"Urban Primary Health Care Delivery System: A Study of Selected PHC Clinics in the Dhaka City Corporation Area".

A Dissertation submitted in partial fulfillment of the requirements for the degree of Master of Philosophy in Geography and Environment in the University of Dhaka.

M. PHIL. THESIS

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I certify that all the work contained in this dissertation is my own (unless otherwise acknowledgement) and that this research has not been submitted before for any degree in my university.

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ABSTRACT

Dhaka is the capital and largest urban center of Bangladesh. It is an area of living for about 20 million people. This growing urban population puts extra demands on existing health care facilities. Urban poor people is also a vital factor for promoting Urban Primary Health Care Project (UPHCP) to provide health care facilities. The provision of preventive health and limited curative care as a responsibility of city corporations and municipalities according to the City Corporation Ordinance 1983. But, the public-sector health services were not appropriately equipped with the required infrastructure so that the city corporations and the municipality's requirements as there were limitations in resources and manpower. Primary health care facilities and services for the urban population at large and, specifically for the urban poor are largely insufficient.

The study has been conducted to explore the existing facilities in the selected Urban Primary Health Care centers and type of services they provided and the socio-economic condition of the people who take the treatment from the clinics.

The data for this study is taken from the city health care clinics – the PHCCs (Primary health care Centre) and the CRHCCs (Comprehensive reproductive health care Centre). This health care center is run by some NGO with the help of Dhaka City Corporation.Five NGOs providing primary care facilities under the UPHCP has been purposively selected from the list provided by the project office located at the Dhaka City Corporation office. The 200 respondent patients were selected randomly from the five selected primary health care centers. Data collected through questionnaires were processed using SPSS statistical software and presented through different graph, charts, tables and texts. Maps showing the service area of the primary health care centers were prepared using ArcGIS software.

The study shows three characteristics like infrastructure and resources of clinics, socio-economic condition of the clients and different services provided by the clinics to the patient as well as their opinion about the problem of services and opinion about the way of developing the standard of services. **C**linics have sufficient people for providing health services to the clients. There are ambulance services for emergency treatment providing and medicine supply to the patient. Clinic

has generator services during load shading period. Toilet condition is more or less good. Patient pressure in the clinics is huge. Clinics follow medicine reservation system for providing good quality of medicine to the patient and the clinics settlement area is good for the establishment of the clinics.Most of the respondents age is in 16-30 about 78% and female respondents is 96.5%. Married respondents are more about 81% of total respondents. Muslim clients is more about 87%. Educational qualification is more on primary level about 36%. Most of the respondents are housewife about 61% and maid servant and garments worker are the main occupation of respondents. Most of respondent use tap water for drinking and cooking water. Most of the clients use semi pucca house for living about 63.5% and use pucca/ring slab latrine.NGOs clinics of Dhaka city provide a lot of health care services to the clients especially on maternal and child health care delivery system. These services is provided to the nearest patient surrounding place of the clinic with less or free of cost. They do not need to wait for a long a long time to get the treatment. Most of the patient are satisfied with the standard of NGO clinics treatment. They also describe some opinion to develop the standard of services.

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ABBREVIATION

MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
UPHCP	Urban Primary Health Care Projects
MOHFW	Ministry of Health and Family Welfare
MCH	Maternal and Child Health
DGHS	Directorate General of Health Services
VCT	Voluntary Counseling and Testing
NGO	Non-Government Organization
EPI	Expanded Program Immunization
HPSP	Health and Population Sector Program
HNPSP	Health Nutrition and Population Sector Program
HPN	Health Population and Nutrition
GP	General Physician
HIS	Health Information System
USAID	United States Agency for International Development
ADB	Asian Development Bank
GoB	Government of Bangladesh
HFA	Hyogo Framework for Action
CC	Community Clinic
UPHCDS	Urban Primary Health Care Delivery System
WHO	World Health Organization
UN	United Nation
EC	European Commission
EU	European Union

IMCI	Integrated Management of Childhood Illness
WHC	Ward Health Committee
CSP	Child Survival Programme
MMR	Maternal Mortality Ratio
BDHS	Bangladesh Demographic and Health Survey
NIPORT	National Institute of Population Research and Training
EOC	Emergency operations center
SIDA	Swedish International Development Cooperation Agency
PHCC	Primary health care Centre
CRHCC	Comprehensive reproductive health care Centre
UNFPA	United Nation Fund for Population Activities
DCC	Dhaka City Corporation
GIS	Geographic Information System
CMC	City Maternity centers

Chapter 1

Introduction

1.1 Background

Bangladesh is going through rapid urbanization (at an estimated rate of 6%) and urban growth. This growth is being fuelled by rising incomes due to rapid expansion of commerce and industry in and around the capital city Dhaka. Currently, about 27% of total population of Bangladesh lives in urban areas. Population growth rate in urban areas (2.7%) is more than the national population growth rate (about 1.4%). Dhaka, the largest city itself accounts for 40% of total urban people. The other five divisional cities account for 29% while 309 municipality towns have 31% of total urban population. Rapid and incessant growth of migrants in urban slum areas of large cities is creating continuous pressure on urban health care services. The access to health care especially primary health care in large cities including Dhaka has been very limited due to the mis-match between demand and supply. The primary health care infrastructure in the cities have not been able to grow at a rate commensurate with the growth of the population of the cities. The result has been the very poor state of the health care situation of the urban populace.

In Bangladesh the urban health care services are the responsibility of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC). A host of legal instruments, The Municipal Administration Ordinance of 1960, ThePourashova Ordinance of 1977, The City Corporation Ordinance of 1983 and The Local Government (Pourashova) Act 2009, all allocated the provision of preventive health and limited curative care as a responsibility of city corporations and municipalities. But, the public-sector health services were not appropriatelyequipped with the required infrastructure so that the city corporations and the municipality'srequirements as there were limitations in resources and manpower. Private health care providers are the main resources for providing remedial care, including tertiary and expertise services to the urban people, but they seldom provide preventive and promotional health services. On the other hand, MOHFW is tasked with setting technical standards, packaging services, strategies and policies of the country's health sector.

A distinctive picture of availability of different facilities and services for secondary and tertiary level health care is being seen in the urban areas, where primary health care facilities and

services for the urban population at large and, specifically for the urban poor are largely insufficient. With the implementation of two urban primary health care projects (UPHCPs) since 1998, the primary services have been provided by the city corporations and municipalities through contracted NGOs under MOLGRDC in the project's areas. The project provides free services to 22% (as per household survey 2007) of the total population of the project areas. The non-project urban areas are being served by the health facilities of MOHFW. To reach the urban poor, there are around 4000 satellite centers in total. Moreover, 35 urban dispensaries under the DGHS are providing outdoor patient services including EPI and maternal and child health (MCH) to the urban population. These urban dispensaries will be equipped with necessary facilities to use as the outlet centers of the tertiary hospitals. Various NGOs provide critical services as well as some special services (52 HIV/AIDS clinics) through 158 PHC centers, 34 comprehensive centers, 56 DOTS centers, 47 VCT centers. In conclusion, to fill up the needs of the fast growing urban population, various urban primary health care services that are being provided are yet largely inadequate.

In order to take up the mutual authorized responsibility on a sustainably effective manner, there is a need to establish a stable harmonized structure between the two Ministries. MOHFW will join to deal with this challenge through a counseling process with MOLGRDC, city corporations and concerned stakeholders in order to jointly assess, map, project, and plan HPN services in urban areas. The emphasis on urban health will be a new (and very singular) element compared to HPSP and HNPSP. It will involve MOHFW inaugurating new ways to work with its partners, notably MOLGRDC, NGOs and others. The UPHCP of MOLGRDC and NGOs have lots of experiences in providing urban primary health care (UPHC) services through contracted NGOs.

There have been striking achievements in terms of coverage, monitored quality of services and monitored exemption schemes for the poorest. These will continue, but side by side MOHFW will seek to extend the coverage of PHC services in the particular urban areas which are not covered by the UPHCP. In order to make the population being ensured with better health care, services in the urban dispensaries under the DGHS will be enhanced by inaugurating an effective referral system in the facilities. MOHFW also provides health services through secondary and

tertiary hospitals that will continue to be reinforced in terms of coverage, quality and equity of service delivery in response to demand.

Priority interventions will include development of an urban health strategy with time-bound action plan in collaboration with MOLGRDC. The focal person for urban health in MOHFW will take the initiative for formulating the strategy in consultation with relevant stakeholders. Commissioning a study to determine how the two Ministries can jointly assess, map, coordinate, plan and work together to provide quality HPN services for the urban population will also be aconcern of priority interventions. It will include establishing a permanent institutional arrangement and governance mechanism to integrate relevant ministries, agencies and institutions with a promised responsibility to urban health. It will also promote ways to expand or upgrade urban dispensaries for effective and eminent PHC services (including services for reproductive health, nutrition and health education). It will also incorporate an adequate referral system between the various urban dispensaries and the second and third level hospitals which will explore feasibility of introducing General Physician (GP) system.

Development and utilization of urban HIS for effective management of urban health care will also be a concern of priority interventions. Thus, it will enhance capacity development of the various service providers under MOHFW and MOLGRDC. Determining the role and accountability of different NGOs and the private sectors in the delivery of urban health care services, and formalizing relationships through PPPs for diversifying delivery strategies health services will also be considered by priority interventions. In spite of availability of all those services at different levels, utilization of the services by the population is comparatively low. Improvement of the access of the population to quality services and increase responsiveness of the service delivery system to the needs and demands of the population is a difficult challenge to be addressed by the government.

Good health of the common people is a basic requirement for national development. As Bangladesh is one of the fastest growing economics in South Asia, the health status of its population is vital for the sustainable of their socio-economic development. Government and NGOs have been providing primary health care through a variety of outlets ranging from satellite

clinics through primary health care centers, many new and innovative programmes are in operation now. Of the notable recent primary health care delivery programmes mention can be made of Smiling Sun project supported by the USAID and the "Rainbow" programmes supported by the ADB.

The network of 317 permanent "Smiling Sun" clinics 8000 satellite clinics and 7000 community health workers, plays a significant role in providing families with high quality and low cost reproductive health and child health care. About twenty million people live in areas by "Smiling Sun" clinics. The clinics provides two million services to the clients each month. Over a million people visit smiling Sun clinic providers for family planning service each year and over 200000 pregnant women receive antenatal care. Almost three quarters of children living in urban areas served by Smiling Sun NGOs have received all their childhood immunizations. Almost a third of children who live in the programmes treatment for acute respiratory tract infection one of the most significant causes of infant mortality in Bangladesh.

Services provided from Smiling Sun which sees upward of two million people each month offer a range of essential health care services including, child health, maternal health, family planning, communicable, limited curative care and behavior change communication.

1.2 Statement of the problem

Dhaka is the capital and largest urban center of Bangladesh. It is an area of living for about 20 million people. This growing urban population puts extra demands on existing health care facilities. Urban poor people is also a vital factor for promoting Urban Primary Health Care Project (UPHCP) to provide health care facilities. So the expansion of present health care facilities and improvement of services is important to fulfill the demands of urban population of Dhaka city.

1.2 Objectives of the study

In the light of the above mentioned healthcare demand picture the primary objective of the study is to study the existing under the Urban Primary Health Care Programmehealth care facilities in

order to gain knowledge about the nature of the services provided. The specific objectives of the study are:

1. to study the services provided by the health care facilities;
2. to study the socio-economic and other conditions of the clients of health care centres; and
3. to make suggestion for the development of Primary Health Care Delivery System.

1.4 Significance of the study

Dhaka is a living place for around 20 million people. The government as well as the City Corporation is not able to provide adequate primary health care facilities to the people. Public health service system is not much developed. It can be found from past studies that the health care history of Bangladesh that it was started in antiquity with the Ayurveda and Unani medicine. In 1714 Indian Medical Service was formed by the British colonial government. In 1938 the National Health (Sokhey) Sub-committee by INC was formed. In 1943 the Health Survey and Development (Bhore) Committee was formed. In 1947 with independence of India and Pakistan paved the way for the emergence of Bangladesh in 1971. In 1961 the Rural Health Center Scheme was adopted. In 1967 Thana Health Complex Schemes to establish 31 bed hospitals in Thana's were started.

In 1978 Bangladesh signed the Alma Ata declaration: PHC for achieving HFA2000. In 1981 Introduction of PHC pilot project was started in six UHCs. In 1986 First evaluation of the National HFA strategy was done. In 1988 Intensified PHC Program by GoB was started.In 1991-DSF; in 1994-EOC; in1995-BINP; in 1996-HPSS; in 1998-HPSP, UPHCP, ESP; in2000. LLP; in2001- IMCI; in2003- HNPSP was adopted. In 2009 National Health Policywas introduced. This saw the reestablishment of CC and two Urban Primary Health Care Projects (UPHCP). The study of these will help to know the nature of the present delivery system and its effectiveness to the people. Based on these further initiatives can be taken to improve the health care delivery system.

1.5 Limitation of the study

The most difficult part of this study was to collect data from different clinics of Dhaka city. It was difficult due to the sensitive attitude of patients and service provider institutions. The authority of the clinics was not cooperative and did not want respond. The transportation to the clinics was also difficult. Some patients was not willing to give information related to maternal health care services and problems.

1.6 A review of related literature

Here, the chapter "Literature Review" is purported to depict the published research materials associated with "Urban Primary Health Care Delivery System" by accredited academicians and researchers. This research addresses the present pattern of Urban Primary Health Care Delivery System in Bangladesh and also the different issues related with Urban Primary Health Care Delivery System. Present concepts, theories, models and explanation about Urban Primary Health Care Delivery System have evolved to the combined efforts made by different scholars and researchers.

Poor People's Access to Health Services in Bangladesh

Majority of people of Bangladesh being poor depend on government health structures for remedies from illness (Rahman et al, 2005). Child and mother malnutrition rate (70%) in Bangladesh remains highest in the world, and more severe than that of the most other developing countries, including Sub- Saharan Africa (WHO 2000; Asiatic Society of Bangladesh 2002).Maternal mortality rate is between 320 and 400 per 100,000 women, which is among the highest in the world and is still higher relative to many developing countries (Titumir, 2005). A majority of infant deaths occur during the first month of life (neonatal mortality) (NIPORT, Mitra and Associates and ORC Macro 2005).All districts of Bangladesh have various types of hospitals (Siddiqui 2003) and all union health care centers have people experienced with the training on family planning, reproductive health, and postnatal and prenatal care (Chowdhury:

2004).Access has at least three components—availability, utilization and timeliness (Kruk and Freedman, 2008).

Availability of services is a process indicator linked to the policies, funding levels and organizational arrangements in each country (UN, 2005). Availability is reported as the level of inputs (physicians, nurses, hospitals, clinics) per population or within a geographic area (UN, 2000). The notion of timely access is increasingly being recognized as an important feature of access although indicators to measure this are few in the developing world (Freedman, 2005). Timely access is essential to save lives in some conditions (e.g., for malaria, birth complications, acute myocardial infarction) and to minimize suffering and disability in others (e.g., chronic illness) (Mackintosh, 2001).

Achieving equity in health requires eliminating health disparities that are avoidable and unfair such as those due to inadequate access to services, unhealthy living or working conditions, or downward social mobility caused by ill health (EC, 2005). A common approach to measuring equity in service delivery is to analyze the markers? Of effectiveness (comprehensiveness, access, quality, continuity, patient satisfaction, etc.) by income quintile, ethnicity, gender, geographic location or other social stratifiers (Ali et al, 2005).Daniels et al (2005) proposed that countries define locally specific indicators to measure reductions in geographical misdistribution of services and supplies, elimination of gender, culturaland other non-financial barriers to access, and theprovision of an appropriate basket of services.

Quality of Urban Primary Health Care Services

The quality of care offered to sick children in these facilities was very poor even without the IMCI strategy being utilized and antibiotics were both overused and underused (Arifeen SE, et al., 2005). Quality of urban primary health services is the lack of essential drugs and poor attitude of health workers (Ehiri JE, et al., 2005).There is no single definition of quality, the frequently cited Institute of Medicine's definition is health care that is safe, effective, patient-centered, timely, efficient, and equitable (Institute of Medicine, 2001).Measurement of quality in

developing countries is accelerating with the introduction of new health programs that are intended for national scale-up (Islam et al, 2005).

Researchers evaluating the effectiveness of the Integrated Management of Childhood Illness (IMCI) constructed a single aggregate measure of technical quality of care comprised of prescribing the correct drug, prescribing it correctly (dosage, timing, duration of treatment) and explaining the treatment to the patient (Gandjour et al, 2002).A set of draft standards has been reviewed by working groups of stakeholders to ensure the standards were applicable, important, understandable, measureable and achievable in urban primary health care centres in Bangladesh. Services are planned and coordinated to meet the needs of the organisation and the community and achieve desired results (Kai, 2010).

Ward Health Committee (WHC) is mandated to coordinate health and family planning activities for their residents; to ensure health education sessions in schools and satellite clinics; and to take necessary steps for treatment or hospital referral by collecting funds locally (Rahman et al, 2005).

Child and Maternal health status

A promising partnership for health has been forming in Saidpur and Parbatipur municipalities in NorthernBangladesh. Under a Child Survival Programme (CSP), a tripartite partnership has developed between Concern, two municipal authorities, and 24 ward health committees (WHC). The CSP's goal is to reduce maternal and child mortality and morbidity, and increase child survival by developing a sustainable municipal health service (Cooperrider, D L. and Whitney, D, 1999).

Maternal health status for many Bangladeshi women remains poor. Around 50% of Bangladeshi women were found to be chronically malnourished with a body mass index less than 18.5. Over 43% of pregnant women were iodine deficient and more than 2.7% developed night blindness during pregnancy (BDHS 2001).The maternal mortality ratio (MMR) in Bangladesh has declined from nearly 574 per 100,000 live births in 1990 to between 320 and 400 in 2004 (NIPORT 2001; BDHS 2004).The estimated lifetime risk of dying from pregnancy and child birth-related causes

in Bangladesh is about 100 times higher than that in developed countries (NIPORT 2003). A tragic consequence of these deaths is that about 75% of the babies born to these women are also likely to die within the first week of their life (WHO 2004).

The major direct causes of maternal deaths in Bangladesh are postpartum haemorrhage, eclampsia, complications of unsafe abortion, obstructed labour, postpartum sepsis, and violence and injuries (Fauveau 1994, NIPORT *et al.* 2003, MOHFW 2003). About one-fourth of the total maternal death in rural Bangladesh is due to unsafe abortion and related complications (Alauddin 1986; MOHFW 2003).Percentages of maternal death from eclampsia varies from 12 to 53% in different studies (Fauveau*et al.* 1994). Around 14% of deaths of pregnant women are associated with injury and violence (WHO 2004).The risk factors for maternal mortality include women's low status in society, poor quality of maternity care services, lack of trained health professionals, lack of EOC services, and low uptake of services by women, infrastructure and administrative difficulties (Haque*et al.* 1997; Streatfield*et al.* 2003).

Infant and child mortality rates reflect a country's level of socioeconomic development and quality of life. The neonatal and under-5 mortality rates are still higher in Bangladesh. Bangladesh ranks seventh among the 42 countries contributing to the 90% of all childhood deaths worldwide (Blum*et al.* 2006).The two most important causes for under-5 children's death are serious infections (31%) from ARI and diarrhea (BDHS 2004; Baqui*et al.* 2001; Fauveau*et al.* 1994). Comparison of surveys revealed that deaths due to almost all causes, especially infectious diseases, declined (Baqui*et al.*2001). The health conditions of the urban poor are extremely unsatisfactory among Chittagong slum living dwellers (Nahar and Rahman, 2010).

Community Clinics (CC) were to provide services for around 6000 people, and it was envisaged that their location would make them accessible for 80% of the population within less than 30 minutes walking distance (Normand et al, 2002).

Urban Primary Health Care Project (UPHCP)

Bangladesh has been implementing Urban Primary Health Care Project (UPHCP) since 1998. The second phase of the project titled Second Urban Primary Health Care Project commenced on 1 July 2005 and the third phase of this project, *i.e.* the Urban Primary Health Care Services Delivery Project has embarked on 1 July 2012. The goal of the project is to improve the health status of the urban population specially the poor through improved access to and utilization of efficient, effective and sustainable Primary Health Care services. At least 30% of each service provided under the project is targeted to the poor. The services are managed by 9 partner NGOs in 21 partnership areas (PAs) of 7 City Corporations and 4 selected Municipalities; 4 partnership areas in new 3 City Corporations are under process. 5 Pas in Chittagong City Corporation has dropped, to cover targeted 30 PAs in this phase it is expected to include 5 more PAs in other urban areas of Bangladesh. The Urban Primary Health Care Services Delivery Project is funded by GoB Grant, ADB Loan, SIDA Grant, and UNFPA Grant (UPHCP Performance Report, 2013).

1.1 Organization of chapters

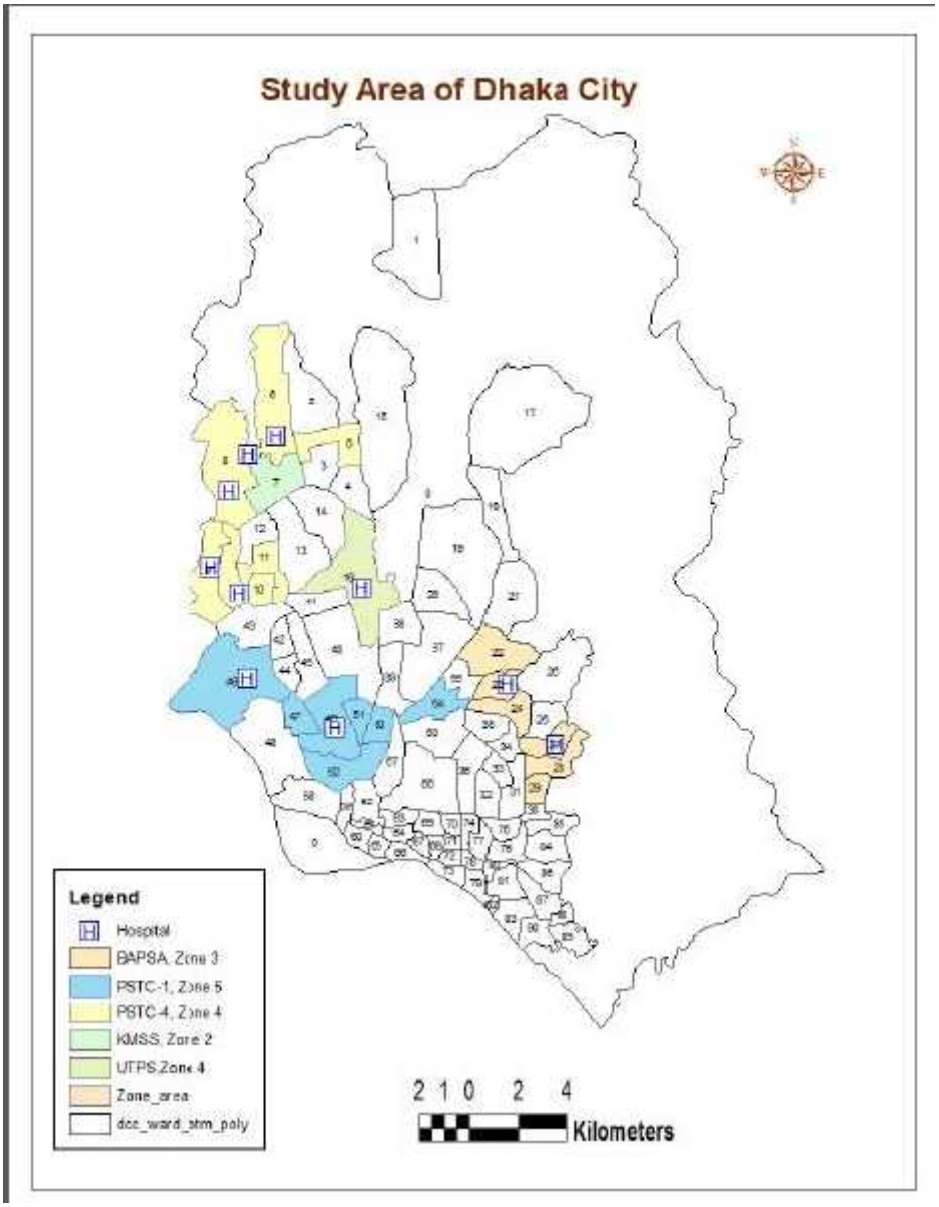
All chapter of the research report has been arranged by followings: Chapter 1 Introduction; Chapter 2 Methodology; Chapter 3 Condition of Urban Primary Health Care Centre in Dhaka City Corporation; Chapter 4 Socio-economic and other conditions of clients; Chapter 5 Services provided by the Urban Primary Health Care Facilities; Chapter 6 Conclusion and recommendation; References.

Chapter 2

Methodology

2.1 Study area

Dhaka city is the most densely populated area of Bangladesh. Most of the people of Dhaka city is urban poor people from the slum. Health care services are very expensive to the slum dwellers and lower class people of Dhaka city. The data for this study is taken from the city health care clinics – the PHCCs (Primary health care Centre) and the CRHCCs (Comprehensive reproductive health care Centre). This health care center is run by some NGO with the help of Dhaka City Corporation.



Map 2.1: Study Area

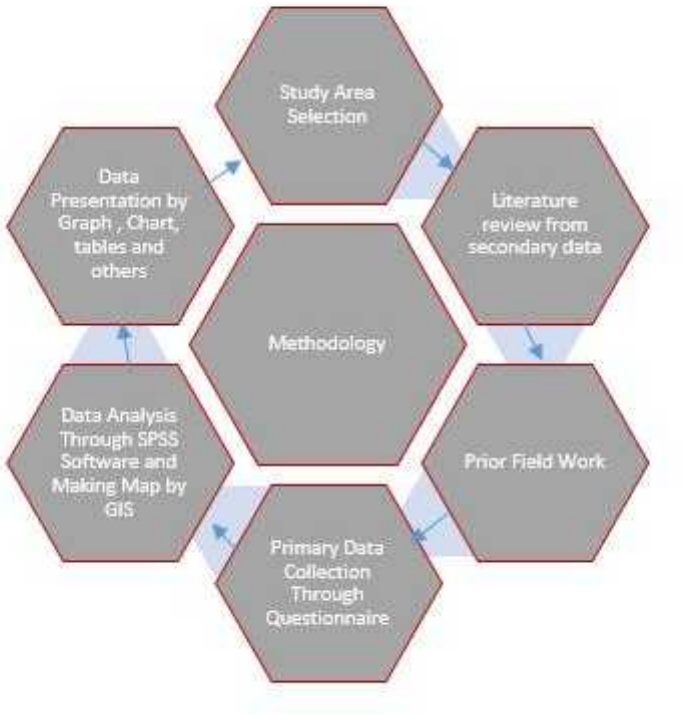


Figure 2.1: Methodology

2.2 Data sources

Most of the literature and pre-work information was taken from different organizations and other secondary sources. Primary data was collected from the field through a set of questionnaires.

2.3 Data collection

Secondary data is collected from different journals, books, published and unpublished articles etc. Primary data is collected through face to face interview with a set of questionnaire. This interview is done with the patient and service provider of the clinic.

2.4 Sampling procedure

Five NGOs providing primary care facilities under the UPHCP has been purposively selected from the list provided by the project office located at the Dhaka City Corporation office. The 200 respondentpatients wereselected randomly from the five selected primary health care centres.

2.5 Data analysis and presentation

Data collected through questionnaires were processed using SPSSstatistical software and presented through different graph, charts, tables and texts.Maps showing the service area of the primary health care centers were prepared using ArcGIS software.

Chapter 3

Condition of Urban Primary Health Care Centre in Dhaka City Corporation

3.1 Introduction

Urban Primary Health Care Centre (UPHCC) has two important goals. One is provide the health care infrastructure in the cities and other is to ensure proper environmental health for the urban populace. Bangladesh government has taken up two successive projects the UPHCP- 1 and UPHCP-2 to develop and provide primary health care service to the urban poor. Under the project UPHCP – 2, a total will of fifty (50) City Health Centers (CHC), fourteen (14) City Maternity centers (CMC),AND other facilities are to be constructed in Dhaka, Chittagong, Rajshahi, Khulna, Barisal, Sylhet City Corporations and the Municipalities of Comilla, Bogra, Sirajgonj, Savar.The details are shown in Table 3.1 below.

Table 3.1: UPHCP-1 and UPHCP-2 construction and infrastructure

Corporation/Municipality	Construction in UPHCP-1		Proposed infrastructure in UPHCP-2			
	CHCs	CMCs	CHCs	CMCs	Purchase Apartment for CHCs	Up-gradation of CHC into CMC
Dhaka	36	6	8	4	12	3
Chittagong	40	0	0	2	0	1
Rajshahi	14	2	0	0	0	0
Khulna	26	1	0	1	0	0
Barisal	0	0	7	1	0	0
Sylhet	0	0	10	1	0	0
Comilla	0	0	5	1	0	0
Bogra	0	0	5	1	0	0
Sirajgonj	0	0	5	1	0	0
Savar	0	0	5	1	0	0
Madhobdi	0	0	5	1	0	0

Source: QPR, 2007

Health care infrastructure is very important for providing good quality of health service to the clients. If the conditions of health care centers is developed, they can provide good quality of health care services**.**

The following provides the information collected from the field survey.

3.2 Ownership of Clinic

Table 3.2: Type of ownership of clinic

Type of ownership of clinic	Number
Individual	0
Joint	0
NGO's branch clinic	10

Source: Field data

All the health care centers are directed by the NGOs and also owned by different NGOs, who are the partner with government in the UPHCP-1 and UPHCP-2.

3.3 Type of clinic settlement

Table 3.3: Type of clinic settlement

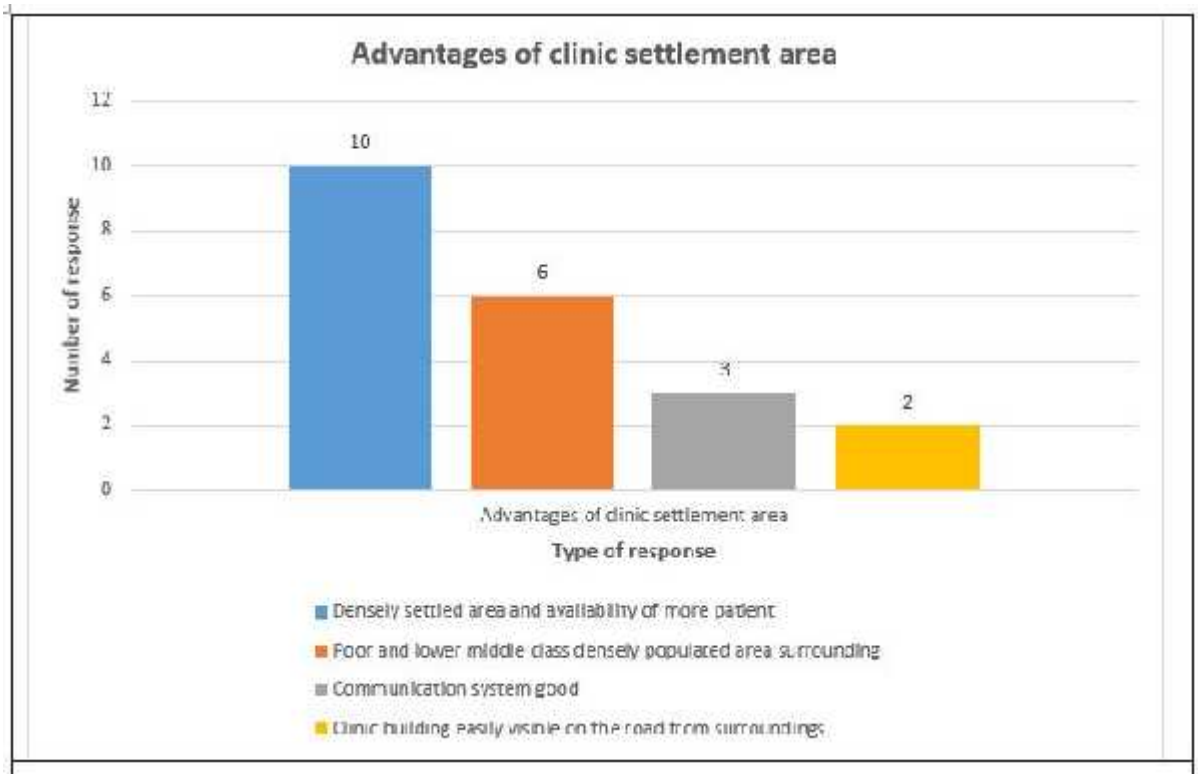
Type of clinic settlement	Number of clinic	Rent/lease amount of taka of 10 clinic per month	Average rent/lease amount of taka per month
Own	0	0	0
Rent	9	180000	20000
Lease	1	22500	22500

Source: Field data

All the clinic building is Pucca type and well structured. There are 9 clinic driven by rent and 1 is driven by lease. Total rent of all clinic per month is 180000 taka and total lease of clinic settlement is 22500. Average cost of rent per clinic settlement is 20000 and lease is 22500.

3.4 Advantages and disadvantages of clinic settlement area

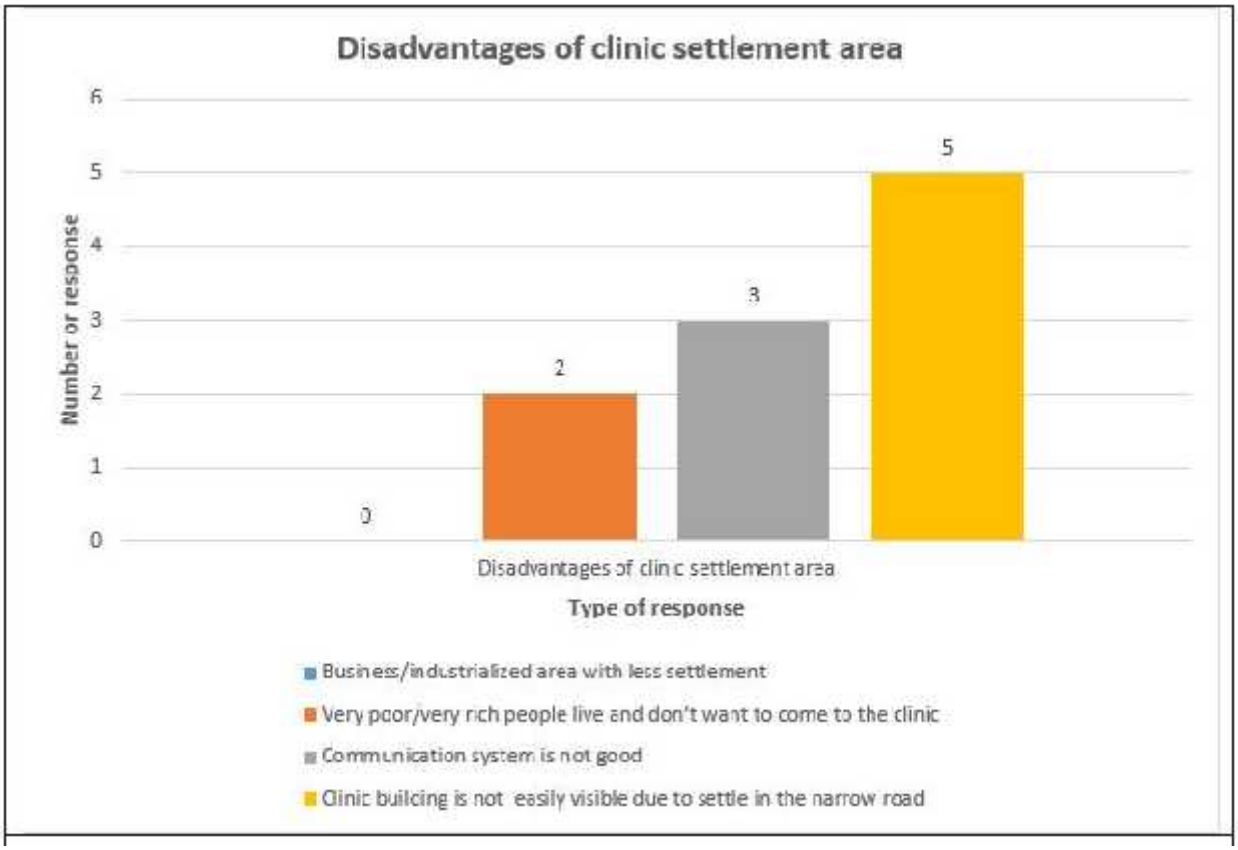
Figure 3.1: Advantages of clinic settlement area



Source: Field data

Clinic settlement area is densely populated, which provide more clients pressure to the clinics. Due to the poor economic condition of urban slum dwellers and huge health service cost in Dhaka city poor and middle class people come to the clinic centers. Surrounding settlement area from the clinic have good communication system.

Figure 3.2: Disadvantages of clinic settlement area



Source: Field data

The main disadvantages of clinic settlement area is the visibility of clinic from long distance. Due to the establishment in the densely populated area with tall building clinics are not seen well from surroundings area. Very poor and rich people do not want to come clinic for health services.

3.5 Administration and staffs of the clinics

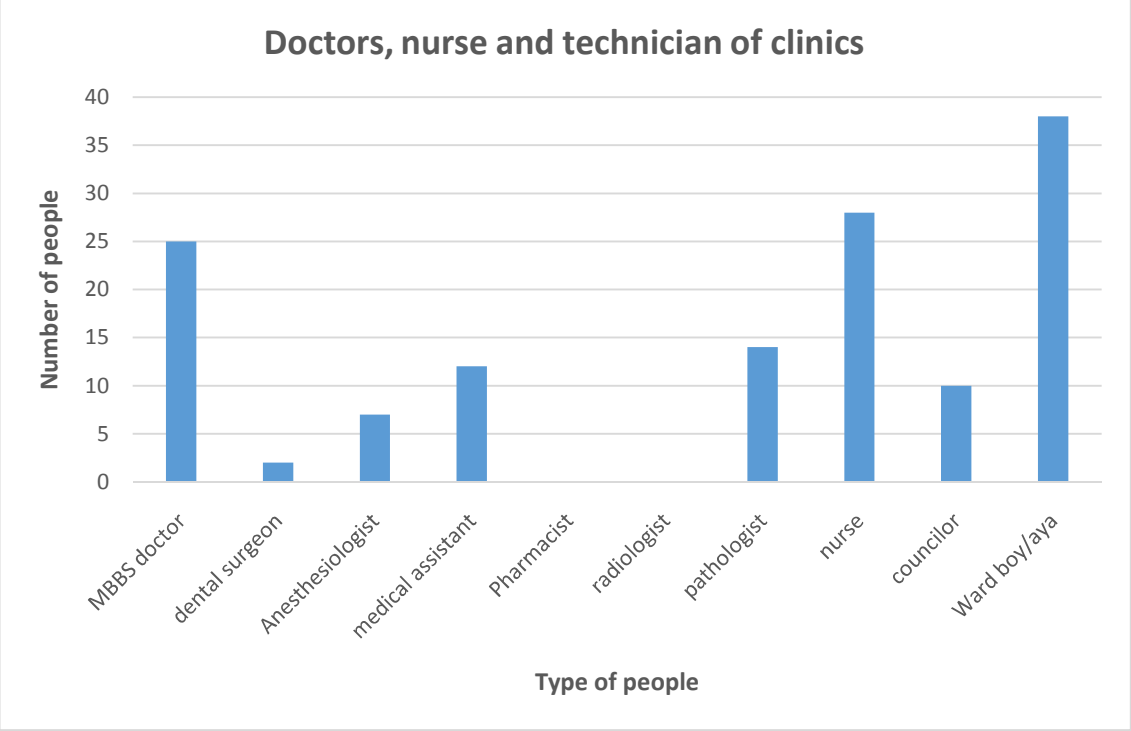
Table 3.4: Administration and others of clinics

Administration and others of clinic	number
administrative officer	9
Clark/ accountant	10
Statistician	7
store keeper	10
typist/ office assistant	9
MLSS	18
driver	6
cleaner	15

Source: Field data

Clinics have some administration people to provide services to the clients. There are 9 administrative officers, 10 clark/accountant, 7 statistician, 10 store keeper, 9 typist/office assistant, 18 MLSS, 6 driver and 15 cleaner in the clinics.

Figure 3.3: Doctors, nurse and technician of clinics

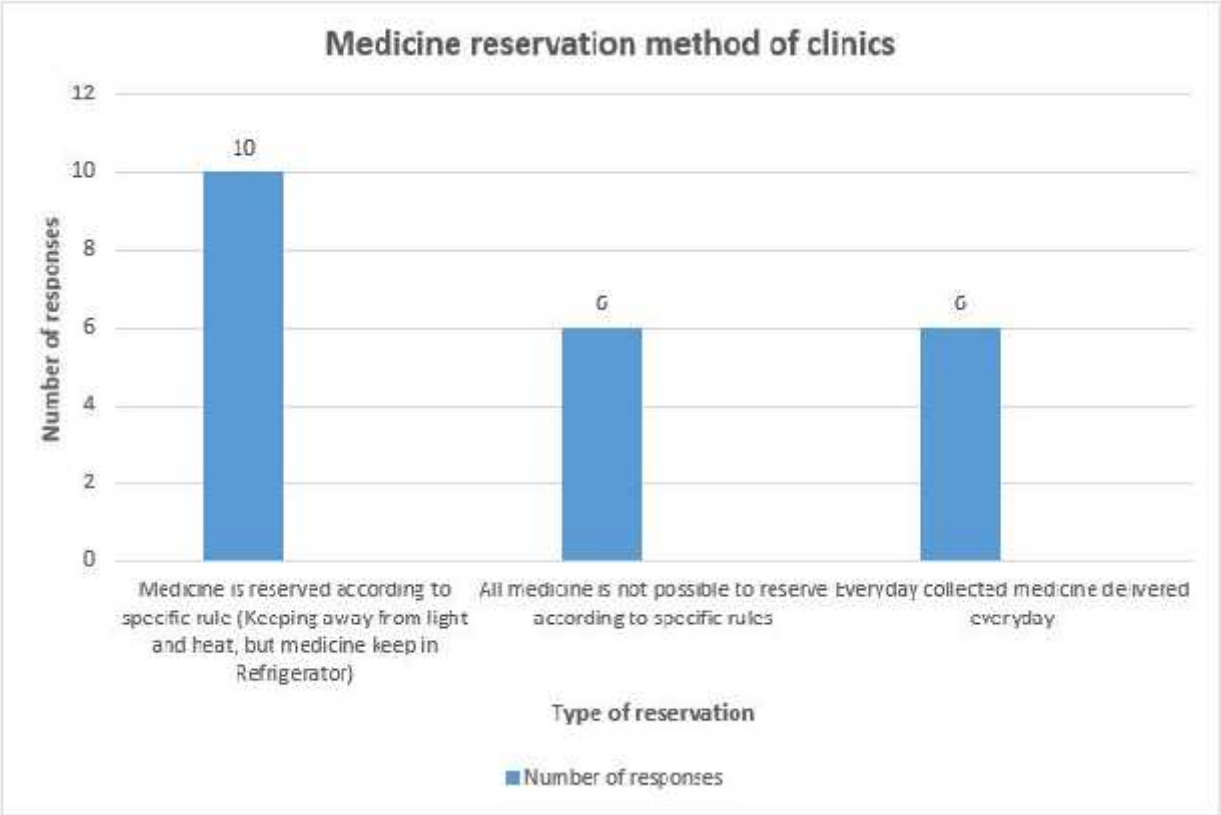


Source: Field data

Doctors, nurse and technician are the important person in the clinics. They provide the treatment to the clients. There are 25 MBBS doctors, 2 dental surgeon, 7 anesthesiologist, 12 medical assistant, 14 pathologist, 28 nurse, 10 councilor and 38 ward boy/aya in the clinics.

3.6 Medicine reservation method in the clinics

Figure 3.4: Medicine reservation method in the clinics

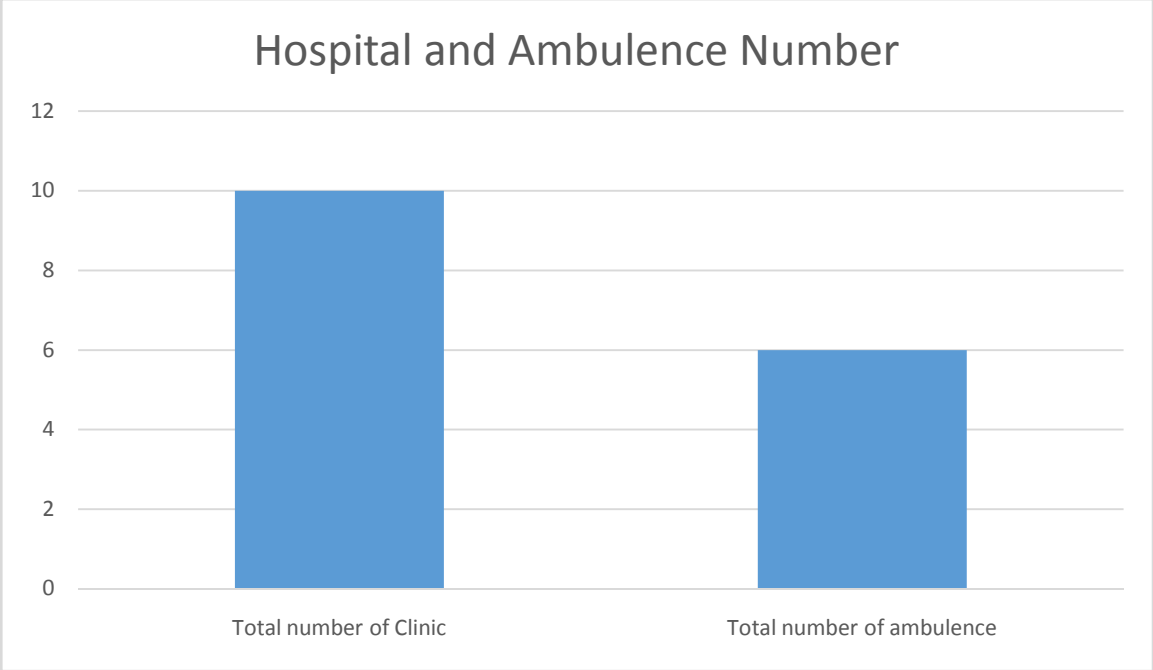


Source: Field data

Medicine reservation system ensures the quality and duration of using those medicine in treatment. All the clinic has a medical reservation system according to the specific rule. Some clinic cannot be possible to reserve all medicine according to specific rule and some collect medicine everyday and also deliver everyday.

3.7 Facilities in the clinics

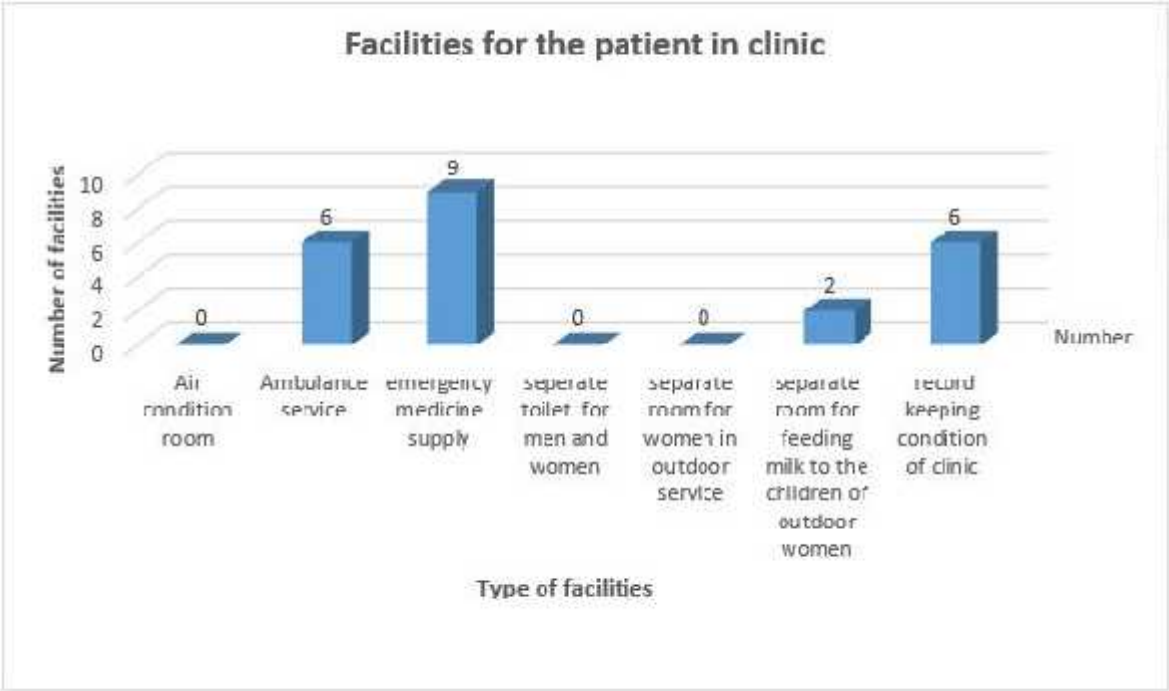
Figure 3.5: Ambulance in the clinics.



Source: Field data

Ambulance services is very essential for emergency patient transport to the clinics. There are 6 ambulances among the 10 clinics.

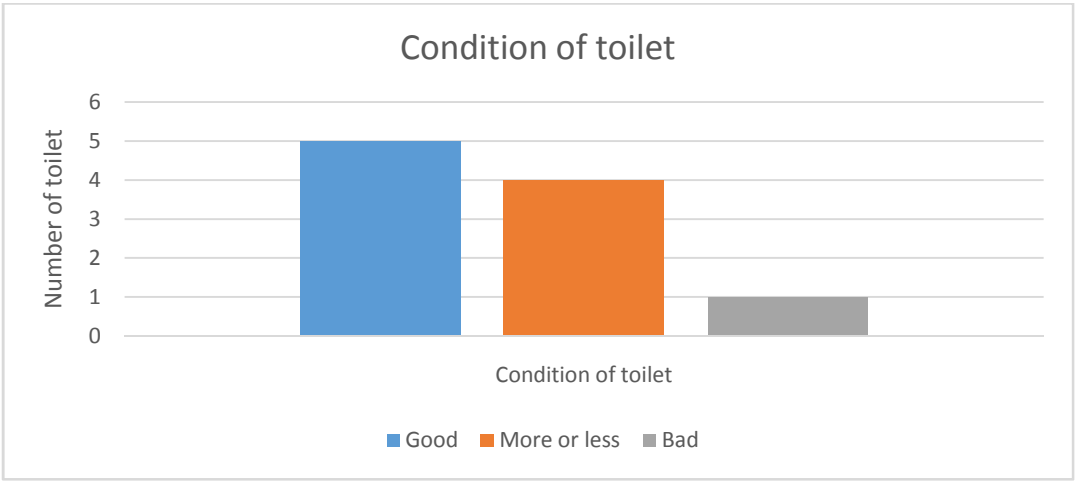
Figure 3.6: Facilities for the patient in the clinic



Source: Field data

Each and every clinic provides some facilities to the clients. These facilities are the ambulance services, emergency medicine supply, separated room for feeding milk to the children and record keeping of clients in the clinics.

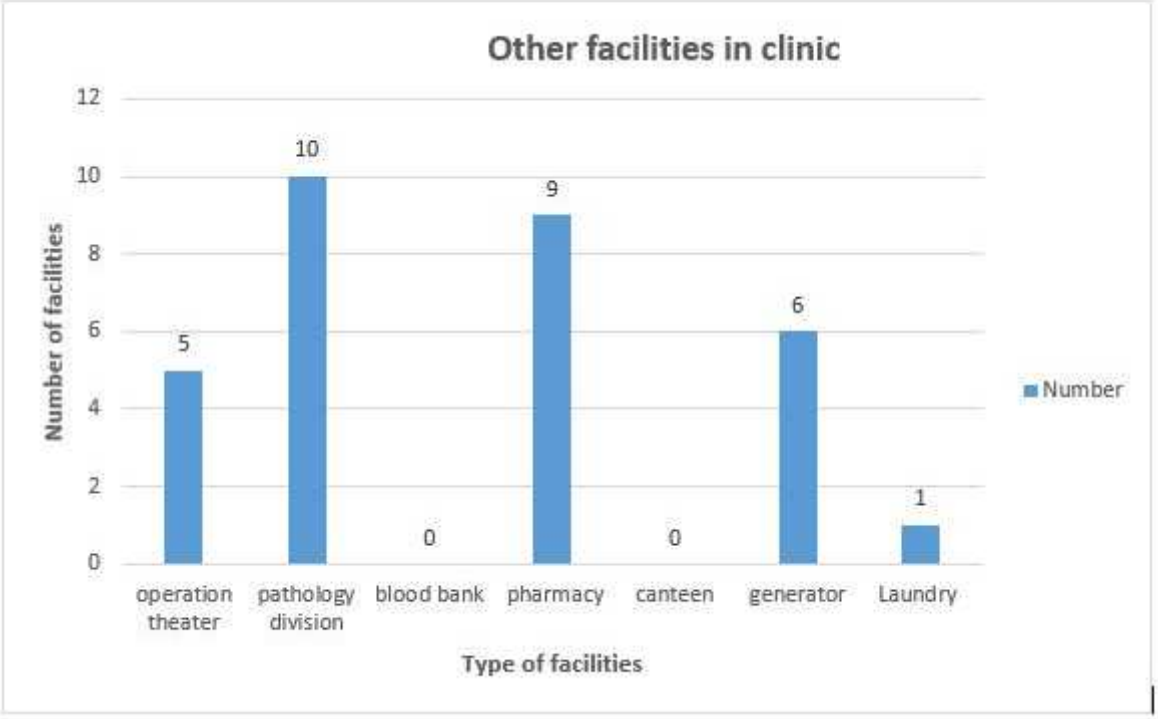
Figure 3.7: Toilet condition in the clinics



Source: Field data

Toilet facilities is very important in health services especially in clinics. There are 5 clinics which have good toilet condition, 4 more or less good toilet condition and 1 has bad toilet condition.

Figure 3.8: Other facilities in the clinic



Source: Field data

There are some basic facilities in the clinic. These are; 5 clinics have Operation Theater, 10 clinics have pathology division, 9 clinics have pharmacy, 6 clinics have generator services and 1 clinic has laundry service out of 10 clinics.

3.8 General Observations:

Most of the clinics have sufficient people for providing health services to the clients. There are ambulance services for emergency treatment providing and medicine supply to the patient. Clinic has generator services during load shading period. Toilet condition is more or less good. Patient pressure in the clinics is huge. Clinics follow medicine

reservation system for providing good quality of medicine to the patient and the clinics settlement area is good for the establishment of the clinics.

Chapter 4

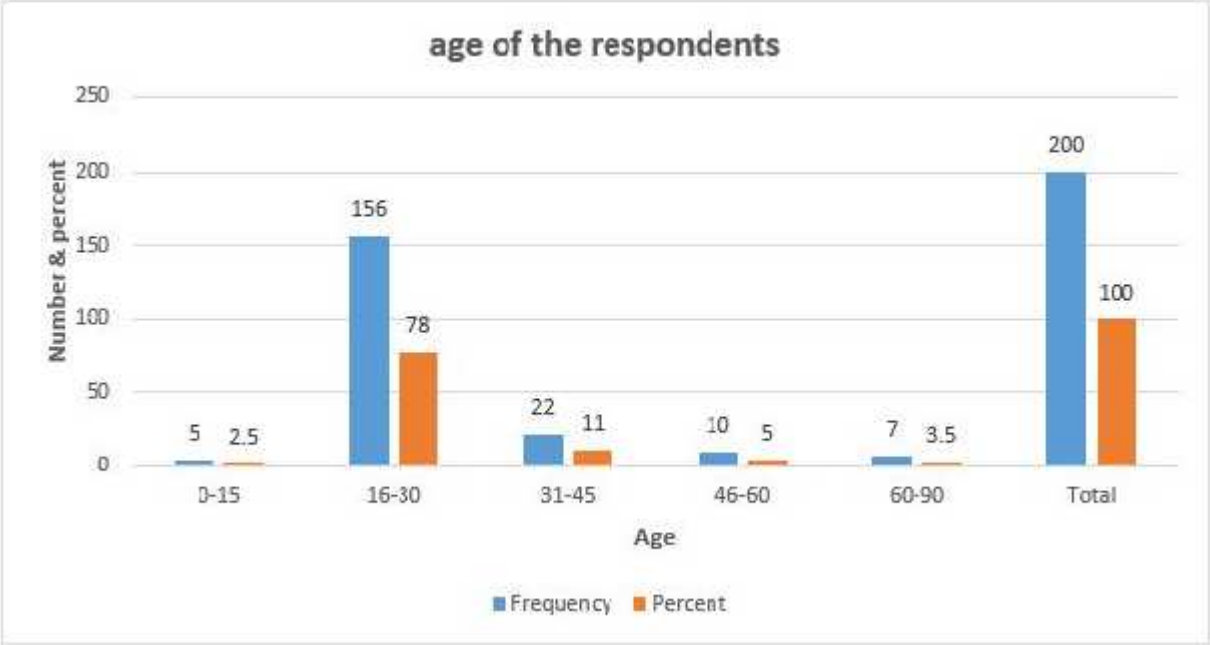
Socio-economic and other conditions of clients

4.1 Introduction

Socio-economic and other condition of the patients help to understand the capability of clients to take health related services and also the probability of being affected by different diseases. In Dhaka city health care services is a major problem for poor urban dwellers. Homelessness and poverty are an international crisis. According to the United Nations, the proportion of urban dwellers living in slums decreased from 47 percent to 37 percent in the developing world between 1990 and 2005 (MRC, 2009). However, due to rising population, the number of slum dwellers is rising. One billion people worldwide live in slums and the figure will likely grow to 2 billion by 2030. Bangladesh with a population of around 147 million is one of the poorest countries of the world with an estimated 3.4 million people living in some 5000 slums in the capital, Dhaka city. The population of Dhaka city has been projected to reach 17.6 million by 2010 - 60% of this population is expected to be living in the slums of Dhaka. Slums, as defined by the United Nations agency UN- HABITAT, are run-down areas of a city characterized by substandard housing and squalor and lacking in tenure security. Slums are also characterized as being heavily populated. One of the major consequences of living in such slums for its inhabitants is the adversity of health. The socio-economic condition of clients is described below;

4.2Age of the Respondents

Figure 4.1: Age of the Respondents



Source: Field data

Most of the respondent age is within 16-30 about 78% of the total respondents. Their ages are 2.5% within 0-15, 11% within 31-45 and 5% respondents within 60-90 years..

4.3Sex of the Respondents

Table 4.1: Sex of the Respondents

Sex	Frequency	Percent
Male	7	3.5
Female	193	96.5
Total	200	100.0

Source: Field data

Sex ratio is very important for any kinds of research or study. About 96.5% of total respondents is female and only 3.5% is male

4.4Marital status of the Respondents

Figure 4.2: Marital status of the Respondents

Source: Field data

Among total clients 81%. Is Married clients. There are 1% separate, 3.5% abandoned, 1% divorced, 5.5% widow and 8% unmarried.

4.5Religion of the Respondents

Table 4.2: Religion of the Respondents

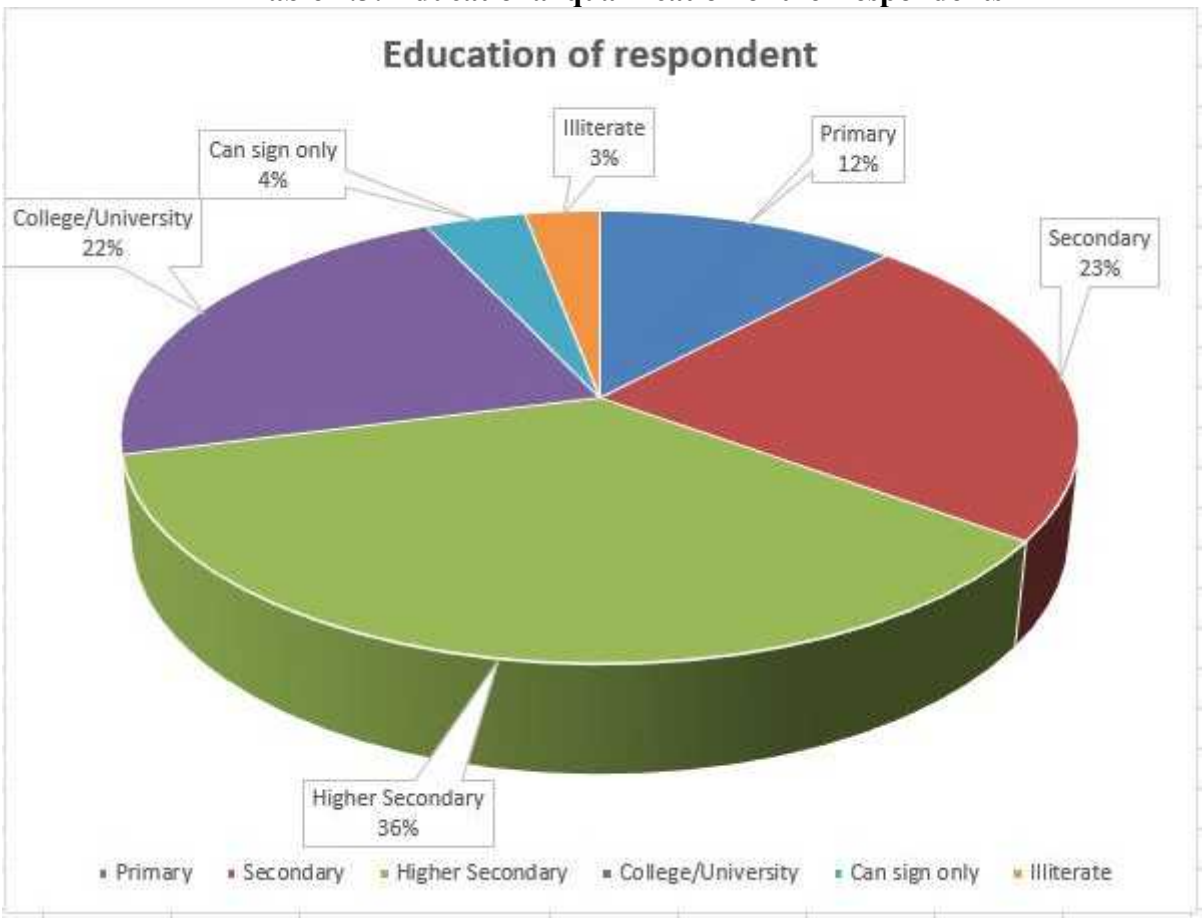
Religion	Frequency	Percent
Islam	174	87.0
Hindu	25	12.5
Buddhist	1	.5
Total	200	100.0

Source: Field data

Most of the respondents is Muslim. There are 87% Muslim, 12.5% Hindu and Buddhist 0.5% among total clients.

4.6Educational qualification of the Respondents

Table 4.3: Educational qualification of the Respondents

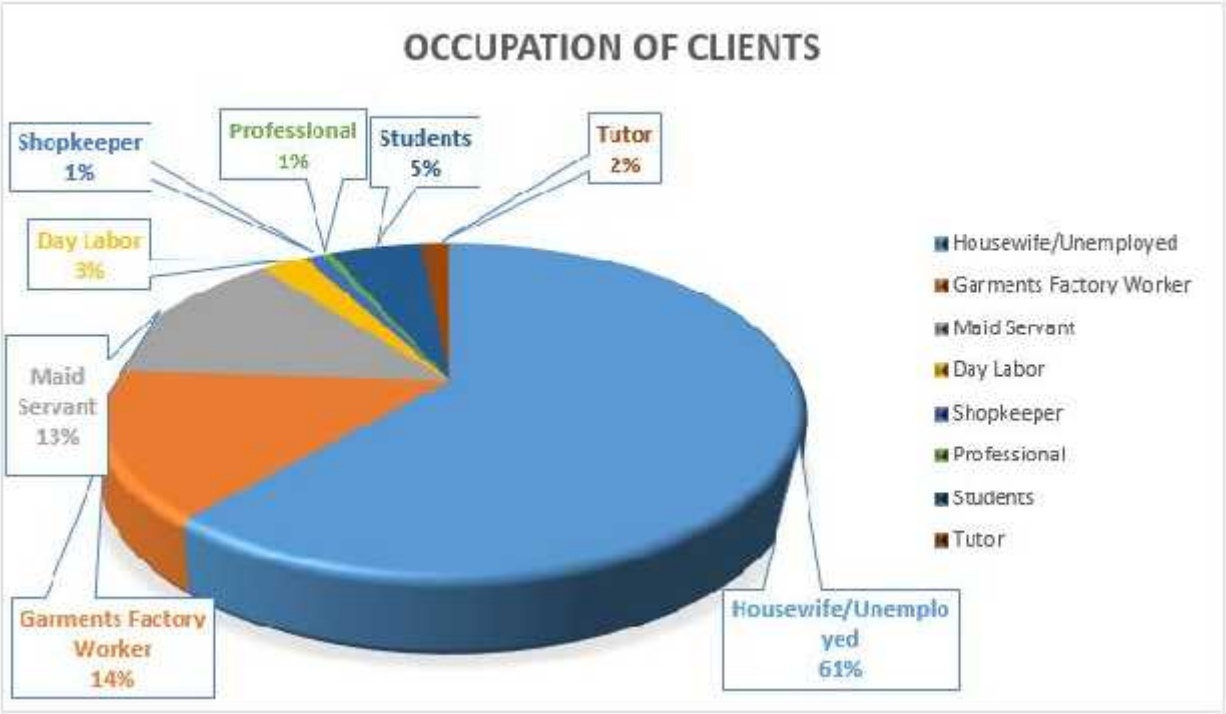


Source: Field data

Educational qualification of the respondent is very important for health related issues. Educational status is 23% can sign only, 22% secondary, 36% primary, 12% illiterate, 4% higher secondary and 3% college/University.

4.7Occupation of the Respondents

Table 4.4: Occupation of the Respondents



Source: Field data

Occupation refers the way of earning their livings. There are 14% garments worker, 13% maid servant, 5% student, 3% day labor, 2% tutor, 1% shopkeeper, 61% housewife/unemployed and 1% professional.

4.8Type of Living House

Table 4.3: Type of Living House

Type of living house	Frequency	Percent
Tin shed	40	20.0
Semi Pucca Building	127	63.5
Pucca Building	33	16.5
Total	200	100.0

Source: Field data

Most of the respondents use semi pucca building type house about 63.5% and 20% use tin shed house and 16.5% use pucca building type house.

4.9Type of Latrine used

Table 4.4: Type of Latrine used

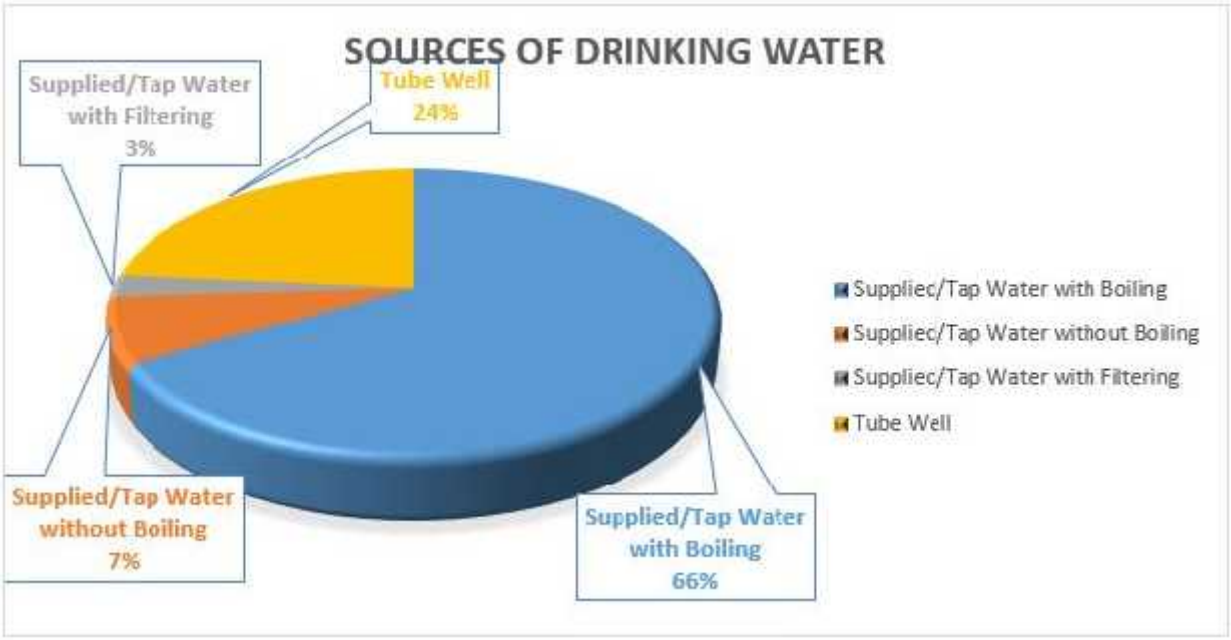
Type of latrine	Frequency	Percent
Sanitary (with water seal)	22	11.0
Pucca/Ring Slab Latrine (without water seal)	176	88.0
Hanging Latrine	2	1.0
Total	200	100.0

Source: Field data

There are about 11% respondents use sanitary (with water seal) latrine, 88% of the clients use pucca/ring slab (without water seal) and 1% of the respondents use hanging latrine.

4.10Source of Drinking water

Figure 4.5: Source of Drinking water



Source: Field data

Sources of drinking water is very important to predict the causes of different water related diseases. There are 66.5% respondents use supplied tap water with boiling, 7.5% use supplied tap water without boiling, 2.5% use supplied tap water with filtering and 23.5% of the clients use tube well water for drinking.

4.11Source of cooking water

Table 4.5: Source of cooking water

Sources of cooking water	Frequency	Percent
Tap Water	153	76.5
Tube Well	47	23.5
Total	200	100.0

Source: Field data

There are 76.5% respondents who use tap water as cooking water and 23.5% respondents use tube well water for cooking. These water is used without filtering and boiling.

4.12Type of Utility facilities in the client's house

Table 4.6: Type of facilities in the client's house

Type of Utility facilities in house	**Yes (out of 200 respondents)**	**No (out of 200 respondents)**
Electricity connection	199	1
Television	155	45
Fridge	58	142

Source: Field data

Resource or facilities in the house indicate the ability and client's economic condition. There are 199 client's house having electricity connection, 155 client's house having TV and 58 client's house having fridge facilities out of 200 clients.

4.13 General Observations:

Socio-economic condition of the clients indicates the ability to carry the health care service cost. Most of the respondents age is in 16-30 about 78% and female respondents is 96.5%. Married respondents are more about 81% of total respondents. Muslim clients is more about 87%. Educational qualification is more on primary level about 36%. Most of the respondents are housewife about 61% and maid servant and garments worker

are the main occupation of respondents. Most of respondent use tap water for drinking and cooking water. Most of the clients use semi pucca house for living about 63.5% and use pucca/ring slab latrine.

Chapter 5

Services provided by the Urban Primary Health Care clinics in Dhaka city

5.1 Introduction

Urban primary health care clinics are driven by different NGOs. They provide different types of health services to the clients. These clinics give more stress on the maternal and child health care services. Different services provided by the urban primary health care clinics in Dhaka city is given below;

5.2 Services provided by the clinics to the patients

Table 5.1: Services provided by the clinics to the patients

Type of treatment service	Frequency	Percent
Physical Diagnosis	33	16.5
Advice/Suggestions	18	9.0
Contraceptive	29	14.5
MR	3	1.5
Medicine	30	15.0
Blood test	22	11.0
X-ray	5	2.5
Stool/Urine Test	6	3.0
EPI/Vaccination	2	1.0
Admission as an Indoor Patient	7	3.5
Dressing for Burn Injury	1	.5
None	43	21.5
Total	199	99.5
Missing System	1	.5

Source: Field data

Different types of health services is provided by the clinics to the clients. These are the physical diagnosis, suggestion, medicine supply, X-ray, MR, blood test, urine test, vaccination, admission of patient, dressing for burn surgery and contraceptive health services provided by the clinics.

5.3 Type of Care/Treatment provided by the clinics to the patients

Table 5.2: Type of Care/Treatment demanded by the patients to the clinics

Type of treatment	Frequency	Percent
Maternal and Obstetric Care	66	33.0
Family Planning counseling or contraceptive collection	14	7.0
Others Reproductive Health Care Suggestion	12	6.0
Cough/Cold/General Fever	38	19.0
Typhoid	1	.5
TB	11	5.5
Other Contagious Disease	5	2.5
Child Health Diagnosis or Care	28	14.0
EPI/Vaccination	8	4.0
Diabetics, Blood Pressure, Cardiac Disease	9	4.5
Road/Transport Accident	1	.5
Other Injury	3	1.5
Skin Disease	1	.5
Patient of Minor Operation	1	.5
MR	2	1.0
Total	200	100.0

Source: Field data

There are a lots of health care services is provided by the Urban Primary Health Care Clinics. Among them 33% of the patients demanded maternal and obstetric health services, 14% demanded child health care, 19% demanded about cough/cold/fever and 5% demanded family planning counseling or contraceptive collection etc. Yet there are some diagnosis and medicine supply services demanded by the clinics to the patients. Patients come to the clinics for above mentioned diseases.

5.4 Type of Treatment received by the patient before come to this clinic

Table 5.3: Type of Treatment received by the patient before come to this clinic

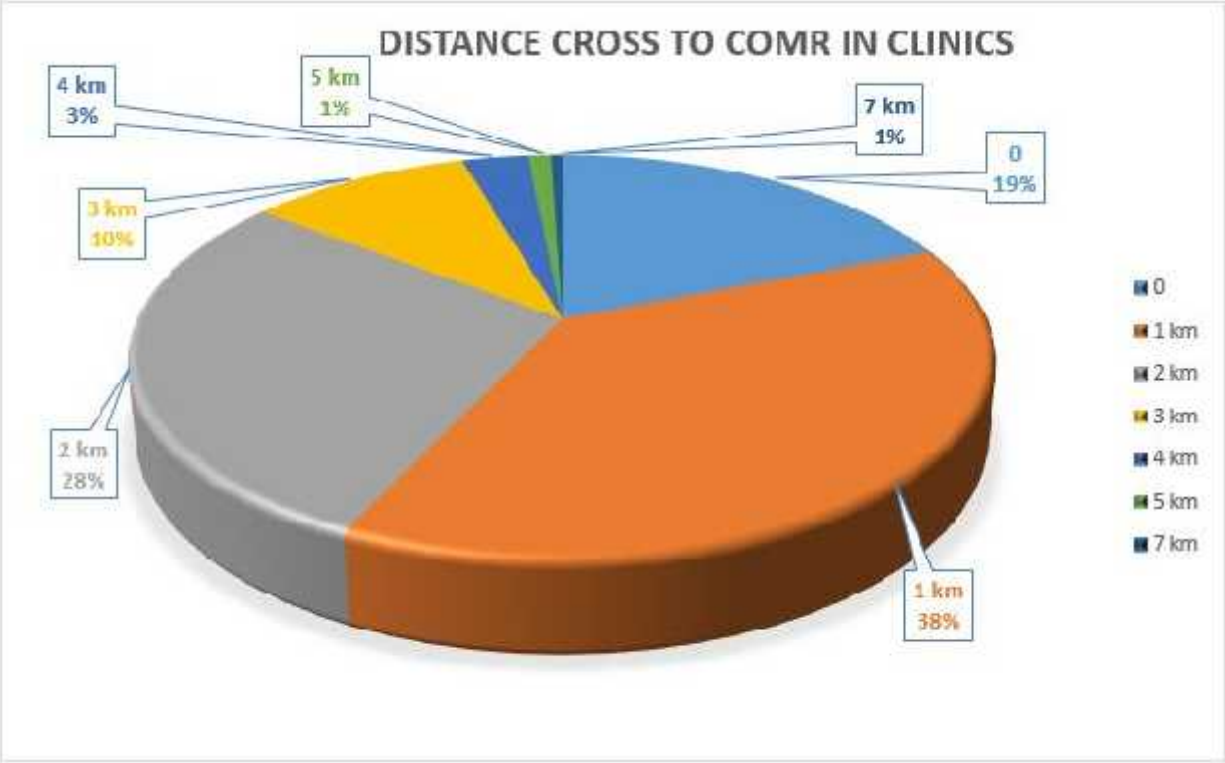
Type of treatment	Frequency	Percent
None	119	59.5
Buying medicine from Pharmacy	62	31.0
Village Doctor/Allopath Doctor without degree	1	.5
Homeopath	2	1.0
Kabiraj/Peer/Fakir	2	1.0
MBBS Doctor (Private Chamber)	4	2.0
Private Clinic	6	3.0
Missing System	4	2.0
Total	200	100.0

Source: Field data

Most of the patient do not receive any kinds of treatment before coming to this clinics. They usually get treatment from general pharmacy, village doctor, kabiraj, private clinic and MBBS doctor.

5.5 Distance has to cross to get health care services from the clinic

Figure 5.1: Distance has to cross to get health care services from the clinic



Source: Field data

Most of the clients come to the clinics for treatment from less than 1 kilometer distance. After that 38% clients come from 1 km, 28.5% come from 2 km, 10% come from 3 km, 3% come from 4 km and 1% come from 5 km distance from the clinics.

5.6 Mode of Transport used to come to the clinics

Table 5.4: Mode of Transport used to come to the clinics

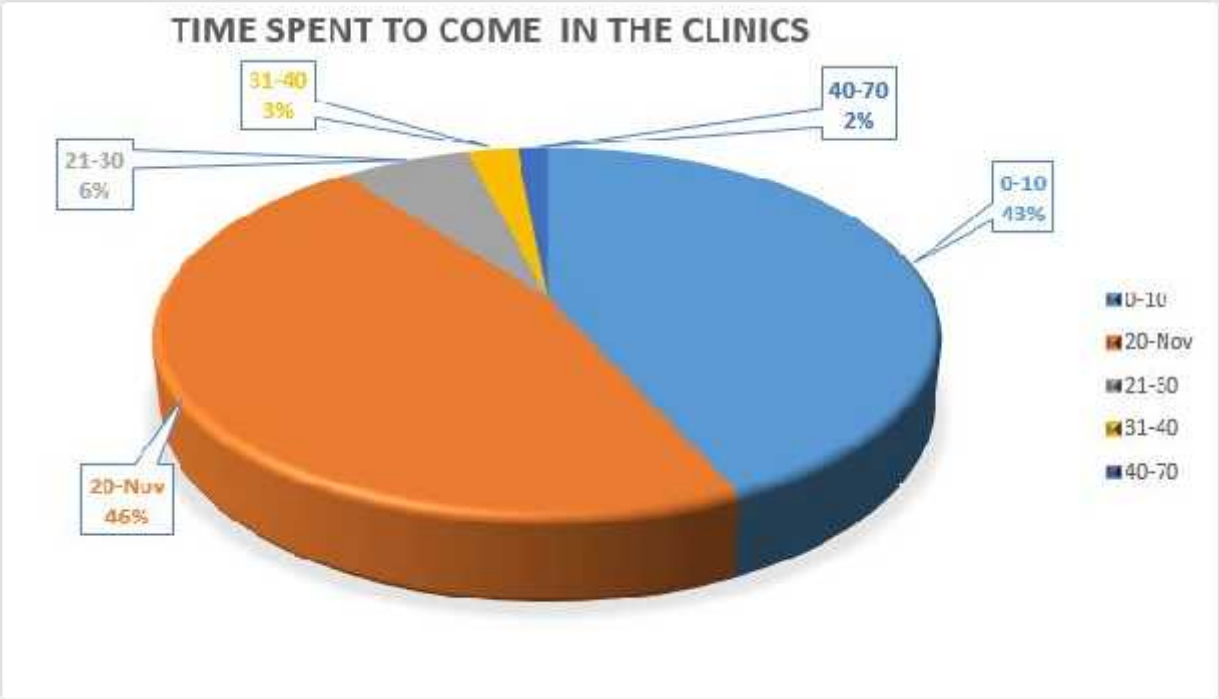
Type of transport	Frequency	Percent
By Walking	114	57.0
Rickshaw	73	36.5
Bus/Tempoo	11	5.5
CNG/Taxicab	2	1.0
Total	200	100.0

Source: Field data

Clients have to come from a long distance to the clinics for getting treatment using different types of transport. About 57% clients come by walking, 36.5% come by Rickshaw, 5.5% clients come by Bus/tempoo and 1% come to the clinics by CNG/Texicab.

5.7 Time spent to come to the clinics for treatment

Figure 5.2: Time spent to come to the clinics for treatment

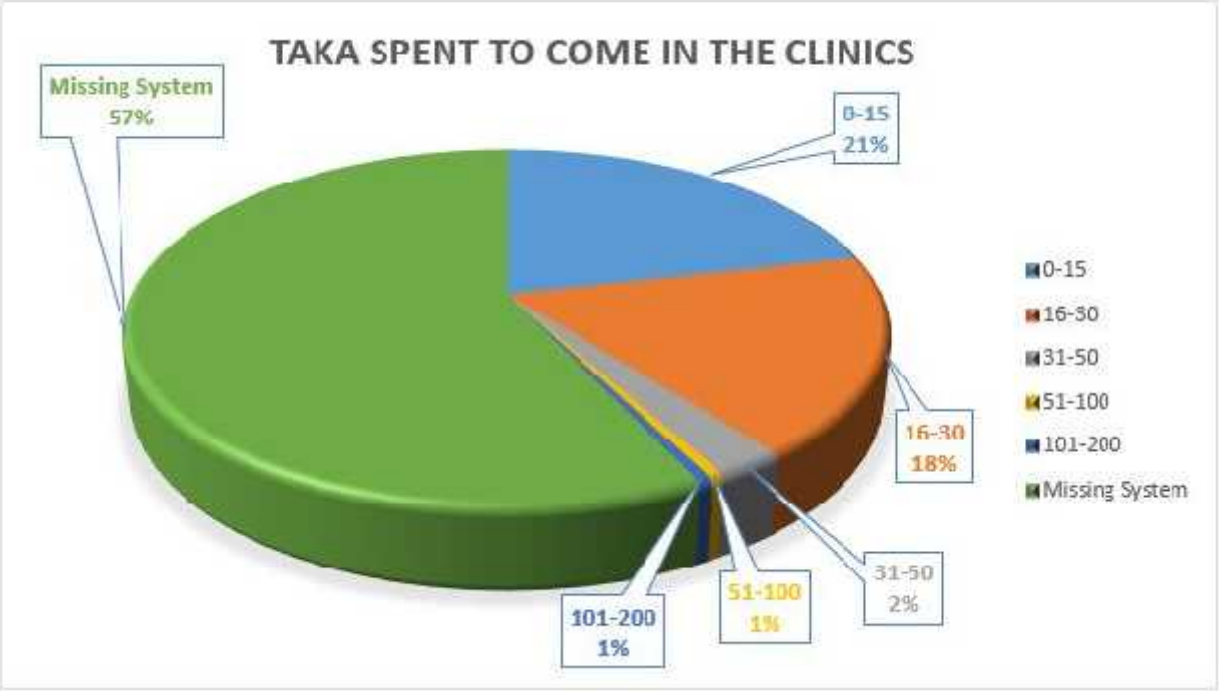


Source: Field data

Most of the clients do not need to wait for a long time to take the health services in the clinics. About 90% clients have to wait less than 20 minutes, 6.5% wait for 30 minutes and 4% wait for 60 minutes to take treatment.

5.8 Expenditure to come to the clinics for treatment

Figure 5.3: Expenditure to come to the clinics for treatment



Source: Field data

Expenditure for transport activities to come to the clinics is expensive. About 21.5% clients have to expend 15 taka to come to the clinics and 18% have to cost for coming to the clinics.

5.9Clients waiting time for taking treatment from the clinics

Figure 5.4: Clients waiting time for taking treatment from the clinics

Source: Field data

Health care delivery system in the clinics is done as soon as possible. About 61.5% patients get treatment within 20 minutes after coming, 21.5% have to wait for 40 minutes and 7.5 % have to wait for 60 minutes to get the health services.

5.10 Night stayed in the clinics for treatment

Table 5.5: Night stayed in the clinics for treatment

Number of night	Frequency	Percent
0	163	81.5
1	17	8.5
2	13	6.5
3	7	3.5
Total	200	100.0

Source: Field data

Health services is provided on regular bases. Most of the patient does not need to stay night in the clinic. There are 8.5% patient stay for 1 night, 6.5% patient stay for 2 night and 3.5% stay for 3 night in the clinic.

5.11Type of bed booked by the patient

Table 5.6: Type of bed booked by the patient

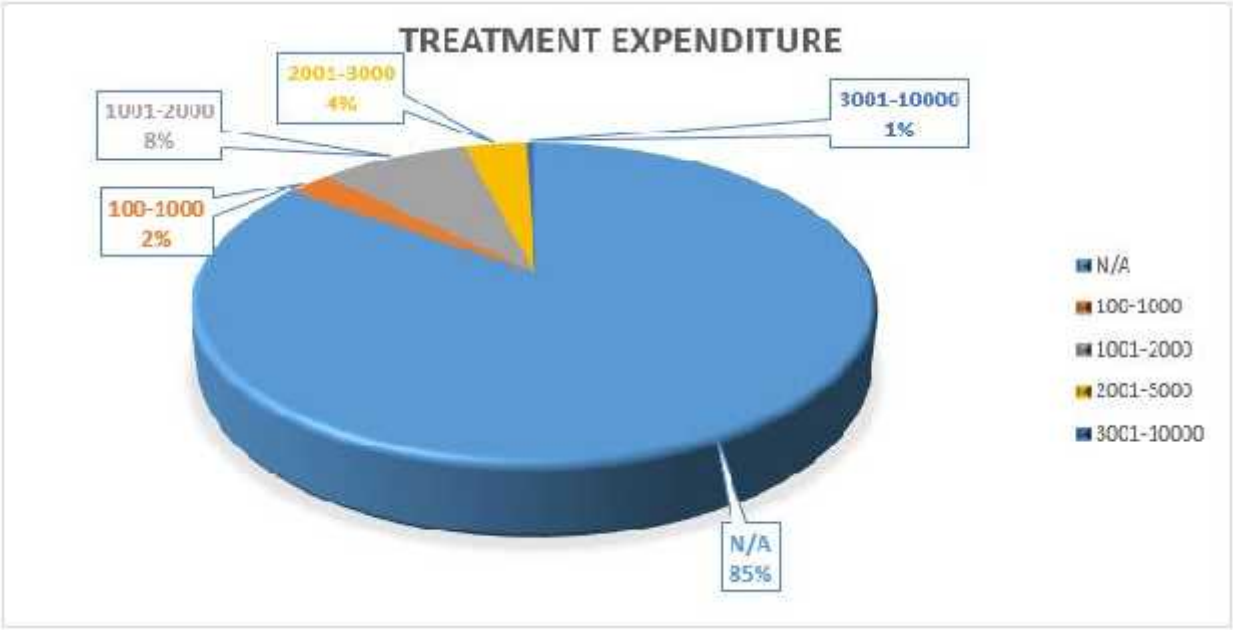
Type	Frequency	Percent
N/A	163	81.5
Ward	32	16.0
Cabin	5	2.5
Total	200	100.0

Source: Field data

Most of the patient does not need to be admitted in to the clinic. They take their health care services and leave the clinics after that. Some patient about 16% have to book in the ward and 2.5% have to book cabin for their treatment in the clinic.

5.12Amount of treatment expenditure

Figure 5.5: Amount of treatment expenditure

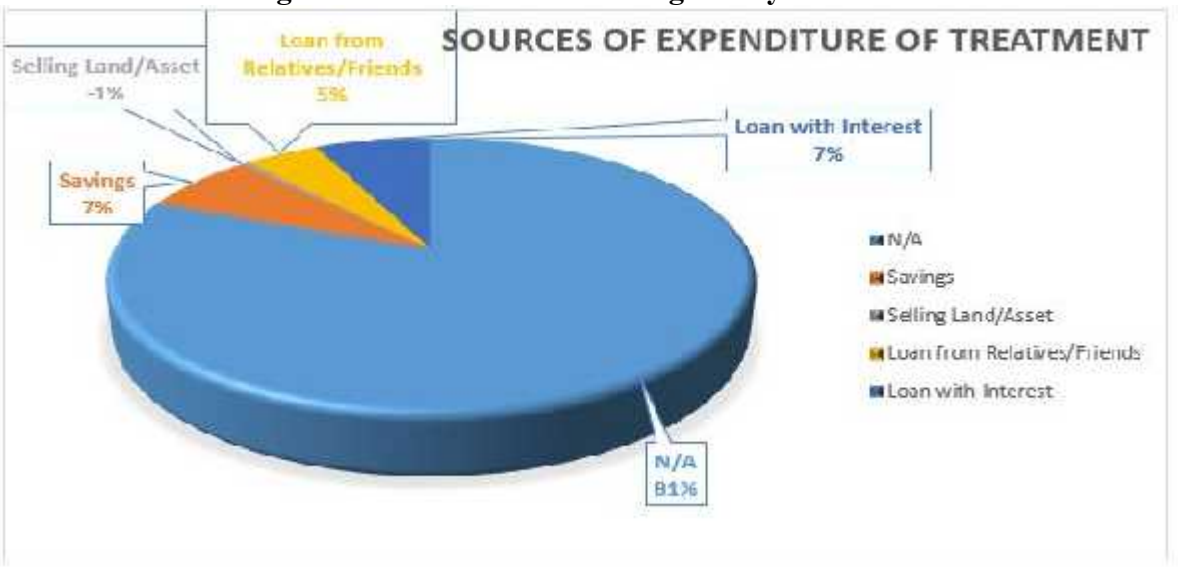


Source: Field data

Health services provided by the clinic is not expensive. Most of the treatment is provided by free of cost. Only 2% of the patient have to expend less than 1000 taka, 8% have to expend less than 2000 taka, 4% have to expend less than 3000 taka and 1% less than 10000 taka for getting treatment from the clinic.

5.13 Sources of collecting money for Treatment

Figure 5.6: Sources of collecting money for Treatment



Source: Field data

Most of the patent does not need to collect money from other sources. About 7% spend from their savings, 0.5% collect money by selling asset, 4.5% collect money from relatives without interest and 7% collect money with interest for their treatment cost.

5.14 Opinion about the Treatment cost

Table 5.7: Opinion about the Treatment cost

Cost	Frequency	Percent
N/A	163	81.5
Expensive	3	1.5
Moderate	24	12.0
Cheap	10	5.0
Total	200	100.0

Source: Field data

Most of the patient does not need to expend money for taking treatment from the clinics due to the free health services or with a few cost. About 81.5% has no cost, 1.5% among the patient think the health treatment is expensive, 12% think moderate and 5% think cheap.

5.15Reason behind for coming clients to this clinic for seeking Treatment

Table 5.8: Reason behind for coming clients to this clinic for seeking Treatment

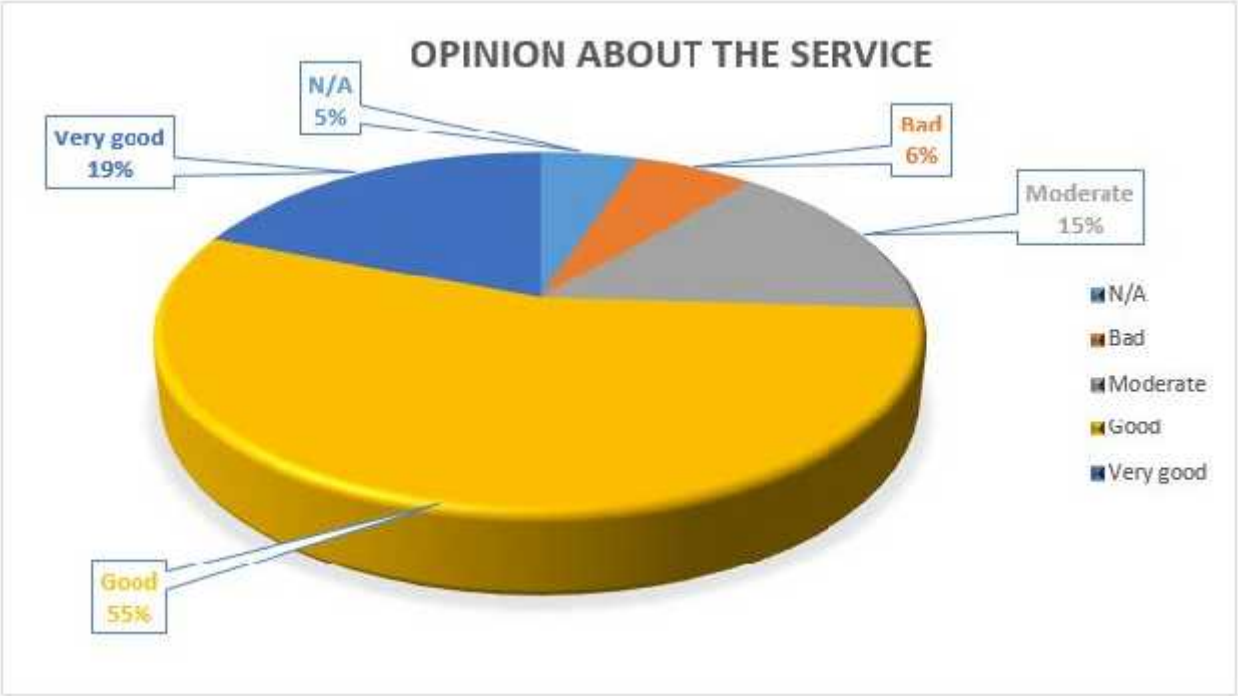
Causes for coming	Frequency	Percent
Treatment of this clinic is good	35	17.5
Available Treatment without any cost	23	11.5
Treatment available with minimum/affordable cost	65	32.5
This clinic is nearby my Home	24	12.0
Medicine are available with a apposite Price	14	7.0
One of my acquaintance worked in this Clinic	2	1.0
Missing System	37	18.5
Total	200	100

Source: Field data

There are a lot of health care institute in Dhaka city. Most of the patient come to the clinics for the good quality of treatment (17.5%), availability of free treatment (11.5%), treatment availability with minimum cost (32.5%), near to the house (12%), apposite price of medicine and acquaintance work of the clinic (1%).

5.16Opinion about the service provided by the clinic

Figure 5.7: Opinion about the service provided by the clinic

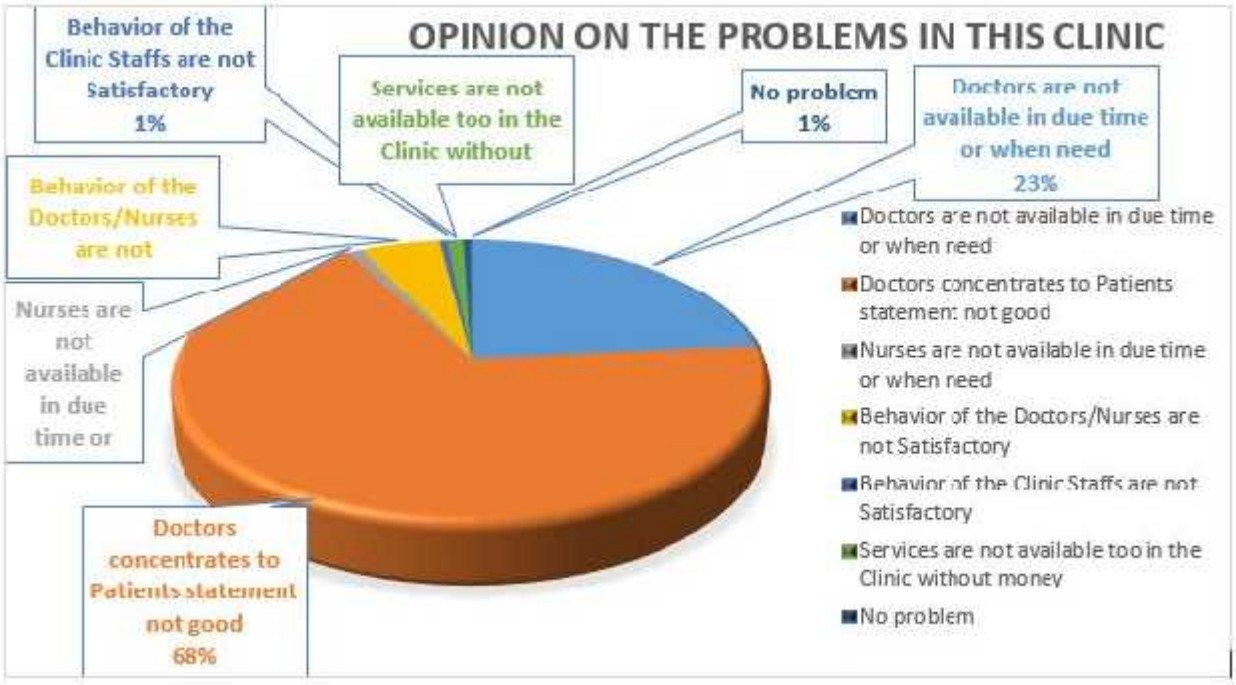


Source: Field data

Health care services of the clinic is good. About 55% of the patient think well, 19% think very well, 15% think moderate and 6% think badly among 200 patient. Due to the good quality of health care services of the clinic most of the patient like the services.

5.17Problems described by the patientsto the services of the clinics

Figure 5.8: Problems described by the patientsto the services of the clinics



Source: Field data

Patients describe some problem about the services and clinics. About 23.5% think Doctors are not available in due time or when need, 68.5% think Doctors concentrates to Patients statement not good, 1% think Nurses are not available in due time or when need, 5% think Behavior of the Doctors/Nurses are not Satisfactory, 0.5 think Behavior of the Clinic Staffs are not Satisfactory and 1% think Services are not available too in the Clinic without money.

5.18 Way of developing standard of NGO clinics services described by clients.

Table 5.9: Way of developing standard of NGO clinics services described by clients.

Type of opinion	Frequency	Percent
Ensure availability of Doctor/Nurse in due time/when need	2	1.0
Ensure to concentration/attention of the Doctors on Patient	1	.5
Behavior of the Doctors/Nurses/Clinic Staffs would be more friendly	6	3.0
Increase Lab Test Facilities	69	34.5
Involve Specialized Doctor in the Clinic/Try to involve female specialized	16	8.0
Increase Cleanliness of Waiting Room, Toilet	20	10.0
Improve overall Management	35	17.5
Reduce Treatment Cost	32	16.0
Ensure Free Treatment for the poor Patient	19	9.5
Total	200	100.0

Source: Field data

To develop the standard of NGO clinics health care service delivery system patient describe different opinion. These are the ensuring availability of Doctor/Nurse in due time/when need (1%), ensuring the concentration/attention of the Doctors on Patient (.5%), Behavior of the Doctors/Nurses/Clinic Staffs would be more friendly (3%), Increasing Lab Test Facilities (34.5), Involving Specialized Doctor in the Clinic/Try to involve female specialized (8%), Increasing Cleanliness of Waiting Room, Toilet (10%), Improvement overall Management (17.5%), Reducing Treatment Cost (16.5%) and ensuring Free Treatment for the poor Patient (9.5%).

5.19 General Observations:

NGOs clinics of Dhaka city provide a lot of health care services to the clients especially on maternal and child health care delivery system. These services is provided to the nearest patient surrounding place of the clinic with less or free of cost. They do not need to wait for a long a long time to get the treatment. Most of the patient are satisfied with the standard of NGO clinics treatment. They describe some opinion about the cost of treatment, clinic and service problem and also give opinion to develop the services of the clinics.

Chapter 6

Conclusions and Recommendations

6.1 Introduction

The following first provides the major findings of this research effort and subsequently provides some conclusions and recommendations.

6.2 Major Findings:

Major findings from the study has found on three characteristics like infrastructure and resources of clinics, socio-economic condition of the clients and different services provided by the clinics to the patient as well as their opinion about the problem of services and opinion about the way of developing the standard of services.

Clinics have the ability for providing health services to the clients with their doctors, nurse and staff. There are ambulance services for emergency treatment providing and medicine supply to the patient. Clinic has generator services during load shading period. Toilet condition is more or less good. Patient pressure in the clinics is huge. Clinics follow medicine reservation system for providing good quality of medicine to the patient and the clinics settlement area is good for the establishment of the clinics. Resources of the clinics is moderate good for providing health care services.

Socio-economic condition of the clients has found as the respondents age is in 16-30 about 78% and female respondents is 96.5%. Married respondents are more about 81% of total respondents. Muslim clients is more about 87%. Educational qualification is more on primary level about 36%. Most of the respondents are housewife about 61% and maid servant and garments worker are the main occupation of respondents. Most of respondent use tap water for drinking and cooking water. Most of the clients use semi pucca house for living about 63.5% and use pucca/ring slab latrine. Their socio-economic condition is not bad like the slum dwellers.

Major health care services is provided by the NGOs clinics to the clients especially on maternal and child health care delivery system. These services is provided to the nearest patient surrounding place of the clinic with less or free of cost. They do not need to wait for a long a long time to get the treatment. Most of the patient are satisfied with the standard of NGO clinics treatment. Study has been gets some opinion about the cost of treatment, clinic and service

problem and also gotten opinion to develop the services of the clinics. Thus the NGOs clinics can provide more and comprehensive health care services to the clients.

Health care financing issues remain a key agenda in global health policy. The most recent World Health Report puts greater emphasis on the country's health financing mechanisms in order to ensure universal coverage (WHO 2010a). Rising health care costs and the large share of out of pocket expenses appear as among major hurdles for the poor to break out of poverty. Consequently, poverty reduction strategies within the purview of the millennium development goals (MDG) necessitate a review andpossible reforms of health care finance so as to arrest the growing impoverishment on account of health shocks (Ahsan et al, 2011).

First UPHCP was initiated in 1998 with the purpose of improving the health status of the urban poor particularly the women and children, by improving access and changing the way in which health services are provided in urban areas. The primary objective was to reduce preventable mortality & morbidity among women and children by establishing the City Health Center2 (CHCs), City Maternity Center3 (CMC) infrastructure under city corporation health department and ensuring that the poor receive good quality preventive, promoting and curative services. The other objective was to sustain the City Health Center (CHCs), City Maternity Center (CMC) by building the capacity of Local Government and changing the role of the Government in the provision of health care services.

The Second Urban Primary Health Care Project (UPHCP-II) in Bangladesh started in 2005 with a mandate to extend every component of health services to at least 30% of the poor in catchment areas. Poor were identified through household survey and were provided with free service entitlement cards by the service delivery partners. UPHCP-II started service delivery in partnership with contracted non-government organizations (NGO) in 2005 (Biswas et al, 2012).The public sector has no structured comprehensive health services in the slums. Instead, citizens rely on facilities that are run by non-governmental organizations, local pharmacies, private practitioners and traditional healers such as *kabiraj* and others.

6.3 Recommendations:

There are some recommendation which can be used to further development of the standard and effectiveness of services provided by the NGO clinics in Dhaka city through UPHCP. These are,

- Governmental and non-governmental organizations should take necessary initiatives to increase the knowledge of hygiene of the urban poor people and clients surrounding area of clinics.
- Health worker both of NGO and governmental should visit the area progressively more to make the women aware about their health care need especially reproductive health and a general healthy life.
- Government should ensure the health services of poor people especially women's and child in the governmental hospital and the UPHCP clinics by providing more resources to the clinics.
- City corporation authority should improve the sanitation facility, water supply, dumping garbage facility in the clinics area to ensure a clean and healthy environment.
- Formal and informal links can be strengthened between NGOs, community based support groups and local health service providers with a sensitized mandate in favor of poor clients who came to take clinics for their treatment.
- Primary healthcare awareness raising activities should be extended large.
- Community based support (CBS) groups can be developed focusing on health, nutrition and hygiene awareness-raising activities along with specific information about affordable service providers from NGO clinics in the study areas.
- Clinics should increase their servicing area to provide more health care services to the clients in Dhaka city.

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APPENDIX 1

(Questionnaire of Client/Service Consumer in the Clinic)

Name of the Clinic : ----------

Name of the NGO : ----------

Ward No : | | | |

Zone No : | | | |

Cluster Number : | | | |

Date of Interview : --------/--------/------

Respondent's Information

Starting time of interview :Hrs ____ Mins ____

1. Name of the Respondent : ----------

2. Sex of the Respondent : 1 = Male, 2 = Female.

3. Date of birth of the Respondent : ---------/--------/--------
   Day Month Year (If specify accurate date of birth)

4. Age of the respondent in full year : ----------Year.

5. Marital status of the Respondent :

   1. Married
   2. Separate
   3. Abandoned
   4. Divorced
   5. Widow
   6. Unmarried

6. Religion of the Respondent :

   1. Islam
   2. Hindu

3. Buddhist
4. Christian

7. Educational qualification of the Respondent :

1. Illiterate
2. Can sing only
3. Primary
4. Secondary
5. Higher secondary
6. Collage/University

8. Profession of the Respondent :

1. Housewife/Unemployed
2. Garments Factory Worker
3. Maid Servant
4. Day Labor
5. Skilled Labor
6. Shopkeeper
7. Clerical Job
8. Professional
9. Cattle/Poultry Rearing
10. Agriculture
11. Don't Agree to Response

Livelihood Standard and Assets:

1. Is the Living House of the Respondent own or not? 1 = Yes, 2 = No.

2. Type of Living House: 1 = Thatched, 2 = Tin made roof and straw/muddy wall, 3 = Tin shed, 4 = Semi Pucca Building, 5 = Pucca Building.

3. Type of Latrine Used: 1 = Sanitary (with water seal), 2 = Pucca/Ring Slab Latrine (without water seal), 3 = Hanging Latrine.

4. Source and Type of Drinking Water: 1 = Supplied/Tap Water with Boiling, 2 = Supplied/Tap Water without Boiling, 3 = Supplied/Tap Water with Filtering, 4 = Tube Well, 5= Pond/Cannel/Bill/River.

5. Source of Water for Cooking and other Works: 1= Tap Water, 2 = Tube Well, 3 = Pond/Cannel/Bill/River.

6. Is your House Electricity Connected? 1 = Yes, 2 = No.

7. Have any TV in your Home? 1 = Yes, 2 = No.

8. Have any Fridge in your Home? 1 = Yes, 2 = No.

Distance of the Clinic:

1. From how many far you come here for treatment?

☐☐ Kilometer.

2. Mode of transport for come to the Clinic: 1 = By Walking, 2 = Rickshaw, 3 = Bus/Tempoo, 4 = CNG/Taxicab, 5 = Boat.

3. How many times spent for come this clinic?

☐☐ Hours ☐☐ Minutes.

4. How many Taka spent for come this clinic? ---------- BDT.

Experience on Disease and Treatment:

1. How many times you wait here for treatment?

☐☐ Minutes.

2. Is there any Doctor Present, when you Come in the Clinic? 1 = Yes, 2 = No.

3. If Response is "No", then how many times later Doctor come to the Clinic?

		Hours			Minutes.

4. Please specify, for which type of care/treatment you come to this clinic:

   1 = Maternal and Obstetric Care, 2 = Family Planning counseling or contraceptive collection, 3 = Others Reproductive Health Care Suggestion, 4 = Cough/Cold/General Fever, 5 = Typhoid, 6 = Malaria, 7 = TB, 8 = Other Contagious Disease, 9 = Child Health Diagnosis or Care, 10 = EPI/Vaccination, 11 = Diarrhea, 12 = Diabetics, Blood Pressure, Cardiac Disease, 13 = Road/Transport Accident, 14 = Other Injury, 15 = Eye/Tooth/Nose/Ear/Neck related problem, 16 = Skin Disease, 17 = Patient of Major Operation, 18 = Patient of Minor Operation.

5. Which type of treatment do you receive before come to this clinic? 1 = none, 2 = Buying medicine from Pharmacy, 3 = Village Doctor/Allopath Doctor without degree, 4 = Homeopath, 5 = Kabiraj (Traditional Healer give treatment by Herbal Medicine).

6. Did it occur anytime that you go back to Home due to absence of Doctor? 1 = Yes, 2 = No.

7. If response is "Yes", how many times occurred such fact? ---------- Times.

8. Which care do you receive form this clinic or service providers? 1 = Physical Diagnosis, 2 = Advice/Suggestions, 3 = Contraceptive (Temporary), 4 = Ligation/Vasectomy, 5 = MR, 6 = Medicine, 7 = Blood test, 8 = X-ray, 9 =

Stool/Urine Test, 10 = EPI/Vaccination, 11 = Bandage/Plaster for Injury, 12 = Operation/Surgery, 13 = Admission as a Indoor Patient, 14 = Dressing for Burn Injury, 15 = None.

For Indoor Patient only:

1. How many days you wait for admission in this Clinic? ------- Days.

2. Did you take suggestion from Private Chamber of any Doctor of this Clinic? 1 = Yes, 2 = No.

3. How many Nights you stay this Clinic? ----- Number.

4. Which Type of Bed Booked by the Patient? 1 = General Ward, 2 = Cabin.

5. Amount of Expenditure by the Patient in the Clinic

Sl. No.	Item of expenditure	BDT
1	Admission Fee/Ticket	
2	Suggestions/Advice	
3	Medicine	
4	Blood/Stool/Urine Test	
5	X-ray/ECG	
6	Ultra sonogram	
7	Other Tests (Specify)	

8	Rent for Bed	
9	Food/Diet Cost	

6. As your opinion the treatment cost of this clinic is cheap/affordable or expensive 1 = Highly Expensive, 2 = Expensive, 3 = Moderate, 4 = Cheap.

7. From which source did you collect money for treatment cost? (May be multiple source) 1 = Savings, 2 = Income, 3 = Leasing Land/Asset, 4 = Selling Land/Asset, 5 = Loan from Relatives/Friends, 6 = Loan with Interest.

Opinion on the Standard of Service Providing Clinic:

1. Why do you come to this clinic for seeking treatment? 1 = Treatment of this clinic is good, 2 = Available Treatment without any cost, 3 = Treatment available with minimum/affordable cost, 4 = This clinic is nearby my Home, 5 = Medicine are available with a apposite Price, 6 = One of my acquaintance worked in this Clinic.

2. Which type of treatment did you receive before come to this clinic? 1 = none, 2 = Buying medicine from Pharmacy, 3 = Village Doctor/Allopath Doctor without degree, 4 = Homeopath, 5 = Kabiraj/Peer/Fakir, 6 = MBBS Doctor (Private Chamber), 7 = Private Clinic.

3. Please opine on the standard of this Clinic:
   Please give your opinion on the following Service Indicators of this Clinic:

Service Indicators	Standard Level of the Services				
	Very Good	Good	Moderate	Bad	Very Bad
Behavior of the Doctor/Service Provider					
Behavior of the Staffs of the Clinic					
Cleanliness					
Confidentiality of the Treatment					
Standard of Diet/Food					
Waiting Time for Services					
Availability/Presence of the Service Provider					
Availability of Medicine					
Availability of Treatment equipment					

4. Opinion on the Problems of this Clinic. (May be multiple answer)

    1. Doctors are not available in due time or when need
    2. Doctors do not concentrate to Patients statement
    3. Nurses are not available in due time or when need

4. Behavior of the Doctors/Nurses are not Satisfactory
5. Behavior of the Clinic Staffs are not Satisfactory
6. No Services are available in the Clinic without money

5. Opinion on the Advantages of this Clinic. (May be multiple answer)

1. Doctors are available in due time or when need
2. Doctors concentrates to Patients statement
3. Nurses are available in due time or when need
4. Behavior of the Doctors/Nurses are Satisfactory
5. Behavior of the Clinic Staffs are Satisfactory
6. Services are available too in the Clinic without money

6. As your opinion how the standard of NGO Clinic will be developed?

1. Ensure availability of Doctor/Nurse in due time/when need
2. Ensure to concentration/attention of the Doctors on Patient's Statement
3. Behavior of the Doctors/Nurses/Clinic Staffs would be more good
4. Increase Lab Test Facilities
5. Open Indoor Facility/Increase number of bed in the Indoor
6. Involve Specialized Doctor in the Clinic/Try to involve for 2/3 days weekly
7. Increase Cleanliness of Waiting Room, Toilet
8. Improve overall Management
9. Reduce Treatment Cost
10. Ensure Free Treatment for the poor Patient

APPENDIX 2

(Questionnaire Service of clinic operators/managers)

Clinic Name : ----------

Name of the NGO : ----------

Ward No : | | | |

Zone No : | | | |

Cluster Number : | | | |

Date of Interview : --------/--------/-------

Personal Information

Starting time of interview :Hrs ____ Mins ____

9. Name : ----------

10. Age : ---------- years.

11. Sex : 1 = Male, 2 = Female.

12. Religion :

    1. Islam
    2. Hindu
    3. Buddhist
    4. Christian

13. Educational Qualification :

    1. Ph. D
    2. Post Graduation or Equivalent
    3. Graduation or Equivalent

14. Designation : 1 = Clinic Manager, 2 = Director, 3 = Medical officer, 4 = Others. |

15. If involve any second profession, please mention this: 1 = Business, 2 = Part-time job, 3 = Private Practice 4 = None. |

16. How many times do you involve with this clinic? -------/-------/-------
Day Month Year

17. Total Experience in the service : 1 = Less than 5 years, 2 = 5-10 years, 3 = More than 10 years.

18. Why do you choose this profession :
    1. This is a public service related profession
    2. Relevant with my academic qualification
    3. Suitable with the present time/age
    4. Start job in the health care service in the early life and continue on this service

Section: A

1. Please mention, year of the establishment of this Clinic -------- year.

2. Did you face any problem in the time of establishment of this Clinic? 1 = Yes, 2= No.

3. Type of the ownership of Clinic: 1 = Single ownership, 2 = Joint ownership, 3 = Branch of NGO Clinic.

4. Type of ownership of Clinic Building: 1 = Own, 2 = Rented, 3 = Lease.

5. If rented, please mention the amount of monthly rent: ---------- BDT.

6. If leased, please mention the duration and amount of lease money: ---- Years, ------ BDT.

7. Type of Clinic Building: 1= Pucca, 2 = Semi-Pucca.

8. Which are the advantages of this place as a Clinic Site?

    1 It is a crowded area, so a lot of patient come here regularly
    2 Poor and lower-middle class people lived in this area
    3 Transportation facility is good with the surrounding area
    4 Clinic building in the road-side, easily seen by the people/patient

9. Which are the disadvantages of this place as a Clinic Site?

    1 Commercial/industrial area, so many people not lived here
    2 Ultra Poor/Highly Rich people lived here; they aren't interested to come NGO clinic
    3 Transportation facility is not so good with the surrounding area
    4 Clinic Building located in the inside of the lane, not seen by the patient easily

10. Arrangement of Water supply: 1 = WASA, 2 = Tube well, 3 = Tube well with own motor

11. Arrangement of Electricity: 1 = Regular electricity, not so much load shading, 2 = Huge load shading, but own generator available, 3 = Huge load shading, but no arrangement of generator, so it is very painful.

Section: B

12. Specify the type of service mode in this clinic: 1 = Emergency, 2 = Outdoor, 3 = Indoor.

13. Please mention the types of services/cares provided from this clinic: 1 = Maternal health care, 2 = MR and post-abortion care, 3 = Child health care, 4 = Adolescent health care, 5 = Care for malnutrition, 6 = Care for communicable and general disease, 7= Care of Eye disease, 8 = Family Planning services, 9 = EPI services, 10 = RTI/STD care.|

14. Which class of people mainly come here for receive care? 1 = Upper class, 2 = Upper middle class, 3 = Middle class, 4 = Lower middle class, 5 = Hardcore poor. |

15. Which type of treatment/ care provided for the client from this clinic? 1 = Prescription, 2 = Diagnosis and lab test, 3 = Referral system, 4 = Indoor treatment, 5 = Medicine supply with significant value.

16. Please mention the number of Indoor patients of last month: Male -------, Female -----, Child -------.

17. How many number of patient admitted in the indoor at now? Male -------, Female -----, Child --------.

18. How much number of patients took treatment fron outdoor in the last month? Male ------, Female -----, Child --------.

19. How many number of patients come today in the Outdoor? Male -------, Female -----, Child --------.

20. How many number of patient come this clinic from long distance? ----- %.

21. How do you collect medicine for this clinic? 1 = Centrally NGO collect medicine and supplied in the clinics, 2 = We buy medicine from different pharmacy/company by

checking market price, 3 = Medical representatives of the companies supplied medicine regularly in the clinic.

22. Please mention the medicine storage procedure of your clinic: 1 = We store medicine following proper rules (such as, away from heat and light, some medicine stored at fridge), 2 = It is not possible to store all medicine in the proper way, 3 = Daily collected medicine distributed in this day.

23. Please mention your suggestions for overall development of the standard of the clinics conducted by your NGOs-

24. Please mention your future planning for overall development of the standard of this clinic.

APPENDIX 3

Checklist/Questionnaire of Service Providers in the Clinic

1. Total number of ward? ……number.
2. Total number of bed in ward? .....number.
3. Total number of cabin? ……..number.
4. Rent of General bed per day? ……taka.
5. Rent of Cabin per day? ……taka.
6. Air-conditioned room? 1= Yes, 2= No
7. If yes, rent of the room per day? ……..taka.
8. Ambulance services? How many? ……..number. (If not then write 0).
9. Emergency medicine supply? 1=Yes, 2=No
10. Condition of Toilet? 1= Good, 2= Moderate, 3= Bad
11. Separate toilet for men and women? 1= Yes, 2= No
12. Separate room for women in outdoor of clinics? 1=Yes, 2=No
13. Separate room for Mother Brest feeding to the children? 1=Yes, 2=No
14. Record keeping system? 1=Very good, 2=try to develop, 3= weak
15. Workforce of clinic (doctor, nurse and technician)

Serial no	Designation	Number
1	Doctor	
2	Dental surgeon	
3	Anesthesiologist	
4	Medical Assistant	
5	Pharmacist	
6	Radiologist	
7	Pathologist	
8	Nurse	
9	Councilor	
10	Boy/Aya	

(If not then write 0).

16. Workforce of clinic (administration and other staff)

Serial no	Designation	Number
1	Administrative officer	

2	Accountant/Clark	
3	Statistician	
4	Store keeper	
5	Typist	
6	MLSS	
7	Driver	
8	cleaner	

(If not then write 0).

17. Otherfacilities

Serial no	facilities	Number
1	Operation theater	
2	Pathology division	
3	Blood bank	
4	Pharmacy	
5	Canteen	
6	Generator	
7	Laundry	