Seminar Paper

On

Effectiveness of Community Clinics (CCs) Services in Primary Healthcare Inclusion: A Study at Keraniganj Upazila in Dhaka District

Submitted To:

DR. MD. MOHOSHIN ALI
DIRECTOR, BPATC &
MODULE COORDIANATOR,
MODULE#02: RESEARCH FOR PUBLIC SERVICE

Submitted By:

MD. ABDUS SALAM
Deputy Secretary, Health Services Division,
Ministry of Health and Family Welfare (MoHFW)
Roll # 121
Email: salammdabdus@yahoo.com

129th Advanced Course on Administration and Development
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Abstract and Key words:

Health Services of Bangladesh were centralized even before the independence. It was mostly in the Thana, district and divisional towns where rural people had very little access particularly for communication and transportation facilities as well as poverty and ignorance. After independence Father of the Nation took initiatives acknowledging health rights in our constitution and establishing IPGMR and other hospitals. But it could not achieve satisfactory progress until 1996-2001 when community clinics were established as brainchild of HPM Sheikh Hasina to decentralize health facilities for rural underprivileged people. Moreover, following the closure by the later government this pro-people project, rural people realized the indispensability in their life. Therefore, understanding the urgency HPM Sheikh Hasina restarted in 2009 following her takeover with a new title "Revitalization of Community Health Care Initiatives in Bangladesh" (RCHCIB) In addition to that for the integration of primary health care services our' National Health Policy-2011' also took community clinics agenda with a highest priority for the implementation of successful projects by Ministry of Health and Family Welfare. Consequently, it became important as a field of study in multidimensional approach. However, for my personal and occupational background I wanted to explore by conducting research at Keraniganj Upazila of Dhaka District setting the title' The Effectiveness of Community Clinics Services in Primary Health Care Inclusion: A study in Keraniganj Upazila of Dhaka District'. I had reviewed literature to justify my study in the Community Clinics perspective. I found a few areas ignored and focused on it. I was innovative to ground two research questions as:(i) to search the human resource development perspective providing health services to rural people in relation to logistics support and effective government policy implementation and (ii) building mass awareness and community integration and cohesion that follow vision of our 'National Health Policy' principles and analysis of people's participations to CCs program in grass root level. Three objectives were: (a) To assess the satisfaction level of the service delivery system of Primary Health Care through Community Clinics) Sustainability of Community Clinics in the Primary health care Inclusion as outlined in the Government Planning) Recommendations of effective reformations to improve and increase health care facilities in rural Bangladesh. Through my fieldwork I have followed the methodology by a brief description of the study area elucidating census data to understand socio-economic context of the study area. Then I organized my fieldwork selecting study population and sampling, developed data collection methods and instruments, using qualitative and quantitative data, both from primary and secondary sources by searching related documents, observational method, interviewing through questionnaires as well. Following data analysis data management, coding, data entry

and editing were done. The major research findings were the shutdown effect of community clinics for both service receivers and providers in the research area, service providers views on the problem in maintaining community clinics, service receiver's opinion regarding service providers, types of patients coming for service to community clinics and key informants' opinions regarding sustainability, utility and indispensability of community clinics services. I had also found other important findings of my study those were patients mostly attended from nearest neighborhoods, even rich people come for service, some expected services that are not available, community collaboration and community health service trust law 2018.Major recommendations were shutdown repetition never took place for people's well-being, reformations of health management and health governance institutions is urgent, specialized institutions for the community clinics staff, community inclusion in rural level to protect property, useful documentation, more training for CCs health providers and digitalization of all community clinics activities. I had concluded that my fieldwork data revealed the demand to evaluate current health care practices of community clinics and overcome the problems they are facing. To implement 'National Health Policy' principles greater community inclusion is needed in government process at local, regional and national levels.

Key words: Community clinics (CCs) services, Primary Health Care Inclusion, Community Health Care Provider (CHCP), Community Support Groups (CSG), Community Group (CG). National Health Policy-2011 Principles,

1.0 Introduction:

To study the health system of Bangladesh 'Community Clinic' is now occupying one of the central points that is getting more importance day by day in shaping our national health policy. So, the impact and contribution of community clinic services requires surveillance by the government to ensure health care facilities to the rural people. That's why evaluating the service implementation process has become an exceptional program of research which was focused on the multidisciplinary approach. In this regard I want to explore my study of 5 community clinics at Keraniganj Upazila of Dhaka District. For this research purpose, I will conduct a fieldwork based on interviewing, analyzing secondary documents and participant observation. By setting two research questions,(i) to search the human resource development perspective providing health services to rural people in relation to logistics support and effective government policy implementation, (ii)building mass awareness and community integration and cohesion that follow vision of our 'National Health Policy' principles and analysis of people's participations to CCs program in grass root level, the study carried out an exceptional program of research in Bangladesh which focused several perspectives of community clinics. The findings will be applicable particularly in the development of community clinic services of the rural people of Bangladesh.

1.1 Background:

Health care is one of the fundamental rights of human being but in Bangladesh health issues were ignored particularly in rural areas for several decades even during Pakistan era and British colonial period. There was very little initiative to ensure medical facilities for government as well as non-government and international organizations for the

underprivileged village people as well as urban areas. That's why establishment of community clinic in our country during 1996-2001 was implementation of a revolutionary vision in our health sector. Our present prime minister Sheikh Hasina took the challenge and founded about 10,723 clinics but unfortunately the project was postponed by the later government.

Bangladesh is determined to achieve all development goals set by the United Nations and other development partners. We have already been recognized by the UN as a middle-income country. So it is now the highest priority challenge of the present government to improve the health sector. Considering the importance of rural health sector, I had planned to develop a research work on 'Community Clinics' as a requirement of my training program at Keraniganj Upazila of Dhaka District while I have been participating in ACAD course at BPATC, Saver, Dhaka, The main foundation of this research paper to see the latest status of "Community Clinics' in Keraniganj Upazila to understand the response from the Service receiver(rural people), Community Health Care Provider(CHCP) and other key informer through fieldwork. This idea originated from my personal background for working as an officer at the Ministry of Health and Family Welfare (MoHFW). Moreover, as I was born and raised in a part of rural Bangladesh, I could still remember the health facilities in my village before establishing a community clinic. Therefore, I thought of measuring the changes and differences occurred by community clinic services with a research mind and now I have found to explore in BPATC.

1.2 Objectives:

a) To assess the satisfaction level of the service delivery system of Primary Health Care through Community Clinics.

b) Recommendations of effective reformations to improve and increase health care facilities in rural Bangladesh

1.3 Justification of the Study:

For a long time, we are pursuing to achieve indicators targets successfully in the health, nutrition and population sectors of our country. Efforts had been implemented by the government following the independence of Bangladesh. For this reason, our Father of the nation Bangabandhu Sheikh Mujibur Rahman acknowledged in our constitution under article 15A the priority of the necessities is one of the fundamental responsibilities of the state as health is regarded one of them and section 18(1) for improving nutritional level of the people and developing the public health is one of the primary obligations. For this reason, he founded Institute of Post Graduate Medical Education &Research (IPGMER) in 1972 which is now BSMMU the only Medical University of our country.

Moreover, being signatory to several international declarations of the World Health Organization on primary health care section 25(1) of universal declaration of Human Rights of the United Nations, Bangladesh was committed to improve health services. Even our MDG and SDG goals also set for achieving health goals.

But still it is a long way to get remarkable progress in our health sector. Realizing all these promises and to ensure health facilities Community Clinics become the brainchild of HPM

Sheikh Hasina. To ensure the top priority She established one Community Clinic for every six thousand people. Even the later government closed it in 2001, Prime minister Sheikh Hasina after coming in power 2nd time in 2009, It was restarted again as a project titled "Revitalization of Community Health care initiatives in Bangladesh". Now the Government is strongly supporting this program and already have achieved remarkable progress. For this reason, the selection of my topic regarding Community Clinic Services is very important for national interest as well as service delivery of rural People of Bangladesh.

Through this study I had achieved huge knowledge and experience regarding the health sector of Bangladesh particularly how the community clinics are delivering service to the rural people of my country. So, I could come to know how the concerned persons like HA, FWA and CHCP are working and rural people are receiving health care facilities as per government policy. I had also gathered several useful information to recommend for the improvement of the health sector of Bangladesh.

I had reviewed a few reports and studies regarding this sector, but I didn't find any one in the Keranigonj Upazila of Dhaka District. So special study of this locality will help to find out a lot of new existing issues to promote services of community clinics of this area.

I think my study had pursued some very important and relevant findings relating to the health sectors of rural Bangladesh which would be very helpful for the patients benefit, advance understanding and will influence health policy to include new issues for solving related problems. At the same time this will fulfill the gaps in existing knowledge or resolve present controversies by revealing new facts and data. I will consult it with the concerned authorities to find my findings and recommendations helpful for relevant policy formulation and thinking. I will try to publish my study as a research article in a journal for the references of other researchers. In addition to that I will also try to focus on my official policy making the knowledge and experiences I will get.

I will also serve on the internet to find interest in community clinic study. My study result will be used by all government and non-government sectors including researchers, students, experts, health professionals, policy makers, planners, administrators and through their contributions and opinion on health care issues, it will be helpful for achieving health development goals as well as human resource development.

2.0 Literature Review:

Initially the insight I revealed to find the source of literature review is mass media; both print and electronic media provided a lot of messages through dissemination by Radios, Televisions and Newspapers in the observance of various special days. In TV broadcasting and Radio for building mass awareness every day we find community clinic slogans "Sheikh Hasinar obodan community clinic Bachai Pran" the Bengali Translation is "Sheikh Hasina's Innovation, Community Clinic saves lives". As we find at the period of the National Immunization Program, Community Clinics gathering becomes a festive place and participation becomes spontaneous. Newspapers publish special features and articles with messages from our honorable President and Prime Minister, Minister of Health and Family welfare, other concerned officials including Secretaries and deliver speeches which is a matter of our great national interest as well as highlighting community Clinic services to

aware rural people. All these sources initially helped to mold my interest and motivate me to conduct research in this precious field. From that thinking I went to search online and found huge literature in the format of "Research report, evaluation report, Project report on Community Clinics and different studies from community clinic perspectives. Publications from MoHFW under DGHS of different training programs and many newsletters, leaflets, brochures were also found very much helpful to think about the issue. Most importantly I found in our National Health Policy-2011, that describes the clause as "To establish one community clinic for every six thousand people with the purpose of ensuring primary health service to all citizens" This narration becomes the very ground to get highest focus in my selecting the research Proposal.

Though the study of community clinics is not available under any theoretical approach, framework or paradigm, a lot of analytical material gives me impetuous to find methodological implications to formulate my study plan and organize my thought. I also saw some research methodology publications that may be helpful to organize my research work.

2.1 Overview Of Community Clinics in Bangladesh:

A lot of conceptual, analytical as well as descriptive studies were found through our literature review which implies and indicates the gradual development of community clinic issues. It helps me to understand and write research report on community clinics. The points which were very much common and important as well, I would like to mention in overview chapter of my study. As I have found Community Clinics (CCs) is the bottom stage of health benefits and the brain child of Hon'ble Prime Minister Sheikh Hasina to include finest Primary Health Care (PHC) to nearest location of village people including far, difficult to coverage, mountainous and remote regions scattered in Bangladesh. After the takeover in 2009, the government led by HPM Sheikh Hasina restarted the project "Revitalization of Community Health Care Initiatives in Bangladesh" (RCHCIB) prioritized to resurrect the shutdown CCs, by renovation, employing a new strength and providing medications and other supports. The renovated CCs belong to 'RCHCIB' become operational. Primarily the projected CCs were 13,500 but later the number were 14,890 incorporating 361 CCs of mountainous and remote areas & 1029 in previous UP wards devoid of health facilities. It has been forecasted that within 2022, 14890 CCs must be founded. CCs were fitted by online connections through internet with Lap Top to equip reporting and communication as necessary. The novelty of the planning the Community Clinic is fundamentally her innovation, thinking the needs of age and for the development of community. Prime Minister is highlighting Community Clinic agenda to various global meeting to inform overseas people regarding poverty-stricken population and cost-effective health approach of Bangladesh. It has become glowing instances of Public Private Partnership through the donation of land to construct community clinic, medication, arrangement and planning. Government employees works in community clinic with a supporting body of named Community Group (CG) from mass people participating in management process in command area. The constituent body is 13-17 members representing by concerned UP member. Government employee works for technical and official management at CG. For helping CG in CC operation and motivating community

regarding CC, additionally 3 Community Support Groups (CSG) formed by 13-17 personnel. Up Chairman's portfolio becomes chief patronize of CCs in union level.

The major services of CCs are:

- Maternal and neonatal health care services
- Integrated Management of Childhood illness
- Reproductive Health and Family Planning services
- EPI, ARI, CCD
- Nutritional education and micro-nutrient supplements
- Health and Family Planning Education & Counseling
- identification of emergency & complicated cases with referral to higher facilities for better management
- Screening of Non-Communicable diseases with upwards referral, e.g. Hypertension, Diabetes, Arsenic sis, Cancer, Heart Diseases, Autism etc.
- Treatment of minor ailments & first aid of simple injuries
- Any other service identified by GOB under HPNSP to be provided
- Establishing effective referral linkage with higher facilities

List of Medicine which provided by Community Clinics:

1. Amoxicillin Capsule (250mg)
2. Amoxicillin Pediatric Drop (125ml/1.25ml)-10ml
3. Amoxicillin Dry Syrup (125mg/5ml) 100ml
4. Antacid Chewable Tablet 650mg
5. Albendazole Chewable Tablet 400mg
6. Benzolic & Salicylic acid ointment
7. Calcium Lactate Tablet 300mg
8. Chlorpheniramine Maleate Tablet 4mg
9. Chirpheniramine Syrup (2mg/5ml) 100ml
10. Clotrimoxazole Tablet 120mg
11. Cotrimoxazole Tablet 960mg
12. Chloramphenicol Eye Drop, 0.5%, 10ml
13. Chlortexidine& Cetrimide Solution, hospital concentration-1 litter
14. Ferrous Fumerate& Folic Acid Tablet 200 mg, 40 mg
15. Gention Violet 2% Topical Solution, 10ml
16. Hyoscine Butyl Bromide Tablet, 10mg
17. Metronidazole Tablet, 400mg
18. Neomycin & Bacitracin Skin Ointment, 10mg
19. ORS-Oral Rehydration Salt
20. Paracetamol Tablet, 500mg
21. Paracetamol Suspension (120mg/5ml), 60ml
22. Penicillin-V Tablet 250mg
23. Salbutamol Tablet (4mg)

24. Salbutamol Syrup (2mg/5ml) 100ml
25. Vitamin A Capsule (2 Lac I.U)
26. Vitamin-B complex Tablet
27. Zine Dispersable Tablet 20mg
28. Benzyle Benzoate Application-100ml (25WV)
29. Chorfemiramine Meliate Syrup 2mg (60ml)

Major Achievements of CCs in last 11 years:

- Had been appointed 14878 community Health Service Providers (CHCP); among them 54% are women
- At present 13922 CCs are functioning all over the country
- HPM Sheikh Hasina is invited 4 Crore villagers at a time through voice call "Please come to CCs, take services and stay healthy life"
- More than 4000 CCs are started normal delivery and more than 27000 normal deliveries have been completed
- Counting on visit, 85 crore visitors have been received services from CCs up to June 2020
- About 1935 women CHCPs have been provided training for Community Based Skilled Birth Attendant (CSBA) program
- Yearly Medicine supplying budget is 200 crore takas for CCs
- About 82,20,000 Antenatal Care (ANC) 24,11, 536 Postnatal Care (PNC) services are provided in CCs.

Health and family welfare programs are coordinated efficiently.

(a) Maternal and neonatal mortality rate
(b) Child Mortality Rate
(c) Controlling communicable diseases
(d) Non-communicable diseases
(e) Emergence and Re-emergence of new diseases
(f) Natural disaster and climate change
(g) Food and nutrition
(h) Urban Health System
(i) Rural health system
(j) Demographic Pattern and Lifestyle Changes
(k) Human resource development and management

Community Based Health Care (CBHC) at a glance:

Specific Objectives:

i. CC to assume full responsibility of health (population and nutrition) of the entire population of its catchment area;
ii. adequately staffing at CC with proper supervision mechanism to effectively deliver the services entrusted by the ESP;

iii. Facilitating CG and CSG for active participation in creating a health movement in the catchment area for improved health outcomes of the population;
iv. Sustaining institutionalization of the community-based health care efforts
v. Streamlining and strengthening Upazila health system;
vi. Establishing functional referral within and beyond Upazila health system;
vii. Ensuring supplies for proper functioning of Upazila health system;
viii. Institutional development at different levels of Upazila health system for improved performance;
ix. Improve urban health through enhanced utilization of facilities;
x. Improving access and utilization of services by the tribal population.

Programs under CBHC:

1: Administration & Finance
2: Procurement & Logistics
3: Human Resource Development (HRD) & Community Mobilization (CM)
4: Infra-structure, Monitoring & Supervision and MIS & E-Health
5: Upazila Health System & Medical Waste management
6: Urban Health & Tribal Health

The activities of CBHC under 4th HPNSP are being implemented through the following components:

1.Measuring health outcomes;
2. Staffing and supervision of CC;
3. Community engagement;
4. Referral System;
5. Sustaining institutionalization;
6. Upazila Health System;
7. Medical Waste Management:
8. Tribal Health;
9. Urban Health

For sustainability and strengthening of community participation "Community Clinic Health Support Trust law 2018" has been passed in the parliament on 8thOctober, 2018. Hence forth Community Clinic part of CBHC will be implemented through the trust.

Monitoring is being done through:

- Monthly report analysis (Online report)
- Routine visit- by GO, NGOs & DPs of different tiers with specific checklist
- Mobile tracking of service providers from HQ
- Monthly meeting at-division/district/upazila/union level taking CC issue as top-most prioritized agenda

(All the CCs have got lap top computer with internet connection & online report is coming from CC)

3.0 Methodology of the Study:

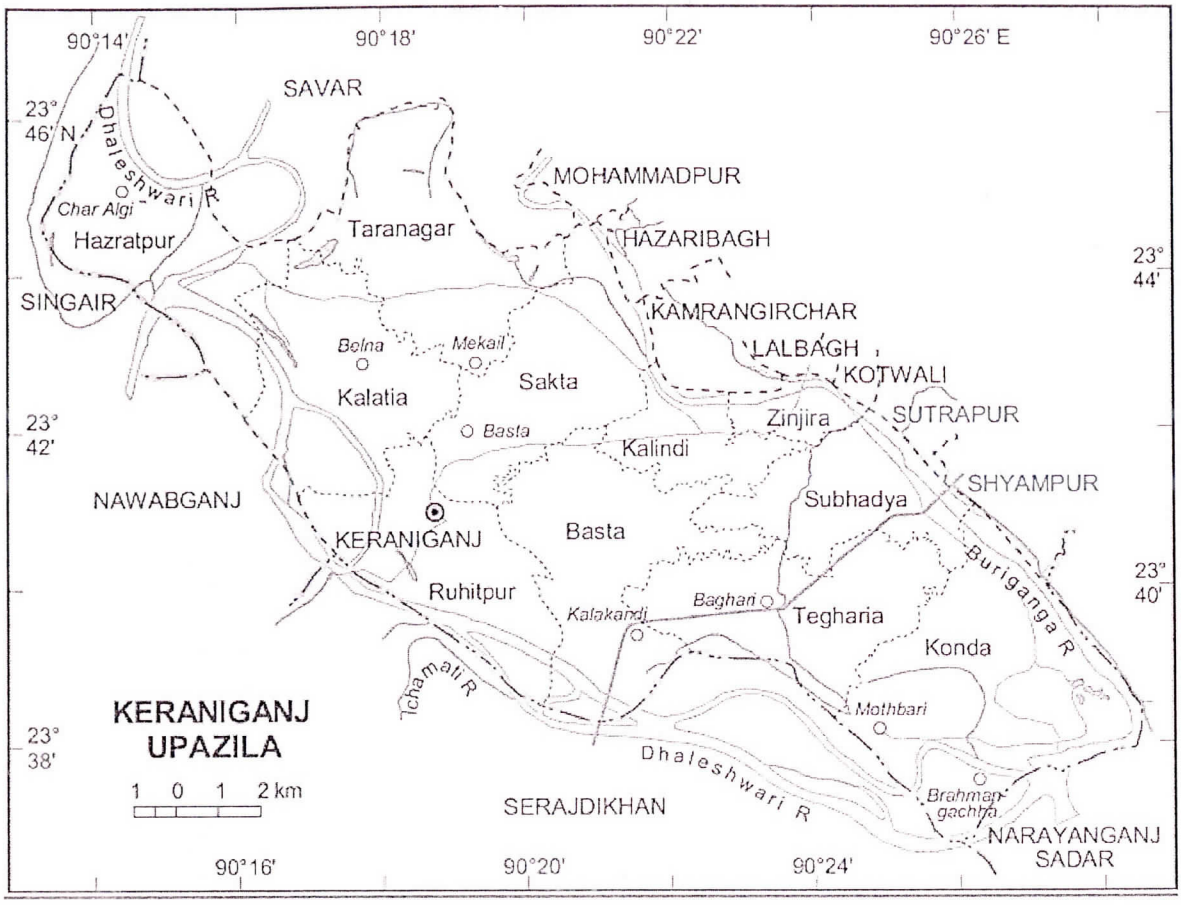
3.1 Introduction:

The study had been conducted to fulfill the partial requirement of my ACAD at BPATC titled "The effectiveness of Community Clinics services in the primary health care inclusion; A study of Keraniganj upazila under Dhaka District."

3.2 Description of the Research Area:

I conducted my field research at Keraniganj Upazila of Dhaka District under Dhaka division. The area of Upazila is 166.87 Sq km with 12 unions and 422 villages. It is bounded by Saver and SingairUpazila on the north, Narayanganj SadarUpazila on the south and east, Dhaka metropolitan area in the East and Nawabganj, Sirajdikhan and Singairupazila on the west. The Upazila HQ is located on the south-western side of Dhaka city. The total population of the Upazila is 830174(as per 2015); density of population is 5000/Sq Km. The average literacy rate is 51.8%. The main source of income is agriculture (11.31%), industry (3.62%) , commerce (29.14%), transport and communication (7.37%), Service (16.94%), remittance(4.65%) and others (26.97%). Ownership of agricultural land is 35.46% and landless 64.54%. There are UHC 01, Union Health & family welfare Centre 15, Family planning Centre 5, Satellite clinic 3, Community Clinics 20.

The location of my field study is very near the capital city, just the other side of the Buriganga river connecting direct road communication over the three bridges and through several waterways by boats and steamers. Though the inhabitants of this area are living out of the Dhaka metropolitan area, they are almost facing the same socio-economic reality because of their jobs, businesses and other related Professions. Even the view looks like the extension of the capital city just a bifurcation of the Buriganga River.



Map of **KeraniganjUpazila of Dhaka District**. (Map Courtesy: Banglapedia)

3.3 Study Population and Sampling:

I interviewed through a questionnaire for which total number is 40. Out of the sample 12 were service providers, 21 were service receivers and 7 were Key Informants (KI). To ensure proper representation, I had selected a total 5 Community Clinics distributed 2 Unions of the Upazila.

I had considered the remotest clinics from Upazila Headquarters to get the most effective results of study. The Sampling were mostly purposive procedure with probability proportional to the whole Upazila that was accounted for proper geographical locations and socio-economic pattern of the local inhabitants.

3.4 Perspective:

How the good Governance issues of accountability, transparency, efficiency and effectiveness of CCs services are in compliancewith our 'National Health Policy' to achieve future goals for MDG and SDG issues and other development agenda.

3.5 Data Collection Methods:

The study was mostly used quantitative and qualitative data using the evaluation method to assess performance of respondents and opinions and reaction of service receivers. The study had analyzed and reviewed related policy and management materials, variety of statistics and figures,a lot of study and research reports, journals, brochures, leaflet, flip-chart, mass campaign materials, several training hand books of various level service providers and local government representatives related with community clinics. I had set individuals of the concerned CCs which indicated the present prevailing context and scenario that covered a lot of facts on CCs overview.

(a)Searching related documents:

In addition to primary data sources, an extensive body of secondary data about community clinic practices, policies and projects had been gathered from government records and publications at local, regional and national levels. At the national level I had collected secondary data directly from Bangladesh Bureau of Statistics (BBS). I had also studied all possible relevant government documents for the collecting data of CCs by the Ministry of Health and Family Welfare (MoHFW), DGHS,CBHC, Community Clinic Health Service Trust (CCHST), HPSP, RCHCIB, Ministry of LGRD & Co-operatives, WHO, UNICEF, UNFPA, UNDP and a lot of official directives circulated available on MOHFW website and database that corresponds and supports my research objectives.

(b)Observational Method:

I was very much participatory with the respondents in my research area to understand their attitude and in rapport building with them. My presence helped me to get related data with a physical verification of CCs amenities and facilities. This technique helped me sometimes to ask some additional queries that strengthened my data collection process. I had interviewed through questionnaires to the service receivers and service providers including Key Person Interview (KPI). All the responses that I had gathered helped me to analyze and compile reports regarding service quality delivered in community clinics as the primary source of data to evaluate government policy implementation and responses of community clinic command areas.

(c)Interviewing method:

Through three types of questionnaires I had included key informants those plays vital role in administering and monitoring community clinic services and possess some sort of authority by hierarchy and responsibilities including Civil Surgeons (CS), UHFPO, UP Chairman, Members, Health Inspector(HI), Health Assistants(HA) & Family Welfare Assistants (FWA). They play a very important role in the formation of community groups and community support groups and other liaisons of communication of higher bodies of government. Next group of respondents were service receiving reportedly common people who come for their receiving services in CCs during service hours. Both types of respondents were interviewed face to face with a set of questions having several options. The purpose of the interview was to understand service receivers and service providers responses that also illustrated the functional activities of community clinics and the context of neighborhood understanding of behavioral patterns.

3.6 Data collection Tools/instruments:

Through my literature review I encountered a lot of research, reports and supporting materials that helped to develop research mind and analysis particularly developing data collection tools that were worked for me to formulate questionnaires to the community clinics with the respondents. The major tools were used by me is the schedule of questionnaire, checklist of observation methods, fixed questionnaire and inventory guidelines to justify accuracy and durability of study. I had also followed the pre-test method before starting data collection.

4.0 Data analysis Methods:

a)Data Management:

Data that I had compiled from questionnaires from field study, were processed by registration and made computer entry as well as editing for my future analysis. I had maintained a chronology of information recorded for the consistency from one questionnaire to another for verification. As my study was qualitative and I had conducted my fieldwork by open-ended questions. I had to do categorization of responses, coded both in the field and in house. I hadnot used any special programming in data entry rather Microsoft Word Computing.

b)Data Analysis:

I had presented key indicators to present frequency and percentage level of qualitative data. Questionnaire results formulated in the findings by summarizing qualitative data. I had received predominantly three types of data; from service receivers, service providers and key informants at community clinics of keraniganj Upazila that I had analyzed for the purpose of evaluating health care services scenarios in the field work area. I had described my data with a statistical analysis by descriptive method for frequency and percentage presentation.

4.1 Limitations of the Study:

As I had undertaken my study from the very beginning I had found a lot of limitations regarding data collection for field work. During my field study, It was COVID-19 time, I was very busy with my ACAD training Course. I got only two days for my field study which was not enough for my data collection and other material collection. In addition to that Community Clinics are located all over the country irrespective of any adverse geographical location in our country but I had just collected information only 5community Clinics within two unions of Keraniganj Upazila which few in comparison with the total number of area and functioning Community clinics of is very 13,743. So, the sample is very few and findings are not representative. Moreover, I couldn't collect information from mostly representative respondents. I had collected data from only 21respondents. For my time limitations and limitations of proper resources I couldn't cover other district or divisions especially in rural area to get overall picture of community health care services in Bangladesh.

4.2 Findings:

Through secondary data along with fieldwork evidence were helpful for describing the community clinic context in the Keraniganj Upazila. I have tried to select a representative and limited area of my field work to gather information through document analysis, direct observation by field visit, interviewing by structured questions and key informant interviews. For this reason, I had collected data from service receivers, service providers and key informants concerned with community clinics in Keraniganj upazila, as suitable for research goals. My study indicated that the management approaches by government and community participation simultaneously ensure primary care services of the marginalized rural people. Based on this idea my study focused community clinic impact in the health sector in rural Bangladesh.

4.3 The major findings of my study are given below:

4.3.1. Shutdown (Closure) effect:

we asked questions depending on 8 parameters for evaluation of closure situation. All the 21-respondent viewed they faced sufferings at the time of closure of the community clinic. So, outcome becomes caused 100% negative results of the closure issue. For the next sequences of questions 3 out of 21 (14.28%) showed they went to visit doctors outside when the community clinic of his locality was closed. At the same time, they paid money to the doctor's chamber. For out of twenty-one (19.04%) bought medicine by themselves without asking anybody about symptoms. Five out of twenty-one (23.80%) went to UHC for their medicine and treatment. Two out of twenty-one (9.52%) ignored diseases and don't go UHC or other places for financial constraints. Again, respondents showed similar data (9.52%) that they needed to get financial help from others to buy their medicine and to go doctors. In the parameters for the second time respondents reply twenty one out of 2 (19.04%) they went pharmacy and ask store worker to buy medicine for their disease by themselves. The last one reported by one out of 21 (4.76%) went to village doctors and pharmacy for their help by paying money for treatment. So, the overall figure illustrated here that the closure effect them vehemently. On the other hand, it means that the indispensability of Community clinic service is urgent for them.

Table-1: Opinion of service receivers regarding their problem face during shutdown of community clinics.

Types of problem	Number of Patients	Percentage (%) of respondents reporting these problems
Problem face during closure of clinics	21	100
Have to go doctor outside community clinic and pay visit at doctor's chamber.	3 (out of 21)	14.28
They must buy medicine by themselves without asking anybody depending on symptoms.	4(out of 21)	19.04
They have to go UHC for their treatment and get medicines.	5(out of 21)	23.80
They ignore their diseases for financial	2(out of 21)	9.52

constraints and can not manage time to go UHC for free treatment and medicine.		
They need to get financial help from others to buy their medicine and to go doctors.	2(out of 21)	9.52
They go to pharmacy and ask the store worker to buy medicine for their problem and buy medicine themselves.	4(out of 21)	19.04
They go to village doctors or pharmacy for their help by paying money for treatment.	1(out of 21)	4.76

Source: Researcher's own data collected from fieldwork.

4.3.2. Assessing the service provider views:

Through my data analysis I had found 66.66% respondents reported that they don't face problem in taking care even fifty patients each working day while 33.33% viewed they face problem to manage patients. Viewing their training experience 75% expressed their satisfaction over the knowledge for patient management while 25% expressed dissatisfaction over their training experience in managing patients. For the supply of medicine to the patients 75% recognized availability while 25 % opinion was lack of medicine for the patients. Regarding furniture and equipment 58.33% opinion was satisfactory but 41.66 viewed they needed more furniture and equipment for their successful operation. For recrement of new staffs the opinion was half and half. They highly appreciated for clinic location as 83.33% in favor but only 16.66% disfavored the location. On getting support from CG and CSG 75% were satisfied but 25 differed with the issue. So out of the seven variables with the respondent all get paramount support that proved community clinic functioning effectively.

Table-2: Service Provider (CHCP, HA, FWA) view on problems they face for service delivery, quality and utilization of services.

List of problems	opinion they face problem	Percentage (%)	opinion they don't face problem	Percentage (%) of respondent reporting the problems
They have to take care almost average fifty patients every working day. Which is too much for their time management.	4 (out of 12)	33.33	8 (out of 12)	66.66
Do they face problems for patient management with the knowledge they received from training?	3(out of 12)	25	9(out of 12)	75
Can they supply sufficient medicine for patient demand?	3(out of 12)	25	9(out of 12)	75
Do they have any problem	5(out of	41.66	7(out of 12)	58.33

with necessary furniture and equipment they need?	12)			
Do they need more strength/staff for office management?	6(out of 12)	50	6(out of 12)	50
Is the location of clinic helpful for them and patients for service delivery?	2(out of 12)	16.66	10(out of 12)	83.33
Support of CG and CSG and local people in maintaining service.	3(out of 12)	25	9(out of 12)	75

Source: Researcher's own data collected from fieldwork.

4.3.3 Service receiver's opinion regarding service providers:

I have asked 8 questions to the service receivers how they meet service from the service provider in their command area clinic. Sixteen out of 21 (76.16%) expressed their opinion they are getting regular service from community clinic but 5 out of 21 (23.81%) reported negative view. For paying visit fee fixed by government (5 taka) all of them (100%) told they just pay the money. They never pay extra money any way to the community clinic service providers. None of them had any negative opinion on this parameter. Asking questions to the service receivers for their necessary medicine from community clinic 18 out of 21 (85.71%) expressed their opinion their getting medicine as much as they needed. But only 3 out of 18 (14.29%) stated they are not getting their necessary medicine. When patients were asked if the service providers spend enough time to take care them 18 out of 3 (85.71%) told positively but only 3 out of 18 (14.29%) answered negatively. For the behavior of service provider to the patients 16 out of 18 (76.19%) said the service providers were well behaved to the service receivers. On the other hand, 5 out of 18 (23.81%) dissatisfied over the behavior of the service providers. When they were asked about counseling regarding health education 15 out of 18 (71.43%) service receivers expressed their opinion that service providers councils with them but 6 out of 18 (28.57%) responded they are not getting counseling. The last question asked to them whether they are getting service for Covid-19 (Corona Virus) 18 out of 21 (85.71%) reported positively rather 3 out of 21 (14.29%) replied negatively.

Table-3: Opinion of service receivers (21 respondents) regarding service providers and other facilities they received from community clinics.

Types of questions	Yes	Percentage (%) of respondents (Yes) reporting these questions.	No	Percentage (%) of respondents (No) reporting these questions.
Do you get regular service from this community clinic?	16	76.19	5	23.81
Do you pay extra fee (five taka fixed by govt.) to community	21	100	0	0

clinic?				
Do you get medicine as you needed most of the time?	18	85.71	3	14.29
Do service provider spend enough time to take care patient?	18	85.71	3	14.29
Are you satisfied with the behave of service providers?	16	76.19	5	23.81
Do they counselling with you regarding health education?	15	71.43	6	28.57
Do you get any service from here for covid-19 (corona virus)?	18	85.71	3	14.29
Average		82.99		17.01

Source: Researcher's own data collected from fieldwork.

4.3.4.Types of Patients coming for service to community clinics:

The service providers reported about the patients coming to community clinic mostly with ten types of diseases. For fever (28.56%), Diarrhea (14.28%), Stomach Pain (4.76%), Skin disease (4.76%), Scabies/Eczema (9.52%), Labor pain (9.52%), Respiratory problem (4.76%), Blood pressure (4.76%), Injury (4.76%), Fracture (4.76%) and others (9.52%).

Table-4: Service provider described for patients come to community clinic with diseases for their treatment.

Types of disease	Number of Patients	Percentage (%) of respondents reporting types of patients
Fever	6	28.56
Diarrhea	3	14.28
Stomach Pain	1	4.76
Skin disease	1	4.76
Scabies/Eczema	2	9.52
Labor pain	2	9.52
Respiratory problem	1	4.76
Blood pressure	1	4.76
Injury	1	4.76
Fracture	1	4.76
Others	2	9.52
Total	21	100

Source: Researcher's own data collected from fieldwork

4.3.5. Key Informants opinions regarding sustainability, utility and indispensability of Community Clinics Services:

In my interviewing through questionnaires I had gathered data from 7 key informants who have official authority on service providers in administering, monitoring, evaluation and implementation activities of Community Clinics. Moreover, they are responsible for supplying drugs, equipment, logistics support and training for service providers and reporting to higher authorities including DGHS and MoHFW. Among them Civil Sturgeon (CS) of Dhaka District, Deputy Director Family Planning(DDFP) of Dhaka District, Upazila Health and Family Planning Officer(UH&FPO) of Keraniganj Upazila, Health Inspector (HI) of Concerned Community Clinics area, 2 UP Chairmen (Shakta and Hazratpur Unions) and one UP member of no. 02 Wards of Shakta UP covered my list. I asked them few similar questions as like as service receivers and service providers. I asked them 12 questions regarding Community Clinics services. They expressed their opinions and observations on the questions I had asked to them. On the first questions if the patients faced problem during the closure of CCs 6(71.42%) replied positively while 1(14.29%) respondent answer negatively. In managing patients 2 respondents(28.58%) replied they faced problem but 5(71.42%) respondents answered they don't face problem. When I asked them if they think CHCP, HA, FWA need more training for community clinics services . Among them 4(57.14%) respondents answered they need more training, on the other hand, 3(42.86%) respondents told they didn't faced problem. If government supply of medicine were sufficient for the patients 5(71.42%) expressed their opinions were positive, In contrast(28.58%) opinion was negative. In answering questions to increase the types and numbers of medicines 5(71.42%) answered yes while 2(28.58%) said no. Having enough furniture and equipment's 4(57.14%) answered positively, In contrast 3(42.86%) opinion demanded more furniture. Answering staff's requirement to help the service providers 5(71.42%) recommended for more staffs while 2(28.58%) responded satisfaction for existing staffs. They responded on the supports of CG,CSG and local people as 5(71.42%) positively but 2(28.58%) differed. In replying Community clinics regular service of the patients 5(71.42%) responded satisfaction while 2(28.58%) dissatisfied. Whether service providers spent enough time for patients 5(71.42%) viewed positively while 2(28.58%) answered negatively. When questions were asked about the satisfaction of the patients to the service providers 6(85.71%) told they were satisfied but 1(24.29%) was not satisfied. In the last question regarding health education if service providers participated counseling to the patients 4(57.14%) told service providers did patients counseling while 3(42.86%) told service providers did not done it. In conclusion the respondents answered 66.66% in favor of community clinics service delivery efficacy. Therefore, (33.34%) opinion was sought more cooperation to ensure effective service. So regarding the respondents answered in this questionnaire it proved research findings supported in favor of the effectiveness of the services rendered by community clinics.

Table-5: Key Informants described their valuable comments regarding Community Clinics Services.

Types of questions	Yes	Percentage (%) of respondents (Yes)	No	Percentage (%) of respondents

		reporting these questions.		(No) reporting these questions.
1. What is your opinion during the closure time of community clinics the patients faced problem or not? successfully?	6	85.71	1	14.29
2. Do you think service providers face problem to manage the patients?	2	28.58	5	71.42
3. Do you think they(CHCP, HA,FWA) need more training for community clinics services?	4	57.14	3	42.86
4.Could Government supply enough medicine for patients demands?	5	71.42	2	28.58
5. Do you think more numbers (types of coverage) of medicines supply for patients needs to be increase?	5	71.42	2	28.58
6.Do Community clinics have enough furniture and equipment's?	4	57.14	3	42.86
7.Do you think community clinics needs more staff for service provider?	5	71.42	2	28.58
8. Do the CG,CSG and local people support for community clinics services?	5	71.42	2	28.58
9. Do the community clinics ensure regular service to the patient?	5	71.42	2	28.58
10. Do the service provider spent enough time for taking care patients?	5	71.42	2	28.58
11. Are the patients satisfied with the service providers?	6	85.71	1	14.29
12. Do service providers council with the patients regarding health education?	4	57.14	3	42.86
Total		799.94		400.06
Average		66.66		33.34

Source: Researcher's own data collected from fieldwork.

4.3.6 Other Findings of Community Clinics:

While I had my survey endeavor to find out existing activities of community clinics in Keraniganj Upazilaof Dhaka District, I had gathered some other important information regarding the presence of large number of patients, the service provider replied 40 to 45 each day take services in each Community Clinics. Though every service receiver supposed to pay 5-taka fee for community service they seldom pay for that. Women and Children mostly come to receive service mostly from nearest neighborhood as they got emergency free medicine. Not only poor but also people those are notably rich people also come to receive their services. I also came to know for why the patients come CCs, types of diseases, what problems do they face for providing services, what are the other facilities if they have could deliver more services. Whether they need more strengths and their types, moreover we find new local people collaborate the CC, particularly community group (CG) and Community Support Group (CSG).For what diseases patient services are not available and where the patients go for their services. What are family planning services are available? If the service provider has any idea about community health service trust law 2018.

Some other data available regarding sex structure, age structure, marital status, occupational structure, income structure, household type, service delivery factor, duration of staying at service, service delivery time, people's satisfaction, expectation of people, respondent's opinion to improve health services etc.

From service providers point of view, we got data about drug supply. Equipment, furniture, service provided range and times, all of which supported me for more research insights to develop intuition for future research outlook.

5.0 Recommendations:

Understanding the community clinics, I have found several health management outcomes at Keraniganj upazila that identified benefits and problems. Depending on the observations I have few recommendations for promoting community clinic services in Keraniganj upazila as well as in a broader sense all over the Bangladesh. I would like to suggest the fallowing recommendations:

1.The shutdown of the community clinics never should happen to ensure the Continuous health facilities for the rural people and to stop endless sufferings occurred at the time of closure. Government vigilance and careful monitoring have to be strengthened.

2. Health management institutions at all levels, from local to national need to be reformed by integrating different sectors and groups to allow for more to play effective role in community participation and inclusion of local knowledge and experience.
3. Health governance institutions should be designed to protect the health care rights of rural underprivileged people by a multilateral approach.
4. Creation of new specialized institutions to train community health care provider at district, divisional and national level for comprehensive reform of other existing medical college and hospitals and consistent with the adoption of best practices and functioning as developed in other settings like UNICEF,UNFPA etc.

5. An effective health management approach needed to expedite community inclusion at rural level could provide the foundation for community clinic sustainability, health rights, protection and protect local common property resources to mobilize financial support for community clinics. Empowering of these socio-economic resources will also provide a foundation for promoting community bonds, social justice and human rights.
6. Extensive documentation also needed regarding the many initiatives to incorporate rules, regulations and instructions to be helpful for servicer receivers and service providers with an updated edition as outlined in various health related departments.
7. Users friendly furniture and store system should be improved.
8. To ensure security of the CCs security staffs should be appointed.
9. More ICT training for the CHCP,HA and FWA should be ensured.
10. More room accommodation needed for waiting patients and administrative purposes.
11. Salary of the CHCP should be raised and other service benefits should be included.
12. Online health ID should be provided to the people in in the catchment area of community clinic as per household distribution.
13. Referral should be given to the breast and uterus cancer patients at Upazila Health Complex for health education and screening.
14. For emergency service patients should be provided five beds in hospital until they got referral to Upazila Health Complex.
15. Medical doctors from UHC or Union Health Complex should serve alternately 6 days. Senior Assistant Community Medical Officer(SACMO) should be appointed in community clinic as in-charge. Because CHCP has no experience or authority to prescribe required medicine for patients.

6.0 Conclusion:

My research report set out to explore current healthcare practices of community clinic and some problems they are facing in existing set up. My fieldwork data revealed that current health management services causes for effective results in sustaining community clinics. I have tried to find out the root causes of community clinic survival challenges. In this context, I reviewed the key problems and their causes to arrive at recommendations for a more just health policy and governance. I concluded with recommendations for how this problem could be solved through application of national health policy principles and greater community inclusion in government process at local, regional and national levels.

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৩১. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিক্লিনিকপরিচালনাবিষয়ক স্থানীয়সরকারপ্রতিনিধিপ্রশিড়্গণসহায়িকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।
৩২. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিসাপোর্ট গ্রন্নপপ্রশিড়্গণ, প্রশিড়্গকপ্রশিড়্গণনির্দেশিকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।
৩৩. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিসাপোর্ট গ্রন্নপপ্রশিড়্গণসহায়িকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।
৩৪. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, মাল্টিপারপাস হেলথ ভলান্টিয়ার (এমএইচভি), কর্মসহায়িকা, মে ২০১৯, কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।

৩৫. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, মাল্টিপারপাস হেলথ ভলান্টিয়ার, পরিচালননির্দেশিকা, মে ২০১৯, কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি), ওয়েবসাইট: www.community clinic.gov.bd

৩৬. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটি হেল্‌থ কেয়ার প্রোভাইডার, প্রশিক্ষাকনির্দেশিকা, পুনঃ মুদ্রণ ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেল্‌থ কেয়ার (সিবিএইচসি)।

৩৭. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটি হেল্‌থ কেয়ার প্রোভাইডার, প্রশিক্ষাকনির্দেশিকা, (প্রথম অংশ), পুনঃ মুদ্রণ ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেল্‌থ কেয়ার (সিবিএইচসি)।

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৩৯. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিক্লিনিকপরিচালনাবিষয়ক, স্থানীয়সরকারপ্রতিনিধিপ্রশিক্ষাণপ্রশিক্ষাকনির্দেশিকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।

৪০. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটি হেল্‌থ কেয়ার প্রোভাইডার, হাতে-কলমেপ্রশিক্ষাণ (প্রশিক্ষাকনির্দেশিকা), আগস্ট ২০১৫, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।

৪১. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, স্মরণিকা, জাতীয় স্বাস্থ্য সেবাসপ্তাহ ২০১৯, ১৬-২০ এপ্রিল।

৪২. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিক্লিনিকপরিচালনাবিষয়ক, স্থানীয়সরকারপ্রতিনিধিপ্রশিক্ষাণসহায়িকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।

৪৩. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, বার্ষিকপ্রতিবেদন, ২০১৭-২০১৮।

৪৪. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটি হেলথ কেয়ার প্রোভাইডারসহায়িকা, হাতে-কলমেপ্রশিক্ষাণ (প্রাকটিক্যালহ্যান্ডবুক), আগস্ট ২০১১, রিভাইটালাইজেশন অব কমিউনিটি হেল্‌থ কেয়ারইনিশিয়েটিভ ইন বাংলাদেশ।

৪৫. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, মাল্টিপারপাস হেল্‌থ ভলান্টিয়ার, প্রশিক্ষাণসহায়িকা, কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি) ওয়েবসাইট: www.communityclinic.gov.bd।

৪৬. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, মাল্টিপারপাস হেল্‌থ ভলান্টিয়ার, প্রশিক্ষাকপ্রশিক্ষাণনির্দেশিকা, মে ২০১৯, লাইনডাইরেক্টর, কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি) ওয়েবসাইট: www.communityclinic.gov.bd।

৪৭. স্বাস্থ্য ও পরিবারকল্যাণমন্ত্রণালয়, স্বাস্থ্য সেবাবিভাগ, স্বাস্থ্য অধিদপ্তর, কমিউনিটিক্লিনিক স্বাস্থ্য সহায়তট্রাস্ট, কমিউনিটিসাপোর্ট গ্রন্নপপ্রশিক্ষাণসহায়িকা, মে ২০১৯, বাস্ত্মবায়নেঃ কমিউনিটি বেইজড হেলথ কেয়ার (সিবিএইচসি)।

৪৮. আলাউদ্দিন,ড. মোহাম্মদ, সামাজিকগবেষণা, বৈজ্ঞানিকজ্ঞানঅন্বেষণপদ্ধতি, ডিসেম্বর ২০০৯, ঢাকা, বাংলাএকাডেমী।