Operations Research on ESP Delivery and Community Clinics in Bangladesh

Preliminary Assessment of Performance of Two Selected Community Clinics

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Glossary

AHI	Assistant Health Inspector
ANC	Antenatal Care
ARI	Acute Respiratory Infection
AUFPO	Assistant Upazila Family Planning Officer
BF	Breast-feeding
BCC	Behaviour Change Communication
CC	Community Clinic
CG	Community Group
CME	Centre for Medical Education
CPR	Contraceptive Prevalence Rate
DD	Diarrhoeal Diseases
DGHS	Directorate General of Health Services
DFP	Directorate of Family Planning
ELCO	Eligible Couples
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FGD	Focus-group Discussion
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HI	Health Inspector
HPSP	Health and Population Sector Programme
IEC	Information, Education and Communication
IUD	Intra-uterine Device
MCH	Maternal and Child Health
MCU	Management Change Unit
MIS	Management Information System
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOLGRD&C	Ministry of Local Government, Rural Development & Cooperatives
MO-MCH	Medical Officer-Maternal and Child Health
MWRA	Married Woman of Reproductive Age
NIPHP	National Integrated Population and Health Programme
NIPORT	National Institute for Population Research and Training
ORP	Operations Research Project
PCC	Programme Coordination Cell

PNC	Postnatal Care
RMO	Resident Medical Officer
RTI	Reproductive Tract Infection
SC	Satellite Clinic
STD	Sexually Transmitted Disease
TB	Tuberculosis Bacillus
TFIPP	Thana Functional Improvement Pilot Project
UHFPO	Upazila Health and Family Planning Officer
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UHFWC	Union Health and Family Welfare Centre
UMIS	Unified Management Information System
UP	Union Parishad
USAID	United States Agency for International Development

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Summary

In Bangladesh, interest in health-sector reform is widespread. One of the reform agenda adopted in Bangladesh National Health and Family Planning Programme is the shift from the home-based to a static centre-based service-delivery system. The five-year plan (1998-2003) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), namely the Health and Population Sector Programme (HPSP), is aimed at providing a range of essential health and family-planning services i.e., the Essential Services Packages (ESP), specially to the vulnerable groups, i.e., women, children, and the poor. The HPSP has delineated three basic features for delivery of the ESP: client-oriented services, unified management, and one-stop service-delivery. To meet the reorganized service-delivery strategy at the community level, fixed-site clinics featuring a one-stop service centre, referred to as Community Clinic (CC), under the supervision of a unified management, will gradually replace the existing home-visit approach. Given the substantial changes suggested in the HPSP, the implementation of ESP delivery, including operationalization of CCs, need close monitoring to derive sufficient information to fine-tune and modify the approach as required.

In the above backdrop, the Operation Research Project of ICDDR,B: Centre for Health and Population Research conducted a study on operationalization of ESP delivery in its rural field sites at Abhoynagar upazila of Jessore district and Mirsarai upazila of Chittagong district. To assess the initial effects of the CC-based delivery of the ESP, an evaluation was made in May 2001. Both quantitative and qualitative methods were employed which included analysis of population-based longitudinal data of the project surveillance system, service statistics from clinics, special surveys, in-depth interviews, and group discussions with users and providers. The Chalisia CC of Abhoynagar and the Dhum CC of Mirsarai were evaluated.

At the time of evaluation, 7 CCs in Chalisia union of Abhoynagar and 2 CCs in Dhum union of Mirsarai were fully functional. Of these, only the Chalisia CC and the Dhum CC have been functioning for eleven and six months respectively. These numbers did not meet the target of the plan for establishment of CCs. Lack of coordination between the concerned agencies at different levels delayed the construction work. In general, the layout supplied by the MOHFW was followed in the physical construction of CCs of the project upazilas, and the physical construction was completed at the government-approved cost. Contribution of the community members to improve the construction work was also noted in some places. The involvement of the Community Groups (CGs) in supervising the construction work help ensured a quality construction.

The clinics under the study were operating on all week days by the Health Assistant (HA) and the Family Welfare Assistant (FWA) as the regular providers, and the Family Welfare Visitor (FWV) was providing routine services every fortnight.

Cleanliness and security of the clinics were well-maintained by the CGs in both the places. The local managers made ad-hoc arrangements to supply medicines and commodities for the clinics, and there was a shortage of enlisted medicines in both the CCs.

The service-delivery system was more or less, organized as instructed in the GoB guidelines on operation, management, and functioning of CCs with, by and large, a satisfactory participation of the community. Plans for phasing-out of the EPI outreach and satellite clinics within the catchments areas of CCs were partially being executed in both the places. The CC workers made limited home-visits to selected households once in a week according to a prefixed workplan. Immunization services were organized at the CCs twice a week with good client attendance. In general, the CC staff used the unified management information system (UMIS) forms and registers easily. At the same time, some old registers and reports continued to be used. Support of the supervisors was felt necessary to overcome the initial confusion.

A good number of clients (472 per month in Chalisia and 605 per month in Dhum) attended the CCs during their functional period. About three-fourth of them were women of reproductive age. While adolescents accounted for 10-17% of service recipients, 14-21% were children aged less than 5 years. With promotion of adolescent health programme, the number of adolescents may increase further in future. Upazila Health Complex was the most common place to refer clients from the CCs. The field supervisors and upazila managers visited the clinics, and discussed relevant issues with the service providers. They did not, however, follow the supervisory checklist while visiting the CCs, resulting in failure to make the supervision supportive and effective. The CGs were yet to understand their specific role in supervision of CCs. Review of the service-delivery registers showed that health-education sessions on different health and family-planning topics were evaluated. Although the providers failed to meet the appropriate standard in providing quality care, the clients were satisfied with the services delivered in both the places. The quality of services at the CCs must be improved further to meet the expectations of the HPSP. Continuing education and supportive supervision may be considered effective tools for the current CC providers.

The CGs, formed for both the CCs, participated in some activities to establish the CCs and use services from the clinics. The community people were aware about the existence of CGs, and many of them recognized that the CGs helped the CCs to function effectively. The CGs, did not however, carry out all the given responsibilities proactively to promote and sustain the CCs with the true spirit of participatory management. It was expected that the Government would look into the issues relating to long-term sustainability, e.g., supply of medicines, maintenance, and financing. Discussions with the supervisors and managers revealed the problem areas for effective functioning of CCs. These problems were primarily related to: personnel

management, supply of drugs, supervision and monitoring of clinics, management of outreach sites, limited home-visits, management information system, community participation and involvement of Union Parishad (UP) in management of CCs, promotional activity for the CCs, waste disposal, and quality of care at the CCs. While some of these being addressed locally and were improving gradually within the unified supervision system, the rest depended on the establishment of a mechanism that needed to be worked upon through a coordinated effort of the local managers and the local community. Although agreed, in general, with the concept of reorganized service-delivery, the managers and supervisors were hesitant about the plausible consequences on the use of services and were unclear about the appropriate mechanisms to address the matters arising.

The effects of the reorganized service-delivery system were measured as the effect of phasing-out of the existing outreach sites and the effects of transition on the service-delivery sites. Interviews with women conducted through household surveys revealed that the majority of them used the CCs as their new source of services. Of those who used to take services from the Satellite Clinics (SCs) of their locality, 68-79% visited the CCs for services. Although travelling outside home and communication to the CCs were regarded as major problems, the availability of services on all working days was also perceived as one of the major advantages of CCs over the SCs organized once in a month. Most respondents in Abhoynagar upazila were aware that the SCs would be withdrawn soon, and the majority of them perceived the CCs as the potential source of services after phasing-out of the outreach sites. The picture was not encouraging in Mirsarai upazila, probably because of poor communication by the health and family-planning workers on the reorganization of service-delivery sites, including phasing-out of the outreach sites. Overall, the change had no apparent adverse effect on the use of services by the community.

Contraceptive use, source of contraceptive methods, and EPI coverage of the selected CC catchment areas were compared with those of the adjacent potential CC catchment areas (a CC is planned but no CC-based service-delivery is initiated) to assess the effect of transition on selected ESP indicators. One of the selection criteria of the three comparison areas for a CC area was their historical performance (high, average and low-performance areas were selected). The contraceptive prevalence rate (CPR) remained the same in the intervention catchment areas of CC throughout the consecutive five quarters (from January-March 2000 to January-March 2001), and was noticeably higher than the comparison catchment areas of CC. In January-March 2001, the Chalisia CC in Abhoynagar contributed a quarter share, and the Dhum CC in Mirsarai shared 8% of supply of contraceptives. No big change in method-mix was noted, except a marginal rise of non-clinical temporary methods over clinical temporary methods in some areas.

Overall, a high EPI coverage with marginal increase in trend was noted in most study areas. The coverage of individual antigen was >80%, except in 2 of the comparison areas. These findings suggest that there was no detrimental effect of the new approach on the 2 critical indicators. These trends need to be followed for a longer period to assess the actual and relatively longer-term consequences of the CC-based service-delivery approach.

Over the past two decades, the domiciliary and outreach-based delivery of health and family-planning services has been recognized as the key to the Bangladesh national health and family-planning programme. To increase the functional efficiency and quality of care, and to ensure a broader range of reproductive health services, the HPSP of MOHFW has emphasized on the need for a shift to a static site or clinic-based approach for providing services. Along with many other considerations, the approach of CC to render one-stop service-delivery also considered the interventions/studies on alternative service-delivery strategies conducted by different organizations, including ICDDR,B. The present assessment of two CCs focused on the issues of programmatic relevance, so that the concerned agencies can take corrective actions to improve the system accordingly. The following lessons were learnt from the study:

- It is possible to implement the CC-based service-delivery strategy. Proper orientation of all the stakeholders is, however, critical to its effective implementation. Without conscious and meaningful participation of the community and the local-level health and family-planning personnel, it is unlikely to operationalize and sustain the CCs.
- With appropriate and effective involvement of the community, it is possible to establish the CCs in optimum locations. A motivated CG can actively be involved in the construction-monitoring process to ensure the quality of construction.
- Adequate training of staff is imperative for successful operation of CCs as the effective service-delivery points for providing essential health and family-planning services to the catchment population.
- A full range of clinical care or technical standard, as envisioned in the HPSP and expected by the local people, may not be achieved by the current providers of CCs. A rational CC-provider recruitment and training plan is, thus, imperative for further improvement.
- The providers of CC with their present skills can serve the community even better if they are allowed to perform the CC-based service-delivery and are not involved in other vertical activities.
- The health and family-planning supervisors should continuously work with the CGs to ensure participatory management of CCs. The supervisory staff should be technically more skilled to perform the supportive supervision of the providers of CCs.
- Although the community people expect high-quality or standard services from the CCs, they do not perceive any problems attending the clinics for required services.
- With an appropriately-developed transition plan, the outreach centres can be gradually withdrawn without affecting the service-delivery, and the CCs can be transformed into the main outlet of ESP delivery in rural areas.
- The preliminary findings showed that the new service-delivery approach and the transition toward the CC-based service-delivery did not affect the CPR and EPI coverage.

- Specific activities need to be undertaken at the community level to increase the participation of male in using services from the CCs and to ensure promotion.

The lessons learnt are not sufficiently conclusive, as the study reports the findings in relation to the performance of only 2 CCs that were even not operational for a long time. To obtain more conclusive evidence, it is necessary to study the performance of these CCs further and CCs of other areas for a longer time. The present findings may, however, be considered for strengthening the ongoing programme and for fine-tuning the future rural ESP delivery.

Introduction

Health-sector reform is either underway or under consideration in various countries throughout the world. While it is difficult to define precisely what constitutes a true reform, there is, however, a common consensus that reform is a process of change involving what, who, and how relating to health-sector actions. Thus, the term 'health-sector reform' has a wide appeal. Like other developing countries, interest in health-sector reform in Bangladesh is widespread. One of the reform agenda adopted in the Bangladesh National Health and Family Planning Programme is the shift from home-based to a static centre-based service-delivery system. Interventions have been carried out by the government and non-government organizations to implement the reorganized service-delivery strategy along with restructuring of the programme management and supervisory systems.

The present report describes the field experiences of an operations research on implementation of Community Clinic (CC)-based delivery of essential health and family-planning services as suggested in the new reform programme. Although the document reports early experiences[1], the initial trends may provide useful information to researchers, programme managers, and policy-makers in assessing the future implications of the changed strategies.

Background

The five-year plan (1998-2003) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), namely the Health and Population Sector Programme (HPSP), is aimed at providing a range of essential health and family-planning services, i.e., Essential Services Package (ESP), being responsive to needs of clients, especially those of vulnerable groups i.e., women, children, and the poor. The overall objectives of the programme entail reductions in maternal and child mortality, burden of communicable diseases, and fertility rate; and an increase in life expectancy at birth, age at first pregnancy, nutritional status; and improvement in health status of the population. The delivery of ESP involves reorganization and restructuring of the service-delivery strategy from the home-visitation approach to a static centre-based service-delivery system (Programme Implementation Plan Part-I, HPSP) [1]. Implementation of a client-oriented cost-effective service-delivery system for the ESP has evolved as the most critical concern of the HPSP.

[1] The early experiences of the study on the operationalization process of ESP delivery and Community Clinics in rural Bangladesh have also been documented elsewhere (ICDDR,B Special Publication No. 103, 104, 105, 106, 110, and Working Paper no. 129, 138, 146 and 147)

The HPSP has delineated three basic features for the delivery of ESP: client-oriented services, unified management, and one-stop service-delivery. To meet the reorganized service-delivery strategy at the community level, fixed-site clinics (featuring a one-stop service centre, referred to as Community Clinic) will gradually replace the existing home-visit approach to offer services by both health and family-planning service providers under a unified management. The CCs, each built for catchment population of 6,000, would be the first level of ESP delivery in rural areas, with better facilities at the union (Union Health and Family Welfare Centre) and upazila levels (Upazila Health Complex) serving as centres for referral and support. Given the substantial changes suggested in the HPSP, the implementation process of ESP delivery, in general, and operationalization of CCs, in particular, need proper documentation and close monitoring in initial stages. This would allow the implementers to derive sufficient information and knowledge to fine-tune and modify the approach, as required.

The Intervention

In the above backdrop, the Operations Research Project (ORP) of ICDDR,B: Centre for Health and Population Research conducted an operations research on Operationalization of ESP delivery and CCs in its rural field sites at Abhoynagar upazila of Jessore district and Mirsarai upazila of Chittagong district. The study was initiated in October 1998 with the objectives to operationalize, document, monitor, evaluate, and improve the implementation of the restructured/ reorganized system for delivery of the ESP, including operationalization of CCs, the lowest tier of health centres for delivery of integrated services in rural areas. It was expected that the barriers to smooth functioning of the ESP delivery system would be identified so that corrective actions be recommended to the concerned government agencies, and the system be improved accordingly. Besides, it was aimed that technical assistance would be provided to the national, regional and local-level managers in implementation of activities critical to effective materialization of the new service systems. One of the key concerns of the study was to facilitate operationalization of CCs in its field sites and to provide feedback to the policy-makers and programme managers on the lessons learnt from the research. The study was carried out in collaboration with the (MOHFW) and its concerned agencies, namely Management Change Unit (MCU), Programme Coordination Cell (PCC), Directorate General of Health Services, and Directorate of Family Planning.

To assess the initial effects of CC-based delivery of the ESP, the study performed an evaluation in May 2001 using a time-series design. Both quantitative and qualitative methods were employed which included an analysis of population-based longitudinal data of the project's surveillance system, service statistics of clinics, special surveys, and in-depth interviews and group discussions with the providers and users.

Intervention Activities

The intervention activities included:

- orientation of the providers and managers on ESP components and the new service-delivery strategy, and selection of optimum sites for the CCs,
- providing technical assistance to the GoB functionaries on formation and functioning of Community Groups (CGs) and selection of appropriate sites for CCs,
- assessing baseline of the ESP indicators,
- developing guidelines for functioning of CCs, including modus operandi of CGs,
- providing training to service providers of CCs for initiation of service-delivery at CCs,
- developing transition plans for shift from outreach to CC-based service-delivery system,
- development of operational subsystems such as behaviour change communication, training, logistics, etc.,
- documentation of process and dissemination of experiences,
- monitoring the use of services at the CCs and the performance of CGs, and
- evaluation of impact of the reorganized service-delivery strategy.

Brief description of the intervention activities is given in Annexure 1.

Evaluation of the Intervention

The specific objectives of the evaluation were to:

- analyze the implementation status of the CC-based service delivery system, and
- assess the effects of the reorganized system on selected health and family-planning services.

In May 2001, the Chalisia CC of Abhoynagar and the Dhum CC of Mirsarai were evaluated because these two CCs were functional for a certain period and might provide some initial results. At the time of evaluation, the Chalisia CC had been in operation for 11 months and the Dhum union for 6 months. Apart from assessing the initial trends in the use of service after implementing the CC-based service system, effects of the transition plan (i.e., phasing out of EPI outreach sites and Satellite Clinics) were of special concern during the evaluation. Details of the indicators assessed during the evaluation along with the means of verifications are shown in Table 1 and 2.

Household surveys were conducted to collect information on the selected indicators (Table 2). Structured instruments were used for collecting data from the sample population of the concerned areas. The methodologies including the means and tools of measurement used for collection of information for evaluation of the programme are given in Table 1. The schedule of assessment activities is shown in Annexure 2. Since the CCs and the CC-based service-delivery system were not operationalized throughout the study areas, the post-intervention assessment of ESP indicators was not done. The authors thought it would be wise to reassess all the ESP indicators once the reorganized service-delivery system was fully operational. Nevertheless, the insights obtained by the study team throughout the intervention and beyond the collected statistics were also considered to answer the evaluation questions.

Table 1. Indicators for assessment of Community Clinics

Issue/indicator	Means of measurement	Tools
Practice of providers - case management - interactions with client (time spent per case, privacy) - client counselling/health education - referral - general clinical skills (blood pressure (BP), weight, stitch, anaemia, thermometer, jaundice, oedema)	Observation of case management	Observation checklist
Knowledge of providers - case management - interactions with client - client counselling/health education - referral knowledge - general clinical skills (BP, weight, stitch, anaemia, thermometer, jaundice, oedema)	Interviews with the providers	Interview questionnaire
Practice of limited home-visit - services given - frequency of visit - criteria for visit	Interview, review of records	Questionnaire / checklist

Table 1. (*contd*.)

Table 1. (*contd*.)

Issue/indicator	Means of measurement	Tools
Organization and management of facility - Organization of physical facility (cleanliness, waiting place, privacy, water supply, adequate light, general condition of structure of building, logistics) - range of services - inter-provider referral - additional sources addressed - clinic hour - visit of Family Welfare Visitors - visit of Medical Officers - display of information, education and communication (IEC) materials	Interview, review of records, observation	Facility assessment form
Attendance of providers - supervision (frequency of visit, who visited, what was supervised, feedback by supervisors, on job training, follow-up issues)	Review of records, analysis of supervisory checklist, provider's interview, union and upazila supervisor's interview	Checklist, Interview questionnaire
Recording and reporting - family health card - register (filled up, updated) - report preparation (complete, routinely generated)	Review of records, interview observation	Observation checklist and facility assessment form
Satisfaction of clients - source of information on CC - satisfaction criteria - reasons for satisfaction and dissatisfaction - suggestions for improvement	Exit interview, focus-group discussion (FGD)	Questionnaire, FGD guideline
Community participation - conducting regular monthly meeting - generating minutes of meeting - ensuring security of CC - ensuring cleanliness of CC - ensuring maintenance/repair - ensuring promotional activity - community financing - application of decisions of CG meeting	Review of record, FGD, key-informant interview (teacher, religious leader, UP member, aged person, youth club, mother's club)	Checklist, FGD guideline, Interview questionnaire
Service-delivery - client attendance - BCC activities - referral - supervision - use of selective ESP services	Service statistics	Prescribed format

Table 2. Indicators for assessment of effect of phasing-out of the outreach-based service-delivery system

Issue/indicator	Means and tool of measurement	Sample population (respondents)
Use of services and perception on the new approach of service-delivery - present source of services of those who used to have services from the Satellite Clinic (SC)/Expanded Programme on Immunization (EPI) outreach sites - perceived problems in getting service from CCs - perceived advantages and disadvantages - messages commonly told to others to use services from CCs	Household survey; interview with married women of reproductive age (MWRA) through structured and semi-structured questionnaires	Locality/community from where the EPI outreach/SCs have already been withdrawn
Perceptions on the phasing-out plan and the new service-delivery approach - awareness on withdrawal of SCs - potential source of receiving services in future - perceived distance from CCs - awareness on CCs - perceived advantages and disadvantages of phasing-out of outreach sites - messages commonly told to others to use services from CCs	Household survey; interview with MWRA through structured and semi-structured questionnaires	Locality/community from where the EPI outreach/SCs are planned to be withdrawn soon
Status of critical indicators - contraceptive prevalence rate (CPR) - method-mix in contraceptive use - total drop-out from family-planning use - total new acceptance - source of family-planning methods - immunization of children by antigens - source of vaccine	Interview of MWRA of sample households of the ORP surveillance system through structured information-recording system	3 different CC catchment populations of intervention area and 1 CC catchment population of the comparison area of both the upazilas. The sampled populations had different criteria for inclusion.

Results

Status of Implementation

The ultimate goal of the study was to facilitate the timely implementation of CCs in compliance with the corresponding government guidelines. At the time of evaluation, 7 CCs in Abhoynagar and 2 CCs in Mirsarai were made fully functional. Of these functional clinics, only the Chalisia CC and the Dhum CC had been in operation for more than 11 months and 6 months respectively. Table 3 and 4 depicts the overall implementation status of CCs in the two study upazilas.

Table 3. Community Clinic profile of Abhoynagar, Jessore

Union	Planned and proposed by Upazila Managers				Functional status	Remarks
	Total no. of CCs to be cons-tructed	No. of CCs in HFWC/ UHC	No. of CCs in flood/ cyclone shelters	Total no. of CCs to be esta-blished		
Prembag (Mohakal)	3	1	-	4	Construction of 3 CCs is in progress	
Sundali (Noapara)	3	1*	-	4	Construction of 3 CCs is in progress	
Subharara	3	1	-	4	Construction work was started at 2 CC sites	
Siddhipasha	4	1	-	5	3 CCs are under construction	1 additional CC proposed, but not yet approved
Baghutia	3	1	-	4	2 CCs are currently functioning	1 additional CC proposed but not yet approved
Sreedharpur	5	1	-	6	Construction of 3 CCs are completed, and 2 CCs are functional	1 additional CC approved
Paira	2	1	-	3	2 CCs are functional	
Chalisia (Rajghat)	3	1	-	4	Construction of 2 CCs are completed, and 1 is functional	Site selection for 1 CC yet to be finalized
Total	26	8	-	34	7 CCs are currently functioning	3 additional CCs proposed for construction in 3 unions, of which 1 approved till-date

* HFWC is not yet constructed

Table 4. Community Clinic profile of Mirsarai, Chittagong

Union	Planned and proposed by Upazila Managers				Functional status	Remarks
	Total no. of CCs to be cons-tructed	No. of CCs in HFWC/ UHC	No. of CCs in flood/ cyclone shelters	Total no. of CCs to be esta-blished		
Dhum	2	1	-	3	1 CC is functional, and construction of 1 CC is in progress	
Durgapur	3	1	-	4	Construction of 1 CC is complete, and 1 CC is in progress	
Hinguli	4	1	-	5	Construction of 3 CCs is complete, and 1 is in progress	
Karerhat	4	1	1	6	1 CC is functional, and construction of 2 more is complete	
Mirsarai	3	1	-	4	1 CC is functional, and construction of 2 CCs is in progress	
Moghadia	2	1	1	4	2 CCs are under construction	
Saherkhali	2	1	-	3	Construction of 1 CC is complete	
Jorarganj	3	1	1	5		
Osmanpur	1	1	-	2		1 additional CC required, but yet to be approved
Ichhakhali	-	1	3	5	No construction required	1 additional CC to be established in cyclone shelter
Kata-chhara	3	1	-	4		1 additional CC required, but yet to be approved
Mithanala	3	1	-	4		1 additional CC required to be constructed
Khoiya-chhara	3	1*	-	4		

Table 4. (*Contd*.)

Table 4. (*Contd*.)

Union	Planned and proposed by Upazila Managers				Functional status	Remarks
	Total no. of CCs to be cons-tructed	No. of CCs in HFWC/ UHC	No. of CCs in flood/ cyclone shelters	Total no. of CCs to be esta-blished		
Mayani	2	1**	-	3		1 additional CC to be established in cyclone centre, but no construction required
Haitkandi	2	1	-	3		1 additional CC required to be constructed, and applied for approval
Wahedpur	3	1	-	4		
Total	40	16	6	62	6 additional CCs are proposed to be established, of which 4 CCs proposed for construction, and 2 CCs to be established in cyclone shelters	

* HFWC is not yet constructed

** There is no HFWC. The CC will be established in the Rural Dispensary (RD)

Organization and Management of Service-Delivery

An assessment of organization and management of service-delivery at the selected CCs was carried out. The assessment covered the physical infrastructure, organization of service provision, human resources management, management information system (MIS), outreach sites and home-visit rescheduling, logistic and supplies, and information, education and communication (IEC) and EPI sessions. These parameters were set to capture the whole range of functional modalities as detailed in the GoB guidelines (Guidelines on Operation, Management and Functioning of Community Clinic, Ministry of Health and Family Welfare, October 2000). The findings of the assessment are described below.

Physical infrastructure

The CC is designed as a small *pucca* structure with concrete roof, two rooms for service-delivery, and one waiting space in front of them. One of the service-delivery rooms accommodates an attached toilet with provision of water supply from a tubewell placed within the toilet. The construction plan of the CCs has been provided by the MOHFW with the flexibility of incorporating minor modifications based on the local geographical conditions. The Chalisia CC was built exactly following the MOHFW-supplied lay-out and specifications without any change, and the construction work was completed at the approved cost of GoB-allocated fund of Tk 2,20,000.00 (Taka two lac twenty thousand), of which one lac seventy thousand was spent on construction, and the rest fifty thousand for procurement of furniture. Involvement of the CG in supervising the construction work ensured a quality construction, which was recognizable.

Ventilation in the room earmarked for the Family Welfare Assistant (FWA) was inadequate due to undersized windows and absence of electric fan and light. Electricity connection could not be established till the date of assessment. The tubewell also went out of order soon after it was installed. It was reported that the CG discussed these issues in its monthly meeting and had been trying to get an electricity connection and a re-sunk tube-well. The built-in concrete benches (length: 6 feet, breadth: 12 inch) located in the waiting space could hardly accommodate 3-4 persons at a time. This sitting arrangement was insufficient particularly on the weekly or fortnightly immunization and satellite clinic days organized on the CC premise.

The Dhum CC has a number of remarkable features compared to the Chalisia CC in terms of physical infrastructure. One of the community leaders (Honourable local Member of Parliament and Minister for Works of the then government) took personal initiatives, and provided additional funds to get the construction done with several improvements in the original government plan. It required an additional amount of Tk 1,11,927.00 (Taka one lac eleven thousand nine hundred and twenty-seven), in addition to the government contribution of Taka two lac twenty thousand for construction and furniture. This additional fund was donated by the honourable local MP through the CG. The major extra inputs given therein included white mosaic floor, electrification of the facility with installation of fans and lights, supply of running water, wash basin with mirror, toilet flash, extra floor space for each room, garden on the CC premise, and a portico in front of it with a brick-soled approach. Such additional improvements, supported by individual or community funding, are encouraged by the government in the operational guidelines for CCs (October 2000).

Organization of clinic

The Chalisia CC was found to be operating from 10:00 a.m. to 3:30 p.m. on all weekdays. The blackboard had been used for multipurpose information display, such as reason for absence of any provider, date of EPI sessions, National Immunization Days (NIDs), schedules for limited home-visits, etc. It was furnished with GoB-supplied furniture only. Overall cleanliness of the clinic was good, but the non-functioning tubewell had long been hindering proper cleaning of the toilet. The CG employed a part-time female cleaner on monthly salary basis (Tk 50 per month). The security measures were very informal. The neighbouring residents and the CG members voluntarily look after the security of the clinic. The clinic wastes were disposed off in a ditch at the backyard of the CC. However, used needles and syringes were returned to the Family Welfare Centre (FWC) for safe disposal.

The Dhum CC was found to be operating from 8:00 a.m. to 2:30 p.m. without any break on all weekdays. The working hours were agreed upon through discussion with the CG members. The monthly schedule for EPI sessions was written clearly on the blackboard. Most furniture were in good condition. In addition to the government supply, 6 more wooden chairs donated by the CG members were found in use. Doors and windows were well-painted and covered with white screens. Overall cleanliness of the clinic (both interior and exterior) was good, and security arrangements were also quite satisfactory. The security guard of the local MP's house also takes care of the security of the clinic. The CG has employed a full-time female cleaner-cum-attendant on a monthly salary basis (Tk 600 per month). A flower garden is maintained in the front-yard adding further attraction to the clinic. The CG has been organizing these things under the active guidance and financial support of the honourable local MP and the community. However, clinic wastes are disposed off in an open ditch nearby, which indicates the need for safer waste-disposal arrangement in the CC.

Human resources management

Usually, each of the service providers (HA and FWA) rendered services at the clinic for 5 days a week, and undertook selected home-visit once a week. These providers also undertook other field activities outside the clinic, e.g. conducting EPI sessions and SC (if any), Geographical Reconnaissance (GR) updating, participating in NIDs etc. The FWV had been attending the CC twice a month as per schedule. This scenario was almost same in both Dhum and Chalisia CCs.

Both the FWA and HA of the Dhum CC received a 3-week ESP training at the Regional Training Centre (RTC), while only the FWA of the Chalisia CC received the training.

Supplies and stock: Family-planning commodities were supplied in sufficient quantity for both the CCs, and the stocks were satisfactory on the day of assessment. However, supply of some enlisted medicines was either in shortage or totally absent in both the facilities. The providers reported that they had a shortage of medicines since the opening of the clinics. Besides, supply and stock of enlisted equipment were also inadequate. All the registers were available, and were maintained properly at the Dhum CC, whereas the Chalisia CC did not have some registers since they were not supplied from the Abhoynagar Upazila Health Complex.

IEC materials

Information, education, and communication (IEC) materials, such as pictorial posters on family planning, immunization, acute respiratory infection (ARI), diarrhoea, nutrition, emergency obstetric care (EOC), tuberculosis-leprosy, and on CCs, were displayed inside the clinic building. Some flip-charts were supplied for demonstration during health-education sessions. Information on clinic hours, name of service providers, and a list of services available at the clinic were written on several mounted whiteboards displayed at the middle of the wall of the waiting space in both the clinics. No billboard was seen outside the clinics. Name and location of the Chalisia CC were written with black ink on outer part of the front wall of clinic, while no such name-display was seen in the Dhum CC.

Phasing-out of outreach sites

In the Chalisia CC, all the 5 combined EPI Outreach Centres and SCs have been phased-out, and new schedules for immunization and maternal child health (MCH) care have begun at the CC.

At the Dhum CC, 5 of 6 EPI Outreach Centres and all SCs have been phased-out, and new schedules have been made for these services. Only one EPI outreach centre has been functioning in Mohajanhat village in response to popular public demand. The inhabitants of Mohajanhat were reluctant to use the Dhum CC because of the 12-km distance between the CC and the village.

Limited home-visits: The HAs or FWAs alternatively visited the selected homes once a week according to a prefixed workplan in both the clinics. They carried the follow-up and service-delivery registers with them during home-visits, performed follow-up of pregnant mothers, registration of new couples, and registration of births and deaths, performed family-planning motivational work, searched for drop-outs, made EPI campaigns, behaviour change communication (BCC), and advice for common ailments provided.

EPI sessions: In both the CCs, immunization services were held twice a week (every Saturday and Tuesday at Dhum CC, and every Sunday and Tuesday at Chalisia CC). Attendance of clients for immunizations in both the locations were quite good.

Management information system (MIS): The FWAs and HAs in both the CCs worked on the unified (UMIS) forms and registers. In addition, they were also provided with daily attendance and inspection books, receipt and dispatch books, a CG monthly meeting register, and a financial accounts book to keep record of respective matters. In Chalisia, the HA also completed some old registers (previously used during home-visitation) as directed by the concerned UHFPO. Reports were sent from the CC to meet other information needs of the managers beyond the present scope of UMIS.

Status of Service Delivery

Utilization of services

Routine monitoring of services was the major source of information to assess the use of CCs under evaluation. Details on the service-use trends over time at the Chalisia CC are given in the tables of Annexure 3-A and those at the Dhum CC in the tables of Annexure 3-B.

Chalisia Community Clinic

The Chalisia CC was one of 4 CCs established in Chalisia union of Abhoynagar upazila. Service-delivery from the Clinic was initiated on 6 June 2000 with deployment of HA and FWA as the main service providers, and the FWV attending the CC twice a month. The then State Minister for Health and Family Welfare formally inaugurated service-delivery from the CC. The inaugural ceremony was also attended by the local Member of Parliament, officials of the MOHFW, service-providers, field supervisors, upazila managers, CG members, and other community leaders and representatives, e.g. UP Chairman and Members.

Attendance of clients: In total, 5,188 clients received services from the Chalisia CC, i.e. on an average 472 per month, since its inception on 6 June 2000. The majority (77%) of the clients were females, and 53% were aged 20-49 years, suggesting that CC services were mostly used by women of reproductive age. Adolescents accounted for 10% of the service recipients. Of the attendees, 21% were children aged less than 5 years, and 12% were children aged less than one year. Four percent of older clients also attended the CC. Figure 1 shows the age distribution of clients attending the Chalisia CC.

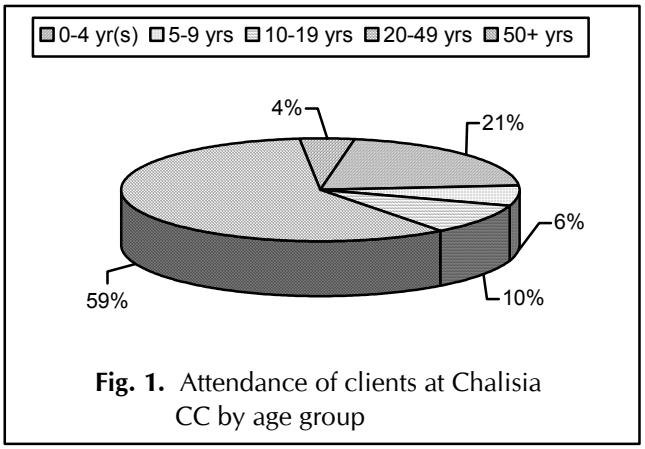

Fig. 1. Attendance of clients at Chalisia CC by age group

Referral: Sixty-one clients were referred to the UHFWC and UHC; most (92%) of whom were referred to the UHC. Of 56 clients referred to the UHC, 3 were referred for family planning, 19 for child health, and the rest 34 for general health services.

Supervision: The UHFPO, UFPO, and MO (MCH-FP) visited the clinic at lease 2-3 times during the 6-month period. During their visits, the Upazila Managers discussed with the CC providers about issues such as attendance of staff members, clinic-operating hours, behavior of providers with clients, CG meetings, motivation of clients to attend the CC, and supply and distribution of medicines. Both AHI and FPI also paid regular visits to the CC.

BCC activities: Thirty-eight health-education sessions were held at the CC to discuss about the common topics, such as diarrhoea, nightblindness, nutrition of pregnant mothers and children, antenatal and postnatal care, family-planning, immunization, child health, pneumonia, dengue fever, safe delivery, anaemia, skin diseases, and cleanliness. These health-education sessions were attended by 2,781 clients (male 23%, and female 77%).

Immunization: The number of BCG vaccinations given in the clinic ranged from 7 to 12 per month with 7 cases in June 2000. The number of DPT3 vaccines ranged from 4 to 12 per month with 4 cases in June 2000. The number of measles vaccines and vitamin A administration remained same over the months, ranging from 6 to 17 per month.

Childhood illnesses: One hundred thirty-six children received services for ARI, of which 5 had pneumonia. Treatment for diarrhoea was given to 160 children.

Family planning: Seven hundred and twenty-four clients received family-planning services, of which 17 were men attending the clinic for condoms. The majority (60%) of the family-planning clients attended the CC for oral pills, followed by contraceptive injections (28%). None was referred from the CC to any higher-level facility for management of their side effects.

Maternal care: In total, 232 antenatal care (ANC) visits, i.e. on an average 21 per month, were registered in the CC. Only 3 cases were referred to the higher level for delivery care. Of the 193 TT immunizations given in the clinic, 47% were given to non-pregnant women of reproductive age. Postnatal care (PNC) services were delivered to 149 mothers.

Dhum Community Clinic

The Dhum CC was one of the 3 CCs established in the Dhum union of Mirsarai upazila. Service-delivery from the clinic was initiated on 7 November 2000 with deployment of HA and FWA as the main service providers, and the FWV visiting the CC 3 times a month on fixed days. Although a formal inauguration was planned to make the local

people aware of the clinic, the launching ceremony could not be held due to non-availability of the influential members of the community. The service providers, field supervisors, upazila managers, CG members, and other attached community members, e.g. UP Chairman and members, disseminated information on the CC before and after initiation of service-delivery from it.

Attendance of clients: A total of 3,626 clients attended the Dhum CC, i.e. on an average 604 clients per month, since its inception of operation in November 2000. The age and sex distribution of clients was almost similar to that of the Chalisia CC. Here too, 74% of the clients were females, and 43% were aged 20-49 years. Adolescents accounted for 17% of the service recipients. Of the attendees, 14% were children aged less than 5 years, and 8% were aged less than one year. The proportion of young children (aged <1 year) brought to the clinic increased over time. What has been notable with the Dhum CC is that 12% of elderly clients also attended it.

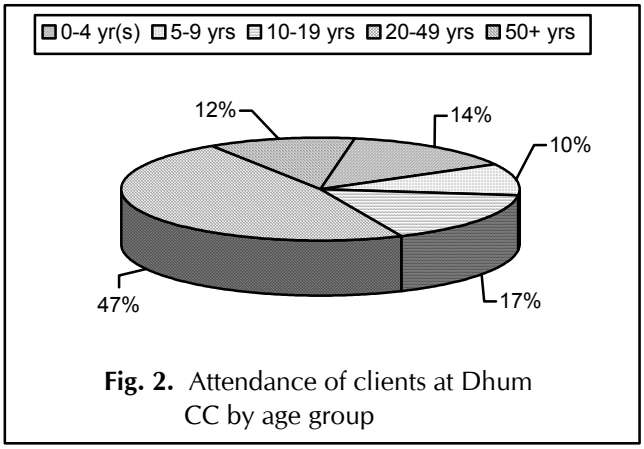

Fig. 2. Attendance of clients at Dhum CC by age group

Referral: In total, 104 clients were referred to the UHFWC and the UHC, of which only 4 clients were referred to the UHC for family-planning services. Of the 100 cases referred to UHFWC, 48 were referred for family-planning services, 30 for maternal health, and 22 for child health services.

Supervision: The UHFPO, MO (MCH-FP) and the UFPO had visited the clinic for at least 2-3 times during the 6-month period, while none of the union-level supervisors paid any visit to the CC. During their visits, the Upazila Managers discussed with the CC providers issues such as attendance of staff members, clinic operating hours, providers' behaviour with clients, Community Group meetings, motivation of clients to attend the CC, and supply and distribution of drugs. Both AHI and FPI were also paying regular visits to the CC.

BCC activities: Thirty-eight health-education sessions were held at the clinic, which were attended by 836 clients (male 36% and female 64%). The common topics of discussion as revealed from the service-delivery register were diarrhoea, nightblindness, malnutrition, ANC, PNC, and cleanliness.

Immunization: The number of BCG vaccinations given in the clinic ranged from 5 to 12 per month. The number of DPT3 ranged from 5 to 15 per month, except in November when only 2 were given. The number of measles vaccines per month ranged from 9 to 17, and was consistently at par with administration of Vitamin A capsules.

Childhood illness: A total of 104 children received services for ARI, of which only 12 had pneumonia. Forty-two children received treatment for diarrhoea.

Family planning: Two hundred and eleven clients received family-planning services, of which only 2 males attended the clinic to obtain condoms. The majority (66%) of family-planning clients attended the CC for oral pills, followed by contraceptive injection (26%). Six clients were referred from the CC to the higher-level facility for management of side effect of contraceptives.

Maternal care: In total, 23 ANC visits were recorded in the clinic. Of 217 TT immunizations given in the clinic, 126 were given to non-pregnant women of reproductive age.

Quality of Care

Case-management practices

The practices of the providers on selected case management were discussed while they were engaged in delivering these services. The main objective was to know how accurately they followed the standard guidelines. An observation guideline was developed for use by the experienced physicians in observing all cases.

Practice of providers at Chalisia CC

Annexure 4-A includes the results of observations of the providers' practices at the Chalisia CC.

Management of ARI

Nine cases were observed. The average time spent per case was 5 minutes. The providers cordially greeted the clients/attendees, and developed rapport with them before starting consultation and in taking case history. Age was determined in all cases. The 5 components of history-taking pertinent to ARI case management were not asked regularly. Duration of cough and history of fever were asked in 5 of the 9 cases. Other components of history were not assessed. The danger signs for ARI were not examined, respiratory rate was not counted, and chest-in-drawing was not looked into altogether.

Seven of the 9 observed cases were diagnosed and classified as ARI according to the guideline, and there was no disagreement between the provider and the observer with respect to the diagnosed cases. Antibiotic, when prescribed, was appropriate, but anti-histamines were prescribed in 2 cases.

With regard to advising mothers on home care, in 4 of the 9 cases, advice was given on increased administration of fluid during illness, and increased feeding during and after illness. In 3 of the 9 cases, advice was given on how to soothe the throat and relieve cough with safe remedy. Only one mother was informed on the danger signs of ARI and when to seek care for danger conditions. Follow-up advice was given to one case, and status of complementary feeding was asked in 2 cases.

Management of diarrhoea

In total, 4 diarrhoea cases were observed. The average time spent per case was 4 minutes. Age of patients was determined in 3 cases. Duration, frequency and consistency of stool were inquired for most cases. Presence of fever and convulsion and signs for dehydration were not assessed or examined. Skin pinch was not tested in any case, and dehydration was not classified. Diarrhoea was diagnosed in 3 of the 4 cases, which was well in agreement with the observers.

Oral rehydration salt (ORS) was prescribed and supplied to all the cases. The providers took feedback on preparation and administration of ORS from 2 clients. An antibiotic was prescribed for 2 cases, while its use was explained to only one client. In half of the cases, the mothers were advised on 3 rules of home management of diarrhoea. Co-infection of ARI was assessed in only one case.

Antenatal care (first visit)

Two ANC cases were observed. On an average, 10 minutes were spent per case. History-taking was not adequately done in most cases. A general physical examination, including per-abdominal examination, was not done in any case. Routine laboratory tests were not advised. Information on TT vaccination, feeding practices, safe delivery practices, follow-up visits, and iron and folic acid was provided to them.

Family-planning services

Oral pill (revisit)

One client attended the CC for oral pills during the 3-day observation period. Three minutes was spent for the client. The screening procedure was not adequately followed. Last menstrual period (LMP) was not asked, and relevant medical history was not taken. No physical examination was done, and no laboratory test was advised. The client was not neither counseled nor given any advice on follow-up visits.

Injectables (revisit)

Seven cases were observed, and all of them were greeted by the FWA. The average time spent per case was 5 minutes. Components of history-taking for the revisit clients were adequately followed. Feedback (problems relating to method use) was taken from 5 cases. A routine general physical examination, including breast examination, was not done in any case, and no laboratory test was advised.

Aseptic techniques were followed for cleaning the injection site and pushing injections. Vein-puncture was not checked in any case. Needles and syringes were disposed off properly. The warning signs and side effects were not discussed with the majority of cases. Follow-up advice was not given to any case.

Limited curative care

Limited curative care, as a component of the ESP, includes management of day-to-day general ailments, such as fever, pain, simple injuries, insect bite, stings, worm infestation, anaemia, weakness, etc.

In total, 19 such cases were observed during service-delivery at the CC. The FWA provided services to 10 cases, and the HA to 9 cases. The providers greeted them. History of present illness, and chief complaints were inquired in all the cases. Other components, such as relevant family history, past history and personal history of patients were less frequently taken. Age was determined in all the cases as relevant, but duration of sickness was inquired in half of the cases.

Both the providers performed poorly in physical examination. Routine physical examinations, such as, pulse, blood pressure, temperature and respiratory rate in children; anaemia, jaundice, etc., were done in one or two case(s) only. But physical examinations, such as palpating abdomen in abdominal pain, etc. was done in both such cases observed.

Correct diagnosis was mostly made for all the valid cases, (13 of 17 cases; 2 were not applicable), and the prescriptions made were, by and large, appropriate. Although the use of medicines was explained to all the cases, feedback was taken and specific advices were given to only 50% of the cases. Referrals, as needed, were made to the UHC or UHFWC. In none of the cases, the need for any additional services was neither assessed nor any information on them was given.

Health education and counselling

Four sessions (3 individual and one group) were observed. The average time spent for individual session was 7 minutes, and for the group session it was 8 minutes. The tables below summarize the number, pattern, and the topics of the sessions.

Practices of providers on health education and counselling

Did the provider	Yes	No	NA
Greet the client	Y		
Wait for sometimes to make group (5-7 persons)	Y		
Make appropriate sitting arrangement	Y		
Ask requested service needs of clients	Y		
Assess the knowledge of clients on topic of health education and counselling	Y		
Assess the knowledge by showing pictures at the beginning of health education session		Y	
Use IEC materials during health education session	Y		
Take feedback after health education session	Y		
Try to involve everyone if it is group session		Y	
Summarize the session after health education session	Y		
Maintain privacy during counselling (RTIs/STDs)			Y
Maintain non-judgmental attitude (RTIs/STDs)			Y
Emphasize on partner management		Y	
Emphasize on completion of treatment	Y		

Number and patterns of health-education sessions

Number and pattern of health-education sessions		Topics of session								
Pattern	Number	Breast-feeding	Diarr-hoeal diseases	Acute respira-tory infec-tion	Clean-liness	Vita-min A	Emer-gency obs-tetric care	Nutri-tion	Wean-ing	Expan-ded pro-gramme on immu-nization
Single discussion				Y	Y			Y		
Group discussion							Y			

Practices of providers at Dhum CC

The results of observation of providers' practice at Dhum CC, Mirsarai are shown in Annexure 4-B.

Management of ARI

Four ARI cases were observed. The average time spent per case was 5 minutes. The providers cordially greeted the clients, and built rapport with them before starting consultation and taking case history.

All the 5 required components of history-taking were not asked regularly. Only duration of cough and history of fever were asked in all the cases. The danger signs for ARI were not assessed, respiratory rate was not counted, and chest in-drawing was not examined. All the cases were diagnosed and classified according to the guideline, and there was no disagreement between the providers and the observer. Antibiotic was prescribed in 2 cases, which was not appropriate. No advice was given to the mothers on home care.

Management of diarrhoea

Four cases were observed. The average time spent per case was 4 minutes. Age of the patients was determined. Duration, frequency and consistency of stool were often inquired. Presence of fever was assessed in half of the cases, but convulsion was not assessed. Signs of dehydration were not screened. In 2 of the 4 cases, the diagnosis was in agreement with the observers.

ORS was prescribed and supplied to half of the cases. The providers did not take any feedback on preparation and administration of ORS from the clients. An antibiotic was prescribed in one case, and its use was properly explained. The mothers were not advised on the 3 rules of home management of diarrhoea. Co-infection of ARI was assessed in one case.

Antenatal care (first visit + revisit)

The ANC cases observed were attended by the FWV. Eight ANC cases were observed (7 first visit and 1 second visit). The average time spent per case was 10 minutes. History-taking was not done adequately in most cases. General physical examinations, including per abdominal examination, were done in most cases. Routine laboratory tests were not advised for any case.

In most cases, information on TT vaccination and feeding practice was given. Advices on safe delivery practices and follow-up visits were given less frequently (three and one case respectively). Iron and folic acid was provided to all the mothers.

Family planning services

Injectables (revisit)

Four cases were observed. All were appropriately greeted by the FWA. The average time spent per case was 6 minutes. Steps of history-taking for the revisit clients were not adequately followed. Feedback (problems related to method use) from any cases was not asked. A routine general physical examination, including breast examination, was not done in any case, and no laboratory tests were advised.

Aseptic techniques were followed for cleaning the injection site and pushing injections. Vein-puncture was not checked in any case. Needles and syringes were disposed off properly. The warning signs and side-effects were not discussed with the majority of cases. Follow-up advice was given to only one case.

Immunization

Seven cases of child immunization and 3 cases of women TT were observed. All the clients were appropriately greeted. The vaccination table was properly organized. Vaccines sterilized syringes, needles, and other equipments were supplied from the UHC.

In general, the providers followed aseptic measures in each case. Vaccines were administered in proper dose and route. An appropriate technique was followed for pushing the injections. In all the cases, vaccination cards (EPI Card) were checked, and necessary information was recorded. Only half of the clients for child immunization were counselled on the necessity for completion of immunization and preservation of cards. The woman attending for TT vaccine was not provided with any of advice on immunization.

Limited curative care

Fifteen cases were observed during service-delivery. In 11 cases services were provided by the FWA, in 2 cases by the HA, and in 2 cases by the FWV. The providers greeted them. History of present illness and chief complaints were inquired in all cases. Relevant family history and personal history of patients were taken in 1 case, and menstrual history was taken in 2 cases. Age was determined in 5 cases, duration of sickness was inquired in 2 cases, and the past history was not inquired in any case.

General and specific physical examinations were not done by any providers. However, a diagnosis, made for most of the cases, was mostly correct (13 out of 14), and appropriate prescriptions were made for most cases. Although the use of medicine was explained to all the cases, feedback was taken from 2 cases, and specific advises were given in 2 cases. No referral was necessary for the cases observed. In none of the cases, the need of additional service was neither assessed nor information on them was given.

Health education and counselling

Only one session conducted at the CC was observed. It was an individual counselling session, covering the topics of family planning and weaning food. Client-provider interaction was in a singular way, and the provider did not use any IEC material to explain the subject to the clients.

Knowledge of Providers

Whether the knowledge of the providers in delivering selected ESP services was adequate or partial was assessed in both the field sites. The knowledge of the providers on family-planning methods, MCH services, diarrhoea, ARI, and some other general health conditions was assessed using an interview questionnaire, prepared following the standard guidelines. Details of the findings have been provided in Annexure 5.

Abhoynagar: In Abhoynagar, the HA had sufficient knowledge on family-planning methods, although his knowledge on screening of clients was not adequate. Similarly, the FWA had inadequate knowledge on screening of clients, but possessed sufficient knowledge on providing pills and administering contraceptive injectables to clients. Both of them had adequate knowledge on ANC, breastfeeding, weaning, and TT immunization, but not on PNC.

The HA had proper knowledge on assessment and management of diarrhoea, whereas the FWA had inadequate knowledge of diarrhoea management, her knowledge on assessment of diarrhoea was satisfactory. Knowledge of both the service providers on use of medicines was not up to the mark. The knowledge of the HA on assessment and management of ARI was adequate, but the knowledge of FWA was adequate only in the case of assessment of ARI. The HA had proper knowledge on malnutrition, measles, ear problems, and vitamin A, while the FWA had partial knowledge on ear problems. The knowledge of FWA on other conditions was adequate.

Mirsarai: In Mirsarai, the FWA, unexpectedly, had partial knowledge on family-planning methods. The HA had adequate knowledge on screening of clients, but his knowledge on oral pill, IUD, and injectables was inadequate. The knowledge of both the providers on ANC, breast-feeding, weaning, TT immunization, and PNC was not adequate.

Although the HA had partial knowledge on assessment of diarrhoea, his knowledge on management of diarrhoea was adequate. The FWA, however, did not have sufficient knowledge on assessment and management of diarrhoea and on use of drugs in diarrhoea. The HA had adequate knowledge on all the three aspects of case management of ARI. The knowledge of FWA on either of these aspects of ARI was not adequate. Both HA and FWA had somewhat adequate knowledge on dealing with malnutrition, measles and vitamin A. Both of them had partial knowledge of ear problems.

Satisfaction of Clients

The clients (50 in Abhoynagar and 47 in Mirsarai) were interviewed at the time of exit, after receiving services, from the CC. Annexure 6 depicts the key findings from these interviews.

Information on CC: Almost universally (96% in Abhoynagar and 89% in Mirsarai) the attending clients received information on the CCs from the service providers. Friends and neighbours were also a major source of information (70% in Abhoynagar and 64% in Mirsarai) on CCs. The role of CG in this respect was minimal (only 4%). Most clients were aware of the availability of services for immunization, family planning, ANC, sick mother, and sick child care at the CCs. But the respondents were almost unaware of PNC, and limited curative care was also available at the CCs.

Satisfaction of clients: Satisfaction of the clients about the services was considerably high. When asked about the reasons of satisfaction, a wide array of response was made. The most frequently-cited responses included neatness and cleanliness of the CCs, good behaviour of the providers, availability of medicines, good waiting arrangements, availability of desired services, provision of services by qualified providers, etc. When asked about the reasons for coming to the CCs for services, the most common (96% in Abhoynagar and 87% in Mirsarai) response was the convenient location of the CCs. Other common responses included: familiarity with the providers, availability of medicines, cleanliness of the clinics, and good behaviour of the providers. Some respondents, expressed dissatisfaction on the shortage of needed drugs at the CCs. The clients also provided some suggestions for improvement. These included, among others, increased and constant supply of essential medicines, provision of electric fans in the waiting area, and deployment of graduate doctors for service-delivery at the CCs.

Community Participation

Performance of Community Group

Monthly meetings

The CG has been mandated to arrange monthly meetings, which were convened regularly at Chalisia. The HA recorded the minutes of all the meetings, but copies of the minutes were not distributed regularly to the concerned persons for their information and necessary actions. The notice of the meeting was signed by the HA, although it was supposed to be signed by the CG President. Despite properly intimated, the UP members did not attend most CG meetings. Some CG members reported that they had found lack of interest among the UP members, although they were expected to play an active role in the entire process. According to them, participation in the CG activities was not a priority for them. This raises the concern that the involvement of UP members in the CG would not be effective. The CG President stated that he would give a personal letter to the concerned UP members before every CG meeting. The timing of CG meetings, which currently take place in the morning, was of concerns to note. This timing, to a number of CG members, might not be suitable for the UP members and some other CG members to attend the CG meetings. In such a case, change in time may improve the situation. It was noted that the same issues were discussed in almost every CG meeting without any follow-up action. The CG President should always assign responsibility to other CG members and, thus, share responsibility.

In the Dhum CC, it was observed that CG meeting was held only once since its launching. The group members acknowledged that there was as such no problem ever so in holding regular monthly meetings. In fact, they were not apprised properly about the importance of organizing regular formal meetings of the CGs. Minutes of the last meeting was recorded by the HA, and its copy was sent to the UHFPO. It was revealed from the discussion that there were some areas from where people had not come to visit the CC. Representatives of these areas can be co-opted in the CG to promote the use of CC by the residents of those areas. Their needs could also be addressed better through such representation.

Maintenance

It was observed that the CG took various steps to maintain the CCs. In Chalisia, the CG appointed a cleaner to maintain the cleanliness of the clinic and its toilet and premises. The President of CG gives Tk 50 per month as her salary from his own pocket. The CG also ensures security of the clinic. Although the CG did not appoint any security guard, the neighbours, including neighbouring CG members, sincerely watched and safeguarded the clinic. There were three sets of keys--two were kept with the two CC providers and one with a CG member who lived close to the clinic. Every morning, the cleaner took the key from the group member, cleaned the clinic, returned the key to the member after her job was finished. Till date, the clinic building did not require any repairing, but the tubewell of the clinic was not functioning properly. The CG members tried to re-fix it, and planned to take up the issue with the UP and the Upazila Engineer.

In Dhum, the CG appointed an Aya who worked full time during the clinic hours, and was paid Tk 600 per month by an influential community leader. The security guard of the residence of the community leader also took care of security of the CC. There were three sets of keys of the clinic--two were kept with the providers and one with the security guard.

Community financing and referral mechanism

It was apparent that the community needed a fund for the clinic. In both the places, the CG felt that the community could take subscriptions from the catchment population or donations from the well-to-do families to develop the fund. The CG could also request NGO or the UP to fund the reasonably high-cost items. The Vice-President and Treasurer should also be selected from the CG, hopefully, in the next meeting. It was discussed that, after a fund was generated, a mechanism for supporting transportation/compliance of the referral of critical clients from the clinic to the higher level could be developed.

Although the CG would create a fund for effective functioning of the clinic, according to the corresponding guidelines of CCs, no such fund was created in either of the places. It was discussed that CG members would take the responsibility of creating a contributory fund, and decided to open a joint bank account soon. In both the places, the CG members were unwilling to charge any fees to clients. The CG decided to deliberate on issues relating to effective referral mechanisms and their compliance, with special emphasis on the poor.

Promotional activities

Many people of Bedvita village of Chalisia were still not aware of CC activities. If the CG participates actively on promotional activities, it would definitely have a stronger impact on the rural population. School children could be informed about the services provided at the clinic by the group. This would help the children influence their parents to receive services from the clinic.

The discussion in Dhum pointed out that much more is needed to be done by the local community and the UP to promote the clinic further, particularly in areas relatively far from the clinic.

Problems faced and suggestions for future

The shortage of medicines was the major problem in effective functioning of the CCs in both the areas. The CG expected that the Government would resolve the problem. Since the people of Bedvita, Doomurtola and Andha of Chalisia seldom avail the CC services, it was suggested to co-opt members from these three villages into the CG. The people of these villages would, then, feel more motivated to use the CC services.

Opinion of Key Informants on Community Clinic and Community Group

Fifty-four key informants of Abhoynagar and 52 of Mirsarai were interviewed to know the community perspectives and insights regarding the CCs and the CG. Results of the interviews are provided in Annexure 7. The key informants were chosen from the agricultural sector, business sector, and other professional sectors of both the areas. Information from senior citizens of the community was also collected. Of the key informants, 28% were female in Abhoynagar and 6% were female in Mirsarai. The age of key informants varied from less than 20 to more than 49 years. The majority of the informants in both the areas received at least primary education.

Of the key informants, 98% in Abhoynagar were aware of the CC. In Mirsarai, all the informants were aware of the CC, and they reported that the local people were being benefited from the CC services, whereas in Abhoynagar only 52% of the respondents shared similar views. The interviewers in Abhoynagar emphasized on the importance and need for more promotional activities. Thirty-seven percent and 73% of the respondents of Abhoynagar and Mirsarai respectively were aware of the availability of immunization services at the CCs. Twenty-five percent and 49%, respectively, in Abhoynagar and Mirsarai were aware of family-planning services provided from the CCs. In Abhoynagar, 36% were aware of the availability of general health services in the CC, whereas in Mirsarai, 71% knew about these. Fifty percent of the informants were aware of the CG in Abhoynagar and 42% in Mirsarai. Of them, 48% in Abhoynagar expressed that the CG has been effectively functioning the clinic. In Mirsarai, 36% thought that CG has been effectively managing the clinic. Eighty-nine percent in Abhoynagar and 55% in Mirsarai believed that participation of the CGs in the organizing and overseeing the CC activities benefited the community.

Views of Supervisors and Managers

Personnel management

Both HA and the FWA deployed in the Chalisia CC were supervised jointly by the AHI and the FPI of the union without any problems. The HA and FWA were not properly accustomed to handle all medical equipment of the CC. The need for their further training to effectively provide ESP services from the CCs, thus, came out as a critical concern.

Although the service providers of the Dhum CC received a 21-day ESP training, there were still some gaps in applying the acquired skills properly. It was assumed that it would take some more time for the service providers to be confident in implementing the knowledge learnt from the training. During supervision, the health managers should discuss the appropriate procedures about treating clients. This would improve the knowledge of service providers and its translation into practice.

Supply of medicines and other logistics

Medicines were not supplied reportedly from the Central Drug Store or the MOHFW to the Upazila Managers for the CC. The local managers initiated service-delivery in the CC with a limited supply from the allotted stock of UHC, the quantity of which was not enough to meet the needs of clients. The local authority tried to provide necessary supplies for the CC. Most informants identified the shortage of medicines as a major problem of the CC. Equipment for the CC were not supplied from the MOHFW, and the local upazila managers supplied only limited items on an ad-hoc basis from the local store. People who resided outside the catchment area of the CC also came for services making the drug situation even more acute at the Dhum CC.

Supervision and monitoring of clinic

The supervisors of Abhoynagar visited the CC, but they did not follow any guideline or checklist, since no such checklist was provided to them. They were oriented with the prescribed checklist on supervision of CC given in the manual on functioning and operation of CCs during the training, and were advised to follow the checklist while supervising the clinic. The supervisors reported that they initially faced some territorial constraints during supervision as everyone was at the primary stage of integration. The situation seemed to be improving day by day.

In Mirsarai, it was found that the AHI supervised the HA and the FPI supervised the FWA while visiting the clinic during their field supervision. The supervisors reported that they did not find any problem regarding supervision in such an arrangement. They, however, felt that they could improve the quality of their supervision further following the prescribed checklists, which they were not doing currently. It was observed that the CG members did not organize the monthly meetings regularly. The managers and supervisors preferred to receive a copy of the notice and the minutes of CG meetings.

Outreach management

Of the 5 outreach sites (combined SC+EPI sites) of the Chalisia CC area, 3 were withdrawn during the first phase of transition from the outreach-based service-delivery to a CC-based system. The remaining 2 would be phased out from May 2001. The participants mentioned that there was no change in the coverage of EPI. But the family-planning supervisors apprehended that the CPR might have decreased since the drop-out rate of registered eligible couples (ELCOs) increased with regard to receiving family-planning services from the CC. The use-rate of injectables remained almost the same, and so was the use of oral pills.

Of the 8 outreach centres (SC and EPI sites) of the Dhum CC area, 5 were withdrawn during the first phase of transition from outreach-based service-delivery to a CC-based system. The remaining 3 would be phased out soon. The participants mentioned that they did not think that the change had an adverse effect on the coverage of EPI. They also did not acknowledge any decline in the CPR that might occur due to drop-outs of ELCOs receiving services from the CC providers. They opined that they might take some more time to properly understand the trends of family-planning use. The use-rate of injectables and oral pills also remained almost the same.

Limited home-visit

Both FWA and HA made limited home-visits but for different services as was practised previously, FWA mainly for family-planning and some MCH services, and HA for EPI and selected health components. It was not possible for the FWA alone to track the drop-outs of family-planning methods among the CC catchment ELCOs or similarly for the HAs to ascertain and address the drop-outs cases of EPI among the catchment children through limited home-visits. It was suggested that both FWA and HA could work together in this respect through a joint workplan which was missing. The field-level supervisors could contribute in this process by supporting the providers to develop such a plan. In each follow-up day, every worker may visit a certain number of households, as deems feasible by the worker, and check their family-planning, EPI and other selected status. Thus, the entire area could be covered in a round of 3-4 months. The service providers emphasized the need for motivating the parents, who do not come to CC for the EPI services, through limited home-visits.

Management Information System

The UMIS introduced recently was practised for record-keeping and reporting the performance of CCs. It was identified that there was no column for 'Remarks' in the UMIS form, which limited the CC providers and supervisors to record and report any additional observations. The upazila managers developed a separate form to identify the family-planning drop-outs of ELCOs from the CCs, in addition to what has been introduced in the UMIS. To what extent the forms were useful needs further observation.

Participation of the community and involvement of Union Parishad

It was felt that a lot had still to be done on the issue of community participation. The CG did not function as much proactively as it was required to effect a substantive community participation in the organization and operation of the CC. The UP Chairman did not take adequate interest in CC-related activities. Both UP and CG need to be motivated further in this regard. The HA, FWA, and union-level supervisors should keep more contact with the CG. It was reported that the field-level supervisors and union and upazila-level managers may take turn to attend as observers in monthly meetings of the CG. The supervisors and managers opined that minutes of regular monthly meetings of the CG should be copied to the UP Chairman, which may encourage highly to participate in CC activities. Some CG members showed lack of interest in the CC activities. The supervisors and managers should maintain more contacts with them to make them more proactive.

Promotional activity

People of some areas did not visit the Chalisia CC, probably due to lack of appropriate promotional activities in those catchment areas. It was suggested that inclusion of representatives of those areas as members of the CG could mobilize people of those areas to receive services from the respective CC.

Disposal of waste

There was no proper guideline on safe management of wastes. In the Chalisia CC, some wastes were deposited in a covered, which were taken to the UHFWC, and were burnt there. Some wastes were also buried in the backyard of the CC. The providers at the Dhum were digging all the CC wastes by themselves in the backyard of the clinic premise. The issue of waste disposal needs further attention to establish a systematic waste-disposal system.

Quality of care

Interaction between the providers and the clients were not up to the mark, and needs to be improved to ensure better quality of services. The supervisors and also the CG members should take more interest in facilitating proper compliance of treatment regimens by the service providers.

Impact of the Reorganized System

Impact of the CC-based one-stop delivery of services was assessed in relation to two aspects of the changeover:

- Effects of the phasing-out of the existing outreach sites (about the new service-delivery arrangements) on use of services and perceptions in the community, and
- Effects of the transition on selected ESP indicators.

The specific indicators measured are shown in Table 2.

Effect of Phasing-out of Outreach Sites (after withdrawal)

Interviews of women were conducted through household surveys in the outreach sites, namely the EPI spots and SCs, which have already been phased out as part of the transition plan. Thirty households were included for each phased-out outreach sites in the survey with the criteria that every third household is interviewed for. Annexure 8 describes in detail the findings of the interviews.

Seventy-six percent of the respondents in Abhoynagar used the CC as the present source of services. In Mirsarai, 51% used it as the new source of services. They also mentioned about use of UHC and UHFWC. Of those who used to take services from the SC of their locality, 79% and 68% visited the CCs in Abhoynagar and Mirsarai respectively for services. Travelling outside the home and communication to the CCs were perceived as the major problem by the interviewees in seeking services from the CCs (46% in Abhoynagar and 53% in Mirsarai). The availability of services at the CCs on all working days was mentioned by the respondents as one of the major advantages as against the outreach sites, which were organized once in a month.

Effect of Plan for Phasing-out of Outreach Sites (before withdrawal)

Interviews of women were conducted through household surveys around the outreach sites, which were still functional during the evaluation, but were planned to be phased out soon. Thirty households were included for each outreach site in the survey with the criteria that every third household is interviewed on their perception in this regard. The findings of these interviews have been provided in detail in Annexure 9.

It was observed that about 71% of the respondents were aware of withdrawal of the outreach sites in Abhoynagar. In Mirsarai, only 9% knew that the SC/EPI sites would soon be withdrawn. Of those who knew about the phasing-out plan, 98% in Abhoynagar believed that the CC would be a potential source of services after phasing-out of the outreach sites. Awareness of the CC was almost universal in Abhoynagar, whereas it was 70% in Mirsarai. Eighty-eight percent of the respondents in Abhoynagar were also aware of the services that would be available from the CC. In Mirsarai, 29% of the women could correctly mention the services that would be available from the CCs.

The respondents also shared their perceptions on the advantages and disadvantages of receiving services from the CCs. Twenty-four percent in Abhoynagar mentioned that service provision from CC on a daily basis would be something very useful to the local community. In Mirsarai, 20% expected that medicines would be more easily available in the CCs. Communication to the CCs was identified as the major problem in both Abhoynagar and Mirsarai.

Effect on Selected ESP Indicators

Effects of the transition (i.e., phasing-out of the outreach sites and initiation of CC-based service-delivery system) on selected critical ESP indicators were assessed using ORP surveillance data for the corresponding study sites. The CPR with method-mix and source of supply, and EPI coverage with source of vaccines were considered as the key indicators. Accordingly, relevant surveillance data for all the four quarters of 2000 and the first quarterly round of 2001 were analysed for the sample households within the 4 CC catchment areas at each study site. The criteria for selecting four different CC catchment areas for the 2 study areas are described in Table 5.

Table 5. CC catchment areas with selective criteria

Upazila	Union	CC catch-ment area	Criteria for selection
Abhoynagar	Chalisia	Chalisia	- The CC-based service-delivery system was in operation since June 2000 - All the outreach sites were merged (SC+EPI) as part of an earlier operations research (OR) intervention of the MCH-FP Extension Project on alternative service-delivery strategies - Performance of the union was historically high
	Sreedharpur	Deapara	- A potential CC area but no CC-based service-delivery system was in operation - No intervention on alternative service-delivery strategies was even tested in this site by the MCH-FP Extension Project - Performance of the union was historically good.
	Siddhipasha	Dhulgram	- A potential CC area but no CC-based service-delivery system was in operation - No intervention on alternative service-delivery strategies was even tested in this site by the MCH-FP Extension Project - Performance of the union was historically low

Table 4. (*contd*.)

Table 4. (*contd*.)

Upazila	Union	CC catch-ment area	Criteria for selection
Keshobpur*	Bidyananda-kati	Hasanpur	▪ A potential CC area but no CC-based service-delivery system was in operation ▪ Performance of the union was average
Mirsarai	Dhum	Dhum	▪ The CC-based service-delivery system was in operation since June 2000 ▪ Performance of the union was historically good
	Myani	Purbo Myani	▪ A potential CC area but no CC-based service-delivery system was in operation ▪ No intervention on alternative service-delivery strategies was even tested in this site by the MCH-FP Extension Project ▪ Performance of the union was historically good
	Haitkandi	Haitkandi	▪ A potential CC area but no CC-based service-delivery system was in operation ▪ No intervention on alternative service-delivery strategies was even tested in this site by the MCH-FP Extension Project ▪ Performance of the union was historically average
Satkania**	Eochia	Gatiadanga	▪ A potential CC area but no CC-based service-delivery system was in operation ▪ Performance of the union was historically low

* The comparison area for the ORP interventions in Abhoynagar
** The comparison area for the ORP interventions in Mirsarai

Trends in contraceptive use

The corresponding findings have been provided in details in Annexure 10A and 10B. It is evident that the CPR varied from 53% to 67% in 3 CC catchment areas in 3 intervention unions of Abhoynagar upazila throughout the study period, i.e. from January-March 2000 to January-March 2001. In the CC catchment area of Keshobpur upazila (comparison area), it ranged from 50% to 53% during the study period. Figure 3 and 4 suggest that the CPR remained almost the same in all the CC catchment areas

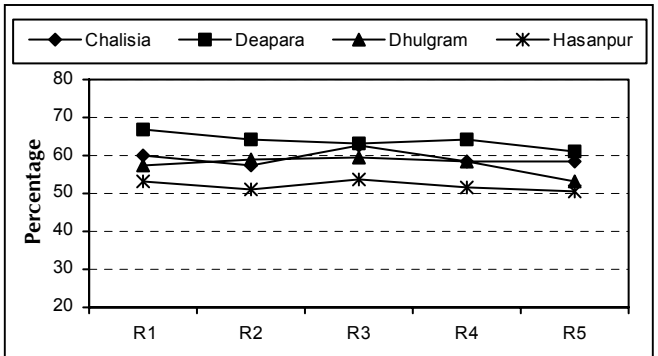

Fig 3. Contraceptive prevalence in different CC catchment areas of Abhoynagar

of the intervention unions, and was noticeably higher than that in the CC catchment areas of the comparison unions. A slight decline was noted in the Dhulgram CC area of Siddhipasha union of Abhoyngar upazila, which may not be attributable to the new approach as the CC of that area was yet to be constructed and functional. In Mirsarai, a negligible decline was also noted for the Dhum CC area of Dhum union where a CC was functional since November 2000. It was difficult to explain whether it was an artifact due to the methodology or an actual fall of coverage, since a rise was also noted in the third quarter surveillance round (July-September) of year 2000.

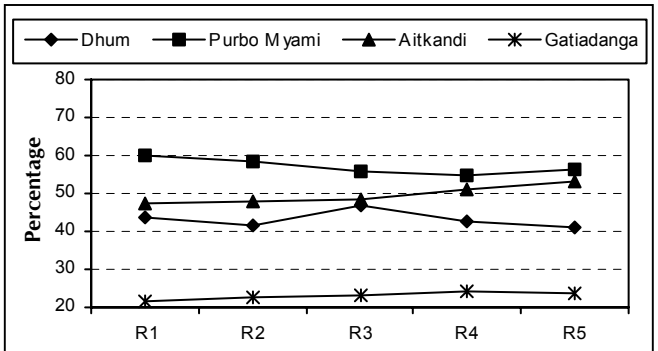

Fig 4. Contraceptive prevalence in different CC catchment areas of Mirsarai

Method-mix

In the method-mix, a nominal shift was observed with a proportional rise of non-clinical temporary methods over clinical temporary methods in recent times in the CC catchment areas of Abhoynagar, except in Dhulgram of Siddhipasha union, where a reverse trend, very little though, was observed. The comparison CC area (Hasanpur of Keshobpur upazila) did not show any such pattern in contraceptive method-mix. The proportion of use of permanent methods was also marginally declined in Chalisia and Dhulgram, but not in Deapara and Hasanpur. No change in method-mix was observed in the selected CC catchment areas of Mirsarai upazila. A proportional increase in clinical temporary methods and a decrease in non-clinical temporary methods were observed in the comparison area (Gatiadanga CC catchment area of Eochia union of Satkania upazila). The proportion of use of permanent methods remained same in the CC areas of the intervention upazila, while it was slightly lower in the CC area of the comparison upazila of Mirsarai. The findings suggest that there was no major change in the family-planning method-mix, except a marginal rise in the use of non-clinical temporary methods over clinical temporary methods in some areas.

R1:Round 1 – January-March 2000
R2:Round 2 – April-June 2000
R3:Round 3 – July-September 2000
R4:Round 4 – October-December 2000
R5:Round 5 – January-March 2001

Source of methods

Results of the last round (January-March 2001) of data showed that the CC supplied 25% of contraceptive methods in Chalisia of Abhoynagar since July 2000, i.e., after the inception of service-delivery at the CC. In Mirsarai upazila, the Dhum CC, was cited as a source of contraceptive supply by 8% of the household respondents.

Coverage of EPI

The coverage of EPI in the selected CC catchment areas is shown in the tables annexed as 11A-11B (1-8). Overall, high immunization coverage with a marginal increase in trend was observed in all selected areas, except in Gatiadanga of Satkania and Purbo Mayani of Mirsarai areas. More than 90% of the children were fully immunized by 12 months in Chalisia and Deapara of Abhoynagar upazila during July 2000-March 2001. This rate was about 60% in other areas throughout the 5 quarters analyzed. In Gatiadanga and Purbo Mayani, traditionally known as low-performing areas, the rate of fully immunized children varied from 25% to 72%. In both the areas, the trend showed a declining pattern with sudden fall in coverage in Gatiadanga during last two quarters.

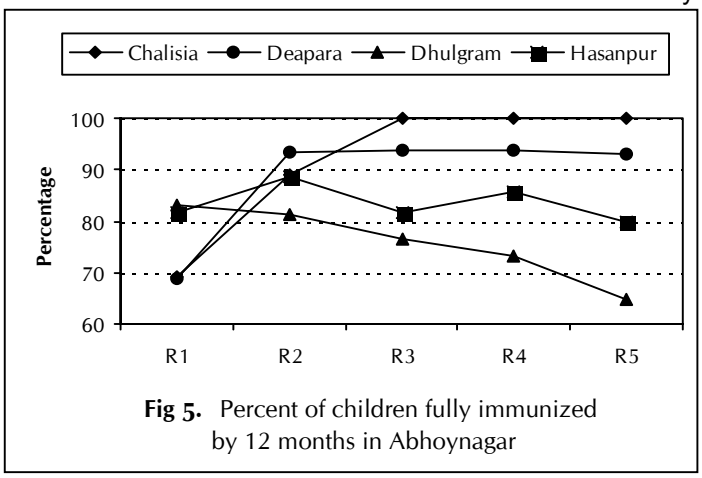

Fig 5. Percent of children fully immunized by 12 months in Abhoynagar

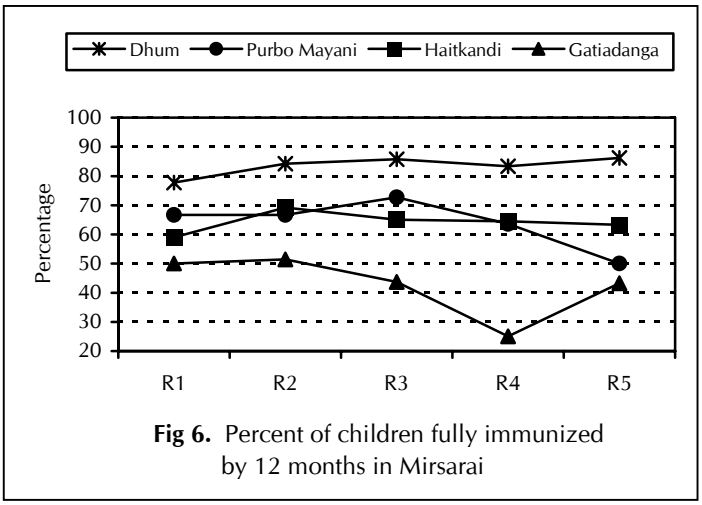

Fig 6. Percent of children fully immunized by 12 months in Mirsarai

The coverage of BCG, DPT1-OPV1, DPT2-OPV2, DPT3-OPV3 and Measles-OPV4 was 80-100% in all areas, except in Gatiadanga and Purbo Mayani, throughout the 5 quarters of reports. A decline in coverage in Purbo Mayani in all individual antigens was observed in the first quarter of 2001. In Gatiadanga, the trend showed a gradual decline in all antigenic coverage throughout the period of analysis with a certain fall in the coverage of Measles-OPV4 in the last quarter of 2000.

Discussion

Over the past two decades, the domiciliary and outreach-based delivery of health and family-planning services has been in practice as the main strategy of primary healthcare and is widely recognized as a key factor for success of the Bangladesh Programme [2]. At the time of study, a huge number of field workers--23,500 FWAs and 21,500 HAs (currently 19,500 and 16,500 are actually in place)--provided these services within the government programme, and another 12,000 in the non-government programmes. These workers were employed in counselling, motivating, and providing basic health and family-planning services and health education. These field workers were supposed to visit routinely--FWA once every two months, and HA once every month--the households and the eligible couples within the specified catchment area.

In recent years, this approach has been facing several challenges. First, because of the increasing numbers of women in the reproductive age group, the family-planning coverage will have to expand from 27 million couples in 1995 to 40 million in 2005. Second, during the same period, the number of contraceptive users will have to be increased from 12 million to 28 million, if the national goal of replacement-level fertility is to be achieved by 2005 [3].

In addition, the programme depends heavily on donor contributions, which cover 63% of the total cost [4]. Salaries of fieldworkers account for approximately 60-65% of these costs [5]. With donor funding expected to level off or be reduced, it would become increasingly difficult for the programme to support enough staff to maintain the current level of client visitation by the fieldworkers [6]. Moreover, according to the demographic and health surveys conducted in 1993-94 and 1996-97, the majority of fecund women (around 3 in 5) in Bangladesh report having had no contact with a fieldworker during the preceding 6 months [7,8].

Given these circumstances, it is necessary for the national programme to shift its emphasis to a static site or clinic-based approach for provision services. The Government of Bangladesh and its principal donors all endorsed the programme of action of the International Conference on Population and Development in Cairo in 1994. This plan calls for providing a broader range of reproductive health services within a framework that supports overall economic advancement of women. This requires an increased emphasis on fixed-site facilities and clinics, which is, thus, justified to address in the HPSP of the MOHFW of Bangladesh.

Considering the importance of reform in service-delivery strategy, the Operations Research Project of ICDDR,B has been experimenting on alternative service-delivery strategies in both rural and urban areas for last few years. The main goal of operations research on alternative service-delivery strategies was to develop less-costly systems based on provision of services from static facilities. It was intended that this would result in the higher use of essential health and family-planning services by the rural and urban population of the country [9].

Several interventions on alternative service-delivery strategies were carried out in the rural areas. These interventions basically tested the effects of site-based service-delivery replacing the home-based service-delivery approach. The ORP intervention on merging of SCs and EPI outreach sites, cluster visitation approach instead of home-visit approach, and expanded service centre approach to incorporate broader range of services were evolutionary in the line of developing strategies for alternative service-delivery.

These interventions, along with some other research on alternative service-delivery strategies conducted by different organizations, e.g., GTZ, contributed significantly to developing, particularly the design of, CCs in the HPSP of MOHFW. The present study, as stated in the objective, has already contributed to fine-tune the programme, and blow up further the design of the static centre-based service-delivery system in the rural areas of the country.

While evaluating the present intervention, our focus was to examine the extent to which we were able to find out answers to the evaluation questions of programmatic relevance. In this connection, we tried to limit our discussion on those questions only.

Q1. Are the desired numbers of Community Clinics functioning in the study area?

The CCs are being established (i.e., constructed and operationalized) in at least two different phases. About half of them were supposed to be established by December 2000. In reality, this did not happen as such. In May 2001, only 7 of the total 34 CCs planned were functioning at Abhoynagar and only 2 of the total 62 CCs planned were functional at Mirsarai. The situation is quite frustrating despite the facilitation efforts continued by the research support staff throughout the intervention period. Multiple factors are responsible for not being able to operationalize the desired number of CCs. Although it was generally assumed initially that the construction work would not take much time, it was observed that the construction of CC buildings was even delayed, particularly in Mirsarai. Lack of appropriate coordination between the construction-implementing agency, health and family-planning managers, construction contractor, and the community members at the upazila and local levels was one of the important

factors for the failure. The compliance of the construction contractor and even the construction-implementing agency, in some cases, to the MOHFW guidelines was lacking, resulting in loss of interest by the Upazila H&FP Managers in accelerating the job. There was not enough persuasion from the supervisory level (district and division) at the initial stages, as the supervisory officials were not appropriately and formally involved in the establishment process of CCs, including monitoring of construction. The CG were passively involved in monitoring the timeliness and quality of construction work, although they have been authorized to oversee these activities by a government circular. One possible reason is that the construction contractors were influential persons (either politically or socially) of the locality or area, and the rural community members were not comfortable to exert their authority over them. There were some objective barriers as well, e.g., non-availability of construction workers during the harvesting season, poor road communication to carry construction materials to the CC site, excessive rains and flooding, etc., that hindered the construction work. Establishment and operationalization of the CCs as per the plans, thus, depend on a complex interaction between the concerned government agencies and non-government functionaries. These activities were seemingly better in terms of timeliness and quality of work in places where the coordination and cooperation between and among the related bodies were more regular and functional despite the above problems.

Q2. How are the service-delivery systems organized in the functioning CCs?

Results of the assessment indicate that the service-delivery systems at these CCs were more or less organized as instructed in the government guidelines on operation, management, and functioning of CCs. By and large, a satisfactory participation of the community, though not very proactive, has been achieved in the management of CCs. Some facilitation, as was provided in the study sites by ICDDR,B research team, is critical to the proper functioning of the CCs. Such facilitation may include activities, such as orientation of stakeholders on the new approach, organization of meetings with the community representatives and service providers and managers to decide on site selection of CCs and review the construction work, and time-to-time monitoring and stocktaking of the implementation process. It was felt that more of such facilitation might be needed for some more time to work out better mechanisms of limited home-visits so that these visits can effectively be linked to CC-based service-delivery.

It appeared that, with a proper transition plan in place, the previous EPI outreach sites and the satellite clinics can be gradually withdrawn without affecting service provision, and the clients can be motivated to make better use of the services provided from the CCs. However, community participation in developing and implementing the transition plan is highly important.

It was also observed that the CC providers could effectively handle the recording and reporting mechanisms suggested in the UMIS. Support of the supervisors is needed to overcome the initial confusions in this regard. However, the reporting formats used on ad-hoc basis at the CCs that are not a part of UMIS must be replaced by the UMIS tools within the shortest possible time.

The statistics on service-delivery suggest that the two CCs functioning in Abhoynagar and Mirsarai for 6 months or more provided services to a fairly good number of clients per month. As expected, the women of reproductive age were the major recipients of service from the CCs, followed by children aged less than 5 years. Immunization of children was the major service sought from the CCs, followed by ARI and diarrhoea. The number of mothers attending the CC for ANC and PNC visits was notably higher in Abhoynagar than in Mirsarai. However, it is also encouraging that adolescents (about one tenth of all the clients) also attended the CCs for services. With the promotion of adolescent health programme, this number should increase further in the future. However, attendance of males was pretty low, indicating that the CCs were perceived in the community for women only. It was observed that the providers of the CCs generally referred the complicated cases to the UHCs, which implies that the CC providers did not consider the union-level H&FWCs to be efficient and effective to deal with such clients.

Q3. Are the clinics supervised appropriately?

The experience of health and family-planning programmes in Bangladesh suggests that proper supervision of clinic activities is a major problem in sustaining programme performance. This as well holds true for the CCs. Since the CCs are supposed to be run through a participatory management of the government and the community, it is expected that both government supervisors and CGs would take interest in effective supervision of CCs. Supervision of CCs is included as one of the job responsibilities of the government supervisors and the CG members. A checklist was developed as the guideline to facilitate proper supervision of CCs by the health and family-planning supervisors. It was observed that, although some supervisory visits were made occasionally to the CCs, the supervisors never followed the checklist, and as a result, the supervision did not prove to be effective and supportive in a true sense. However, some management issues were resolved through the supervision of the upazila managers. The union-level supervisors (AHI and FPI) were not technically equipped to provide supportive supervision for clinic-based service-delivery, and moreover, the FPI

was not comfortable to supervise the HA and similarly the AHI to supervise the FWA. The FWV visited the CCs for delivering services on specific days, and was practically unable to perform the role of a supervisor for the clinic-based services rendered by the CC providers. One of the main reasons was the increased client load that the FWV had to handle on her visit-day, and another reason was that she was more accustomed to consider herself as a clinical provider rather than as a supervisor, as she essentially did not perform as a supervisor in the past. Although the CGs have been supervising the CCs to the extent possible for them, they are yet to understand the specific supervisory responsibilities that they need to extend. However, whatever supervision the CGs provided resulted in good support for the providers to run the clinic effectively. The supervisory potentials of the CGs, thus, need to be explored further, and a guideline in this regard needs to be worked out.

Q4. What is the quality of service-delivery in functioning clinics?

In a clinic-based service-delivery system, the quality of care is mostly dependent on proper adherence to the technical aspects of service provision by providers. It was observed that, particularly in the assessment (history-taking and examination) and management of ARI, diarrhoea, and limited curative care, the quality was not that much satisfactory. However, the promotional aspect of management (e.g., preparation and use of ORS, messages on home management) of these conditions was generally satisfactory. For family-planning services, the clients were not properly assessed to screen out the adverse physical conditions, and necessary advices were not appropriately given. The aseptic measures were, by and large, properly followed for administering injectables. The immunization session, when organized, was-organized well, aseptic measures were followed, and appropriate records were maintained. The standard of health education and counselling was not up to the mark in terms of appropriate communication efficacy. Although a number of topics were mentioned by the providers as discussed in the CC sessions, very little was followed in reality while providing services. The service providers generally greeted the clients well, and were able to build an effective rapport with them pretty quickly, since these providers were much familiar with the clients of those areas. This helped them to earn clients' satisfaction despite the inadequacies in meeting the technical standards of services provider. The quality of service provision may be improved further with successive training and refresher courses for the providers, once the entire ESP delivery system is in place. It is also important to improve and enhance the technical supervision to support the desired quality of care of the CC-based service-delivery system.

Q5. Are the providers trained enough to perform the job at the CC?

Knowledge of providers is an important component to ensure quality of services. As part of the quality-improvement strategy, a 3-day training was provided to all the providers and supervisors to start up service-delivery at the CCs. All the providers (HAs and FWAs), except the HA of the Chalisia CC, also underwent a 21-day ESP training

organized by the government. Besides, in the past, they also received training and orientation on many components of the ESP. Despite this, they were, in general, not very conversant with some basic issues covered in these training programmes. They had satisfactory knowledge only of those activities that they routinely dispense. This is, however, not the case for all. For example, the FWA and FWV of Dhum CC failed to respond properly on issues relating to family planning and basic maternal and child healthcare. All the providers were also quite aged, except the HA of Dhum CC, which may also pose some difficulty in retaining the needed knowledge on the ESP issues. In general, the present knowledge of the providers may be considered enough as a community-based worker but not sufficient as a clinic provider, with necessary knowledge on clinical aspects of the ESP. Refresher courses should, therefore, be conducted for the existing providers. In future, the recruitment criteria of providers should emphasize on the technical quality and knowledge of applicants.

Q6. What do the clients know about the CC? Are they satisfied with the services available?

The clients attending the CC had fairly adequate knowledge about the CCs. They received these information mostly from the service providers. They had less interaction with the CG members about the CC, which may be considered a weakness of the CG. Most components of the ESP which are to be made available from the CCs were known to the clients. However, there were some lackings with regard to PNC and some limited curative services that will be provided at the CCs. Overall, the clients were satisfied with different aspects of CCs and the service providers. The location of the CCs within the vicinity of their houses encouraged them to attend the facility. The suggestions of clients on continuing increased supply of medicines, provision of electric fan and light, and arrangement of visits of qualified doctors to the CCs on specified days need to be duly considered in the future.

Q7. How are the Community Groups performing in managing the CCs?

The performance of the CG varied in places. While the CG was relatively more active and functional at the Chalisia CC, the community contribution was observed to be much more at Dhum CC. In both places, the CGs were not very proactive in performing their routine responsibilities. Monthly meetings were not organized regularly, and were held only if facilitated by others. In Abhoynagar, although the CG performed some responsibilities, e.g., ensuring cleanliness and security, and some promotional activities, they are yet to properly appreciate the idea that the CG is the co-owner and joint-manager of the CC also with the government.

The CGs were still completely unaware of the mechanisms of raising fund locally needed for maintenance and development of the CCs. The CGs are also yet to understand the need for developing an appropriate referral support mechanism. The current status of performance of the CGs suggests that there still remains external facilitation needs to enable the CGs understand and play their designated roles and perform the responsibilities vested in them. The UPs need to be instructed by the Ministry of Local Government, Rural Development and Cooperative (MOLGRD&C) to share greater responsibility in the organization and management of CCs to properly reflect the community perspectives in the CC-based service-delivery approach.

Q8. What do the community people think about the CCs and the CG?

Overall, the key informants were aware of the CCs, and believed that the new service-delivery arrangements were beneficial to the community. The informants were not, however, aware of the full list of services available at the CCs, but they had better knowledge on EPI, family planning, and general health services for mothers and children. The CCs were attended mostly by the females. Since the majority of key informants were males, their knowledge on the availability of specific services at the CCs was not very clear. Although the awareness in the community of the CCs was high, the clients from distant parts of the catchment areas still did not visit the CCs. Non-involvement and non-representation of community members in the CGs from those distant parts of the catchment areas may be a factor in the lacking of appropriate and effective promotional initiatives to motivate people of those areas visiting the CCs. The relatively longer walking distance could also be another possible factor for this.

It appeared that the CGs did not undertake enough organized efforts to promote the CCs as suggested in the guidelines on the CCs, nor were they enough proactive to monitor their use by the local people. This was evident when over half of the respondents expressed their ignorance about the existence of CGs. Practical efforts are needed to make the CGs effective and active to develop and sustain the CCs as a functional partnership between government and the local community. The respondents felt that such a partnership is possible to evolve and should benefit the community at large.

Q9. What are the views and perceptions of the health managers and field supervisors on management of CCs?

Discussions with the concerned managers and supervisors revealed that they were gradually getting accustomed to the new management aspects of the reorganized service-delivery system. Integration of functional responsibilities was gradually taking place, although there still exists some territorial constraints in the supervision of staff. They reported that proper and adequate supply of medicines and equipment was the major problem in the operation of CCs. However, as initial steps they had arranged

supply of medicines for the two CCs from the upazila store, which would not be possible to do once all other CCs are set up and need to be made operational. The ESP managers at the central level should address the issue of drugs very urgently, else it should impede needed service-delivery from the CCs and create unwanted negative impact among the users from the very initiation of these new facilities.

Although agreed in principle to the concept of gradual phasing-out of the outreach sites and the old practice of routine home-visits, the supervisors and managers were hesitant and unclear about the plausible consequences of the change on contraceptive prevalence in the community. A mechanism for addressing the specific family-planning and EPI service needs during limited home-visits and a feasible strategy for periodically monitoring the CPR and EPI coverage within the CC-based service-delivery system were emphasized.

It appeared that the local supervisors and managers were still not comfortable with the UMIS developed for supporting the delivery of ESP. Although they expressed interests to work in partnership with the CG and facilitate community participation, they were not adequately motivated and open to such collaboration. More time is possibly needed to implement this partnership effectively and to make this concept reasonably acceptable to the health managers and supervisors.

Q10. What are the effects of the shift from home- and outreach-based service-delivery to a CC-based system on the use of selected key services?

As part of the transition towards the CC-based approach, the former EPI outreach sites and the Satellite Clinics are gradually being phased out in the study area in a planned way. Some outreach centres have already been phased out at the time of this evaluation, and the remaining ones were in the process of being withdrawn. This change did not have any apparent adverse effect on the use of services by the community since most mothers, who previously used to receive services from the Satellite Clinics of their locality, were receiving services presently from the CC. Unlike the Satellite Clinic and EPI spots that were arranged on specified day of a month/week, the availability of services at the CCs on all working days of a week attracted them towards the CC. Also, the fact that, unlike the outreach sites, the CC is not in the premise of anyone's house, and therefore, better privacy could be ensured there while providing service. Awareness on the availability of services at the CCs, though satisfactory, varied among the respondents. Distance of the CC from the homes of clients was identified as a potential factor in using the CC.

Q11. Was there any change in status of major critical indicators (CPR, family-planning method use, and EPI coverage) due to transition of service-delivery (i.e., gradual shift from home- and outreach-based to a CC-based system)?

Contraceptive prevalence

The CPR and the immunization coverage are the two most critical indicators for the Bangladesh health and family-planning programme, as reduction in fertility and infant mortality are considered objectives of high importance. An apprehension about decrease in the coverage of these two indicators commonly prevailed among the service managers and supervisors. Relevant data from the specific CC catchment areas generated by the Project's longitudinal surveillance system, however, do not confirm this notion. There has been no significant decrease in the CPR and method-mix in areas where a CC was functioning compared to the areas where the old service-delivery strategy was still in operation. The CCs have gradually started to be popularly used as the source of family-planning methods for the local community. Nevertheless, it may be too early to conclusively comment that the reorganized delivery strategy produced no adverse effects on the use and method-mix of family-planning services. There is a critical need to follow-up these trends for a longer period to assess the actual and relatively long-term consequences of the CC-based service-delivery approach.

Immunization coverage

The results on immunization coverage showed some increase over time in all the high-performing areas under evaluation. The CC-based approach did not have any adverse effects neither on the overall immunization completion rate nor on the individual antigenic coverage. This arguably indicates to historically high performance and unlikeness of decrease in the EPI coverage in the study areas. However, the slight decline in the EPI coverage at Gatiadanga and Purbo Mayani might be attributed to low-performing history of these two areas. Based on such short-period follow-up in these two areas, it is, probably, hard to conclude that the decrease occurred as a result of the change in the service-delivery approach. More so, because no CG yet started functioning in these two areas, implying, in fact, no change or transition to CC-based service-delivery till the time of this evaluation.

Lessons Learnt

This study on the operationalization process of the CC-based service-delivery approach has yielded a number of lessons that will be useful to future implementation plans of the HPSP, especially to the changes in the health and family-planning systems at the lower (community) level. Findings of operations research on site selection, orientation needs for managers, providers, and community representatives on the new reform

programme, and facilitation guidelines to expedite the implementation process have been documented in various reports and papers (ICDDR,B special publication no.105 and 106 and working paper no. 129, 138, and 146). The lessons learnt from these earlier studies and the findings of the present analysis are presumed to provide the relevant programme managers and policy-makers with valuable information with regard to the field-level status of the implementation process of the changed service-delivery approach and help adopt the needed refinement and modifications in the corresponding policies and guidelines. The salient lessons that we have learnt from operations research are the following:

1. It is possible to implement the CC-based service-delivery strategy which is one of the core concept of the HPSP and a commended model for delivering essential health and family-planning services at the community level through a government-community partnership. However, since this suggested reform is a challenging concept and a major departure from the old service-delivery strategies, proper orientation of stakeholders on the new approach and programme is critical to its effective implementation. Without conscious and meaningful participation of the community and local-level health and family-planning personnel, it is unlikely to operationalise and sustain the CC-based service-delivery approach.

2. It is possible to establish CCs in the optimum location as suggested in the corresponding government guidelines through appropriate and effective involvement of the community at the local levels.

3. Quality of construction work of CCs would be better if the CG is motivated to actively get involved in the construction-monitoring process. Inter-sectoral coordination between and among the concerned government agencies at the local level needs to be strengthened to complete the construction work of CCs timely and in compliance of the corresponding national guidelines and instructions.

4. To make the operation of CCs efficient and effective, adequate training of the HAs and FWAs is imperative. On-the-job training/refreshers training and supportive supervision are also of high importance in this regard.

5. Although the full range of clinical quality or technical standard may not be achieved by the current providers of CCs, these facilities may, however, be made effective service-delivery points for providing essential health and family-planning services to the surrounding community people, if supervised appropriately.

6. The service providers, even with their present skills, can serve the community better if they are allowed to concentrate mostly on service-delivery at the CC and are not involved in other community-based promotional activities or special campaigns.

7. Organized efforts need to be pursued using the supervisors to make the CGs more participatory in the organization and management of CCs, and gradually turn these facilities as real examples of an effective government-community partnership initiative.

8. The supervisory staff should be made technically more skilled to provide support to the service providers of CCs. Appropriate measures need to be developed to make them more proactive and accountable to the health managers and CGs.

9. The community members welcome the CCs, although they expect higher quality or standards of services to be ensured at the community level. There is no such problem for the community people to come to the CCs for the required services.

10. With an appropriate transition plan developed in discussion with the local health and family-planning personnel and community representatives, the outreach centres (Satellite Clinics and EPI outreach sites) can be gradually withdrawn without affecting service-delivery and transforming the CCs into the main outlets for delivery of the ESP. However, such initiative should be supplemented with effective promotional activities to inform and motivate the community people to use CCs.

11. The preliminary findings showed that the new service-delivery approach and the transition towards the CC-based service-delivery strategy did not have any notable detrimental effects on the CPR among the eligible couples.

12. Similarly, the new service-delivery approach did not affect the EPI coverage in the community, neither in the overall completion of immunization shots before 12 months nor in the coverage of individual antigens.

13. Specific activities need to be taken at the community level for males to increase their attendance and to use the needed services provided from the CCs, thereby, ensuring more participation of males in healthcare seeking of households and promotion of CCs.

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Annexure 1

Brief Description of Intervention Activities for Operationalization of ESP Delivery and Community Clinics

Orientation of concerned stakeholders on ESP, new service-delivery strategy, and site selection of Community Clinics

Orientation of the upazila-level managers, union-level supervisors, and field-level service-providers, CG members, and the community leaders (UP Chairmen) on the reorganized service-delivery strategy and site selection of CCs was the initial activity of the intervention at the field sites. Concerned officials of the concerned district and divisions were also oriented on the said issues. The basic intention of the orientation was to sensitize the GoB functionaries, community leaders, and local community members on the new service-delivery system and to acquire valuable insights on the different steps of operationalization. Planning workshops were also held with the managers and providers on different aspects of selection of optimum sites for CC in the locality. The orientation helped the concerned stakeholders understand the concept of the reorganized service-delivery strategy, including the upcoming shift in the service-delivery process, and their role in participating and implementing the programme in their area. The lessons learnt from the experience of conducting orientation activities have been documented in ICDDR,B special publication no. 105.

Facilitation in site selection for Community Clinics

Selection of sites for CCs was a very crucial task of the whole intervention. The previous experience with regard to the site selection of UHFWCs suggests that the use of such centres by the community largely depends on the location of clinics. Realizing the rationale, the study team worked closely with local managers and supervisors to walk along the steps suggested by the MOHFW in selecting sites for the CCs. Problems were identified and solutions were worked out in practical situation. The experiences and lessons learnt on site selection of CCs were documented in ICDDR,B special publication no. 106. This activity contributed significantly to perform the task by the local managers and enabled the national-level managers to expedite the whole process throughout the country. Major policy reforms were made in the national programme as the lessons of site selection in the ORP field sites were adopted.

Baseline assessment of ESP indicators

Baseline measurement of the ESP indicators in the study areas was assessed through a combined baseline survey during October 1998-March 1999. The measured indicators covered all the components of ESP. The results have been reported in ICDDR,B special publication no. 147.

Development of guidelines for functioning of CCs and the CG

Participatory workshops were conducted with the service providers, field supervisors, CG members, and other community members to explore the feasible ways of functioning of CCs and the means of community involvement in the operation and management of CCs. The perspectives of providers on the issues were also addressed through individual and group discussions with the field workers, programme supervisors and managers. Based on the experience of these workshops and discussions, an operational manual (ICDDR,B working paper no. 138) for the CG was prepared, incorporating the key suggestions of formal and informal community representatives. This manual also helped the MOHFW develop a comprehensive guideline on the functioning, management, and operation of CCs.

Development of guideline on transitional plan

Six participatory workshops were organized to develop a transitional plan for shifting the existing domiciliary and outreach-based service system to the CC-based service-delivery system. The workshops were participated by the service providers, programme supervisors, and managers, including senior managers form the national level. The process and experiences in developing the plan have been documented in the ICDDR,B working paper no. 146. The report includes analysis of critical activities the local managers need to perform for implementing the transition to the new service delivery-system. The process of scale-up of the plan throughout the country by the MOHFW is underway.

Assessing BCC needs for ESP delivery in CCs

Behaviour change communication needs for CCs were assessed with an active involvement of the corresponding GoB partners. The participatory learning approach was used through workshops, held at the field sites, participated by field-level service providers, supervisors, and managers, and the BCC activities deemed necessary for promoting the CCs and ESP delivery from the CCs were identified. A report had also been prepared, with inputs from Line Director, BCC (ICDDR,B working paper no. 129) who, jointly with the ORP, initiated activities to finalize the BCC plans for CCs.

Dissemination of experiences on site selection of CCs

Three workshops were conducted as part of dissemination of lessons learnt on site selection of CCs. These were:

- Dissemination Workshop on Operationalization of Community Clinics and ESP Delivery on 31August-1 September 1999;
- Orientation Workshop for National-level Facilitators on Site Selection of Community Clinics on 25 September 1999; and
- Debriefing Workshop with National-level Facilitators on Establishment of Community Clinics on 13 November 1999.

The overall objectives of these workshops were to: (i) share experiences gained on the operationalization of CCs and site selection in particular, (ii) identify the critical operational issues, and (iii) fine-tune the implementation strategy. This chain of dissemination activity made significant policy implications for the national programme. The 2nd and 3rd activities were generated as a result of the 1st one and were conducted jointly with the MOHFW. Two separate guidelines on facilitation of site selection by the national-level task force members, and the district and upazila managers (ICDDR,B special publication no. 103 and 104) were developed jointly by the ORP and the MOHFW to help them facilitate the entire process. Details of the dissemination process has been described in the ICDDR,B special publication no. 110.

Providing training to CC providers and supervisors

To initiate service-delivery from CCs, a 3-day training was organized for the CC providers and concerned supervisors in collaboration with the local managers. The participants of the training were selected from those areas where construction of CCs was completed, and service-delivery was about to be initiated from the respective CCs. The training emphasized on the most important and critical ones as felt necessary to start service-delivery from the CCs, with the assumption that all the CC providers would be trained by the MOHFW on the ESP Training Curriculum for Field Service Providers. The start-up package of training intended to cover issues on concept of ESP and ESP delivery strategy; components of ESP at CCs; role of service providers and community group in delivering services and managing CCs; use of supplies (medicines and equipment) to be given to CCs for service-delivery; supervision and monitoring of performances of CCs and CGs; planning and organization of service-delivery at CCs; and planning of a transition from the outreach-based service-delivery system to a CC-based service-delivery system, including a plan for limited home-visits. A considerable time was spent to provide hands-on exposure to the staff to equip them to perform their newly-assigned role as a clinic worker as opposed to their previous role of community-based providers of promotional activities. The training helped develop some confidence of the providers to start with the new responsibility.

Participation in developing national ESP manual

The ORP staff participated actively and enormously in the entire process of developing the national ESP training and orientation curriculum for clinical service providers and field service providers, and contributed significantly to developing the respective manuals. The national curriculum-development process was initiated by the Line Director, Training of the DGHS, and was executed through the Centre for Medical Education and National Institute of Population Research and Training. The process involved series of workshops and meetings to ensure full participation of the agencies involved. The draft of these manuals was used for the 3-day start-up training for initiation of service-delivery at the OR field sites.

Monitoring of the performance of CG

As instructed by the MOHFW, the CGs were expected to hold monthly meetings from the very initial stage of the whole process. The CGs were provided with the draft instructions to begin with their activities. The study team provided facilitative support to organize their activities, including holding of monthly meetings. The research team monitored this activity, and necessary feedback was given to them from time to time through discussions with them to involve them in the participatory process of management of CCs.

Monitoring of service delivery at the CCs

As directed in the UMIS, the CC providers recorded information in the Daily Service-Delivery Register, and provided performance reports through the UMIS Form 1(A). The performance of the FWV during her visits to the CC was disseminated through the report of the union. Based on the existing UMIS recording and reporting system, CC-wise service statistics on selective indicators were collected to understand the trend in using functioning CCs and to monitor the changes in coverage, if any.

Annexure 2

Evaluation Schedule for Rural ESP Intervention

Schedule of activities at Chalisia, Abhoynagar, Jessore

Date	Study Group 1	Study Group 2	Study Group 3
May 21	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Facility assessment Interview with key informants
May 22	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Discussion with Community Group Interview with Union Parishad Chairman Interview with key informants
May 23	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Discussion with H&FP union supervisors and upazila managers Interview with providers

Schedule of activities at Dhum, Mirsarai, Chittagong

Date	Study Group 1	Study Group 2	Study Group 3
May 28	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Facility assessment Interview with key informants
May 29	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Discussion with Community Group Interview with Union Parishad Chairman Interview with key informants
May 30	Observation of service delivery at the Community Clinic	Exit interview with clients at the Community Clinic	Discussion with H&FP union supervisors and upazila managers Interview with providers

Service Statistics of Community Clinic
Chalisia, Abhoynagar, Jessore

1. **Client attendance**

Demographic characteristics		Jun/00	Jul/00	Aug/00	Sep/00	Oct/00	Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
<1yr	M	26	35	29	30	23	25	14	41	38	23	18	302
	F	16	31	38	31	33	25	17	40	38	20	24	313
	Total	42	66	67	61	56	50	31	81	76	43	42	615
1-4 yr.	M	18	25	25	20	16	19	17	37	28	16	07	228
	F	16	24	35	23	23	10	19	26	25	26	18	245
	Total	34	49	60	43	39	29	36	63	53	42	25	473
5-9yr.	M	11	21	17	18	06	05	15	13	13	10	07	136
	F	22	22	24	26	19	09	14	16	12	19	08	191
	Total	33	43	41	44	25	14	29	29	25	29	15	327
10-14yr.	M	10	12	19	12	10	02	09	19	06	00	10	109
	F	09	16	10	08	10	08	02	10	06	08	03	90
	Total	19	28	29	20	20	10	11	29	12	08	13	199
15-19yr.	M	01	03	17	06	08	01	05	04	03	06	01	55
	F	08	38	30	32	16	28	14	27	18	25	11	247
	Total	09	41	48	38	24	29	19	31	21	31	12	303
20-49yr.	M	08	34	46	43	25	13	17	41	30	13	18	288
	F	152	227	342	283	286	222	191	354	275	191	233	2756
	Total	160	261	388	326	311	235	208	395	305	204	251	3044
50+yr.	M	03	06	08	03	02	06	06	13	06	02	00	55
	F	11	39	19	08	16	09	12	18	17	13	10	172
	Total	14	45	27	11	18	15	18	31	23	15	10	227
Grand Total		311	533	660	543	493	382	352	659	515	372	368	5188

2. **Referral**

Demographic characteristics		Jun/00	Jul/00	Aug/00	Sep/00	Oct/00	Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
FWC	FP	00	00	00	00	00	00	00	00	00	00	00	00
	Child health	00	00	00	00	01	00	00	00	00	00	00	01
	Maternal care	01	00	00	00	00	00	00	00	00	00	00	01
	Other	01	00	00	00	02	00	00	00	00	00	00	03
UHC	FP	02	00	00	00	01	00	00	00	00	00	00	03
	Child health	07	03	02	03	01	01	00	02	00	00	00	19
	Maternal care	02	00	00	00	03	00	00	00	00	00	00	05
	Other	06	03	02	10	00	04	00	01	03	00	00	29
Others*	FP	00	00	00	00	00	00	00	00	00	00	00	00
	Child health	00	00	00	00	00	00	00	00	00	00	00	00
	Maternal care	00	00	00	00	00	00	00	00	00	00	00	00
	Other	00	00	00	00	00	00	00	00	00	00	00	00
	Total	19	06	04	13	08	05	00	03	03	00	00	61

** Others include NGO clinic/Hospital, private clinic and District Hospital etc.*

3. **Supervision**

Month	Description of Supervisors		
	Designation of Supervisors	No. of visits	Issues discussed
June/00	MO-MCH, FPI	02	Tour programme
July/00	AUFPO, HI, AHI	-	FP motivation
Aug/00	MO-MCH, UFPO	-	Contraceptive supply
Sep/00	AUFPO, DDFP	-	UMIS report, service of CC, supply
Oct/00	AUFPO, MO-MCH, UFPO, HI	-	Service register, medicine supply, cleanness of CC
Nov/00	AUFPO	01	Service of CC, cleanness of CC
Dec/00	00	00	-
Jan/01	AUFPO, UHFPO	02	Service of CC, cleanness of CC
Feb/01	AHI	02	Measurement of BP
Mar/01	AUFPO	01	-
Apr/01	HI, AHI	02	-

4. **BCC activities**

Month	No. of session held	No. of client attended			Subject/topics discussed
		Male	Female	Total	
Jun/00	08	48	118	166	Cleanness, ANC, FP method, dirrhoea, nutrition, EPI, worm.
Jul/00	06	15	85	100	Cleanness, ANC/PNC, pregnancy complication, diarrhoea, dysentery, nutrition, EPI, worm.
Aug/00	14	89	289	378	Child health, worm, ANC/PNC, dirrhoea, nutrition, EPI, safe delivery
Sep/00	13	63	232	295	PNC, child nutrition, save delivery, worm, nutrition of pregnant mother, complicacy of delivery, general nutrition, dirrhoea, Night blindness, dengue fever.
Oct/00	10	42	180	222	Skin disease, dirrhoea, lactating, FP method, ANC, pneumonia, dengue, night blindness, Iodine deficiency.
Nov/00	12	82	176	258	Skin disease, ANC, child nutrition, nutrition of pregnant mother & TT, dirrhoea, pneumonia, polio, EPI.
Dec/00	08	43	114	157	Skin disease, ANC, FP method, worm, anemia, polio, dirrhoea, maternal & child nutrition.
Jan/01	15	71	242	213	FP method, worm, anemia, ANC, infected disease, diarrhoea, complex pregnancy, STI, EPI, pneumonia.
Feb/01	14	63	244	307	ANC/PNC, FP method, pneumonia, dirrhoea, infected disease, night blindness, nutrition, safe delivery.
Mar/01	12	65	297	362	Dirrhoea, scabies, worm, ANC/PNC, pneumonia, polio infected disease.
Apr/01	11	48	175	223	Worm, scabies, ANC/PAC, FP-method, dirrhoea, complexity of pregnant mother, highrisk pregnancy, infected disease,
Total	123	629	2152	2781	

5. **Utilization of selected ESP services**

Child health		Jun/00			Jul/00			Aug/00			Sep/00			Oct/00			Nov/00		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
BCG		04	04	07	05	04	09	04	08	12	05	06	11	04	06	10	06	06	12
DPT-1		02	02	04	10	05	15	03	05	08	04	05	09	04	09	13	06	04	10
DPT-2		02	01	03	06	04	10	09	05	14	03	05	08	01	04	05	04	05	09
DPT-3		02	02	04	04	03	07	06	03	09	09	03	12	03	03	06	01	05	06
Measles		07	03	10	09	08	17	04	07	11	07	03	10	02	04	06	07	04	11
Vit. A		07	03	10	09	08	17	04	07	11	07	03	10	02	04	06	07	04	11
ARI	Cough and cold	03	03	06	12	05	17	08	08	16	04	10	14	02	04	06	06	01	07
	Pneumonia	02	00	02	00	00	00	01	00	01	00	00	00	00	00	00	00	00	00
	Severs pneumonia	00	00	00	00	00	00	00	00	00	00	00	00	00	01	01	00	00	00
	Very severe disease	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00
Dirrhoea		15	08	23	11	09	20	11	11	22	05	01	06	04	01	05	07	00	07

Child health		Dec/00			Jan/01			Feb/01			Mar/01			Apr/00			Total	
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
BCG		00	05	05	13	08	21	07	02	09	01	01	02	02	06	08	51	56
DPT-1		03	05	08	09	11	20	07	06	13	02	00	02	01	07	08	53	59
DPT-2		02	02	04	08	07	15	09	12	21	03	01	04	04	01	05	51	47
DPT-3		03	05	08	06	02	08	07	11	18	06	09	15	04	04	08	51	50
Measles		00	00	00	05	05	10	05	03	08	05	01	06	03	07	10	54	45
Vit. A		00	00	00	05	05	10	05	03	08	05	01	06	03	07	10	54	45
ARI	Cough and cold	06	00	06	08	11	19	06	06	12	13	13	26	04	03	07	72	64
	Pneumonia	00	00	00	01	00	01	00	01	01	00	00	00	00	00	00	04	01
	Severs pneumonia	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	01
	Very severe disease	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00
Dirrhoea		06	04	10	20	08	28	13	11	24	05	04	09	04	02	06	101	59

Family planning	Jun/00		Jul/00		Aug/00		Sep/00		Oct/00		Nov/00	
	M	F	M	F	M	F	M	F	M	F	M	F
Oral Pill	00	19	00	56	00	44	00	29	00	31	05	36
Condom	00	00	02	12	10	04	04	06	00	09	00	13
Injection	-	24	-	70	-	50	-	34	-	61	-	58
IUD	-	01	-	00	-	01	-	00	-	00	-	01

Family planning	Dec/00		Jan/01		Feb/01		Mar/01		Apr/01		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Oral pill	00	35	00	49	00	37	00	42	00	51	05	429
Condom	01	07	00	16	00	11	00	10	00	13	17	101
Injection	00	32	-	55	-	49	-	23	-	38	-	165
IUD	-	00	-	01	-	01	-	01	-	04	-	07

Family planning side effect management	Jun/00	Jul/00	Aug/00	Sep/00	Oct/00	Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
Oral pill	00	00	00	00	00	00	00	00	00	00	00	00
Injection	06	07	06	05	04	05	06	01	00	00	04	44
IUD	00	00	00	02	00	00	01	01	02	00	00	06
Referred for side effect												

Maternal care		Jun/00	Jul/00	Aug/00	Sep/00	Oct/00	Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
ANC	1st visit	00	14	02	02	05	00	00	00	01	00	04	28
	2nd visit	00	05	11	00	05	00	00	00	04	05	01	31
	3rd visit	00	00	05	00	06	00	00	00	03	00	01	15
TT pregnant women	1st dose	04	03	00	02	01	03	00	00	03	02	01	19
	2nd dose	01	06	04	00	01	00	02	02	00	03	03	22
	3rd dose	02	06	05	02	02	02	00	06	00	00	00	25
	4th dose	00	03	01	02	01	01	00	03	03	00	04	18
	5th dose	04	04	01	03	02	00	00	02	01	01	00	18
TT non-pregnant women	1st dose	00	03	02	01	00	04	02	03	01	03	01	20
	2nd dose	00	00	04	01	00	00	02	00	01	01	02	11
	3rd dose	00	01	00	05	00	10	01	02	06	00	00	25
	4th dose	00	00	01	03	00	04	00	06	08	01	02	25
	5th dose	00	00	00	02	01	02	00	03	02	00	00	10
Referred for delivery care		00	00	01	00	01	00	01	00	00	00	00	03
PNC		03	04	12	23	23	20	15	19	11	11	08	149

Follow-up care (Services during follow-up visit)	Jun/00			July/00			Aug/00			Sep/00			Oct/00			Nov/00		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
EPI drop out	01	01	02	00	02	02	00	03	03	03	02	05	04	02	06	02	04	06
Pregnant women	00	00	00	00	15	16	00	08	08	00	07	07	00	04	04	00	03	03
FP method drop out	00	00	00	00	06	06	00	07	07	00	05	05	00	04	04	00	11	11
DOTs cases treated	00	00	00	02	01	03	02	01	03	02	01	03	02	01	03	02	01	03
Other follow-up	00	00	00	00	00	00	01	03	04	00	00	00	00	00	00	00	00	00

Follow-up care (Services during follow-up visit)	Dec/00			Jan/01			Feb/01			Mar/01			Apr/01			Total	
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
EPI drop out	01	04	05	01	04	05	03	06	09	01	01	02	01	03	04	17	32
Pregnant women	00	04	04	00	02	02	00	05	05	00	05	05	00	00	00	-	53
FP method drop out	00	06	06	00	15	15	00	02	02	00	13	13	00	26	26	-	95
DOTs cases treated	01	01	02	01	00	01	01	00	01	01	00	01	01	00	01	15	06
Other follow-up	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00

Service Statistics of Community Clinic
Dhum, Mirsarai, Chittagong

1. **Client attendance**

Demographic characteristics		Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
<1 yr.	M	11	15	29	33	29	21	138
	F	14	16	30	35	17	27	139
	Total	25	31	59	68	46	48	277
1-4 yr.	M	11	18	17	17	18	33	114
	F	17	08	24	24	20	32	125
	Total	28	26	41	41	38	65	239
5-9 yr.	M	18	21	31	28	35	65	198
	F	11	32	27	21	32	36	159
	Total	29	53	58	49	67	101	357
10-14 yr.	M	13	29	29	23	24	35	153
	F	07	26	24	34	27	33	151
	Total	20	55	53	57	51	68	304
15-19 yr.	M	10	06	06	06	03	08	39
	F	26	35	60	50	42	42	255
	Total	36	41	66	56	45	50	294
20-49 yr.	M	34	16	25	25	28	41	169
	F	129	218	352	297	258	301	1555
	Total	163	234	377	322	286	342	1724
50+ yr.	M	14	13	35	31	20	16	129
	F	35	48	74	62	42	41	302
	Total	49	61	109	93	62	57	431
Grand Total		350	501	763	686	595	731	3626

2. **Referral**

Step	Services	Nov/00	Dec/00	Jan/00	Feb/00	Mar/01	Apr/01	Total
Union Health & Family Welfare Centre	Family planning	02	-	12	12	11	11	48
	Child health	01	-	03	-	10	08	22
	Maternal health	05	-	05	05	05	10	30
	Others	-	-	-	-	-	-	-
Upazila Health Complex	Family planning	01	-	-	01	01	01	04
	Child health	-	-	-	-	-	-	-
	Maternal health	-	-	-	-	-	-	-
	Others	-	-	-	-	-	-	-
Others	Family planning	-	-	-	-	-	-	-
	Child health	-	-	-	-	-	-	-
	Maternal health	-	-	-	-	-	-	-
	Others	-	-	-	-	-	-	-

3. **Supervision**

Month	Description of supervision		
	Designation of supervisors	No. of visits	Issues discussed
November, 00	TFPO MO(MCH-FP)	02	- Behaviour with clients - Staff members attendance & timing at CC
December, 00	MO(MCH-FP) & UH&FPO	01	-do-
January, 01	UFPO	01	- About CC group meeting - Supply issues
February, 01	UFPO	01	- Client motivation to attend the CC - Medicine distribution
March, 01	-	-	-
April, 01	-	-	-
Total	-	05	-

4. **BCC activities**

Month	No. of session held	No. of clients attended			Subject/ Topics discussed
		Male	Female	Total	
Nov, 00	03	23	47	70	- Night blindness - Malnutrition - Diarrhoea
Dec, 00	05	27	60	87	- ANC - PNC - Diarrhoea - Night blindness - Malnutrition
Jan, 01	08	64	121	185	- Diarrhoea - Malnutrition - Night blindness - Cleanliness - ANC
Feb, 01	08	69	119	188	- ANC - PNC - Diarrhoea - Night blindness - Malnutrition - Cleanliness
March, 01	07	62	109	171	- Night blindness - Malnutrition - Diarrhoea - Cleanliness
April, 01	07	54	81	135	- Diarrhoea - Cleanliness - Night blindness - Malnutrition
Total	38	299	537	836	-

5. **Utilization of selected ESP services**

Child health		Nov/00		Dec/00		Jan/01		Feb/01		Mar/01		Apr/01		Total	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
BCG		3	4	5	7	3	6	7	3	3	2	4	7	25	29
DPT-1		3	3	4	7	6	7	7	3	4	3	4	6	28	29
DPT-2		1	1	1	6	7	7	9	7	8	3	4	6	30	30
DPT-3		-	2	4	1	4	6	6	9	5	5	4	8	23	31
Measles		5	4	8	1	5	4	9	8	6	2	4	9	37	28
Vitamin		5	4	8	1	5	4	9	8	6	2	4	9	37	28
ARI	Cough and cold	10	4	6	5	14	7	10	10	10	12	7	9	57	47
	Pneumonia	4	-	1	-	2	-	4	1	-	-	-	-	11	1
	Severe pneumonia	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Very severe diseases	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diarrhoea		3	3	9	7	4	12	5	2	6	3	21	15	48	42

Family planning	Nov/00		Dec/00		Jan/01		Feb/01		Mar/01		Apr/01		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Oral Pill	-	25	-	13	-	30	-	20	-	19	-	30	-	137
Condom	-	-	1	3	-	4	-	3	1	1	-	4	2	15
Injection	-	2	-	13	-	12	-	6	-	11	-	11	-	55
IUD	-	-	-	-	-	-	-	-	-	-	-	2	-	2

Family planning side-effect management	Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
Oral pill	-	-	-	-	-	-	-
Injection	-	-	-	-	-	-	-
IUD	-	-	-	-	-	-	-
Referred for side-effect	5	-	1	-	-	-	6

Maternal care		Nov/00	Dec/00	Jan/01	Feb/01	Mar/01	Apr/01	Total
ANC	1st visit	-	2	2	-	1	-	5
	2nd visit	-	3	2	3	2	-	10
	3rd visit	3	2	-	3	-	-	8
TT: Pregnant women	1st dose	3	2	10	3	1	2	21
	2nd dose	3	4	7	3	3	4	24
	3rd dose	-	2	5	7	3	3	20
	4th dose	-	-	2	1	1	5	9
	5th dose	-	2	1	-	-	-	3
TT: non-pregnant women	1st dose	5	6	14	5	2	3	35
	2nd dose	4	2	4	12	3	6	31
	3rd dose	1	4	5	2	5	3	20
	4th dose	4	5	9	2	1	1	22
	5th dose	-	6	6	3	2	1	18
Referred for delivery care		-	-	-	-	-	-	-
PNC		-	4	-	-	5	-	9

Follow-up care (Services during follow-up visits)	Nov/00		Dec/00		Jan/01		Feb/01		Mar/01		Apr/01		Total	
	M	F	M	F	M	F	M	F	M		M	F	M	F
EPI drop out	-	-	-	-		15		16	-	-	-	-		31
Pregnant women	-	-	-	4	-	11	-	1	-	-	-	-	-	16
FP method drop out	-	-	-	-	-	2	-	4	-	-	-	-	-	6
DOTS cases treated	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other follow-up	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Annexure 4A

Providers' Practice at Chalisia Community Clinic, Abhoynagar

Providers' Practice on ARI Case Management at Chalisia Community Clinic, Abhoynagar

Total observation : 9 cases
Average time spent per case : 7 minutes

Items	Observation
History taking	History of fever was assessed in all cases and the duration of cough was asked in half of the cases. Other information was not assessed.
Looking danger sings	The danger signs were not assessed at all
Checked respiratory rate	Not assessed
Checked chest indrawing	Not assessed
Classify illness (as per guidelines)	7/9 cases were classified
Disagreement P/O	3 cases
Drug prescribed appropriate	Antibiotic was prescribed appropriately in all cases. Histacin was found to be prescribed in 2 cases
Advise mother home care	4/9 cases were advised on increased intake of fluid, increased feeding after illness. 3/9 cases were given advise on soothe the throat and relief cough with safe remedy
Inform mother danger signs	Only one mother were given information on when to bring the child back to the facility
Follow up advice	Provided in 1 case only
Co infection of diarrhoea	Not asked
Missed opportunity screened	Status of complementary feeding was asked only in 2 cases

Providers' Practice in Diarrhoeal Diseases Cases Management at Chalisia Community Clinic, Abhoynagar

Total observation : 4
Average time spent per case : 6 minutes

Items	Observation
History taking	Consistency of stool was asked most frequently followed by duration and frequency of stool. Fever and convulsion were not assessed
Look dehydration sings	Not assessed by the providers
Pinched skin for dehydration	None
Classify dehydration (As per guidelines)	None
Disagreement P/O	Not Applicable
Make a diagnosis	In 3 cases diagnosis were made
Disagreement P/O	No Disagreement
Prescribe/Supply ORS	3/4 cases
Checked ORS preparation & dispensing knowledge of client	In 2 cases, correctly in 1 case
Took feedback from client	In 2 cases
Prescribed antibiotics	Yes (2/4)
Explain antibiotic administration	1/4
Prescribe anti-diarrhoeal agents	None
Advised on hygienic practice	1/4
Explain 3 rules of treating diarrhoea at home	2/4
Follow up advice (6 signs and symptoms)	None
Checked co-infection of ARI	1/4
Missed opportunity screened	None

Providers' Practice on Antenatal Care at Chalisia CC, Abhoynagar
Those who attended for first time

Total observation : 2
Average time spent per case : 11 minutes

Items	Observation
History taking	Not adequate
Physical examination (General+Abdominal)	Not done
Lab tests	Not done
Information given on:	
Warning signs	Yes, all cases
TT vaccination	Yes, 1/2
Feeding practice	Yes, all
Provided iron/folic acid	Yes, all
Safe delivery practice	Yes, all
Follow up visit	Yes, all
Missed opportunity screened (PNC visit/Breast feeding/ Complementary feeding/Immunization)	None

Providers' Practice on Family Planning Service Delivery at Chalisia CC, Abhoynagar

Oral Pill Clients (Revisit)

Total observation : 2 cases Average time spent per case : 5 minutes

Items	Observation
Greetings	Yes
History taking	Not done
LMP	Not asked
Problem related to use	Not done
Decide to switch method	Not done
Lab tests	Not done
Follow up visit	Not done
Missed opportunity	Not done

Injectables (Revisit)

Total observation : 7 Average time spent per case : 7 minutes

Items	Observation
Greetings	Yes, all
History taking	Adequate
LMP	Not applicable
Feedback on method use	Yes, 5/7
Decide to switch method	
Physical examination	Not done
Breast examination	Not done
Lab tests	Not done
Cleaned injection area	Yes, all
Used non-touch technique	Yes, all
Ensured non-puncture of blood vessel	Not done
Disposed used needles/syringes properly	Yes, all
Follow up visit	Not done
Missed opportunity	Not done

Condom (Revisit)

Total observation : 1 Average time spent per case : 10 minutes

Items	Observation
Greetings	Yes
History taking	Yes
Problem related to use	Yes
Decide to switch method	Not done
Discussed different methods	Not done
IEC materials used	Not done
How the method works	Not done
How to use the method	Not done
Side effects/Warning signs	Not done
Follow up visit	Not done
Missed opportunity screened	Not done

Limited Curative Care: Abhoynagar
Observation of practice of FWA/HA, Total Observation: 10+9=19

History taking	**Yes**	**No**	**NA**
Greet the client/Patient	All	0	0
1. Age of the patient	12	0	7
2. Presenting complaints/Chief complaints	All	0	0
3. Duration of sickness	10	9	0
4. History of present illness	All	0	0
5. Patient's family history	0	16	3
6. Patient's personal history	2	16	1
7. History of past illness	3	11	2
8. Food habit	4	13	2
9. Menstrual history, in case of women	1	12	6
General physical examinations			
a. Pulse	3	14	2
b. Blood pressure	1	15	3
c. Temperature	2	9	8
d. Respiratory rate	1	7	11
e. Anaemia	2	15	2
f. Jaundice	1	13	5
g. Oedema	1	12	6
h. Body weight (in case of children)	1	10	8
Specific physical examinations	2	2	15
Make a diagnosis	19	0	0
Discrepancy with the observer	4	13	2
Prescribe drug	14 correct	0	0
Explain how to take drug	18	1	0
Take feedback from the client about taking drug	9	10	0
Give any other specific advices	9	10	
Check whether patient knew how to comply with the treatment advices	4	15	0
Refer the patient to			
a. Union Health & Family Welfare Centre	2	3	14
b. Upazila Health Complex	3	1	15
Missed opportunity	**Yes**	**No**	**NA**
Advise on giving colostrum to the newborn	0	9	10
Advise on exclusive breastfeeding for 6 months	0	9	10
Demonstrate proper technique of breastfeeding	0	9	10
Inform on danger of bottle-feeding/refer to counsellor	0	9	10
Advise on complementary feeding after 6 months	0	9	10
Advise on contraception	0	15	4
Advise on immunization/vitamin A of the child	0	15	4
Ask about TT immunization status of mother and advise accordingly	0	15	4
Inform about other services available in the clinic	0	19	0

Providers' Practice in Health Education & Counselling at Chalisia CC, Abhoynagar

Total observation : 4 sessions (3 individual + 1 group session)
Average time per Group session : 8 minute
Average time per individual session : 7 minute

Did the provider	Yes	No	NA
1. Greet the client	Y		
2. Wait for sometimes to make group (5-7 persons)	Y		
3. Make appropriate sitting arrangement	Y		
4. Ask requested service needs of client	Y		
5. Assess the knowledge of clients about the topic of HE & counseling	Y		
6. Assess the knowledge by showing pictures at the beginning of the HE session		Y	
7. Use IEC materials during HE session	Y		
8. Take feedback after HE session	Y		
9. Tried to involve everyone if it is group session		Y	
10. Summarize the session after the HE session	Y		
11. Maintain privacy during counselling (RTI/STDS)		Y	
12. Maintain non-judgmental attitude (RTI/STDs)		Y	
13. Emphasize on partner management		Y	
14. Emphasize on completion of treatment	Y		

Number and pattern of health education by flip-chart/summary of health education

Pattern of health education	No.	Breast-feeding	FP	Diarrh-oea	Pneu-monia	Clean-liness	Night blindness	EOC	Nutrition	Weaning food	EPI
		1	2	3	4	5	6	7	8	9	10
Single discussion	3			Y		Y			Y		
Group discussion	1										
Total								Y			

Comments: The group session was arranged by HA, who used EOC poster for demonstration. The number of participants was 15 who were not involved in the discussion.

Annexure 4B

Providers' Practice at Dhum Community Clinic, Mirsarai

Providers' Practice on ARI Case Management at Dhum Community Clinic, Mirsarai

Total observation : 4 cases
Average time spent per case : 3 minutes

Items	Observation
History taking	History of fever and the duration of cough was asked in all the cases. Other information was not assessed
Looking danger sings	The danger signs were not assessed at all
Checked respiratory rate	Not assessed
Checked chest indrawing	Not assessed
Classify illness (as per guidelines)	All 4 cases were classified
Disagreement P/O	No disagreement
Drug prescribed appropriate	Antibiotic was prescribed in 2 cases which was not appropriate. Paracetamol was given in 2 cases
Advise mother home care	Not done
Inform mother danger signs	No
Follow up advice	Not done
Co infection of Diarrhoea	Not assessed
Missed opportunity screened	No

Providers' Practice in Diarrhoeal Diseases Cases Management at Dhum Community Clinic, Mirsarai

Total observation : 4
Average time spent per case : 4 minutes

Items	Observation
Greetings	Greetings done in 2 cases
History taking	Consistency, duration and frequency of stool was asked most frequently. Fever was assessed in half of the cases. Convulsion was not assessed.
Look dehydration sings	Not assessed
Pinched skin for dehydration	None
Classify dehydration (As per guidelines)	None
Disagreement P/O	Not Applicable
Make a diagnosis	In 2 cases diagnosis was made.
Disagreement P/O	Disagreement 50%
Prescribe/Supply ORS	2/4 cases
Checked ORS preparation &	None
Dispensing knowledge of client	None
Took feedback from client	None
Prescribed antibiotics	Yes (1/4)
Explain antibiotic administration	1/4
Prescribe anti-diarrhoeal agents	None
Advised on hyginic practice	No
Explain 3 rules of treating diarrhoea at home	Not done
Follow up advice (6 signs and symptoms)	None
Checked co-infection of ARI	1/4
Missed opportunity screened	None

Providers' Practice on Antenatal Care at Dhum CC, Mirsarai
Those who attended for first time

Total observation : 8 (first visit-7, second visit-1)
Average time spent per case : 7 minutes

Items	Observation
History taking	Adequate
Physical examination (General+Abdominal)	Done in most cases
Lab tests	Not done
Information given on:	
Warning signs	Not given
TT vaccination	Yes, 6/8
Feeding practice	Yes, all
Provided iron/folic acid	Yes, all
Safe delivery practice	Yes, 3/8
Follow up visit	Yes, 1/8
Missed opportunity screened (PNC visit/Breast feeding/ Complementary feeding/Immunization)	None

Providers' Practice on Family Planning Service Delivery at Dhum CC, Mirsarai

Injectables (Revisit)

Total observation: 4 Average time spent per case : 5 minutes

Items	Observation
Greetings	Yes, all
History taking	Not adequate
LMP	Not applicable
Feedback on method use	Not done
Decide to switch method	Not done
Physical examination	Not done
Breast examination	Not done
Lab tests	Not done
Cleaned injection area	Yes, all
Used non-touch technique	Yes, all
Ensured non-puncture of blood vessel	Not done
Disposed used needles/syringes properly	Yes, all
Follow up visit	Yes, 1/4
Missed opportunity	Not done

Providers' Practice in Providing Immunization at Dhum CC, Mirsarai

Child Immunization (EPI)

Total observation : 7
Average time spent per case : 9 minutes

Items	Observation
Greetings	Adequate
Sterilized properly	Yes
Vaccinators' table organized	Yes
Follow the proper pushing technique	Yes
Documented properly	Yes
Information given on	
Benefit of Immunization	No
Side effects	No
Necessity for completion	Yes, 3/7
Necessity for card preservation	Yes, 3/7
Follow up visit	Yes, all cases
Missed opportunity screened	Not done

Women TT

Total observation : 3
Average time spent per case : 7 minutes
Age determination :

Items	Observation
Greetings	Adequate
Sterilized properly	Yes, all cases
Vaccinators' table organized	Yes
Follow the proper pushing technique	Yes
Information given on	
Benefit of Immunization	Not done
Side effects	No
Necessity for completion of doses	No
Necessity for card preservation	No
Follow up visit	No
Documented properly	Yes
Missed opportunity screened	FP status and availability of other services was explained in 1 case

Limited Curative Care: Dhum. Observation of practice of FWA/HA\FWV
Total Observation: 11+2+2=15

History taking	**Yes**	**No**	**NA**
Greet the Client/Patient	All	0	0
1. Age of the patient	5	0	10
2. Presenting complaints/Chief complaints	15	0	0
3. Duration of sickness	2	13	0
4. History of present illness	14	1	0
5. Patient's family history	1	14	0
6. Patient's personal history	1	14	0
7. History of past illness	0	15	0
8. Food habit	1	14	0
9. Menstrual history, in case of women	2	7	6
General physical examinations			
a. Pulse		12	3
b. Blood pressure		12	3
c. Temperature		5	10
d. Respiratory rate		1	14
e. Anaemia		8	7
f. Jaundice		5	10
g. Oedema		1	14
h. Body weight (in case of children)		2	13
Specific physical examinations			14
Make a diagnosis	14	1	
Discrepancy with the observer	13 C 1 IC		
Prescribe drug	12 C 3 IC		
Explain how to take drug	14	1	
Take feedback from the client about taking drug	2	12	1
Give any other specific advices	4	11	
Check whether patient knew how to comply with the treatment advices	2	13	
Refer the patient to			
a. Union Health & Family Welfare Centre			15
b. Upazila Health Complex			15
Missed opportunity			
Advise on giving colostrum to the newborn		11	4
Advise on exclusive breastfeeding for 6 months		11	4
Demonstrate proper technique of breastfeeding		11	4
Inform on danger of bottle-feeding/refer to counselor		11	4
Advise on complementary feeding after 6 months		11	4
Advise on contraception		6	9
Advise on immunization/ vitamin A of the child		11	4
Ask about TT immunization status of mother and advise accordingly		13	2
Inform about other services available in the clinic		15	0

Providers' Practice in Health Education & Counselling at Dhum CC, Mirsarai

Total observation : 1 session (individual)
Average time per Group session : 8 minute
Average time per individual session : 7 minute

Did the provider	Yes	No	NA
1. Greet the client	✓		
2. Wait for sometimes to make group (5-7 persons)			✓
3. Make appropriate sitting arrangement			✓
4. Ask requested service needs of client		✓	
5. Assess the knowledge of clients about the topic of HE & counselling			✓
6. Assess the knowledge by showing pictures at the beginning of the HE session			✓
7. Use IEC materials during HE session			✓
8. Take feedback after HE session			✓
9. Tried to involve everyone if it is group session			✓
10. Summarize the session after the HE session		✓	
11. Maintain privacy during Counselling (RTI/STDS)		✓	
12. Maintain non-judgmental attitude (RTI/STDs)			✓
13. Emphasize on partner management	✓		
14. Emphasize on completion of treatment	✓		

Number and pattern of health education by flip-chart/summary of health education

Pattern of health education	No.	Breast-feeding	FP	Diarrh-oea	Pneu-monia	Clean-liness	Night blindness	EOC	Nutrition	Weaning food	EPI
Single discussion											
Group discussion	1		Y							Y	
Total											

Comments: The group session was arranged by HA, who used EOC poster for demonstration. The number of participants was 15 who were not involved in the discussion.

Providers' Knowledge on Selected ESP Services

Items	Mirsarai				Abhoynagar			
	Adequate		Partial		Adequate		Partial	
	HA	FWA	HA	FWA	HA	FWA	HA	FWA
A. Knowledge on FP methods								
1. Screening of clients	U			U			U	U
2. Pill			U	U	U	U		
3. IUD			U	U	U	N/A		
4. Injectables			U	U	U	U		
B. MCH services								
1. ANC	U	U			U	U		
2. PNC			U	U			U	U
3. Breastfeeding	U	U			U	U		
4. Weaning	U	U			U	U		
5. TT immunization	U	U			U	U		
C. Diarrhoea								
1. Assessment			U	U	U	U		
2. Management	U			U	U			U
3. Use of drug			U	U			U	U
D. ARI								
1. Assessment	U			U	U	U		
2. Management	U			U	U			U
3. Use of drugs	U			U	U			U
E. Other conditions								
1. Malnutrition/anaemia	U	U			U	U		
2. Measles	U	U			U	U		
3. Ear problems			U	U	U			U
4. Vit-A	U	U			U	U		

Annexure 6

Tables on Client Satisfaction Through Exit Interview

1. Major source of information of clients about CC

Type of source	Abhoynagar n=50	Mirsarai n=47	Total n=97
Husband/relative	26.0	31.9	28.9
Friends/neighborhood	70.0	63.8	67.0
Provider	96.0	89.4	92.8
Community group member	8.0	-	4.1
Other	60.0	40.4	50.5

**Multiple responses accepted*

2. Clients know about the services available

Type of service	Abhoynagar n=50	Mirsarai n=47	Total n=97
Immunization	54.1	45.9	87.6
Family planning	54.5	45.6	91.7
ANC	53.3	46.7	77.3
PNC	44.4	55.6	9.3
Sick mother	50.5	49.5	95.9
Sick child	50.0	50.0	94.8
General health	52.6	47.4	97.9
Emergency service	50.0	50.0	8.2

**Multiple responses accepted*

3a. Clients' satisfaction

Criteria of satisfaction	Abhoynagar n=50	Mirsarai n=47	Total n=97
Waiting arrangement	92.0	97.9	94.9
Waiting time	60.0	63.8	61.9
Cleanliness	82.0	89.4	85.6
Privacy	90.0	83.0	86.6
Interaction with provider	90.0	98.1	93.8
Behaviour with provider	96.0	97.9	96.9
Perceived quality of service	94.0	93.6	93.8

**Multiple responses accepted*

3b. Clients' dissatisfaction

Criteria of dissatisfaction	Abhoynagar n=50	Mirsarai n=47	Total n=97
Waiting arrangement	8.0	3.1	5.1
Waiting time	40.0	36.2	38.1
Cleanliness	18.0	10.6	14.4
Privacy	10.0	17.0	13.4
Interaction with provider	10.0	1.9	6.2
Behaviour with provider	4.0	2.1	3.1
Perceived quality of service	6.0	6.4	6.2

**Multiple responses accepted*

4a. Distribution of satisfaction by type of category (q14)

Type of satisfaction	Abhoynagar n=50	Mirsarai n=47	Total n=97
Enough information was given	24.0	31.9	27.8
Did not have to wait long	42.0	34.0	38.1
Clinic staff behaved well	64.0	53.2	58.8
Qualified person provided service	18.0	10.6	14.4
Provider behaved well	86.0	91.5	88.7
Medicine was given	78.0	87.2	82.5
No or less charge for the service	56.0	53.2	54.6
Received the desired service	46.0	59.6	52.6
Received more than what was asked for	14.0	17.0	15.5
The service was appropriate	22.0	17.0	19.6
Good waiting arrangements	38.0	78.7	57.7
Neat and clean	78.0	74.5	76.3
Privacy was maintained	44.0	29.8	37.1
Was examined properly	2.0	8.5	5.1
Received prompt service	12.0	2.1	7.2
Other (specify) _____	20.0	8.5	14.4

**Multiple responses accepted*

4b. Distribution of dissatisfaction by type of category (q14)

Type of dissatisfaction	Abhoynagar n=50	Mirsarai n=47	Total n=97
Enough information was not given	-	-	-
Had to wait long	12.0	8.5	10.3
Clinic staff did not behave well	-	-	-
Qualified person did not provide service	-	-	-
Provider did not behave well	-	2.1	1.0
No medicine was given	12.0	2.1	7.2
Charged for the service/charged for the medicine	4.0	2.1	3.1
Did not receive the desired service	12.0	10.6	11.3
Did not inquire about any other problem	10.0	4.3	7.2
Service given was not appropriate	6.0	4.3	5.1
Very crowded/no queue maintained	24.0	-	12.4
Not clean	-	-	-
Privacy was not maintained	4.0	10.6	7.2
Was not examined/was not properly examined	-	-	-
Had to wait long	-	2.1	1.0
Other (specify) _____	52.0	40.4	46.4

**Multiple responses accepted*

5. Reasons for selecting the facility (Q15)

Type of response	Abhoynagar n=50	Mirsarai n=47	Total n=97
Less distance	96.0	87.2	91.7
Better waiting arrangement	26.0	42.5	34.0
Less waiting time	18.0	17.0	17.5
Experienced/ qualified provider	12.0	8.5	10.3
Providers' good behaviour	60.0	38.3	49.5
Privacy arrangements	24.0	14.9	19.6
Cleanliness	40.0	40.4	40.2
Availability of Drugs	52.0	48.9	50.5
One-stop service	28.0	6.4	17.5
Better treatment facility	34.0	23.4	28.9
Provision of quality/effective service	10.0	-	5.1
Convenient clinic hours	22.0	17.0	19.6
Provider is known	40.0	42.5	41.2
This is the clinic of the community	76.0	68.9	72.3
Others	30.0	12.8	21.6

**Multiple responses accepted*

6. Reasons for disliking the facility (Q16)

Type of response	Abhoynagar n=50	Mirsarai n=47	Total n=97
Long distance	2.0	6.4	4.2
Uncomfortable waiting time	4.1	-	2.1
Long waiting time	4.1	2.1	3.1
Too crowded	16.3	-	8.3
Providers' behaviour not good	-	2.1	1.0
Less qualified providers	6.1	-	3.1
Lack of privacy arrangements	2.0	8.5	5.2
Not clean enough	-		
Shortage of drugs	46.9	34.0	40.6
Uncomfortable clinic hours	-		
Other	51.0	29.8	40.6

**Multiple responses accepted*

8. Suggestions for improvement

Type of comments	Abhoynagar n=50	Mirsarai n=47	Total n=97
Supply of drugs to be increased for all types of diseases	22.0	6.4	14.4
Advices should be given clearly	2.0	25.5	13.4
Supply of medicine should be continuous	14.0	10.6	12.4
There should be drugs for toothache		2.1	1.0
FWV should sit everyday		2.1	1.0
Another doctor is required	8.0	6.4	7.2
Fans should be provided in the waiting space	16.0	8.5	12.4
All the family members should be given medicine		2.1	1.0
Arrangement should be made for drinking water	8.0		4.1
Arrangement should be made for delivery care		4.3	2.1
More medicine to be supplied		4.3	2.1
Supply of capsules should be there			
The hospital should be made bigger			
There should garden around the clinic			
More sitting arrangements should be made	8.0	2.1	5.1
Graduate doctor should be deployed in the CC	12.0	8.5	10.3
High quality drugs (liquid) should be supplied in the CC	4.0	4.3	4.1
Vitamin bottles should be supplied in the CC		2.1	1.0
Curtains should be provided for privacy		2.1	1.0
Arrangements for BP examination			
Arrangement for surgical operation			
Providers' behaviour should be better		4.3	2.1
All FP methods should be available constantly			
Physical examination of mother and the child should be done with the help of instruments	2.0		1.0
Facility for examination all types of diseases			
Syrup for gastric patients		2.1	1.0
Arrangement for toilets			
Don't know			
The supervisors to ensure availability of services at the CC	2.0		1.0
Clinic hour should be extended	2.0		1.0

**Multiple responses accepted*

Annexure 7

Key Informants on Community Clinic and Community Group

Table1. Background characteristics of respondents

Characteristics	Abhoynagar n=54	Mirsarai n=52
Respondents age		
<20		
20-24	9.3	1.9
25-29	13.0	3.8
30-34	11.1	11.5
35-39	20.4	15.4
40-44	7.4	7.7
45-49	38.9	59.6
Sex		
Male	72.2	94.2
Female	27.8	5.8
Married	85.2	90.4
Unmarried	11.1	7.7
Divorced		
Widow	3.7	1.9
Major occupation		
Farmer	11.3	13.5
Service person		21.1
Business	18.8	42.3
Unemployed	9.4	
House work	20.7	
Professional	30.2	5.8
Disabled	1.9	1.9
Retired person	3.8	7.7
Other	3.8	7.7
Educational status		
Never gone to school	5.6	5.8
Primary (1-5 years education)	20.4	15.4
Secondary (6-10 years education)	25.9	42.3
Higher secondary or above (<11 years schooling)	48.1	36.5

Table2. Respondents know about the CC

Categorey	Abhoynagar n=54	Mirsarai n=52
Yes	98.2	100
No	1.8	

Table 3. Respondents know about the services available in the CC

Services	No. of respondents	Mirsarai n=52
Immunization	37	72.5
Family planning	25	49.0
Antenatal care	20	39.2
Postnatal care	7	13.7
Sick mother care	19	37.2
General health care	36	70.6
Primary health care in emergency	8	15.7
Other (specify)	13	25.5

Table 4. Respondents know about the service provider (Q10)

Type of providers	No. of respondents	Mirsarai n=52
HA	8	15.4
FWA	33	63.5
Graduate doctor	4	7.7
FWV	1	3.8
THC doctor	1	1.9
Do not know	4	7.7

Table5. Respondents know about the clinic hour (Q11)

Clinic Hours	No of respondents	Mirsarai n=52
3 hours	1	1.9
4 hours	10	19.2
5 hours	7	13.5
6 hours	11	21.1
7 hours	8	15.4
8 hours	2	3.8
9 hours	2	3.8
Don't know	11	21.1

Table 6. Respondents know about the distance of CC from their house (Q12)

Category	No. of respondents	Mirsarai n=52
Near to my house (can go on foot)	10	19.2
Not too far from home	5	9.6
Can reach in 10 minutes by rickshaw/van	3	5.8
With half of a mile	14	26.9
Can reach in 30 minutes walk	16	30.8
Can reach in 30 minutes walk	4	7.7

Table 7. Respondents know about the service provider

Type of	No. of respondents	Mirsarai n=52
Yes	8	15.4
No	44	84.6

Table 8. Respondents mentioned that the community benefited from CC Q14

Response	No. of respondents	Mirsarai n=52
Yes	52	100

Table 9. Respondents mentioned how the community is benefited from CC

Type of providers	No of respondents	Mirsarai n=52
Community is receiving health services	14	26.9
Community is receiving medicine	3	5.8
Community is receiving free treatment	6	11.5
CC is near to the client's house	18	34.7
CC provides immunization services	2	3.8
CC provides mother-child care	3	5.8
CC provides first-aid treatment	2	3.8
FWA and HA offers counselling	4	7.7

Part-B

Table 1. Respondents know about CG Q16

Response	Abhoynagar n=54	Mirsarai n=52
Yes	50.0	42.3
No	50.0	57.7

Table 2. Respondents know about CG Q17

Response	Abhoynagar n=27	Mirsarai n=22
CG is ensuring service utilization	7.4	4.5
CG is promoting the clinic	3.7	13.6
CG is in the management of effective functioning of the clinic		9.1
CG supervises the clinic		36.4
CG manages clinic functioning	48.1	18.2
Don't know	11.1	
CG takes care of the community people		4.5
CG takes care of the construction		4.5
CG is expanding the capacity of CC	7.4	
CG is in the maintenance of the CC	14.8	
CG requests the community to take medicine	3.7	
CG works for maternal health development	3.7	4.5

Table 3. Respondents know about cleanliness Q17

Response	Abhoynagar n=54	Mirsarai n=52
Yes	48.1	42.3
No	51.9	57.7

Table 4. How the cleanliness is ensured Q23

Response	Abhoynagar n=27	Mirsarai n=21
Don’t know	37.5	33.3
Cleaner cleans the clinic	37.5	14.3
CG supervises the cleanliness	4.2	
Aya cleans the CC	12.5	52.4
Local people takes care	4.2	
Population of the catchment area takes care	4.2	

Table 5. Respondents know about security Q24

Response	Abhoynagar n=54	Mirsarai n=52
Yes	46.3	42.3
No	53.7	57.7

Table 6. Respondents know how security is ensured Q25

Response	Abhoynagar n=24	Mirsarai n=21
Guard	8.3	9.5
Don't know	12.5	57.1
Guard of the minister's residence		9.5
Lock and key	20.8	9.5
CG and neighboring households take care	25.0	4.8
CG and local people	4.2	
Providers	8.3	
Youngsters of the locality	16.7	
Not applicable	4.2	9.5

Table 7. Publicity done by CG members

Response	Abhoynagar n=27	Mirsarai n=22
Yes	70.4	50.0
No	29.6	50.0

Table 9. Informant ever told by any CG member

Response	Abhoynagar n=27	Mirsarai n=22
Yes	55.6	45.4
No	44.4	54.6

Table 11. Respondents mentioned that CGs participation benefited the community

Response	Abhoynagar n=26	Mirsarai n=22
Yes	88.5	54.6
No	11.5	
Don't know		45.4

Annexure 8

Tables on Effects of Phasing-out on Use of Services and Perceptions of the Community (After Phasing-out of Outreach Sites)

1. **Background characteristics of respondents**

Characteristics	Abhoynagar n=113	Mirsarai n=173	Total n=286
Women's age			
<20	6.2	7.0	6.7
20-24	17.7	18.0	17.9
25-29	19.5	19.2	19.3
30-34	16.8	15.7	16.1
35-39	20.3	11.6	15.1
40-44	10.6	11.0	10.9
15-49	8.8	17.4	14.0
Mean			***32.0***
Marital status			
Married	92.0	91.3	91.6
Unmarried	1.8	2.3	2.1
Divorced		0.6	0.3
Widow	6.2	5.8	5.9
No. of children			
No child	6.2	11.6	9.4
1-2	47.8	38.7	42.3
3-4	38.0	24.9	30.1
5-6	6.2	19.6	14.3
7+	1.8	5.2	3.8
Mean			***2.7***
Women's education			
No education	45.1	41.0	42.7
1-4	19.5	5.2	10.8
5-9	31.0	35.8	33.9
10+	4.4	17.9	12.6
Median			***4.0***
Husband's education			
No education	35.4	29.5	31.8
1-4	15.0	11.0	12.6
5-9	36.3	29.5	32.2
10+	13.3	30.1	23.4
Median			***5.0***

Contd...

Contd...

Characteristics	Abhoynagar n=113	Mirsarai n=173	Total n=286
Husband's occupation			
Unemployed	0.9	0.6	0.7
Rickshaw puller	10.6	1.7	5.2
Service	16.8	22.0	19.9
Business	28.3	23.1	25.2
Skilled labour	7.1	2.9	4.5
Day labour	8.0	8.7	8.4
Agricultural worker	22.1	16.8	18.9
Others	6.2	24.2	17.2
Husband's income			
<2000	33.6	6.9	17.5
2000-3000	30.1	15.6	21.3
3000-4000	20.3	17.9	18.9
5000+	15.9	59.5	42.3
Median			***3000***

2. **Present source of services**

Source of services	Abhoynagar n=113	Mirsarai n=173	Total n=286
Community clinic	76.1	50.9	60.8
UHFWC	2.6	37.6	23.8
UHC	89.4	48.5	64.7
Pharmacy	25.7	32.4	29.7
Private doctor/village doctor	59.3	71.1	66.4
Home visit by field workers		23.1	14.0
Others	23.9	14.4	18.2

** Multiple responses accepted*

3. **Source of service of those who used to take service from satellite clinic**

Source of services	Abhoynagar n=102	Mirsarai n=72	Total n=174
Community clinic	79.4	68.1	74.7
UHFWC	2.9	40.3	18.4
UHC	90.2	44.4	71.3
Pharmacy	24.5	13.9	20.1
Private doctor/village doctor	58.8	72.2	64.4
Home visit by field workers		40.3	16.7
Others	25.5	1.4	15.5

** Multiple responses accepted*

4. **Perceived problems in getting service from CC by those who receives services from CC**

Category	Abhoynagar n=13	Mirsarai n=17	Total n=30
Medicine is not available	7.7	5.9	6.7
Need to walk a long way	46.1	52.9	50.0
Walk long way, yet drugs are not available	7.7		3.3
Injectables are not available regularly	7.7		3.3
Medicine is not always available	23.1	17.6	20.0
All medicines were available at SC but not in CC	7.7		3.3
Providers' behaviour is not good		5.9	3.3
Providers don't want to give good medicines		17.6	10.0

5. **Advantages of the new approach over the outreach site mentioned by respondents**

Category	Abhoynagar n=113	Mirsarai n=129	Total n=242
The CC will be a public place, not in one's private premises	7.1		3.3
SC used to be held once in a month, not always available	12.4	2.3	7.0
Services are available everyday, opened everyday	28.3	1.5	14.0
Drugs are available	2.6	1.5	2.1
Medicines were not available in SC	2.6	5.4	4.1
Services were not provided with sincerity and importance		0.8	0.4
Providers work sincerely	0.9	1.5	1.2
Good service is available		0.8	0.4
Costs less (Tk 1) at CC for FP Injection than at SC (Tk 2)		0.8	0.4
Behaviour of the worker is good	7.1	3.1	5.0
The Clinic is on the government property	1.8	3.1	2.5
No transport cost is required	3.5		1.6
Services for child heath is available at CC		3.9	2.1
Children's vaccination is given here		0.8	0.4
Medicines for all types of diseases are available at CC	0.9	0.8	0.8
Drugs can be obtained everyday from the CC with privacy	5.3	5.4	5.4
Sitting arrangement is there	0.9		0.4
CC is close to the home		4.6	2.5
FP methods and other health services are available	0.9		0.4
CC is neat and clean, Sc was not clean	1.8	4.6	3.3
CC is community's own clinic		1.5	0.8
FWV attend the CC, but did not attend the EPI spot		14.0	7.4
Privacy would be maintained better		2.3	1.2

7. **Percentage of respondents disseminate messages to use services from the cc s**

Messages	Abhoynagar n=113	Mirsarai n=173	Total n=286
Yes	42.5	17.3	27.3
No	57.5	82.7	72.7

8. **Messages commonly told to motivate others**

Category of motivate	Abhoynagar n=48	Mirsarai n=29	Total n=77
Family planning service is available at the CC	27.1	3.4	18.2
Services are available for fever, headache, diarrhoea, cough	41.7	3.4	27.3
Treatment for gastric is given from the CC	2.1		1.3
TT injection for pregnant women is given at the CC	4.2	13.8	7.8
Drugs are available for different diseases	10.4	37.9	20.8
Treatment for scabies is available at the CC	4.2		2.6
The CC is opened everyday	2.1	13.8	6.5
Treatment for children is available		6.9	2.6
Oral Saline is available	4.2		2.6
Poster demonstrated in the provides many information	4.2	3.4	3.9
Good medicine without any cost or fee		10.3	3.9
Providers give good services		6.9	2.6

Annexure 9

Tables on Effects of Phasing-out Plan on Perceptions of the Community (Before Withdrawal of Outreach Sites)

1. **Background characteristics of respondents**

Characteristics	Abhoynagar n=58	Mirsarai n=64	Total n=122
Women's age			
<20	12.1	3.1	7.4
20-24	13.8	23.4	18.8
25-29	12.1	20.3	16.4
30-34	22.4	14.1	18.0
35-39	17.2	17.2	17.2
40-44	10.3	14.1	12.3
15-49	12.1	7.8	9.8
Mean			**32.0**
Marital status			
Married	98.3	90.6	94.3
Unmarried		6.2	3.3
Divorced		1.6	0.8
Widow	1.7	1.6	1.6
No. of children			
No child	5.2	12.7	9.1
1-2	62.1	39.7	50.4
3-4	32.8	28.6	30.6
5-6		14.3	7.4
7+		4.8	2.5
Mean			**2.7**
Women's education			
No education	46.5	40.6	43.4
1-4	10.3	3.1	6.6
5-9	39.7	46.9	43.4
10+	3.4	9.4	6.6
Median			**4.0**
Husband's education			
No education	32.8	31.2	32.0
1-4	10.3	9.4	9.8
5-9	39.7	39.1	39.3
10+	17.2	20.3	18.8
Median			**5.0**

Contd...

Contd...

Characteristics	Abhoynagar n=58	Mirsarai n=64	Total n=122
Husband's occupation			
Unemployed	1.7		0.8
Rickshaw puller	5.2	1.6	3.3
Service	10.3	25.0	18.0
Business	10.3	29.7	20.5
Skilled labour	3.4	4.7	4.1
Day labour		3.1	1.6
Agricultural worker	60.3	20.3	39.3
Others	8.8	15.6	12.4
Husband's income			
<2000	17.2	12.5	14.7
2000-3000	20.7	12.5	16.4
3000-4000	17.2	14.1	15.6
5000+	44.8	60.9	53.3
Median			**3000**

2. **Awareness on satellite clinic**

Comments	Abhoynagar n=58	Mirsarai n=64	Total n=122
Women aware about SC services	100	100	100
Women aware about withdrawal/phase out of SCs	70.7	9.4	38.5

3. **Potential source of receiving services as mentioned by the respondents**

Source of services	Abhoynagar n=41	Mirsarai n=6	Total n=47
Community clinic	97.6	100	97.9
UHFWC	34.1	33.3	34.0
UHC	65.8	16.7	59.6
Pharmacy	7.3	16.7	8.5
Private doctor/village doctor	4.9	16.7	6.4
Home visit by field workers others	43.9	-	38.3

4. **Awareness on Community Clinic**

Service type	Abhoynagar n=58	Mirsarai n=64	Total n=122
Women aware about CC	100	70.3	84.4
Women aware about services from CCs	87.9	28.9	62.1
Family planning	N=51	N=13	N=64
Pill	94.1	69.2	89.1
Condom	58.8	15.4	50.0
Injectables	92.2	84.6	90.6
IUD follow-up	21.6	7.7	18.7
Other (specify)	1.9	-	1.6
Immunization	N=51	N=13	N=64
Child's immunization	96.1	100	96.9
Women TT	90.2	100	92.2
Antenatel care	86.3	38.5	76.6
Postnatal care	33.3	15.4	29.7
RTI/STD	21.6	-	17.2
Diarrhoea	N=51	N=13	N=64
Children	70.6	23.1	60.9
Elder	43.1	7.7	35.9
Other members of the household	27.4	-	21.9
Respiratory infections	N=51	N=13	N=64
Children	41.2	15.4	35.9
Self	13.7	-	10.9
Other members of the household	5.9	-	4.7
General health services	78.4	84.6	79.7

** Multiple responses accepted*

5**. Perceived distance from the CC**

Opinion	Abhoynagar n=58	Mirsarai n=45	Total n=103
Near to home (walking distance)	15.5	2.2	9.7
A little far from home	-	8.9	3.9
10 minutes time by rickshaw/van	3.4	6.7	4.8
Between half of mile	3.4	77.8	36.9
30 minutes time by walking	5.2	4.4	4.8
Other (specify)	68.9	-	38.8
Don't know	3.4	-	1.9

6. **Perceived advantages of the CC as mentioned by respondents**

Category	Abhoynagar n=58	Mirsarai n=54	Total n=112
Health and family planning methods will be available easily	8.6	1.8	5.4
Services will be available everyday	24.1	1.8	13.4
Expenses will be less	12.1	33.3	22.3
Transportation problem	-	3.7	1.8
No work loss, medicine will be available easily	6.9	20.4	13.4
Do not have to go to UHC	10.3	-	5.4
Will be easier for the women	1.7	1.8	1.8
Children's diseases can be treated easily	1.7	7.4	4.4
Treatment of diarrhoea will be available	1.7	-	0.9
Any service for any disease will be available	8.6	3.7	6.2
No problem in getting the FP methods	1.7	1.8	1.8
Doctor's advice will be available	1.7	-	0.9
One stop service will be available	6.9	1.8	4.5
Clients will be referred if necessary	1.7	-	0.9
The clinic is very close to residence	1.7	-	0.9
Services for mother and children will be available	6.9	1.8	4.5
Treatment and medicine for emergency will be nearby	1.7	-	0.9
Don't need to spend money to go to the UHC	-	7.4	3.6
Services and medicine will be free of cost	-	5.6	2.7
Treatment and medicine will be available at a low cost	1.7	3.7	2.7
Advantageous in all aspects	-	3.7	-

7. **Perceived disadvantages of phase-out of the SC as mentioned by respondents**

Category	Abhoynagar n=30	Mirsarai n=55	Total n=85
Will be a little difficult in the rainy season	13.3	-	4.7
No road communication	20.0	-	7.1
The clinic is far away from home	10.0	76.4	52.9
Women won't be able to go there due to long distance	3.3	-	1.2
Problematic to take the children due to lack of transports	20.0	1.8	8.2
Whole day will be wasted	3.3	-	1.2
Much problematic in the rainy season	20.0	-	7.1
Good services will be available	3.3	-	1.2
Will be problematic to get curative health services	3.3	-	1.2
All staff are new	-	1.8	1.2
EPI spot will be away	-	12.7	8.2
Doctors are not always available	-	3.6	2.3
Workers will not be available	-	3.6	2.3
Location of CC is far away	3.3	-	1.2

8. **Messages commonly to be told to other about the use of services from the CC**

Category	Abhoynagar n=52	Mirsarai n=19	Total n=71
Services will be available nearby	11.5	5.3	9.9
The Clinic will be opened everyday	13.5	-	9.9
Services for women and children will be available	5.8	21.0	9.9
All types of healthcare will be available	15.4	-	11.3
Use health and family planning services from the CC	3.8	-	2.8
Less expense	-	10.5	2.8
Medicine may be obtained everyday	7.7	-	5.6
Don't need to go to the UHC	15.4	-	11.3
Antenatal care with FP methods for mothers will be nearby	1.9	-	1.4
Children's vaccine will be available	3.8	26.3	9.9
FP methods will available easily	3.8	-	2.8
Receive service for any problem	7.7	10.5	8.4
Good service and medicine will be available	7.7	5.3	7.0
Services can be taken everyday	1.9	-	1.4
I will go first and then tell others	-	15.8	4.2
Visit clinic for treatment of diseases	-	5.3	1.4

Percentage of CMWRA with Current Use of Contraceptives at Selected CC Areas in Abhoynagar

Percentage of CMWRA of Chalisia CC Area, Rajghat Union, Abhoynagar with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	60.2	57.5	62.8	58.5	58.3
Method mix					
Non-clinical (%)	32.5	34.8	39.5	34.7	40.5
Pill	23.4	26.1	30.3	25.0	29.7
Condom	9.1	8.7	9.2	9.7	10.8
Clinical (%)	45.5	39.0	38.2	38.9	35.1
Injectables	35.1	30.4	30.3	33.3	29.7
IUD	7.8	7.2	6.6	5.6	5.4
Norplant	2.6	1.4	1.3	-	-
Permanent (%)	19.5	20.2	15.8	16.7	16.2
Tubectomy	18.2	18.8	14.5	15.3	14.9
Vasectomy	1.3	1.4	1.3	1.4	1.3
Traditional (%)	2.5	6.0	6.5	9.7	8.2
Total CMWRA (n)	128	120	121	123	127
Total drop out (%)	7.0	5.8	2.5	6.5	4.7
Total new acceptance (%)	4.7	4.2	7.4	0.8	5.5

Percentage of CMWRA of Chalisia CC Area, Rajghat Union, Abhoynagar with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=77	Surveillance round Apr-Jun 2000 n=69	Surveillance round Jul-Sep 2000 n=76	Surveillance round Oct-Dec 2000 n=72	Surveillance round Jan-Mar 2001 n=74
GOB field workers	52.0	43.5	27.6	23.6	21.6
Satellite clinics	13.0	15.9	5.3	4.2	6.8
Community clinics	-	-	22.4	30.6	25.7
FWC/RD	2.6	2.9	2.6	2.8	2.7
THC	11.7	11.6	10.5	8.3	8.1
Other GOB facilities	-	-	22.4	30.6	25.7
NGO clinic/hospital	9.1	8.7	7.9	8.3	6.8
Private sources	9.1	10.1	17.1	12.5	20.3
Others	-	1.4	-	-	-
Self	2.6	5.8	6.6	9.7	8.1

Percentage of CMWRA of Deapara CC Area, Sreedharpur Union, Abhoynagar with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	66.7	64.2	63.0	64.2	61.1
Method mix					
Non-clinical (%)	36.8	37.8	40.4	37.5	47.2
Pill	34.2	34.2	36.0	35.8	44.5
Condom	2.6	3.6	4.4	1.7	2.7
Clinical (%)	43.0	41.4	40.3	43.3	33.6
Injectables	43.0	41.4	40.3	43.3	33.6
IUD	-	-	-	-	-
Norplant	-	-	-	-	-
Permanent (%)	12.2	12.6	12.2	11.7	12.7
Tubectomy	9.6	9.9	9.6	9.2	10.0
Vasectomy	2.6	2.7	2.6	2.5	2.7
Traditional (%)	9	8	8	9	7
Total CMWRA (n)	171	173	181	187	180
Total drop out (%)	5.3	5.2	8.8	2.1	6.1
Total new acceptance (%)	8.2	5.8	11.6	4.8	5.0

Percentage of CMWRA of Deapara CC Area, Sreedharpur Union, Abhoynagar with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=114	Surveillance round Apr-Jun 2000 n=111	Surveillance round Jul-Sep 2000 n=114	Surveillance round Oct-Dec 2000 n=120	Surveillance round Jan-Mar 2001 n=110
GOB field workers	60.5	58.6	50.9	55.0	57.3
Satellite clinics	3.5	3.6	6.1	3.3	3.6
Community clinics	-	-	-	-	-
FWC/RD	-	-	-	-	-
THC	12.3	12.6	13.2	11.7	12.7
Other GOB facilities	5.3	4.5	6.1	9.2	4.5
NGO clinic/hospital	-	-	-	-	-
Private sources	10.5	12.6	16.7	13.3	15.4
Others	0.9	0.9	0.9	0.8	0.9
Self	7.0	7.2	6.1	6.7	5.4

Percentage of CMWRA of Dhulgram CC Area, Siddhipasha Union, Abhoynagar with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	57.6	58.8	59.3	58.6	53.2
Method mix					
Non-clinical (%)	50.0	46.8	47.5	48.5	51.7
Pill	40.8	40.3	39.4	42.4	44.0
Condom	9.2	6.5	8.1	6.1	7.7
Clinical (%)	32.9	35.1	34.3	34.3	30.8
Injectables	30.3	31.2	30.3	30.3	26.4
IUD	1.3	1.3	2.0	1.0	1.1
Norplant	1.3	2.6	2.0	3.0	3.3
Permanent (%)	15.8	16.9	13.1	12.1	12.1
Tubectomy	15.8	16.9	13.1	12.1	12.1
Vasectomy	-	-	-	-	-
Traditional (%)	1.3	1.0	5.0	5.0	5.5
Total CMWRA (n)	132	131	167	169	171
Total drop out (%)	4.5	4.6	4.2	3.5	6.4
Total new acceptance (%)	4.5	3.8	18.0	4.7	3.5

Percentage of CMWRA of Dhulgram CC Area, Siddhipasha Union, Abhoynagar with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=76	Surveillance round Apr-Jun 2000 n=77	Surveillance round Jul-Sep 2000 n=99	Surveillance round Oct-Dec 2000 n=99	Surveillance round Jan-Mar 2001 n=91
GOB field workers	55.3	55.8	45.4	42.4	39.6
Satellite clinics	3.9	3.9	2.0	2.0	3.3
Community clinics	-	-	-	-	-
FWC/RD	-	-	-	-	-
THC	7.9	7.8	7.1	6.1	6.6
Other GOB facilities	2.6	1.3	4.0	6.1	7.7
NGO clinic/hospital	7.9	10.4	9.1	11.1	9.9
Private sources	21.0	19.5	27.3	27.3	27.5
Others	1.3	1.3	4.0	2.0	2.2
Self	-	-	1.0	3.0	3.3

Percentage of CMWRA of Hasanpur CC Area, Bidyanandokathi Union, Keshobpur with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	53.2	51.1	53.6	51.8	50.3
Method mix					
Non-clinical (%)	44.6	45.9	50.0	48.3	40.9
Pill	42.8	42.8	45.9	44.2	36.6
Condom	1.8	3.1	4.1	4.1	4.3
Clinical (%)	31.9	33.9	25.8	29.1	33.5
Injectables	25.9	28.9	18.8	23.3	28.7
IUD	6.0	5.0	4.7	3.5	2.4
Norplant	-	-	2.3	2.3	2.4
Permanent (%)	15.6	15.7	15.8	15.2	15.8
Tubectomy	7.8	8.8	8.2	7.6	7.9
Vasectomy	7.8	6.9	7.6	7.6	7.9
Traditional (%)	1.3	1.3	5.0	5.0	5.5
Total CMWRA (n)	166	159	170	172	164
Total drop out (%)	5.1	6.4	3.8	4.2	4.9
Total new acceptance (%)	3.8	6.1	6.0	5.7	3.1

Percentage of CMWRA of Hasanpur CC Area, Bidyanandokathi Union, Keshobpur with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=166	Surveillance round Apr-Jun 2000 n=159	Surveillance round Jul-Sep 2000 n=170	Surveillance round Oct-Dec 2000 n=172	Surveillance round Jan-Mar 2001 n=164
GOB field workers	21.7	18.2	19.4	12.8	10.4
Satellite clinics	9.6	-	1.2	-	11.0
Community clinics	-	-	-	-	-
FWC/RD	20.5	32.7	24.7	27.9	20.7
THC	6.6	6.9	8.8	7.6	7.9
Other GOB facilities	3.0	3.1	2.9	2.9	3.0
NGO clinic/hospital	7.2	6.3	7.1	7.0	7.3
Private sources	18.7	20.1	19.4	24.4	18.9
Others	4.8	8.2	8.2	10.5	11.6

Percentage of CMWRA with Current Use of Contraceptives at Selected CC Areas in Mirsarai

Percentage of CMWRA of Dhum CC Area, Dhum Union, Mirsarai with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	43.7	41.8	46.7	42.8	40.9
Method mix					
Non-clinical (%)	59.4	56.5	56.9	55.1	60.3
Pill	46.4	49.3	50.0	46.4	49.2
Condom	13.0	7.2	6.9	8.7	11.1
Clinical (%)	18.8	21.7	20.9	23.1	20.7
Injectables	15.9	18.8	16.7	17.4	15.9
IUD	2.9	2.9	4.2	4.3	3.2
Norplant	-	1.4	1.4	1.4	1.6
Permanent (%)	15.9	13.0	15.2	14.5	15.9
Tubectomy	15.9	13.0	15.2	14.5	15.9
Vasectomy	-	-	-	-	-
Traditional (%)	5.8	7.2	5.5	7.2	3.2
Total CMWRA (n)	158	165	154	161	154
Total drop out (%)	1.3	5.4	1.3	3.7	4.5
Total new acceptance (%)	5.1	4.8	3.2	5.0	2.6

Percentage of CMWRA of Dhum CC Area, Dhum Union, Mirsarai with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=69	Surveillance round Apr-Jun 2000 n=69	Surveillance round Jul-Sep 2000 n=72	Surveillance round Oct-Dec 2000 n=69	Surveillance round Jan-Mar 2001 n=63
GOB field workers	11.6	11.6	12.5	13.0	14.3
Satellite clinics	2.9	1.4	-	4.3	1.6
Community clinics	-	-	-	-	8.0
FWC/RD	13.0	17.4	18.1	15.9	17.5
THC	11.6	11.6	12.5	13.0	14.3
Other GOB facilities	2.9	2.9	2.8	2.9	1.6
NGO clinic/hospital	1.4	1.4	1.4	1.4	1.6
Private sources	23.2	27.5	33.3	34.8	30.2
Others	1.4	1.4	1.4	1.4	-
Self	4.3	5.8	4.2	5.8	3.2

Percentage of CMWRA of Purbo Mayani CC Area, Mayani Union, Mirsarai with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	60.0	58.6	55.9	54.5	56.1
Method mix					
Non-clinical (%)	25.0	25.8	24.9	24.1	27.2
Pill	19.6	24.1	21.1	20.4	21.8
Condom	5.4	1.7	3.8	3.7	5.4
Clinical (%)	21.4	18.9	19.2	16.6	16.3
Injectables	19.6	17.2	17.3	14.8	10.9
IUD	1.8	1.7	1.9	1.8	1.8
Norplant	-	-	-	-	3.6
Permanent (%)	51.8	51.7	51.9	55.6	52.7
Tubectomy	51.8	51.7	51.9	55.6	52.7
Vasectomy	-	-	-	-	-
Traditional (%)	1.8	3.6	4.0	3.7	3.8
Total CMWRA (n)	95	99	93	99	98
Total drop out (%)	3.2	3.0	4.3	1.0	4.1
Total new acceptance (%)	3.2	5.0	2.1	5.0	6.1

Percentage of CMWRA of Purbo Mayani CC Area, Mayani Union, Mirsarai with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=56	Surveillance round Apr-Jun 2000 n=58	Surveillance round Jul-Sep 2000 n=52	Surveillance round Oct-Dec 2000 n=54	Surveillance round Jan-Mar 2001 n=55
GOB field workers	12.5	19.0	11.5	16.7	7.3
Satellite clinics	3.6	-	-	-	-
Community clinics	-	-	-	-	-
FWC/RD	16.1	13.8	15.4	13.0	12.7
THC	35.7	37.9	36.5	37.0	38.2
Other GOB facilities	10.7	12.1	9.6	13.0	16.4
NGO clinic/hospital	5.4	5.2	5.8	5.6	5.4
Private sources	10.7	5.2	11.5	7.4	14.5
Others	3.6	3.4	5.8	3.7	1.8
Self	1.8	3.4	3.8	3.7	3.6

Percentage of CMWRA of Haitkandi CC Area, Haitkandi Union, Mirsarai with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	47.5	48.0	48.6	51.0	53.2
Method mix					
Non-clinical (%)	39.6	41.7	40.3	38.4	40.5
Pill	33.6	36.7	34.4	31.2	32.1
Condom	6.0	5.0	5.9	7.2	8.4
Clinical (%)	13.0	11.6	13.5	15.2	15.2
Injectables	11.2	10.8	11.8	11.2	11.4
IUD	0.9	-	-	-	-
Norplant	0.9	0.8	1.7	4.0	3.8
Permanent (%)	37.9	35.8	35.3	36.8	35.1
Tubectomy	37.9	35.8	35.3	36.8	35.1
Vasectomy	-	-	-	-	-
Traditional (%)	9.5	10.9	10.9	9.6	9.2
Total CMWRA (n)	244	250	245	245	246
Total drop out (%)	0.8	1.6	2.4	3.3	2.4
Total new acceptance (%)	3.3	3.2	4.1	6.1	5.3

Percentage of CMWRA of Haitkandi CC Area, Haitkandi Union, Mirsarai with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=116	Surveillance round Apr-Jun 2000 n=120	Surveillance round Jul-Sep 2000 n=119	Surveillance round Oct-Dec 2000 n=125	Surveillance round Jan-Mar 2001 n=131
GOB field workers	30.2	35.0	30.2	24.8	25.2
Satellite clinics	3.4	5.0	4.2	4.8	6.1
Community clinics	-	-	-	-	-
FWC/RD	6.9	3.3	5.9	1.6	2.3
THC	21.5	20.8	21.0	24.8	20.6
Other GOB facilities	10.3	9.2	9.2	12.0	13.7
NGO clinic/hospital	7.8	7.5	7.6	6.4	6.9
Private sources	9.5	8.3	10.1	13.6	12.2
Others	2.6	1.7	1.7	3.2	3.0
Self	7.8	9.2	9.2	7.2	6.9

Percentage of CMWRA of Gatiadanga CC Area, Eochia Union, Satkania with Current Use of Contraceptives by Methods

Contraceptive methods	Surveillance round Jan-Mar 2000	Surveillance round Apr-Jun 2000	Surveillance round Jul-Sep 2000	Surveillance round Oct-Dec 2000	Surveillance round Jan-Mar 2001
CPR (%)	21.8	22.4	23.3	24.1	23.5
Method mix					
Non-clinical (%)	53.5	60.4	55.5	52.1	46.8
Pill	51.2	55.8	51.1	47.9	46.8
Condom	2.3	4.6	4.4	4.2	-
Clinical (%)	9.3	9.2	11.1	16.6	20.2
Injectables	2.3	4.6	4.4	8.3	8.5
IUD	7.0	4.6	6.7	8.3	6.4
Norplant	-	-	-	-	5.3
Permanent (%)	25.6	23.3	22.2	18.7	21.3
Tubectomy	25.6	23.3	22.2	18.7	21.3
Vasectomy	-	-	-	-	-
Traditional (%)	11.6	7.1	11.2	12.6	11.7
Total CMWRA (n)	197	192	193	199	200
Total drop out (%)	4.6	1.0	3.6	3.0	3.5
Total new acceptance (%)	3.5	3.6	3.6	4.5	3.0

Percentage of CMWRA of Gatiadanga CC Area, Eochia Union, Satkania with Current Use of Contraceptives (Any Method) by Source of Supply

Source of method	Surveillance round Jan-Mar 2000 n=43	Surveillance round Apr-Jun 2000 n=43	Surveillance round Jul-Sep 2000 n=45	Surveillance round Oct-Dec 2000 n=48	Surveillance round Jan-Mar 2001 N=47
GOB field workers	11.6	18.6	13.3	16.7	6.4
Satellite clinics	2.3	7.0	2.2	4.2	6.4
Community clinics	-	-	-	-	-
FWC/RD	11.6	9.3	8.9	8.3	4.3
THC	27.9	23.3	26.7	22.9	31.9
Other GOB facilities	-	-	-	-	-
NGO clinic/hospital	20.9	18.6	8.9	16.7	17.0
Private sources	13.9	16.3	28.9	18.7	21.3
Others	2.3	-	2.2	2.1	2.1
Self	9.3	7.0	8.9	10.4	10.6

Percentage of Children (Aged 12-23 Months) Immunized by Types of Vaccine at Selected CC Areas in Abhoynagar

Percentage of Children (12-23 Months) of Chalisia CC Area, Rajghat Union, Abhoynagar Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=13	Surveillance round Apr-Jun 2000 n=9	Surveillance round Jul-Sep 2000 n=6	Surveillance round Oct-Dec 2000 n=8	Surveillance round Jan-Mar 2001 n=10
BCG	76.9	100	100	100	100
DPT1-OPV1	100	100	100	100	100
DPT2-OPV2	100	100	100	100	100
DPT3-OPV3	100	100	100	100	100
Measles-OPV4	92.3	88.9	100	100	100
Fully immunized					
- by 12 months	69.2	88.9	100	100	100

Percentage of Children (12-23 Months) of Deapara CC Area, Sreedharpur Union, Abhoynagar Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=16	Surveillance round Apr-Jun 2000 n=15	Surveillance round Jul-Sep 2000 n=16	Surveillance round Oct-Dec 2000 n=16	Surveillance round Jan-Mar 2001 n=14
BCG	75.0	100	100	100	100
DPT1-OPV1	93.7	100	100	100	100
DPT2-OPV2	100	100	100	100	100
DPT3-OPV3	100	100	100	100	100
Measles-OPV4	93.7	93.3	93.7	93.7	92.8
Fully immunized					
- by 12 months	68.7	93.3	93.7	93.7	92.9

Percentage of Children (12-23 Months) of Dhulgram CC Area, Siddhipasha Union, Abhoynagar Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=12	Surveillance round Apr-Jun 2000 n=16	Surveillance round Jul-Sep 2000 n=17	Surveillance round Oct-Dec 2000 n=15	Surveillance round Jan-Mar 2001 n=17
BCG	100	100	94.1	93.3	88.2
DPT1-OPV1	100	100	94.1	93.3	88.2
DPT2-OPV2	100	100	94.1	86.7	82.3
DPT3-OPV3	91.7	93.7	88.2	80.0	82.3
Measles-OPV4	91.7	87.5	82.3	86.7	70.6
Fully immunized					
- by 12 months	83.3	81.2	76.5	73.3	64.7

Percentage of Children (12-23 Months) of Hasanpur CC Area, Bidyanandokathi Union, Keshobpur Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=22	Surveillance round Apr-Jun 2000 n=26	Surveillance round Jul-Sep 2000 n=22	Surveillance round Oct-Dec 2000 n=21	Surveillance round Jan-Mar 2001 n=20
BCG	86.4	96.1	95.4	95.2	95.0
DPT1-OPV1	86.4	96.1	100	100	100
DPT2-OPV2	90.9	96.1	100	100	100
DPT3-OPV3	90.9	96.1	100	100	100
Measles-OPV4	86.4	92.3	86.4	90.5	85.0
Fully immunized					
- by 12 months	81.8	88.5	81.8	85.7	80.0

Percentage of Children (Aged12-23 Months) Immunized by Types of Vaccine at Selected CC Areas in Mirsarai

Percentage of Children (12-23 Months) of Dhum CC Area, Dhum Union, Mirsarai Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 N=18	Surveillance round Apr-Jun 2000 n=19	Surveillance round Jul-Sep 2000 n=21	Surveillance round Oct-Dec 2000 n=24	Surveillance round Jan-Mar 2001 n=29
BCG	88.9	94.7	95.2	95.8	96.5
DPT1-OPV1	94.4	100	100	100	100
DPT2-OPV2	100	100	100	100	100
DPT3-OPV3	88.9	89.5	90.5	91.7	100
Measles-OPV4	100	100	100	95.8	89.6
Fully immunized					
- by 12 months	77.8	84.2	85.7	83.3	86.2

Percentage of Children (12-23 Months) of Purbo Mayani CC Area, Mayani Union, Mirsarai Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=18	Surveillance round Apr-Jun 2000 n=16	Surveillance round Jul-Sep 2000 n=11	Surveillance round Oct-Dec 2000 n=11	Surveillance round Jan-Mar 2001 n=10
BCG	94.4	93.7	100	90.9	70.0
DPT1-OPV1	94.4	93.7	100	90.9	80.0
DPT2-OPV2	88.9	87.5	90.9	81.8	60.0
DPT3-OPV3	77.8	75.0	81.8	72.7	60.0
Measles-OPV4	77.8	75.0	81.8	72.7	50.0
Fully immunized					
- by 12 months	66.7	66.7	72.7	63.6	50.0

Percentage of Children (12-23 Months) of Haitkandi CC Area, Haitkandi Union, Mirsarai Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=39	Surveillance round Apr-Jun 2000 n=26	Surveillance round Jul-Sep 2000 n=20	Surveillance round Oct-Dec 2000 n=31	Surveillance round Jan-Mar 2001 n=30
BCG	79.5	88.5	90.0	90.3	93.3
DPT1-OPV1	89.7	96.1	100	96.8	96.7
DPT2-OPV2	92.3	96.1	100	93.6	93.3
DPT3-OPV3	84.6	84.6	85.0	83.9	80.0
Measles-OPV4	89.7	88.5	90.0	83.9	73.3
Fully immunized					
- by 12 months	59.0	69.2	65.0	64.5	63.3

Percentage of Children (12-23 Months) of Gatiadanga CC Area, Eochia Union, Satkania Immunized by Types of Vaccine

Source of vaccine	Surveillance round Jan-Mar 2000 n=30	Surveillance round Apr-Jun 2000 n=35	Surveillance round Jul-Sep 2000 n=32	Surveillance round Oct-Dec 2000 n=36	Surveillance round Jan-Mar 2001 n=37
BCG	56.7	57.1	56.2	36.1	51.3
DPT1-OPV1	60.0	62.8	59.4	36.1	51.3
DPT2-OPV2	60.0	62. 8	59.4	36.1	51.3
DPT3-OPV3	60.0	62.8	59.4	36.1	48.6
Measles-OPV4	53.3	57.1	53.1	30.5	51.3
Fully immunized					
- by 12 months	50.0	51.4	43.7	25.0	43.2