালব্ধ ফলাফল বাংলাদেশের গ্রমাঞ্চলে জনগনের স্বাস্থ্যের মান উন্নয়নের লক্ষ্যে জনসাধারণের কার্যকরী অংশগ্রহনের বিষয়ে প্রয়োজনীয় পদক্ষেপ নেয়ার ক্ষেত্রে বিশেষ ভূমিকা পালন করবে।

তথ্য প্রদান সম্পর্কিত গোপনীয়তা:-

আপনার প্রদানকৃত তথ্য গোপন থাকবে। আমরা কোন ব্যাক্তি বা প্রতিষ্ঠানের কাছে আপনার দেয়া তথ্য প্রকাশ করব না। আপনার নাম বা পরিচয় কোথাও প্রকাশিত হবে না।

গবেষণায় অংশগ্রহন থেকে অব্যহতি/গবেষণায় অংশগ্রহন না করা বা প্রত্যাহার করার অধিকার:-

এই গবেষণায় আপনার অংশগ্রহন সম্পূর্ণ ঐচ্ছিক। আপনি চাইলে এই গবেষণায় অংশগ্রহন থেকে নিজেকে সরিয়ে নিতে পারেন। যদি আপনি অংশগ্রহন করেন তারপরও যেকোন সময় সম্মতি প্রত্যাহার করার অধিকার আপনার আছে।

গবেষণায় অংশগ্রহনের সম্মতি:-

"বাংলাদেশের গ্রামাঞ্চলে কমিউনিটি ক্লিনিক কার্যক্রমে স্থানীয় জনসাধারণের অংশগ্রহনের ধরণ ও তার প্রভাব"

শীর্ষক গবেষণায় অংশগ্রহণ করার জন্য আমাকে আমন্ত্রণ জানানো হয়েছে। গবেষণায় উদ্দেশ্য, অংশগ্রহণের ধরণ, সময়কাল, পদ্ধতি, উপকারীতা, ঝুঁকি, অস্বস্তি এবং আর্থিক পূনর্ভরণ সম্পর্কে আমাকে বিস্তারিত জানানো হয়েছে। এই গবেষণা সংক্রান্ত বিষয়ের বিভিন্ন প্রশ্নের সন্তোষজনক উত্তর আমি পেয়েছি এবং এই গবেষণা চলাকালীন যে কোন সময়ে এবং যেকোন পর্যায়ে আমার সম্মতি আমি প্রত্যাহার করতে পারব সে অধিকারও আমাকে দেওয়া হয়েছে।

আমি স্বেচ্ছায় এই গবেষণায় অংশগ্রহণ করার সম্মতি প্রদান করছি।

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গবেষণায় অংশগ্রহনকারীর নাম ও	তথ্য সংগ্রহকারীর নাম ও স্বাক্ষর
স্বাক্ষর/বৃদ্ধাঙ্গুলের ছাপ	তারিখ:
তারিখ:	

স্বাক্ষীর নাম ও স্বাক্ষর
তারিখ:

Annexure-IV

Questionnaire (English)

Pattern and Effects of Community Participation in Health Care Delivery in Rural Bangladesh through the Community Clinic Approach

- ID No: | | | | |
- Date of the Interview: | | | | |
- Time of the Interview: | | | | |

Section-A: Community Clinic (CC) Survey

- Name of the Community Clinic (CC):----------
- Code number of the Community Clinic (CC): |
- Address of the CC:----------
- ✓ Village/Ward:----------
- ✓ Union: ----------
- ✓ Upazila:----------
- ✓ District: [Put code number]---------- |

A-1: Infrastructure of the Community Clinic (CC)

A.1.1 Accessibility to the community clinic |

1. Easy to access
2. Difficult to access |

A.1.2 Location of the CC

1. Middle of the catchments area and easy to reach |
2. Out of the surveyed village
3. Near to residing area of the village
4. Near to flood prone area
5. Marshy and water logged land

A.1.3 Level of land where the CC is located

1. High land
2. Low land
3. Low land with water logging

A.1.4 Land of the CC donated by

1. Government2. CG member

3. CSG member 4. Local member of community

5. Others (Specify……)

A.1.5 Size of the community clinic

1. Govt. approved (450 sq ft)
2. Smaller than Govt. approved size

A.1.6 Quality of construction of the CC

1.6.1 Door's quality: 1. Good 2. Broken

1.6.2 Window's quality: 1. Good 2. Broken

1.6.3 Roof's quality: 1. Good 2. Broken

A.1.7 Number of Rooms in the CC

A.1.8 Position of latrines of CC

1.8.1 Number of latrine: 1. One 2. Two

1.8.2 Condition of latrine: 1. Clean 2. Dirty

A.1.9 Condition of tube-wells installed in CCs

1. Have and functioning
2. Have but not functioning
3. Do not have

A.1.10 Waiting space for patients

1. Well equipped with bench and others
2. Not equipped (Patients remain standing)

A. 1. 11 Electricity supply at the CC

1. Present 2. Absent

A.1.12 Sufficiency of chair/table in HA/ FWA's room for providing services

1. Sufficient 2. Insufficient

A.1.13 Any hotline number at the CC

1. Present 2. Absent

A.1.14 If yes, is it active?

1. Yes 2. No

A.1.15 Availability of providers (Multiple response possible):

1. HA
2. FWA
3. CHCP

A.1.16 Presence of night guard at the CC:

1. Yes 2. No

A.1.17 Maintenance of security of the CC:

1. Yes 2. No

A.1.18 Security of the CC is maintained by

1. Guard 2. Lock and key
3. CG and neighboring household take care
4. Local people 5. Providers 6. Don't know

A-2: Service delivery, drugs and logistics

A.2.1. Availability of equipments

Sl. No	Name of the Equipment	Supply		Condition		Score Adequate and good=2, Inadequate & good/Adequate & damaged=1 Inadequate and damaged=0
		1.Adequate	2.Inadequate	1.Good	2.Damaged	
2.1.1	Primary medical kits (scissors, forceps)					
2.1.2	BP instrument with stethoscope					
2.1.3	Tool kits (1-gauge, 6 masks, 4 thermometers, 2 timers, one sensor kits)					
2.1.4	Insecticide spraying machine					
2.1.5	Bathroom scale					
2.1.6	Kerosene store					

2.1.7	Hanging scale					
2.1.8	Umbo bag and penguin sucker					
2.1.9	Urinary catheter					
2.1.10	Syringe					
2.1.11	Vaginscope					
2.1.12	Flash cards titled "Sonali Alo"					
2.1.13	Others (Specify……)					
2.1.14	Overall score					
2.1.15	Remark					

2.1.16 Reasons of inadequacy of equipments? (Multiple Responses)

1. Out of order
2. Lost/ stolen
3. Not given
4. Do not know

A.2.2. Drug supply services

Sl. No	**Attribute**	**Availability**		**Score 1=1, 2=0**
2.2.1	Availability of all essential drugs (30)	1. Available	2. Not Available	
2.2.2	Time of essential drugs supply	1. In due time	2. Not in due time	
2.2.3	Quantity of essential drugs supply	1. Sufficient	2. Insufficient	
2.2.4	Quantity of essential drug dispensed	1. Sufficient	2. Insufficient	
2.2.5	Dispensing of essential drugs by	1. Assigned person	2. Others	
2.2.6	Overall score on drug supply services			
2.2.7	Remark			

A.2.3. Availability of furniture/logistics

Sl. No	Furniture/Logistics	Availability		Condition		Score 1=1, 2=0
		1.Availabe	2.Not available	1.Good	2.Damaged	
2.3.1	Labor table					
2.3.2	Investigation table					
2.3.3	One steel almirah with two compartments					
2.3.4	Two back rest bench (for 4-5 person)					
2.3.5	Two mat/cushion bed for service receiver					
2.3.6	One black board with stand					
2.3.7	Wooden/plastic chair					
2.3.8	One table with one-drawer					
2.3.9	Patient's register book					
2.3.10	Report card					
2.3.11	Provider's attendance book					
2.3.12	Laptop					
2.3.13	Internet facility (Modem)					
2.3.14	Overall score on availability of furniture / logistics					
2.3.15	Remark					

2.3.17 Reasons of insufficiency of furniture:

1. Not given
2. Damaged

A.2.4. Services provided by the CC

Sl. No	Service	Provision		Score 1=1, 2=0
		1. Yes	2. No	
2.4.1	Reproductive and FP services			
2.4.2	Integrated management of childhood illness (IMCI)			
2.4.3	Maternal and neonatal health care			
2.4.4	EPI, ARI			
2.4.5	Nutritional education and micro-nutrient supplements			
2.4.6	Health and Family Planning Education & counseling			
2.4.7	Communicable disease control			
2.4.8	Identification of emergency & complicated cases with referral to higher facilities for better manage			
2.4.9	Screening of Non Communicable diseases like- Hypertension, Diabetes, Arsenicosis, Cancer, Heart diseases, Autism etc & referral			
2.4.10	Conduction of normal delivery			
2.4.11	Treatment of minor ailments & first aid of simple injuries and handling of emergency cases like Poisoning, Snake bite, burn etc			
2.4.12	Establishing effective referral linkage with higher facilities			
2.4.13	Establishing an effective MIS and database of community			
2.4.14	Other services identified by GOB under ESP to be provided			
2.4.15	Overall score on services provided by the CC			
2.4.16	Remark			

A.2.5. Issues/Subjects included in health education

Sl. No	Health education issue	1. Yes	2. No	3. Remark
1.	Ante-natal care (ANC)			
2.	Delivery plan			
3.	Post natal care (PNC)			
4.	Child Health and Nutrition			
5.	Growth monitoring of children			
6.	Common health problems			
7.	Family planning			
8.	Nutrition			

A.2.6. Number of medicine items supplied at the CC during the last five financial years

Sl. No	Financial Year	1. Number	2. Remark
2.5.1	2011-2012		
2.5.2	2012-2013		
2.5.3	2013-2014		
2.5.4	2014-2015		
2.5.5	20154-2016		
2.5.6	Total		

A.2.7. Number of patients utilizing CC services during the last five years (See records)

Sl. No	Year	1. Male	2. Female	3. Children	4. Total	5. Remark
2.6.1	2012					
2.6.2	2013					
2.6.3	2014					
2.6.4	2015					
2.6.5	2016					
2.6.6	Total					

A.2.8. Number of normal delivery conducted at the CC during the last five years (See records)

Sl. No	Year	1. Number	2. Remark
2.7.1	2012		
2.7.2	2013		
2.7.3	2014		
2.7.4	2015		
2.7.5	2016		
2.7.6	Total		

Section-B: Providers Survey

QUESTIONNAIRE

❖ Name of the provider:----------

B 1: Designation: 1.CHCP 2. HA 3. FWA

B 2: Age (Years):

B 3: Sex: 1. Male 2. Female

B 4: Educational status:

1. S.S.C 2. HSC

3. Graduation 4. Others (Please specify……..)

B 5: Have you received any additional training?

1. Yes 2. No

B 6: If yes, what type of training(s) you have received?

1. ESP training 2. EOC training

3. CC management 4. Basic training of CHCP

5. Refresher training of CHCP 6. SBA training for female CHCP

7. Training on Nutrition 8. Training on computer,

9. Training on autism 10. Training on arsenicosis

11. Training on tuberculosis 12. Training on NCDs

13. Training on MIS 14. Others (Please specify……)

B 7: Is the training you have received necessary to improve skills and experience?

1. Yes 2. No

B 8: Do you attend the clinic on time every day?

1. Yes 2. No

B 9: What is the duration of your work per day (Hours)?

1. <3 hours 2. 3-4 hours 3. 5-6 hours

B 10: What is your working days?

1. 6 days per week 2. 4-5 days per week

3. 2-3 days per week 4. Once in a week

5. Once in a month

B 11: Do you maintain Register book / Report card regularly?

1. Yes 2. No 3. Sometime

B 12: Average number of patients treated on the day of survey:

1 Male …… 2 Female……. 3 Children……4 Total……..

B 13: Average number of patients provided FP services on the day of survey:

1 Male… 2 Female…… 3 Children… 4 Total……..

B. 14: Does the CC have any referral system?

1. Yes 2. No 3. Do not know

B 15: If yes, then where the patients referred to? (Multiple response possible)

1. USC (Union Sub-center)
2. UHC (Primary level)
3. District hospital (Secondary level)
4. Medical college hospital (Tertiary level)
5. Others (please specify……)

B 16: If no, please mention the reason

B 17: Are there any referral slip?

1. Yes 2. No 3. Do not know

B 18: Does FWA visit the CC every week?

1. Yes 2. No

B 19: Do you make home visit regularly?

1. Yes 2. No

B 20: If yes, then how many days per week do you make home visit?

1. <2 days 2. 2-3 days 3. >3 days

B 21: Which service(s) do you provide during home visit?

1. DOTS (TB)
2. FP (Contraceptive) services
3. EPI (Vaccination) services
4. Others (Please specify----------)

B 22: If you don't go for home visit, please mention the reason

B 23: Are you satisfied with your salary and other allowances?

1. Yes 2. No

B. 24: Do you get any festival bonus?

1. Yes 2. No

B 25: Is there any Community Group (CG) for management of the CC?

1. Yes 2. No 3. Do not know

B 26: If there is no CG, please mention the reason

1. Not formed 2. No one is interested 3. Do not know

B 27: Is the number of the members of the CG adequate? (Ideal-13-17)

1. Yes 2. No

B 28: Is the number of female members of the CG adequate? (At least one third)

1. Yes 2. No

B 29: Are you included in the CG?

1. Yes 2. No

B 30: If yes, what is your designation/role?

B 31: Who is the member secretary of CG?

1. CHCP 2. Other (Please specify……..)

B 32: Who is the chief patron of the CG?

1. UP chairman 2. Other (Please specify……..)

B 33: Are the CG members trained following training manual & trainer's guide?

1. Yes 2. No 3. Do not know

B 34: How often the CG members meet?

1. Once in week 2. Once in a month

3. Every 3 months 4. Every six months 5. Once in a year

B 35: Is there any community support group (CSG) to support CG?

1. Yes 2. No 3. Do not know

B 36: If there is no CSG, please mention the reason

1. Not formed 2. No one is interested 3. Do not know

B 37: Is there any community support group (CSG), please mention its number

1. Yes 2. No 3. Do not know

B 38: Is the number of the members of the CSG adequate? (Ideal-13-17)

1. Yes 2. No

B 39: Is the number of female members of the CSG adequate? (At least one third)

1. Yes 2. No

B 40: Are you included in the CSG? 1. Yes 2. No

B 41: If yes, what is your designation/role?

B 42: Who is the member secretary of CSG?

1. CG member 2. Other (Please specify…..)

B 43: Are the CSG members trained following training manual & trainer's guide?

1. Yes 2. No 3. Do not know

B 44: How the cleanliness of the CC is ensured?

1. Cleaners clean the clinic
2. CG/CSG supervises the cleanliness
3. Aya cleans the CC 4. Local people takes care
5. Don't know

B 45: How many times does the FWA/HA come to the CC for providing services?

1. Never 2. Once in a week
3. Twice in a week 4. Do not know

B 46: How monitoring of the CC is done

Sl. No	Way	1. Yes	2. No	Remark
46.1	Monthly report analysis			
46.2	Routine CC visit by G0, NGOs & DPs of different tiers with specific checklist			
46.3	Mobile tracking of service providers from HQ			
46.4	Monthly meeting at division, district, upazilas, union level taking CC issue as top mot prioritized agenda			
46.5	Online report communication through internet			

B 47: What service reports do you use for reporting? (Multiple Responses)

1. Child health 2. Maternal health
3. General health 4. Family planning
5. Nutrition 6. Referral

B 48: What service reports do you use for child health? (Multiple Responses)

1. Neonate care 2. Infant care
3. Under five health care

B 49: What service reports do you use for maternal health? (Multiple Responses)

1. Antenatal care 2. Normal delivery
3. Postnatal care

B 50: Where do you refer pregnant women in case of any complication

1. USC (Union Sub-center)
2. UHC (Primary level)
3. District hospital (Secondary level)
4. Medical college hospital (Tertiary level)
5. Others (please specify……)

B 51: What are the effects on community health due to community participation?

B 52: What are the ways to strengthen community participation in the activities of community clinic?

Section-C: Patients Survey

- Name of the patient:----------
- Address:----------

C 1 Age (Years): ☐

C 2 Sex: 1. Male 2. Female ☐

C 3 Occupation: ☐

1. Business 2. Farmer
3. Service 4. Housewife
5. Student 6. Day laborer
7. Retired 7. Unemployed
8. Others (Please specify…….)

C 4 Education ☐

1. Never gone to school
2. Primary (1-5 years of education)
3. Secondary (6-10 years of education)
4. SSC 5. HSC
6. Graduate 7. Post-graduate

C 5 Do you know about the services available in the CC? 1. Yes 2. No

C 6 If yes, please mention the services available in the CC? (Multiple Responses) ☐

1. Maternal and Neonatal services
2. Integrated management of childhood illness (IMCI) ☐
3. Reproductive Health services and Family Planning ☐
4. EPI (Vaccination) services ☐
5. Registration of newly married couple, pregnant mothers, birth and death; preservation of EDD

a. Nutritional education and micronutrient supplementation
b. Health, Nutrition and FP education & counseling
c. Treatment of common diseases and problems & first aid for the minor injuries
d. Screening of Diabetes, Hypertension, Autism, Club feet and referral to higher facilities
e. Normal delivery with the availability of trained manpower & other facilities
f. Identification of emergency and complicated cases with referral to higher facilities

g. Establishing an effective referral linkage.

h. Provide Essential Service Package (ESP)

C 7 Is the community benefited from the CC?

1. Yes 2. No

C 8 If yes, then how the community is benefited? (Multiple Responses)

1. Community is receiving health services
2. Community is receiving medicine
3. Community is receiving free treatment
4. Easy to access as the CC is near to my house
5. CC provides immunization services
6. CHCP, FWA and HA offers counseling

C 9 Are the staff trained enough to provide designated services?

1. Yes 2. No 3. Do not know

C 10 If not, which subject(s) do they need training on?

C 11 What are the reasons of selecting the CC for treatment? (Multiple Responses)

1. Less distance 2. Better waiting arrangement
3. Less waiting time 4. Experienced and qualified provider
5. Providers good behavior 6. Cleanliness
7. Availability of drugs 8. One stop service
9. Convenient clinic hour 10. Provider is known/others

C 12 What is your level of satisfaction about the services and facilities of the CC?

Sl. No	**Service/Facility**	**1. Satisfied**	**2. Partially satisfied**	**3. Not satisfied**	**Score 1=2, 2=2, 3=0**
12.1	Waiting arrangement				
12.2	Waiting time				
12.3	Cleanliness of the CC				
12.4	Privacy maintained				
12.5	Interaction and behavior of provider				
12.6	Perceived quality of services				
12.7	Availability of medicine				
12.8	Qualified person provide service				
12.9	Enough information was given				

12.10	Received prompt service				
12.11	Quality of health education				
12.12	Overall Score				
12.13	Level of satisfaction				

C 13 Please mention the benefits of the CC

Sl. No	Benefit	1. Yes	2. No
13.1	CC is located close to the inhabitation		
13.2	One stop outlet for Health, FP & Nutrition		
13.3	Service is free of cost		
13.4	Need no transport to reach the CC		
13.5	Necessary advice is available		
13.6	Emergency & complicated cases are referred		
13.7	Knowledge, skill & behavior of provider are good		
13.8	Service provider is from same locality		
13.9	Management by the community		

C 14 What are the effects on community health due to community participation?

Section-D: Household Survey

- Name:----------
- Village:----------
- Ward no:----------
- House no:----------
- Phone no:----------
- Name of the head of the house:----------
- Date of the interview:----------
- Time of the interview----------

D1 Age (Years): ☐

D2 Sex: 1. Male 2. Female

D3 Occupation: ☐

1. Business 2. Farmer 3. Service 4. Housewife
5. Student 6. Day laborer 7. Retired 8. Unemployed

9. Others (Please specify…….)

D4 Education: ☐

1. Never gone to school
2. Primary (1-5 years of education)
3. Secondary (6-10 years of education)
4. SSC 5. HSC
6. Graduate 7. Post-graduate

D5 Do you know about the CC? ☐

1. Yes 2. No

D6 If yes, then from where did you first hear about the community clinic?

1. Health Workers
2. Public representatives?
3. Neighbors/ relatives
4. Radio/ TV/ Newspapers
5. Others (Please specify……)

☐

D7 What is the distance of the CC from your house?

1. Can go on foot 2. Not too far from home

3. Can reach in 10 minutes by rickshaw/van

4. Within half a mile walk 5. Can reach in 30 minutes walk

D8 Does the CC open every day? 1. Yes 2. No

D9 What is the working hours of the CC?

1. <3 hours 2. 3-4 hours

3. 4-5 hours 4. 5-6 hours

5. >6 hours 6. Don't know

D10 Who are the service providers in the CC? (Multiple Responses)

1. CHCP 2. HA 3. FWA

4. MBBS Doctor 5. Don't know

D11 Does the CC has lacking of medicine?

1. Yes 2. No

D12 Do you know about the CG?

1. Yes 2. No

D13 Do you think that CG's participation has benefited the community?

1. Yes 2. No 3. Don't know

D14 Do you know about the CSG?

1. Yes 2. No

D.15 Do you think that CSG's participation has benefited the community?

1. Yes 2. No 3. Don't know

D.16 Do you know about the clinic hour?

1. Yes 2. No 3. Don't know

D.17 What are the constraints associated with the CC?

1. Medicine is not available

2. Need to walk a long way

3. Providers behavior is not good

4. Others (Please specify……)

D.18 What are the effects of community participation in community clinic activities?

D19 What are the effects on community health due to community participation?

Section-E: Survey of Key Informants

(Qualitative Part of the Study)

Key Informants' Interview (KII): Interview Schedule

- Name:----------
- Address:----------

E1 Age (Years): ☐

E2 Sex: 1. Male 2. Female ☐

E3 Occupation:

1. Business 2. Farmer
3. Service 4. Housewife
5. Student 6. Day laborer
7. Retired 7. Unemployed
8. Others (Please specify…….)

E4 Education:

1. Never gone to school ☐
2. Primary (1-5 years of education)
3. Secondary (6-10 years of education)
4. SSC 5. HSC
6. Graduate 7. Post-graduate

E5 Are there any management committee for the CC? ☐

1. Yes 2. No 3. Do not know

E6 If yes, mention the name of management committee?

1. CG 2. CSG 3. Others (Please specify……..)

E7 Are the committees functional?

1. Yes 2. No 3. Do not know

E8 Are the members of the committees included as per eligibility criteria?

1. Yes 2. No 3. Do not know

E9 What are the responsibilities of the CG?

9.1. Ensure security of the CC: 1. Yes 2. No ☐
9.2. Ensure cleanliness at the CC: 1. Yes 2. No ☐
9.3. Day to day operation of the CC: 1. Yes 2. No ☐

9.4. Local fund generation and transparent utilization: 1. Yes 2. No

9.5. Coordination with other providers and stakeholders 1. Yes 2. No

9.6. Monitoring and evaluation of CC performance 1. Yes 2. No

9.7. Monitoring and evaluation of community participation 1.Yes 2. No

E10 How many CSGs are there for this CC?

E11 What are the responsibilities of the CSG?

11.1. Keep close contact with the CG: 1. Yes 2. No

11.2. Help CG in fund generation: 1. Yes 2. No

11.3. Make the community aware of the CC services: 1. Yes 2. No

11.4. Help the poor, marginalized & vulnerable in getting services: 1. Yes 2. No

11.5. Help the community to get emergency services 1. Yes 2. No

11.6 Help the poor in referral

11.7 Disseminate Health, Nutrition & FP messages 1. Yes 2. No

E12 Does the committee collect money locally?

1. Yes 2. No 3. Do not know

E13 Was any money collected in the past?

1. Yes 2. No 3. Do not know

E14 How was the money spent? (Multiple Responses)

1. To treat poor patients 2. To treat women
3. To treat children 4. Others (Please Specify……..)
5. Do not know

E15 What are the problems faced by the committees? (Multiple Responses)

1. Poor patronization of Government
2. Financial constraint 3. Insufficient logistics supply
4. No public support 5. Scarcity of equipments
6. Inadequate drug supply 7. Pressure of power groups
8. Others (Please specify……..)

E16 Has the community donated land?

1. Yes 2. No 3. Do not know

E17 Was the CG involved in supervision of the construction of infrastructure?

1. Yes 2. No 3. Do not know

E18 Was the CG involved in operational management & maintenance the CC?

1. Yes 2. No 3. Do not know

E19 Does the CG assist in keeping the premises neat and clean?

1. Yes 2. No 3. Do not know

E20 How many members are there in the CG?

E21 Are there any female member in the CG?

1. Yes 2. No 3. Do not know

E22 If yes, how many females are included in CG?

E23 Is the land donor included in this CG?

1. Yes 2. No 3. Do not know

E24 Is any service provider (CHCP) included in this CG?

1. Yes 2. No 3. Do not know

E25 Does the service provider (CHCP) act as the member-secretary of CG?

1. Yes 2. No 3. Do not know

E26 Please mention the stages of CG formation

1. Before site selection
2. Before construction
3. After hand over
4. Do not know

E27 Does the UP chairman supervise the functioning of CC once in a month?

1. Yes 2. No 3. Do not know

E28 Are the CG members oriented about their roles and responsibilities?

1. Yes 2. No 3. Do not know

E29 How often the CG members meet?

1. Every month 2. Every 3 months
3. Every 6 months 4. Every 12 months
5. No meeting held 3. Do not know

E30 What is your opinion about the overall operation/services of CC?

1. Satisfactory 2. Partly satisfactory
3. Not satisfactory

E31 Was there any training for the committee members?

1. Yes 2. No 3. Do not know

E32 If training was given, was the training useful?

1. Yes 2. No 3. Do not know

E33 What are the ways and means of community participation (CP) with the CC activities?

E34 What aspects of community health have improved due to community participation (CP)?

E35 Which areas of health awareness of the community people were increased due to CP?

E36 What is the effects of CP on improvement of information communication of the community people?

E37 What are the effects of CP on improvement of lifestyle of community?

E38 What are the effects of CP on increasing institutional delivery care (antenatal/ intranatal/ post natal) in the community?

E39 What are the effects of CP on strengthened management of the CC?

E40 What are the roles of CC on disease prevention and control through CP?

E41 What are the barriers of community participation with the CC?

E42What are the ways to increase the sense of responsibility of the community people regarding CC?

E43 What are the roles of community people to increase the quality of service of CC?

E44 What are the ways of increasing the usage of CC through CP?

E45 What are the ways of strengthening CP in CC activities?

……

Signature with Date

(Field Investigator)

Name:

Annexure-V

বাংলাদেশের গ্রামাঞ্চলে কমিউনিটি ক্লিনিক কার্যক্রমে এলাকাবাসীর / স্থানীয় জনসাধারনের অংশগ্রহনের ধরণ ও তার ফলাফল / প্রভাব

- ❖ আইডি নাম্বার: | | | | |
- ❖ সাক্ষাৎ কারের তারিখ: | | | | |
- ❖ সাক্ষাৎ কারের সময়: | | | | |

প্রশ্নমালা

অনুচ্ছেদ-এ:কমিউনিটি ক্লিনিক জরিপ

- কমিউনিটি ক্লিনিকের নাম :
- কমিউনিটি ক্লিনিকের কোড নাম্বার : | | | | | | | | |
- কমিউনিটি ক্লিনিকের ঠিকানা :.....
  - ✓ গ্রাম/ওয়ার্ড :.....
  - ✓ ইউনিয়ন :.....
  - ✓ উপজেলা :.....
  - ✓ জেলা [কোড নাম্বার বসান] : | |

এ১: কমিউনিটি ক্লিনিকের অবকাঠামো সংক্রান্ত তথ্যাবলি

এ১.১: কমিউনিটি ক্লিনিকে যাতায়াত ব্যবস্থা: |

১. সহজে যাতায়াত করা যায়
২. যাতায়াত করা কঠিন/দূরুহ

এ১.২: কমিউনিটি ক্লিনিকের অবস্থান: |

১. পথের মাঝখানে এবং সহজেই পৌঁছানো যায়
২. জরিপকৃত গ্রামের বাইরে
৩. গ্রামের আবাসিক এলাকার কাছাকাছি
৪. বন্যাদূগর্ত/বন্যাকবলিত এলাকার কাছাকাছি
৫. জলাবদ্ধ এবং পানিতে নিমজ্জিত এলাকায়

এ১.৩: কমিউনিটি ক্লিনিক যেখানে অবস্থিত সেই জমির ধরণ: |

১. উচ্চ-ভূমি
২. নিম্নভূমি
৩. পানিতে নিমজ্জিত নিম্নভূমি

এ১.৪: কমিউনিটি ক্লিনিকের জমি দানকারী: |

১. সরকার
২. কমিউনিটি গ্রুপের সদস্য
৩. কমিউনিটি সাপোর্ট গ্রুপের সদস্য
৪. স্থানীয় জনসাধারন/এলাকাবাসীর কোন সদস্য
৫. অন্যান্য (উল্লেখ করুন.....)

এ১.৫: কমিউনিটি ক্লিনিকের আকার: ☐

১. সরকার অনুমোদিত (৪৫০বর্গফুট)
২. সরকার অনুমোদিত আকারের চেয়ে ছোট

এ১.৬: কমিউনিটি ক্লিনিকের অবকাঠামোর গুনগত মান:

১.৬.১ দরজার মান- ১.ভালো ২.ভাঙ্গা ☐

১.৬.২ জানালার মান- ১.ভালো ২.ভাঙ্গা ☐

১.৬.৩ ছাদের মান- ১.ভালো ২.ভাঙ্গা ☐

এ১.৭: কমিউনিটি ক্লিনিকে কক্ষের সংখ্যা: ☐

এ১.৮: কমিউনিটি ক্লিনিকে শৌচাগারের অবস্থা:

১.৮.১ শৌচাগারের সংখ্যা: ☐

১.৮.২ শৌচাগারের অবস্থা: ১.পরিষ্কার ২.ময়লাযুক্ত ☐

এ১.৯: কমিউনিটি ক্লিনিকে খননকৃত নলকূপের অবস্থা: ☐

১. নলকূপ আছে এবং কাজ করে
২. নলকূপ আছে কিন্তু কাজ করেনা
৩. নলকূপ নেই

এ১.১০: রোগীদের অপেক্ষা করার স্থান: ☐

১. চেয়ার,বেঞ্চ ইত্যাদি দিয়ে ভালভাবে সজ্জিত করা
২. সজ্জিত করা নয়, রোগীরা দাঁড়িয়ে থাকে

এ১.১১: কমিউনিটি ক্লিনিকে বিদ্যুৎ সরবরাহ: ☐

১. আছে ২.নাই

এ১.১২: সেবা গ্রহনের জন্য সেবা প্রদানকারীদের কক্ষে চেয়ার টেবিলের পর্যাপ্ততা: ☐

১. পর্যাপ্ত ২.অপর্যাপ্ত

এ১.১৩: কমিউনিটি ক্লিনিকের কোন টেলিফোন নাম্বার আছে কিনা? ☐

১. আছে ২.নাই

এ১.১৪: যদি থাকে, সেটি সক্রিয় কিনা? ☐

১. হ্যাঁ ২.না

এ১.১৫: সেবা প্রদানকারীর উপস্থিতি (একাধিক উত্তর হতে পারে): ☐☐☐

১. এইচ.এ.
২. এফ. ডব্লিউ.এ.
৩. সি.এইচ.সি.পি.

এ১.১৬: কমিউনিটি ক্লিনিকে নৈশপ্রহরীর উপস্থিতি: ☐

১. হ্যাঁ ২.না

এ১.১৭: কমিউনিটি ক্লিনিকের নিরাপত্তা বিধানের ব্যাবস্থা আছে কিনা? ☐

১. হ্যাঁ ২.না

☐

এ১.১৮: কমিউনিটি ক্লিনিকের নিরাপত্তা বিধান করে:

১. প্রহরী
২. তালাচাবি
৩. কমিউনিটি গ্রুপ এবং আশপাশের বাসিন্দারা দেখাশোনা করেন
৪. এলাকাবাসী
৫. সেবা প্রদানকারী
৬. জানিনা

এ ২: সেবা প্রদান, ঔষধ এবং অন্যান্য সরঞ্জামাদি:

এ২.১: যন্ত্রপাতির পর্যাপ্ততা:

ক্রমিক নং	যন্ত্রপাতির নাম	সরবরাহ		অবস্থা		স্কোর
		১. পর্যাপ্ত	২. অপর্যাপ্ত	১.ভালো	২.অকেজো	পর্যাপ্ত ও ভালো=২ অপর্যাপ্ত ও ভালো/পর্যাপ্ত ও অকেজো=১ অপর্যাপ্ত ও অকেজো=০
২.১.১	প্রাথমিক চিকিৎসা সামগ্রী (কাচি, ফরসেপ)					
২.১.২	ব্লাড প্রেশার মাপার যন্ত্র এবং স্টেথোস্কোপ					
২.১.৩	উপকরণ সমূহ (গজ-১, মাস্ক-১, থার্মোমিটার-৪, টাইমার-২, একটি সেন্সরকীট)					
২.১.৪	জীবানুনাশক স্প্রে করার মেশিন					
২.১.৫	বাথরুম স্কেল (ওজন মাপকযন্ত্র)					
২.১.৬	কেরোসিন চুলা					
২.১.৭	ঝুলানো স্কেল (ওজন মাপক)					
২.১.৮	আম্বো ব্যাগ ও পেঙ্গুইন সাকার					
২.১.৯	মূত্রনালীর ক্যাথেটার					
২.১.১০	সিরিঞ্জ					
২.১.১১	ভেমইনোস্কোপ					
২.১.১২	'সোনালী আলো' নামক ফ্ল্যাশকার্ড					
২.১.১৩	অন্যান্য (নির্দিষ্ট করুন)					
২.১.১৪	সর্বমোট স্কোর					
২.১.১৫	মূল্যায়ন					

এ ২.১.১৬: যন্ত্রপাতির অপর্যাপ্ততার কারণ সমূহ: (উত্তর একাধিক হতে পারে)

১. নষ্ট হয়ে যাওয়া
২. চুরি হওয়া
৩. সরবরাহ নেই
৪. জানিনা

এ২.২: ঔষধ সরবরাহ ব্যবস্থা:

ক্রমিক নং	বৈশিষ্ট্য	প্রাপ্যতা		স্কোর: ১=১, ২ = ০
২.২.১	অত্যাবশ্যকীয় সকল ঔষধ (৩৩) প্রাপ্তি	১.পাওয়া যায়	২.পাওয়া যায়না	
২.২.২	অত্যাবশ্যকীয় ঔষধ সরবরাহের সময়	১.সময়মত	২.সময়মত নয়	
২.২.৩	সরবরাহকৃত অত্যাবশ্যকীয় ঔষধের পরিমান	১.পর্যাপ্ত	২.অপর্যাপ্ত	
২.২.৪	বিতরণকৃত অত্যাবশ্যকীয় ঔষধের পরিমান	১.পর্যাপ্ত	২.অপর্যাপ্ত	
২.২.৫	অত্যাবশ্যকীয় ঔষধ যার মাধ্যমে বিতরণ করা হয়	১.নির্দিষ্ট ব্যাক্তি	২.অন্যান্য	
২.২.৬	ঔষধ সরবরাহ ব্যাবস্থা সম্পর্কীত সর্বমোট স্কোর/ফলাফল			
২.২.৭	মূল্যায়ন			

এ২.৩: আসবাবপত্র/অন্যান্য সরঞ্জামাদির প্রাপ্যতা:

ক্রমিক নং	আসবাবপত্র/অন্যান্য সরঞ্জামাদি	সরবরাহ		অবস্থা		স্কোর
		১. আছে	২. নাই	১.ভালো	২.অকেজো	১=১,২=০
২.৩.১	লেবার টেবিল					
২.৩.২	রোগী পরীক্ষা নিরীক্ষা করার টেবিল					
২.৩.৩	২ কক্ষ বিশিষ্ট ১টি ষ্টীলের আলমারী					
২.৩.৪	পিছনে হেলানদিয়ে বসার ২ টি বেঞ্চ (৪-৫ জন বসার জন্য)					
২.৩.৫	সেবা গ্রহীতাদের জন্য ২টি গদিওয়ালা বা তোষকসহ বিছানা					
২.৩.৬	স্ট্যান্ডসহ একটি ব্ল্যাকবোর্ড					
২.৩.৭	কাঠের/প্লাষ্টিকের চেয়ার					
২.৩.৮	একটি ড্রয়ারসহ একটি টেবিল					
২.৩.৯	রোগীদের রেজিষ্ট্রেশন বই					
২.৩.১০	রিপোর্ট কার্ড					
২.৩.১১	স্বাস্থ্যসেবাদানকারীর উপস্থিতি বই					
২.৩.১২	ল্যাপটপ					
২.৩.১৩	ইন্টারনেট সুবিধা (মডেম)					
২.৩.১৪	আসবাবপত্র/অন্যান্য/সরঞ্জামাদি প্রাপ্ত সম্পর্কিত সামগ্রিক স্কোর/ফলাফল					
২.৩.১৫	মূল্যায়ন					

এ ২.৩.১.১৬: আসবাবপত্র অপর্যাপ্ততার কারণ:
১.সরবরাহ করা হয়নি ২.নষ্ট হয়ে গেছে

এ২.৪: কমিউনিটি ক্লিনিক যে সকল স্বাস্থ্যসেবা প্রদান করে:

ক্রঃনং	সেবা	সেবা প্রদান ব্যবস্থা		স্কোর
২.৪.১	প্রজনন এবং পরিবার পরিকল্পনা সেবা	১.হ্যাঁ	২.না	১=১,২=০
২.৪.২	শৈশব কালীন অসুস্থতার সমন্বিত ব্যবস্থাপনা (IMCI)			
২.৪.৩	মা ও নবজাতকের স্বাস্থ্যসেবা			
২.৪.৪	ইপিআই, অকস্মাৎ শ্বাসতন্ত্রের সংক্রমণ			

২.৪.৫	পুষ্টি বিষয়ক শিক্ষা এবং অনুপুষ্টি সরবরাহ			
২.৪.৬	স্বাস্থ্য ওপরিবার পরিকল্পনা শিক্ষা এবং কাউন্সেলিং			
২.৪.৭	সংক্রামক ব্যাধি নিয়ন্ত্রন এবং রেফারকরা			
২.৪.৮	জরুরী এবং জটিল রোগী সনাক্ত করণ এবং উন্নততর চিকিৎসার জন্য উচ্চতর স্বাস্থ্য প্রতিষ্ঠানে প্রেরণ / রেফার করা			
২.৪.৯	অসংক্রামক ব্যাধি সনাক্তকরণ,যেমন-উচ্চ রক্তচাপ, বহুমুত্র, আর্সেনিকোসিস, ক্যান্সার, হৃদরোগ,অটিজম ইত্যাদি			
২.৪.১০	নরমাল ডেলিভারী করানো			
২.৪.১১	সামান্য অসুস্থতার চিকিৎসাকরা, যেমন-সাধারণ আঘাত জনিত সমস্যার প্রাথমিক চিকিৎসা দেওয়া এবং জরুরী ক্ষেত্রে যেমন বিষ আক্রান্ত, সাপেকাটা, পোড়া রোগীদের জন্য ব্যবস্থা নেয়া			
২.৪.১২	উচ্চতর স্বাস্থ্য সেবা প্রতিষ্ঠানের সাথে একটি কার্যকর রেফারাল সিস্টেম প্রতিষ্ঠা করা			
২.৪.১৩	একটি কার্যকরী ম্যানেজমেন্ট ইনফরমেশন সিস্টেম ও কমিউনিটি ডাটাবেজ স্থাপন করা			
২.৪.১৪	বাংলাদেশ সরকার কর্তৃক নির্দেশিত ইএসপি এর আওতায় অন্যান্য সেবা প্রদান করা			
২.৪.১৫	সর্বমোট স্কোর			

এ২.৫: কমিউনিটি ক্লিনিক কর্তৃক প্রদত্ত স্বাস্থ্য শিক্ষার বিষয়:

ক্রঃ নং	**স্বাস্থ্য শিক্ষার ক্ষেত্র / বিষয়**	**১. হ্যাঁ**	**২. না**	**মন্তব্য**
২.৫.১	গর্ভকালীন যত্ন / পরিচর্যা			
২.৫.২	প্রসব পরিকল্পনা			
২.৫.৩	প্রসব পরবর্তী যত্ন			
২.৫.৪	শিশু স্বাস্থ্য ও পুষ্টি			
২.৫.৫	শিশু বৃদ্ধি পরীবিক্ষণ			
২.৫.৬	সাধারণ স্বাস্থ্য সমস্যা			
২.৫.৭	পরিবার পরিকল্পনা			
২.৫.৮	পুষ্টি			

এ২.৬: বিগত ৫ অর্থবছরে কমিউনিটি ক্লিনিকে সরবরাহকৃত বিভিন্ন ঔষধ এর সংখ্যা (প্রকার):

ক্রঃ নং	**অর্থবছর**	**১. সংখ্যা (প্রকার)**	**২. মন্তব্য**
২.৬.১	২০১১-২০১২		
২.৬.২	২০১২-২০১৩		
২.৬.৩	২০১৩-২০১৪		
২.৬.৪	২০১৪-২০১৫		
২.৬.৫	২০১৫-২০১৬		
২.৬.৬	মোট		

এ২.৭: বিগত ৫ বছরে কমিউনিটি ক্লিনিকে সেবা গ্রহণকারী রোগীর সংখ্যা (রেকর্ডদেখুন):

ক্রঃ নং	**বছর**	**১.পুরুষ**	**২.মহিলা**	**৩.শিশু**	**৪.মোট**	**৫.মন্তব্য**
২.৭.১	২০১২					
২.৭.২	২০১৩					
২.৭.৩	২০১৪					

২.৭.৪	২০১৫					
২.৭.৫	২০১৬					
২.৭.৬	মোট					

এ.২.৮: গত ৫ অর্থবছরে কমিউনিটি ক্লিনিকে স্বাভাবিক প্রসব এর সংখ্যা (রেকর্ডদেখুন):

ক্রঃনং	**বছর**	**১.সংখ্যা**	**২.মন্তব্য**
২.৮.১	২০১২		
২.৮.২	২০১৩		
২.৮.৩	২০১৪		
২.৮.৪	২০১৫		
২.৮.৫	২০১৬		
২.৮.৬	মোট		

কোড নং | | | |

অনুচ্ছেদ-বি: সেবা প্রদানকারীর সাক্ষাৎকার

সেবা প্রদানকারীর নাম:.....

কমিউনিটি ক্লিনিকের নাম ও ঠিকানা: .....

বি১: পদবী: ১.সি.এইচ.সি.পি. ২.এইচ.এ. ৩. এফ.ডব্লিউ.এ.

বি২: বয়স (বছর):

বি৩: লিঙ্গ:১. পুরুষ ২. মহিলা

বি৪: শিক্ষাগত যোগ্যতা:

১. এস.এস.সি. ২.এইচ.এস.সি.

৩. স্নাতক ৪.অন্যান্য (উল্লেখ করুন.....)

বি৫: আপনি কি পেশাগত কোন প্রশিক্ষণ গ্রহণ করেছেন?

১.হ্যাঁ ২. না

বি৬: উত্তর যদি হ্যাঁ হয়, তাহলে কোন ধরণের প্রশিক্ষণ নিয়েছেন? (উত্তর একাধিক হতে পারে)

১.ই.এস.পি. প্রশিক্ষণ ২.ই.ও.সি. প্রশিক্ষণ

৩.সি.সি. ব্যবস্থাপনা ৪.সি.এইচ.সি.পি.ব্যাসিক প্রশিক্ষণ

৫.সি.এইচ.সি.পি. রিফ্রেশার প্রশিক্ষণ ৬.মহিলাদের সি.এইচ.সিপি. এসবিএ-প্রশিক্ষণ

৭.পুষ্টি বিষয়ক প্রশিক্ষণ ৮.কম্পিউটার প্রশিক্ষণ

৯.অটিজম বিষয়ক প্রশিক্ষণ ১০.আর্সেনিকোসিস বিষয়ক প্রশিক্ষণ

১১.টিউবারকুলোসিস বিষয় কপ্রশিক্ষণ ১২.এনসিডি'স প্রশিক্ষণ

১৩.ম্যানেজমেন্ট অব ইনফরমেশন সিস্টেম (এমআইএস) প্রশিক্ষণ

১৪.অন্যান্য (অনুগ্রহ পূর্বক বিস্তারিত লিখুন.....)

বি৭: যে প্রশিক্ষণ আপনি গ্রহন করেছেন সেটাকি আপনার দক্ষতা এবং অভিজ্ঞতাকে উন্নত করার জন্য অপরিহার্য ছিল?

১.হ্যাঁ ২.না

বি৮: আপনিকি প্রতিদিন সময়মত ক্লিনিকে উপস্থিত থাকেন?

১.হ্যাঁ ২.না

বি৯: আপনার প্রতিদিনের কাজের সময়কাল কত (ঘন্টায়)?

১. ৩ ঘন্টার কম ২. ৩-৪ ঘন্টা ৩. ৫-৬ ঘন্টা

বি১০: আপনার কাযদিবস কত দিন?

১.সপ্তাহে ৬ দিন ২.সপ্তাহে ৪-৫ দিন

৩.সপ্তাহে ২-৩ দিন ৪.সপ্তাহে ১ দিন ৫. মাসে ১ দিন

বি১১: আপনিকি নিয়মিত নিবন্ধন বহি/প্রতিবেদনপত্র ব্যবহার করেন?

১.হ্যাঁ ২.না ৩. মাঝেমাঝে

বি১২: সার্ভের দিন চিকিৎসাপ্রাপ্ত রোগীর গড় সংখ্যা:

১. পুরুষ..... ২. মহিলা ..... ৩. শিশু..... ৪. সর্বমোট.....

বি১৩: জরিপের দিনে পরিবার পরিকল্পনা বিষয়ক সেবা প্রদানকৃত রোগীর সংখ্যা:-

১.পুরুষ.....২.মহিলা .....৩.শিশু.....৪.সর্বমোট.....

বি১৪: কমিউনিটি ক্লিনিক থেকে কি রোগী রেফার করার পদ্ধতি চালু আছে?

১.হ্যাঁ ২.না ৩.জানিনা

বি১৫: উত্তর হ্যাঁ হলে, রোগী কোথায় রেফার করা হয়? (উত্তর একাধিক হতে পারে)

১. ইউনিয়ন উপ-স্বাস্থ্যকেন্দ্র

২. উপজেলা স্বাস্থ্য কমপ্লেক্স (প্রাইমারী লেভেল)

৩. জেলা হাসপাতাল (সেকেন্ডারী লেভেল)

৪. মেডিকেল কলেজ হাসপাতাল (টারশিয়ারী লেভেল)

৫. অন্যান্য (উল্লেখ করুন.....)

বি১৬: উত্তর না হলে, রোগী রেফার করার পদ্ধতি চালু নাথাকার কারণ উল্লেখ করুন

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বি১৭: কোন রেফারাল স্লিপ আছে?

১. হ্যাঁ ২. না ৩. জানিনা

বি১৮: স্বাস্থ্যকর্মীরা কি প্রতিমাসের প্রত্যেক সপ্তাহে কমিউনিটি ক্লিনিকে আসে?

১. **হ্যাঁ** ২.না

বি১৯: আপনিকি নিয়মিতভাবে বাড়ি-বাড়ি পরিদর্শন করেন?

১.হ্যাঁ ২.না

বি২০: উত্তর হ্যাঁ হলে, প্রতিসপ্তাহে কতদিন বাড়ি পরিদর্শন করেন?

১. ২দিনের কম ২. ২-৩দিন ৩. ৩দিনের বেশী

বি২১: বাড়ি-বাড়ি পরিদর্শনকালে আপনি কী কী ধরণের সেবা প্রদান করেন? (উত্তর একাধিক হতে পারে)

১. ডিওটিএস

২. পরিবার পরিকল্পনা (জন্মনিয়ন্ত্রন)সেবা

৩. ইপিআই (ভেক্সিনেশন)সেবা

৪. অন্যান্য (দয়া করে নির্দিষ্ট করুন.....)

বি২২: যদি আপনি বাড়ি-বাড়ি পরিদর্শন না যান, তাহলে তার কারন উল্লেখ করুন

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বি২৩: আপনিকি আপনার বেতন এবং অন্যান্য ভাতাদি নিয়ে সন্তুষ্ট?

১.হ্যাঁ ২.না

বি২৪: আপনিকি কোন উৎসব ভাতা পান?

১.হ্যাঁ ২. না

বি২৫: কমিউনিটি ক্লিনিকের ব্যবস্থাপনার জন্য কোন কমিউনিটি গ্রুপ (সিজি) আছে?

১.হ্যাঁ ২. না ৩.জানিনা

বি২৬: যদি কমিউনিটি গ্রুপ (সিজি) না থাকে তাহলে দয়া করে না থাকার কারন উল্লেখ করুন

১. গঠিত হয়নি ২. কেউ ইচ্ছুক নন ৩.জানিনা

বি২৭: যদি কমিউনিটি গ্রুপ থাকে, তাহলে এই গ্রুপের সদস্য সংখ্যা কি যথেষ্ট? (আদর্শ ১৩-১৭জন)

১.হ্যাঁ ২.না

বি২৮: কমিউনিটি গ্রুপের মহিলা সদস্য সংখ্যা কি যথেষ্ট? (অন্তত পক্ষে এক তৃতীয়াংশ)

১.হ্যাঁ ২. না

বি২৯: আপনিকি কমিউনিটি গ্রুপে অন্তর্ভূক্ত?

১.হ্যাঁ ২. না

বি৩০: উত্তর হ্যাঁ হলে সেখানে আপনার ভূমিকা/পদ কি?

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বি৩১: কমিউনিটি গ্রুপের সদস্য সচিব কে?

১.সি.এইচ.সি.পি ২.অন্যান্য(দয়া করে নির্দিষ্ট করুন .....)

বি৩২: কমিউনিটি গ্রুপের প্রধান পৃষ্ঠপোষক কে?

১.ইউ.পি.চেয়ারম্যান

২.অন্যান্য (দয়া করে নির্দিষ্ট করুন.....)

বি৩৩: কমিউনিটি গ্রুপের সদস্যরা কি প্রশিক্ষণ সহায়িকা এবং প্রশিক্ষক নির্দেশিকার উপর প্রশিক্ষিত?

১.হ্যাঁ ২.না ৩.জানিনা

বি৩৪: কমিউনিটি গ্রুপের সদস্যরা কখন মিলিত হন?

১. সপ্তাহে ১ বার ২. মাসে ১ বার

৩. প্রতি ৩মাসে ১বার ৪. প্রতি ৬মাসে ১বার ৫. বছরে ১ বার

বি৩৫: কমিউনিটি গ্রুপকে সহযোগিতা করার জন্য কি কোন কমিউনিটি সাপোর্ট গ্রুপ (সিএসজি)আ ছে?

১.হ্যাঁ ২. না ৩.জানিনা

বি৩৬: যদি কমিউনিটি সাপোর্ট গ্রুপ (সিএসজি) না থাকে তাহলে দয়া করে না থাকার কারন উল্লেখ করুন

১.গঠিত হয়নি ২.কেউ ইচ্ছুক নন ৩.জানিনা

বি৩৭: কমিউনিটি সাপোর্টগ্রুপের সদস্য সংখ্যা কিয থেষ্ট? (আদর্শ ১৩-১৭জন)

১.হ্যাঁ ২. না

বি৩৮: কমিউনিটি সাপোর্ট গ্রুপ থাকলে, কয়টিআছে?

বি৩৯: কমিউনিটি সাপোর্ট গ্রুপ এর মহিলা সদস্য সংখ্যা কি যথেষ্ট? (অন্তত পক্ষে এক তৃতীয়াংশ)

১.হ্যাঁ ২. না

বি৪০: আপনিকি কমিউনিটি সাপোর্ট গ্রুপে অন্তর্ভূক্ত?

১.হ্যাঁ ২. না

বি৪১: উত্তর হ্যাঁ হলে, সেখানে আপনার ভূমিকা/পদ কি?

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বি৪২: কমিউনিটি সাপোর্ট গ্রুপ এর সদস্য সচিব কে?

১. কমিউনিটি গ্রুপের সদস্য

২. অন্যকেউ (দয়া করে নির্দিষ্ট করুন .....)

বি৪৩: কমিউনিটি সাপোর্ট গ্রুপের সদস্যরা কি প্রশিক্ষণ সহায়িকা এবং প্রশিক্ষক নির্দেশিকার উপর প্রশিক্ষিত?

১.হ্যাঁ ২. না

বি৪৪: কমিউনিটি ক্লিনিকের পরিষ্কার পরিচ্ছন্নতা কিভাবে নিশ্চিত করা হয়?

১.পরিচ্ছন্নতাকর্মী ক্লিনিকটি পরিষ্কার করেন

২.কমিউনিটি গ্রুপ/কমিউনিটি সাপোর্ট গ্রুপ পরিষ্কার পরিচ্ছন্নতার বিষয়টি তত্ত্বাবধান করে

৩.কমিউনিটি ক্লিনিকটি আয়া পরিষ্কার করেন ৪.স্থানীয় জনসাধারণ দায়িত্ব গ্রহন করেন ৫. জানিনা

বি৪৫: সেবা প্রদানের জন্য এফ ডব্লিউএ/এইচ এ কতবার কমিউনিটি ক্লিনিকে আসেন?

১.কখনও না ২.সপ্তাহে ১দিন
৩.সপ্তাহে ২দিন ৪.সপ্তাহে ৩ দিন

বি৪৬: কিভাবে কমিউনিটি ক্লিনিকটির কার্যক্রম মনিটর করা হয়?

ক্রমিক নং	পদ্ধতি	১. হ্যাঁ	২. না	মন্তব্য
৪৬.১	মাসিক প্রতিবেদন বিশ্লেষণ করে			
৪৬.২	সরকারী, বেসরকারী এবং উন্নয়ন সহযোগী প্রতিষ্ঠানের বিভিন্ন স্তর কর্তৃক নির্দিষ্ট চেকলিষ্ট ব্যবহার করে নিয়মিতভাবে কমিউনিটি ক্লিনিক পরিদর্শন			
৪৬.৩	হেডকোয়ার্টার থেকে সেবা প্রদানকারীদের সাথে মোবাইল ফোনে যোগাযোগে রমাধ্যমে			
৪৬.৪	বিভাগ, জেলা, উপজেলা এবং ইউনিয়ন পর্যায়ের মাসিক সভায় কমিউনিটি ক্লিনিক ইস্যুকে শীর্ষ আলোচ্য বিষয় হিসেবে প্রাধান্য দিয়ে			
৪৬.৫	ইন্টারনেট/ইন্টারনেট ভিত্তিক অনলাইন প্রতিবেদনের মাধ্যমে			

বি৪৭: প্রতিবেদন জমা দেয়ার সময় কোন্ কোন্ সেবা সম্পর্কিত প্রতিবেদন আপনি প্রেরণ করেন?
(উত্তর একাধিক হতে পারে)

১.শিশুস্বাস্থ্য ২.মাতৃস্বাস্থ্য
৩.সাধারণ স্বাস্থ্য ৪.পরিবার পরিকল্পনা
৫.পুষ্টি ৬.রেফারাল/রোগীপ্রেরণ

৪বি৪৮: শিশু স্বাস্থ্যের কোন্ কোন্ সেবা সম্পর্কিত প্রতিবেদন আপনি প্রেরণ করেন?
(উত্তর একাধিক হতে পারে)

১. নবজাতকের স্বাস্থ্য সেবা
২. ২বছরের কম বয়সী শিশুদের স্বাস্থ্য সেবা
৩. পাঁচ বছরের কমবয়সী শিশুদের স্বাস্থ্য সেবা

বি৪৯: মাতৃ স্বাস্থ্যের কোন্ কোন্ সেবা সম্পর্কিত প্রতিবেদন আপনি প্রেরণ করেন?(উত্তরএকাধিকহতেপারে)

১. গর্ভকালীন স্বাস্থ্য সেবা
২. নরমাল ডেলিভারী/প্রসবকালীন স্বাস্থ্য সেবা
৩. প্রসব পরবর্তী স্বাস্থ্য সেবা

বি৫০: প্রসবজনিত জটিলতার ক্ষেত্রে গর্ভবতী মা কে কোথায় রেফার করেন?

১. ইউনিয়ন উপ-স্বাস্থ্য কেন্দ্র
২. উপজেলা স্বাস্থ্য কমপ্লেক্স (প্রাইমারী লেভেল)
৩. জেলা হাসপাতাল (সেকেন্ডারী লেভেল)
৪. মেডিকেল কলেজ হাসপাতাল (টারশিয়ারী লেভেল)
৫. অন্যান্য (উল্লেখ করুন.....)

বি৫১: কমিউনিটি ক্লিনিকে এলাকাবাসীর অংশগ্রহন স্থানীয় জনসাধারণের স্বাস্থ্যের উপর কিরূপ প্রভাব ফেলে?

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বি৫২: কমিউনিটি ক্লিনিক কার্যক্রমে জনসাধারণের অংশগ্রহণ কিভাবে আরও জোরদার করা যায়?

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কোড নং | | | |

অনুচ্ছেদ-সিঃ সেবা গ্রহনকারীর সাক্ষাৎকার

অংশগ্রহনকারীর নাম:.....

ঠিকানা:.....

সি১: বয়স (পূর্ণবছর) |

সি২: লিঙ্গঃ ১.পুরুষ ২.মহিলা |

সি৩: পেশাঃ |

১. ব্যবসা ২.কৃষিকাজ ৩.চাকুরী
৪. গৃহিনী ৫.ছাত্র/ছাত্রী ৬.দিনমজুর
৭. বেকার ৮.অন্যন্য (নির্দিষ্ট করুন)

সি৪: শিক্ষাগত যোগ্যতাঃ |

১.কখনও স্কুলে যান নাই ২. প্রাথমিক (১-৫ বছরের শিক্ষা গ্রহন করেছেন)
৩.মাধ্যমিক (৬-১০ বছর শিক্ষা গ্রহন করেছেন) ৪.এস এসসি ৫.এইচ.এস.সি.
৬. স্নাতক ৭.স্নাতোকত্তোর

সি৫: কমিউনিটি ক্লিনিকে কোন্ কোন্ সেবা পাওয়া যায় আপনিকি জানেন? |

১. হ্যাঁ ২.না

সি৬: উত্তর হ্যাঁ হলে, কমিউনিটি ক্লিনিকে যে সকল সেবা পাওয়া যায় তাউ ল্লেখকরুন | | |
(উত্তর একাধিক হতে পারে) | | |

১. মা ও নবজাতকের স্বাস্থ্য সেবা
২. শৈশব এর অসুস্থ্যতার সমন্বিত ব্যাবস্থাপনা (আই.এম.সি.আই.)
৩. প্রজনন স্বাস্থ্যসেবা এবং পরিবার পরিকল্পনা
৪. ইপিআই (টিকাদান)সেবা
৫. নব/নতুন বিবাহিত সম্পতি, গর্ভবতী মা, জন্ম ও মৃত্যু নিবন্ধন;
৬. পুষ্টি বিষয়ক শিক্ষা এবং অনুপুষ্টি সরবরাহ
৭. স্বাস্থ্য পুষ্টি এবং পরিবার পরিকল্পনা বিষয়ক শিক্ষা ও কাউন্সেলিং
৮. সাধারণ রোগ ও স্বাস্থ্য সমস্যার চিকিৎসা এবং ক্ষুদ্র আঘাত জনিত সমস্যার প্রাথমিক চিকিৎসা
৯. ডায়াবেটিস, উচ্চরক্তচাপ, অটিজম, ক্লাবফুটরোগ সনাক্তকরণ এবং উচ্চতর স্বাস্থ্যসেবার কেন্দ্রেপ্রেরণ/রেফারকরা
১০. প্রশিক্ষিত জনবল এবং অন্যান্য সুযোগ সুবিধার প্রাপ্তির মধ্য দিয়ে/নরমাল ডেলিভারী করানো
১১. ইমার্জেন্সী/অতিজরুরী এবং জটিল রোগী সনাক্তকরণ এবং উচ্চতর স্বাস্থ্য সেবার কেন্দ্র প্রেরণ/রেফার
১২. রোগী রেফার করার একটি কার্যকর সংযোগ পদ্ধতি স্থাপন করা
১৩. অতি প্রয়োজনীয় স্বাস্থ্যসেবা (ইএসপি)

সি৭: জনসাধারণ কি কমিউনিটি ক্লিনিক এর মাধ্যমে উপকৃত হচ্ছেন? |

১. হ্যাঁ ২.না

সি৮: উত্তর হ্যাঁ হলে, জনসাধারণ কিভাবে উপকৃত হচ্ছেন? (উত্তর একাধিক হতে পারে) | | |

১. জনসাধারণ স্বাস্থ্যসেবা গ্রহন করছেন
২. জনসাধারণ ঔষধপত্র পাচ্ছেন
৩. জনসাধারণ বীনামূল্যে চিকিৎসাসেবা গ্রহন করছেন
৪. কমিউনিটি ক্লিনিক বাড়ীর কাছে হওয়ায় সহজে যাতায়াত করা যায়
৫. কমিউনিটি ক্লিনিক টিকাদান সেবা প্রদান করছে
৬. সিএইচসিপি,এফডব্লিউএ,এইচএ,কাউন্সেলিং করছেন

সি৯: কর্মচারীবৃন্দ কি নির্দিষ্ট সেবা প্রদান করার জন্য যথেষ্ট প্রশিক্ষিত?

১. হ্যাঁ ২.না ৩.জানিনা

সি১০: যদি নাহন, কোন্ বিষয়গুলোতে তাদের প্রশিক্ষণ প্রয়োজন?

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সি১১: চিকিৎসাসেবা পাওয়ার জন্য কমিউনিটি ক্লিনিককে বেছেনেয়ার কারন কি কি? (উত্তরএকাধিকহতেপারে)

১.দূরত্ব কম ২.অপেক্ষা করার আয়োজন উন্নততর

৩.অল্প সময় অপেক্ষা করতে হয় ৪.সোব প্রদানকারী অভিজ্ঞ এবং প্রশিক্ষিত/যোগ্য

৫.সেবা প্রদানকারীর ভালো ব্যবহার ৬.পরিষ্কার পরিচ্ছন্নতা

৭.ঔষধের সহজ প্রাপ্যতা ৮.এক জায়গায় সব ধরনের সেবা

৯.সুবিধাজনক সময় ১০.সেবা প্রদানকারী পরিচিত

সি১২: কমিউনিটি ক্লিনিকের সেবা এবং সুযোগ সুবিধা সম্পর্কে আপনি কতটুকু সন্তুষ্ট?

ক্রমিক নং	সেবা/সুযোগসুবিধা	১.সন্তুষ্ট	২.আংশিক সন্তুষ্ট	৩.অসন্তুষ্ট
১২.১	অপেক্ষা করার আয়োজন / ব্যবস্থাপনা			
১২.২	অপেক্ষা করার সময়			
১২.৩	পরিষ্কার পরিচ্ছন্নতা			
১২.৪	গোপনীয়তা রক্ষা করা			
১২.৫	সেবা প্রদান কারীর ব্যবহার এবং পারস্পরিক যোগাযোগ			
১২.৬	সেবার গুনগত মান সম্পর্কে ধারনা			
১২.৭	ঔষধের সহজ প্রাপ্যতা			
১২.৮	যোগ্য ব্যক্তি সেবা প্রদান করছেন			
১২.৯	পর্যাপ্ত তথ্য দেওয়া			
১২.১০	সেবা প্রদানে তৎপর			
১২.১১	স্বাস্থ্য শিক্ষার গুনগত মান			
১২.১২	সর্বোপরি সন্তুষ্টি			

সি১৩: কমিউনিটি ক্লিনিকের উপকারিতা উল্লেখ করুন:

ক্রমিকনং	উপকারিতা	হ্যাঁ	না
১৩.১	কমিউনিটি ক্লিনিকের অবস্থান স্থানীয় অধিবাসীদের নিকটবর্তী		
১৩.২	স্বাস্থ্য, পুষ্টি ও পরিবার পরিকল্পনা বিষয়ক সবধরনের সেবা এক জায়গায় প্রাপ্তিরস্থান		
১৩.৩	বিনা মূল্যে সেবাপ্রাপ্তি		
১৩.৪	কমিউনিটি ক্লিনিকে পৌছাঁনোর জন্য যাতায়াতের কোন খরচ নেই		
১৩.৫	প্রয়োজনীয় পরামর্শ পাওয়া যায়		
১৩.৬	জরুরী ও জটিল রোগীদেরকে রেফার করা হয়		
১৩.৭	সেবা প্রদানকারীর জ্ঞান, দক্ষতা এবং ব্যবহার ভালো		
১৩.৮	সেবা প্রদান কারী একই এলাকার বাসিন্দা		
১৩.৯	স্থানীয় জনসধারনের মাধ্যমেই ব্যবস্থাপনা		

সি১৪: কমিউনিটি ক্লিনিকে এলাকাবাসীর অংশগ্রহন স্থানীয় জনসাধারণের স্বাস্থ্যসেবার উপর কিরূপ প্রভাব ফেলে?

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কোড নং- | | | | |

অনুচ্ছেদ-ডি: গ্রামের সাধারণ জনগনের সাক্ষাৎকার

অংশগ্রহনকারীর নাম:.....

গ্রাম :.....

ওয়ার্ড নং:.....

বাড়ী নং:.....

টেলিফোন নং:.....

বাড়ীর প্রধানের নাম:.....

সাক্ষাৎকার গ্রহনের তারিখ: | | | |

সাক্ষাৎকার গ্রহণের সময়:.....

ডি ১:বয়স (পূর্ণ বছরে): |

ডি২:লিঙ্গ ১.পুরুষ ২.মহিলা |

ডি৩:পেশা: |

১. ব্যবসা ২.কৃষিকাজ ৩.চাকুরী

৪.গৃহিনী ৫.ছাত্র/ছাত্রী ৬.দিনমজুর

৭.অবসরপ্রাপ্ত ৮.বেকার ৯.অন্যান (নির্দিষ্ট করুন.....)

ডি৪: শিক্ষাগত যোগ্যতা: |

১. কখনও স্কুলে যাননি ২. প্রাথমিক (১-৫ বছর শিক্ষা গ্রহন করেছেন)

৩. মাধ্যমিক (৬-১০ বছর শিক্ষা গ্রহন করেছেন) ৪. এসএসসি

৫. এইচএসসি এবং তদূর্ধ্ব (১১ বছরের বেশী শিক্ষা গ্রহণ করেছেন)

ডি ৫: আপনি কি কমিউনিটি ক্লিনিক সম্পর্কে জানেন?

১.হ্যাঁ ২.না

ডি ৬: উত্তর হ্যাঁ হলে আপনি কমিউনিটি ক্লিনিক সম্পর্কে প্রথম কোথা থেকে শুনেছেন? |

১. স্বাস্থ্যকর্মী ২. জন প্রতিনিধি |

৩. প্রতিবেশী/আত্মীয় ৪. রেডিও/ টিভি/ সংবাদপত্র

৫. অন্যান্য (উল্লেখ করুন.....)

ডি৭: আপনার বাড়ী থেকে কমিউনিটি ক্লিনিকের দূরত্ব কত? |

১. পায়ে হেঁটে খাওয়া যায় ২. বাড়ী থেকে খুব দূরে নয়

৩. রিক্সা / ভ্যানএ যেতে ১০মিনিট সময় লাগে ৪. হেঁটে আধা মাইল দূরত্বের মধ্যে

৫. হেঁটে যেতে আধঘন্টা সময় লাগে

ডি৮: কমিউনিটি ক্লিনিককি প্রতিদিন খোলা থাকে? |

১.হ্যাঁ ২.না

ডি৯: কমিউনিটি ক্লিনিকের কর্মঘন্টা কতক্ষন? |

১. ৩ঘন্টারকম ২. ৩-৪ ঘন্টা ৩. ৪-৫ঘন্টা

৪. ৫-৬ঘন্টা ৫. ৬ঘন্টার বেশী ৬.জানিনা

ডি১০: সেবা প্রদানকারী কে? (উত্তর একাধিক হতে পারে) | |

১. সিএইচসিপি ২. এইচএ ৩. এফডব্লিউএ | |

৪. এমবিবিএস চিকিৎসক ৫. জানিনা

ডি১১: কমিউনিটি ক্লিনিকে কি ঔষধের স্বল্পতা রয়েছে? |

১.হ্যাঁ ২.না

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ডি১২: আপনি কি কমিউনিটি গ্রুপ সম্পর্কে জানেন?

১.হ্যাঁ ২.না

ডি১৩: উত্তর হ্যা হলে, আপনি কি মনে করেন যে কমিউনিটি গ্রুপের অংশগ্রহনে জনসাধারণ উপকৃত হচ্ছে?

১.হ্যাঁ ২.না

ডি১৪: আপনি কি কমিউনিটি সাপোর্ট গ্রুপ সম্পর্কে জানেন?

১.হ্যাঁ ২.না

ডি১৫: উত্তর হ্যা হলে,আপনি কি মনে করেন যে কমিউনিটি সাপোর্ট গ্রুপের অংশ গ্রহনে জনসাধারণ উপকৃত হচ্ছে?

১.হ্যাঁ ২.না

ডি১৬ : আপনি কি কমিউনিটি ক্লিনিকের কর্মঘন্টা কত ঘন্টা তা জানেন?

১.হ্যাঁ ২.না

ডি১৭: কমিউনিটি ক্লিনিকের সমস্যা / বাধা সমূহকি? (উত্তর একাধিক হতে পারে)

১. ঔষধ পত্র সহজ প্রাপ্ত নয় ২. অনেক দূর হেঁটে আসতে হয়

৩. সেবা প্রদান কারীর ব্যবহার ভালো নয় ৪. সেবা প্রদান কারীর অপর্যাপ্ততা

৫. অন্যান্য (দয়া করে নির্দিষ্ট করুন----------)

ডি ১৮: এলাকাবাসীর অংশ গ্রহণ কমিউনিটি ক্লিনিকের কার্যক্রমে কিরূপ ভূমিকা রাখে?

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ডি১৯: কমিউনিটি ক্লিনিকে এলাকাবাসীর অংশগ্রহন স্থানীয় জনসাধারণের স্বাস্থ্যের উপর কিরূপ প্রভাব ফেলে?

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কোড নং- | | | | |

অনুচ্ছেদ-ই: সমাজের গন্যমান্য ব্যক্তিদের সার্ভে

(গবেষণার একটি গুণগত অধ্যায়)

Key Informant's Interview (KII): Interview Schedule

অংশগ্রহনকারীর নাম:.....

ঠিকানা: .....

ই১: বয়স (পূর্ণবছর)

ই২: লিঙ্গ: ১.পুরুষ ২.মহিলা

ই৩: পেশা: ১. ব্যবসা ২.কৃষিকাজ ৩.চাকুরী
৪. গৃহিণী ৫.ছাত্র/ছাত্রী ৬.দিনমজুর
৫. বেকার ৮.অন্যান্য (নির্দিষ্ট করুন .....)

ই৪: শিক্ষাগত যোগ্যতা:
১. কখনও স্কুলে যান নাই ২. প্রাথমিক (১-৫ বছরের শিক্ষা গ্রহন করেছেন)
৩. মাধ্যমিক (৬-১০ বছর শিক্ষা গ্রহন করেছেন) ৪. এসএসসি ৫.এইচ.এস.সি.
৬. স্নাতক ৭.স্নাতোকত্তোর

ই৫: কমিউনিটি ক্লিনিকের জন্য কোন ব্যাবস্থাপনা কমিটি আছে?
১.হ্যাঁ ২.না ৩.জানিনা

ই৬: উত্তর হ্যাঁ হলে / যদি থাকে তাহলে ব্যাবস্থাপনা কমিটির নাম উল্লেখ করুন
১.সিজি ২.সিজিএ ৩.অন্যান্য (নির্দিষ্ট করুন .....) | |

ই৭: কমিটি গুলো কি সক্রিয়? | |
১.হ্যাঁ ২.না ৩.জানিনা

ই৮: কমিটির সদস্যরা কি যোগ্যতার ভিত্তিতে কমিটিতে অন্তর্ভূক্ত হয়েছেন? | |
১.হ্যাঁ ২.না ৩.জানিনা

ই৯: কমিউনিটি গ্রুপের দায় দায়িত্ব কি কি? (উত্তর একাধিক হতে পারে)

৯.১ কমিউনিটি ক্লিনিকের নিরাপত্ত নিশ্চিতকরা	১.হ্যাঁ	২.না	
৯.২ কমিউনিটি ক্লিনিকের পরিষ্কার পরিচ্ছন্নতা নিশ্চিত করা	১.হ্যাঁ	২.না	
৯.৩ প্রতিদিনের কার্যক্রম নিশ্চিত করা	১.হ্যাঁ	২.না	
৯.৪ স্থানীয়ভাবে অর্থ সংগ্রহ এবং এর সদ্ব্যাবহার / সদ্ব্যাবহার	১.হ্যাঁ	২.না	
৯.৫ অন্যান্য সেবা প্রদানকারীদের সাথে সমন্বয় সাধন	১.হ্যাঁ	২.না	
৯.৬ কমিউনিটি ক্লিনিকের কার্যক্রম মনিটর এবং মূল্যায়ন করা	১.হ্যাঁ	২.না	
৯.৭ স্থানীয় জনসাধারনের (এলাকাবাসীর) সম্পৃক্ততা / অংশগ্রহন, মনিটর এবং মূল্যায়নকরা	১.হ্যাঁ	২.না	

ই১০: এই কমিউনিটি ক্লিনিকটির জন্য কয়টি কমিউনিটি সাপোর্ট গ্রুপ রয়েছে?

ই১১: কমিউনিটি সাপোর্ট গ্রুপের দায়দায়িত্বগুলো কি কি?

১১.১ কমিউনিটি গ্রুপের সাথে নিবিড় যোগাযোগ রাখা		১.হ্যাঁ
১১.২ কমিউনিটি গ্রুপকে অর্থ সংগ্রহের বিষয়ে সহযোগিতা করা		১.হ্যাঁ
১১.৩ এলাকাবাসী স্থানীয় জনসাধারনকে কমিউনিটি ক্লিনিকের সেবা সম্পর্কে সচেতন করা	১.হ্যাঁ	২.না
১১.৪ দরিদ্র, প্রান্তিক এবং সংকটাপন্ন জনগনকে সেবা পেতে সাহায্য করা	১.হ্যাঁ	২.না
১১.৫ জরুরী সেবা পেতে জনগনকে সাহায্য করা	১.হ্যাঁ	২.না
১১.৬ দরিদ্র জনগোষ্ঠীকে রেফারাল সুবিধা পেতে সাহায্য করা	১.হ্যাঁ	২.না
১১.৭ স্বাস্থ্য, পুষ্টি এবং পরিবার পরিকল্পনা বিষয়ক তথ্য ছাড়িয়ে দেয়া	১.হ্যাঁ	২.না

ই-১২: কমিটি কি স্থানীয়ভাবে অর্থসংগ্রহ করে? | |
১.হ্যাঁ ২.না ৩.জানিনা

ই১৩: অতীতে ওকি এভাবে অর্থ সংগ্রহ করা হয়েছিল? | |

১. হ্যাঁ ২. না ৩. জানিনা

ই১৪: সেই অর্থ কিভাবে ব্যয় করা হয়েছিল? (উত্তর একাধিক হতে পারে)

১. গরীব রোগীদের চিকিৎসার জন্য ২. মহিলাদের চিকিৎসার জন্য

৩. শিশুদের চিকিৎসার জন্য ৪. অবকাঠামো তৈরি / উন্নয়নের জন্য

৫. অন্যান্য (নির্দিষ্ট করুন.....) ৬. জানিনা

ই১৫: কমিটি কি কি ধরনের সমস্যার সম্মুখীন হয়েছিল? (উত্তর একাধিক হতে পারে)

১. সরকার কতৃক দূর্বল পৃষ্ঠপোষকতা ২. আর্থিক সমস্য

৩. অপর্যাপ্ত দ্রব্য সামগ্রী সরবরাহ ৪. জনসাধারনের সহযোগীতা না থাকা

৫. অপর্যাপ্ত যন্ত্রপাতি ৬. অপর্যাপ্ত ঔষধ সরবরাহ

৭. দলীয় চাপ / বল প্রয়োগ কারীদের চাপ ৮. অন্যান্য (নির্দিষ্ট করুন----------)

ই১৬: এলাকাবাসী /স্থানীয় জনসাধারন কি জমি দান করেছিলো?

১.হ্যাঁ ২.না ৩.জানিনা

ই১৭: অবকাঠামো নির্মানের সময় তত্ত্বাবধানের কাজে কি কমিউনিটি গ্রুপ অন্তর্ভূক্ত ছিল?

১.হ্যাঁ ২.না ৩.জানি না

ই১৮: কমিউনিটি ক্লিনিকের কার্যকম পরিচালনা এবং রক্ষনাবেক্ষনের কাজে কি কমিউনিটি গ্রুপ অন্তর্ভূক্ত ছিলেন?

১.হ্যাঁ ২.না ৩.জানি না

ই১৯: জায়গাটি পরিষ্কার পরিচ্ছন্ন রাখার ক্ষেত্রে কমিউনিটি গ্রুপ কি সাহায্য করে?

১.হ্যাঁ ২.না ৩.জানিনা

ই২০: কমিউনিটিগ্রুপএকতজনসদস্যআছেন?

ই২১: কমিউনিটিগ্রুপএকিকোনমহিলাসদস্যআছেন?

১.হ্যাঁ ২.না ৩.জানিনা

ই২২: উত্তর হ্যাঁ হলে, কতজন মহিলা সদস্য কমিউনিটি গ্রুপে অন্তর্ভূক্ত আছেন?

ই২৩: জমি দানকারী কি কমিউনিটি গ্রুপে অন্তর্ভূক্ত আছেন?

১.হ্যাঁ ২.না ৩.জানিনা

ই২৪: কোন সেবা দানকারী (সিএইচসিপি) কি কমিউনিটি গ্রুপে অন্তর্ভূক্ত আছেন?

১.হ্যাঁ ২.না ৩.জানিনা

ই২৫: সেবা দান কারী (সিএইচসিপি) কি কমিউনিটি গ্রুপের সদস্য হিসেবে দায়িত্ব পালন করছেন?

১.হ্যাঁ ২.না ৩.জানিনা

ই২৬: কমিউনিটি গ্রুপ গঠনের সময় কাল উল্লেখ করুন

১. স্থান নির্ধারনের পূর্বে ২. অবকাঠামো নির্মানের পূর্ব

৩. হস্তান্তরের পরে ৪. জানিনা

ই২৭: ইউনিয়ন পরিষদের চেয়ারম্যান কি মাসে একবার চালু কমিউনিটি ক্লিনিক তত্ত্বধান করেন?

১.হ্যাঁ ২.না ৩.জানিনা

ই২৮: কমিউনিটি গ্রুপের সদস্যরা কি তাদের ভূমিকা ও দায়িত্ব সম্পর্কে অবহিত?

১.হ্যাঁ ২.না ৩.জানিনা

ই২৯: কমিউনিটি গ্রুপের সদস্যরা কখন কি ভাবে সভায় মিলিত হন?

১. প্রতিমাসে ১বার ২. প্রতি ৩ মাসে ১বার

৩. প্রতি ৬ মাসে ১বার ৪. প্রতি ১২মাসে ১বার

৫.মিলিতহননা ৬. জানিনা

ই৩০: কমিউনিটি ক্লিনিক পরিচালনা / সেবা প্রদান সম্পর্কে সব মিলিয়ে আপনার মতামত কি?

১. সন্তোষজনক

২. আংশিক সন্তোষজনক

৩. সন্তোষজনক নয়

ই৩১: কমিটির সদস্যদের জন্য কোন প্রশিক্ষন হয়েছিল?

১.হ্যাঁ ২.না ৩.জানিনা

ই৩২: যদি প্রশিক্ষন দেয়া হয়ে থাকে তবে কি প্রশিক্ষনটি উপকারী ছিল?

১.হ্যাঁ ২.না

ই৩৩: কমিউনিটি ক্লিনিকের কার্যক্রমে এলাকাবাসীর অংশগ্রহনের পথ / উপায়গুলো কি কি?

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ই৩৪: কমিউনিটি ক্লিনিকের কার্যক্রমে অংশগ্রহনের ফলে এলাকাবাসীর স্বাস্থ্যসেবার কী কী উপকার হয়েছে?

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ই৩৫: কমিউনিটি ক্লিনিকের কার্যক্রমে অংশ গ্রহনের ফলে এলাকাবাসীর কোন কোন বিষয়ে স্বাস্থ্য সচেতনতা বৃদ্ধিপেয়েছে?

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ই৩৬: কমিউনি টিক্লিনিকের কার্যক্রমে অংশগ্রহনের ফলে এলাকাবাসীর তথ্য ও যোগাযোগে কী কী উন্নতি হয়েছে?

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ই৩৭: কমিউনিটি ক্লিনিকের কার্যক্রমে এলাকাবাসীর অংশগ্রহন স্থানীয় জনসাধারণের জীবন যাত্রার মানোন্নয়নে কী কী বিষয়ে ভূমিকা রাখছে?

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ই৩৮: এলাকাবাসীর অংশগ্রহন প্রাতিষ্ঠানিক গর্ভকালীন সেবা (প্রসবপূর্ব / প্রসবকালীন / প্রসবপরবর্তী) কী কী উপায়ে বৃদ্ধি করে?

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ই৩৯: এলাকাবাসীর অংশগ্রহন কী কী উপায়ে কমিউনিটি ক্লিনিকের ব্যবস্থাপনা জোরদার করে?

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ই৪০: এলাকাবাসীর অংশগ্রহনের মাধ্যমে কমিউনিটি ক্লিনিক রোগপ্রতি রোধও রোগ নিরাময়ে কী কী ভূমিকা রাখে?

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ই ৪১: কমিউনিটি ক্লিনিক কার্যক্রমে এলাকাবাসীর অংশগ্রহনের ক্ষেত্রে সমস্যা সমূহ কী কী?

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ই ৪২: কমিউনিটি ক্লিনিকের কার্যক্রমে অংশগ্রহনে এলাকাবাসীর দায়িত্ব পরায়নতা বৃদ্ধির উপায় কী কী?

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ই ৪৩: কমিউনিটি ক্লিনিকের স্বাস্থ্য সেবার গুনগতমান বৃদ্ধির ক্ষেত্রে এলাকাবাসীর করণীয় কী কী?

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ই ৪৪: এলাকাবাসীর অংশগ্রহনের মাধ্যমে কিভাবে কমিউনিটি ক্লিনিকের ব্যবহার বৃদ্ধি করা যায়?

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ই ৪৫: কমিউনিটি ক্লিনিকের কার্যক্রমে এলাকাবাসীর অংশগ্রহন কিভাবে জোরদার করা যায়?

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সাক্ষর ও তারিখ
(মাঠ পরিদর্শক)
নাম: