Seminar Paper on

Ensuring Primary Health Care for Rural People: Case Study of a Community Clinic

Submitted
To
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Submitted
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Mentor's Authorization

I, hereby recommend and certify that the research work titled "**Ensuring Primary Health Care for Rural People: A Case Study of a Community Clinic**" has been performed by **Md. Rafiqul Islam, Roll no. 127,** 126thACAD Course held in Bangladesh Public Administration Training Centre, Savar, Dhaka under my guidance and direct supervision.

I wish him every success of life.

Naseem a Hussain.

(Professor Dr. Naseem Akhter Hussain)
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Abstract

Community clinic is the brain child of Honorable prime Minister Sheikh Hasina to extend and ensure quality Primary Health care(PHC) to the door steps of rural community including remote, hard to reach, hilly and isolated areas all over the Bangladesh. Now a days Bangladesh has achieved notable progress on different health parameters during last two decades in comparison to the neighboring countries and many other developing counties of the world. community clinic is a unique example of public-private partnership as it is constructed in community donated land. The community clinic building construction, medicine, logistics, community health care provider are of government part but management and operation of a community clinic by both government and community participation through community group (CG).The community clinic is the one point service outlet for health, nutrition and family Planning. With a view of target to establishing 13,500 community clinics construction started in 1998. From 1998-2000 period more than 10500 community clinics were constructed of which about 8500 community clinics started function to provide primary health care services. But in 2001 community clinics are closed and continued as such till 2008.

After resuming responsibility in 2009, the Present government takes a project as a priority basis to revitalize the closed community clinics through a project on priority basis titled " Revitalization of community Health care initiatives in Bangladesh "(RCHCIB) With necessary repair, deploying a new category of service provider and supply of medicine and logistics. The newly constructed community clinics under RCHCIB have also been made functional. Initial target of community clinic was 13500 but it becomes 13861 including 361 community clinics for hilly and very hard to reach areas. All the community clinics have been provided with a laptop and internet connection and are reporting in online regular basis. After this the present government of Bangladesh to established a Trustee board about community clinics titled " Community Clinic Health support Trust "(CCHST) through Parliament in 2018 for smoothly running and functioning of community clinics in Bangladesh.

Each community clinics has one management committee titled "Community Group "(CG) comprising of 13-17 members (at least one third are female) form different segments of the people of a community clinics catchment area headed by local union parishad member. Concerns government staff Provides technical and secretarial support to the CG for smooth functioning of community clinic. To give support of CG in a community clinic management and to make the community aware in respect of community clinics, there are 3 community support Groups(CSG) each group with 13-17 members . Respective local union parishad chairman is the chief patrol for all the community clinics of the union. It is to be mentioned that community mobilization is one of the important pillars and is being done through community group, community support group and local union parishad.

Key words: community clinic, community group, community support group : community health care Provider.

List of Acronyms/ Abbreviations

HFA	Health for All
CC	Community Clinic
CCMC	Community Clinic Management committee
DDFP	Deputy Director of Family Planning
DGHS	Director General of Health Services
DGFP	Director General of Family Planning
CG	Community Group
CSG	Community Support Group
EPI	Extended Programme on Immunization
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
HA	Health Assistant
HI	Health Assistant
UHFPO	Upazilla Health and Family Planning Officer
UHC	Upazilla Health Complex
RMO	Residential Medical Officer
ACAD	Advanced Course on Administration and Development
MO	Medical Officer
UP	Union Parishad
BPATC	Bangladesh Public Administration Training Centre
CCHST	Community Clinic Health Support Trust
MD	Managing Director
WHO	World Health Organization

Chapter-1

Introduction

1.1 Background: Community clinic is the lowest tier of health faculty of primary level to established is rural areas all over the Bangladesh, including very hard to reach, remote and isolated localities. It is the first and foremost to contact and get one point service outlet for health, family Palaung and nutrition. Since 2009 community clinics are being revitalized making the old (constructed during 1998-2001) and new constructed during (2019-2015) functional after taking all necessary actions. At present 13793 (95% of the target,13861) are on board and soon 200 wore community clinic will be added in this list. For providing better and efficient service, community health care provider (1CHCP for each CC) have been recruited, provided basic and refresher training. They have also been provided training from other programmes. They have been providing health services to the rural peoples particularly to the poor and vulnerable. Health assistant (HA) and family welfare assistant (FWA) have also been supportig them at community clinics. Essential medicines (4 simple antibiotics and rest of OTC Products) and temporary contraceptives are supplied to community clinics for villagers.

The community clinic is a unique extension of primary health care services to the doorsteps of rural people of Bangladesh. Basically, community clinic is the brain child of the honourable prime minister sheik Hasina. It is being branded in her name. Now a days it has become an integral part of health system is Bangladesh and millions of people are getting primary health services from community clinics.

1.2. Problem statement:

The provision of basic health services in Bangladesh is a constitutional obligation of the government. Article 15 of the constitution stipulates that it shall be a fundamental responsibility of the state to secure for its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. In addition Article 18 of the constitution asserts that the state shall raise the level of nutrition of its population and improve public health as some of its primary duties. Besides this, Bangladesh was on of the countries that signed' Alma –Ata declaration in 1978 with a pledge to ensure' Health for ALL

"(HFA) by 2000 through primary health(PHC). But in 1996 it has been observed that Bangladesh was far behind the destination as per the set of health indicators. To address those shortfalls, the then Government of Bangladesh in 1996 planned to establish community clinic (CC) (1 CC for about 6000 population) to extend Primary Health care to the door steps of the villagers all over the country.

The community Health care Providers (CHCP) is the key personnel for ensuring primary health care at community clinic level. Health assistant (HA) and Family welfare assistant(FWA) also health service provider at community clinic for its catchment area. In order to ensure better primary health services and proper management of a community clinics and introduce to peoples active participation in health services as a driven force community group (CG) has been formed in each catchment area of community clinic. Along with this community support group (CSG) has also been formed with a view to create awareness of the people about health hazards and fund collection from local resources to give support deprived and poor people of the catchment area of community clinic to bring them essential primary health care services. For smooth and better running of community clinic through involvement and active Participation of community group (CG) and community support group (CSG) has a large number of challenges now days.

1.3. Objectives of the study :

(1).To find out the impact of community clinic to providing primary health care services to the people of rural community.

(2).To find out the satisfaction level of stakeholder (service recipient) regarding community health care provider(CHCP, Service provider)

1.4. Research questions:

(1).How to ensure providing better primary health care services to rural community people ?

(2).What is the satisfaction level of stakeholder (recipient) about health service provider (CHCP)?

1.5. Conceptual framework:

Present conditions of community clinic are very dynamic for providing better primary health care to rural people. From various sources data, opinion of expert and my person experiences of working here at community clinic health support trust. It can be cited that how to increased the primary health care facilities in a community clinic. How to increased the skillness of community health care provider for ensure quality health services. Therefore increasing the number of community clinic,supplied medicines and training and refresher training of community health care provider that can ensure the maximum level of satisfaction of stakeholder that means service recipients.

1.6:Community : A community consists those of people living together in some form of social organization and cohesion. Although it may way significantly in size and socioeconomic profile, its every members usually share social, cultural and economic features as well as common interests including health facilities.

1.7: Community clinic: Community clinic (CC) is the lowest tier of health facility at primary level established in rural areas all over the Bangladesh including very hard to reach, remote and isolated area. It is the first to contact and one point service outlet for health, family planning and nutrition. Basically, community clinic is the brain child of Honorable prime minister Sheikh Hasina.

1.8: community group : Each community clinic has one management community titled " community group " (CG) comprising of 13-17 members (at least one third member of the committee are female from differ segments of people of its CC catchment are headed by local union parishad member.

1.9: Community support Group (CSG) : community support group (CSG) is a new and an addition for better community engagement under the catch at area of a community clinic to bring the people under quality primary health services. To support the community group (CG) and community clinic management and to make the community aware in inspect of community clinic in order to bring all deprived people under emergency primary health care services. There are 3 community support groups (CSG) in each community clinic with 13-17 members. Concerned union parishad chairman is

the chief patron for all the community clinic of the onion. It to be mentioned that community mobilization is one of the most important pillars is being done through community group(CG), community support group(CSG) and union parishad (UP).

1.10.Scope: Through this seminar paper the impact and role community clinic is providing quality primary health care services to the rural community people was assessed and the role of community group (CG) and community support Group (CSG) in maintenance, monitoring and smooth functioning of community clinic was identified.

1.11.Limitations: The seminar paper has been developed on the basis of Primary and secondary data. There are few number of publications in community clinic context. It has been found that different categories of report, papers, articles and journals books, reviews were published in this regards, but review it is revealed that no formal research was done specially on community clinics. On the other hand stipulated time provided by BPATC authority to collect data and information was very limited. Only three days was not more sufficient of time of respondents had no score to exploit themselves through brain storming in regarding to provide sufficient appropriate opinions and suggestions. For that reason some important points and issues might be missing.

1.12. Rationale:

The Government of Bangladesh in every year is spending a sizeable amount of money from its annual budget to provide free health care services to the rural people through community health care initiatives. So it is felt necessary to assess the utility of community clinics i.e. its operation, physical condition, availability of human resources, staff training and commitment, service coverage, quality of services, management functions and peoples' perception of the community clinics; and finally put recommendations for its further development and increase facilities the primary health care for rural people .These considerations led to me to undertake this study.

1.13. Organization of a seminar paper: This study will contain five chapters those are as follows

Chapter one: Fist chapter will include the introductory chapter like background of the topic, problem statement, objectives of the study. Research questions, Rationale of study etc. The chapter ends with organization of the study.

chapter two : This chapter will highlight with the literature review. The purpose of literature review is to critically analyze the existing concepts, thoughts and ideas to define the know ledge gaps. This will focus on conceptual overview about community clinic to ensure primary health care and the challenges to possible initiatives to make more effective and fruitful primary health service by a community clinic .

chapter three: This chapters will focus on research methodology that includes methods, tools and techniques of data/ informations collection, data processing and data analysis.

chapter four : This chapter deals with the data collection from various sources which covered the results and discussion .

chapter five : This chapter will focus on findings, conclusion and recommendations as reference to the discussions and results. This is the guideline and suggestions for a seminar paper writing style.

Chapter-2

2.1. Literature Review

After assuming office in 2009, the present government started refocusing on the community clinics. At that time about 8,500 clinics were re-commissioned. The Government has also set up a new vertical office under a new Project Director to revitalize the community health care initiatives and has allocated about 2,500 crores taka for the project. The government has created a post of Community Health Care Providers (CHCPs) for each of the community clinics, who will sit in the clinic 6 days a week and recruited CHCP in almost all of the community clinics.

The other most peripheral health and family planning workers - Health Assistants (HAs) and Family Welfare Assistants (FWAs), under the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) respectively are also supposed to sit together with the CHCP in these clinics, alternatively for 3 days a week and provide the identified services from this one stop service centre. Initially it was planned that two days a week these fringe level workers will make home visits in turn for the drop outs of immunization and maternal care and also for weaker patients.

One unique approach taken by the Government at that time was to construct these community clinics on lands which would be donated by the community, to be managed by a community based committee, formed by the local people and to be chaired by a representative of the local government bodies, i.e., union parishad, as per a manual prepared by the Ministry of Health & Family Welfare, Government of Bangladesh. Land donor is a mandated member of the committee. The member secretary of the committee is CHCP. The committee has to have at least four women as members. All these clinics were constructed over a piece of land of 3 to 5 decimals, a prototype structure with 2 rooms and a waiting space. Each clinic has a sanitary latrine and a tube well. As a condition the piece of donated land required to be in at least at street level and not a ditch or low land and should be at a well-connected place, transportable and easily accessible.

The immediate supervisors of these clinics are the union level field supervisors, i.e., Assistant Health Inspectors (AHIs) and Family Planning Inspectors (FPIs) from the Directorate of Health and Directorate of Family Planning respectively. The clinics are also visited on a monthly basis by the union level service providers, e.g., Family Welfare Visitors (FWVs) and Medical Assistants (MAs)/Sub-Assistant Community Medical Officers (SACMOs) from the two directorates respectively. It is expected that medical officers working at the union level might also visit these clinics when an order is passed to this end.

Almost 13,500 Community Health Care Providers have been recruited by the present government from among the locals, with preference to the females under the above named project. During recruitment preference was given to those who have their own laptops or notebooks for reporting performance and other technical matters to the DGHS. They take care of the clinic and would also provide services in absence of the HAs and FWAs. Terms of reference for them have been prepared and a manual developed for their training.

The basic health care services are supposed to be provided by the community clinics. CHCPs have been provided with basic training on health care services along with guidelines. They render services 6 days a week and keep record of their services in service registers supplied by the government. HAs provide vaccination, distribute vitamin A capsules, iron tablets, oral saline, anti-malarial and anti-filarial medicines, uncomplicated pneumonia cases and skin diseases with antibiotics and anti-fungal etc. They have to register eligible children for EPI. Death registrar for respective jurisdiction has also to be maintained. They will refer illnesses which would be beyond their scope to manage after providing first aid. FWAs are supposed to distribute contraceptives, monitor child growth, register marriage and child birth and refer clinical contraceptive cases. All the above grass root staffs are trained for at least once for 21 days. Besides they have also been trained by different program managers. But refresher trainings are hardly any. Hence the quality of services of these workers requires to be improved constantly.

Chapter-3

Methodology (Methods and Materials)

3.1. Research Method :

Both primary and secondary sources of data have been in the analysis. Personal experiences of working in the arena, intervening various group of people regarding community clinic, observation focus group discussion and opinion of health experts has been taken. In addition to qualitative analysis statistical tools has been used whenever applicable. However, mainly qualitative method has been followed to collect necessary data. Because this study has aimed to bring primary health care experiences of people to documents. In addition to that the techniques of key information interview (KII) is adopted. According to Marshell (1996) KII technique is a qualitative research method which is able to supply more information in a short period of time. In addition to this purpose sampling exercise to interview of respondents who are experienced and knowledgeable, well–informed on this context.

3.2.Methods of data collection : Data of this study were collected from shubgacha community clinic at khamarkandi union under sherpur upazilla of bogra district in 18-20 August /2019. These data were collected from different types of stakeholder, including,

1. Service recipient / Stakeholder from this community clinic
2. The Health sector Personnel (eg, Doctors and Inspector)

3.3.Sources of data:

Both primary and secondary sources were used to collect necessary data to conduct the study. Primary data were collected through interview and from content analysis, while secondary sources of data were both published and unpub lished documents and literatures. In this study secondary data are also used to enrich this article. The data are collected from books of various authors, handbook, magazines, Newspaper, journals, Websites, public records and statistics and internet.

3.4. Primary Sources of data :

Expertise opinion have been taken through interview to a research questions. Moreover meetings were held with local representative from various key stakeholder groups including men, women, government official especially doctors. For this propose two set of questions were prepared for interviewing two groups as field based primary data was required of this study.

3.5. Secondary Sources of data: This article was prepared by exploiting secondary data along with primary data. The secondary data have been taken from different relevant papers and documents like as research work, seminar paper, periodicals, INGO and NGOS reports and survey result. In addition to this online mews, journals, books, online articles etc. were also considered is this purpose.

3.6. Materials and methods : To develop this seminar paper required data and information collected from beneficiaries of shuvgacha community clinic through interviewing by questionnaire. secondary data from relevant office and other documents from CCHST and DGHS related publication and reports.

Chapter-4

4.1. Results and Discussions : In this chapter collected primary and secondary data have been presented and analyzed systema tically in alignment with the research objectives , research questions and analytical framework. To explore the real condition of a community clinic to identify the existing problems and their way of future development. Fifteen(15) persons of the two categories were interviewed following two set of pre-determine checklist of 14 questions. They were as follows

(i) Beneficiaries/stakeholder in this community clinic catchment areas people .

(ii) Physicians of upazilla Health complex.

4.2. Response of Service recipients/stakeholder of shuvgacha community clinic:

10 service recipients of shuvgacha community clinic were interviewed by a checklist of 14 questions (annex-1)

Questions no. 1,6,7 and 8 are about the satisfaction leved of beneficiaries group regarding about the medicines in respect of different primary health problems , antenatal, post natal and non communicable disease related medicines supply by community clinic.

Question no. 2 is about counseling for every health hazard addressed by community health care proudest (CHCP) before provide medicine.

Question no. 3 and 4 is about involvement of community group and community support group (CSG) for improvement and better running of community clinic and much participation and engagement of rural community .

Question no. 5,10 and 11 are about skillness of service delivery by CHCP, health assistant (HA) and family welfare assistant(FWA)

Question no. 9 is about water, sanitation and hygiene condition in this community clinic .

Question no. 12 and 13 is about present problem and further improvement techniques in community clinic in respect to provide more better way.

Question no. 14 is about the opinion of normal delivery for rural people in this community clinic.

Ranking of satisfaction level of stakeholder:1means lowest level of satisfaction and 5 means highest level of satisfaction in shuvgacha community clinic, under khamarkandi union, at sherpur upazila in bogra district.

1. First question, i.e. question no. 1 was regarding overall medicines provided by community health care provider at community clinic for stakeholder. If we summarize the stakeholder answers we revealed that the following results. All respondents answered that the overall provided medicines by community clinic is satisfactory and very good. That means satisfaction level is highest.

Responses/answered to the questions Q#1.	Number of respondents	Percentage
Highest satisfaction level-5	10	100%

2. 2nd question was regarding counseling before providing medicines stakeholder. If we summarize the answers we get the following result. All respondents answered that overall counseling made by community health care provider is very satisfactory. That means satisfaction level is highest.

Responses/answered to the questions Q#2.	Number of respondents	Percentage
Highest satisfaction level-5	10	100%

3. 3rd question was regarding community group activities at community clinic .

Responses/answered to the questions Q#3.	Number of respondents	Percentage
Medium-highest satisfaction level-3	6	60%
Medium satisfaction level-4	4	40%

4.4th question regarding community support group (CSG) activities at community clinic.

Responses/answered to the questions Q#4.	Number of respondents	Percentage
satisfaction level-1	4	40%
satisfaction level-2	6	60%

4. 5th question regarding skillness of service provided by community health care provider (CHCP) at community clinic.

Responses/answered to the questions Q#5.	Number of respondents	Percentage
satisfaction level-5	8	80%
satisfaction level-4	2	20%

5. 6th and 7th question regarding ante natal care (ANC) and post natal care (PNC) at community clinic level for pregnant mother

Responses/answered to the questions Q# 6 and 7.	Number of respondents	Percentage
satisfaction level-5	6	60%
satisfaction level-4	4	40%

6. 8th question counseling regarding non – communicable disease (i,e, diabetes, hypertension, cancer, cardiovascular disease etc.)

Responses/answered to the questions Q#8.	Number of respondents	Percentage
satisfaction level-5	2	20%
satisfaction level-4	8	80%

7. 9th question regarding wash facilities in the community clinic .

Responses/answered to the questions Q#9.	Number of respondents	Percentage
satisfaction level-1	8	80%
satisfaction level-2	2	20%

8. 10th question regarding service provided by health assistant in the community clinic .

Responses/answered to the questions Q#10.	Number of respondents	Percentage
satisfaction level-4	8	80%
satisfaction level-2	2	20%

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10.11th question regarding service provided by family welfare assistant in the community clinic.

Responses/answered to the questions Q#11.	Number of respondents	Percentage
satisfaction level-3	3	30%
satisfaction level-2	7	70%

11.12th question regarding further improvement of community clinic.

Responses/answered to the questions Q#12.	Number of respondents	Percentage
positive impact level is high	8	80%
positive impact level is medium	2	20%

12.13th question regarding overall present condition of community clinic .

Responses/answered to the questions Q#13.	Number of respondents	Percentage
positive impact level is high in present condition	7	70%
positive impact level is medium in present condition	3	30%

13.14th question regarding normal delivery wash in the

community clinic .

Responses/answered to the questions Q#14.	Number of respondents	Percentage
positive impact level is high	8	80%
positive impact level is medium	2	20%

4.3. Response of physicians/Doctors from upazila health complex at sherpur of bogra

Five (5) doctors of upazila health complex (UHC) at sherpur upazila under bogra district were interviewed by a check list of 14 questions (Annex-2).Ranking of satisfaction level: 1means lowest level of satisfaction and 5 means highest level of satisfaction in shuvgacha community clinic, under khamarkandi union, at sherpur upazila in bogra district.

1. 1st question was regarding medicine provided by community clinic .

Responses/answered to the questions Q#1.	Number of respondents	Percentage
satisfaction level-3	4	80%
satisfaction level-4	1	20%

1. 2nd question was regarding counseling provided by community health care provider at community clinic .

Responses/answered to the questions Q#2.	Number of respondents	Percentage
satisfaction level-2	2	40%
satisfaction level-3	2	40%
satisfaction level-4	1	20%

1.3rd question was regarding community group activities at community clinic level .

Responses/answered to the questions Q#3.	Number of respondents	Percentage
satisfaction level-3	1	20%
satisfaction level-4	4	80%

1.4th question was regarding community support group activities at community clinic level .

Responses/answered to the questions Q#4.	Number of respondents	Percentage
satisfaction level-3	2	40%
satisfaction level-4	3	60%

1.5th question was regarding skillness of community health care provider at community clinic.

Responses/answered to the questions Q#5.	Number of respondents	Percentage
satisfaction level-3	2	40%
satisfaction level-4	3	60%

1. 6th question was regarding ante natal care (ANC) provided by community clinic .

Responses/answered to the questions Q#6.	Number of respondents	Percentage
satisfaction level-3	3	60%
satisfaction level-4	2	20%

1.7th question was regarding post natal care (PNC) provided by community clinic .

Responses/answered to the questions Q#7.	Number of respondents	Percentage
satisfaction level-2	1	20%
satisfaction level-3	3	60%
satisfaction level-4	1	20%

1.8th question was regarding counseling about non communicable disease by community clinic .

Responses/answered to the questions Q#8.	Number of respondents	Percentage
satisfaction level-3	2	40%
satisfaction level-4	2	40%
satisfaction level-5	1	20%

1.9th question was regarding wash facilities provided by community clinic .

Responses/answered to the questions Q#9.	Number of respondents	Percentage
satisfaction level-2	3	60%
satisfaction level-3	2	20%

1.10th question was regarding service provided by health assistant community clinic .

Responses/answered to the questions Q#10.	Number of respondents	Percentage
satisfaction level-4	2	40%
satisfaction level-3	3	60%

1.11th question was regarding service provided by family welfare assistant community clinic .

Responses/answered to the questions Q#11.	Number of respondents	Percentage
satisfaction level-3	4	80%
satisfaction level-4	1	20%

1.12th question was regarding further improvement of community clinic.

Responses/answered to the questions Q#12.	Number of respondents	Percentage
positive impact level is high	4	80%
positive impact level is medium	1	20%

1.13th question regarding overall present condition of community clinic .

Responses/answered to the questions Q#13.	Number of respondents	Percentage
positive impact level is high in present condition	3	60%
positive impact level is medium in present condition	2	40%

1.14th question regarding normal delivery wash in the community clinic .

Responses/answered to the questions Q#14.	Number of respondents	Percentage
positive impact level is high	3	60%
positive impact level is medium	2	40%

Total number of respondents persons between the groups was 15.From the analysis of collected primary data answers within two groups are found almost same in most of the cases, but some answers vary far differences from one to another in same cases. It may be due to lack of clear knowledge or may be to self interest. Some of the respondents said more than one answers to a single query in some cases. The findings of this study are summarized according to the results and discussion.

Chapter-5

Findings of the study, conclusion and recommendations for further improvement

5.1. Findings of the study:

From the analysis of interview of 10 stakeholders who are living surrounding shuvgacha community clinic is found that regarding medicines and counseling all respondents are highly satisfied. Another regarding issues community group and community support group activities are not highly satisfied of all respondents. Regarding activities of community health care provider respondents are highly satisfied. Everybody of stakeholder and government officers are more or less satisfied regarding each and every query. Some obstacles prevailing in the community clinic like diagnosis and investigation of diseases. Lack of space for men and women . Toilets are unclean and dirty, water supply not sufficient.

Scarcity of medicines is very common events in the community clinics. Required equipment and furniture are not up to the mark. Load shading is a regular phenomenon. Health assistant and family welfare assistant are not dutifull regarding their responsibilities. No medical waste management facility in the community clinic.

5.2 .Conclusions

Ensuring primary health care by a community clinic is very good for rural people. In everyday large number of patients including male, female, children and adolescents are attending the community clinics daily for primary health care services. The perceptions of patients on behavior of service providers and about health care services provided in the community are found encouraging as four–fifths of users are at least fairly satisfied with behavior of service providers and health services received . Supply of human resources, training provided to the service provider, supply of medicines and other logistics are reasonably good. However there are still enough rooms for improvement of primary health care services in the community clinic. so , based on the findings some specific recommendations are placed below for further improvement of the primary health care initiatives through community clinics for rural people.

5.3. Recommendations

Recommendations are given below separately on the findings

5.4. Infrastructure

Construction of approach road and boundary wall/fencing to community clinics or relocation of some these should get priority.

Arrange adequate facility for primary diagnosis and investigations.

Renovate the community clinic building with adequate spacious rooms for maintaining privacy of the patients especially for women.

Ensure adequate sitting arrangement for the patients and cleanliness of the community clinic and its premises.

Repairing and renovation of tube-well and toilet should get priority.

5.5.Logistics

A significant proportion of the service recipients reported that lack of medicine. Increase supply of medicines by at least 50%, particularly the antibiotics including for children and supply adequate medicine for non-communicable diseases like high blood pressure, diabetes and Autism.

Supply adequate furniture namely steel almirahs; equipment, namely, weighing machines and height measuring tool for the children and other logistics.

Ensure electricity supply in the community clinic.

5.6.Management

Developed improve systems of software and build local capacity to maintain and use the this infrastructure.

Promote a culture of information use at all levels of the health system, and strengthen good governance.

Recruit service providers in the vacant positions of CHCP, HA, and FWA.

Ensure medical officer – preferably lady doctor, and FWV to sit fortnightly in the community clinic.

Ensure SACMO sit once a week in the community clinic.

Update the job descriptions of service providers according to the envisioned responsibilities for specific service provider – CHCP, HA, and FWA.

Review and modify the service registers for proper monitoring of different age categories of people, e.g, men, women, children and adolescents.

Ensure required need based basic and regular refreshers training for the service providers.

Arrange training for CHCP and others on how to use equipment supplied in the community clinic.

Develop supervision and monitoring guidelines and mechanism for the immediate supervisors and for the upazila officers and increase supervision and monitoring.

Develop a guideline for waste management.

5.7. Others Issues

Take necessary steps for better engagement of community group, community support group and multipurpose health volunteer(MHV).

Initiate conduction of normal child delivery providing with necessary equipment and trained personnel.

Motivate service providers to be pleasant in behavior and listen to the problems of the patients attentively; and provide health service with more care.

Increase awareness among people about the community clinic. Government agencies and NGOs should use innovative strategies arriving at demonstrable and fundamental changes in stakeholder behavior.

"Community clinic is certainly a poor people oriented health initiative led by the present government. If quality primary health services can be ensured near doorsteps services even at the remotest corner of the country, people will regularly seek required service from the well-trained community health care providers at the health facilities, instead of the untrained traditional health worker. It is expected that community clinics will ensure provision of quality healthcare services for the mass people of rural area of Bangladesh, particularly the poor, vulnerable, and the underprivileged and will contribute to the achievement of the health development goals under SDGs and in the post-2030 period.

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CHECKLIST OF QUESTIONS FOR INTERVIEW (stakeholder) (Annex-1)

Number of Responded 10(stakeholder)

Name of the Responded (optional) Nationality:

Community Clinic : Age :

Tick the number for your satisfaction level as a service provider from non government part (1 means lowest and 5 means highest satisfaction level

SL. NO.	QUESTIONS TO BE ASKED	ANSWERS
1	What is your satisfaction level regarding medicine provided by community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
2	What is your satisfaction level regarding counseling before provided medicine	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
3	What is your satisfaction level regarding community group activities in community clinic	1 ☐ 2 ☐ 3 ☐ ☐ ☐
4	What is your satisfaction level regarding community support group activities in community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
5	What is your satisfaction level regarding service delivery about community health care provider	1 ☐ 2 ☐ 3 ☐ ☐ ☐
6	What is your satisfaction level regarding ante natal(ANC) care	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
7	What is your satisfaction level regarding post natal(PNC) care	1 ☐ 2 ☐ 3 ☐ ☐ ☐
8	What is your satisfaction level regarding counseling about non-communicable-disease (NCD) in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
9	What is your satisfaction level regarding wash facilities in the community clinic	1 ☐ 2 ☐ 3 ☐ ☐ ☐
1o	What is your satisfaction level regarding service provided by health assistant in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
11	What is your satisfaction level regarding service provided by family welfare assistant in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
12	What is your opinion about community clinic for further improvement(open question)	
13	What is your suggestion regarding present condition in community clinic (open question)	
14	What is your opinion about normal delivery in the community clinic (open question)	

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CHECKLIST OF QUESTIONS FOR INTERVIEW (Physician at UHC) (Annex-2)

Number of Responded 5 (Doctors)

Name of the Responded (optional) Nationality:

Community Clinic : Age :

Tick the number for your satisfaction level as a service provider from non government part (1 means lowest and 5 means highest satisfaction level

SL. NO.	QUESTIONS TO BE ASKED	ANSWERS
1	What is your satisfaction level regarding medicine provided by community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
2	What is your satisfaction level regarding counseling before provided medicine	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
3	What is your satisfaction level regarding community group activities in community clinic	1 ☐ 2 ☐ 3 ☐ ☐ ☐
4	What is your satisfaction level regarding community support group activities in community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
5	What is your satisfaction level regarding service delivery about community health care provider	1 ☐ 2 ☐ 3 ☐ ☐ ☐
6	What is your satisfaction level regarding ante natal(ANC) care	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
7	What is your satisfaction level regarding post natal(PNC) care	1 ☐ 2 ☐ 3 ☐ ☐ ☐
8	What is your satisfaction level regarding counseling about non-communicable-disease (NCD) in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
9	What is your satisfaction level regarding wash facilities in the community clinic	1 ☐ 2 ☐ 3 ☐ ☐ ☐
1o	What is your satisfaction level regarding service provided by health assistant in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
11	What is your satisfaction level regarding service provided by family welfare assistant in the community clinic	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
12	What is your opinion about community clinic for further improvement(open question)	
13	What is your suggestion regarding present condition in community clinic (open question)	
14	What is your opinion about normal delivery in the community clinic (open question)	