CONTEXT ANALYSIS: CLOSE-TO-COMMUNITY HEALTH CARE SERVICE PROVIDERS IN BANGLADESH

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Introduction

Close-to-community (CTC) health service providers are playing an important role in delivering health services in both urban and rural areas of Bangladesh. CTC health service providers are the most easily accessible and widely accessed providers. There is a gap in the evidence base on the roles, responsibilities and interaction between formal and informal providers, particularly in the growing urban slum areas. Also, there is a need to further understand the facilitators and barriers that influence the performance of different groups of CTC health service providers and their interrelationships.

The aim of this study was to identify the facilitators and barriers which affect the performance of these providers who work in close proximity to the community. Our research explored the role of CTC health service providers in the provision of sexual and reproductive health (SRH) services, with a focus on menstrual regulation (MR) services (manual vacuum aspiration and other ways to safely establish non-pregnancy up to 8–10 weeks after a missed menstruation period) and needs in two urban slum settings in the city of Dhaka and one urban slum and one rural setting in the city of Sylhet.

We started with a desk review to understand the existing situation of the CTC health service providers and their role in the health care systems of Bangladesh. The desk review was followed by a mapping of stakeholders and complementary quantitative and qualitative research to understand the context in which CTC services are operating in poor communities in Bangladesh.

Desk review

The existence of various types of CTC health service providers is a common scenario in Bangladesh. Most of them are from the private or informal health sectors; include *kabiraj*,[1] *dai*,[2] drugstore salespeople and Ayurvedic practitioners. Many of them are not 'formally trained', and the country faces a huge shortage of human resources for health.

The literature indicates that the overall quality delivered by health service providers is unclear, with reports of poor quality of care and challenges to accountability, in both the formal and informal sectors. In addition, poor regulation and limited referral and interaction between formal and informal providers has negative impacts on the health of the poor people in rural

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[1] *Kabiraj* is a term used for spiritual healers or herbal treatment providers or traditional healers who belong to the category of informal health service provider in the research setting.
[2] Traditional Birth Attendants are commonly known as *dai*.

areas and, particularly, in neglected urban slum settlements. The desk review found a systematic lack of structures in place to make the public health care system operational in urban slums as they are in rural areas. In the private sector, the number of providers and the fact that they include health actors from both formal and informal categories make the structure very complex.

Mapping of stakeholders

We organized two stakeholder workshops to understand SRH-related needs, with researchers and service delivery organizations and service providers (both formal and informal). Participants in the meeting included researchers from different research institutions and government and private academic institutions, all with much experience in the field of SRH. They discussed and agreed that, while there is a lot of interest, very little research has been conducted on SRH, the role of informal providers and their linkages with private providers and the formal public health care sector. During the workshop many of the participants shared concerns on engaging with the informal sector, where many providers were seen as having no skills and were viewed as 'quacks'. This was a view also shared by the formal providers in the second workshop.

Participants in the provider-level stakeholder meeting included SRH service providers from non-government organizations (NGOs) (Marie Stopes and RHSTEP) and informal providers (drug sellers, village doctors, informal homeopathic practitioners etc.) from four sites: Kallyanpur, Keraniganj, Ghashitola and Lakkatura. Participants agreed that formal referral systems between the private, public and informal sectors were non-existent and that this meant that most providers worked in competition with one another.

Particularly for the NGO sector, community health workers were often underpaid or worked as volunteers, leading to poor commitment and high turnover. There is no consistency among NGOs regarding community health workers' pay scales. Government field-level health workers experience little supervision, and it was found that they did not visit communities regularly or provide regular services.

Methodology

This study involved both quantitative and qualitative methods. To identify the diversity of CTC providers and their roles, we conducted a comprehensive mapping in three urban slums and one poor rural village in two districts.

Different strategies were adopted to conduct the CTC mapping, including Participatory Rural Appraisal (PRA) techniques such as physical mapping, informal group discussion (IGD),

participant listing and the validation of primary listing for all providers working in the selected slum areas. The physical map and health resource mapping techniques helped us to identify the exact location of the popular providers. A total of 540 participants, of which 160 were male and 380 female, took part in the IGDs, and there were 183 individual discussions.

To understand the context in which CTC health service providers operate in poor communities in Bangladesh with respect to SRH, we conducted a qualitative study including 12 focus group discussions with (married) male and female community members, 32 semi-structured interviews with formal and informal CTC health service providers and 24 in-depth interviews with clients of MR services. Semi-structured interviews with key informants were conducted with doctors, paramedics and programme staff.

Findings

Mapping of CTC providers
There were 74 CTC health service providers per 10,000 population in the four selected study areas. Formal CTC health service providers comprised 32% of all providers interviewed, and included community health workers (27%, including Trained Birth Attendants and midwives), para-professionals (5%) and physicians (2%). The remaining 68% of providers interviewed were informal CTC health service providers, including traditional healers (22%), traditional (untrained) birth attendants (19%), allopathic drug sellers (13%), village doctors (12%) and informal homeopaths (4%). Providers reported having an average of 15 clients per day, providing services related to pregnancy care, treatment of common illnesses (fever, cold, cough, headache and diarrhoea), neonatal and child care, family planning and other SRH problems. Nearly half (45%) of all CTC health service providers reported that they had not received any kind of formal health education or training to prepare them for their role.

Qualitative research findings
We found that informal CTC health service providers are well accepted in urban slums for all types of health problems. They are more acceptable to the community than formal CTC health service providers in terms of their availability, accessibility and affordability. Consequently, formal CTC health service providers have to work very hard to build a rapport with and gain the trust of community members; they face challenges of workload and limited incentives. As found in the study, having a strong relationship with the community is particularly important to carry out the services to support community members.

In addition, providing services is a multi-tasking scenario with a heavy workload, as explained by both the formal and informal providers. Formal providers often find it difficult to balance their

professional and personal lives. For some formal CTC health service providers, the daily workload may compromise the quality of services. Limited training, irregular logistical supplies and an absence of effective referral links between various (formal and informal) CTC health service providers are also key factors that affect their performance in the field of SRH. The supervision system is mostly weak and lacks a proper documentation process and reporting system. While informal providers are very content with non-financial support, formal providers find it hard to meet their financial needs with the limited salary/incentive they receive.

From our findings it became evident that the imbalances in the Bangladeshi health system create segregation between formal and informal providers. Establishing closer communication, coordination and appropriate referral between formal and informal CTC health service providers would be required to build more effective and equitable community health systems in urban slums in Bangladesh.

MR is a stigmatized and sensitive issue in all four locations. Women visit both formal providers, such as government, NGO or private hospitals or clinics, and informal providers, such as drug sellers and informal practitioners of herbal medicines, for MR services. In selecting a provider, either formal or informal, the MR clients depend on their relatives' and neighbours' suggestions.

Discussions of findings
Since our study focused on the factors acting as facilitators of or barriers to CTC health service providers' performance, it was important to get to know the community's preferences for choice of health care providers. We found that, due to certain preconceived notions and disappointing experiences in terms of the quality of care and cost of formal health care, people sought 'low-cost' treatment from informal providers. As for these informal providers, the trust and recognition they generate offer hope to people who believe in such providers; they can be approached easily and are always available. Formal providers, meanwhile, have difficulties in gaining and maintaining such trust and community access.

Informal providers are seen as family members in the community, and with their flexible service delivery they establish a stronger relationship with clients than the formal providers, who are bound by organizational rules and regulations for service provision. As for the recruitment process, government and private organizations have a standard procedure followed by basic training options. Our study found that continuous education is desired and would help to maintain and improve the quality of service. This would also be applicable to the informal providers, especially the drugstore salespeople and village doctors, and would reduce the 'malpractice' related to SRH services in the informal sector.

As our literature review also showed that there is no regulatory authority to perform monitoring and evaluation of informal providers, concerns about the quality of services remain. Although the NGO sector offers some supervisory mechanism, that, too, in most cases lacks a systematic approach. In general, there are weaknesses in feedback, coaching, problem solving, skills development and regarding initiatives identified in the formal sector (government and NGOs). Neither government nor private sectors incorporate informal providers, who are mainly independent providers and, therefore, lack supervision, support and capacity development opportunities. At the same time, maintaining proper supervisory systems is important, as these can identify gaps in service delivery and address the quality of care, and can thereby provide CTC health service providers with recommendations and feedback.

As stated by formal CTC health service providers, the magnitude of their workload restricts their ability to visit the same community frequently. Government providers such as Family Welfare Assistants and Family Welfare Visitors have limited time to visit community households to offer services, and a 'huge target' to meet. Furthermore, inappropriate monetary benefits, non-systematic working hours and poor coordination between the supervisors and the front-line providers hamper good performance. However, this research also found that the informal providers do not see workload as a problem, since they work independently and have flexible working hours. Finally, the research also revealed that although in most cases MR clients are referred by the informal providers to the formal providers, not all informal providers are linked to the formal health care referral system. Moreover, the government is lagging in creating policies to regulate informal providers at all, and thus they cannot join the existing formal referral system.

Summary of facilitating factors of and barriers to CTC health service providers' performance
Several broad contextual factors were identified that, sometimes indirectly, influenced the performance of CTC health service providers. Barriers identified included limited local government participation in decision-making, linked to decentralization processes; a lack of opportunities for community participation; and a lack of health sector policies addressing the role of informal care providers. On the other hand, the legal recognition of MR facilitated the role of CTC health service providers in this area, although socio-cultural issues limit openness to talk about sensitive issues and limit the choice of (informal vs. formal) providers. While formal providers attempted to maintain good relationships with their communities, communication and interaction with clients was limited and undermined trust and health-seeking behaviour.

Health system factors influencing performance were varied. The pluralistic nature of the health care system was seen as a facilitating factor more than as a barrier, offering a wide range of care options to community members. However, user fees involved in formal CTC health services

were perceived as a barrier; quality was perceived as poor, and cost was seen as being unaffordable and led to a preference for informal over formal services. That informal providers were 'part and parcel' of the community was perceived to be a facilitating factor, as it contributed to trust and led to a better overall perception by community members. The lack of regulations addressing the quality of care, which also leads to weak accountability mechanisms, was seen as a barrier. Additionally, the fact that informal providers are not 'organized' limits opportunities for coordination, while the lack of refresher training was felt to affect many of the formal providers.

In the domain of intervention design factors, the performance of CTC health service providers was felt to be affected by a number of issues. Again, interaction, communication and trust between CTC health service providers and community members were seen as being very important; the context and also the regulations concerning such interaction limited formal providers' ability to build trust among communities. Recruitment procedures and the payment of salaries for formal CTC health service providers were seen as facilitating their performance and the quality of care. Continuous education and training, seen only among formal providers, also aided the performance of both government and non-government organizations.

On the other hand, the excessive workload seen among many formal providers acted as a barrier, as it limited frequent interaction with the same households and may affect the quality of care. The lack of proper supervision systems and their implementation further aggravate this. Furthermore, insufficient monetary benefits, irregular working hours, poor coordination between the supervisors and the CTC health service providers, and limited monitoring and evaluation systems hampered performance. The lack of any potential for promotion for government CTC health service providers sometimes demotivates them from putting in more effort. Furthermore, the findings of this research revealed that there is no effective referral system in place among (formal or informal) providers.

Implications and the way forward
With respect to the REACHOUT quality improvement cycles in Bangladesh, it is important to develop a communication strategy for the formal and informal CTC health service providers to support further collaboration. Enabling partnerships will also ensure that the two sectors remain up to date regarding relevant information and support on SRH and MR treatment methods, which they can then share with different community members.

The existence of an unbalanced health system creates segregation between formal and informal providers, leading to formal providers not always linking with the informal providers and a lack of consistent, proper communication between the two. There is a need to evaluate

this partnership and extend it to formal and informal CTC health service providers, and to design a systematic referral process that can link formal and informal providers and can effectively facilitate the service delivery system for efficient provider performance. This will also ensure better linkages among health services and improve access to services for communities.

Formal CTC health service providers working in SRH require continuing education and a better supervisory system to enhance their performance. Structured monitoring and evaluation processes and supervisory support are also important elements to be explored in the development of quality improvement cycles. The supervisory system needs to be well documented to monitor the formal and informal (when involved in referral processes) CTC health service providers and also to evaluate the quality of the SRH and MR services they provide.

CONTENTS

ABBREVIATIONS AND ACRONYMS

BHW	Bangladesh Health Watch
CHW	Community Health Worker
CTC	Close-to-community
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DOTS	Directly Observed Treatment, Short-course
DSK	Dushtho Shashthya Kendra
EPI	Expanded Programme of Immunization
FGD	Focus group discussion
FPI	Family Planning Inspector
FPO	Family Planning Officer
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant
HEED-BD	Health, Education and Economic Development Bangladesh
HI	Health Inspector
HPNSDP	Health, Population and Nutrition Sector Development Programme
IDI	In-depth interview
IGD	Informal group discussion
JPGSPH	James P Grant School of Public Health
KII	Key informant interview
LGD	Local Government Division
LMAF	Local Medical Assistant and Family Planning
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and evaluation
MNCH-FP	Maternal, neonatal and child health and family planning
MoHFW	Ministry of Health and Family Welfare
MoLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MR	Menstrual regulation
NGO	Non-government organization
NIPORT	National Institute of Population Research and Training
PHC	Primary health care
PO	Programme Organizer
RA	Research Assistant
RHSTEP	Reproductive Health Services Training and Education Program
RTI	Reproductive tract infection

SK	Shasthya Karmi
SRH	Sexual and reproductive health
SS	Shasthya Shebika
SSI	Semi-structured interview
STI	Sexually transmitted infection
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
UBA	Urban Birth Attendant
UNFPA	United Nations Population Fund
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
UTPS	Unity through Population Service

CHAPTER 1 – INTRODUCTION

BACKGROUND

Many low- and middle-income countries are striving to achieve the Millennium Development Goals and universal health coverage, and are increasingly implementing close-to-community (CTC) health services. Public health services in Africa and Asia are struggling to serve poor and vulnerable communities that bear the brunt of the global burden of disease. CTC health service providers are the front-line health workers in many countries and are mostly embedded within the community. Hence, they can, if they are given appropriate training and are regulated, make health care services more equitable and efficient. In most cases, however, their training and regulation needs are unmet. A diverse group of CTC health service providers, such as Community Health Workers (CHWs), midwives, Traditional Birth Attendants (TBAs) and informal private practitioners of biomedicine, deliver a wide range of health services in rural and urban slum areas of many low- and middle-income countries. These CTC health service providers are engaged in roles such as education, counselling, treatment, follow-up and even data collection. Even with these roles, there still remain some issues in terms of the quality of care, starting with the service delivery platform, which, if strengthened, can meet the health needs of individuals and households, making it more appropriate to link the health sector and beyond. There is a need for health systems to understand the context and conditions in which CTC services operate, to strengthen and support these critical services to realize their potential.

The aim of the REACHOUT consortium has been to maximize the equity, effectiveness and efficiency of CTC health services in rural areas and urban slums in six countries: Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique. The project has been coordinated by the Liverpool School of Tropical Medicine (LSTM) in the UK and the Royal Tropical Institute (KIT) in the Netherlands.

REACHOUT has set objectives to: build the capacity to conduct and use health systems research to improve CTC services; identify how community context, health policy and interactions with the rest of the health system influence the equity, effectiveness and efficiency of CTC services; develop and assess interventions to improve CTC services; and inform evidence-based and context-appropriate policymaking for CTC services.

REACHOUT in Bangladesh is implemented by the James P Grant School of Public Health (JPGSPH) of the BRAC Institute of Global Health, BRAC University, Bangladesh. JPGSPH is reputed for its vast array of research activities in rural and urban communities, including but not limited to research in the fields of nutrition, health workforce, universal health coverage

schemes, sexual and reproductive health (SRH) and gender equity. The institute is a hub for evidence-based research platforms in public health, with expertise in health systems and health priority areas relevant to current CTC services, and works in close collaboration with health policymakers, service providers and other research organizations to implement intervention research. The institute also has a reputation for designing and establishing capacity-building strategies and modelling, which would be one of the key elements for this REACHOUT consortium as a whole. REACHOUT in Bangladesh focuses on the potential to improve SRH services in urban slums. The specific objectives of REACHOUT in Bangladesh are:

- to conduct a context analysis of CTC health service providers in Bangladesh;
- to adapt the REACHOUT framework to the Bangladeshi context, with a focus on SRH;
- to carry out two improvement cycles in urban slum areas focusing on the interrelationship between CTC health service providers and the rest of the health system;
- to conduct an intra-country comparison and contribute to inter-country learning;
- to advocate for and inform evidence-based policymaking and operational planning;
- to build capacity with a focus on local CTC health service providers, researchers and policymakers;
- to devise an overall capacity development plan and develop indicators to monitor progress;
- to ensure responsive, timely and appropriate delivery of capacity development activities including South–South technical assistance; and
- to conduct two capacity audit cycles and monitor training effectiveness.

This report contains the context analysis findings on the CTC health service providers in urban slum communities in Bangladesh, focusing on generic SRH and also on the specific issue of menstrual regulation (MR). The purpose of the context analysis was to develop an analytical framework that would evolve from the evidence base and from the qualitative and quantitative research findings. This analytical framework will guide the quality improvement cycles that will be delivered in two phases. The context analysis also assessed the existing structure and policies in the health system that strengthen or weaken the CTC services, and gathered data to inform a more comprehensive understanding of the barriers to and facilitators of the performance of CTC health service providers. This report will also describe the knowledge gaps existing in the health care service delivery, as well as how the community understands the quality of care in terms of SRH.

CONTEXT ANALYSIS

The context analysis research comprised desk review (literature review), a mapping of close-to-community (CTC) health service providers, stakeholder meetings and qualitative research. This section provides an overview of each of these components.

The desk review investigates the existing situation of CTC health service providers and their role in the health care systems of Bangladesh under the different parts of the Ministry of Health and Family Welfare (MoHFW). The review also examines the importance of CTC health service providers' activities and how their performance influences decision-making in health system management. The desk review shows that a market-driven economy has led to the existence of many health service providers in Bangladesh. Most of these providers are from informal sectors. It also shows that about 70–75% of Bangladeshis go to informal providers (traditional healers, informal practitioners of biomedicine etc.). The desk review has identified that there is a lack of systematic and defined health policy for unregulated CTC health service providers in Bangladesh.

A mapping of CTC health service providers was conducted in four research sites. They were listed according to the responses of respondents from the community. Every CTC provider identified was engaged in an individual discussion session with the mapping team to validate the information received from the community. Finally, a comprehensive and reliable list was developed at the end of the research process. The CTC mapping showed that most of the providers are from the informal sector, which confirms the findings from the desk review. Furthermore, it was found that informal providers were the most popular service providers in the community.

Two stakeholder workshops were organized to collect the views of stakeholders from a variety of backgrounds. One researcher-level stakeholder workshop was held on 27 August 2013 during fieldwork, and a provider-level stakeholder workshop was held on 30 September 2013. The third workshop will be held at the end of April 2014 for policy-level stakeholders. The researcher-level stakeholder workshop suggested that there is a lack of research into SRH and that there is a need for collaborative research initiatives. The stakeholder workshop with CTC health service providers, on the other hand, suggested that there is a willingness among CTC health service providers and various service delivery providers to work together to deliver effective and efficient health care services.

Finally, a qualitative research study was conducted to explore the performance of the CTC health service providers in four locations of two districts. The research focused on identifying substantial evidence to design an effective intervention. It also provided an opportunity to hear

the community's perceptions of the work and performance of the CTC health service providers working within or in close proximity to selected study areas. This qualitative research showed the existence of a variety of CTC health service providers in the three urban slums and one rural location where the study was conducted. Most of these providers were informal providers who were mostly untrained. It was reported that most community members prefer to visit the informal providers. It was also revealed that the lack of training, supervision and effective linkage of referrals between formal and informal providers are the key areas that affect the CTC health service providers' performance.

To ensure the compatibility of findings between countries, a generic protocol was developed by KIT and LSTM. This was then adapted to the country context. During the methodology workshop in Liverpool a training of trainers was conducted with the aim of developing a generic approach to the training of data collectors and familiarizing and adapting generic instruments for the stakeholder workshop and data collection. During the consortium meeting in Amsterdam preliminary results of the country analysis reports and a root cause analysis for further discussion in the stakeholder workshops were drafted. The rationale for this is to generate consistency and to ensure that the work across the country teams is visible.

REPORT SECTIONS

This report has seven chapters. Chapter 1 introduces key issues including the justification and purpose and the specific role of the JPGSPH. It also discusses the components of the context analysis. Chapter 2 discusses the health system of Bangladesh, with literature on CTC health service providers. It also focuses on the quantitative research (CTC health service provider mapping) methodology and the key findings that have emerged. Chapter 3 presents the outcome of the two stakeholder workshops carried out among the researcher and provider levels. Chapter 4 deals with the methodology, findings and discussion of the quantitative research of the context analysis. Chapter 5 discusses the methodology, findings and discussion of the qualitative part of the context analysis research on a variety of CTC health service providers from two districts (Dhaka and Sylhet). Chapter 6 provides an overview of implications for the draft analytical framework by prioritizing the problem areas for the quality improvement cycle of the project.

BACKGROUND

GENERAL HEALTH SITUATION

Bangladesh is facing rapid urbanization. Dhaka City is projected to become the fourth largest city in the world by 2025, with 22 million people, due to its rapid urban migration and growth in urban slum populations (United Nations, 2007; NIPORT et al., 2008). A majority of the slum settlements tend to be located in low-lying, flood-prone areas, with poor drainage, limited formal garbage disposal and minimal access to safe water and sanitation and services, and are often neglected by the State. The conditions of high population density and poor sanitation exacerbate the spread of disease and other kinds of vulnerability (Rashid, 2009).

The existing health services represent a rather pluralistic health system in this context, with CTC providers being one of its ultimate resources and the first line of contact for many Bangladeshis. In fact, evidence suggests that the first line of health professionals (nurses and doctors working in lowest-level health facilities) are the most critical driving force for any health system for promoting health and preventing and treating diseases (Joint Learning Initiative, 2004). In Bangladesh, it has been noted that some positions at the district and sub-district level remain perpetually vacant, even though these positions were created at an earlier stage by the MoHFW Civil Surgeon Offices (a few districts in 2012 — personal communication). Due to this situation in the health sector, sometimes it is a difficult task to support the government-level CTC health service providers adequately and to measure their performance effectively.

INTRODUCTION

In the 1970s, many low-income countries invested in Community Health Workers (CHWs) who received basic training and were often volunteers. However, from the 1980s onwards, programmes involving CHWs went into decline due to political instability, economic policies and financing difficulties (REACHOUT Description of Work, 2012, unpublished). The objective of this systematic literature review is to investigate the situation of CTC health providers and their role in the health care system of Bangladesh under the different wings of the MoHFW. Thus, this review focuses mainly on the CTC health service providers. The review also examines the importance of their activities and how their performance influences policymakers in decision-making in health system management.

The document has been organized around topics relevant to CTC health service providers — namely, characteristics of the CHWs, history of the CHW programme, the recruitment process,

retention, management etc. It also highlights characteristics of the CTC providers from the experiential side and how their functions are embedded in community well-being. The document briefly describes the monitoring and evaluation (M&E), quality assurance and human resource management processes of the CTC health service providers.

METHODOLOGY

The search strategy accommodated the broader range of health systems in the context of a developing country. We combined 'CTC health service providers' with the term 'health system' or 'primary health care' and 'community health services' and with impact or outcome measures and with specific search terms relating to human resource management, quality assurance, M&E, community or policy factors, health provision, government actors, characteristics of the health system in Bangladesh with an urban focus, or extent of decentralization. In general, the study was limited to a literature search of articles published in English within the past 10 years (from 2003 to 2013), with a focus on low- and middle-income countries in South Asia.

Search strategy

A total of 13 articles were obtained from Urban Health in Bangladesh, Local Government and Engineering Department. These articles were retrieved from the Internet using the Google Scholar search engine. Of the 13 articles, four were found to be relevant to the activities of urban health service provision by government actors. In addition, websites of urban health services provided by the government's Local Government and Engineering Department were reviewed. The remaining nine articles were excluded, since they did not match the study objectives for CTC health service providers.

Routine publications from the Directorate General of Health Services (DGHS) of the Government of Bangladesh were collected in person. Some of the keywords used were: 'heath system', 'rural urban bifurcation' and 'reporting recruitment maternal health'. The publications obtained included: health bulletins, newsletters, annual reports, yearbooks, non-routine departmental surveys, and government–NGO collaboration programmes (five articles and reports were obtained). All of these reports provided information on the government's activities in health service provision by the DGHS and Directorate General of Family Planning (DGFP) in rural areas.

Peer-reviewed scientific journal databases such as Medline, Hinari, PLOS Medicine, Open Access Journals Search Engine (OAJSE) and JSTOR (digital library) were the sources for the journal search. The keywords used for the search strategy were: 'community health worker', 'health system service delivery', 'public private health initiatives' and 'management reporting

authority'. A total of 24 articles were reviewed, of which 10 were relevant to the keywords in the context of developing countries, with a specific focus on Bangladesh.

A search of routine and ad hoc organizational reports/monographs resulted in seven articles which were found to match the study objectives. The keywords used were: 'health service provision: public and private sector actors in Bangladesh', 'primary, secondary and tertiary health facilities', 'monitoring and evaluation', 'quality assurance', 'human resource management', 'referral chain', and 'reproductive and other health rights'. All seven of these articles were found to be relevant to the study.

CHARACTERISTICS OF THE HEALTH SYSTEMS IN BANGLADESH

EXTENT OF DECENTRALIZATION

Bangladesh has made significant progress in health indicators in recent years despite the low level of per capita income. Life expectancy at birth for both males and females has gone up since the 1980s. Infant and under-five mortality, the maternal mortality ratio and fertility rates have also declined considerably (NIPORT, 2011; 2012). According to national health policy of Bangladesh, the provision of primary health care (PHC) services is a public responsibility, and the government is committed to fulfil this role through its own facilities, which are geographically dispersed (MoHFW, 2011a). A well-developed rural health infrastructure exists in Bangladesh compared to urban areas, but they are inefficiently operated, and there is a trend of declining use of public facilities in recent years (Cockcroft et al., 2004; 2007). People rely increasingly for curative care on the private sector, which includes different types of actors.

Available studies on the problems of the health care sector focus on proximate causes such as the absence of doctors, incompetence and indifference of health staff, and corruption related to medical supplies and unofficial fees charged from patients (Cortez, 2006). However, the underlying causes of inefficiency are rooted in the system, which lacks both incentives and accountability. PHC service facilities in Bangladesh are not completely decentralized. This is because of the lack of participation of the local government and the community, particularly in the financial and decision-making processes, in which the central government is directly involved.

Administratively, Bangladesh's health system is decentralized, with weak intersectoral discipline that affects service provision in curative care (Cockcroft et al., 2004; 2007). The concept of decentralization has been considered instrumental in achieving development goals such as improved provision of public health services (Mills et al., 1990). It is argued that in a

decentralized system service provision may be geared to people's needs and demands; it can be cost-saving for the central government because local resources may be mobilized; and it can be cost-effective in the sense that community participation and social accountability ensure good services.

Decentralization not only changes the role of the MoHFW and the DGHS, which make policy and administrative decisions centrally, but also devolves responsibility to peripheral units of health care services with more administrative management and financial authority in decision-making and implementation (Cockcroft et al., 2004; 2007). As a result, the MoHFW and DGHS can concentrate more on legislation, policy and strategy formulation, standard setting, supervision, M&E and research. It is expected that the future health policy or public health policy of Bangladesh will reflect a PHC approach, with proper decentralization of health services (Cortez, 2006).

PROVISION OF PRIMARY HEALTH CARE SERVICES

The formal document on the national health policy of Bangladesh was first made available in 2000. Prior to that, policies related to health issues were a part of development strategies envisaged in Five-Year Plans and implemented through Annual Development Plans. Since the 1970s the government, supported by donors, has focused on family planning, reproductive health and child-care services to be delivered by local-level government facilities dispersed throughout the country (Ahmed et al., 2007). According to the national health policy undertaken in 2000 (MoHFW, 2003), the government accepts responsibility for delivering PHC as included in essential service packages with limited curative care. It guarantees access and quality of care to the population at affordable prices, and services are to be provided through local-level health complexes. An additional goal is to create a pluralistic environment among service providers, with a reliance on NGOs for preventive care and promotional activities.

The public sector commonly bears the responsibility of basic service provision through a central bureaucracy that reflects the obligation of the State to its citizens. Government failures, however, occur due to the lack of incentives to improve quality and cost control, and often equity goals are not met. Given the inefficiencies of market and central bureaucracies in service provision, some of the health service interventions are contracted out to NGOs and other not-for-profit organizations that have a similar (non-profit) mission orientation as the State.

In 2011, the Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011–2016 was launched (MoHFW, 2003) with the following components: unifying the bifurcated health and family planning service delivery structure; shifting to the provision of 'one-stop' service delivery by phasing out the existing Expanded Programme of Immunization (EPI)

outreach and satellite clinics and establishing fixed service points (community clinics); restructuring the directorates and the ministry through a redefinition of roles, responsibilities and accountabilities, especially developing integrated support services focusing on human resource management, development and training; management information systems; behaviour change communication; quality assurance and procurement (Planning Commission, 2012); decentralizing *thana*-level health and family planning services; improving hospital management through delegation and financial authority; and enhancing cost recovery (through fee retention and local fee utilization).

Some progress has been achieved with respect to directing more resources to PHC, especially for essential service package services and targeting poor people, unification of health and family planning services at the *upazila*[3] level, and the adoption of a sector-wide programme at the ministerial level. However, inequity in access to curative services remains a serious problem (MoHFW, 2003).

PROVISION OF PUBLIC HEALTH SERVICES

Rural areas are served through *upazila* health complexes and union-level health and family welfare centres. In addition to government facilities, NGOs and private practitioners, including dispensaries, provide PHC services. The private sector mainly provides curative care services that are paid for out of pocket by clients (Ahmed et al., 2007). The overall health system could be described as follows: while the central government of Bangladesh, through the MoHFW, is involved in policymaking, design, allocation of resources, regulation and M&E, actual service delivery functions are entrusted to local-level facilities (Cortez, 2006). With respect to staffing, the MoHFW operates through two directorates, mainly the DGHS and the DGFP. The health sector reform outlined in the HPNSDP envisages an integration of the two directorates, but little progress has been made (Cortez, 2006).

The DGHS and DGFP are responsible for functionaries, and all human resources including the community health care providers are recruited at local level and administered by the Civil Surgeon Office at the district level, while the official appointment letter is released from the central level — i.e. the MoHFW. Some of the recruitment such as the appointment of ancillary staff (cleaners, security guards) takes place at the *upazila* (sub-district) level. The medical chiefs of health care facilities handle daily managerial duties without any local government involvement. While all health workers are accountable to the MoHFW and to their respective directorates, there are hierarchies of accountability at different levels of government (Cockcroft et al., 2004; 2007).

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[3] Bangladesh is divided into seven administrative divisions: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur and Sylhet. Each division is divided into *zilas*, and each *zila* into *upazilas*.

HEALTH INFRASTRUCTURE IN BANGLADESH

The government health services are provided by the five-tier administrative units of government-owned and -staffed facilities (Planning Commission, 2012), such as: ward level — EPI outreach centre and satellite clinic/community clinic (lowest administrative units having a population of around 25,000 people); union level –- health and family welfare centres; *thana/upazila* level — health complex providing PHC and some referral services; district level — providing both primary and tertiary care through district hospitals; and medical college hospitals in divisional cities and a few district towns providing tertiary as well as primary care.

HEALTH PROVISION BY GOVERNMENT ACTORS

The government plays the pivotal role in rendering nationwide health services (Planning Commission, 2012). Within the government health system, some actors have a direct mandate for health — i.e. the front-line actors (primary actors). These actors have a direct mandate to provide health services to the people and also play a key role in policy formulation and implementation (Ara, 2008). This group includes the MoHFW, the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC, and the Local Government Division (LGD) (NIPORT et al., 2012). In addition to acting as regulatory/monitoring bodies, both ministries have operational wings (Planning Commission, 2012).

In the MoHFW, two separate directorates exist: the DGHS and the DGFP. With support from these two directorates, the government runs health care facilities throughout the country, including city corporations such as Dhaka (NIPORT et al., 2006). The implementation arm of the MoLGRDC and the LGD are Urban Local Bodies, which comprise municipalities and city corporations. In addition to urban dispensaries, the LGD supports the Urban Primary Health Care Project (UPHCP), which aims to provide PHC and associated support to poor people in urban areas through a donor-supported public–private partnership arrangement, while others are involved as expeditors/facilitators (secondary actors) (MoHFW, 2011b).

MINISTRY OF HEALTH AND FAMILY WELFARE

The MoHFW seeks to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health (NIPORT et al., 2008). To this end, it is responsible for health-related policy and planning, and service delivery. In rural areas, primary-level services are provided at the ward (community clinics), union and *upazila* levels. Secondary services are offered at the district level, while the tertiary level is found in larger municipal centres in all seven divisions of the country (MoHFW, 2011b). In urban areas, MoHFW support to primary service delivery is largely confined to outpatient services provided through tertiary and specialized hospitals (NIPORT et al., 2008).

Directorate General of Health Services (DGHS)

The DGHS is the largest executing authority of the MoHFW. The main responsibilities of this directorate are to implement the plans, policies and decisions of the ministry and provide technical support. In urban areas the DGHS operates the Civil Surgeon Office and public tertiary facilities such as the medical college hospitals (MoHFW, 2011b). The MoHFW is currently implementing the sector-wide HPNSDP 2011–2016, with several operational plans falling under the DGHS. Line Directors are responsible for the implementation of operational plans, and supervise the work of programme managers. The listed operational plans are: Maternal, Neo-natal, Child and Adolescent Health Care; Essential Service Delivery; Community-based Health Care; TB and Leprosy Control; National AIDS/STI Programme; Communicable Disease Control; Non-communicable Disease Control; National Eye Care; Hospital Services Management and Safe Blood Transfusion; Alternative Medical Care; In-service Training; Pre-service Education; Planning, Monitoring and Research (DGHS); Health Information System and e-health; Health Education and Promotion; Procurement, Logistics and Supply Management; and National Nutrition Service (Planning Commission, 2012).

Directorate General of Family Planning (DGFP)

The DGFP is another executing authority of the MoHFW. There are seven operational plans operating under the DGFP — namely, Maternal, Child, Reproductive and Adolescent Health; Clinical Contraception and Service Delivery; Family Planning Field Services Delivery; Planning, Monitoring and Evaluation of Family Planning; Management Information Systems; Information, Educations and Communication; and Procurement, Storage and Supply Management for Family Planning. The administrative and managerial structure of the DGFP is almost identical to the DGHS in rural areas; however, no such structure exists in urban areas. In Dhaka City, only two facilities are operated by the DGFP: the Maternal and Child Health Training Institute, Azimpur, and Mohammadpur Fertility Services and Training Centre (MoHFW, 2011b).

MINISTRY OF LOCAL GOVERNMENT, RURAL DEVELOPMENT AND COOPERATIVES

The mission of the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC) is to improve the public standard of living by strengthening local government systems and institutions and implementing activities for social, economic and infrastructure development (MoHFW, 2011b). Under the LGD, the Urban Local Bodies are responsible for managing the public health services in urban areas only.

Urban Bangladesh is divided into nine city corporations and 306 municipalities (see Figure 1). According to the LGD (City Corporation) Amendment Act, there are 10 zones and 90 wards that make up the Dhaka metropolis, which is divided between Dhaka South City Corporation and Dhaka North City Corporation (Planning Commission, 2012). Under the LGD, Dhaka City

maintains two hospitals and one maternity centre — Dhaka Mahanagar General Hospital, Dhaka Mohanagar Sishu Hospital and Nazira Bazar Maternity Centre — and 35 urban dispensaries. Two Chief Health Officers are responsible for supervising EPI with support from the DGHS (MoHFW, 2011b).
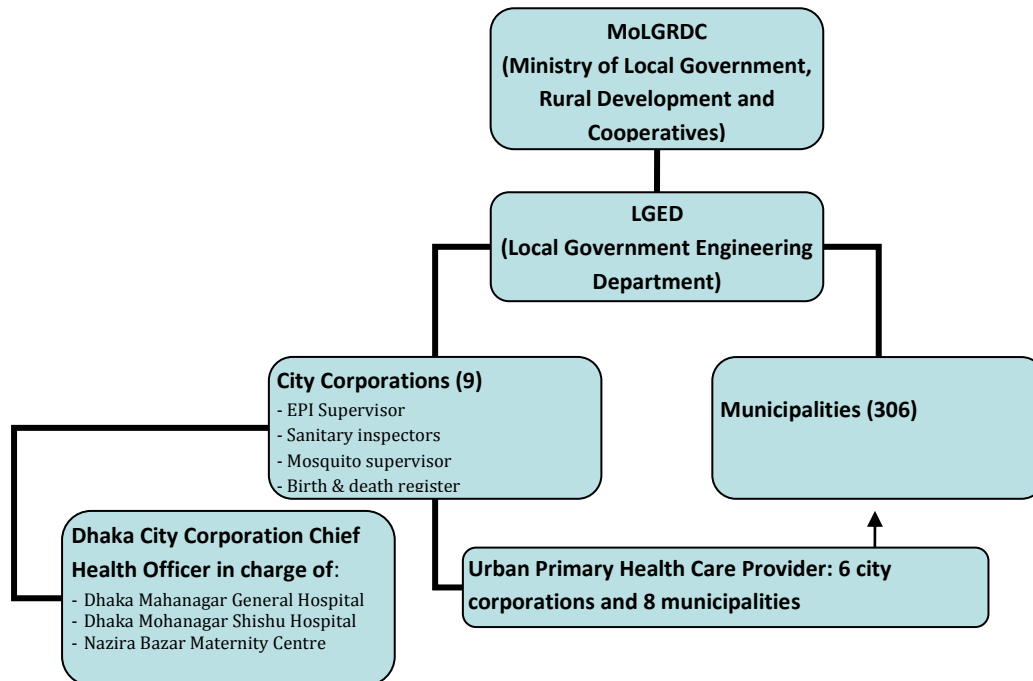
Figure 1. Organogram of urban health service provision

Other actors (secondary government actors) may not have a direct mandate for rendering health services that contribute in critical ways to the broader picture of urban health. In this group are ministries that run large urban-based hospital facilities for their employees such as the Ministry of Railways (Railway Hospital), the Home Ministry (Police Hospital) and the Defence Ministry (Combined Military Hospital) (MoHFW, 2011b).

SERVICE PROVIDERS IN URBAN HEALTH SYSTEMS

The most visible actors in the urban health care system are the health care providers who render health services to the people, such as urban providers of maternal, neonatal and child health and family planning (MNCH-FP) and nutrition services. These MCNCH-FP and nutrition services range from outdoor to indoor, from counselling to consultation, and from prevention to surgical intervention. The urban MNCH-FP and nutrition health service providers are further grouped into four types: public, private, NGO and charitable (trusts/faith-based foundations) (MoHFW, 2011b).

PUBLIC-SECTOR ACTORS

The urban public health system is far less comprehensive and organized than that found in rural areas, where clear hierarchies of service provision are apparent (primary, secondary and tertiary), each with designated responsibilities and requirements in terms of population coverage (Chaudhury, 2002). The national public system in urban settings is effectively restricted to tertiary hospitals, which include various specialized hospitals, medical college hospitals and maternity and infertility clinics. As previously described, the urban health system comprises two parts with distinct regulatory functions: the MoHFW and the MoLGRDC of the LGD. Overseen by the MoHFW, facilities under the DGHS and the DGFP represent the tertiary level of the national health system, while urban primary- and secondary-level public facilities are the responsibility of Urban Local Bodies under the LGD (MoHFW, 2011b).

PRIVATE-SECTOR ACTORS

These are the most complex type of providers, encompassing actors involved in the formal and informal health systems. They include private clinics and hospitals, pharmacists, homeopaths, herbalists, village doctors, faith-based healers, Traditional Birth Attendants and mobile drug vendors (Alam et al., 2010). Although private clinics and hospitals are rarely located within the slum settlements, some are found in the close vicinity. The most accessible source of health care for poor people in urban areas are informal providers who offer services ranging from prescription drug dispensing to minor surgical interventions. Pharmacists (drug salespeople) and informal doctors are the main sources of family planning in urban slums, and very often they also represent the most accessible health care provider, their sole link to the formal health sector being through the referral system (UNICEF, 2010).

NGO-SECTOR ACTORS

The service delivery structure of larger NGOs somewhat resembles the conventional government structure, with a central health facility (tertiary) connected to a network of regional (secondary) and local (primary) static clinics. Sometimes local static services are further extended into the community through a network of satellite or mobile clinics. Most NGO health services include a pro-poor strategy, and provision is made for subsidized care to this segment of the population. While mainly funded by donors, some provide services through health insurance — i.e. Dushtho Shashthya Kendra (DSK), a national NGO — while others go for subsidization of service costs — i.e. Marie Stopes (UPPR, 2011).

CHARITABLE ACTORS (TRUSTS/FOUNDATIONS)

These philanthropic health system actors are mainly funded by charitable institutions or groups and, in a few cases, receive financial support from the Ministry of Social Welfare (Alam et al., 2010). One of the largest cardiac facilities, the National Heart Foundation, receives a regular

donation from the Ministry of Social Welfare, as does the Bangladesh Institute of Research & Rehabilitation in Diabetes, another health facility dedicated to diabetes and endocrine disorders. There is also the Ispahani Islamiya Eye Institute and Hospital, the largest multispecialty eye hospital in Bangladesh and a philanthropic institution established to ensure that facilities are available for those patients who cannot afford to pay. The patients at Ispahani are covered by cross-subsidization — funds from those who pay more go to offset the costs of treating poor patients (Chaudhury, 2002).

It is difficult to stratify the urban health system compared to the well-organized hierarchy of the health system in rural areas. The formal health service provision that is available in urban areas is locally situated (within the slum) and focuses on serving residents in the near vicinity. Services are provided by both formal and informal care providers, working in private facilities such as consultation chambers, IHPs, NGO satellite clinics, grocery shops and urban pharmacies (UNICEF, 2010).

PRIMARY AND SECONDARY HEALTH FACILITIES

These are mostly situated outside slum areas, often at the periphery, and cater to a larger client pool. Examples are PHC services provided by NGOs and static clinics run by partner NGOs under the UPHCP, including private clinics, and other independent NGOs such as Marie Stopes. A smaller number provide more specialized secondary health services such as emergency obstetric care (Planning Commission, 2012).

TERTIARY HEALTH FACILITIES

Providing specialist or super-specialist care, these facilities serve poor patients all over the country. Examples include large private hospitals such as United Hospital, Square Hospital, Apollo Hospital; trust-run (charity/faith-based) hospitals such as Ad-din Hospital where health services are rendered at nominal costs; public medical college hospitals such as Dhaka Medical College Hospital and Sir Salimullah Medical College Hospital; and private medical college hospitals such as Bangladesh Medical College Hospital, Uttara Adhunik Medical College Hospital, National Medical College Hospital etc. (UPPR, 2011).

MASS MEDIA

Electronic, TV and print media are considered to be important stakeholders in urban health care, given their social commitment and capacity to influence and mobilize the government and the general public through advocacy, mass education and news reports. While it is evident that the mass media can sensitize the general public towards healthy behaviour, the opposite may happen as well when the news agendas of print and broadcast media are distorted by political

or business interests or are not evidence-based. Rarely are consumers capable of distinguishing between questionable and bona fide messages (UPPR, 2011).

DONORS

Based on their important financial and technical contributions to the health and health-related sectors, donors constitute a major stakeholder group. In the health sector, donors are usually national and/or international bodies that provide funds to support the design and implementation of health-related activities such as intervention programmes, health-related research or policy change. Given their important role in funding technical assistance and innovation in health service delivery, they represent important stakeholders to include in thinking about reform of urban health systems (Chaudhury, 2002). Among donors whose primary mandate is health are international agencies such as the United States Agency for International Development (USAID), Asian Development Bank, Swedish International Development Cooperation Agency (SIDA), Global Fund to Fight AIDS, Tuberculosis and Malaria, Orbiting Radio Beacon Ionospheric Satellite (ORBIS) and the United Nations Population Fund (UNFPA). Through the Smiling Sun Franchise Program, USAID provides integrated family planning and health service coverage in urban areas throughout the country. Funded by the Government of Bangladesh and a variety of donors, the UPHCP is one of the largest and most extensive PHC providers for poor people in urban areas.

CTC HEALTH SERVICE PROVIDERS

The REACHOUT review team in April 2013 defined the CTC provider as "a health worker who carries out promotional, preventive and/or curative health services and who is first point of contact at community level for health-related services. A CTC provider can be based in the community or in a basic primary facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training."

In Bangladesh there are many types of CTC health service providers or community health agents; the broad categories are formal and informal providers. Formal providers are the health workers of the NGOs and government personnel such as *Shasthya Shebikas* (SSs)[4] (health volunteers), *Shasthya Kormis* (SKs)[5] (health workers), Family Welfare Assistants (FWAs), Family Welfare Visitors (FWVs), Health Assistants (HAs) and midwives, while the informal private providers are drugstore salespeople, village doctors, pharmacists, *dai*[6] Traditional Birth

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[4] BRAC's *Shasthya Shebikas* (Health Volunteers) are community-based health volunteers in both rural and urban areas delivering health services.
[5] BRAC"s front-line health workers, known as *Shasthya Shebikas*.
[6] Traditional Birth Attendants are commonly known as *dai*.

Attendants (TBAs), Trained Traditional Birth Attendants (TTBAs), traditional medicine practitioners, homeopaths etc. The CTC health service providers are often poorly supported in terms of follow-up training and regular supervision.

These health workforces have been seen for several decades as an alternative to complete professionalization, particularly in developing countries, and Bangladesh is no exception. However, in this country a remarkable improvement was visualized among the key health Millennium Development Goal indicators of infant mortality, under-five mortality, fertility and maternal mortality (NIPORT, 2011; BMMS, 2010; BHW, 2008), and there has been no notable improvement and nearly consistent child nutritional status in the last couple of years (NIPORT, 2011). A wide range of disparities in these health indicators are seen across the different geographical regions and the diversified social classes of the country. The Bangladesh Health Watch (BHW), a civil society voice, published its first report in 2006 and argued that there is a big challenge for achieving equity in health and social justice for appropriate policy development (BHW, 2008).

Recently, Bangladesh was identified as one of the low-income countries with a huge shortage of qualified health care providers (Ahmed et al., 2011), estimated as an average of 146 health care providers (of all types) per 10,000 population. The 2008 BHW study also confirmed that qualified modern practitioners, including physicians, dentists and nurses, have a density of 7.7 per 10,000 population; traditional healers — i.e. *kabiraj,*[7] *totka,*[8] herbalists and faith healers have a density of 64.2 per 10,000 population; and allopathic practitioners (village doctors and drug sellers) have a density of around 12 per 10,000 population. Ahmed et al. (2011) argued that there is a shortage of qualified health workers, especially in low-income countries, which has drawn attention in recent times, and the reason might be that there is no specific or defined policy for CTC health service providers to support them with appropriate supervision and capacity development (Ahmed et al., 2011; MoHFW, 2011a; BHW, 2008; WHO, 2006; Task Force on Health Systems Research, 2004; GHW, 2005).

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[7] Practitioners of traditional medicine.
[8] A combination of traditional and modern medicine often used by the *kabiraj.*
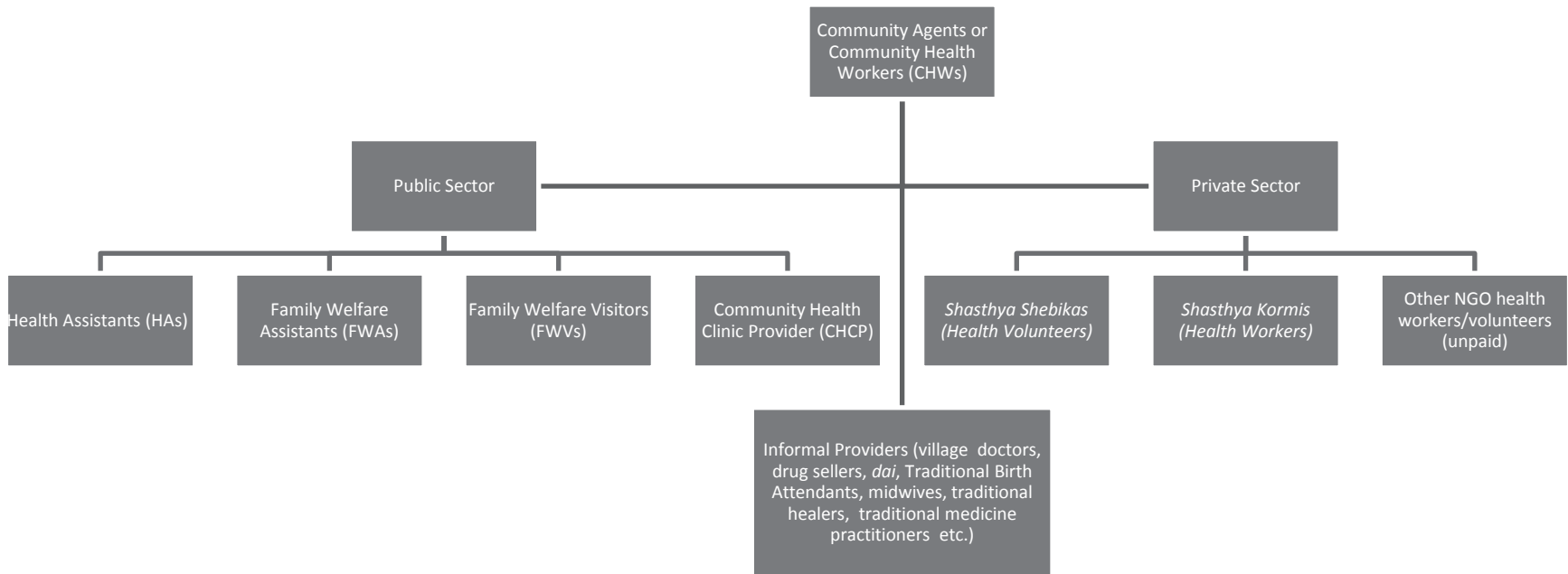
Figure 2. Health service providers of first contact at the community level in Bangladesh

Community health agents have been used in many settings as a way of filling gaps in service provision where more skilled personnel are not available. They have also fulfilled a more transformative role in broad-based community development (Standing & Chowdhury, 2008). African and Asian countries are struggling to provide public health services among the poor and vulnerable communities which bear the major burden of the diseases in the world. In the 1970s, many countries invested heavily in CHWs who received basic training and were often volunteers. However, from the 1980s onwards, programmes involving CHWs went into decline due in part to political instability, economic policies and financing difficulties (Standing & Chowdhury, 2008).

With different kinds of community-level health agents, Bangladesh has a long history of engagement with these issues and of experimentation. On paper, Bangladesh has a three-tier service delivery system with a comprehensive network of public facilities at tertiary, secondary and primary levels. In practice, the health system is pluralistic, with all the characteristics of an unregulated market. A mix of public and private, including NGO and traditional, providers operate with variable population reach and quality. It is estimated that less than 20% of curative health services are offered to the general population with the help of public-sector providers. A diversified category of private providers, including traditional healers, semi- and unqualified doctors known as 'quacks', qualified doctors working privately and NGOs deliver health services. Many practitioners prescribe and sell drugs through the numerous pharmacies across the country. The boundaries of the public sector are very porous, with many private doctors having links with publicly owned medical facilities, and public-sector providers working privately in so-called 'dual practice'. In both urban and rural areas, the private sector is the major provider of curative services for poor as well as rich people (Begum et al., 2001).

However, our knowledge regarding these providers is very limited. *The World Health Report 2006* (WHO, 2006) acknowledged the absence of credible information on this sector worldwide and thus devoted the report to the public sector alone. Other important groups of front-line workers are CHWs and Skilled Birth Attendants for safe motherhood and improved newborn survival who are being trained by both the government and NGOs. Then there are broader questions about each group of personnel, both public and private, in terms of quality, practice, production, training, attrition and motivation.

There is a long history of adequately using community-based health workers in Bangladesh. Mainly, they form the base of the government PHC structure in all districts and sub-districts. In Bangladesh, health and family planning services are organizationally separated at the level of

service delivery. HAs of the health service cadre and the FWAs of the family planning service cadre are actually working at the delivery level in the community. HAs and FWAs mostly have 12 years of schooling and receive three to four weeks of basic training to provide domiciliary services at home and also provide services from the satellite clinic or community clinic at ward level. However, conflict between the sector's two arms has led to under-utilization of their potential contribution to the health sector (WHO, 2012).

Alongside this structure, major national NGOs such as Gonoshasthaya Kendra, BRAC and others have used community heath volunteers to deliver health services to rural communities. Recently, there has been a revived discourse in Bangladesh on the potential of community health volunteers to fill critical human resource gaps. BRAC began experimenting with community heath volunteers from its formation in the 1970s, and the programme has since been progressively scaled up. BRAC initially set up a curative health care programme with four clinics. In 2007, BRAC initiated its Manoshi programme, a comprehensive five-year community-based project launched in January 2007, which aims at reducing maternal and child mortality and illness in the urban slums of Dhaka. The CHWs such as SSs, SKs, Urban Birth Attendants (UBAs) and Programme Organizers (POs) are utilized for this programme, and its scale-up aimed to extend to all slum areas by the end of 2011 (Bhuiya, 2009).

UNICEF had already conducted MNCH programmes from 2007 to 2012 in rural Bangladesh, and suggested that there is strong evidence that CHWs are playing a critical role in supporting MNCH at the local level, although there is substantial variation in the manner in which these workers are trained, remunerated and supervised, which leads to inefficiency in UNICEF's investments (JPGSPH, Columbia University and icddr,b, 2013).

Characteristics of CHWs: numbers, skills mix, workload, retention, motivation
There are many types of CTC health service providers or CHWs, such as HAs, FWAs, SSs, SKs, midwives, TBAs, informal private practitioners and lay counsellors, delivering a wide range of services in different contexts. Most of the government CTC health service providers — HAs, FWAs and FWVs — have 12 years of schooling and receive three to four weeks of basic training to provide services at home and in satellite clinics (Baqui et al., 2009).

The main responsibilities of HAs are to provide vaccinations to children and pregnant women, organize health sessions in the community, provide PHC services in community clinics, provide reproductive health services to women, refer patients to a hospital in case of an emergency etc. Health Inspectors (HIs) supervise and monitor the performance of the HAs.

FWAs are selected based on certain criteria such as the applicants must be local residents who will know the community well, have a minimum level of education, such as completion of matriculation, and are of a minimum age for employment; recently married women are recruited to provide reproductive health-related services, as the service recipients can be reluctant to share information with unmarried individuals. The main responsibilities of FWAs include reproductive health services for women, referring pregnant women to the nearest health centre in case of delivery complications, and giving support to women who need special reproductive health services such as MR, ligation etc. The performance of FWAs is evaluated by FWVs, who in turn report to Family Planning Officers (FPOs) at union level (Ahmed et al., 2007). Relationships between CHWs and other health workers, particularly professional staff, who are generally in a supervisory role, may be ill defined. CHWs are often poorly supported in terms of follow-up training and regular supervision (Friedman, 2003; Lehmann et al., 2004).

The non-government CHWs or CTC health service providers such as SSs, SKs and UBAs are utilized for the community health programme, and the aim was to scale up this programme by extending it to all slum areas by the end of 2011 (Bhuiya, 2009).

Selection of SSs is based on five criteria: female (25–45 years); married and with children not below 2 years of age; a few years of schooling; willing to provide voluntary services; and acceptable to the community they serve. The main responsibilities of the SSs include providing reproductive health services to women, referring pregnant women to the nearest health centre in case of delivery complications, and giving support to women who need special reproductive health services such as MR, ligation etc.

The SKs actually supervise the SSs working at the community level, provide antenatal care and postnatal care and carry out immunization programmes. They are provided with fundamental and essential curative training and are supervised by POs at area-level offices (sub-district). Furthermore, an SK visits households three days a week, during which time she reviews the work done by SSs related to Directly Observed Treatment, Short-course (DOTS), family planning, EPI motivation and maintenance of their registers. Each SS is also visited by a PO at an average of three to four times a month (Ahmed, 2008). The delivery centres established by the Manoshi programme ensure privacy, maintain improved hygiene and cleanliness at the facilities, and provide quick diagnosis and referrals to hospitals in case of complications. One delivery centre covers a population of 10,000 and is staffed by two full-time UBAs supported and supervised by Manoshi midwives and medical doctors. BRAC POs are mainly responsible for supervising the work of all SSs, SKs and UBAs.

The global community is largely prepared to make an effort to scale up provision of modern health care to those in need, but this is hampered by a crisis in the health workforce. There is a perennial shortage of appropriately trained health care workers in low-income countries. In addition, in the few places where there are enough workers, there are problems of misdistribution and inappropriate skills mix. To address this, countries have tried various measures, one of them being the training of CHWs. Following China's 'barefoot doctors' concept, BRAC trained over 80,000 such workers in rural Bangladesh. Female and often illiterate, these workers are now trained to treat common illnesses and refer more complicated cases to formal health centres. The availability of CHWs in a village increases access to basic care and connectedness to the broader health systems, and thereby resilience against disease. Like Bangladesh, many countries have adopted this approach as a way to increase their communities' capacity to manage their own health affairs to a great extent (Standing & Chowdhury, 2008). CHWs tended to be given inadequate support, and were sometimes seen as lacking legitimacy. In an effort to reach out to underserved communities, volunteers often dropped out due to a lack of motivation (Ahmed et al., 2011). Health systems are once again looking to strengthen CTC services; therefore, to learn from what went wrong previously and not make the same mistakes, research is needed that takes a health systems approach. This should consider CTC health service providers as a diverse group who are a critical interface with the rest of the health system (Standing & Chowdhury, 2008).

FACTORS INFLUENCING THE PERFORMANCE OF CTC HEALTH SERVICE PROVIDERS

Kelly et al. (2001) reported that a better understanding of the factors that influence the CHWs' performance would assist in addressing the limitations in CHWs' skills. Dieleman and Harnmeijer (2006) argued that too few workers and workers who are not responsive to the needs of the community and patients lead to poor performance. This is why encouraging the recruitment and retention of health workers is vital to improving the performance of CTC health services in low-income countries (WHO, 2006). Given the many health challenges associated with urban living, especially for the poorest people, there is an urgent need for a customized urban health delivery system in Bangladesh that is responsive to the general health, SRH and nutritional needs of poor women and children (MoHFW, 2011b). Developing effective strategies to ensure optimum health care for poor people in urban areas requires careful study of the diverse array of stakeholders in the urban space, as their engagement and support is critical in efforts to translate strategy into action, which in turn will create a platform for sustainable health services (Rashid, 2009). However, it is still unclear whether non-financial factors have an impact on performance in resource-poor settings; therefore, that requires more research (Dieleman & Harnmeijer, 2006).

To date, most of the studies on CTC health service providers have been conducted in rural Bangladesh; a few studies are available which have been conducted in urban settings to understand their performances. A case-control study was recently conducted applying mixed methods, focused only on the BRAC CHWs in the urban slums of Dhaka City, and it found that some other factors such as income, social respect and encouragement of a family attitude towards the CHWs' role are positively associated with their performance (Alam et al., 2011). When all types of CTC health service providers (health care providers) are considered in the study, other factors may affect their performance and thus warrant further exploration.

ENVISAGED ROLES OF CHWS IN VERTICAL PROGRAMMES AND HORIZONTAL DELIVERY

The results from this review will inform the larger questions related to the role of CTC health service providers or CHWs in the provision of PHC services and the role of informal private providers and non-state-sector entities in the public health system. The results are, therefore, very relevant for and of potential interest to the national, NGO and international donor communities.

The CHWs' roles include education, counselling, screening and point-of-care diagnostics, treatment, follow-up and data collection. The scope of their work ranges from maternal and child health to HIV counselling and testing and TB diagnosis (Standing & Chowdhury, 2008). What these approaches have in common is their reliance on staff who live and work at the community level, engaging with people in their own dwellings or workplaces. By meeting people in their homes, CTC health service providers are in a unique position to observe and understand the factors that influence health, thus gaining insights that may have been missed if the consultation had taken place in a health facility. Clues relating to poverty, nutrition, family size, bed net use, alcohol dependency and other information which is otherwise difficult to obtain may become obvious. This means that there is true potential for CTC services to strengthen delivery of health services by tailoring services to best meet the needs and realities of individuals and households, and making more appropriate links to the health sector and beyond (Standing & Chowdhury, 2008).

Bangladesh is experiencing rapid development. The limited number and quality of public health providers, and the poor availability of drugs and equipment, has led to under-use of government services and high levels of use of CHWs and other private services in a wide variety of settings. The role of CHWs in providing preventive and curative care to the population is enormous and diverse. The private sector plays a large and important role in providing health care to the slum population. In the informal sector, pharmacies, informal health care providers such as village doctors, homeopaths, *kabiraj*, *maulanas* (faith-based healers) and TBAs are key health system actors. In terms of general treatment-seeking options for most age groups, home

remedies and neighbourhood pharmacies remain the first stop for low-cost treatment. For family planning and reproductive health issues, the oral pills that are preferred are obtained from the local pharmacies. Pharmacies are perceived to offer low-cost treatment, and they represent a convenient and trusted place where advice and medicine can be sought for all sorts of health conditions. During home deliveries, pharmacies provide oxytocin injections to facilitate labour. Pharmacies also provide support for detecting chronic diseases. For certain health issues such as hepatitis, reproductive tract infections (RTIs) and sexually transmitted infections (STIs), informal health care providers, such as homeopaths and traditional healers, are consulted based on beliefs related to the causes of diseases and their cures. TBAs appear to remain preferred attendants for home delivery, as they are frequently respected and trusted family or community members.

In the formal sector, NGOs, private clinics and doctors' chambers provide health care services in close proximity to slum residents. They gain the respect of the community through their reputation for curing patients and being close and available to serve them. Indeed, the success of the informal health care market offers many important lessons that could usefully inform the design of more effective and trusted formal health service delivery systems. There are also critical opportunities to bring informal providers into the mainstream through training on quality of care and how to minimize harm through inappropriate use of drugs or failure to refer in case of emergency.

Many diverse NGOs have been instrumental in creating community health volunteers/workers for providing basic health services and contributing to improving overall population health outcomes (Streatfield & Karar, 2008). CHWs are recognized as having potential in Bangladesh, but they need to adapt to an environment in which they must compete with other providers and prove their competence. There are about 62,000 unregistered pharmacies (without a licence) under the Directorate General of Drug Administration. There is a list of pharmaceuticals and pharmacies which are registered, and this list is updated regularly; however, there are many pharmacies operating without registration and legally not accountable and offering different types of health services to communities across lower strata of the population (Rashid, 2009). Overall, the health system accommodates multiple forms of practice with varying degrees of legitimacy (UPPR, 2011).

PUBLIC SECTOR

At the field level, HAs collect data on health indicators of households. They are provided with a geographic reconnaissance record sheet to track health information on individuals in a household, and an HI ensures that the forms related to geographic reconnaissance are filled in properly.

The Family Planning Inspector (FPI) ensures that the forms with household information on the eligible couple register for family planning issues are filled out properly and accurately. They also ensure that the field health workers are meeting the daily requirements of the household visits to fill up the daily register.

Both FWAs and HAs have a catchment area of household to cover each month, and their supervisors monitor their activities by making regular visits. Monthly reporting is verified by their respective supervisors. There is a monthly meeting at the *upazila* health complex to share information on their data collection/information procedures. The respective supervisors are also present during the dissemination sessions. The data collected at field level are compiled into a specific report format for sub-district (*upazila*) level and sent to district-level offices, and the district statistician sends these data to central level — i.e. the MoHFW.

PRIVATE/NGO SECTOR

BRAC: A standard auditing system is reported to exist in the evaluation format, and it is carried out mainly by the ministry or directorates and special auditing teams (Ahmed et al., 2007). Performance evaluation of CHWs and their impact on service utilization has been observed in BRAC internal reports. The SSs are each responsible for 150–200 households in the slums and have a specific list of deliverables for the community.

Smiling Sun Franchise Program: The health workers at the community level are called CHWs, and they work in the disadvantaged urban areas of the metropolitan cities. They gather information on SRH issues in slum areas in and around Dhaka. Their work is monitored by field inspectors on an ad hoc basis. The forms used to collect data are administered and verified by the inspectors. The CHWs are given monthly targets for their work.

Marie Stopes: The field staff and paramedics collect information on comprehensive reproductive health issues at household level in the urban slums. The data collection forms are verified each month to monitor the reliability of data.

PUBLIC SECTOR

HAs and FWAs are supervised at the field level by HIs. They are also provided with training on identifying the catchment areas. They are also periodically trained in simple remedies for common illnesses. In-service training and evaluation are conducted to assess the level of knowledge on emerging health issues and technical expertise (Crotez, 2006). At *upazila* health complexes, an *Upazila* Health and Family Planning Officer (UHFPO) is in charge of both health and family planning, overseeing the standardization and quality of the health services at sub-district level. Training of health personnel and other administrative officials usually takes place at the district-level office. At district level, the Civil Surgeon Office supervises the quality of services of the doctors, nurses and other allied health professionals at district hospitals. The UHFPO reports to the Civil Surgeon Officer (CSO). A register of all logistics supplied to the health workers at field level and daily data records are maintained by a statistician at *upazila* and district levels and sent to the national level independently.

PRIVATE/NGO SECTOR

BRAC: The SSs attend refresher training sessions once every month, conducted by the programme organizers. Refreshers are conducted in an interactive and problem-solving way, in which problems encountered during the month are discussed alongside new aspects of health and nutrition. In this way the SSs update their knowledge about health interventions and the management of diseases, and, most importantly, it gives the SSs the motivation to continue their work. To ensure the quality of services provided by BRAC SSs, an incentive mechanism started in 1984 particularly for the TB control programme for detecting more cases in the community. Until then, the programme only used volunteers, and SSs benefitted from the sales of medicines and commodities provided by BRAC; as non-monetary rewards, motivational factors such as enthusiasm to work for the betterment of the community, social prestige and acclaim were important inspirational factors. For TB programme DOTS, the SSs receive monetary incentives for each of their patients who complete their TB treatment (Ahmed, 2008). The BRAC health programme also introduced an incentive mechanism for SSs for their other activities such as identification of a woman's pregnancy during her first trimester, after delivery whether the newborn child is breastfed and whether the mother keeps her child close to her body, and whether the pregnant woman visits the SK for her antenatal care.

Smiling Sun Franchise Program: The field and office staff are oriented with quality-assurance guidelines. A number of quality-assurance committees, from clinic-level circles to a national group, address quality, but these focus on the limited activities covered by the programme.

There is a standardized Management Information System to improve the use of data for project management and quality control (Lance et al., 2008).

Marie Stopes: Marie Stopes's services can be delivered from referral clinics or from one of the many outreach-based sites. In both cases, quality of care is a concern and the responsibility of every team member. Marie Stopes ensures internationally established clinical standards in all its clinics and outreach services and focuses on client preferences. A dedicated quality team is being engaged in monitoring the standards in all sector development programmes (SDPs). The Marie Stopes team follows protocols developed by the government, Marie Stopes International (MSI) and other NGOs. Marie Stopes has its own Quality Manual which incorporates all these protocols/guidelines, and all clinics strictly follow this manual. The Technical Quality Checklist is revised annually to incorporate updates of the MSI Quality Technical Assistance checklist (Marie Stopes Bangladesh website). The field staff receive regular training to improve their service provision.

Marie Stopes's quality of care system has specified standards in the following areas: clinic environment; client registration; client flow; counselling; client–provider interaction; client discharge; and technical quality (as per Government of Bangladesh and MSI protocols).

HUMAN RESOURCE MANAGEMENT SYSTEMS FOR CHWS

PUBLIC SECTOR

HAs and FWAs are recruited from the Civil Surgeon Office at district level and DGFP office at district level, respectively. Both male and female candidates are recruited; preference is given to married couples with children (Planning Commission, 2012). Relevant experience is taken into consideration in the selection criteria. HAs report to Assistant Health Inspectors (AHIs) who in turn report to HIs — i.e. the HI supervises and monitors the performance of the HAs, and the different queries are addressed by the HI to improve service delivery. HIs receive EPI technical service training.

FWAs are selected based on certain criteria including: being from within the community and, therefore, knowing the community well; having a minimum level of education such as completion of matriculation; a minimum age for employment; and recently married women are recruited to provide SRH-related services, as the service recipients can be reluctant to share information with unmarried individuals.

The FPI supervises and monitors the performance of the FWAs at the field level, and different queries are addressed by the FPI to improve service delivery. FPIs report to *Thana* Family Planning Officers (TFPOs). In family welfare clinics, maternal and neonatal services are provided by FWVs, and Sub-Assistant Community Medical Officers (SACMOs) provide other health-related services (Planning Commission, 2012).

BRAC SSs are recruited from the active village-based BRAC credit and development group called the Village Organization, which is formed by the poor women in the village. The Village Organization usually sanctions small loans to the potential members for income-generating activities. Initially its members discuss and mutually nominate prospective SSs and then propose nominated candidates to regional office members. Based on the recommendations forwarded by the members, the final selection is done at the BRAC regional office. In the regional office, a general meeting is held to ratify the nomination, and finally the candidate has to undergo a selection interview (Ahmed, 2008). The performance evaluation of SSs is determined by their acceptance in the community, their care for newborn babies and also how quickly they refer patients with complications (Ahmed, 2008). Their activities are monitored and evaluated by SKs at the field level, particularly in assessing the SSs' activities in organizing community group meetings and in taking part in community-level advocacy issues pertaining to health services. Preferably, they should not be living near a local health facility, to avoid competition, and should extend basic health facility coverage to places far away from any health facility (Ahmed, 2008).

Marie Stopes is governed by a strong board of directors comprising of nine members who meet regularly to provide strategic direction to the management and formulate polices to enable smooth functioning. Each clinic programme is run by an experienced manager and a team of one or two doctors, one to three nurses, a paramedic, a nurse-aide, a counsellor, a receptionist and a cleaner. The team is support by an outreach team of Field Coordinator/Health Educator (one or two), Mini-clinic In-charge (one paramedic for two clinics) and a number of volunteers. The recruitment for all staff including all community health service providers mainly takes place centrally at the head office, and only the low-tier staff (receptionists, security guards and cleaners) are recruited from the local clinic administration by POs.

Monitoring of the quality of care takes place at two levels: at the head office and at clinic level. At head office, there is monitoring of clinic visits, technical audits, exit interviews and a client complaints line. At the clinic level, there are a clients' comments book, exit interviews, a mood-meter box and report cards. There are systems to receive feedback on the clients' satisfaction

through comments books and their exit interviews (each manager must conduct at least five such interviews every month), a direct complaints phone line and a mood-meter box. Clinic staff are required to discuss all the quality standards in the fortnightly meetings arranged in each clinic, under the leadership of the Clinic Manager (Marie Stopes, 2012). The activities of the health service providers are monitored at the satellite clinics by Health Officers, who make frequent surprise visits to the satellite clinics to monitor the services rendered by the field staff.

CLIENT REFERRAL SYSTEMS FOR CHWS

PUBLIC SECTOR

Following detection of complicated cases the HAs and FWAs refer cases to community clinics which then have the authority to refer cases to the *upazila* health complex, which has ambulatory services to transport further complicated cases to a district hospital. The district hospital has the authority to transfer cases to a tertiary public hospital for better treatment (Planning Commission, 2012).

PRIVATE/NGO SECTOR

At BRAC, the SSs identify emergency cases and verbally refer them to a heath facility. Health workers at field level inform health centre staff about the emergency case by mobile phone, and thus these workers ensure that the patients are transferred to facilities by proper transport. They also follow up the patients at home after they receive treatment at the health facility. In the TB programme, the SSs sometime refer patients to a health facility when they fail to response to drugs (Ahmed, 2008).

The Marie Stopes's referral clinics are located in the major cities of Bangladesh. The clinics provide SRH services including family planning, antenatal care and management of STIs to poor people in urban areas. Apart from these services the clinics also support an extensive network of outreach activities such as satellite services to marginalized people (Lance et al., 2008).

The health service providers from Marie Stopes at the community level are called Field Officers. They collect information at household level from their designated catchment areas. Although they do not provide any services in the community directly, they refer people for SRH-related services to their static clinics.

CONCLUDING REMARKS

Bangladesh is undergoing rapid urbanization due to rural-to-urban migration, and the growth in urban slum populations has increased considerably over a period of time if Dhaka can be taken as an example. The situation of poor people in urban areas is dismal due to overcrowding and a lack of access to basic services, such as water and sanitation. The consequences of these living conditions include stress due to crowding, insecurity due to a lack of housing and land tenure, and lack of support from the State.

The provision of PHC services is a public responsibility, and the government tries to fulfil this role through its own facilities that are geographically dispersed (Bangladesh Health Policy, 2000). A well-developed rural health infrastructure exists in Bangladesh compared to urban areas, but it is inefficiently operated, and there has been a trend of declining use of public facilities in recent years. The central government has a direct mandate for health services and plays a key role in policy formulation and implementation.

Bangladesh has been identified as one of the low-income countries with a huge shortage of qualified health care providers. In this context it is particularly important to better understand the relationships between formal and informal CTC health service providers and develop a specific policy framework to support them with effective supervision and capacity development.

The private sector is the main provider of curative services for poor as well as rich people. The most accessible and trusted sources of health care for poor people in urban areas are informal providers who offer services ranging from prescriptions and dispensing drugs to minor surgical interventions. The drug salespeople and informal doctors are the main sources of family planning in urban slums, and very often they also represent the most accessible health care provider, their sole link to the formal health sector being through the referral system.

Important research findings (on general health, SRH and nutrition) show that a lack of workers, and workers who are not responsive to the needs of the community and patients, leads to poor performance. This is why encouraging the recruitment and retention of health workers is vital for improving the performance of CTC services in low-income countries. Developing effective strategies to ensure optimum health care for poor people in urban areas requires careful study of the diverse array of stakeholders in the urban space, as their engagement and support are critical in efforts to translate strategy into action, which in turn will create a platform for a sustainable health service. However, it is still unclear whether non-financial factors have an impact on performance in resource-poor settings, and this requires more research.

CHAPTER 3 – STAKEHOLDER MAPPING

INTRODUCTION

The REACHOUT consortium has its objectives in terms of achieving the work packages for each of the partner countries involved in the project. The work packages for Bangladesh include SRH, while the research objective focuses on the performance of CTC health service providers, both from the formal and informal sectors, who are acting as the front-line health care providers in the urban slum communities. There is a need to better understand the interactions between the diverse CTC health service providers. In a pluralistic health care system, it is important to understand the interactions between the formal and informal CTC service providers to get a better grip on the health service delivery system and make it more pro-poor.

For the consortium, the REACHOUT Bangladesh team mapped out the CTC health service providers working in the urban slum communities on SRH (see Annex 2), to gain insights into the formal and informal links working for the CTC service providers with the community, and how to ensure quality service provision. The importance lies in designing M&E tools, which could be further achieved by engaging policymakers, researchers and other stakeholders involved in service provision, to develop appropriate standard materials for training and workshops on relevant issues and improve the knowledge and treatment platforms of the CTC service providers.

At the researcher level, the focus has mainly been on the institutional, governmental and academic researchers who have much experience in the field of SRH and also with CTC service providers. There is limited research on the knowledge and treatment practices of informal providers, their interaction with the formal health care system and how they can engage with it. Hence, the stakeholders at the researcher level could give important feedback on how to carry out the research for the CTC service providers, and what important aspects should be considered.

At the CTC service providers' level, it is important to understand the activities of the various formal and informal providers who serve the community from outside or are embedded within the community setting. By gaining more comprehensive knowledge about their roles and responsibilities and also with proper training opportunities and other capacity-building options, the CTC health service providers could become more competent and better serve the community. However, the REACHOUT Bangladesh team would like to learn about their complementarity and competition, and whether it affects or influences the health care service

delivery system. Moreover, it is also important to know about the possible ways to create synergy among the stakeholders.

There is a need to take evidence-based research to the policymaking level, since this would help to shape policy and practice. At the moment policymakers are not always aware of what is happening at the local or the community level. Therefore, there is a great need for proper advocacy methods, building effective communication strategies and also a firm commitment to undertaking research.

AT THE RESEARCHER LEVEL

REACHOUT Bangladesh: Second stakeholder meeting with formal and informal CTC health service providers and partner organizations
Photo: Kazi Shamsul Amin

The first stakeholder workshop was held with researchers on 27 August 2013. There were 20 participants (see Annex 2) who attended this meeting at the JPGSPH, BRAC Institute of Global Health, BRAC University. The objective of the meeting was to explore the strengths and needs of the researchers in relation to CTC health services focusing on general SRH and, specifically, MR. It was important to explore the key messages of the six discussion topics for the CTC providers (formal and informal) and services. The discussion topics were:

- Are there any research activities focusing on CTC service providers involved with SRH and MR/abortion issues in Bangladesh?

- What is the importance of CTC service providers (for SRH and MR/abortion services) in Bangladesh? Do they actually have any capacity that can play a role in delivering health services in urban slum communities?
- What are the main sources of resistance to evidence-based policymaking in relation to CTC services in Bangladesh?
- What are the strengths of or opportunities for CTC services focusing on slum communities?
- What are the existing health care services that are provided by CTC health service providers (formal/informal)?
- What are the main threats to CTC service providers (for SRH and MR/abortion services) in Bangladesh?

In the discussion the researchers expressed their views on CTC service providers and the kind of evidence-based research platform that needs to be strengthened. From this discussion, it was also important to understand the complementarity or the competition that exists among the researchers, their expectations and the resistance that might occur among them. The discussion topics could be summarized as follows:

THEIR RELATIONSHIPS (COMPETITION/COMPLEMENTARITY)

- Researchers work in silos in terms of SRH- and MR-related fields; there is not much coordination between the researchers, and they prefer to work independently.
- They are always in competition for research funds, resulting in little interaction between the researcher levels.
- Unless collaborative projects are undertaken, there is very little translation of knowledge from evidence-based research into policies.
- Development partners are uncoordinated in their efforts to fund research, as little interest is shown in performing research on SRH and MR.

EXPECTED SUPPORT OR RESISTANCE

- Research on SRH is neglected, and little funding for MR research exists in Bangladesh.
- However, for research, there is consistent support from the government on MR policy.
- Some active policymakers are involved in ensuring quality of care in MR, and this is performed through further research, such as on medicated abortion as another option for women who usually undertake clinical procedures.

AT THE CTC SERVICE PROVIDER LEVEL

The REACHOUT Bangladesh team organized a second stakeholder workshop on 30 September 2013 with the CTC service providers and the organizations engaged in delivering SRH services in urban slum communities. The workshop was held at the JPGSPH, BRAC Institute of Global Health, BRAC University. Altogether, there were 27 participants (see Annex 2). The objectives of the workshop were to learn about CTC health care provision at the local level; to understand the provision of homeopathic and allopathic medicine in MR; to emphasize that health care trainers need to involve them in providing interventions; and to look into the areas of political influence in the field of MR.

In this workshop, discussions were mainly about service delivery, the facilitators of and the barriers to the CTC health service providers' roles and responsibilities, and the complementarity and the competition that exists in serving the community. In addition, the CTC service providers also highlighted other aspects of MR services, such as the systematic procedures, and also the need to address the diverse needs in MR.

SYSTEMATIC PROCEDURES AND ADDRESSING THE DIVERSE NEEDS IN MR

In terms of addressing care given to adolescents and young mothers, access to hospitals for patients was considered particularly important. The CTC health service providers mentioned that the limited availability of MR services contributes to unrest within families, citing the large number of children a couple may end up with, and the increasing financial responsibilities. In terms of addressing the issues brought forward by women, key points included women seeking MR services when five or six months pregnant, and looking at other non-pregnancy gynaecological problems brought forward by women. These included vaginal discharge and hymen bleeding. As patients visit the CTC health service providers for advice and help, they are referred to the hospitals.

When addressing the homeopathic (herbal medicine) industry, CTC health service providers mentioned that pregnant women do come over two to five months into their pregnancy, and some incidents which are categorized as accidents. Specific types of diseases listed as such include viral gynaecological diseases, among others. Emphasis was placed on the referral system that is used primarily to transfer patients from CTC health service providers to organizations and hospitals.

The rest of the discussion topics could then be summarized in the context of their relationships and the expected support and resistance.

THEIR RELATIONSHIPS (COMPETITION/COMPLEMENTARITY)

- Different providers mostly do not work together, which often creates miscommunication among the providers; therefore, there is a gap that needs to be filled.
- Competition exists between the CTC health service providers in terms of service delivery in a community setting.

EXPECTED SUPPORT OR RESISTANCE

- It is a market-led economy, hence there is a demand for providers across all categories and also for SRH and MR services. This interest results in the pluralistic nature of the health care in community settings, while the formal and informal providers sometimes show willingness to work in partnerships. But it is often difficult to maintain effective communication between the formal and informal providers.
- There is competition for funding among the organizations that affects their sustainability and has an impact on their retention of front-line workers.
- There is no systematic salary and recruitment structure for CTC health service providers.
- Formal providers are resistant to working with informal providers, with the exception of a few public–private partnership initiatives.
- Public–NGO partnership has been successful so far in providing SRH and MR services in the communities, and there is some acceptability.

AT THE POLICY LEVEL

The stakeholder meeting at the policy level is expected to be held later in 2014.

CONCLUSION

The stakeholder workshops with researchers and CTC service providers gave the REACHOUT Bangladesh team a more comprehensive understanding of the research methodology and how to perform the analysis, bearing in mind the country context, and also to learn about the MR service delivery system and identify problem areas which should be addressed for the REACHOUT quality improvement cycle in 2014. Furthermore, it also gave the team a better understanding of how to carry out capacity-building strategies for the researchers and also the CTC service providers' as a whole that could eventually be made into an inter-country comparison for this consortium project.

CHAPTER 4 – MAPPING OF CTC HEALTH SERVICE PROVIDERS

INTRODUCTION

The mapping process for the CTC providers was important to identify the CTC health service providers and their different categories in four selected sites. The first phase of data collection was to identify the CTC health service providers, which was followed by a second phase that included in-depth interviews (IDIs) with them.

OBJECTIVES OF THE CTC HEALTH SERVICE PROVIDER MAPPING

The broad objective of this study was to conduct a situation analysis of the CTC health service providers in the selected urban slums and rural area of Bangladesh. The specific objectives were:

- to estimate the density (per 10,000 population) of different types of CTC health service providers in three urban slums and one rural area of Bangladesh;
- to identify and locate the different types of CTC health service providers in the selected study sites; and
- to know the health-related training of different types of CTC health service providers, and the range of health services provided by them in the selected study sites.

METHODS

STUDY DESIGN

The study was a cross-sectional design for identifying the CTC health service providers working in three slum areas and one rural area. Data were collected between 21 July and 4 September 2013.

OPERATIONAL DEFINITION OF TERMS

CTC SERVICE PROVIDERS

The operational definition for the REACHOUT consortium was followed: "A CTC service provider is a health worker who carries out promotional, preventive and/or curative health services and is the first point of contact at community level. A CTC provider can be based in the community or in a basic primary health facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training" (REACHOUT Literature Review, 2013).

FORMAL CTC HEALTH SERVICE PROVIDERS

Providers who are affiliated to any kind of institution and have recognized qualifications from any formal, registered and regulated government, NGO or private institution are considered formal providers (BHW, 2008). This group includes:

Para-professionals: medical assistants, assistant medical officers, paramedics, lab technicians, dental technologists and marketing managers who completed a three-year medical assistant training programme from a public or private institution.

Trained Traditional Birth Attendants (TTBAs)/Urban Birth Attendants (UBAs): TBAs who received one week of training from any institution and provide either home-based or delivery centre-based services.

Community Skilled Birth Attendants: providers who at least completed secondary schooling and received six months of intensive training on pregnancy, delivery and pregnancy-related complications from any formal institution.

Midwives: with an HSC degree and two or three years of professional training from any public/private institution.

Community Health Workers (CHWs): the field workers who work in the community. CHWs work in both public and NGO sectors. The ratio between the number of CHWs working in the NGO sector and in the public sector is 2:1 (BHW, 2008). Usually they have variable lengths of basic preventive and curative health care training from various NGOs providing health care. However, some of them also received training from the public sector.

CHWs (Government of Bangladesh): CHWs that work under the MoHFW are FWAs, FWVs, HIs, FPIs etc.

CHWs (NGOs): CHWs who work in the NGO sector include the SSs, SKs, FWAs, health educators, *community pusti karmi*, Marie Stopes volunteers, Health Service Promoters etc.

INFORMAL AND NON-ALLOPATHIC CTC PROVIDERS

Health service providers who are not affiliated to any formal institution or registered with or regulated by any government regulatory body are called informal providers (Ahmed et al., 2009). They include:

Drugstore salespeople: Most drugstore salespeople have no training in dispensing drugs or in diagnosis and treatment. However, some have completed Local Medical Assistant and Family Planning (LMAF) training and Rural Medical Practitioners (RMP) degrees from a private institution or NGO.

Village doctors/*Polli Chikitsok*: The majority have short training (from a few weeks to a few months) on some common illnesses/conditions, from semi-formal private institutions which are unregistered and unregulated. Only a few of them have 12 months of training from a government-sponsored training programme.

Untrained TBAs/*dai*: TBAs do not have any training and provide home-based services during delivery of a pregnant woman.

***Kabiraj*:** practitioners of traditional medicine — for example, Ayurvedic or Unani medicine. Most are self-trained; however, some have training from government or private colleges of Ayurvedic medicine.

***Totka*:** a combination of traditional and modern medicine often used by the *kabiraj*.

Herbalists: providers who grow, sell or use herbs to treat illness.

Faith healers (*Hujur, Imam, Khatib*): healers who use religious beliefs in the form of incantation, sanctified water, oil or written verses from holy books to treat patients.

Traditional healers: practitioners of traditional medicine such as Ayurvedic and Unani.

Homeopaths: the majority of these providers are self-educated, while some of them have a recognised degree from a government or private homeopathic college.

RECRUITMENT AND TRAINING

RECRUITMENT

A team of three persons, consisting of two researchers and one administrative person, worked to recruit Research Assistants (RAs) from 15 May to 16 June 2013. They performed the following tasks sequentially:

- An advertisement was circulated by the human resources section of JPGSPH, BRAC Institute of Global Health, for Research Assistants on 15 May 2013.

- Individual interviews for the recruitment of male and female RAs was held at JPGSPH on 11 June 2013
- A total of 14 RAs were recruited for this context analysis.

In addition, one senior research associate and one consultant (anthropologist) were recruited as supervisors for the data collection team on 16 June 2013.

TRAINING

The objective of the training was to provide a practical lesson on data collection to the recruited RAs, to enable them to collect individual and group-level data for the context analysis study using the relevant tools and techniques. A five-member team, comprising a senior statistician, a senior anthropologist, two senior research associates and a researcher and led by the coordinator, conducted the training session for two weeks in June 2013. The formats for the mapping of CTC health service providers, IGD tools and the field trip strategy were finalized through pre-testing conducted by the RAs during the training session on 29 June 2013 at the slum area of Mohakhali, Dhaka.

PILOTING

A team of three researchers conducted the pilot testing of the CTC mapping methods and its tools for the main data collection session. The piloting was done on 12 June 2013 at the slum area of Dowaripara at Mirpur, Dhaka.

STUDY AREA AND POPULATION

Four field sites — three urban slums and one rural area — were selected from two districts: Dhaka and Sylhet. Two urban slums from Dhaka district, Kallyanpur and Nayem Colony, and one urban slum, Ghasitola, and one rural area, Lakkatura Tea Estate, from Sylhet district were selected. Kallyanpur urban slum is located in between Mirpur *thana* and some part of Darus Salam *thana* under the Dhaka City Corporation. Nayem Colony is located between the Keraniganj Model *thana* and Imam Bari graveyard, just beside the south bank of the river Buriganga. Ghasitola slum of Lamapara is situated in the Sylhet City Corporation. Lakkatura Tea Estate is under the Sylhet Airport *thana* of Sylhet district.

The study population for this investigation were all CTC health service providers who generally carry out promotive, preventive and/or curative health services and are often the first point of contact in their community.

DATA COLLECTION TECHNIQUES FOR LISTING/INVENTORY/MAPPING

This study adopted both qualitative and quantitative techniques for data collection. The mapping team was responsible for listing/mapping the CTC health care workforce in the study sites through IGDs with the slum communities. The team members introduced themselves to local people and built a relationship with them. While building rapport they explained the research objectives clearly to the slum-dwellers and took their verbal consent for conducting research in their community. Various strategies were used to collect the information for mapping CTC health service providers in the selected slums areas. The formats (see Annex 8) were IGD participant listing, primary listing and the validation of the primary listing for all providers working in the selected slum area. A physical map and health resource mapping techniques were also used to identify the exact location of the popular providers.

The data collection process was conducted in several steps:
- a physical mapping of the study area was drawn up by walking through the community;
- a list of CTC health service providers was developed through the IGDs with different members of the community; and
- the list of CTC providers and their locations were validated through visits and individual interviews.

PHYSICAL MAPPING USING PRA TOOLS

A physical map was created using one of the Participatory Rural Appraisal (PRA) techniques. The map was drawn with the help of the slum-dwellers (8–10 persons) in a specific location of each selected slum. The important places in the slum areas were included in the map, such as schools, *madrassa,*[9] mosques, temples, markets, ponds, health centres, delivery centres, health clinics, NGO offices, dispensaries, hospitals etc.

After preparing a preliminary map, the data collection team observed all the segments and/or roads in the whole research area drawn on the map, to see whether they were correctly drawn. If anything was drawn differently on the map, it was corrected instantly. The physical map prepared was also helpful for the qualitative data collection team to identify the health care providers in the selected research sites.

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[9] The Islamic education system in Bangladesh taught in specific institutions is commonly known as *madrassa*. *Madrassa*s have their own curriculum that emphasizes the importance of studying various aspect of Islam.

LISTING PROCEDURE

The data on health care providers were collected using two types of discussions: IGDs and individual discussions. IGDs were performed with the slum-dwellers, while individual discussions were conducted with different types of health care providers. The purpose of the IGDs was to discover the name and location of PHC providers working in that community. We collected information from the health service providers to cross-check the findings of the IGDs.

A total of 107 IGDs were held (27 in Kallyanpur, 22 in Keranignaj, 23 in Ghashitola and 35 in Lakkatura), with a total of 540 participants (160 male and 380 female). Each IGD involved 5–12 people, with a cross-section of gender and age (male, female, young, adult etc.). In addition, 79 individual discussions took place in Kallyanpur, 42 in Keranignaj, 27 in Ghashitola and 35 in Lakkatura.

Through the IGDs the RAs obtained information about the name, type and location of the health care providers working in the selected areas. The RAs also collected information about the perceived quality of the services provided. In addition, so as not to miss any health care providers, the RAs also asked about different specific types of providers, such as those who provide SRH, MR or delivery services etc.

The RAs wrote down the names of the providers and the places where they were providing services and/or wrote down the providers' home address to enable the qualitative research team to easily identify them. For example, "the location of this provider is close to *Kalu Mohajon's* house; north side of Bou Bazar; adjacent to the school etc." was considered a means of identifying the service providers' address.

After completion of the group discussion, the participants were asked, 'Can you tell us about the other providers or where we can get better information about them?', to locate more service providers working in that area. The process was continued until no new names of health care providers were found/reported (saturation of data/point of redundancy reached).

The name of the health centres (e.g. community clinics, satellite clinics, family welfare clinics), hospitals and private clinics, NGOs and independent private health practitioners located in the study sites were collected, even if these names were not reported in the IGDs. Some providers were reported who usually reside outside the research areas, but selected slums dwellers access their services; therefore, these providers' names and addresses were also collected. In addition, key information about the community members who participated in the discussion was collected (see Annex 8).

DATA VALIDATION PROCEDURE

Apart from validating the information from the IGDs and individual discussion sessions with the health service providers, health workers or the facilities at which they work were also visited. If anybody was not found during the validation process — i.e. if the reported providers listed through the primary listing process were not found or had left the area, passed away or given up his/her profession, their names were excluded from the providers' listing. In cases when the listed providers were not available for the individual discussion session, the RAs collated all information from trustworthy sources such as family members, neighbours, relatives and friends. If any new provider's name came up during the validation process, the new name was added to the primary listing.

COMPILATION OF DATA ON CTC HEALTH SERVICE PROVIDERS IN THE FIELD

After the validation process for each provider's data, their information was included in the final mapping format. Different IGD groups often reported different identities for the same provider. For example, some informants reported the provider's title instead of their main name (e.g. *hujur,*[10] doctor), some reported their family name (*Mirja, Khan, Choudhury* etc.), while some others their given name. The research team ensured that no one was listed twice in the listing format. There were cases when providers had the same common names. We avoided including the providers with common names in the final list by requesting further clarification of the information during the IGDs and also by cross-checking against their addresses.

DATA ANALYSIS

IGDs with key informants were conducted to understand their experience with and perceptions of the basic health care services and their providers, and three types of formats were used for collecting data: the listing of IGD participants; the primary listing of CTC health service providers; and the validation of primary listings of CTC health service providers.

In the listing of IGD participants, information on the profile of the IGD participants was collected. The primary listing of CTC health service providers collected data on all the possible names, locations and provider types, and involved the name of the providers' organizations.

The validation of the primary listing of CTC health service providers collected data on their name, gender, age, education, type of health care services provided, type of health-related education/training, type of health care provider, questions such as 'to how many people do you provide health services per day/week?', referral patients, monthly income from these CTC

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[10] Religious leader in Islam commonly addressed as *hujur* in Bangladesh.

services, main location for providing health care services, problems encountered during service delivery, and locations of health care providers.

At first, the profiles of IGD participants and the CTC health service providers, and the types and density of providers, health service delivery, health-related training, main locations of health services provided, and problems encountered were analysed through univariate distribution. Finally, bivariate relationships were examined between the indicators and the research site variables.

ETHICAL ISSUES

Ethical approval for this research was obtained from the Ethical Review Committee of the JPGSPH (see Annex 7). Written, informed consent in Bengali was sought from all respondents before interviewing, but respondents with poor literacy provided verbal consent to the RAs. The confidentiality of the information provided and anonymity of the respondents were maintained. During data collection, RAs were respectful of the beliefs and values of the respondents and community members.

FINDINGS

BASIC CHARACTERISTICS OF KEY INFORMANTS FOR IDENTIFYING CTC HEALTH SERVICE PROVIDERS

A total of 107 IGDs with community members were organized (27 in Kallyanpur, 22 in Keraniganj, 23 in Ghasitola and 35 in Lakkatura Tea Estate — see Table 1).

Table 1. Characteristics of IGD participants by study site

	Study site				All
	Dhaka		Sylhet		
Variables	Kallyanpur	Keraniganj	Ghasitola	Lakkhatura	
Mean age of the IGD participants	*34.47*	*31.54*	*33.69*	*35.61*	*33.9*
Mean number of participants per IGD	*5*	*6*	*5*	*4*	*5*
Female participants %	69.2	80.60	74.80	59.10	70.40
Involvement with social organizations %	68.4	4.5	5.9	3.2	20.2
Number of participants in IGDs (n)	133	134	119	154	540
Number of IGDs conducted (n)	27	22	23	35	107

The mean age of the participants was 34 years. The majority of them were female. Over one fifth of all informants reported that they were engaged in different social activities, such as work for developing road infrastructure and/or water and sanitation, maintain the cleanliness

of the surrounding environment, pregnancy/neonatal health care counselling, parents counselling for children's schooling, preventing child marriage, social justice, involvement in *Somobaye Samity* (a cooperative society), NGO membership, political work etc. More than two thirds of the informants were engaged in social activities in the Kallyanpur slum (see Table 1).

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF CTC HEALTH SERVICE PROVIDERS

The profile indicates considerable diversity among CTC health service providers. Table 2 and Figure 2 show the basic demographic and socio-economic characteristics of the identified formal and informal providers. The overall mean age of the CTC health service providers was about 44 years, with the higher mean age for male providers. The mean ages of the providers at all sites were also higher for the male than the female providers, except for Keraniganj. Nearly one fifth of the providers were aged below 30 years. About 60 per cent of the providers are over 40 years old.

Figure 3 shows the age distribution of CTC health service providers, but the data indicate that there was some misreporting of ages, probably due to digit preference in age reporting.

Figure 2. Age distribution of CTC health service providers
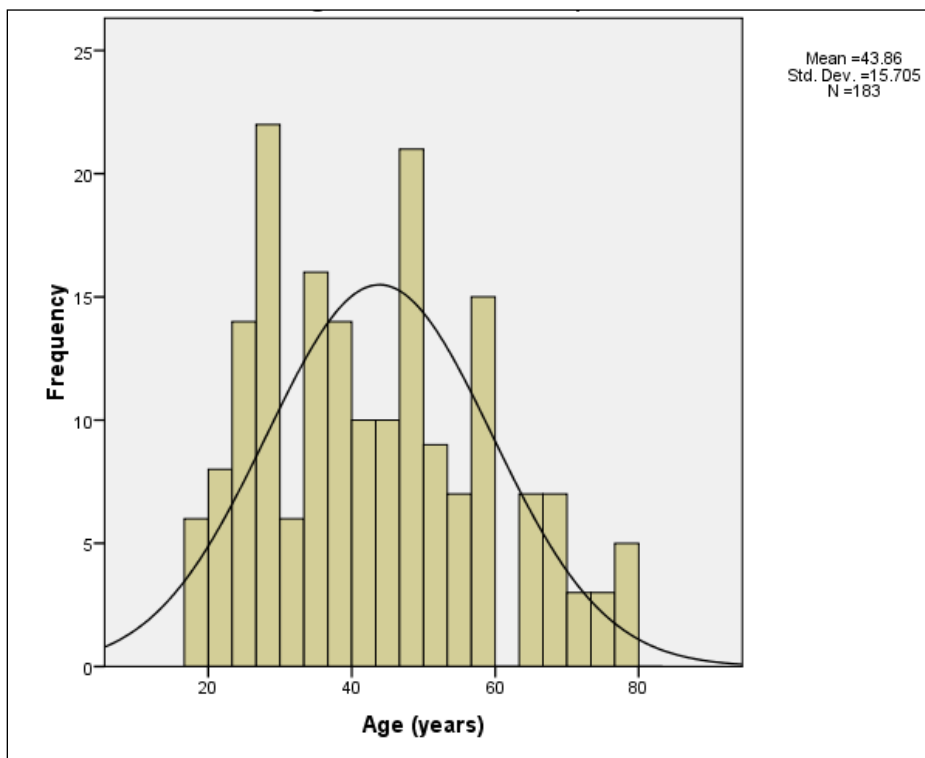
Figure 3. CTC health service providers' age distribution by single year of age
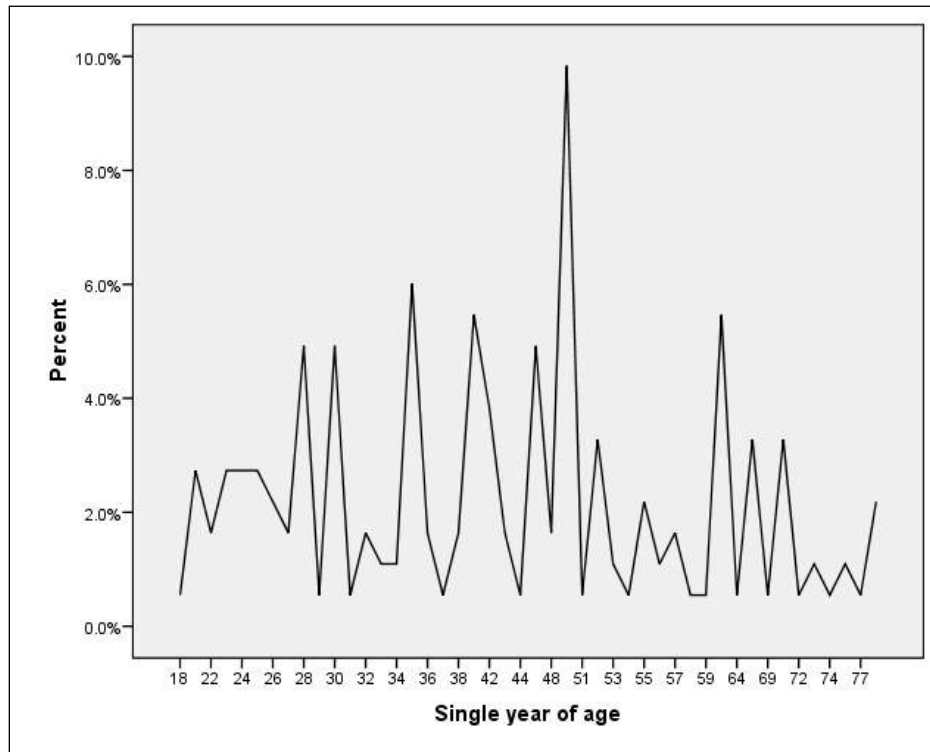
Overall, the CTC health service providers had spent an average of 8.5 years in school. Of the four sites, the Ghasitola providers had spent the highest number of years in school (10.3 years), followed by the Keraniganj, Kallyanpur and Lakkatura Tea Estate area (9.5, 8.6 and 5.8 years, respectively). More specifically, only 16.4% of the CTC health service providers had only completed primary- or secondary-level education, with nearly 54% of them having completed at least higher secondary-level education (see Table 2). An average of 30 per cent of the providers had no education, and this figure was highest for the Lakkatura providers (48.6%) and lowest for the Kallyanpur providers (24.1%).

In all study sites, overall, the average income of the CTC health service providers from this profession was reported as about BDT6151.9 or US$79 (US$1 = BDT77.8), and the four study sites varied by their average income. The highest average income (BDT7772.8) was found for the Keraniganj providers, and the second highest (BDT7631.4) for Lakkatura providers, followed by those in Ghasitola and Kallyanpur (BDT5917.2 and BDT4712.5, respectively) (see Table 2). Moreover, about 22% of the CTC health service providers in all sites reported that they had no income from this profession. The highest percentage of providers with no income was reported in Ghasitola (29.6%), followed by Keraniganj (21.4%), Kallyanpur (20.3%) and Lakkatura Tea Estate (20%).

Table 2. Socio-economic characteristics of CTC health service providers by study site

Socio-demographic characteristics	Study site				All
	Dhaka		Sylhet		
	Kallyanpur	Keraniganj	Ghasitola	Lakkhatura	
Age (years)					
Mean age in years	*42.3*	*41.98*	*43.93*	*49.51*	*43.86 (183)*
Female providers %	51.9	50.0	48.1	57.1	51.9 (95)
Female mean age in years	*37.68*	*43.62*	*40.38*	*48.25*	*41.59 (95)*
Male mean age in years	*47.34*	*40.33*	*47.21*	*51.20*	*46.31 (88)*
Formal schooling %					
No education	24.1	26.2	29.6	48.6	30.1 (55)
Primary/secondary (I-IX)	20.3	9.5	25.9	8.6	16.4 (30)
Senior secondary +	55.7	64.3	44.4	42.9	53.6 (98)
Mean years of schooling	*8.6*	*9.5*	*10.3*	*5.8*	*8.5 (183)*
Income from this profession					
No income %	20.3	21.4	29.6	20.0	21.9 (40)
Mean income from this profession (BDT)	*4712.5*	*7772.8*	*5917.2*	*7631.4*	*6150.9 (183)*
Number of CTC health service providers (N)	79	42	27	35	183

Note: US$ 1= BDT77.8; figures in parentheses indicate numbers of cases.

Density and types of CTC health service providers

Table 3 presents the density of CTC health service providers per 10,000 population by study site. The highest number of CTC health service providers per 10,000 population appeared in Keraniganj (167 per 10,000), followed by Ghasitola (163 per 10,000), Lakkatura Tea Estate (149 per 10,000) and Kallyanpur (43 per 10,000). However, there was a higher density of informal providers than formal providers in all study sites, and an average of 51.9 compared to 21.7.

Table 3. Density of CTC health service providers per 10,000 population by study site

Study sites	CTC health service providers		
	Formal	Informal	All
Dhaka district			
Kallyanpur	15.3	27.8	43.1
Keraniganj	47.7	119.3	167.1
Sylhet district			
Ghasitola	60.3	102.5	162.8
Lakkatura	34.0	114.9	148.9
All	23.3	50.3	73.6

Table 4 shows the distribution of types of CTC health service providers by study site. Overall, more than 68% of the CTC health service providers are informal, and the informal providers' distribution varied by study site. Lakkatura had the highest informal group (77%), followed by Keraniganj (71.4%), Kallyanpur (64.6%) and Ghasitola (63.0%). Data revealed that the largest group were the traditional healers (21.9%) which include *kabiraj*, *totka*, herbalists, faith healers (*hujur, imam,*[11] *khatib,*[12] *pir*[13]). The second largest group were the CHWs involved with NGOs (21%), who are formal providers; Kallyanpur had the highest (30.4%) and Lakkatura the lowest percentage of NGO health workers (11.4%). The third largest group were the TBAs/*dai* (18.6%), who are informal providers, followed by drugstore salespeople (12.6%), village doctors/*polli chikithsoks* (11.5%), para-professionals (4.9%), homeopaths (3.8%), government CHWs (2.2%), CSBAs/UBAs/midwives (2.2%) and physicians (1.6%).

Table 4. Distribution of CTC health service providers by study site

	Study site				
	Dhaka		Sylhet		
Indicators	Kallyanpur	Keraniganj	Ghasitola	Lakkatura	All
Type of CTC health service providers %					
Formal providers	*35.4*	*28.6*	*37.0*	*22.9*	*31.7 (58)*
CHWs, NGO	30.4	14.3	14.8	11.4	20.8 (39)
CHWs, government	-	2.4	3.7	2.9	2.2 (3)
Para-professionals	2.5	9.5	7.4	2.9	4.9 (9)
UBAs/CSBAs/Midwives	1.3	-	7.4	2.9	2.2 (4)
Physicians, MBBS	-	2.4	3.7	2.9	1.6 (4)
Informal providers	*64.6*	*71.4*	*63.0*	*77.1*	*68.3 (125)*
Drug sellers	12.7	19.0	11.1	5.7	12.6 (23)
Village doctors/*Polli chikitsok*	13.9	9.5	3.7	14.3	11.5 (21)
TBAs/d*ai* (trained and untrained)	13.9	19.0	7.4	37.1	18.6 (34)
Traditional healers	21.5	16.7	37.0	17.1	21.9 (40)
Homeopaths	2.5	7.1	3.7	2.9	3.8 (7)
All providers (N)	79	42	27	35	183

Note: Figures in parentheses indicate cases; para-professionals: AMOs/SACMOs/ paramedics/lab technicians/MAs/dental technologists; traditional healers: *kabiraj, totka*, herbalists, faith healers (*hujur, imam, khatib*)

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[11] *Imam* is the leader of prayers.
[12] *Khatib* are those people who preach at Friday prayers in mosques.
[13] *Pir* is a religious leader who has disciples.

Health resource maps focused on existing CTC health service providers and health care facilities available in all study sites. The location of the residence of CTC providers in the working area varies significantly. While in Lakkatura, Sylhet, most of the CTC health service providers live within the area, in Keranigonj only 26% live there (see Figure 4).

Figure 4. CTC health service providers' residence (inside/outside the study area) by study site (July–August 2013)

Figure 4a. Kallyanpur Pora Bosti, Dhaka

Figure 4b. Keraniganj, Dhaka

Figure 4c. Ghasitola, Sylhet

Figure 4d. Lakkatura, Sylhet
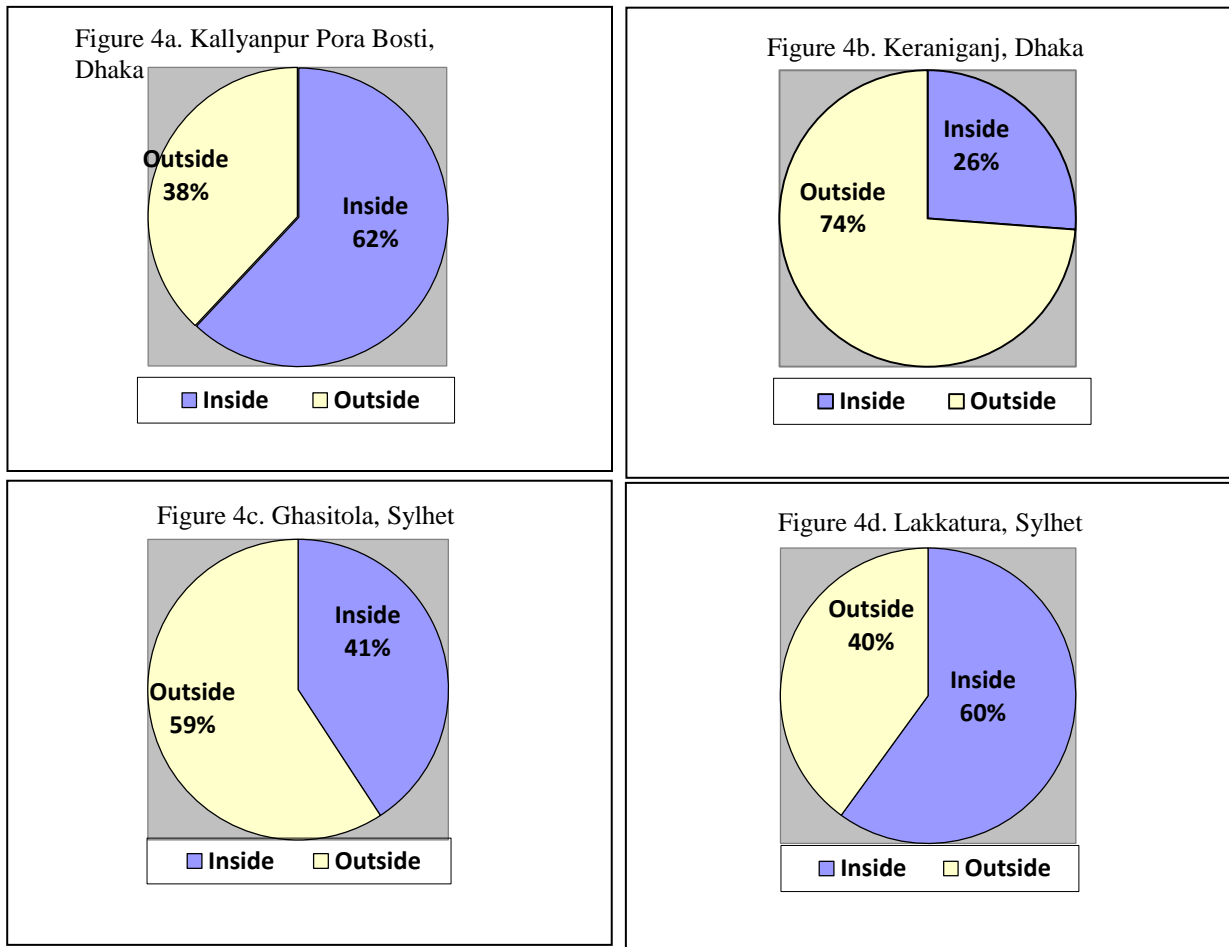
HEALTH CARE SERVICES PROVIDED BY CTC HEALTH SERVICE PROVIDERS

Table 5 illustrates the various curative as well as preventive health care services that were provided by the CTC health service providers. On average, about 15 patients were treated by each provider each day in the study areas. The highest number of patients treated was found in Ghasitola (61 patients treated/day), followed by Keraniganj (21/day), Kallyanpur (12/day) and Lakkatura Tea Estate (11/day). Almost 43% of the health care services were reported as pregnancy-related services, which were mostly provided by female CTC health service

providers. The second highest number of health care services was reported as being health education services (39.9%); followed by services related to common illnesses such as fever, colds, coughs, headaches and diarrhoea (35%); education related to pregnancy-related complications (34.4%), which was also mostly provided by female CTC health service providers; traditional treatment (27.9%); neonatal or childcare-related services (21.9%); and family planning counselling services (16.4%). Besides these services, injury-related services, TB identification and DOTS supply, and dental care or asthma (3.8%, 2.2% and 1.6%, respectively) were also provided by the CTC health service providers. The other services provided by the CTC health service providers (4.4%) addressed STIs/RTIs, MR, Leukorria, bloodstained vaginal discharge, and EPI services.

Table 5. Health services provided by CTC health service providers by study site

	Study site				
	Dhaka (%)		Sylhet (%)		%
Type of treatment provision	Kallyanpur	Keraniganj	Ghasitola	Lakkhatura	All
Pregnancy-related services	43.0	40.5	33.3	51.4	42.6
Awareness regarding pregnancy complications	32.9	26.2	44.4	40.0	34.4
Family planning counselling	24.1	16.7	11.1	2.9	16.4
Neonatal/child care	17.7	28.6	29.6	17.7	21.9
Common illness (fever, cold, cough, headache, diarrhoea)	30.4	50.0	29.6	31.4	35.0
Health education	*45.6*	*40.5*	*33.3*	*31.4*	39.9
Traditional treatment	26.6	21.4	48.1	22.9	27.9
TB identification and DOTs supply	1.3	0.0	3.7	5.7	2.2
Injury	0.0	9.5	0.0	8.6	3.8
Dental care/asthma	0.0	7.1	0.0	0.0	1.6
Others	6.3	7.1	0.0	0.0	4.4
Mean number of patients treated per day	*12.32*	*20.57*	*60.59*	*11.32*	*14.65*
Referral of emergency patients by CTC health service providers	96.2	100.0	92.6	91.4	95.6
Number of CTC health service providers (N)	79	42	27	35	183

Note: Multiple responses accepted; Others: STIs/RTIs, MR, Leukorria, Bloodstained vaginal discharge, EPI services etc.

Overall, nearly 96% of the CTC health service providers reported that they usually refer emergency patients to hospitals or clinics (see Table 5). At Keraniganj, all CTC health service providers reported that they usually took part in referring emergency patients to hospitals or clinics, compared to 96.2% in Kallyanpur, 92.6% in Ghasitola and 91.4% in Lakkatura.

HEALTH CARE EDUCATION AND TRAINING

Table 6 describes the health education and health training received by the CTC health service providers ever in their professional life. Nearly half (45.4%) of them reported that they had not received any kind of health education or training. The highest numbers without any health training or education were in Keraniganj (52.4%), and the lowest in Kallyanpur (40.5%). Overall, almost 55% of the CTC health service providers had received various types of health care education or training, such as basic health services (15.8%) — with the highest in Kallyanpur (21.5%) and the lowest in Keraniganj (9.5%) — LMAF training (14.8%), mother and child health (12.6%), rural medical practitioners (8.2%), family planning (8.2%), disease control of ARI/diarrhoea/TB (6.6%), SS/SK training (6.0%), diploma in medical technology (6.0%), birth attendance (4.4%), pharmacy (4.4%), homeopathy (3.3%), STIs/RTIs (1.6%), nutrition (1.1%), Ayurvedic medicine (1.1%) etc.

Table 6. Health care education/training received by CTC health service providers by study site

	Study site				
	Dhaka		Sylhet		
Training received %	Kallyanpur	Keraniganj	Ghasitola	Lakkhatura	All
No training	40.5	52.4	44.4	48.6	45.4
Basic health service	21.5	9.5	14.8	11.4	15.8
LMAF	15.2	14.3	3.7	22.9	14.8
Mother and child health	17.7	9.5	14.8	2.9	12.6
Rural medical practitioners	5.1	9.5	11.1	11.4	8.2
Family planning	7.6	7.1	14.8	5.7	8.2
Disease control (ARI/diarrhoea/TB)	6.3	2.4	14.8	5.7	6.6
SS/SK training	8.9	2.4	11.1	0.0	6.0
Diploma in medical technology	5.1	11.9	3.7	2.9	6.0
Birth attendance	3.8	0.0	7.4	8.6	4.4
Pharmacist training	2.5	2.4	3.7	11.4	4.4
Nutrition-related training	2.5	0.0	0.0	0.0	1.1
Homeopaths	2.5	4.8	3.7	2.9	3.3
STI/RTI	2.5	2.4	0.0	0.0	1.6
Ayurvedic	1.3	2.4	0.0	0.0	1.1
MBBS	0.0	2.4	3.7	2.9	1.6
Number of CTC health service providers (N)	79	42	27	35	183

Note: Multiple responses accepted; LMAF: Local Medical Assistant and Family Planning.

INVOLVEMENT OF CTC HEALTH SERVICE PROVIDERS WITH ORGANIZATIONS

Table 7 presents the CTC health service providers' organizational involvement by study site. The majority of them were seen as not involved with any organizations; they were actually informal providers or self-employed (70.5%). Lakkatura had the highest proportion of informal providers (80%), and Kallyanpur had the lowest (65.8%). About 12% of the CTC health service providers were reported as BRAC employees, with the highest percentage of BRAC providers in Ghasitola (25.9%) and no BRAC CHWs in Lakkatura Tea Estate. Only a few of the providers (4.8%) were found to be involved with a government hospital, *upazila* health complex or health centre, and 4.8% of the CTC health service providers were involved with other organizations — namely, Shakti Foundation, diagnostic centres, Health, Education and Economic Development Bangladesh (HEED-BD) and Voluntary Association for Rural Development (VARD).

Table 7. CTC health service providers' involvement with organizations by study site

	Study site				
	Dhaka		Sylhet		
Indicators	Kallyanpur	Keraniganj	Ghasitola	Lakkatura	All
CTC health service providers' employer (%)					
BRAC	16.5	2.4	25.9	0.0	11.5
DSK	8.9	0.0	0.0	0.0	3.8
Marie Stopes	3.8	7.1	0.0	0.0	3.3
UTPS[14]	6.3	0.0	3.7	0.0	3.3
RHSTEP	0.0	4.8	0.0	0.0	1.1
Hospital/UHC/health centre	4.8	3.7	8.6	3.3	4.8
Others*	4.8	0.0	11.4	3.3	4.8
Self-employment (informal provider)	64.6	76.2	66.7	80.0	70.5
Number of CTC health service providers (N)	79	42	27	35	183

Note: *Others: Shakti Foundation/diagnostic centre/HEED-BD/VARD

PROBLEMS ENCOUNTERED BY THE CTC HEALTH SERVICE PROVIDERS IN SERVICE DELIVERY

Although extensive IDI sessions had been performed in the qualitative research sessions on the facilitators of and barriers to the CTC health service providers, the semi-structured interviews (SSIs) with CTC health service providers shed further light on the possible problems they

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[14] UTPS stands for Unity through Population Service, a non-government, non-profit voluntary organization. UTPS is actively engaged in the government's Urban Primary Health Care Project (UPHCP) under the Local Government Division of the Ministry of Local Government Rural Development & Cooperatives.

encountered. A lack of health awareness or lack of health education (5.5%) was identified as a problem for treating patients, and this figure was highest for Kallyanpur (6.3%) and lowest for Ghasitola (3.7%). They also acknowledged other problems, including financial problems (3.3%), lack of basic health care training (3.3%), problems related to religious beliefs (2.2%), lack of delivery kits/space or physical problems or insecurity (3.3%), as having some possible relevance to service delivery. However, nearly 87% of CTC health service providers reported that they had no problems regarding their treatment of patients in the community (see Table 8).

Table 8. Problems of the CTC health service providers during service delivery by study site

| Problems of the CTC health service providers identified | Study site | | | | All |
| | Dhaka | | Sylhet | | |
	Kallyanpur	Keraniganj	Ghasitola	Lakkatura	All
No problems	86.1	90.5	92.6	80.0	86.9
Lack of basic training	5.1	4.8	0.0	0.0	3.3
Lack of health awareness/education	6.3	4.8	3.7	5.7	5.5
Financial problems	1.3	2.4	0.0	11.4	3.3
Religious beliefs	1.3	0.0	3.7	5.7	2.2
Others*	5.1	2.4	0.0	2.9	3.3
Number of CTC health service providers (N)	79	42	27	35	183

Note: Multiple responses accepted; *Others: lack of delivery kits/space, physical problems, insecurity.

DISCUSSIONS AND CONCLUSION

This study helped us build a better understanding of the role of CTC health service providers in four selected study sites in Bangladesh. The informal sector is very much a part of the health system catering to the needs of the majority of people, particularly to poor people living in urban slums and underserved rural areas. Although most of the CTC health service providers provide basic health care services, their roles are not defined or understood by the public health sector (i.e. the Health, Population and Nutrition Sector Development Programme — HPNSDP) or the donor agencies.

The overwhelming majority of health care providers are from the informal sector and of questionable quality. The existing situation of CTC health service providers is further challenged by the rapid increase in migration of poor people from rural to urban areas. Thus community health care services (among slum-dwellers and underserved rural people in Bangladesh) are suffering from a severe health workforce crisis in terms of qualified providers; therefore, a lot

of attention needs to be paid to improve the current situation. The expected density of trained CTC health service providers needs to be ensured. Currently, the qualified health practitioners (physicians, dentists and nurses) have a density of 7.7 per 10,000 population, while the traditional healers — i.e. *kabiraj, totka*, herbalists and faith healers — have a density of 64.2 per 10,000 population, and the informal allopathic practitioners (village doctors and drug sellers) have a density of around 12 per 10,000 population (BHW, 2008).

The density of all types of CTC health service providers confirms that a significant shortage of qualified health care providers exists in the study sites. The density of formal CTC health service providers (qualified or semi-qualified) is much lower than that of informal providers (21.7/10,000 vs. 52/10,000); this pattern is consistent across the study sites and confirms findings from the Bangladesh Health Watch (2008). The majority (70.5%) of CTC health service providers, particularly the informal providers, were not involved with any organizations but were self-employed. Hence, they remain unsupervised and unregulated. Therefore, the quality of the services provided by these providers is often questionable. Among the institutional CTC health service providers, a large proportion belong to BRAC (nearly 12%), fewer (4.8%) were from the government sector, and only a handful were from different NGOs — DSK, Marie Stopes, UTPS, RHSTEP, Shakti Foundation, HEED-BD and VARD.

It is noted that the CTC health service providers had to deliver a number of curative care as well as preventive care services to the community. The most common treatments were reported as pregnancy-related services, treatment related to common illness (fever, cold, cough, headache, diarrhoea) and neonatal or child health services. The providers were also involved in offering preventive services such as health education, awareness of pregnancy complications, and family planning counselling. Besides these services, injury-related services, TB identification and DOTS supply, dental care or asthma services were also provided by some CTC health service providers. In addition, a small number of providers were involved in providing services for STIs/RTIs, MR, Leukorria, bloodstained vaginal discharge and EPI. This indicates that CTC health service providers provide a wide range of services to the community.

Almost all CTC health service providers reported that they refer emergency patients to hospitals or clinics. To reduce harmful practices and also to provide effective health services to the slum-dwellers and underserved poor people, a comprehensive and standard package of health services focusing on SRHs that incorporates both community- and facility-oriented services needs to be developed to address the multiple dimensions of health care for poor people living in urban and peri-urban slums. Data revealed that the majority of CTC health service providers claimed to have received various types of health care training. But it is important to know the content of the training and their expected roles after receiving the training.

It is interesting to note that only a few of the CTC health service providers reported encountering problems in treating their patients (13.1%). A lack of health awareness or education, basic health care training and delivery kits/space were reported to be major hindrances for health service delivery. A standard health care education or training package prioritizing the CHWs and informal providers is essential for various types of CTC health service providers, to reduce health vulnerabilities, with a focus on SRH, for various groups living in urban slums and underserved rural areas.

Finally, to address the existing dynamic pluralism in health matters in slums and underserved rural area, effective coordination needs to be brought about between informal and formal providers as well as private practitioners in Bangladesh. The government, in collaboration with NGOs, needs to be more involved in projects in urban slums, provide the basic services/facilities, including SRH, to all slum-dwellers and plan for future urban expansion and development.

CHAPTER 5 – CONTEXT ANALYSIS: QUALITATIVE RESEARCH

OBJECTIVES

The purpose of the context analysis was to develop an analytical framework that would be used to design and analyse the quality improvement cycles of service delivery of MR (manual vacuum aspiration to safely establish non-pregnancy up to 8–10 weeks after a missed menstruation period) in two phases. The broader objective of our research was to gain an insight into CTC service provision, which would encompass the equity, efficiency and effectiveness of the health care services offered in the slum community setting for our country context. The specific objectives of this context analysis were:

- to identify evidence for interventions which have an impact on the contribution of CTC health service providers to the delivery of effective, efficient and equitable care in SRH and MR;
- to assess structures and policies of the health systems for strengths and weaknesses regarding the organization of CTC services and management of CTC health service providers in SRH and MR;
- to identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC health service providers and services in SRH and MR; and
- to synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services in SRH and MR.

METHODS

QUALITATIVE STUDY DESIGN

The CTC context analysis study adopted both qualitative and quantitative research techniques for data collection (see Annex 4 for the data collection tools used). The qualitative study involved interviewing CTC health service providers and MR clients, and holding Focus Group Discussions (FGDs) among married women and men from the respective communities. For the quantitative part of the study we conducted a comprehensive CTC mapping, as discussed in the previous chapter.

In-depth interviews (IDIs) were conducted with clients of MR services. Key informant interviews (KIIs) were conducted with doctors, paramedics and programme staff from Marie Stopes and RHSTEP. Separate FGDs were conducted with married men and women of the selected urban

and peri-urban slums. In addition, SSIs were conducted with formal and informal CTC health service providers working in the respective community.

In each study site, six IDIs, two key informant interviews (KIIs), three FGDs (one with married men and two with married women) and six SSIs (two formal and four informal) were conducted. Further details of the types of interviews and respondents are presented in Table 9.

Table 9. Types of respondents for the qualitative research

Types of interviews	Number of interviews	Types of respondent
IDI	6 x 4 = 24	IDIs were conducted among those who went through an MR experience in the past one year: 2 with women who have never given birth 2 with women with 1 or 2 children 2 with women with 3 children
KII	2 x 4 = 8	1 with doctors/paramedics (from Marie Stopes in one site and RHSTEP in another site) 1 with programme staff (from Marie Stopes in one site and RHSTEP in another site)
FGD	3 x 4 = 12	1 FGD with married men in the community 2 FGDs with married women in the community
SSI (Formal CTC provider)	2 x 4 = 8	1 with government health worker 1 with NGO health worker
SSI (Informal CTC provider)	4 x 4 = 16	*Dai* (untrained TBAs, allopathic drug sellers, traditional healers and village doctors who provide health services (including SRH and MR) to the community

SELECTION OF SITES

Two urban slums were selected from Dhaka, and one urban slum and one rural area from Sylhet district. One Dhaka site, Kallyanpur, falls into the catchment area of a branch of Marie Stopes, while the other Dhaka site, Keraniganj, is located near an RHSTEP centre. Both Marie Stopes and RHSTEP provide SRH, including MR, services. Similarly, the Sylhet urban site was located near an RHSTEP centre, and the rural site was served by a Marie Stopes branch.

DESCRIPTION OF RESEARCH SITES

The selected study sites consisted of three urban slums (Kallyanpur and Keranigonj in Dhaka and Ghashitola in Sylhet) and a rural village, Lakkatura, located at the periphery of the city corporation area of Sylhet. Kallyanpur and Lakkatura were situated on government lands, while

the Keraniganj and Ghashitola slums were built on privately owned land. Selected urban slums were densely populated, and almost all of the dwellers were migrants from different districts of Bangladesh.

From the field observation it was found that all sites were divided into various sections. The slum situated in Kallyanpur was divided into 10 sections, with each one identified by a number. In the slums of Keraniganj and Ghashitola, the sections were known as colonies (14 colonies in each site). Each colony was identified by the name of the landowner. For example, *Montu Ukiler bari* (1, 2 and 3) *(*house of Montu Ukil*), Masud Miyar bari* (1 and 2), *Nazur bari, Nazim er bari, Sintiar bari, Abeder bari* (1 and 2), *Sadeker bari, Situ Miyar bari, Akhila Khatun er bari* and *Mukul er bari* in Keranigonj*, and *Rashid Miyar Bari*, *Kamal Miyar bari*, *Layek Miyar bari*, *Shoheler bari, Mohon Miyar bari, Motin Miyar bari, Mustaq Hajir bari* (1, 2 and 3), *Juber Miyar bari, Kajol Hajir bari, Bachu Miyar bari, Hannan Miyar bari* and *Moksud Alir bari* in Ghashitola. For the rural location of Lakkatura in Sylhet, the entire village was divided into various sections named *Chapatol, Uria para, Club line, Upar tila, Lower para, Krishna para, Raja bari*, and *2 no. tila/line*.

Residents of the three urban slums (Kallyanpur, Keraniganj and Ghashitola) were paying rent for their room to their landowner. The average cost of renting a room in urban slums is BDT1000–2600. But it was found that the rent cost differs from place to place; for Dhaka it was BDT1000–2600 per month, and for Ghashitola it was BDT1000–2000, while in Lakkatura, residents were not paying any rent because it was a village for the tea garden labourers, and the tea estate authority allocated the land for the residents to build houses. During interviews, FGDs and informal discussion we observed that most of the people in the three urban slums rent a single room in which to live with their family; the number of family members ranged from 2 to 10 in all sites.

Observations on housing patterns, professions and the physical environment gave us an understanding of the socio-economic status of the communities covered by this research. In Kallyanpur most of the houses in this urban slum were made of tin and bamboo. Many of them had a television with satellite connection, a refrigerator and a CD player. From IGDs it was found that some of the residents own land or property in their village. The professions of the community members were rickshaw pulling, running small businesses (tea stalls, selling cigarettes and betel nuts etc.), auto (motorized) rickshaw driving, domestic work as maids/servants, and working on construction sites, in garments factories and as tea garden labourers (Lakkatura). The water and sanitation situation of Kallyanpur was better than the other two urban sites. There were four or five toilets and a shower placed in a cluster (called a

'cluster latrine') built by an NGO named DSK. Some cluster latrines in the slum were well managed by the community members.

On the other hand, many people living in the slum of Keranigonj stated they were extremely poor and were struggling to maintain their minimal living costs. Hence, they preferred to live in low-cost colonies, where houses were made of bamboo and tin. Some people preferred to live in *semi-paka* buildings (brick-made buildings with a tin roof). Observations revealed that many families had televisions with satellite connection and a CD player. Gas burners for cooking were very common for most colonies in this slum. Many community members reported that people go to work in locations such as Babu Baazar, Sadar Ghat and old Dhaka (*puratan* Dhaka) in various types of businesses and shops; many work as day labourers, rickshaw pullers etc. Furthermore, there were no structured toilets as in Kallyanpur; an open drainage system was observed, houses were congested, and the overall picture represented a low socio-economic situation. The landowner had built common toilets for the residents.

For Ghashitola in Sylhet, the majority of the community members were from neighbouring districts. Houses were mostly tin shaded buildings (*semi-paka*) with verandahs. Rickshaw pulling, day labour and sewing work were found to be common professions in this slum. Sewing work was a source of income for women who work from home. An open drainage system was seen in this slum area during data collection.

In the Lakkatura site in Sylhet, most of the residents were tea garden workers, who were earning only BDT65–75 per day. The population of Lakkatura consisted of different ethnic groups apart from Bangalees — for example, migrated *santal*, some *oriya* people migrated from Orissa, India, and some *khasias* who generally live in the hilly areas of Sylhet. These ethnic groups migrated a long time (two or three generations) ago. The economic situation of Lakkatura residents was worse than the other three locations. Most houses were built with bamboo and tin. There were some tin shaded buildings for the better-off people. It was observed that an NGO was providing facilities for safe drinking water in the community. It was found from the IGDs that many people were leaving their traditional occupations (as day labourers in the tea estate) to work in the city area of Sylhet; however, this statement cannot be generalized to all people living in that community.

Figure 5: Political map of Bangladesh indicating two districts where study sites were selected

SAMPLING, PARTICPANT SELECTION

For the IDIs, MR clients were selected from the respective clinics (Marie Stopes in one site and RHSTEP in another site from each district) after they received a follow-up session. Selection criteria were designed to enable us to understand the diversity of the data regarding respondents' experiences of MR services. Hence, the range of respondents included women who had never given birth and women with up to three children. The selection of the IDI respondents had been difficult from the community perspective, as it was evident from the pre-test where the research team had faced difficulties in finding respondents from these categories. Therefore, we carried out exit interviews with MR clients at the respective clinics. In every two KIIs, one was conducted with the people directly involved in providing MR services,

such as doctor, paramedic, nurse and counsellor, while the other was conducted with management-level staff, such as a programme officer or manager.

FGD participants were selected purposively and by following a snowball sampling technique in every site. Each FGD had 8–10 and participants, who were selected from slum communities. Separate FGDs were organized with married men and women. In selecting participants for FGDs, special care was given to maintaining a relatively homogenous group to overcome group dynamics.

For SSIs, four CTC informal providers (TBAs, allopathic drug sellers, traditional healers, village doctors etc.) from each study site were selected from the CTC mapping, based on their popularity within the community. In addition, two formal providers from each study site were selected purposively from government service providers and from NGOs (one from each category) operating in that area.

PILOTING THE METHODS AND MATERIALS

A team of three RAs field-tested the CTC identification (mapping), IDI, SSI and FGD tools for the main data collection session for one day on 12 June 2013 at Dowaripara slum (*Vola bosti*) at Mirpur, Dhaka.

Voice recorders were used during the field-testing of different interview tools, but the respondents raised concerns about this. Moreover, the use of a recorder also hampered the data collection process, as many of the respondents did not answer the questions and also demonstrated a lack of interest in responding when the recorder was turned on, due to the sensitive nature of some of the questions related to SRH and MR.

DATA COLLECTION PROCESS, DATA PROCESSING, DATA ANALYSIS

The RAs worked in pairs for data collection. Due to the sensitivity of the issues (SRH and MR) under investigation, the research team decided not to use a voice recorder throughout the research process. Hence, two RAs conducted each interview to capture as much data as accurately as possible. One RA's role was to conduct the interview, and the other's was to take detailed notes, while both RAs contributed to writing a comprehensive transcript of the interviews each day.

Two FGDs were conducted among married women and one among married men in each site in order to understand the first point of contact for community members, particularly women, to access SRH care. Through FGDs, a list of popular providers in the slum area was prepared (for general health issues, SRH and MR). Two teams conducted FGDs in the community. One team

comprised female RAs who conducted FGDs with married women, and one team with male RAs conducted FGDs with married men in the community. On completion of an interview (IDI or SSI), the note-taker prepared a transcript, and the interviewer cross-checked the transcript to see if there was any inconsistency in the data. Transcriptions were translated directly from Bangla into English. The translators selected have experience of translating interviews for different research projects at JPGSPH for the past five or six years and received training for the translation process. In addition, a team of experienced researchers from the JPGSPH rigorously reviewed all translated copies to cross-check the quality of the translations. Likewise, if the translation lacked important information, the transcripts were sent back to translators for re-working.

The next and final step was data coding using Atlas. ti software for analysis. Initially, all transcripts were coded manually following the coding framework developed and finalized during a qualitative research workshop at JPGSPH. Coded transcripts were checked and reviewed by experienced researchers from the team to ensure the quality of coding. All coded transcripts were then entered into Atlas. ti software.

Thematic outputs have been generated to write narratives based on the draft framework of the REACHOUT project. Themes were prioritized based on Bangladesh country perspectives.

QUALITY ASSURANCE/TRUSTWORTHINESS

Various types of measures were adopted for quality assurance and trustworthiness. Before commencing data collection, we provided training to the RAs. The objective of the training was to provide a practical lesson for data collection to the RAs and enable them to collect individual and group-level data for the CTC context analysis using relevant tools and techniques. A four-member team comprised of experienced researchers conducted the training session for a month from 19 June to 20 July 2013.

Discussing SRH issues in public is not appreciated in Bangladesh, where people are culturally and religiously more sensitive, particularly the people from Sylhet, who are more conservative in terms of key health indicators than those in Dhaka (Bangladesh Demographic and Health Survey, 2012). Given the sensitive nature of the issues (SRH and MR), the team decided not to use the recorder during data collection. However, to ensure the quality of the data, the team took the following measures: two RAs worked in pairs during the interview session. One RA conducted the interview, while another took detailed notes. Moreover, the RAs were given rigorous training in ensuring the flow of the interview sessions and appropriate probing, and conversations were noted as much as possible verbatim by the note-taker. After each interview, the interviewer cross-checked the collected data thoroughly with the note-taker.

Transcription took place on the same day to avoid a backlog of notes and to ensure that the information transcribed was accurate for each respondent. This also ensured a good review of data collection every few days by field supervisors and senior project team members.

STUDY LIMITATIONS

Since the issue of SRH/MR is reasonably sensitive in the context of Bangladesh, the team avoided using tape recorders in the field. The team took necessary measures to capture as much information from interviews as possible by taking detailed field notes. However, there may have been concerns about missing details or misinterpreting data, since a recorder was not used. There may also have been an issue of recall bias.

We conducted exit interviews with MR clients while they were at the facilities of the service providers (Marie Stopes and RHSTEP). In some cases, it was difficult to ensure adequate privacy; hence sometimes it was observed that the respondents were not comfortable to speak freely. We interviewed some women who were accompanied by their relatives (husband, mother-in-law etc.). Though we conducted interviews only with the respondents, sometimes a session was interrupted by the accompanying relatives. Therefore, it was difficult for respondents to talk openly about their gynaecological problems and their experience of MR.

ETHICAL CLEARANCE

Ethical clearance for this study was obtained from the Ethical Review Committee of the JPGSPH at the BRAC Institute of Global Health (see Annex 7). In addition, ethical approval was also obtained from the KIT ethics committee.

Participants who were approached for interviews were fully informed of the nature of the study and the research objectives. Confidentiality and anonymity of their participation and the data collected were maintained throughout the research process and will be maintained in any future publication of the data. The potential benefit in participating in the study was disclosed to all participants, and they all provided informed consent (written or verbal). Interviews were arranged at appropriate settings and times agreed earlier by the data collection team and the participants. Before the interviews commenced, participants were informed of the research and its objectives and asked for their participation. If any respondents declined to participate, the interviews were ceased immediately. The participants were also informed that they could skip any question they did not wish to answer. Participants were assured that no one other than the research team would have access to their information. They were informed that they could leave the interview at any time. They were given the opportunity to refuse answers to any questions that made them uncomfortable. At the end of the interviews, they were given

the opportunity to make comments or ask the interviewers any questions. The team ensured that ethical guidelines were followed when interviewing all respondents.

FINDINGS

The findings of this study have been divided into seven sections, covering:

- health services in the community;
- a description of characteristics, tasks and the process of recruitment of the CTC health service providers;
- findings on the relationships among CTC health service providers and between providers and their clients;
- job satisfaction of various CTC health service providers, to identify gaps in their performance;
- findings on the referral system that exists in the community settings among the CTC health service providers;
- findings on the quality of health care from the perspective of both community members and CTC health service providers; and
- the facilitators of and barriers to the CTC health service providers in delivering health care services to the community.

HEALTH SERVICES IN THE COMMUNITY

This section presents the findings of the research from four sites (Kallyanpur, Keraniganj, Ghashitola and Lakkatura). From 12 FGDs (eight with married women and four with married men) in local communities and 24 IDIs with women who have past MR experience, varied responses were received on their understanding of SRH and MR services, the availability of health services in the community, their choice of treatment and their relationships with CTC health service providers.

A total of 26 SSIs (10 with formal CTC providers and 16 with informal CTC providers) provide us with an understanding of the SRH behaviour of the community. Community members (both men and women) talked about the common SRH problems women face and the availability of services in or near to the community. We begin with the common SRH-related problems identified in discussions and interviews.

COMMON SRH PROBLEMS REPORTED

The most common SRH problems reported by women who participated in the FGDs and IDIs in the four sites were pregnancy-related problems (discomfort, dizziness, vertigo, weakness, nausea, abdominal pain, excessive bleeding), complications while using family planning

methods, menstruation problems (excessive bleeding, white discharge, pain in waist, backache and irregular menstruation), itching and infections in the genital area and uterus-related problems (infections in uterus, uterine prolapse) etc. Several respondents mentioned pregnancy-related problems and side-effects related to the use of family planning methods, a larger number mentioned menstruation-related complications, and some of the women also talked about problems in their genital organs.

Women who participated in the FGDs and IDIs reported menstrual problems as the most common problem for them. Furthermore, of the 24 women with past MR experience, four women revealed in the IDIs that they developed various problems after performing MR — for example, irregular menstruation, abdominal pain, excessive pain and bleeding during menstruation.

WHERE DO THE COMMUNITY MEMBERS GO?

Through 12 FGDs with men and women in four locations, we explored where women go when they suffer from SRH-related problems. The 26 interviews with CTC health service providers and 24 IDIs with MR clients showed that community members seek health services from a range of health providers including formal (government, NGO and private sector) and informal (allopathic drug sellers, *dai* and *kabiraj*/traditional healers).

CHOICE FOR TREATMENT

Formal providers

Different types of formal health service providers were found in the four research locations through our CTC mapping and FGDs. The community members also reported that they use health services outside their own local community. Many of them (both men and women) visit government and NGOs hospitals depending on where they live and what is considered easily accessible and familiar.

In the FGDs with women and 13 SSIs with CTC health service providers in urban slums of Dhaka it was revealed that a large number of community members visit Mitford Hospital (a government hospital) for general SRH problems and for critical health issues, and for pregnancy terminations they visit RHSTEP, while others visit Marie Stopes, and a smaller number visit Shohrawardy Hospital (a government hospital). Some of the women also prefer NGOs for pregnancy care, with several women stating that they visit a BRAC delivery centre that is situated within the compound of the slums. The rest of the women visit NGOs (UTPS, Sajeda Foundation, Smiling Sun and Dustho Shastho Kendro) and private hospitals for general SRH problems and family planning.

For the case of Sylhet, a conservative rural area, in the six FGDs with women from the community and 13 SSIs with CTC health service providers in an urban slum (Ghashitola) and a rural location (Lakkatura), a large number of the women stated that they visit MAG Osmani Medical College Hospital (a government hospital) for their general health issues and SRH problems. They visit RHSTEP and Marie Stopes for MR services. A smaller number reported visiting a BRAC delivery centre, seven go to various NGO clinics (Shimantik[15] and Similing Sun), and 10 use the service from a tea estate hospital in Lakkatura for pregnancy, family planning, MR etc.

It can be seen from the situation described above that, among the formal providers, Mitford Hospital is the most popular destination for the community in Keraniganj for general SRH and MR, Marie Stopes for MR services/family planning for the community in Kallyanpur, and the MAG Osmani Medical College Hospital for women living in Ghashitola (urban slum location) and Lakkatura (rural slum location) in Sylhet for general SRH and MR.

Out of these providers, Marie Stopes and RHSTEP are the most popular for providing MR services. All MR clients in the 24 IDIs reported that Marie Stopes and RHSTEP were their first choice. Similarly, in the eight FGDs women also reported that many visit Marie Stopes and RHSTEP for SRH services (MR and post-MR services, family planning, antenatal and postnatal care etc.). In the IDIs, 10 out of the 24 MR clients said that they chose Marie Stopes and RHSTEP on their own, without any referral from drugstores or doctors, but with the advice and suggestions of their relatives and neighbours in the locality. The rest of the 14 women were referred by drugstore salespeople, village doctors, local doctors or Marie Stopes and RHSTEP community health volunteers.

According to the findings from the FGDs in the four research locations, the next most popular provider from the formal sector is the BRAC delivery centre. Community members reported that health workers from the BRAC delivery centre come to them to provide services on family planning and mother and child care. They also give out cards when they refer patients, and women get free delivery from BRAC by showing this card.

Although the community members mentioned that they visit government hospitals, they expressed huge dissatisfaction with the services provided by the government hospitals such as Mitford and the MAG Osmani Medical College Hospital. In the FGDs, many of the men and women stated that they prefer not to go to government hospitals as a first choice because they do not provide good health services. Furthermore, they also had complaints about the number

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[15] Shimantik is an NGO working in Sylhet which is also funded by the Government of Bangladesh.

of beds available for patients, long waiting hours, bribery/corruption, and the influence of brokers[16] at government hospitals (Mitford and Osmani hospitals). Among them, three married men who took part in an FGD in the urban slum of Keraniganj talked about brokers in a government hospital:

> *"You cannot get the doctor directly at Mitford [public hospital] and it needs a broker. They take you to the doctor, and then the doctor will treat you. You do not need to get them. They are available at the hospital gate."* (Married man, aged 58, Keraniganj, Dhaka)

> *"You just have to go to the bank of the river, and they will take you. They do everything, though it needs extra money."* (Married man, aged 32, Keraniganj, Dhaka)

> *"Sometimes while you cannot get a seat at the hospital, they [brokers] manage it easily."* (Married man, aged 40, Keraniganj, Dhaka)

Brokers are an issue only at government hospitals; they demotivate many community people from using those services. However, none of the women from any of the four slum locations mentioned any issues related to brokers.

Informal providers

Apart from various types of formal health service providers there are many informal health service providers that community members prefer to visit. For the urban locations in Dhaka (Kallyanpur and Keraniganj), it was reported through six FGDs with the community and 13 SSIs with CTC health service providers that many people also go to nearby drugstores, three respondents go to *kabiraj,* four respondents go to *dai*s, and four use the services of village doctors for general SRH services. In Sylhet it was reported through six FGDs and 13 SSIs from an urban slum and a rural location that 24 respondents go to nearby drugstores, 18 go to *kabiraj,* and five go to *dai*s.

It was also found from the discussions with men in the three urban slum locations (Kallyanpur, Keraniganj in Dhaka and Ghashitola in Sylhet) that they go to drugstores as the first point of contact when they suffer from any type of disease. Women from the FGDs in urban locations in Dhaka mentioned that they go to drugstores before going anywhere else for any health problems, including general SRH. A married woman from the urban slum of Kallyanpur said that

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[16] Brokers are generally seen mostly in the government hospital compound looking for patients to assist them to see doctors for money. Brokers are not authorized service providers in the hospital compound, but they are well connected with the hospital staff, and it is very difficult for people from slum communities to see a doctor by bypassing brokers.

she goes to a drugstore first and, if it does not help her, then she goes to a government hospital:

> *"We go to the pharmacies without consulting a doctor. We talk about our problems to the pharmacy people who sell medicines, and they give us medicines. If their medicines work for our diseases, then we are saved. We will feel that Allah has forgiven us. If we are not cured then we go to Sohrawardy hospital."* (Married woman, age not mentioned, Kallyanpur, Dhaka)

Likewise, for the community in Sylhet (for both Ghashitola and Lakkatura), drugstores are the most popular CTC health service providers for services for general and SRH-related problems. A 66-year-old married man from an FGD conducted in urban Sylhet stated that people go to drugstores first:

> *"Initially no one goes to the hospital. They wait for one or two days. They only take medicine from the pharmacy. They only go to the hospital if the medicine does not work."* (Married man, aged 66, Ghashitola, Sylhet)

A married woman from the rural location of Lakkatura, Sylhet, who works in the government tea estate said that she buys medicine from a pharmacy:

> *"…during my period there is pain in my abdomen. When I had pain in my abdomen, then every month I bought painkillers from the pharmacy. When the pain subsides, then it's no longer remembered. Next month I again take painkillers."* (Married woman, aged 22, Lakkatura, Sylhet)

All of these statements highlight the community's preference to seek health care from drugstore salespeople without consulting a doctor. A possible explanation could be the easy access and availability of various types of drugstores within their reach. However, a different opinion was expressed by a married woman from an urban location (Kallyanpur, Dhaka) who thinks that people should consult a doctor before taking any medicine. She also expressed her reliance on government hospitals:

> *"It is seen that many of us have confidence in the treatment provided at the Medical College. They feel that they should consult a doctor before taking any medicine. Some people also think that they may get cured by taking medicines from the pharmacy. But those who understand things better feel that it is better to take the medicines after consulting a doctor. That is why most of the people take medicines after consulting a doctor."* (Married woman, age not mentioned, Kallyanpur, Dhaka)

However, in the rural location of Lakkatura in Sylhet, FGDs with men and women found that some of them visit the hospital inside their village, which was established by the government-

owned tea estate. All the men and women reported that this hospital does not have sufficient medicine and does not have a full-time doctor. Hence, visiting drugstore salespeople and *kabiraj* are also popular options for men and women in Lakkatura. They visit various types of *kabiraj* for their health problems, including SRH. For gynaecological problems (menstruation and pregnancy-related problems), they reported that they visited a female *kabiraj* (*pirani*).[17] A housewife from the urban slum of Ghashitola in Sylhet mentioned that she had relied on *kabiraj* for a safe delivery:

> *"If a woman conceives, we take a Tabij [amulet] to protect the child. Then we would not face any problem. I brought a Tabij from my home (Mymansingh). My mother brought it. I wore it. I did not face any problem. The delivery was fine."* (Housewife, aged 31, Ghashitola, Sylhet)

The findings on the health-seeking behaviour of the community showed that the community members visit various types of CTC health service providers. For the two urban slums of Dhaka, although people go to various formal providers, including government hospitals, they prefer to try informal providers such as drugstores before going to hospitals. For MR services, Marie Stopes and RHSTEP remain the most popular option for women. Drugstores, *dai*s and *kabiraj*s were very popular among the community members of Sylhet for SRH, and they can obtain health services from these providers at low cost.

COST IMPLICATIONS FOR TREATMENT OPTIONS

We wanted to know whether cost remains a factor for community members accessing health services or whether they have different reasons for selecting providers.

Formal providers

From the five community FGDs (two in Kallyanpur in Dhaka and two in Ghashitola and one in Lakkatura in Sylhet) and one interview with a government family planning worker, many respondents stated that they go to an NGO clinic for their SRH needs, as NGOs provide services for free or at a low or discounted rate. However, some of the other respondents in the community and a few informal providers expressed a different view and countered that NGOs are supposed to provide all services free of charge, but the NGOs had not been doing that in practice; rather, they charge more, hence they think that it is expensive to obtain services from them. A few of the women living in Keraniganj and Kallyanpur said that health services at NGO clinics were more expensive than neighbouring drugstores. A married woman from Kallyanpur mentioned:

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[17] A female *kabiraj* or spiritual healer is also known as a *pirani*.

"I do not feel good about the health workers of the Urban Health Centre. Whenever I get the chance to face them, they will have to pay costs. …They even charge a huge amount of money. Whenever I face any kind of difficulty, I go to Suhrawardi." (Married woman, age not mentioned, Kallyanpur, Dhaka)

A married woman from the urban slum of Kallyanpur reported that NGOs take money but the patients do not receive quality services in return:

"They take money but do not give [family planning] injections according to the scheduled dates. They say 'not today, come tomorrow; not tomorrow, come day after tomorrow' and things like this." (Married woman, age not mentioned, Kallyanpur, Dhaka)

However, two women from the urban slum of Kallyanpur expressed a different opinion: that although NGO clinics charge money, they provide better services. In contrast to NGO clinics, several women in the FGDs in both Dhaka and Sylhet also stated that government hospitals provide quality services at low or minimal cost. Therefore, many choose the government hospitals. Two married women from the urban slum of Ghashitola in Sylhet expressed their satisfaction with the government hospital:

"The doctors of Osmani also behave in a nice way. The most important thing is they make us understand." (Married woman, aged 20, Ghashitola, Sylhet)

"If something is good, we have to say it is good." (Married woman, aged 30, Ghashitola, Sylhet)

However, a married girl from Keraniganj expressed her dissatisfaction with the charges of a government hospital:

"The government hospital charges 200–300 taka but does not give good medicine, and they take less money from the poor and from the rich people they take more. They do not give good medicine, so that patient visits them repeatedly." (Married woman, aged 15, Keraniganj, Dhaka)

Furthermore, there was an issue of brokers near the government hospitals in Dhaka and Sylhet, who also charge money and refer women to providers. This was a problem for women who were vulnerable and desperately seeking care for MR, particularly for a late-term pregnancy, and often could not distinguish between the qualities of different providers. Brokers looked for MR clients from within the community and referred them to local clinics where unqualified low-skilled doctors and paramedics provide MR services with insufficient equipment at higher cost and at risk to women's health. In reference to cost, a smaller number of respondents living in the urban slums of Kallyanpur and Keraniganj in Dhaka mentioned that many rich people go to

private clinics either because they can afford it or because they are referred by drugstore salespeople or organizations.

Informal providers

Participants in the seven FGDs (four with women and three with men) in the four locations mentioned that they first visit drugstore salespeople for SRH problems for low-cost or minimal-cost services. This can include treatment for family planning, pregnancy pain, asking for a pill to terminate pregnancies etc. A smaller number of women in the FGDs mentioned visiting a *kabiraj* at first, because it was the cheapest option for them. In many cases, *kabiraj*s do not charge money. In this context, a 39-year-old married woman who works in the tea garden and lives in Lakkatura in Sylhet explained why she preferred to visit a *kabiraj*:

> *"Bonaji[18] medicine is what we take. We hope that we will get cured using a smaller amount of money. If we spend too much money, we then have to starve to death. Then nobody will take care of us. And then again if we start owing a lot of money, it creates a lot of mental pressure on us."* (Married woman, aged 39, Lakkatura, Sylhet)

In another case, a 30-year-old married woman from the urban slum of Ghashitola in Sylhet talked about her neighbour who went to Osmani Medical College Hospital in Sylhet for treatment but, due to the high cost, went back to a *kabiraj*:

> *"She could not bear the expenses of Osmani anymore, so she went back home. She was under lot of debts. After going home, she went to a kabiraj, and the kabiraj said she was cursed. She had to spend a lot to break the curse."* (Married woman, aged 31, Ghashitola, Sylhet)

Research findings show that informal providers such as drug sellers working in pharmacies, *kabiraj*s *and dais* were the most popular health service providers as a first point of contact for the community in urban slums and in rural settings. Further evidence also suggests that trust and easy access to these types of informal provides were some of the reasons for their popularity.

CTC SERVICE DELIVERY — PROVIDERS' PERSPECTIVES

In addition to learning about the community's perspective, we asked various CTC health service providers to talk about their roles, responsibilities, recruitment, training and supervisory processes. The aim was to identify and explore the factors in their service delivery process that might affect their performance. To discover this, we conducted 26 SSIs with formal and

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[18] Bonaji is a herbal plant that is used by *kabiraj*s in Sylhet to heal various types of diseases, including women's SRH problems.

informal providers in four locations — the urban slums of Kallyanpur and Keraniganj in Dhaka and the urban slum of Ghashitola and the rural location of Lakkatura in Sylhet.

CTC PROVIDERS' ROLE: FORMAL

Of 26 SSIs conducted among CTC health service providers (formal and informal), five respondents (three FWAs, an HA and a FWV) mentioned that they have a specific job description with a target to meet every month. For example, FWAs, who are government-recruited field staff, stated that they have to cover a specific area and carry out door-to-door visits to a certain number of households (1600–1800) every two months to provide services on family planning, refer MR clients to FWVs and provide general health awareness. One of the FWAs from the three interviews from the rural location of Lakkatura, Sylhet, talked about her work:

> "First, I register couples. ...We register family planning couples, give vaccine to girls and children and take care of the women. Sometimes we provide iron tablets to pregnant and young girls. Again, we provide services to one-to-five-year-old kids. (FWA, aged 41, in practice for 23.9 years)

FWAs are primarily responsible for visiting women door to door; however, one FWV reported that FWVs also have to visit various community members regularly to monitor and to organize health camps. For the providers from the private sector (NGOs and private clinics) the roles and responsibilities varied depending on the reach of the programme and target areas.

Two SSs — community health volunteers working at BRAC, one in Kallyanpur, Dhaka, and one in Ghashitola, Sylhet — mentioned that their job responsibilities include visiting 8–10 households every day. They also stated that, unlike other providers, BRAC SSs are not paid a salary but can earn an income from the number of referrals and by selling medicines to local communities. An SS from BRAC from the urban slum of Kallyanpur in Dhaka explained how she earns through her work:

> "I get 150 taka for delivery work, 50 taka for issuing cards and 150 taka for baby care. In total I get 300 taka. Sometimes I get 1500 taka in a month. In some months, I get 3000 taka. Sometimes I do not get anything in a month." (Shasthya Shebika, aged 30, in practice for 9 years, Kallyanpur, Dhaka)

She also described the regular work that she carries out in the community:

> "When I find a pregnant woman in this area, I advise her to go to the BRAC delivery centre, which is located here. SK [Shashtho Karmi] Apa[19] is available there. I tell her to go

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[19] Apa means 'sister' in Bangla.

to her. I advise pregnant women to maintain a proper diet and take enough rest. We also talk about various birth control methods like Norplant, tablet etc. now birth control pills are in demand." (Shasthya Shebika, aged 30, in practice for 9 years, Kallyanpur, Dhaka)

It was found during the data collection that NGOs such as UTPS (Dhaka) and Shimantik (Sylhet) have paid community workers to promote their services and to raise awareness in relation to SRH and MR services available at their clinics. An exception was found in terms of a private clinic having a paid front-line provider from Keraniganj to promote referral of patients to the clinic. She said the following about her work:

"The care I provide is delivery and providing advice. Suppose, a seven-months pregnant woman is facing problems, then I give her advice on her problem. ...I would advise an eight-months pregnant women to take green coconut water, take oral saline and also advise them to visit the gynaecologists at Keraniganj." (Front-line provider, aged 29, in practice for more than five years, Keraniganj, Dhaka)

Furthermore, outside these private-sector providers, Marie Stopes and RHSTEP provide SRH services (for example, ante- and postnatal care, RTIs/STIs, SRH care for adolescents etc.) and MR for women in the community. KIIs with representatives of Marie Stopes in Dhaka and in Sylhet revealed that there are community-level Marie Stopes volunteers who are paid by the organization and work in Dhaka but not in Sylhet. The position of Marie Stopes volunteers in Sylhet was vacant at the time of data collection. Marie Stopes provides various SRH services in a close proximity to slum communities at Kallyanpur, Dhaka, and Lakkatura, Sylhet. RHSTEP[20] provides SRH and MR services at Mitford Hospital in Dhaka and the MAG Osmani Medical College Hospital in Sylhet in collaboration with the government.

CTC PROVIDERS' ROLE: INFORMAL

In five SSIs with drugstore salespeople, they mentioned that they provide services and medicines for SRH-related diseases and problems (problems with menstruation such as irregular menstruation and white discharge, ante- and postnatal services etc.). Three drugstore salespeople (one in Keraniganj, Dhaka, and two in Ghashitola, Sylhet) confirmed that they provide pregnancy termination medicines (which restart menstrual flow). One of the drugstore salespeople from the urban slum of Keraniganj of Dhaka reported that:

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[20] The government permits RHSTEP to carry out its activities in public hospitals. RHSTEP has activities (MR and post-MR services, SRH services for adolescents, family planning etc.) in 13 public medical college hospitals and in eight public general hospitals. RHSTEP also has its own community clinics.

"If they do not want to keep the baby, then I give them misoprostol[21] tablet; if anybody does not want to take the pill, then I ask them to go for MR. I suggest they visit Marie Stopes. If anybody was afraid of visiting hospital, then I use a tablet to do MR." (Drugstore salesperson, aged 45, in practice for eight years, Keraniganj, Dhaka)

The rest of the drugstore salespeople in Dhaka and in Sylhet mentioned that they do not perform MR but refer MR clients to hospitals and clinics. (The referral process will be discussed in detail later). One drugstore salesperson from the urban slum of Kallyanpur in Dhaka stated that she used to provide medicine for MR services, but she stopped offering this service because of a complication in one case where the termination of pregnancy was not entirely successful:

"I do not give that medicine now; I do not keep it in my pharmacy. Because, few days back, a woman took medicines at a hospital. She was five months pregnant, but the MR was not successful. They informed me to see her, and when I asked, she told me 'I got medicines from hospital, and they suggested me to go to home.' …Since that incident, I do not keep that medicine and do not prescribe to anyone. If anything goes wrong, people will catch me. I have been so frightened soon after that incident." (Drugstore salesperson, female, aged 29, in practice for 1.5 years, Kallyanpur, Dhaka)

Another drugstore salesperson with 22 years of experience from Lakkatura described how a representative from Marie Stopes came to him to motivate him to sell medicine to perform MR, but he was not convinced by Marie Stopes:

"People came from Marie Stopes. They wanted to give me those medicines [for MR]. But I did not take those. I do not advise to take these medicines because it does not work. Besides, I heard many chemists say that it is risky. The patients who come to me, whether they are poor or rich, I do not suggest them for this [MR through medicine]." (Drugstore salesperson, aged 42, in practice for 22 years, Lakkatura, Sylhet)

He refused to keep that particular medicine because his understanding was that it was unable to perform MR completely; rather, it causes problems. Furthermore, according to this drugstore salesperson, he did not receive any training on how to use the medicine properly.

In this context, a Marie Stopes Programme Officer and Centre Manager from Sylhet (close to Lakkatura) mentioned that Marie Stopes and icddr,b have been working with the government to promote MR using medication (MRM) since 2007 and have found that it is very effective. However, he mentioned that Marie Stopes does not supply medicines for drugstore salespeople to perform MR. Marie Stopes only provides information to drugstore salespeople, village

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[21] This tablet is available for inducing labour — not a legal way to terminate pregnancy in Bangladesh.

doctors and doctors on the MR services available from Marie Stopes. Furthermore, he added that there are some pharmaceutical companies that supply medicines that can be used for MR:

> *"No, we do not supply medicines to drugstores for MR, and we also do not motivate them to perform MR. We only inform them about our services. 90% of MRM is done through drugstores. They get medicines from various types of pharmaceutical companies."* (Staff member, Marie Stopes, Sylhet)

Other than seeking medicine for MR from drugstores, there are local birth attendants who provide medicines for the termination of pregnancies. A *dai* who is also a *kabiraj* from Lakkatura mentioned that she performs MR using herbs and plants in rural locations of Sylhet. Four *kabiraj*s (two from Kallyanpur, one from Ghashitola and one from Lakkatura) mentioned that they provide general and SRH-related health services to the community — particularly for pregnant women. All of these *kabiraj*s mentioned that they use holy water, spiritual plants and amulets to cure 'evil eye' (*bod nojar*) 'evil spirit' (*kharapatma*) or 'bad omen' (*batashlaga* or *upri laga* in rural Sylhet) for pregnant women who fear attacks by 'evil spirits' and miscarriages. A male *kabiraj* from urban location of Sylhet told us about his work:

> *"I serve the people; it is Allah who cures them. I mostly work with problems of bad omens (supernatural spirits; mantras; water, amulets or oil with supernatural power etc.). The Hindus will say that Bhogoban [God in Hindu religion] cured them, and the Muslims will say that Allah cures them. I do not hold the power to cure them. Allah holds the power to cure them."* (*Kabiraj*, aged 50, in practice for 12 years, Ghashitola, Sylhet)

One of the roles of the *kabiraj* and *dai* was to provide amulets to pregnant women as well as to newborns to protect them from 'evil eye' and 'evil spirit'. A *kabiraj* from the urban slum of Ghashitola, Sylhet, mentioned that the main clients for amulets are women. He also uses amulets as a birth control method:

> *"A Tabij [amulet] is only for those who have a baby and do not want to have another baby for the next two years. It is haram [an unlawful activity that is not permitted from a religious perspective] if they want to use birth control methods because they are concerned about being unable to feed or provide education for the children."* (*Kabiraj*, aged 50, in practice for 12 years, Ghashitola, Sylhet)

The use of holy water, coconut oil and Marium flower[22] was also reported from Kollyanpur as being used by two *kabirajs* to treat diseases such as jaundice and liver problems in all research sites. *Kabiraj* often read Qur'anic (religious) verses to get rid of the alleged '*koofrey*' (curse). All *kabiraj*s mentioned that they received informal training on this profession by working with senior and experienced *kabirajs*. However, a *dai* (who sometimes provides medicines for

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[22]An Arabian flower used by traditional healers to facilitate delivery.

general health issues apart from child delivery) from the Kallyanpur urban slum of Dhaka reported that her learning came from dreams and guided her to make healing medicines for patients:

> *"In my dream, I was instructed about certain trees to prepare medicines with other ingredients that need to mix together. For example, medicines for headache, gastric pain etc."* (*Dai,* aged 65, in practice for 50 years, Kallyanpur, Dhaka)

This is one of the ways for her to learn how to prepare medicines. Since *kabirajs* are not recruited by anyone, they enjoy the independence of serving the community, and many of them have close and informal relationships with members of the community. In contrast, all formal providers are recruited by their respective organizations.

SELECTION AND RECRUITMENT OF CTC HEALTH SERVICE PROVIDERS

It was understood from 10 SSIs with formal providers (five from the government and five from the private sector) that they follow a standard process to recruit CTC health service providers. For example, the government providers have to follow instructions and guidelines from the MoHFW through two directorates — the DGHS and the DGFP — to recruit HAs, FWAs and FWVs. They advertise the positions in national newspapers before recruiting FWAs, FWVs or HAs. NGOs and private-sector organizations also follow a similar recruitment process. Applicants for the job of FWA must have a Higher Secondary Certificate (HSC) educational qualification and must be at least 18 years old. In the past, the minimum educational qualification was a Secondary School Certificate (SSC).

However, when NGOs are selecting volunteers, the organization may not always follow this standard process, since they are not paid workers. According to two BRAC SSs (one from Kallyanpur and one from Ghashitola), BRAC selects volunteers informally by using a local network by observing the keenness of a potential volunteer to work for BRAC. However, "to become a *Shashto Shebika,* the woman has to be >25 years of age, married having children not below two years, few years of schooling, willing to provide voluntary services and acceptable to the community they serve" (Ahmed, 2008: 40).

However, the case of informal providers is different from the formal providers because they are not recruited by any organization, the community or the government. All informal service providers are independent. Since they do not work at any institutions, they have no fixed salaries, working hours or supervisors. Almost all informal providers such as local *dai*s and *kabiraj*s said that they are happy with what people give them, and this could range from money to gifts. Most of them perform their services from home. Two *kabiraj*s from the urban slums in Dhaka mentioned that they have rented a work space near to the community. All drugstore

salespeople mentioned that they provide health services from the drugstore located near to the community.

A case was found from an urban slum of Kallyanpur in Dhaka of a drugstore salesperson joining a clinic following a recommendation from her friend to begin her career, but later on she was motivated enough to set up her own drugstore by attending a 15-day training course on 'modern herbal medicine'. Personal motivation was very important for her to begin an independent profession where she prescribes, sells medicines and carries out home visits. A *kabiraj* from Kallyanpur mentioned that he learned spiritual healing from his spiritual master (locally known as *pir*):

> "I am a disciple of a pir [sufi master]. He told me to help people. That is why I help people. There is no business in this." (*Kabiraj,* aged 70–75, in practice for 30 years, Kallyanpur, Dhaka)

As for the *dai*s, they came into this profession by working with an experienced *dai*. However, the case of drugstore salespeople may not be the same as *kabirajs* and *dais*, because many of them reported that to join this profession they had to take basic training on drugs and medicines, which will be discussed in the following section.

TRAINING

The government providers (FWAs, FWVs, HAs), five of whom were interviewed, receive basic training after joining the service. FWVs receive training on MR, delivery and child and maternal health issues to make them efficient in providing health services at their respective health centres. NGOs also run training for their regular staff and volunteers. For example, a BRAC 'model *Shastho Shebika*'[23] explained that she participated in an 18-day special training course organized by BRAC on maternal health so that she can provide basic reproductive health information to the community (more discussion on this follows later).

Four out of five drugstore salespeople mentioned that they received training on alternative and modern herbal medicine, and basic training on drug selling from the *upazila* health complex, Shishu Hospital, NGOs etc. However, this did not cover all areas in which they provided services in the community, and it is unclear as to the level, quality, duration and rigour of the training provided. One drugstore salesperson out of the five interviewed stated that he had never

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[23] The term 'model' has been given in the title of a *Shashtho Shebika* to explain that this informal provider who works as a volunteer in the community setting has received a certain level of health training from BRAC.

received any kind of formal training. A village doctor[24] from the rural location of Lakkatura in Sylhet reported that he had received training on drugs from the *upazilla* health complex.

All traditional *dai*s (three from Dhaka and three from Sylhet) said that they received informal training on child delivery from their relatives, such as their aunts, grandmothers, mothers and mother-in-laws. One *dai* mentioned that she learned it from her mother. However, three of the *dai*s (two from Dhaka and one from the rural location of Sylhet) mentioned that they had received formal training on child delivery and hygiene during child delivery from NGO or government hospitals. All of them who received training mentioned that it made them more efficient and competent for child delivery. One of them was also known as a TTBA after receiving the training.

Similarly, there were a few *kabiraj*s (two from Dhaka and two from Sylhet) who stated that they never went through any formal training, while two of them said that they learned from their grandfather and uncle, and two others reported learning from their *ustad* (mentor) or *pir* (spiritual master). For them, training is the process of learning in an informal way. A *kabiraj* from an urban slum of Kallyanpur expressed that he provides services by reading verses from the Qur'an and, therefore, received inspiration spiritually, which was superior to all kinds of formal training:

> *"These are the words of Allah and the prophets. What kind of training might one get on that?"* (*Kabiraj,* aged 70–75 years, in practice for 30 years, Kallyanpur, Dhaka)

He provides health care services by reading verses from the Qur'an, which is the word of God (Allah). This is how he provides treatment for the community; hence, he did not see any relevance in receiving training to provide services. Our research evidence shows that the informal providers do not have any formal training except for the training reported by drugstore salespeople and trained *dai*s (TTBA); however, drugstore salespeople and *dai*s have very little scope for continuing training or refreshers. In addition, the quality of training received by drugstore salespersons is not clear; therefore, a need for training is evident for informal providers.

NEED FOR A SYSTEMATIC SUPERVISORY SYSTEM FOR CTC HEALTH SERVICE PROVIDERS

The results of the CTC mapping showed that the majority of CTC health service providers in the four locations operate in the informal sector, and, as most worked independently, they did not have any system of supervision. Of the 26 CTC health service providers interviewed, five formal

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[24] Village doctors are those who have either six months of training, called RMP, or one year of training, called LMAFP. This covers very basic elements of diagnosing diseases, prescribing medicines, referring patients to hospitals etc.

government service providers (FWAs, FWVs and HAs) reported that an informal system was in place for monitoring work. They explained that they needed to report verbally to a supervisor, who filled in a monthly register on how they were managing assigned targets. An FWA from the Keraniganj urban slum in Dhaka stated that that her supervisor sometimes goes into the field to check on how she is working:

> *"I have to give a monthly report to the inspector of the family planning office. She is our boss. She sometimes goes into the field with us, and sees our work and motivates households if needed. She gives us feedback on our work. And gives advice if we don't do the work properly, and tells us how we should do it. Besides we have monthly meetings where we have to submit the report."* (FWA, aged 42, in practice for 25 years, Keraniganj, Dhaka)

Sometimes supervisors report on the work of fieldworkers, and if they find anything lacking, then they tell them what to do. An HA from Lakkatura in Sylhet mentioned that he works according to his own schedule but has to report weekly to his supervisor about his tasks and performance. He mentioned that his supervisor sometimes visits the field, and officers from head offices come for an audit.

NGO providers, however, claimed to have a more thorough and systematic process of supervision. For example, Marie Stopes has a fieldwork plan for every fieldworker. Fieldworkers have to report to Programme Officers, who check these reports every day. Sometimes supervisors conduct surprise visits at the field level to check on the activities of field staff. Respondents from Marie Stopes through four KIIs (two in Kallyanpur and two in Ghashitola) mentioned that a manager regularly supervises their community health volunteers. Supervisors also go into the field to see the work of CTC health service providers, and sometimes they attend meetings carried out by CTC health service providers with village doctors or drugstore salespeople. Respondents from RHSTEP through two KIIs in Keraniganj mentioned that they also have a system of supervising fieldworkers through staff referred to as field mobilizers. Field mobilizers have to report to the team leader of the relevant programmes; however, RHSTEP did not have a field mobilizer in Sylhet. Two SSs (one from Kallyanpur and one from Ghashitola) reported that they have to maintain a register to record their work:

> *"I do not have to report to anyone for my work. But I have to maintain a register book. I maintain three register books for three slums."* (Model *Shashto Shebika,* aged 30, in practice for nine years, Kollyanpur, Dhaka)

Almost all providers mentioned that they have a very good relationship with their supervisor and that they listen to their views and suggestions. However, a different view was expressed by an FWA from Lakkatura in Sylhet who complained about her supervisor:

"Already he [an EPI-Family Planning Inspector) writes a report on our work. Actually, supervisors (FWVs and EPI-Family Planning Inspectors) were supposed to motivate us. But they do not. They only produce reports. Even though they were supposed to go into the field with us, they do not." (FWA, aged 41, in practice for 23 years, Lakkatura, Sylhet)

This statement highlights the weak supervision and lack of accountability. While the literature points to this problem, the government providers interviewed from three other locations did not raise any problems with their supervisors or a lack of supervision and monitoring. Most (four out of five) government providers mentioned that friendly communication with their supervisor motivates them to deliver quality service. An FWV from the urban slum of Kallyanpur in Dhaka talked about how she can share her views with her supervisor:

"They give importance to my suggestions, ideas and views. They accept my suggestions warmly. Some days ago a Thana Family Planning Officer (TFPO) came to our office. I told him that we need a good MBBS doctor for our centre. He suggested that I share these things at an official meeting and assured me that a good MBBS doctor will be appointed at our centre." (FWV, aged 43, in practice for 23 years, Kallyanpur, Dhaka)

She was the only person who stated confidently that she can share her views with her boss and that these are listened to. Indeed, later on, a doctor was appointed. However, other government providers also mentioned that they could share their views but that there were no indications that their advice and suggestions were reported.

The research shows that all formal providers claim to have a supervisory system — which is verbal in many cases. A systematic and regular supervisory system is lacking, however. Indeed, there is no supervisory system for the informal providers; thus, they are not accountable to anyone. A system of supervision may allow informal providers to be linked with the formal health system to ensure a quality health service for the community.

RELATIONSHIPS AMONG CTC HEALTH SERVICE PROVIDERS AND WITH THEIR CLIENTS

Some 26 SSIs with CTC health service providers at all four sites were conducted to understand their relationships with other providers and with clients and to assess whether this has any impact on their performance. They spoke about their relationships with the others providers who work in the community, and also their relationships with the community.

RELATIONSHIPS AMONG CTC HEALTH SERVICE PROVIDERS

Ten of the 26 SSIs with CTC health service providers reflected that they maintain good relationships with other providers in their neighbouring area. Out paramedic working in an

NGO in Ghashitola, one *dai,* also from Ghashistola, and one government HA from Lakkatur all mentioned that they have good relationships with other providers working in the area, which helps them to learn from each other on various aspects of their services.

A drugstore salesperson in the urban slum of Kallyanpur in Dhaka mentioned that she always contacts two of her mentors, from whom she learned many things about health services, in case of emergency. Likewise, an experienced *dai* from the urban slum of Ghashitola, Sylhet, mentioned that other *dai*s from her area respect her because they have learned the role of *dai* by assisting her in child delivery:

> *"My relationship with others [dais] is good. They learned [child delivery] from me."* (*Dai,* aged 50, in practice for 30 years, Ghashitola, Sylhet)

A similar opinion was expressed by a paramedic with two and a half years of experience from the same location of Sylhet:

> *"I have a good relationship with them. I get help and support from them when I am in trouble [in providing health services]."* (Paramedic, aged 25, in practice for 2.6 years, Ghashitola, Sylhet)

Both of them kept good relationships with others to help each other in case of need. However, not everyone had a cooperative relationship with other providers. This view was shared by a *kabiraj* in Kallyanpur, an urban slum in Dhaka, a *kabiraj* and drug seller from Ghashitola and a government fieldworker (FWA) and two local birth attendants in Lakkatura. They mentioned that they did not even communicate with other providers and did not have any formal or informal relationships for referrals or support with any of the other providers in their locality. According to two informal providers from the rural location of Sylhet:

> *"I have never been to anyone for advice. Usually I do not go [to someone] and do not advise [other providers]. I provide a better service; I know everything."* (*Dai,* aged 79, in practice for 10 years, Lakkatura, Sylhet)

> *"Everyone is selfish. Everyone is concerned about his/her own income only. I get less work because of Jhumi [another provider]. If Jhumi takes a patient to hospital, she gets commission."* (Village doctor, aged 50, in practice for 25 years, Lakkatura, Sylhet)

Both of these statements show that there is competition between informal providers. The first statement reflects that she provides a better service, hence she does not need to go to another provider. The latter statement highlights that the provider loses clients because of another provider. A competitive relationship between providers was also evident in the urban slum location in Dhaka. According to a drugstore salesperson from Kallyanpur:

"One beggar cannot tolerate another beggar. People love to defame others. …If I charge extra for any medicine or service from a patient, he/she will check it with another drug seller or doctor. Patients are like that. Then they will come back to me to get the money back. In return, the patient will not have any faith on me." (Drugstore salesperson, aged 29, in practice for 1.5 years, Kallyanpur, Dhaka)

In this case, 'beggar' refers to a drugstore salesperson, who can take advantage if the other informal provider charges extra to provide services. Sometimes training creates a superiority complex among providers — for example, a trained *dai* does not want to value the service of the *dai*, because a *dai* does not have institutional training for her job. Furthermore, a *kabiraj* form the Kallyanpur urban slum in Dhaka mentioned, *"no pharmacy supplies good medicines."* A midwife from a rural location in Sylhet was critical about the healing activities of *kabirajs* such as the healing process of 'evil spirit' by providing *lobonpora, panipora, chailpora* etc. (these are the process of healing by reading verses, and blowing in salt, water and rice, which are treated as medicines). On the other hand, only one drugstore salesperson from Ghashitola, Sylhet, mentioned that he does not have a bad relationship with other providers but has regular communication with various NGOs:

"I have good communication with NGO health workers. Often I received invitations from BRAC for various programmes." (Drugstore salesperson, aged 55, in practice for 10 years, Ghashitola, Sylhet)

This is interesting because this drugstore salesperson is interested in keeping a good relationship with NGOs, which helps him to build rapport with the formal health sector, and the experience of participating in various NGO programmes may be helpful for him to attract patients and build a reputation within the community.

The research findings show that a competitive relationship exists among informal providers — for example, between drugstore salespeople and *dai*s. This competition is greater in Sylhet, where more members of the community visit the informal providers than in Dhaka. This competition also reflects the wider range of choice for the community.

CTC HEALTH SERVICE PROVIDERS' RELATIONSHIPS WITH THEIR CLIENTS

It was evident from SSIs that all government CTC health service providers (FWAs, FWVs and HAs) maintained a good relationship with community leaders and influential community members (elected local government representatives i.e. chairmen, members, female members and teachers), which helped them to gain access to the community. In contrast, informal providers who were from the community claimed to have a reputation within the community

for their services. Of the 26 CTC health service providers, 19 stated that that they have good relationships with community clients — for example:

> *"I pay attention to when they want to share something with me, give priority to their problem, and provide them quality service."* (FWV, aged 43, in practice for 23 years, Kallyanpur, Dhaka)

A similar opinion was expressed by a drugstore salesperson from the urban slum of Kallyanpur in Dhaka:

> *"I maintain good relationship with those who come to me. They share with me their mental sufferings. …It is also seen that they have family problems. There are so many things which they can't share with anyone. So they come to me and say all those things."* (Drugstore salesperson, aged 29, in practice for 1.5 years, Kallyanpur, Dhaka)

Both of these two statements highlight the need to pay attention to community clients, and it is important for clients to have faith and trust in the provider. It also reflects how a provider can build trust and faith within the community. This is one of the ways how providers maintain a good relationship with the community. According to a drugstore salesperson from the urban slum in Sylhet:

> *"Patients send me Panjabi [traditional Bangladeshi dress] during Eid as a gift. Some clients take me to their home to have a cup of tea."* (Drugstore salesperson, aged 55, in practice for 10 years, Ghashitola, Sylhet)

A BRAC SS from Lakkatura mentioned that when she visits households in a community, women welcome her and trust her. However, a rather different opinion was expressed by a *dai* from the urban slum of Keraniganj in Dhaka: she mentioned that she does not follow up with patients because it might create suspicion among the clients, thus it can hamper her relationships with them:

> *"If I stay in touch, they think that I am doing so for the money; that I am going back every time for the money. That is why I do not check up on those to whom I have provided delivery services."* (*Dai,* aged 70, in practice for over 40 years, Keraniganj, Dhaka)

According to her, the willingness to maintain a good relationship with clients often creates a suspicion among women in the community that the providers are behaving well to earn extra money. She always keeps a distance with her clients, who are mainly women, after providing a service and does not keep in touch with them unless there is a health issue.

Cooperative relationships between community members and CTC health service providers (formal and informal) encourage them to provide services in the community. A midwife, HA and drugstore owner from Lakkatura further added that because of their good relationships with clients, they managed to continue offering services in the locality. Furthermore, a government provider (FWA) from this location expressed that a good relationship with community leaders makes her job easy in the community.

Maintaining good relationships between CTC health service providers and clients helps to create a comfortable space for the community clients to discuss their health problems freely. Therefore, they can share and discuss their psycho-social and other health problems that they are unable to share with others.

JOB SATISFACTION

INCENTIVES: FINANCIAL AND NON-FINANCIAL

In SSIs, some informal providers mentioned that they do not demand any money or any other incentives for the services they provide; however, if providers pay, they will take money, but often they receive incentives which are non-financial, such as gifts, which the patients give them willingly. Their job satisfaction lies mainly in serving the community, rather than monetary benefits. In this context, a *kabiraj* from the urban slum of Sylhet mentioned:

> *"I take as much as the patient gives me. Often patients give me 10–20 Taka, and I take it. I never ask for money. I take what they give me from their love. Many times I do not take money from many people. How would they pay me? They could pay me if they had any money."* (*Kabiraj,* aged 50, in practice for 12 years, Ghasitola, Sylhet)

The *kabiraj* understands the financial difficulties of the poor people from the community, so he does not ask them to pay; rather, he is happy with what they willingly give in return for his services. However, two drugstore salespeople who are also informal providers working in the urban slum of Keraniganj, Dhaka, mentioned that they charge money for selling medicines, and also sometimes there are service charges for door-to-door visits to families in the community:

> *"I take 50 Taka here. If I go to this lane or the lane beside, inside the colony, then I take 100 Taka. And I take a little bit more if I have to give saline — for example, I have just given saline to someone a while ago; they have given me 500 Taka, there I have to talk for 5–10 minutes, have to give some time, so I charge more."* (Drugstore salesperson, aged 45, in practice for eight years, Keraniganj, Dhaka)

For the drugstore salesperson, the charge is mainly because he has to travel some distance to provide a door-to-door service to the families. Hence, depending on the type of services being

provided, the fee has been charged. When asked particularly about any financial incentives, the respondents (both formal and informal providers) emphasized that they receive monetary benefits based on the type of treatment they give, the number of referrals they make, meeting the target for numbers of patients (only for the formal providers) and by selling medicines.

Five CTC health service providers (two *dais,* two government FWAs and one BRAC SS) mentioned financial benefits, which they would usually receive through these services. Their services allow them to leverage additional income in this way, which they claimed motivated and influenced them to remain in the CTC profession.

SOCIAL RECOGNITION AND TRUST

In 10 (six informal and four formal) of the 26 SSIs with the CTC health service providers, there was an emphasis on community respect and trust. Interviews with two drugstore salespeople*,* a *kabiraj, two dais*, a village doctor, three government-level community workers and a BRAC SS revealed that social recognition and the faith and trust of the community was an enormous motivating factor for them to work harder and provide good services. A local *kabiraj* stated that earning the trust and a sense of faith from the community allowed them to work freely and without much difficulty. A 50-year-old informal provider *(dai)* from Ghashitola, Sylhet, with thirty years of experience mentioned that the local people respected her for the work, and she was known in the community and moved about freely with support from everyone in the locality:

> "*No, I don't face any problems. I go at 2.00am too. No one says anything. Even the Mafias [referring to the leaders of local thugs] don't say anything to me. Their children's delivery also happens by my hand. They know that they need me. If I go somewhere late at night, they understand that I have a delivery to attend. That day I went to Kolapara at 2.00am. On the way I met a Mastan [referring to a local thug]. He asked me, 'Aunty, where are you going?'. I told him, 'Kolapara, a patient's house.' He told me, 'You can go, Aunty. There's no problem. If there's any problem, just tell them my name.' Then I said, 'You guys are the Mastans. If you don't do any harm to me, who else would do it?' I talked like this. They respect me. That's why he didn't say anything.*" (*Dai,* aged 50, in practice for 30 years, Ghashitola, Sylhet)

While one experienced government HA emphasized the quality of the service he provides, he believed that respect could be earned through the kind of service being provided to the community:

> "*I can work for poor people. I can provide a service for a couple of complex diseases in children. Serving humankind is a great service. Good people are very cordial. They show*

enough respect for me." (HA-EPI, aged 42, in practice for 24 years and 1 month, Lakkatura, Sylhet)

This statement demonstrates that the CTC health service providers do want recognition, and that being 'wanted' by the community influences them to be engaged in providing such services. The BRAC SS from the urban slum of Ghashitola in Sylhet mentioned that for her it was more important to serve the community than about earnings. For her, getting the health training motivated her to serve her community. Similar responses were obtained from two interviews with government FWAs from the urban slum of Keraniganj in Dhaka and an HA-EPI from the rural location of Lakkatura in Sylhet. All three interviewees focused on training as being an inspiration for them to serve the community better. For the BRAC Model SS, learning from the training and how to take care of the patients on various disease-profiles has helped her to take care of her family better. This made her feel more inclined to serve the people in the community:

> *"If my child suffers from Dengue fever, I can take his temperature. I know how to measure the weight, BP [blood pressure], sugar [diabetes] of others. I can look after the problems of anyone in my home by myself just because I have got this training."* (Model *Shashto Shebika*, aged 30, in practice for nine years, Kallyanpur, Dhaka)

WORKLOAD

When asked about their workload or the pressure of work, the respondents gave varied responses. While the three informal CTC health service providers (two drugstore salespeople and one village doctor) from the urban and rural locations of Sylhet mentioned that work pressure has not been much of a factor for the duties they perform, they also stated that there is a sense of mental happiness to the kind of work they do. For an informal provider (*dai*) from the urban slum of Kallyanpur in Dhaka, work pressure has been supported by her family. She said that she wanted to pass on this type of work to her children, and now the family members are more used to the kind of work she does. This allows her to serve the community with a lot of enthusiasm:

> *"They [the family] look at it positively. They do not make any complaints. Only my youngest son asks me to retire gradually, since I have to go from one place to another and cross roads. My children never complain about my job. Even if I bring any patient to the room while they are taking their meals, they will not complain. Even if the room gets dirty with the patients' stool and urine, they will never complain."* (*Dai*, aged 65, in practice for 50 years, Kallyanpur, Dhaka)

By comparison, a different view came from an interview with a formal CTC provider (a government FWA) from the urban slum of Ghashitola, Sylhet. She mentioned that if she can do

the work well, then she can meet the target, and the work pressure would not be much of a problem. But if the job is not well done, then her target is not met; this may cause more pressure in her duties afterwards.

However, there were diverse views from three formal CTC health service providers (a midwife, an HA-EPI and an FWA) from the urban slum of Keraniganj, Dhaka, and the rural location of Lakkatura, Sylhet. They complained that work pressure was immense and that such a heavy workload often makes them think that they are not able to give much time to their families. This made them unhappy, but they also said that they realize it is a responsibility that they have to take as providers.

From the research evidence, it can be understood that community recognition, trust and acceptance help the CTC health service providers to be more committed towards delivering health services in their local communities. It was also found that the workload and monetary benefits often made the providers feel motivated in their roles and responsibilities, although there are exceptions. Informal providers who are embedded within the community setting felt attached to the community members, and they choose this profession, as it allows them to hold a certain position and earn respect from the community.

REFERRAL

COMMUNITY PERSPECTIVE

From three FGDs conducted with the community (men or women) in the urban locations of Dhaka and Sylhet, we have come to know that both formal and informal providers usually refer community members to nearby government hospitals or clinics (private and NGO). Eleven respondents from these three FGDs mentioned that the providers only refer them once they are unable to treat the illness. According to these respondents, an informal referral system does exist, and most of the CTC health service providers (both formal and informal) refer patients to government hospitals. In this regard, three male respondents from one of the FGDs in the urban slum of Kallyanpur, Dhaka, said:

> *"They don't send patients to Dhaka Medical College unless there is a serious problem."* (Married man, aged 28)

> *"Marie Stopes refers patients to Dhaka Medical College most of the time."* (Married man, aged 27)

> *"They also send patients to Notun Bazar clinic."* (Married man, aged 25)

These statements reflect that there is a system of referral in the community. In three FGDs in the urban slum of Keraniganj, Dhaka, and the rural location of Lakkatura, Sylhet, a few participants stated that there was a formal card system provided by an NGO for referrals to a private hospital. The rest of the respondents said that NGOs such as Marie Stopes provided cards which allowed patients to obtain proper referral to government clinics; though one of the four female respondents complained that referrals to government facilities were useful, but the waiting time to meet the doctor was very long.

In 24 IDIs with married women who had experienced MR, 12 mentioned that they had been referred for MR-related problems to several different providers, including RHSTEP or Marie Stopes, drugstore salespeople, local doctors and local clinics. A married woman from the urban slum of Kallyanpur, Dhaka, said:

> *"There was a pharmacy underneath my house. I went to the doctor, as there was a pain inside my tummy. As it was a gynaecological issue, he sent me to Marie Stopes. Here they give incredibly good service." (Married woman, aged 20)*

Another woman (from the 12 IDIs) from the urban slum of Ghashitola, Sylhet, mentioned that she had been advised to go to RHSTEP by one of the providers:

> *"A woman [a formal CTC provider] came to visit our home. I discussed it with her. She also told me to go to the red building [RHSTEP office], as medicines do not work to do MR. She said it is better if I go to the red building."* (Married woman, aged 20, Ghasitola, Sylhet)

MAINTAINING A REFERRAL SYSTEM — THE PROCESS

Referral system for NGOs

Marie Stopes has close links with local drugstore salespeople, village doctors, NGO workers and city doctors to refer MR clients from the community. Providers receive a gift from Marie Stopes for referring MR clients to them. In this process, providers use a card for referral so that patients can go and Marie Stopes can locate the providers for their 'gifts'. A Marie Stopes paramedic in the rural location of Sylhet said that, depending on the type of referral, they provide some monetary benefits to the informal providers:

> *"Yes, it [money] is given by category. Suppose, for normal MR we give 100 Taka, for less pain 400 Taka, and for anaesthesia we give 500 Taka to a doctor. In here we have a list of referral persons; our health educators take those names and addresses and go to them for checking. If they match, then we give money to the person who did the referral."* (Paramedic, Marie Stopes clinic, aged 23, in practice for two years, Lakkatura, Dhaka)

Through this process, Marie Stopes motivates providers to refer patients and MR clients. Marie Stopes also sometimes refers critical MR clients which are beyond their capacity to solve to the government hospitals. The Centre Manager of Marie Stopes working in Kallyanpur, Dhaka, stated that Marie Stopes also referred patients based on the treatment required to specific government hospitals where they were confident of the capability of the doctors available:

> *"We refer them to any of our centres or government hospitals. We don't refer them to a private hospital. We send them to that place where a renowned doctor is available. We fill in a card from here. Among government hospitals, we send them to Dhaka Medical or Sohorwardi Hospital."* (Centre Manager, Marie Stopes clinic, aged 35s, in service for 10 years with Marie Stopes, Bangladesh)

By contrast, RHSTEP has a system of referral when they are unable to solve an MR problem. It then refers patients to government hospitals and bears all costs of the patient. RHSTEP also refers patients to government hospitals, since RHSTEP works in partnership with the government; therefore, it is easy for them to refer patients. RHSTEP also bears all costs for the patient in such cases of referral. Both of these organizations follow up on the progress of patients after referring them to a government hospital.

BRAC SSs also refer patients to BRAC delivery centres and government hospitals. A BRAC SS working in the Ghashitola urban slum in Sylhet mentioned that records are maintained by asking the drugstores and other relevant referral sources to keep a list of the patients who have visited them and to whom they have shown the membership card given by the SS.

Talking about the monetary benefits, the CTC health service providers (both formal and informal) provide an understanding of the financial benefits that are involved with the referral system. Five respondents (a *dai,* a drugstore salesperson, a Model SS, an SS and an FWA) said that there are some financial incentives involved with referrals of community members. The *dai* explained the process as follows:

> *"Nowadays, I send them to the hospital. At the hospital, if you say my name and ask for my services, I receive Taka 100–300 from the hospital itself."* (*Dai*, aged 70, in practice for over 40 years, Keraniganj, Dhaka)

Referral to government hospitals

Likewise, similar responses were obtained from the 26 SSIs. Six providers from Dhaka and Sylhet (a Model SS, an SS, two drugstore salespeople and two village doctors) stated that they refer patients to government hospitals and also to a few private clinics. Three FWAs mentioned that they refer patients to FWVs available to their respective facilities and to government

hospitals. They said that government hospitals have reliable doctors and that patients can receive satisfactory treatment.

Box 1. Case Study of a Formal Health Provider

Although there is some explanation of the formal ways of documentation, one case of a government provider (FWV) gave a different insight into issues of not following a formal process. She shared her fears about record-keeping and documentation. She explained her understanding of the referral documentation process that led to unexpected situations and caused her problems:

"No, I do not keep any documents. It may create problems if any patient files a police case. At Natore I have seen such a case. A patient has been referred to another centre with a referral slip. Then for some reason that patient filed a police case; the police also caught the nurse who referred that patient to that nurse. I never experienced this case, but I am concerned with this issue since then. I do refer to my colleagues, whom I trust. I never send my patients to unknown places or unknown nurses." (FWV, aged 43, in practice for 23 year, Kallyanpur, Dhaka)

For being in practice for so long, this provider fears being misunderstood by clients, and this gave her the wrong impression of the documentation process entirely. For her, record-keeping can only cause more problems for the providers, as the law enforcers would be more in favour of the clients, rather than listening to them if something goes wrong — even if it is not the fault of the service provider. Thus, not keeping any documentation is the best way to avoid any such consequences of being demeaned by the community, which can harm their reputation as health providers.

According to a BRAC SS from the urban slum of Kallyanpur:

> *"Dhaka Medical College is the best hospital in Bangladesh. You will not get some treatments anywhere but Dhaka Medical. I refer patients at risk to Dhaka Medical College."* (BRAC *Shasthya Sebika*, aged 30, in practice for nine years, Kallyanpur, Dhaka)

The choice of selecting the government hospitals over private/NGO clinics was based by four CTC health service providers (two government field-level providers and two drugstore salespeople) on the socio-economic status of the patient and whether they would be able to afford the treatment if they were sent to a private clinic. As mentioned by an FWA from the rural location of Lakkatura, Sylhet:

"No, I only refer to Osmani Medical; no other places. They are poor people who come to me for free services. So, I send them to Osmani. But I send some people to private providers; those who have money." (FWA, aged 41, in practice for 23.9 years, Lakkatura, Sylhet)

Similarly, the drugstore salesperson stated:

"They are poor people. They don't have money. How can I refer a private clinic for them? I send them to Osmani Medical. If I write them the medicine, they can't buy them. Many pharmacies send patients to MBBS doctors. They even send them to private clinics. Then instead of going to the doctors, they go to the kabiraj. If they had money, would they come to me? They would go directly to private clinics." (Village doctor, aged 50, in practice for 25 years, Lakkatura, Sylhet)

From the research evidence, it seems that certain systematic procedures are being followed in the referral system (depending on assessments of a patient's income profile) and that the people involved in the process are also being acknowledged through financial incentives, but this may not be generalized for both the formal and informal sectors, as there remain certain exceptions as well. Moreover, our results find that proper documentation does not take place in all cases and that verbal communication may be the means of referral for both formal and informal providers in most cases.

QUALITY OF CARE

All respondents explained that, with minimal income, it often becomes difficult to afford medicines and to pay the service charges for some formal CTC health service providers. For them, the formal providers do not even give any consultation for free, and there is money involved with whatever service they provide. According to a married woman from one of the three FGDs:

"The main thing is that they do not love the poor people. The poor people are ignored everywhere. They are all the same; maybe it is Arman,[25] maybe BRAC or maybe Marie Stopes. Suppose, I have money today, I am solvent, I have a high position, I can talk to them nicely, I am able to pay them 10 Taka then I am good, but if I cannot then I am not good. The only bad thing is that I am poor. I don't have money, and that is why I am bad." (Married woman, no age mentioned, Kallyanpur, Dhaka)

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[25] By 'Arman' the community members refer to an NGO called Unity through Population Service (UTPS), a non-government, non-profit voluntary organization. UTPS is actively engaged in the government's UPHCP under the Local Government Division of the Ministry of Local Government, Rural Development & Cooperatives. Since UTPS is implementing the UPHCP, the representative of UTPS at community level is known as '*arman apa*'.

A drugstore salesperson (an informal CTC provider) from the rural location of Lakkatura, Sylhet, said that the community always expects better treatment at a low cost. This is often not possible as a provider himself, as it is hard to make the people content. It is not always affordable for a good doctor to go to a drugstore and serve the people:

> *"If there were more medicines in the pharmacy, if I were able to bring a good doctor once in a week and can provide service at a low cost, then the people of this area could get services at a low cost. But there is no way of doing so."* (Drugstore salesperson, aged 42, in practice for 22 years, Lakkatura, Sylhet)

When asked about how the CTC health service providers have maintained the quality of care, the responses varied. CTC health service providers raise awareness and build strong relationships with the community through follow-ups with their patients and also by respecting and maintaining their clients' confidentiality, especially for MR-related cases. These responses came from nine SSIs from the 26 interviews with both formal and informal CTC health service providers (a BRAC Model SS, an SS, an FWV, two drugstore salespeople, a Centre Manager, a paramedic, a Programme Officer and an FWA) from the four locations of the research sites. From these interviews, two CTC health service providers, both drugstore salespeople, agreed on the point that clients need to have confidence in the service providers and that it is essential to provide a good-quality service to retain clients and to expand their own profession:

> *"The relationship has to be good. It's good. If there weren't any good relationships, why would they come to me? They believe in me. Everyone forgets me after the danger is gone. So it is important to continue relationships with your clients and ensure the quality of the work."* (Drugstore salesperson, aged 40, in practice for 30 years, Keraniganj, Dhaka)

Likewise, three formal CTC health service providers (an FWV, an FWA and a BRAC SS) expressed similar views in these interviews to those of the two drugstore salespeople. In addition, they said that if they can provide the services quickly and on time with strong dedication, the clients are more eager to use their services.

Also, it is important for formal CTC health service providers to understand their clients' needs, and sometimes it is more a question of the psycho-social needs than the physical problems they suffer from, especially for women undergoing MR treatment. The FWV among these providers mentioned that giving time to the clients and listening to their problems allow her to build a strong relationship with the community, and her generosity towards her clients would always maintain her popularity. For the FWA in the interviews, to maintain the quality of care, she also prefers to take suggestions and recommendations from other doctors outside her duty station if the health problem is beyond her own capabilities.

From the five interviews with four key informants (a Centre Manager, a paramedic and a Programme Officer from Marie Stopes and a Programme Officer from RHSTEP) and a government FWV, the participants stated that they are very strict about patient confidentiality. As mentioned by the FWV, client information should not be disclosed to anyone else and that there should not be any witnesses while the MR process is being completed. This practice also ensures that patients are satisfied with the confidentiality of the service and allows them to trust the formal providers. On further probing, two of the key informants (a Centre Manager and a paramedic from Marie Stopes) emphasized the quality checks used for MR cases to ensure good quality of care in the field of MR and also to ensure client satisfaction. The Centre Manager explained that it is important to understand whether the MR patient could be treated under the legal processes and without any complications. As there is a timeline for performing a proper MR procedure, it is also not possible for patients with various health complications:

> *"If MR is done within 8–10 weeks, then it will be considered legal. But if it exceeds 8–10 weeks, then it will be considered illegal. If it is done after this time period, it will be considered an abortion. That time, we can't do it. Besides, because of some difficulties it becomes impossible to do MR sometimes. MR can't be done when the patient suffers from pressure, diabetes or has a negative blood group."* (Centre Manager, aged 35, in service for 10 years)

She further explained that as MR is a clinical procedure, it is important to maintain hygiene. An incomplete MR process would involve random bleeding and cause more complications, which could only be avoided if the tools are cleaned properly. Hence, it is important that the quality of the service is well maintained for client satisfaction. The Programme Officer in Lakkatura, Sylhet, and the Centre Manager from Marie Stopes in Kallyanpur, Dhaka, mentioned that they have a complaints book and a complaints box in all the clinics in our research sites to allow the patients to share their own perceptions about the quality of care. However, a one-week observation of the urban slum of Kallyanpur found no such activities being undertaken by the clients visiting that clinic. After further observation, it was also found that the complaints book was not being used either.

By comparison, a village doctor (informal provider) from Lakkatura, Sylhet, said that government staff in his location are not properly maintaining the quality of care. He explained that the government health centres are not providing good services in Lakkatura, about which community members often complain when they come to him for treatment. The comment relates to a dispensary that is present in the tea garden where the community members work and where a doctor should be available, which on most occasions is not the reality. The unmet needs of the patients are eventually reflected in their dissatisfaction:

"There is a hospital and dispensary in the garden. Doctors are not present there regularly. There are no good medicines. There is not enough medicine either. If someone needs to take medicine for seven days, he/she is given medicine once. This only does more harm. If something happens, there is not even a system of giving primary treatment before sending the patient to Osmani Medical College. Then would the service be good here? If there were necessary medicines, then it would be fine." (Village doctor, aged 50, in practice for 25 years, Lakkatura, Sylhet)

There were three respondents (a drugstore salesperson, an FWA and a *dai*) from the urban slums of Kallyanpur and Ghashitola who said that due to a lack of more training they lack the expertise to diagnose complex diseases. For a drugstore salesperson and a *dai* it is not possible to treat for lipid profile tests, TB or diabetes. As for the formal FWA, she also mentioned that her training is basic; hence there is not much she can do for patients with critical diseases. This may affect the quality of care from the providers' perspective.

From the evidence of the research findings, the community respondents, through the FGDs, expressed the opinion that the services are expensive and that they do not appreciate the formal providers who charge for all kinds of services. The interviews with the informal providers gave the impression that community clients are more inclined towards low-cost services and that a good relationship would always work in favour of the provider. Interviews with the formal sector gave us a comprehensive understanding of the process of maintaining a high quality of service, including MR-related issues, but the patients' evaluation of the service may need more investigation.

FACILITATORS OF AND BARRIERS TO CTC PROVIDERS' PERFORMANCE

From the 26 SSIs, we obtained a wide range of responses regarding the facilitators of and barriers to the performance of CTC health service providers. The responses were mainly based on the factors that these providers from the informal and formal sector have found to be influencing their performance at the community level. Although the responses showed some variation by location, many of them shared similarities with some common themes that have emerged from the data analysis such as community context, workload, financial incentives and other monetary benefits, supervisory systems and logistics and supplies of medicines and other equipment.

Community context

Considering the community context, four respondents (both formal and informal CTC health service providers — namely, an FWA, a *kabiraj,* and a Centre Manager and a Programme Officer from Marie Stopes) from the urban slums of Kallyanpur and Keraniganj in Dhaka and Ghashitola

in Sylhet explained that having a strong relationship is very important to carry out the services for the community. An experienced *kabiraj* from the urban slum of Ghashitola, Sylhet, stated that his relationship with clients acts as a facilitator to receive more patients from the community:

> *"I have good relationships with my patients. They would not come to me if the relationship was not good. …Because of this good relationship one patient brings in another five patients."* (*Kabiraj*, aged 50, in practice for 12 years, Ghshitola, Sylhet)

Community trust and familiarity are developed over a period of time by maintaining a good relationship with clients through the services offered within a community setting. Gaining trust is particularly important for providing awareness services on SRH-related issues to adolescents and newly married couples. For example, the FWA mentioned in her interview that it is very difficult for her to promote SRH-related information to newly wed couples who are not open and also do not want to share or learn about SRH issues. In most cases, a series of counselling sessions is needed to help the young married girls to learn about SRH and how to access proper advice and treatment. According to the FWA:

> *"It is our duty to motivate a newly married girl to take a method [MR] and show the right path to her husband. This problem occurs because of early marriage. If we ask the girl's parents, they say we didn't marry off our daughter. They are kids; they get married without telling us. For this our responsibilities increase. It's hard to motivate too."* (FWA, aged 42, in practice for 25 years, Keraniganj, Dhaka)

Likewise, as explained by the Centre Manager from Marie Stopes in Kallyanpur, there are various religious stigmas attached to MR in a community context, and one of the prime challenges they face is that MR has been considered a 'sin' in the community, so people do not want to talk about it much:

> *"They often consider MR a sin. Even today, a patient came and after having done her MR, she said that she has committed a sin."* (Centre Manager, aged 35, in service for 10 years)

There was an interesting finding from the rural location of Lakkatura, Sylhet, where a Counsellor Officer from RHSTEP claimed that spiritual healers were not opposed to MR services. She explained that even the *hujurs* or *pir* did not oppose MR and that some informal providers — for example, a *dai* from the same rural location — had been providing this service without facing any religious obstacles from the community.

Workload

Asking the CTC health service providers (both formal and informal) about their workload in the interviews, eight respondents (a BRAC SS, two FWAs, a drugstore salesperson, a FWV, an HA-EPI, a midwife and a Centre Manager from Marie Stopes) from the four locations out of 26 interviews said that for them it is always a multi-tasking scenario; they have to perform on various health-related problems. All these respondents gave similar responses regarding their job responsibilities, while the formal providers mentioned only that they always have to meet the targets being set by their supervisors. From these respondents, a drugstore salesperson and an FWA also emphasized that it often got difficult for them to manage household activities and their time for work in a day, while two FWAs gave similar responses about the fact that they served the community even at weekends and also late at night, depending on the emergency of the client. This may act as a barrier to CTC providers in terms of the magnitude of the work that they have to perform, which may compromise the quality of services. One of the FWAs from the urban slum of Keraniganj, Dhaka, mentioned:

> "I have a lot of work pressure. I do a private job, OT starts/opens from the afternoon, I do my study, I have a child, and he/she goes to school; all these add to the workload. OT does not run without me; I look after every side. Last night I came back at 10.00 pm at night seeing a patient from far away." (FWA, aged 30, in practice for over nine years, Keraniganj, Dhaka)

She also added:

> "…the work pressure is huge. The target is given. Projections are made for every FWA at the start of the year. There are 40 permanent methods all year round, like we have to give ligation or vasectomy and non-scalpel vasectomy, have to give pills to 100+ people, have to give 100 injections over a three-month period. We have to give around 10 IUDs [Internal Uterus Devices]. But permanent methods are given more priority."

These two statements highlight the fact that multi-tasking increases their workload, which may have a negative impact on their performance. Ten respondents (both formal and informal providers: three drugstore salespeople, three *dais,* a *kabiraj,* an FWA, an HA-EPI and a village doctor) out of the 26 interviews from the four locations talked about their immense workload to accomplish each day considering the time needed and the duties they have to perform. The village doctor mentioned:

> "The workload is a lot. As much as I have work in the pharmacy, I have work at home too. Patients start coming from the morning. They come to my home, and many patients come to my home. When I go to the pharmacy, they come to this chamber from the chamber beside. The funny thing is an MBBS doctor sits at the pharmacy next to me. When I open my shop, patients instantly come to me. So you can now understand my

workload from my activities." (Village doctor, aged 50, in practice for the past 25 years, Lakkatura, Sylhet)

Out of these 10 respondents, the three drugstore salespeople, two of the three *dais,* two FWAs and an HA-EPI said that they have flexible time for their work. However, most of the CTC health service providers from the formal sector do not have flexible working hours and are monitored by their supervisors all the time. As for the informal providers, the evidence from the interviews shows that such providers do not have any strict working hours and, therefore, can treat patients outside normal working hours. Research observations have complemented the findings for the informal sector, that most of the informal providers have flexible times and do not follow any regular schedules.

Financial incentives

As for the financial incentives, we received some significant responses. Considering nine of the 26 SSIs with formal and informal providers, one BRAC SS from the urban slum of Kallyanpur, Dhaka, responded that there is no monthly salary but that earnings are more dependent on the different types of services that she offers and also by selling medicines. Two formal CTC health service providers from the urban and rural locations of Sylhet (an HA-EPI and a midwife) mentioned that they do not receive any additional bonus from their organizations but do receive a monthly salary, which at times is not enough. Hence, financial barriers do prevail for such providers in the community:

> *"I always reach my target. Nothing bad happened yet. The only thing is I don't get paid much. After working all this year, I get only 1100 Taka. And another thing is that we don't get a government time scale. It might create problems for us in the future. We have a corporation. We give money for that. But they take our money, and the inspectors take that money for their purpose. It doesn't help us. It only helps them."* (FWA, aged 41, in practice for 23.9 years, Lakkatura, Sylhet)

In addition, out of these nine interviews, two drugstore salespeople and a *dai* from the urban slums of Kallyanpur and Ghashitola mentioned commission being awarded based on the types of referrals made by the informal providers. This acts as a facilitating factor for such providers who have an income-generating source. One FWA from the urban location of Ghashitola, Sylhet, also claimed to receive similar financial incentives for referring patients to hospitals and clinics, which adds to her regular income.

Lack of supervision

Answering the questions about systematic supervision, the government CTC health service providers (five government providers out of the 26 CTC health service providers) mentioned

that the supervisory system has various flaws that act as a barrier to their performance in service delivery. Describing how the system works, one FWA from the rural location of Lakkatura, Sylhet, said there used to be a written reporting system in the past, which had now been changed to a different method. Now they use the clients' phone numbers to record the number of clients being reached in a day, and the system is not appreciated. On the other hand, for an HA-EPI from the same location, there is no reporting system as yet, and the number of EPI clients covered only depends on the statistics given by the provider:

> *"…And now, the system has changed. So I do not like to report. …Like now, we have to insert phone numbers; that is a problem. If the number is unreachable, then that is another problem. They say I gave a false number. And those patients who don't have numbers; I give them the number of the garden's midwife."* (FWA, aged 41, in practice for 23.9 years, Lakkatura, Sylhet)

Need for logistics and training

Evidence from the two FGDs for community members in the urban slum of Ghashitola, Sylhet, suggests that proper equipment and supplies should be given to the CTC health service providers. One of the FGDs conducted among men in the urban slum of Ghashitola focused on this issue, with two male respondents raising this concern:

> *"BRAC doesn't have the equipment for check-ups. As a result, we have to go to medical centres and private clinics. It would be very good if there were equipment for check-ups."* (Married man, aged 20, electrician, Ghashitola, Sylhet)

> *"Because of the absence of checking equipment, they give medicines without checking. In any kind of pain, they give only medicine. They do not understand what the pain is for."* (Married man, aged 30, restaurant businessperson, Ghashitola, Sylhet)

In addition, from our interview sessions, three respondents (an FWA, a village doctor and a *dai*) from the urban locations of Keraniganj in Dhaka, Ghashitola and the rural site of Lakkatura, Sylhet, added that due to a lack of proper training opportunities, they could not diagnose complex illnesses such as TB, diabetes, lipid profile tests etc. This often makes them lose valuable clients; thus, there is a need for proper training opportunities:

> *"I don't have training on everything. We are not even supposed to. If it's out of our hands, we refer the patients."* (FWA, aged 40, in practice for 21 years, Ghashitola, Sylhet)

The evidence from the result findings highlights the community contexts as well as the workload of the CTC providers, which often acts as a barrier. Moreover, interviews with the formal providers have shown that there is a need for proper financial benefits other than their regular monthly salary, while the informal providers are still content with non-financial

benefits, but both the sectors earn certain monetary incentives through the referral system. As further evidence also focuses on the importance of strengthening supervisory systems, it also highlighted that a lack of proper training may cause the CTC health service providers to lose clients, as they do not know how to identify complex disease profiles.

CHAPTER 6 – DISCUSSION

In this chapter we reflect on the previous chapters and discuss the factors that facilitate or hinder CTC health service providers' performance.

BROAD CONTEXTUAL FACTORS

As of 2010, Bangladeshi women risked their health by having clandestine abortions at a rate of 18 per 1000 women each year (Singh et al., 2012). It has also been stated that in that same year almost 231,000 cases of unsafe abortion were recorded at health facilities. Hence, despite the documented decline in abortion-related maternal mortality and a decrease in the number of the most dangerous methods of induced abortion, unsafe abortion remains widespread in Bangladesh. There are various broad contextual factors that ultimately influence CTC providers' performance to provide quality MR services to their clients. In our review we found that the country-wide decentralization process was accompanied by a weak participation of local government structures in decision-making and related budgeting. This implies that local governments may often not be in a position to establish or monitor local health-related programmes. Also, a lack of participation by community structures in decentralized decision-making was observed.

The health sector has no structured policy on informal CTC health service providers; also, formal policies do not refer to informal health care providers, which constitutes a 'disconnect' with reality, as many — if not most — people use informal providers as their first choice for treatment for their health concerns.

On the positive side, MR is legally recognized, and this can be regarded as a factor facilitating the role of CTC health service providers in MR service delivery. However, culturally and religiously defined social norms, beliefs and taboos lead to various stigmas that make it difficult for community members to talk about sensitive issues such as MR. Akhtar (2001) mentions that "in spite of the widespread availability of MR services, utilization remains low, especially by those who need it most. There could be a number of reasons for this. Due to religious and political reasons, MR-related messages are not published." This influences whether women seek legal and safe MR services or go to unauthorized clinics and providers. Men tend to see SRHR and MR issues as 'women's issues' and often are not very involved in addressing the related concerns — this may be good when a woman seeks autonomy but less so if she feels in need of support from her male counterpart or relatives.

The formal government CTC health service providers try to maintain a good relationship with community leaders and influential community members (elected local government representatives i.e. chairmen, members, female members and teachers), as it allows them to

gain better access to the community. However, the formal providers are yet to establish strong and effective communication and relationships with their clients. The socio-economic status of the urban slum settings has shown a similar scenario of people renting houses and having similar kinds of work and lifestyles. For the rural setting, this research found the socio-economic status to be low. Gender issues in terms of patriarchal norms are still followed; thus, women are yet to become the decision-makers.

HEALTH SYSTEM FACTORS

This group of factors includes issues around human resources for health, service delivery, financing, information, governance and supplies and logistics.

Various types of health service providers exist in Bangladesh, most of which are for-profit and from informal sectors. According to the Bangladesh Health Watch, there is an average of 146 health care providers (of all types) per 10,000 population; among them, 64.2 are traditional healers, 33.2 are TBAs/TTBAs, 12.5 are village doctors/rural medical practitioners, and 11.4 are drug sellers. Another 7.7 are the qualified modern practitioners (physicians/nurses/dentists), 1 is a para-professional, 9.6 are CHWs, 5.9 are homeopaths, and 0.9 per 10,000 population are others (BHW, 2008). However, the formal public health system provides few services for SRH problems (Rashid et al., 2011). Within such a context, recent literature shows that most people in Bangladesh seek health services from these various informal service providers. According to two recent studies, 70–75% of Bangladeshis go to informal providers (traditional healers or homeopaths) (BHW, 2008; Rashid et al., 2011). Literature reviews also show the scarcity of government and trained service providers for disadvantaged and poor communities. This particularly affects the population living in urban slum and rural areas. Therefore, there is little choice for the community to select trained health service providers.

However, the pluralistic nature of the health care system overall acts as a facilitator more than as a barrier, as it broadens the options of services to the community; the wide range of formal and informal service options is well accepted by the community. Competition between different formal and informal providers ensures that clients have many options (mostly informal and untrained), but those of a better perceived quality usually carry a higher cost and are unaffordable for many clients, while those of lower cost are of lower (or unknown) quality. Furthermore, the available services are inadequate to meet the needs of a vast population, and there is a "huge shortage" of human resources for health care services (WHO, 2006).

There was a common perception among many of the slum-dwellers (both men and women) that quality services are expensive. This perception arises from their unfavourable experiences while seeking health care services from various NGOs and private clinics. Therefore, most of

them prefer to go to traditional healers (*kabirajs*, *dais*, religious leaders, spiritual healers) and drugstore salespeople whom they trust and believe to provide services at a low or minimal cost. Local drugstore salespeople have managed to establish trust by providing services for a longer time in the community; this helps to create a good reputation among the community, and, as also agreed by Bloom et al. (2011), providers had to maintain a good reputation to compete with newcomers. It was found that most of the people in the community, from all locations, prefer to visit their known drugstore salespeople, *dai*s and *kabiraj*s, whom they trust and with whom they are comfortable, rather than going to a doctor. Many of these providers are often seen as well-respected members of their communities (Sharmin et al., 2009).

Many community members also perceive that representatives from some NGOs, private clinics or hospitals visit slums only to make money. Hence, they believe that these providers are not interested in providing good health services. Easy access to various providers was also reported to be a factor for community members, stimulating them to go to informal providers. In Bangladesh, village doctors do not charge for consultations, and provide services through the day and night (Bloom et al., 2011), which community members might not get from government or NGO providers.

This situation also highlights the lack of health-sector regulation in Bangladesh by the government. The literature review showed that there are no mechanisms or systematic regulatory authority in Bangladesh to monitor and evaluate the quality and services of various types of informal providers. Hence, the health-sector market in Bangladesh is unorganized, and, according to Bangladesh Health Watch (2010), CTC health services (both public and private) are "unregulated". This shows the unwillingness and incapability of governments to establish an appropriate regulatory framework (Bloom et al., 2011). At the same time, accountability of providers, both formal and informal, to the community is weak. Unregulated medical brokers in hospitals and elsewhere charge fees for getting patients quick access to services.

One barrier is that the many types of informal providers offer services individually and are not 'organized'. This makes it difficult to regularly engage with or coordinate these cadres in a systematic way. Also, formal providers are often reluctant to work with informal counterparts for a number of reasons.

Regarding building and maintaining capacity, the lack of cultural or refresher training in the formal health sector (public and private) constitutes a barrier to the quality of services.

INTERVENTION DESIGN FACTORS

These factors include specific issues related to the design of CTC programmes, such as around intervention focus, human resources, referrals, community links, M&E, quality assurance and communication among and with providers.

In Bangladesh, CTC providers' performance is shaped by many factors such as relationships with the community; who they are and where they are located; locality, accessibility and the needs of clients (e.g. drugstores that are close by; *kabirajs* and *dai*s are in the community, which is useful for women who have restricted mobility); and the type and number of providers available in the community, which may result in lower costs, improved services, home visits, providing medicines on credit and ensuring treatments work to maintain a good reputation in the community. CTC providers meet people in their homes, and this provides them with a unique opportunity to understand factors underlying health conditions. As explained by Nashid and Olsson (2007), MR services are relatively safe in the first three months of pregnancy, while in later cases clients suffer during delayed treatment, which in most cases is carried out by informal providers in Bangladeshi communities. Hence, providers' performance depends on their ability to offer a correct diagnosis and effective and timely treatment.

Gaining community trust was not considered a problem by most informal providers from the four locations of the research; a possible explanation would be that most informal providers lived in the community or had their office/chamber in close proximity of a community. Hence, accessing the community is not a major problem for them. However, the situation was not the same for government, NGO and private-sector providers. In most cases, these providers were not located within the slum settlement. A possible explanation could be that the government has a structure for establishing a health centre that occasionally happens to be in the close vicinity of a community setting, but not necessarily within the community. Consequently, these formal providers have to work hard to build rapport and trust with the community to provide SRH and other necessary services.

In addition, familiarity was also an issue in providing services and receiving patients from a community. In some cases, informal providers (drugstore salespeople, village doctors, *dai*s, *kabirajs*) receive gifts that reflect the recognition of their relationship with the community. These informal providers are treated like family members and trusted in many cases because they are embedded within a community setting. The situation is not the same for government providers (FWAs, FWVs and HAs). Some NGO providers (such as BRAC SSs) reported that they also have very good relationships with community members because SSs work as volunteers and are recruited from the community; thus, the community sees them as their own. Meanwhile, informal providers are independent providers and are not recruited by any

organization, which gives them flexibility in building trust and providing services, whereas formal providers from the government or NGOs have to follow certain regulations and restrictions regarding their mobility and time to provide services within the community.

The government recruits FWAs, FWVs and HAs following rules and regulations, and they have a fixed salary; NGOs also have standard processes of recruitment as per their policies. The mapping exercise showed that around 30% of CTC providers had no formal education, while 45% had received no training. Both government and NGOs provide basic training for their front-line providers prior to beginning their services. As explained by Akhtar (2001), MR service facilities were extended in several phases, while, according to Singh (1997), there are approximately 8000 doctors and 6500 paramedics trained on MR in government clinics at national, district, *thana* and union levels.

Studies suggest that, to be certified, every trainee doctor has to perform at least 20 MR cases independently and run counselling sessions for 20 clients. Every new FWV trainee has to perform at least 25 MR cases independently and has to perform counselling for 25 clients, and every refresher FWV trainee has to perform 10 MR cases independently and counsel 10 clients (Akhtar, 2001). The study findings show that continuous training and education is helpful for the performance of most formal community service providers (both government and NGO), and a need for refresher training was raised by many of these providers from the formal sector.

On the other side of the spectrum, most informal providers never receive formal training, except for few informal community service providers (e.g. drugstore salespeople, TBAs). NGOs (e.g. Marie Stopes and RHSTEP) are in the middle and have training provisions (i.e. basic training at the beginning and refresher training) for their front-line service providers and providers who perform MR/counselling etc.

This research also showed that in ensuring quality of care in health services, the workload of formal CTC health service providers is an area that needs to be given some attention. Almost all CTC health service providers from the formal sector raised the concern that excessive workloads restrict their ability to visit the community frequently. Government providers such as FWAs and FWVs have limited time to visit households, and a 'huge target' to meet. Such work pressure may affect the quality of care and the balance of work versus private time. In addition, a lack of a proper supervision system hampers the quality of care provided by the formal CTC providers. They do not always follow the formalized and regular supervision system. Sometimes the supervisors supervise the CTC providers over the phone or just ask them about their work. Therefore, an undocumented supervision system does not allow the supervisors to take the necessary steps to improve the quality of care. As the informal providers are completely

independent, nobody can supervise them. Thus, it would be a big challenge to bring them into a programme and supervise their activities.

Furthermore, insufficient monetary benefits, non-systematic working hours and poor coordination between the supervisors and the front-line providers hamper good performance. This limits the opportunity for improving the quality of health care services for the community, although some maintain that many CTC providers operate on the basis of altruistic values and provide services in the community based on mutual respect, not for money. Hardly any of the providers from the formal sector receive incentives or financial benefits for working extra hours. BRAC has volunteer services with money earned through selling medicines and through referrals. Incentive-based targets can increase the providers' motivation to deliver effective health services. Also, government providers such as FWAs do not have any provision for gaining promotion, which sometimes demotivates them from working extra hours. The introduction of performance-based incentives or appreciation from the relevant authority could be helpful to increase motivation. On the other hand, this research shows that informal providers do not see their workload as a problem. Since they all work independently and see as many clients as they can, which is directly linked to their earnings, they manage their lifestyle with their workload.

This research identified that the provision of training could enhance the performance of many informal providers, especially drugstore salespeople and village doctors, in providing basic health care services. As there are few or no training options available for informal providers, and, since the government bodies have not yet assumed responsibility for facilitating training opportunities for such providers, what remains is the willingness of the informal providers to gain skills and serve the community better. While the context may vary for some providers who want to serve the community and need the training, there are others who want to balance this with an opportunity to develop an income source. As is also well explained by a study conducted in sub-Saharan Africa, the combination of appropriate training and incentives could improve the performance of informal CTC health service providers (Goodman et al., 2007). For the context of Bangladesh, detrimental health care practices can be reduced by providing awareness training. However, the providers are unlikely to accept any advice that may have a negative impact on their earnings (Bloom et al., 2011).

Since the government and NGOs have their own systems for recruiting CTC health service providers, they have certain regulations and some degree of supervision. Studies have shown that the standard of patient or client care has been weak (Bhuiya, 2012), and it has been mentioned that poor care also includes inadequate pain relief, lack of privacy and being subjected to providers' judgemental and punitive attitudes. To avoid these resolvable problems, increased supervision is needed, along with improved basic training and repeat

refresher training. However, the government does not carry out systematic supervisory processes that can ensure quality of service. Government providers say there is no written format for supervision; it is mainly verbal. Their evaluation process is often non-systematic (i.e. there is no standardized process or structure). NGOs (e.g. Marie Stopes and RHSTEP) state that they use an evaluation system based on an annual audit to meet their targets. However, in general, in the formal sector (government and NGO) there are supervision gaps in feedback, coaching, problem-solving and skills development initiatives. Informal providers, meanwhile, are mainly independent providers who, thus, have no supervision and often no capacity development opportunities.

Informal providers need to be involved for a referral system to function well, as 80% of health care clients use their services. The findings of this research reveal that there is no effective, systematic referral system in existence among providers (both formal and informal), except for some drugstore salespeople and village/quack doctors who have informal partnerships with some NGOs. These informal providers (mostly drugstore salespeople) refer patients (including those coming for MR) to the government hospitals and NGO facilities. Some NGOs (e.g. Marie Stopes, BRAC) link with informal providers (drugstore salespeople) to some extent to serve the community, but it is not adequate. NGOs also link with the government for MR services by referring patients to government hospitals in exceptionally difficult cases. Moreover, as one of the many steps to be taken for improving MR service delivery, a closer link could be created with government health services, which would improve the performance of informal providers (Bloom et al., 2011) and would be a more feasible approach to monitor the impact of the process.

In summary, at the moment there is no effective link between government services and informal providers in terms of referral, coordination and communication in MR services. Furthermore, there is no government initiative or strong policy in place to recognize informal providers more authoritatively because of the lack of a systematic and defined health policy for CTC health service providers (Ahmed et al., 2011). Hence, we recommend an initiative to develop a closer link between the formal and informal health service providers, through systematic referral, as this could be effective in improving the performance of many informal providers. Furthermore, the development of a systematic referral process to link various types of informal providers with the government and NGO facilities could be useful to encourage informal providers to avoid the 'malpractices' related to SRH services in the community setting and to encourage formal providers to work with informal providers. Unregulated health services and a lack of proper supervision have a negative impact on health care services. It is evident from this research that effective and supportive supervision and communication can help to improve the quality of services, because an effective supervisory system can identify

gaps and address the quality of care, and recommendations and feedback can pass on to CTC health service providers.

CONCLUSION

It is clear from the research that informal CTC health service providers are embedded within the community. Formal providers (government or NGO health workers) mainly operate their services at close proximity to the community setting and engage in community sensitization and mobilization activities. Accessibility, availability and acceptance of the community for both formal and informal CTC providers shape the health service delivery system in the community setting. Likewise, defining roles and responsibilities and maintaining a quality service are essential to sustain the effective performance of CTC services; this would encompass specified interventions that are simple, rigorous and easy to monitor and evaluate.

Major issues were identified in the areas of training and continuous professional development; effective links between the government, NGOs and the CTC health service providers; a systematic M&E feedback loop; supportive and systematic supervision; workload; providing health information over mobile phones; and a formal structured policy on CTC health service providers. Effective referral by CTC providers to government and private-sector hospitals or facilities could also be helpful to increase the quality of services. Finally, a proper referral system could be effective to incorporate many informal sector providers into the mainstream health system.

CHAPTER 6 – IMPLICATIONS

The findings from the qualitative and quantitative research have given us a broader understanding of the prevailing conditions in the urban and rural slum communities with respect to SRH and, in particular, MR. Although MR has been the main focus on this study, the general aspects of CTC providers' performance and their clients' perspectives have become evident. However, the research findings show that the community is more inclined towards informal service providers (mostly the drug sellers, *kabirajs* and *dais*) than formal providers. The informal providers are more accessible and more easily trusted, making the community think of such providers as their own people, since they are embedded within the community. Moreover, the cost of care is an issue that cannot be neglected for marginalized populations, and by providing services at minimal cost, informal providers are more acceptable in the community. Therefore, the informal sector plays a significant role in service delivery, but the quality of care is always a concern, as neither the informal providers nor the community may be updated with the latest health information.

Considering all the issues mentioned, this research aims to design an effective intervention plan to improve the performance of various CTC health service providers working in urban slum locations in the research area. We found that the informal and the formal service providers are not working in unison; thus, there are more cases of competition and less complementarity. Consequently, there is insufficient communication among formal and informal providers and few or no links between these two sectors. This may hamper the quality of services being provided in a community. In the case of MR, brokering and stigma can affect whether women access legal or illegal MR services. Therefore, there should be a proper communication strategy between the formal and informal sectors of health providers. Building a proper strategy would not only enable the two sectors to work in collaboration but would also enable them to minimize any issues of stigma and other barriers to selecting providers which prevail in the community.

The evidence points to weaknesses in the referral system, which affects CTC providers' performance and needs further attention; this issue can be considered for the quality improvement cycle for the REACHOUT Bangladesh team. As stated in the discussion, the complexity of the referral system, and the existence of an unorganized process, works to the detriment of poor and vulnerable populations and against interventions which reduce the costs, minimize the intervention of brokers, recognize the way in which cultural stigma is experienced and take a structured approach that is easy to understand and important to take forward. MR services are also affected by poor referral systems.

The findings of the qualitative research also raise some questions about the kind of supervisory system that exists in the formal service provider organizations. As the supervisory system is not well organized, some formal providers also explain that they need to have more proper documentation support and better monitoring processes to improve the quality of work and thus improve CTC providers' performance. Meanwhile, no supervision mechanism is available for the informal sector.

Understanding these problem areas would allow the REACHOUT Bangladesh team to design the appropriate interventions to be implemented in the quality improvement cycle for 2014 and after. However, it is important to understand the relevance of and the extent to which the elements of the interventions are consistent with the beneficiaries' requirements and the country's needs, and the appropriate policies which could emerge.

The above implies that, for the quality improvement cycle, our research findings point to the following three problem statements:

- There is segregation and a lack of trust between formal and informal providers regarding SRH services, which negatively affect providers' responsiveness and performance.
- Women bear the consequences of a poor referral system which limits access to MR and other services and results in late treatment and inconsistent quality of care.
- The supervisory mechanisms of the formal (private and public) sector remain weak and unsystematic and require strengthening to improve the quality and responsiveness of CTC services. No supervisory system is present for the informal providers.

Considering the problems, the root cause analysis (see Annex 5) gives us a more comprehensive understanding of the types of intervention that could be designed for the quality improvement cycle. The findings from research point to the main causes of the poor cooperation and communication between the informal and the formal providers and the consequences for their performance. The informal providers are not always acknowledged for the services they provide to the community, and are not well recognized by the formal providers either. For the formal providers, there remains a sense of superiority where those who are well trained can give better services to their clients. As for the reality, most of the work is related to maternal and child health, with less importance paid to other aspects of SRH. Thus, there is a sense of competition for donor funds, where MR and SRH often remain a lower priority in health programmes. Furthermore, the informal providers' roles and responsibilities are not completely recognized at the governmental level, since more emphasis is always placed on policies for the formal health care providers.

The interesting point lies with Bangladesh's free-market-driven health care system, which has allowed these informal providers to be more popular with community members. Though the formal providers are not in close collaboration with these key health care providers, they cannot ignore their existence either. Thus, there needs to be an effective model/strategy for communication and coordination, which would pave the way towards collaborative intervention designs that can act as a mediator for community empowerment.

Our research findings also show us that CTC health service provider services related to SRH can be strengthened when there is a strong referral system. This can be followed with a structured and organized setting, which is easy to monitor and also to evaluate. This would ensure that the quality of care is not compromised and is not suffering from any unregulated service provisions causing a threat to the community population, especially women. Due to a poor referral system (see Annex 5) the community has suffered from a lack of proper SRH treatment options, which has often burdened family members with out-of-pocket payments which often drive them into further impoverishment. Likewise, the community has often been unaware of the proper referral methods and options available to them, which leads them towards a dependence on brokers who are working with various hospitals and clinics. Such conditions make treatment more expensive than necessary; thus, the affordability and quality of SRH services are often questionable. There is a need to make the referral system more systematic, with proper guidelines and protocols to be followed, and there is a need to link the informal providers with the formal ones to build up a strong partnership for the referral system and improve performance. It is also important that there should be proper health service literacy for the community and to inform them about various alternative treatment options such as semi-permanent methods and counselling on post-abortion care etc., so that community members are more aware of health issues and can be an informed decision-maker for their SRH.

The quality of care can be strengthened through supportive supervision and an M&E framework that is easy to implement and used for regular measurement and monitoring. The supervisory systems in both public and private sectors are often flawed and are unsystematic, causing more miscommunication and unorganized ways of serving the community. Effective supervision should be paired with a strong quality control system. Some of the private-sector organizations do use good supervision mechanisms, but they should be properly reviewed to understand whether there have been gaps in workflow and to identify potential measures for improvement. It is also important to understand that the informal providers do not have any supervisory mechanisms for their work in the community.

The problems identified through this research have guided us to devise an analytical framework for the CTC health service providers in Bangladesh for this intervention cycle which could be

more pragmatic and feasible to implement. The intervention design factors, as mentioned in problem statements, have been crucial, and we have adapted the generic framework for the CTC health service providers developed by KIT for this exercise (see Annex 3). We intend to implement the intervention factors in the first quality improvement cycle and to gain a more comprehensive understanding of how to improve for the second quality improvement cycle in terms of strategies and indicators. We expect that the analytical framework will reflect the Bangladeshi context better by considering the problem statements mentioned earlier.

The quality improvement cycle would focus on the interventions being designed for the CTC service providers and the indicators that would best fit for M&E. For the entire quality improvement cycle, coordination and communication, strengthening the referral system and having a well-coordinated systematic supervision mechanism would enable the formal and informal CTC health service providers to work in an organized manner and might improve the quality of MR care. The intervention design factors would enable the CTC health service providers to learn about making services more equitable, and would allow services to be delivered efficiently and meet clients' health needs more effectively. MR cases in Bangladesh require more attention, and it is these front-line service providers who have a significant stake in PHC provision. While the formal providers have not been completely successful in gaining the trust needed to meet the demand of all community groups, the informal provider market is now dominant, client-focused and trusted, though untrained in most cases, but sustained through its strong links with the community. It is important to address the problems with simplified but effective strategies that could be easily embedded within the existing systems of communication, referral and supervision and organizations' health objectives for SRH. This would give a strong foothold towards understanding and strengthening CTC health service providers' overall performance.

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ANNEX 1: DEFINITION CTC SERVICE PROVIDER

A close-to-community (CTC) provider is a health worker who carries out promotional, preventive and/or curative health services and who is first point of contact at community level. A CTC provider can be based in the community or in a basic primary facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than 2 to 3 years para-professional training (REACHOUT Literature Review 2013).

CTC healthcare service providers in Bangladesh

• Formal: Health workers of the NGOs and government personnel such as *Shasthya Shebika* (health volunteer), *Shasthya Kormi* (health worker), Family welfare assistants (FWAs), Family welfare visitors (FWVs), Health assistants (HAs), Midwives (BHW, 2008).

• Informal: Drug store sales people, Village doctors, Dai/Traditional birth attendants (TBAs), Trained traditional birth attendants (TTBAs), Traditional medicine practitioners, homeopath etc. (ibid, 2008).

ANNEX 2: LIST OF PARTICIPANTS FOR THE STAKEHOLDERS MEETINGS

List of participants for the Stakeholders Meeting at the Researcher Level on August 27, 2013

1.   Prof. LatifaShamsuddin, President of the Obstetrical & Gynaecological Society of Bangladesh (OGSB)
2.   Prof. Ferdoushi Begum, Sir Salimullah Medical College
3.   Dr.KaosarAfsana, BRAC HNPP
4.   Dr.Altaf Hossain, Director of the Bangladesh Association for Prevention of Septic Abortion (BAPSA)
5.   Prof. RowshanAra, Bangladesh Institute of Health Sciences (BIHS)
6.   Dr.Ferdous Hakim, Senior Researcher, Bangladesh Women Health Coalition (BWHC)
7.   Dr.Taposh Roy-BRAC HNPP
8.   Dr.Mahbub Elahi, icddr'b
9.   Dr.Anadil Alam, icddr'b
10.   Dr.Moloy Mridha, icddr'b
11.   Dr.Sadia Chowdhury- JPGSPH
12.   Prof. Sabina Faiz Rashid, JPGSPH
13.   Prof. Malabika Sarker, JPGSPH
14.   Ismat Bhuiya, Community-based Midwifery Development Programme
15.   Showkat Gani, JPGSPH
16.   Suborna Camellia, JPGSPH
17.   Kazi Shamsul Amin, JPGSPH
18.   Samia Bari, JPGSPH
19.   Shaila Nazneen, JPGSPH
20.   Nayna Ahmed, JPGSPH.

List of participants for the Stakeholders Meeting at the CTC service providers level on September 30, 2013

1.   P.S. Das Parthoshanto Das, Pharmacist/DMF at the Onukul Pharmacy in Sylhet, Bangladesh.
2.   Shima and Moni, healthcare Workers from BRAC Sylhet, Bangladesh.
3.   Dr. AlauddinChowdhury, Homeopathic from the Al ShafiHomeo Hall, in Sylhet.
4.   Nishi, a Fieldworker from Zestway Medical, Dhaka, Bangladesh.
5.   Helena Chowdhury, Paramedic from the Shakti Foundation in Dhaka, Bangladesh.
6.   Tahmina Kazi, Village Doctor from Dhaka, Bangladesh.
7.   Rowshon Ara and Bokul/Koli, ShasthyaShebikas from BRAC, Bangladesh.
8.   Mr. Kamal Kanti Biswas, Research and Evaluation Adviso at IPAS, Bangladesh.
9.   Mr. Tanvir, BSWS, Bangladesh.
10.   Dr. Elvina in place of Mr. Mahbubul Haque, PM.
11.   Jesmin Nahar, P.A., RHSTEP, Dhaka, Bangladesh.
12.   Dr. Dr. Sabina Faiz Rashid, Dean, JPGSPH, BIGH, BRAC University.
13.   Dr. Malabika Sarker, Director Research, JPGSPH, BIGH, BRAC University.
14.   Zakia Sarmin, Research Assistant, JPGSPH, BIGH, BRAC University.
15.   Sumona Siddiqua, Research Assistant, JPGSPH, BIGH, BRAC University.
16.   Yamin Jahangir, Senior Research Asssociate, JPGSPH, BIGH, BRAC University.
17.   Bulbul Siddiqi, Consultant, Research Assistant, JPGSPH, BIGH, BRAC University.
18.   Konoc Fatama, Research Officer, JPGSPH, BIGH, BRAC University.
19.   Salauddin Biswas, Senior Research Associate, JPGSPH, BIGH, BRAC University.
20.   Kuhel Islam, Lecturer II, JPGSPH, BIGH, BRAC University.
21.   Showkat Gani, Senior Statistician, JPGSPH, BIGH, BRAC University.
22.   Shaila Nazneen, Research Associate, JPGSPH, BIGH, BRAC University.
23.   Md. Riaz Hossain, Research Assistant, JPGSPH, BIGH, BRAC University.
24.   Salahuddin Mollik, Research Assistant, JPGSPH, BIGH, BRAC University.
25.   Tamanna Majid, Research Assistant, JPGSPH, BIGH, BRAC University.
26.   Kazi Shamsul Amin, Communications and Knowledge Manager, JPGSPH, BIGH, BRAC University.
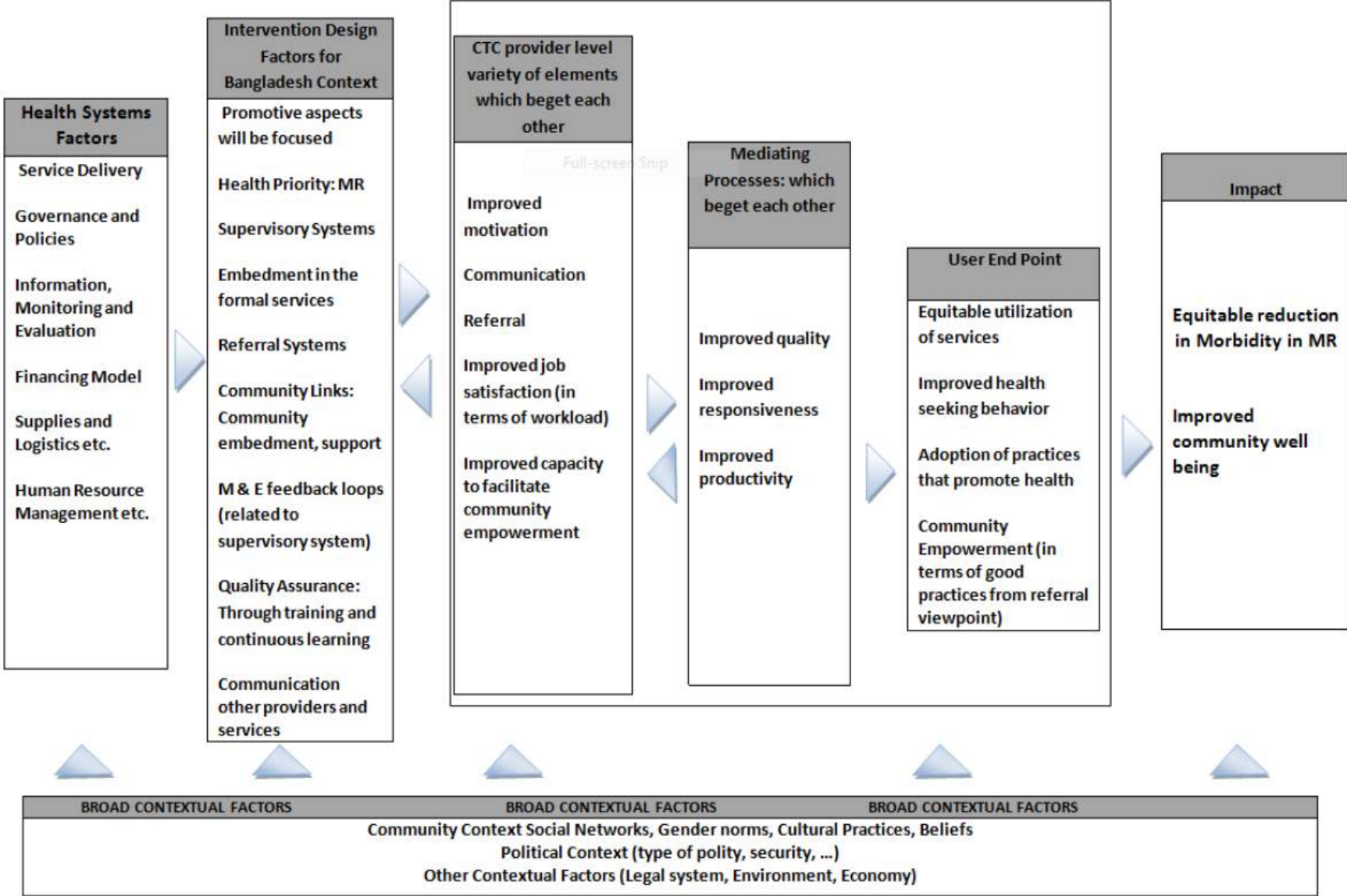
ANNEX 4: DATA COLLECTION TOOLS FINAL VERSION

Topic Guide SSI CTC healthcare service providers

Take individual consent (INFORMED CONSENT)

By taking individual's permission please fill up the cover sheet.

Data Recording Sheet: SSI CTC healthcare service providers:

Date:	Code (ID):
Interview start time	
Interview finish time	
Number of times we had to go to take the interview	
Interviewer	
Note taker	
Name/ address of the slum	
Name of the Ward	
Name of the Thana (Sub-district)	
Name of the Zila (District)	
Type of the slum ☐ Governmental ☐ Non-governmental ☐ Privately-owned	

General Information:

1. Name:					
2. Sex:	Male	☐	Female	☐	
3. Age (In year):					☐
4. Marital status:	Married	☐	Unmarried	☐	
	Widower	☐	Widow		
	Divorced	☐	Others…………….	☐	
5. Educational Qualification:	Uneducated	☐	Primary – Incomplete	☐	
	Primary – Complete	☐	S.S.C – Incomplete	☐	
	S.S.C – Complete	☐	H.S.C	☐	
	Madrasa Education	☐	Others…………….	☐	
6. Religion:	Islam	☐	Hinduism	☐	
	Christianity	☐	Buddhism	☐	
	Others…………….	☐			☐
7. Ethnicity:	Bengali	☐	Others…………….		

8. Type of CTC provider:	

Information:

9. Where do you work? Would you please say something about your work?

10. For how many days have you been in this profession?

11. Which type of treatment do you provide to the people of this area? What are those?

(Probe: Primary healthcare service, family planning and birth control, maternal and child healthcare)

12. How much time do you spend for doing this work?

(Probe: Day/ Week)

13. If anyone doesn't want to have baby then do you work on that too?

14. How much time do you spend for doing work related to this?

(Probe: Day/ Week)

15. How many cases do you get per month?

(Probe: In last 2 months how many cases did you get?)

16. Can you earn from this work on a regular basis? If you can then how much money do you earn monthly?

17. Apart from this, do you have any other source of earning? If you have then what are those?

(Probe: By selling medicine, sending patients to doctors etc.)

18. Have you received any health related basic training or medical training?

(Probe: Name of the training, duration of the training, training year, name of that organisation that provided training etc.)

(In the next part of guideline, as a synonymous word for MR, the interviewer has to use MR related functional word. Notable point is that the interviewer shouldn't use the word 'MR' in advance in any case.)

Recruitment of formally engaged CTC healthcare service providers

19. How did you get involved in this profession?

(Probe: Did you get appointment in the area by the ministry/ NGO/ CBO or did you get appointment as you live here)

20. Why did you become interested in this field of work?

21. For being appointed as a MR Service provider what are the qualities (Criteria) a person should have?

Clients Community:

22. Who obtains service from you? How do you find them?

(Probe: For example, ultra poor, poor and people of a particular age may come to you. Please share with an example.)

23. In case of providing treatment do you get any cooperation from the people of this area? If so, what type of cooperation do you get?

(For example, do you get help from pharmacist, private provider, other CTC service provider, government healthcare provider etc.?)

24. How is your relation with the clients? Does this relation have any impact on your work?

25. Whichaspectsof yourjobare good andthebad to you? Why?

Motivation (Incentives/ Remuneration etc.)

25. Which parts of your work do you like and which parts of your work do you dislike? Why?

26.Anyissuesthatimpact onthesatisfactionof yourworkplace? Which things in this work encourage you? How?

27. Which things of this work make you satisfied and dissatisfied?

28. Which work of other providers helps to feel good?

29. Which works of other provider sometimes make bad feeling?

(Prove: Jobstress, work environment, communication, MR Clinicalinstrumentsusedto carryandtransport, safetyandsexual harassment, career perspective,supervision, community, client, colleague, familypressure, socialpressure(more or long walkingandgoinghome), havea longtrip,workoremploymentbarriers(stigma),betterincome, gender empowerment, aswomenseehowMRservices)

30. Do you have to perform any additional task which is out of your responsibilities? If so then what are the additional tasks that you have to perform?

(Probe: Are these additional tasks out of her job description? And does she receive any additional benefit for doing these?)

31. How is your work environment?

(Probe: What type of work environment it is, how far the distance is and what type of work it is)

32. Whatcanyoucontributeby thiswork? What kind of incentives you get for this work?

(Probe:social status, housing, economic benefits, and otherrewards, jobbarriersorstigma,economicempowerment, and religiousrestrictions)

33. Do you want that your family members or relatives get involved in this profession? If you want then what is the reason/ if you don't want then what is the reason?

(Probe: Brother – sister, son – daughter etc.)

34. How is your relation with your colleagues?

(Probe: What are the positive aspects/ what are the negative aspects?)

Supervision/ Control at Work:

35. Do you have to report anyone for your work? How do you have to do it? Which aspects of this process do you like? And what are the aspects that you don't like? Why?

36. Howtheaccountability(Supervision)is? Whenwasthe lastto beheld accountable?What happenedthen?

37. What type of freedom do you have in terms of work?

38. If you have any work related opinion/ suggestion, can you share this with your office? If you can then how much importance does the office give to that? Could you give us a specific example? If you can't, how you feel work like this?

(Probe:impact ondecision making, theability to think, lack ofdrugs.)

39. Do you have monitoring system in your work? Howisit?Give an example?

40. Have you got any feedback for your work? If yes, then how you got it and who give you the feedback?Doyou haveanysuggestionsforimprovingyourjobskills? If yes, How doyougetandfrom whom? Give an example?

General wellbeing and home-work interface:

41. Does the work you do have any impact on your family life?

(Probe: For example, wellbeing, relation between husband-wife, spending time with children, getting leisure time etc.)

Quality of care:

42. According to you, what is the standard of MR that you do?

43. What do you think about other services that's you don't provide? Who provide these kinds of services?

44. What do you think about the quality of your MR service?

45. According to you, can you provide the type of treatment that the women expect to get from you? If not then why can't you provide that? What is the role of those providers (good, bad)? Please explain.

46. Howtoassessthequality ofyourwork? ByWho? Did they give any feedback?Howaboutyourservicesin thisarea, youcan findit? Whichservice theyprefer?Do theyhaveanycomplaintsaboutthe service?

47. Do you know anyone who wanted to do MR but she couldn't do so due to an obstacle (From family or society)

Communication and Interaction with colleagues:

48. Doyouhavesomeoneelsewhogivesserviceto thisarea? If so,how isyour relationshipwiththem? If youaregood, thenwhatisgoodand ifnotbetter, thenwhynot?

49. How tocommunicatewithyour colleagues (supervisor, in charge, volunteer, TBA)andyourjobsatisfactionand motivationto buildrelationshipsaffected?

(Probe:throughcommunication, throughmeetings, informalcontacts,oftenat thekindsofcommunication, whatiscommunicationissues, how you feel.)

Referral:

50. Did you ever refer any person, who came to you to do MR? Where did you refer? If yes, can you please explain the entire process? Please share an incident as an example.

(Probe: If any slip is given, why it is given, how it is given etc.)

51. When you cannotsolvetheproblem,thenwhatdoes? Issentorreferthemto somewhere?If youaresent, then why? Give an example; do you have a partnership whit those organisations?

52. Do you refer to any other organisation apart from your organisation? If you do, then in which case do you refer outside? When do you refer? How do you refer?

(Probe: What do you do when a patient is in an emergency condition? What do you do in normal case?)

53. Which things work well in referral and what things do not work well? If you are good ,then how,? If not, the why not? Give an example.

54. After referring a patient do you make enquiries about her?

Mobile Health:

55. Do you provide any type of service through mobile phone? If so then how do you do this? Please tell us in detail.

(Probe: For how long the service is given? When is it given? And for this does the servicer receiver have to pay extra money?)

56. Whogaveyouthisphone? Whobearsthe cost ofit? Do you liketousethis phone? TheFacility- What arethe difficulties?

Barriers and Difficulties:

57. While performing the tasks do you face any difficulty or obstacle? If so, then what sort of obstacle is that?

(Probe: Social obstacle, adjusting with local people, political influence etc.)

58. In case of doing work do you face any difficulty from family or society?

(Probe: For example, from relatives, due to the type of work, due to moderate earning, security at work place, sexual harassment etc.)

Suggestions/ Recommendations:

59. What can be done for the development of the work? What is your suggestion? Please explain with an example.

60. If we go to another area to provide MR treatment then what are the things that we should do in order to improve this?

Topic Guide SSI Key Informant (Doctor/ Nurse/ Paramedic and Program Staff)

Take individual consent (INFORMED CONSENT)

By taking individual's permission please fill up the cover sheet.

Data Recording Sheet: SSI Health Managers/ Doctor/ Nurse

Date:	Code (ID):
Interview start time	
Interview finish time	
Number of times we had to go to take the interview	
Interviewer	
Note taker	
Name/ address of the organisation	
Name of the Ward	
Name of the Thana (Sub-district)	
Name of the Zila (District)	

General Information:

1. Name:				
2. Sex:	Male	▭	Female	▭
3. Age (In year):				▭
4. Marital status:	Married	▭	Unmarried	▭
	Widower	▭	Widow	
	Divorced	▭	Others…………….	▭
5. Educational Qualification:	Uneducated	▭	Primary – Incomplete	▭
	Primary – Complete	▭	S.S.C – Incomplete	▭
	S.S.C – Complete	▭	H.S.C	▭
	Madrasa Education	▭	Others…………….	
6. Religion:	Islam	▭	Hinduism	▭
	Christianity	▭	Buddhism	▭
	Others…………….	▭		▭
7. Ethnicity:	Bengali	▭	Others…………….	▭

Information:

8. For how long have you been working here? Prior to this, where did you work? What were the tasks you performed there?

9. Would you please say something about your current job? Do you have to perform similar type of activity every day?

10. What are the issues on which the people at field level work?

(Probe: The entire work process has to be known)

11. Which sort of patient comes over here mostly? Which type of treatment do you provide them?

(In the next part of guideline, as a synonymous word for MR, the interviewer has to use MR related functional word. Notable point is that the interviewer shouldn't use the word 'MR' in advance in any case.)

12. How did you get involved in MR? Prior to this, did you do similar type of job? If so, kindly tell us something about that.

The following are specific issues to be explored, if not already addressed (Not applicable for Doctor/ Nurse/ Paramedic)

13. Would you please say about policy and procedure of MR?

(Probe: Do you have any written policy? If you have then what extent of it is followed?)

14. In your opinion, which aspects of the policy are important?

15. According to you is the policy of MR appropriate? If not, then according to you, what type of changes is necessary to bring?

Recruitment and staff retain policy
(Not applicable for Doctor/ Nurse/ Paramedic)

16. How do you appoint MR worker (CTC provider)?

(Probe: Selection procedure (Education, age, religion, experience, sex and area basis))

17. How are their salary and other benefits? Do you think that these are sufficient?

(Probe: Promotion, incentive, salary increment, festival bonus, transportation expense and treatment –

Are these facilities enough? What else do you do for the employees?)

18. Do you take any step to ensure long term existence of those employees who are efficient?

19. Do MR workers think that these are sufficient?

20. If they don't think that these are sufficient then how it affects their work?

21. If it affects then what sort of step do you take?

   (Prove: Bewarned, counselling, trimming)

22. How do you evaluate the opinion/ suggestion of MR workers? Please state with an example.

Clients Community:

23. Whom do you provide service? Do you provide service to everyone?

(Probe: Adolescent, poor people, disable or physically handicapped people, unmarried (Those women who live alone in hostel or stay alone away from their families))

24. Underprivileged/ deprived people (Ultra poor/ HIV/ AIDS, TB, SEX worker, and drug addicted) get service?

25. How is your experience of providing service to them?

(Have you faced any obstacle? Is there any social barrier?)

Quality of care:

26. What is meant by good quality MR treatment?

27. How is MR treatment provided in your clinic?

28. How is the privacy of the patients maintained, who come here to do MR?

(Probe: Which information is kept? How is it kept? Is it shared with any other individual or organisation?)

29. Is there any arrangement of counselling for those who come to take MR Service? If there is an arrangement then how is it done?

(Probe: Is counselling done before and after having MR treatment? After having MR service are they helped out by giving any information or data? Is counselling provided to the person only who comes to receive MR Service? Otherwise, is counselling provided to the person/ persons who come along with the patients? How mental support is given? How follow up is done?)

30. Is there any arrangement to follow up those people who take MR Service?

31) In thisareaforany otherservices are needed that youdonotprovide? Whodo you thinkcangivethese services?

32) What is the role of those service providers in this area? Is it satisfactory or not? Please explain.

33) How did you know about what people are thinking about service and service provider's quality?

34) How did you know about what people are thinking about service? In this case which think they like most? And for which services people complain?

Referral:

35. When and how women come over here to do MR? Please tell us something about your referral system.

36. How those people who take MR come over here?

(Probe: Do adolescent and women having rape case come over here to do MR?)

37. For the referral is any sort of money charged from clients?

(Probe: How much money is charged?)

38. For referring is any sort of incentive given to the referrer employee? If given, please share the process in detail.

(If incentive is given then what is the type of incentive?)

39. What are the obstacles or difficult situation you face while providing service through referral system? Please state in light of your experience.

40. Have youeverreferredto yourcompanybyany otherorganisationorinstitution? If yes, then in what condition or illness you refer the patients? Did you ever refer patients for this? Those who have provided this kind of services, do you have any partnership or referral relation with them?

(Prove: if there is any emergency then what you do, in normal case what you do.

41. For providing services with the referral system did you faced any problem or hard situation? If yes, then lighten us with an example.

42. Do you have any suggestion about the referral system?

(Probe: Good-bad parts, why she wants the changes, why she doesn't want the changes,)

Motivation (Incentives/ Remuneration etc.)

43. Which parts of your work do you like and which parts of your work do you dislike? Why?

44. What do you think about the issuesthataffecttheirsatisfaction in this job? Beside this which things make them encourage? How?

45. What do you think about, in this work which thinks makes them satisfied and dissatisfied

46. For what reason people in this work (MR) feel good.

47. For what reason people in this work (MR) does not feel good.

(Prove: workload, working environment, Communication, equipment that's used in MR, transport, safety, sexual harassment, career perspective, supervision, communication, clients, colleagues, family pressure, social pressure (walk for a long distance and have to go different house), work for a long time, work or employment restriction, good income, gender empowerment, how woman see the MR service.

48. Do you have to perform any additional task which is out of your responsibilities? If so then what are the additional tasks that you have to perform?

(Prove: Is this extra work is out of their job description? And for this, are they having any extra benefit?)

49. How is the working environment?

Probe: What type of work environment it is, how far the distance is and what type of work it is)

(Probe: Are these additional tasks out of her job description? And does she receive any additional benefit for doing these?)

50. Are these works having any impact on CTC healthcare service providers work?

51. What kind of incentives the take?
(Prove: social status, residence, economically benefited,

Supervision/ Control at work

52. Do you have to report for CTC provider work? Could you tell us about the process? In this process which things you like and which things you don't like? Why?

53. Are you supervised the CTC healthcare service providers regularly? What was the last time you supervised? What happed then?

54. What do you think about their freedom in work?

55. If there is any suggestion of the work are the CTC provider shares this with the office? If they, then how much importance the office gives? Can you give some examples of what to do in particular cases?

56. If the CTC provider can't do it, what do you think about this?Whatwouldyou liketoworkout? Give an example.
(Prove:Influence decisions, the ability to think, lack of drugs.)

M&E

(Not applicable for Doctor/ Nurse/ Paramedic)

57. Is there any arrangement for monitoring MR program? Is there is such arrangement then how is it done? Please share in detail.
(Prove: We have to know the entire process; who do monitoring, why they do and how they do? Is information collected for monitoring? Are post monitoring recommendations implemented?)

58. Is the information, derived from the monitoring system, shared with employees?

Mobile Health:

59. Which type of MR related service is provided through mobile phone? Please tell us in detail.

60. According to you how effective is it to provide MR related healthcare service through mobile phone?
(Probe: Advantage-disadvantage)

For Doctor/ Nurse/ Paramedic only:

61. Have you received any MR related training? If so then from where have you received it? What was the time duration of the training?

62. What do you do at the time when people come to the clinic for doing MR although the doctor is not available? In that case do you do MR? If you don't do so then what do you do?

(Probe: Telling them to wait or come at a later time, providing with medicine and advising them to take some rest) (For nurses only)

63. During post MR period if anyone stays admitted to the clinic in that case how do you take care of them?

(Probe: Bleeding, pain, fever, advice – medicine, cleanliness etc.)

Facilitators & Barriers:

64. According to you, how much necessity does MR have in this area?

65. According to you, which aspects of MR are useful? Please state an example.

66. Do you find any aspect of MR awful? If so, then what are those aspects? In your opinion what types of steps can be taken for running MR in a better way?

(Probe: If you are given the chance to make decision about MR then which new aspects will you suggest to add?)

Suggestions & Recommendations:

67. Forthistowork,whatcould bebetterdo you think? In this case,what isyoursuggestion? Explainwithexamples.

68. What should we do if we want to provide quality MR Service in other area? What things we should avoid?

Community Clients (IDI)

Take individual consent (INFORMED CONSENT)

By taking individual's permission please fill up the cover sheet.

Data Recording Sheet: Community Clients (IDI)

Date:	Code (ID):
Interview start time	
Interview finish time	
Number of times we had to go to take the interview	
Interviewer	
Note taker	
Name/ address of the slum	
Name of the Ward	
Name of the Thana (Sub-district)	
Name of the Zila (District)	
Type of the slum ☐ Governmental ☐ Non-governmental ☐ Privately-owned	

General Information:

1. Name:				
2. Sex:	Male	☐	Female	☐
3. Age (In year):				☐
4. Marital status:	Married	☐	Unmarried	☐
	Widower	☐	Widow	
	Divorced	☐	Others…………….	☐
5. Number of Children				
6. Educational Qualification:	Uneducated	☐	Primary – Incomplete	☐
	Primary – Complete	☐	S.S.C – Incomplete	☐
	S.S.C – Complete	☐	H.S.C	☐
	Madrasa Education	☐	Others…………….	☐
7. Occupation:				
8. Income Source:				
9. Religion:	Islam	☐	Hinduism	☐
	Christianity	☐	Buddhism	☐
				☐

	Others…………….	☐		
10. Ethnicity:	Bengali	☐	Others…………….	

Introduction:

11. From which diseases do the women of this area suffer usually? From which types of problems do the married women suffer?

12. Which types of pregnancy related (reproductive health) services are available in your area? Who provides these services? Are these services is available when you need? Which things should add, what you think about this?

13. Do you use any kind of family planning method? If yes then who takes the decision? After conceiving or becoming pregnant, where do women go for advice or treatment?

14. Sometimes it is seen that women conceive baby but because of various situations (For example, family problem or financial insolvency) they can't keep the baby. What do they do then? In that case, where do they go? Why do they go there? From whom do you get to know these?

15. Till now for how many times have you conceived? (Applicable for married women only).

16. Did any situation arise where you (Husband-wife) didn't want but you conceived baby. What did you do then?

17. If they kept the baby then this question would be applicable. Well, did anything ever happen that you conceived but decided not to keep the baby? Why did you take this decision? What did you do then?

(Probe: Did anyone tell you about any abortion method? If yes then what did s/he say?)

18. Did you take your husband's suggestion while making the decision? What was your desire (Opinion)?

(Probe: Did you have any fight/clash with your husband?)

19. While making the decision what was the role of your other family members? Did other family members say you anything about this issue?

(Probe: Did you have fight with any family member?)

20. Did you ask suggestion from anyone in this situation? If yes, then whom do you go.

21. After how many days of conceiving baby did you make decision to avoid the baby? At that time did you undergo any mental or physical problem?

(In the next part of guideline, as a synonymous word for MR, the interviewer has to use MR related functional word. Notable point is that the interviewer shouldn't use the word 'MR' in advance in any case.)

22. Where did you go to do MR? Why did you go there? Who informed you about that place?

23. You remember the day you went to do MR, don't you? Could please say something about that experience that you had on that day?

(Probe: How was your mental condition on that day? Who went there with you?)

24. How was the behaviour of the nurse, ayah and doctor of that clinic where you went to do MR? Did they say you anything about MR? If yes then what did they say?

25. How did you feel when you were taken into OT? Would you please share your experience of that time?

(Probe: Were you afraid of? Were you nervous?)

26. Did you face any trouble while doing MR? If you faced then how much time did you take to overcome? In that case did the doctor or the family members helped it?

(Probe: After doing MR, did you go through any kind of physical and mental trouble? Please tell us in detail)

27. After doing MR, did you get any advice from clinic on how to maintain daily activities? If yes, what did they say?

28. After doing MR, when did you come back to home? At that time, were the family members (Husband and other members) with you?

29. After how many days of doing MR, you came back to normal life? At that time, how did your family members (Husband and other members) help you?

30. After doing MR did you adapt any special family planning method? Why? From whom did you receive information and suggestion on this matter?

Perceptions of Service Quality:

31. When you went to do MR for how long did you have to wait at clinic or hospital?

(Probe: After how many times of reaching the hospital was your MR done?)

32. Do you think that the standard of MR which was done in this hospital was satisfactory?

33. Are you satisfied with the MR you had?

(Probe: personal experience, how efficient the doctors – nurses are and if it is necessary to improve, environment of the clinic – O.T, uniform, bed and also behaviour of nurses and doctors during the time of MR)

34. Would you suggest other women to do MR in this hospital? If yes then why?If no, then why?

35. In your opinion what aspects of MR should be more developed?

36. What do you think about the doctor's efficiency who did your MR? In this case, which sides was good and which sides they have less efficiency?

37. What do you assume about the doctor who did your MR? (Prove: sufficiency (how much time they give or are they always available), distance (what is the distance from the residences MR clinic?) effectiveness,limitations etc.?

38. How is the behaviour of MR Service provider with MR clients? What do you think? Give us an example.

39. Do theirservicesseem to beprettyto you? Give an example.

40. What do youthinkabouttheimportance ofprovidingMRservices? What is the effective contribution of MR Service providers? Do youhave anyof the negativeaspects ofthisprogram?

41. Which sides are good of MR Service providers? Give an example. Which thinks are making good of this service?

(Prove: in which way, events, what are the causes of good things.)

42. About this service which things are not always or sometimes good to you? Give an example. Which thinks are making bad this service? Give an example.

(Prove: if the answer is not coming spontaneously then, when the informant gives an example, you have to try to find out the betteror worse things are effected the work.)

Barriers and Difficulties:

43. While doing MR, did you face any family problem?

(Probe: Blame from family, quarrel/clash etc.)

44. Because of region did you have to face any trouble while doing MR? If you had faced, how was that?

45. Did anyone apart from your family members know that you did MR? After knowing what did they say you?

(Probe: What was the reaction?)

46. Did any of your neighbours help or create obstacle when you did MR? If yes then how?

47. Did you face any trouble in collecting money for doing MR? If you faced then how did you collect the money?

48. Apart from the above mentioned difficulties, did you go through any other trouble while going to clinic for doing MR?

Costs:

49. How much money did you have to spend to do MR?

50. To do MR did you have to pay any extra amount of money? If you had to pay then how did you arrange the expense?

(Probe: Medicines, test/ diagnosis, transportation, expense of referral etc.)

Referrals:

51. Is there any referral system for MR? Were you sent anywhere else? If you were sent then where was it?

52. How do the MR workers refer? What is the process of referral?

(Probe: Why, how, different types of referral processes, if slip is given and other factors)

Mobile Health:

53. Using mobile phone did you ever receive any MR related advice or treatment from MR workers?

(Probe: Why did you call? What do you think about using mobile phone?)

54. How will it be if treatment related advice is given through mobile phone?

FGD Client Check List

1)   What kinds of illnesses do women in your area generally have?

2)   Where do women generally go for primary treatment of when they fall ill? Where after that? O whose advice do they go?

3)   Who provides medical guidance/treatment in your area? Do they come from any specific organisation? What kinds of services/information do they provide? Do you have to give any financial compensation to get the required services?

4)   Do you face any difficulties in accessing healthcare?

5)   What kinds of health problems do pregnant women face? Where do they go for treatment and on whose advice?

6)   Many-a-times, a pregnant woman (either because of financial or homely duties) are not able to keep their child. What do they do then? Where do they go? Why do they go there? From whom did you get this information? (Probe: monetary, societal, familial, and home-based).

7)   Who takes the decision/ makes the decision to not keep the child? What position do men occupy when it comes to making this crucial choice?

8)   Who do they (men/women) consult with before making a choice? (Probe: monetary, societal, familial, friends, relatives)

9)   What kinds of problems do women face when accessing care from different organisations? What can be done to overcome these challenges?

10)   Are you satisfied with the kind of service you are receiving? Exemplify the reasons if you received good service? Exemplify the reasons if you received bad service?

11)   Where are you sent for treatment? Which healthcare centre are you sent to? (Probe: clinic, diagnostic centre)

12)   What kinds of problems exist in the treatment provided by your healthcare providers to you?

13)   What kinds of steps undertaken will reduce the difficulties you face when receiving treatment?

14)   How is the health service providers are related to health service in this area? Could you give us an example?

15)   What do you think about the MR Service program? In this case, what is the role of MR Service providers? Did you notice any negative impact of this program?

16)   Which sidedo youthinkis the best of MRService providershaveserved? Can you give us an example? What do you think, which thing should take to improve the service? (Prove: could you tell us any related story? Which things are making this service good?)

17)   In this service, which are totally worse to you? Give an example? Which things are making   the   service   worse?   Give   an   example?

(Prove: if the answer is not coming spontaneously then, when the informant gives an example, you have to try to find out the betteror worse things are effected the work.)

Perceptions of Service Quality

18)   What do you think about the MR Service provider's skill? Which sides of the service are better and which sides are less efficient?

19)   How is the behaviour of the MR Service providers with the MR clients? Give an example?

20)   Theirservicesseem to beprettyto you? Give an example.

21)   What do you think about how this service can improve?

Referrals

22)   Are there sufficient referral system be present in the health service (with MR)?

23)   How did the health service providers referred?

24)   Are there is any expense when they refer? Who have to give the money?

(Prove: for different situation, different referral system)

25)   Which sides of referral system are good and which sides are bad? Why? Give an example?

Mobile health

26)   Do you know about mobile health service?

27)   In this area, are the provider give services over mobile phone? Are the other service providers give advices over phone? Why they use this kind of methods? Howdo youseemobilehealthserviceto give? Advantage and disadvantage?

28)   Did you ever take any service over the phone from the health service providers?

Topic guide SSI CTC healthcare service providers
Take individual consent (INFORMED CONSENT)
ব্যক্তিগতসম্মতিগ্রহণকরুন, কাভারসিটপূরণকরুন।

Data Recording Sheet: SSI CTC healthcare service providers

তারিখঃ	কোড(ID):
সাক্ষাৎকারগ্রহনেরসময়ঃ	
সাক্ষাৎকারশেষকরারসময়ঃ	
সাক্ষাৎগ্রহনেরজন্যকতবারযেতেহয়েছিল?	
সাক্ষাৎকারগ্রহণকারীঃ	
Note taker:	
বস্তিরনাম/ ঠিকানাঃ	
ওয়ার্ডএরনামঃ	
থানারনামঃ	
জেলারনামঃ	
বস্তিরধরনঃসরক☐নরকারিব্যক্তিমালিকানা।☐ ☐	

সাধারনতথ্যঃ

১.নাম:				
২.লিঙ্গ:	পুরুষ	☐	মহিলা	☐
৩. বয়স (বছরে):				
৪. বৈবাহিকঅবস্থাঃ	বিবাহিত	☐	অবিবাহিত	☐

	বিপত্নীক	☐	বিধবা	☐
	তালাকপ্রাপ্ত	☐	অন্যান্য............................	☐
৫.শিক্ষা:	নেই	☐	প্রাইমারী-অসম্পূর্ণ	☐
	প্রাইমারী-সম্পূর্ণ	☐	মাধ্যমিক-অসম্পূর্ণ	☐
	মাধ্যমিক-সম্পূর্ণ	☐	উচ্চমাধ্যমিক +	☐
	মাদ্রাসাশিক্ষা	☐	অন্যান্য.........................	☐
৬.ধর্ম:	ইসলাম	☐	হিন্দু	☐
	খ্রিষ্টান	☐	বৌদ্ধ	☐
	অন্যান্য...............	☐		
৭. জাতিগোষ্ঠী:	বাঙ্গালী	☐	অন্যান্য.........................	☐
৮CTC Provider এরধরনঃ			

Introduction

৯. আপনিকোথায়কাজকরেন? আপনারকাজসম্পর্কেকেএকটুবলবেন?

১০.এইপেশায়কতদিনধরেআছেন?

১১. আপনিএইএলাকারমানুষদেরকোনধরনেরচিকিৎসাদিয়েথাকেন, সেগুলোকি?

(**Probe**ঃপ্রাথমিকস্বাস্থ্যসেবা, পরিবারপরিকল্পনাওজন্মনিয়ন্ত্রণ, মাওশিশুসেবা।)

১২. আপনিএইকাজেকতসময়দিয়েথাকেন?

(**Probe**ঃদিন/ সপ্তাহ)

১৩. কেউযদিবাচ্চানিতেচায়তবেআপনিকিসেবিষয়েকাজকরেন?

১৪. এইসম্পর্কিতকাজেআপনিকতটাসময়দিয়েথাকেন?

(**Probe**ঃদিন/ সপ্তাহ)

১৫. আপনিমাসেএইধরনেরকয়টিকেইসপান?

(Probe:গতদুইমাসেআপনিএইধরনেরকয়টিকেইসপেয়েছেন?)

১৬. এইকাজথেকেকিআপনারনিয়মিতআয়আসে? যদিহয়তবেমাসিককত?

১৭. এছাড়াআপনারআয়েরঅন্যকোনোউৎসআছেকি? যদিথাকেতবেকিকি?

(Probe ঃঔষুধবিক্রিরমাধ্যমে, রোগীকেডাক্তারেরকাছেপাঠানোরমাধ্যমেইত্যাদি।)

১৮. আপনিকিস্বাস্থ্যবিষয়েকোনোবেসিকট্রেনিংবামেডিকেলট্রেনিংপেয়েছেন?

(Probe ঃট্রেনিংএরনাম, ট্রেনিংএরমেয়াদ, সাল, প্রদানকারীসংস্থারনামইত্যাদি।)

(গাইডলাইনেরপরবর্তীঅংশেMRএরসমার্থকশব্দহিসেবেউত্তরদাতারMRবিষয়কব্যবহৃতশব্দব্যবহার করাহবে।লক্ষ্যণীয়বিষয়হলোকোনোভাবেইযেনInterviewer MRশব্দটাআগেব্যবহারনাকরেন।)

Recruitment of formally engaged CTC healthcare service providers

১৯. এইপেশায়আপনিকিভাবেএসেছেন?

(Probe: আপনিকিএইএলাকাতেমন্ত্রণালয়, NGO/ CBO এরদ্বারানিয়োগপ্রাপ্তঅথবাএখানেবসবাসকরেনবলেকিনিয়োগপ্রাপ্তহলেন?)

২০. এইপেশায়কাজকরতেআপনিকেনআগ্রহীহলেন?

২১. MR সেবাপ্রদানকারীদেরনিয়োগেরক্ষেত্রেকিকিযোগ্যতা (criteria)থাকাউচিৎ?

Clients Community

২২. কারাআপনারকাছথেকেসেবানেয়? আপনিকিভাবেতাদেরখুঁজেপান?

(Probe ঃযেমনধরেন- অনেকগরীব, গরীবএবংকোনবয়সেরমানুষআপনারকাছেআসে।উদাহরণসহবলুন।)

২৩. চিকিৎসাদেওয়ারক্ষেত্রেআপনিএইএলাকারমানুষদেরকাছথেকেকোনোসাহায্যসহযোগিতাপানকিনা? পেলেকিধরনের? (যেমন- ফার্মাসিস্ট, প্রাইভেটপ্রভাইডার, অন্যান্যCTC সেবাদানকারী, সরকারীস্বাস্থ্যকর্মীদেরকাছথেকেকোনোসাহায্যপানকি?)

২৪.Clients দেরসাথেআপনারসম্পর্ককেমন? এইসম্পর্ককিকোনোভাবেআপনারকাজেপ্রভাবফেলে?

Motivation (Incentives/remuneration etc)

২৫. আপনারকাজেরকোনদিকগুলোভাললাগেএবংকোনদিকগুলোখারাপলাগে? কেন?

২৬. কোনবিষয়গুলোআপনারকর্মক্ষেত্রেরসন্তুষ্টিতেপ্রভাবরাখে?এইকাজকরতেকোনবিষয়গুলোউৎসাহযোগায়?কিভাবে ?

২৭. এইকাজেরকোনবিষয়গুলোআপনারমাঝেসন্তুষ্টিঅথবাঅসন্তুষ্টিরজন্মদেয়?

২৮. এইকাজেযুক্ত (MR) অন্যান্যসেবাপ্রদানকারীরাকোনকোনবিষয়গুলোরকারণেকাজকরতেভালবোধকরে?

২৯. এইকাজেযুক্ত (MR) অন্যান্যসেবাপ্রদানকারীরাকোনকোনবিষয়গুলোরকারণেকাজকরতেভালবোধকরেননা?

(Probe: কাজেরচাপ, কাজেরপরিবেশ, যোগাযোগ, MR করতেব্যবহৃতক্লিনিক্যালযন্ত্রপাতিওপরিবহন, নিরাপত্তাওsexual harrasement, career perspective, তদারকি, community, client, সহকর্মী,

পরিবারেরচাপ, সামাজিকচাপ (একাধিকবাআনেকবারহাঁটাএবংবাড়িতেযাওয়া), দীর্ঘসময়কাজেথাকা, কাজেরবাচাকুরিরবাঁধা (stigma), ভালআয়করা, লিঙ্গীয়ক্ষমতায়ন, নারীরাMR সেবাকেকিভাবেদেখেপ্রভৃতি)

৩০. আপনারযেকাজকরারকথাতারচেয়েওকিবাড়তিকাজকরতেহয়? হলেকিকিবাড়তিকাজকরতেহয়?

(**Probe**ঃএইবাড়তিকাজকিতারJob Description এরবাইরেকিনাএবংএরজন্যসেকোনোবাড়তিসুবিধাপায়।)

৩১. আপনারকাজেরপরিবেশকেমন?

(**Probe:**কাজেরপরিবেশকিধরনের, দূরত্বকতটুকু, কাজেরধরণকিধরনেরইত্যাদি)

৩২. এইকাজেরমাধ্যমেআপনিকীঅবদানরাখতেপারেন?এইকাজেরবিনিময়েআপনিকিপেয়েথাকেন (সহায়তাবাincentives)

(**Probe:** সামাজিকমর্যাদা, বাসস্থান, অর্থনৈতিকভাবেলাভবান ,অন্যান্যপুরস্কার, কাজেরবাচাকরিরবাঁধাবাstigma, অর্থনৈতিকক্ষমতায়ন, ধর্মীয়বিধিনিষেধ)

৩৩. আপনিকিচানযেআপনারপরিবারেরসদস্যবাআত্মীয়স্বজনএইপেশায়আসুক? যদিচানতবেকেন/ যদিনাচানতবেকেননয়?

(**Probe:**ভাই-বোন, ছেলে-মেয়েইত্যাদি)

৩৪. আপনারসহকর্মীদেরসাথেআপনারসম্পর্ককেমন?

(**Probe**ঃভালোদিকগুলোকিকি/ খারাপদিকগুলোকিকি)

Supervision/ Control at work:

৩৫. আপনারকাজেরজন্যকিকারোকাছেরিপোর্টবাজবাবদিহিতাকরতেহয়? কিভাবেকরতেহয়? এইপ্রক্রিয়ায়কোনবিষয়গুলোভালোলাগেএবংকোনদিকগুলোআপনারভালোলাগেনা? কেন?

৩৬. কতদিনপরপরজবাবদিহিতা(Supervision) করতেহয়? সর্বশেষকবেজবাবদিহিতাকরতেহয়েছিল? তখনকিহয়েছিল?

৩৭. কাজেরক্ষেত্রেআপনারকিরকমস্বাধীনতাআছে?

৩৮. আপনারকাজেরবিষয়েযদিকোনোমতামতবাপরামর্শথাকেসেটাআপনিঅফিসেবলতেপারেনকি? যদিপারেন, তবেসেইবিষয়সম্পর্কেঅফিসকতটুকুগুরুত্বদেয়? নির্দিষ্টকরেকোনঘটনাউদাহরণদিয়েবলতেপারবেনকি? যদিনাপারেন, তবেএইভাবেকাজকরতেআপনারকেমনলাগেবিস্তারিতবলবেনকি?

(Probe: সিদ্ধান্তগ্রহণেপ্রভাব, ক্ষমতাহীনমনেহওয়া, ঔষধেরঅভাব।)

৩৯. আপনারকাজেরMonitoring হয়কি? হলেতাকিভাবে?বিস্তারিতবলুন?

(**Probe:**বিশেষভাবেMR প্রোগ্রামেMonitoring টাকিভাবেহয়?কোনো format maintain করাহয়কি? কিকিতথ্য format এরমাধ্যমেসংগ্রহকরাহয়?)

৪০. আপনিকিআপনারকাজেরফলাফলেরউপরকোনফিডব্যাকপান? যদিপান, তাহলেকিভাবেএবংকাদেরমাধ্যমেপান? আপনারকাজেরদক্ষতাবাড়ানোরজন্যকোনপরামর্শকিআপনিপান? যদিহ্যাঁহয়, তাহলেকিভাবেওকারকাছথেকেপান? উদাহরণদিন?

General wellbeing and home-work interface:

৪১. আপনিযেকাজকরেনতাআপনারপারিবারিকজীবনেকিকোনোপ্রভাবফেলে?

(**Probe**ঃযেমন- ভালোথাকা, স্বামী-স্ত্রীরসাথেসম্পর্ক, সন্তানেরসময়দেওয়া, কোনোঅবসরসময়পানকিনাইত্যাদি?)

Quality of care:

৪২. সাধারণস্বাস্থ্যসেবাপ্রদানকারীদেরসেবারমানকেমনবলেআপনিমনেকরেন?

৪৩.

এইএলাকায়অন্যকোনসেবারকিদরকারআছেযাআপনিদিতেপারছেননা?কারাএইসেবাগুলোদিতেপারছেবলেআপনিম
নেকরেন? এলাকায়তাদেরভূমিকাকেমনবলেআপনিমনেকরেন? (ভাল,খারাপ) বিস্তারিতবলুন?

৪৬. আপনিযেMR করানতারমানকেমনবলেআপনিমনেকরেন?

৪৭. আপনারকাছেমহিলারাযেধরনেরচিকিৎসাচায়তাকিআপনিদিতেপারেন? নাপারলেকেনদিতেপারছেননা?

৪৮. আপনারকাজেরমানকিভাবেমূল্যায়নকরাহয়? কারাকরে? এক্ষেত্রেআপনিকিকোনfeedback/ ফিডব্যাকপান?
এইএলাকারমানুষআপনারসেবাসম্পর্কেকিভাবে, তাআপনিকিভাবেজানতেপারেন?
তারাসেবারকোনবিষয়গুলোবেশিপছন্দকরে? সেবানিয়েতারাকিকোনঅভিযোগকরে?

৪৯. আপনারজানামতেএমনকেউকিআছেযিনিMR করাতেচেয়েছেনকিন্তুবাধার (পারিবারিক, সামাজিক)
কারনেপারেনি?

Communication and Interaction with colleagues:

৫০.আপনিছাড়াঅন্যকেউকিআছেযারাএইএলাকায়সেবাদেয়?যদিথাকে, তাদেরসাথেআপনারসম্পর্ককেমন?
যদিভালহয়, তাহলেকেমনভালএবংযদিভালনাহয়, তাহলেকেনভালনয়?

৫১. আপনারসহকর্মীদের (supervisor, in charge, volunteer,
TBA)সাথেযোগাযোগএবংসম্পর্ককিভাবেআপনারকাজেরসন্তুষ্টিওঅনুপ্রেরণাতৈরিতেপ্রভাবরাখে?

(Probe: যোগাযোগেরমাধ্যমে, মিটিংএরমাধ্যমে, ইনফরমালcontacts, প্রায়ইকিএধরণেরযোগাযোগহয়,
কিকিবিষয়েযোগাযোগহয়, এইযোগাযোগসম্পর্কেআপনারঅনুভুতিকেমন)

Referral

৫২. আপনারকাছেMR সমস্যানিয়েআসাকাউকেকিআপনিকখনওrefer করেছেন? কোথায়করেছেন? হ্যাঁহলে,
পুরোপ্রক্রিয়াটাএকটুবলবেন? উদাহরণহিসেবে২-১টাঘটনাআমাদেরকেএকটুবলেন।

(**Probe**ঃকোনোস্লিপদেওয়াহয়কিনা, কেনদেন, কিভাবেদেনইত্যাদি)

৫৩. যখনএকজনclient এরসমস্যারসমাধানকরতেপারেননাতখনকিকিকরেন?
তাদেরকেকিকোথাওপাঠানোবাrefer করাহয়? যদিপাঠানোহয়, তাহলেকেন? উদাহরণহিসেবে২-
১টাঘটনাআমাদেরকেএকটুবলেন?যারকাছেবাযাদেরকাছেপাঠানতাদেরসাথেকিআপনিpartnershipএকাজকরেন?
উদাহরণদিন?

৫৪. আপনিকিআপনারপ্রতিষ্ঠানেরবাইরেঅন্যকোনোপ্রতিষ্ঠানেrefer করেছেন? করলে,
কোনকোনক্ষেত্রেআপনিবাইরেreferকরেথাকেন? কখনকরেন? কীভাবেকরেন?

(**Probe**ঃযদিরোগীরঅবস্থাখারাপহয়তখনকিকিকরেন, বাnormal case একিকরেন?)

৫৫.	Referral এরক্ষেত্রেকোনকোনবিষয়গুলোভালভাবেকাজকরেএবংকোনগুলোভালভাবেকাজকরেনা? যদিভালহয়তাহলেতাহলেকিভাবেহয়এবংযদিভালনাহয়তাহলেকেনহয়না? দুইএকটাঘটনাবলবেনকি?

৫৬. আপনিরোগীকেrefer করারপরেতারকোনোখোঁজথবরনেনেনকি?

Mobile Health:

৫৭.	আপনিকিমোবাইলেরমাধ্যমেকোনোধরনেরসেবাদিয়েথাকেন? দিয়েথাকলেকিভাবে? বিস্তারিতবলুন। (**Probe**ঃকতক্ষনদেন, কোনসময়টায়দেন, এবংএরজন্যকিসেবাগ্রহণকারীদেরবাড়িতিথরচকরতেহয়?)

(**Probe:** তথ্যসংগ্রহ, তথ্যদেয়া, সহযোগিতাকরতে, অন্যরকাছথেকেপরামর্শনিতে, **client** এরসাথেযোগাযোগকরতে)

৫৮. আপনাকেএইফোনটাকেদিয়েছিলো? এটারখরচকেবহনকরে? এইফোনব্যাবহারকরতেআপনারকেমনলাগে? এরসুবিধা-অসুবিধাগুলোকি?

Barriers and Difficulties:

৫৯. কাজকরতেযেয়েআপনিকোনোবাঁধারসম্মুথিনহনকি? হলেকিধরনের?

(**Probe:**পারিবারিকচাপযেমন- আত্মীয়-স্বজনদেরকাছথেকে, কাজেরধরণএরকারণে, কমআয়এরকারণে,সামাজিকবাধা, স্থানীয়মানুষদেরসাথেমানিয়েনেয়া, স্থানীয়মানুষওclient দেরসাথেভুলবোঝাবুঝিরাজনৈতিকপ্রভাব,কর্মক্ষেত্রেনিরাপত্তা, sexual harassment ইত্যাদি।)

৬০.	আপনারকাছেএসেবারকোনদিকগুলোঅনেকসময়বাসবসময়ইভাললাগেনি? উদাহরণদিন।কোনকোনবিষয়গুলোএসেবাভালোনাহওয়ারজন্যদায়ীবলেআপনিমনেকরেন? উদাহরণদিন।

Suggestions & Recommendations:

৬১. কিভাবেএইকাজকেআরওভালোকরাযায়? আপনারপরামর্শকি? উদাহরণদিয়েব্যাখ্যাকরুন।

৬২.	আমরাযদিঅন্যএলাকায়এইMR চিকিৎসাদিতেচাইতাহলেএরমানআরোভালকরারজন্যআমাদেরকিকিকরাউচিত? আরকোনবিষয়গুলোএড়িয়েচলাউচিত ?

Topic guide SSI health managers/Doctor, Nurse, Program Officer, Program Manager.

Take individual consent (INFORMED CONSENT)

ব্যক্তিগতসম্মতিগ্রহণকরুন, কাভারসিটপূরণকরুন।

Data Recording Sheet: SSI health managers/Doctor Nurse

তারিখঃ	কোড(ID):
সাক্ষাৎকারগ্রহনেরসময়ঃ	
সাক্ষাৎকারশেষকরারসময়ঃ	
সাক্ষাৎগ্রহনেরজন্যকতবারযেতেহয়েছিল?	
সাক্ষাৎকারগ্রহণকারীঃ	
Note taker:	
প্রতিষ্ঠানেরনাম/ ঠিকানাঃ	
ওয়ার্ডএরনামঃ	
থানারনামঃ	
জেলারনামঃ	

সাধারনতথ্যঃ

১.নাম:				
২.লিঙ্গ:	পুরুষ		মহিলা	
৩. বয়স (বছরে):				
8. বৈবাহিকঅবস্থাঃ	বিবাহিত		অবিবাহিত	
	বিপত্নীক		বিধবা	

	তালাকপ্রাপ্ত	☐	অন্যান্য............................	☐	
৫.শিক্ষা:	নেই	☐	প্রাইমারী-অসম্পূর্ণ	☐	
	প্রাইমারী-সম্পূর্ণ	☐	মাধ্যমিক-অসম্পূর্ণ	☐	
	মাধ্যমিক-সম্পূর্ণ	☐	উচ্চমাধ্যমিক +	☐	
	মাদ্রাসাশিক্ষা	☐	অন্যান্য.........................	☐	
৬.ধর্ম:	ইসলাম	☐	হিন্দু	☐	
	খ্রিষ্টান	☐	বৌদ্ধ	☐	
	অন্যান্য..............	☐			
৭. জাতিগোষ্ঠী:	বাঙ্গালী	☐	অন্যান্য.........................	☐	

Introduction

৮. আপনিএখানেকতবছরধরেকাজকরছেন? এরআগেকোথায়কাজকরতেন? ওইখানেআপনিকিকিকাজকরতেন?

৯.আপনিকিআপনারএখনকারকাজসম্পর্কেএকটুবলবেন?প্রতিদিনকিআপনাকেএকইধরণেরকাজকরতেহয়?

১০. আপনারএখানেযারামাঠপর্যায়েকাজকরছেতারাকিকিনিয়েকাজকরে?

(Probe: পুরোকাজেরপ্রক্রিয়াজানতেহবে।)

১১.আপনারএখানেকোনধরনেররোগীরাবেশিআসে?আপনারাতাদেরকিধরনেরচিকিৎসাদিয়েথাকেন?

(গাইডলাইনেরপরবর্তীঅংশেMRএরসমার্থকশব্দহিসেবেউত্তরদাতারMRবিষয়কব্যবহৃতশব্দব্যবহার করাহবে।লক্ষ্যণীয়বিষয়হলোকোনোভাবেইযেনInterviewer MRশব্দটাআগেব্যবহারনাকরেন।)

১২.আপনিMR

এরসাথেকিভাবেযুক্তহলেন?আপনিকিএরআগেওএইরকমকাজকরতেন?যদিকরেনতাহলেসেসম্পর্কেকিছুবলুন?

The following are specific issues to be explored, if not already addressed (ডাক্তারএবংনার্সদেরজন্যপ্রযোজ্যনয়)

১৩.আপনাদেরMRএরনীতিমালাওকার্যপদ্ধতিসম্পর্কেকিআমাদেরবলবেন?

(**Probe:**আপনাদেরকিলিখিতনীতিমালাআছে? থাকলেতাকতটুকুঅনুসরণকরাহয়?)

১৪.নীতিমালারকোনকোনবিষয়গুলোআপনারকাছেগুরুত্বপূর্ণমনেহয়?

১৫.আপনারমতেMRএরনীতিমালাকিযথাযথ?   যদিনাহয়,
তবেকিধরনেরপরিবর্তনআনারদরকারবলেআপনিমনেকরেন?

Recruitment and staff retain policy

(**ডাক্তারএবংনার্সদেরজন্যপ্রযোজ্যনয়**)

১৬.আপনারাকিভাবেMR কর্মী(CTC Provider) নিয়োগদিয়েথাকেন?

[**Probe:**বাছাইপ্রক্রিয়া (শিক্ষা, বয়স, ধর্ম, অভিজ্ঞতা, লিঙ্গ, এলাকাভিত্তিক)]

১৭.তাদেরবেতন-ভাতাএবংঅন্যান্যসুযোগসুবিধাকেমন? আপনিকিএইগুলোকেযথেষ্টবলেমনেকরেন?

[**Probe:**প্রমোশন, ইনসেন্টিভ(Incentive), বেতনবৃদ্ধি, উৎসবভাতা, যাতায়াতখরচ, চিকিৎসা-এইসুবিধাগুলোযথেষ্টকিনা? কর্মীদেরজন্যআপনারাআরকিছুকরেনকি?]

১৮.যারাভালোকাজকরেতাদেরধরেরাখারজন্যআপনারাকিছুকরেনকি?

১৯.MR কর্মীকিমনেকরেনযেএইগুলোযথেষ্ট?

২০.যদিতারাএটাযথেষ্টমনেনাকরেতবেতাদেরকাজেরউপরতাকিরকমপ্রভাবফেলে?

২১.যদিপ্রভাবফেলেতাহলেআপনিকিধরণেরপদক্ষেপনেন?

(**Probe:**সতর্ককরা, কাউনসেলিং, ছাঁটাইপ্রভৃতি)

২২.MR কর্মীদেরমতামতবাপরামর্শকেআপনিকিভাবেমূল্যায়নকরেন? উদাহরণদিয়েবলুন।

Clients community

২৩. আপনারাকাদেরকেসেবাদেন? সবাইকেকিকিসেবাদিতেপারেন?

[**Probe:**কিশোর-কিশোরী, দরিদ্রমানুষ, বুদ্ধিবাশারীরিকপ্রতিবন্ধী, অবিবাহিত (একামেসেথাকামেয়ে, পরিবারথেকেদূরেবাএকাথাকে)]

২৪.প্রান্তিক/সুবিধাবঞ্চিত(অতিদরিদ্র/HIV/AIDS, TB, SEX Worker, Drug Addicted) মানুষজনসেবাপায়কি?

২৫.তাদেরকেসেবাদেওয়ারঅভিজ্ঞতাকেমন?

(**Probe:**জটিলতারসম্মুখীনহয়েছিলেনকিনা? সামাজিকপ্রতিবন্ধকতাআছেকি?)

Quality of care

২৬.মানসম্মতMR চিকিৎসাবলতেকিবোঝায়?

২৭.আপনাদেরক্লিনিকেMR চিকিৎসাকিভাবেদেওয়াহয়?

২৮. এখানেযারাIMR করতেআসেনতাদেরগোপনীয়তারবিষয়টাকিভাবেরক্ষাকরাহয়?

(**Probe:**কিকিতথ্যরাখাহয়? কিভাবেরাখাহয়? অন্যব্যক্তিবাপ্রতিষ্ঠানএরসাথেশেয়ারকরাহয়কিনা?)

২৯.যারাMR সেবানিতেআসেতাদেরজন্যকোনকাউন্সেলিংএরব্যাবস্থাআছেকি?যদিথাকেতবেকিভাবেকরাহয়?

[**Probe:**কাউন্সেলিং, MRচিকিৎসাএরআগেওপরে, MRসেবাগ্রহনেরপরতাদেরকোনতথ্যবাInformation দিয়েসহায়তাকরাহয়কিনা?   কোনআইনিসহায়তাদেওয়াহয়কিনা?   MR

সেবানিতেআসাব্যক্তিরসাথেইকিকাউন্সেলিংহয়নাকিযিনিবাযারাতারসাথেআসেনতারসাথেইহয়।মানসিকসহায়তা(Mental Support), ফলোআপ(Follow Up) কিভাবেকরাহয়।]

৩০.যারাMR সেবানিয়েছেনতাদেরফলোআপ(Follow Up) ব্যবস্থাআছেকিনা?

৩১.আপনারজানামতেএইএলাকায়অন্যকোনসেবারকিদরকারআছেযাআপনারাদিতেপারছেননা?কারাএইসেবাগুলোদিতেপারছেবলেআপনিমনেকরেন?

৩২.এইএলাকায়বাcommunityতেতাদেরভূমিকাকেমনবলেআপনিমনেকরেন?সন্তোষজনকনাকিবেশিসন্তোষজনকনয়, বিস্তারিতবলুন?

৩৩.স্বাস্থ্যসেবারএবংসেবাপ্রদানকারীদেরসেবারমানসম্পর্কেএলাকারলোকজনকিভাবেছেতাআপনিকিভাবেজানতেপারেন?

৩৪.যেসেবাসমূহদেয়াহচ্ছেসেইসম্পর্কেএলাকারলোকজনবাসেবাগ্রহীতারাকিভাবেছেতাআপনিকিভাবেজানতেপারেন ? এইক্ষেত্রেতারাকোনবিষয়টাবেশিপছন্দকরে? এবংকোনবিষয়গুলোসম্পর্কেতারাঅভিযোগকরে?

Referral

৩৫.আপনাদেরএখানেকখনএবংকিভাবেমহিলারাMRকরাতেআসে? আপনাদেররেফারেলব্যবস্থা(Referral System)সম্পর্কেকিছুবলুন।

৩৬.এখানেMR সেবাগ্রহণকারীব্যক্তিকিভাবেআসে? [**probe**: Adolescent, Rape caseএরাকিএখানেMR করাতেকিআসে?]

৩৭.রেফারেলএরজন্যসেবাগ্রহীতা(Clients) দেরকাছথেকেকোনোধরনেরফি(fee) নেওয়াহয়কি? (**probe:**কতটাকানেয়াহয়?)

৩৮. রেফারকরারজন্যরেফারকারীকর্মীকেকোনধরনেরইনসেন্টিভ(incentive) দেয়াহয়কি? যদিদেয়াহয়েথাকে,তবেপ্রক্রিয়াটাএকটুবিস্তারিতবলবেনকি? [**Probe:**ইনসেন্টিভ(incentive)দেওয়াহলেইনসেন্টিভের(incentive)ধরনকি?]

৩৯.যখনএকজনClient এরকোনসমস্যাআপনারাসমাধানকরতেপারেননাতখনআপনারাকিকরেন? তাদেরকিতখনঅন্যকোথাওপাঠিয়েদেন?উদাহরণদিন।

৪০.আপনিকিআপনারপ্রতিষ্ঠানছাড়াঅন্যকোনপ্রতিষ্ঠানেবাসংস্থায়কখনওরেফারকরেছেন?যদিকরেথাকেনতবেকোনধরনেরকেসবাঅসুস্থতারকারনেতাদেরআপনিবাইরেরেফারকরেন?কখনএইরেফারকরেছিলেন? কিভাবেএইরেফারকরেছিলেন?

এইধরনেরসেবাদিচ্ছেএইরকমঅন্যকোনপ্রতিষ্ঠানেরসাথেবাসেবাপ্রদানকারীদেরসাথেআপনারকোনোধরনেরপার্টনারশিপবারেফারেলেরসম্পর্কআছেকি?

(**probe:** একজনরোগীরইমারজেন্সীঅবস্থায়আপনারাকিকরেন? নরমালকেসেরক্ষেত্রেকিকরেন?)

৪১.এখানেরেফারেলব্যবস্থা(Referral System)এরমাধ্যমেসেবাদেওয়ারক্ষেত্রেআপনারাকিকিঅসুবিধাবাকঠিনপরিস্থিতিরসম্মুখীনহন?যদিহন, আপনারঅভিজ্ঞতারআলোকেবিস্তারিতবলুন।

৪২.রেফারেলব্যবস্থা(Referral System) নিয়েআপনারকোনোপরামর্শআছেকি?

(**Probe:**ভাল-খারাপ, কেনপরিবর্তনচায়, কেনচায়না?)

Motivation (Incentives/Remuneration) of CTC provider (only relevant)

৪৩. তাদেরকাজেরকোনদিকগুলোভাললাগেএবংকোনদিকগুলোখারাপলাগে? কেন?

৪৪.আপনারজানামতেকোনবিষয়গুলোতাদেরকর্মক্ষেত্রেরসন্তুষ্টিতেপ্রভাবরাখে?এছাড়াএইকাজকরতেকোনকোনবিষয়গুলোতাদেরউৎসাহযোগায়? কিভাবে?

৪৫.এইকাজেরকোনবিষয়গুলোতাদেরমাঝেসন্তুষ্টিঅথবাঅসন্তুষ্টিরজন্মদেয়বলেআপনিমনেকরেন?

৪৬.এইধরনেরকাজেযুক্ত   (MR)

অন্যান্যসেবাপ্রদানকারীরাকোনকোনবিষয়গুলোরকারণেকাজকরতেভালবোধকরে?

৪৭.এইধরনেরকাজেযুক্ত   (MR)

অন্যান্যসেবাপ্রদানকারীরাকোনকোনবিষয়গুলোরকারণেকাজকরতেভালবোধকরেননা?

(**Probe:**   কাজেরচাপ, কাজেরপরিবেশ, যোগাযোগ, MRকরাতেব্যাবহৃতক্লিনিক্যালযন্ত্রপাতিওপরিবহন, নিরাপত্তাও**sexual harrasement, career perspective,** তদারকিবা**supervision, community, client,** সহকর্মী, পরিবারেরচাপ, সামাজিকচাপ (একাধিকবাআনেকবারহাঁটাএবংবাড়িতেযাওয়া), দীর্ঘসময়কাজেথাকা, কাজেরবাচাকুরিরবাঁধা (**stigma**), ভালআয়করা, লিঙ্গীয়ক্ষমতায়ন, নারীরাMRসেবাকেকিভাবেদেখেপ্রভৃতি।

৪৮.   তাদেরযেকাজকরারকথাতারচেয়েওকিতাদেরবাড়তিকাজকরতেহয়?   যদিহয়েথাকে, তবেতাদেরকিকিবাড়তিকাজকরতেহয়?

(**Probe :**এইবাড়তিকাজকিতাদেরJob Description এরবাইরে? এবংএরজন্যসেকোনোবাড়তিসুবিধাপায়কি?)

৪৯. আপনারকাজেরপরিবেশকেমন?

(**Probe:**কাজেরপরিবেশকিধরনের, দূরত্বকতটুকু, কাজেরধরণকিধরনেরইত্যাদি)

৫০.এইকাজ CTC Provider দেরকাজেকোনধরনেরঅবদানবাপ্রভাবিকিরাখে?

৫১.কিধরণেরসাপোর্টবাincentivesগ্রহণকরেন?

(**Probe:**   সামাজিকমর্যাদা,   বাসস্থান,   অর্থনৈতিকভাবেলাভবান   ,অন্যান্যপুরস্কার, কাজেরবাচাকরিরবাঁধাবাstigma, অর্থনৈতিকক্ষমতায়ন, ধর্মীয়বিধিনিষেধ।

Supervision/ Control at work:

৫২.CTC   Provider দেরকাজেরজন্যকিকারোকাছেরিপোর্টকরতেহয়?আপনিকিএইপ্রক্রিয়াটিসম্পর্কেআমাদেরবলতেপারবেন? এইপ্রক্রিয়ায়কোনবিষয়গুলোভালোলাগেএবংকোনদিকগুলোআপনারভালোলাগেনা? কেন?

৫৩.CTC Provider দেরকিপ্রায়ইসুপারভাইসডকরতেহয়? আপনিসর্বশেষকবে CTC Provider দেরএইধরনেরসুপারভিশনকরেছিলেন? তখনকিহয়েছিল?

৫৪.কাজেরক্ষেত্রেতাদেরকিরকমস্বাধীনতাআছেবলেআপনিমনেকরেন?

৫৫.যদিতাদেরকাজেরসাথেপ্রাসঙ্গিকবিষয়েযদিকোনোমতামতবাপরামর্শথাকেতবেসেটাকিতারাঅফিসেবলতেপারেনবাশেয়ারকরতেপারেন? যদিপারেন, তবেসেইবিষয়সম্পর্কেঅফিসকতটুকুগুরুত্বদেয়? নির্দিষ্টকরেকোনঘটনারউদাহরণদিয়েবলতেপারবেনকি?

৫৬.যদি CTC Provider রাতানাকরতেপারেন, তবেএইক্ষেত্রেতাদেরঅনুভূতিকেমনহয়বলেআপনিমনেকরেন? ভাবেকাজকরতেআপনারকেমনলাগেবিস্তারিতবলবেনকি? নির্দিষ্টকরেকোনঘটনারউদাহরণদিয়েবলতেপারবেনকি?

(Probe: সিদ্ধান্তগ্রহণেপ্রভাব, ক্ষমতাহীনমনেহওয়া, ঔষধেরঅভাব।)

M&E

(ডাক্তারএবংনার্সদেরজন্যপ্রযোজ্যনয়)

৫৭.আপনাদেরMR প্রোগ্রামটামনিটরকরারজন্যকোনব্যাবস্থাআছেকি? থাকলেকিভাবেকরাহয়? একটুবিস্তারিতবলুন।

(Probe:পুরোপ্রক্রিয়াজানতেহবে, কারামনিটরিংকরে, কেনকরেএবংকিভাবেকরে, মনিটরিংএরজন্যকিকিতথ্যসংগ্রহকরেন? মনিটরিংপরবর্তীসুপারিশগুলোবাস্তবায়িতহয়কিনা?)

৫৮.মনিটরিংব্যবস্থায়প্রাপ্ততথ্যগুলোকিকিকর্মীদেরসাথেশেয়ারকরাহয়?

Mobile Health:

৫৯.মোবাইলএরমাধ্যমেMR সম্পর্কিতকোনোধরনেরসেবাদেওয়াহয়কি? বিস্তারিতবলুন।

৬০.মোবাইলএরমাধ্যমেMR সম্পর্কিতস্বাস্থ্যসেবারবিষয়টিকেআপনারকতটাকার্যকরমনেহয়?

(Probe:সুবিধা-অসুবিধা)

শুধুমাত্রডাক্তারএবংনার্সদেরজন্যঃ

৬১.MRবিষয়েআপনারকোনোপ্রশিক্ষনআছেকি? যদিথাকেতবেকোথাথেকেনিয়েছিলেন? সেটাকতদিনেরট্রেনিংছিল?

৬২.ক্লিনিকেMRকরাতেআসলেডাক্তারনাথাকলেআপনারাকিকরেন? সেক্ষেত্রেকিআপনারাMRকরান? যদিনাকরানতাহলেকিকরেন? **(Probe**:অপেক্ষাকরতেবলা, পরেআসতেবলা, ঔষধদেয়া, বিশ্রামনিতেবলা।) [শুধুমাত্রনার্সদেরজন্য]

৬৩.MRপরবর্তীতেযদিকেউক্লিনিকেভর্তিথাকেসেক্ষেত্রেআপনারাতাদেরদেখাশুনাকিভাবেকরেন? **(Probe**:রক্তপরা, ব্যথা, জ্বর, পরামর্শ- ঔষধ, পরিষ্কারপরিচ্ছন্নতাইত্যাদি।)

Facilitators & Barriers

৬৪.এইএলাকায়MRCTC Provider প্রোগ্রামেরপ্রয়োজনীয়তাকতটুকুবলেআপনিমনেকরেন?এইক্ষেত্রেCTC Provider দেরকার্যকরীঅবদানকেমনবলেআপনিমনেকরেন? আপনিকিএইপ্রোগ্রামেরকোনধরনেরনেতিবাচকদিকলক্ষ্যকরেছেন?

৬৫.MRCTC Provider প্রোগ্রামেরকোনকোনদিকগুলোভালোভাবেচলছেবলেআপনিমনেকরছেন? উদাহরণদিন। এইক্ষেত্রেকোনকোনবিষয়গুলোসহায়তাকরছেবলেআপনিমনেকরেন?

(Probe: কোনউপায়ে, ঘটনাপ্রবাহ, ভালহওয়ারকারনগুলোকিকিইত্যাদি)

৬৬.MRCTC Provider প্রোগ্রামেরকোনোদিককিআপনারকাছেখারাপলেগেছে? উদাহরনদিন।এইক্ষেত্রেকোনবিষয়গুলোদায়ীবলেআপনিমনেকরেন? উদাহরণদিন।

(বিঃদ্রঃযদিউত্তরগুলোস্বতঃস্ফূর্তভাবেনাআসেসেইক্ষেত্রেযখনউদাহরণগুলোদেয়াহবেতখনজানতেচেষ্টা করবেনযে, এইক্ষেত্রেকোনদিকগুলোবাবিষয়গুলোকাজটিভালোবাখারাপহতেপ্রভাবরাখে?)

Suggestions & Recommendations:

৬৭. এইকাজকেআরওভালোকরারজন্যকিকিকরাযেতেপারেবলেআপনিমনেকরেন? এইক্ষেত্রেআপনারপরামর্শকি? উদাহরণদিয়েব্যাখ্যাকরুন।

৬৮. আমরাযদিঅন্যএলাকায়এইMR চিকিৎসাদিতেচাইতাহলেএরমানআরোভালকরারজন্যআমাদেরকিকিকরাউচিতবলেআপনিমনেকরেন? আরকোনবিষয়গুলোএড়িয়েচলাউচিতবলেআপনিমনেকরেন?

MR Clients (IDI)

Take individual consent (INFORMED CONSENT)

ব্যক্তিগতসম্মতিগ্রহণকরুন, কাভারসিটপূরণকরুন।

Data Recording Sheet: Community Clients (IDI)

তারিখঃ	কোড(ID):
সাক্ষাৎকারগ্রহনেরসময়ঃ	
সাক্ষাৎকারশেষকরারসময়ঃ	
সাক্ষাৎগ্রহনেরজন্যকতবারযেতেহয়েছিল?	
সাক্ষাৎকারগ্রহণকারীঃ	
Note taker:	
বস্তিরনাম/ ঠিকানাঃ	
ওয়ার্ডেরনামঃ	
থানারনামঃ	
জেলারনামঃ	
বস্তিরধরনঃসরক ☐ সরকারিব্যক্তিমালিকানা। ☐ ☐	

সাধারনতথ্যঃ

১.নাম:				
২.লিঙ্গ:	পুরুষ	☐	মহিলা	☐
৩. বয়স (বছরে):				
8. বৈবাহিকঅবস্থাঃ	বিবাহিত	☐	অবিবাহিত	☐
	বিপত্নীক	☐	বিধবা	☐

	তালাকপ্রাপ্ত	☐	অন্যান্য.............................	☐
৫. ছেলেমেয়েরসংখ্যাঃ				
৬.শিক্ষা:	নেই	☐	প্রাইমারী-অসম্পূর্ণ	☐
	প্রাইমারী-সম্পূর্ণ	☐	মাধ্যমিক-অসম্পূর্ণ	☐
	মাধ্যমিক-সম্পূর্ণ	☐	উচ্চমাধ্যমিক +	☐
	মাদ্রাসাশিক্ষা	☐	অন্যান্য.........................	☐
৭. পেশাঃ				
৮. আয়ঃ				
৯.ধর্ম:	ইসলাম	☐	হিন্দু	☐
	খ্রিষ্টান	☐	বৌদ্ধ	☐
	অন্যান্য..............	☐		
১০. জাতিগোষ্ঠী:	বাঙ্গালী	☐	অন্যান্য........................	☐

Introduction

১১.এএলাকায়মহিলাদেরসাধারনতকোনধরনেরঅসুখবেশিহয়?

বিবাহিতমহিলাদেরকোনধরনেরশারিরিকসমস্যাহয়?

১২.আপনাদেরএএলাকায়গর্ভকালীনসময়ে(প্রজননস্বাস্থ্য)কিধরনেরস্বাস্থ্যসেবারব্যবস্থাআছে?

এইসেবাগুলোকারাদেয়?   এইসেবাটাআপনাদেরপ্রয়োজনমতোপানকি?

এইসেবায়আরকিকিযোগকরাপ্রয়োজনবলেআপনিমনেকরেন?

১৩.আপনিকিকোনোপরিবারপরিকল্পনাপদ্ধতিব্যবহারকরেন?   যদিহ্যাঁহয়,

তবেকেএইসিদ্ধান্তনেয়?গর্ভধারণেরপরেবাপেটেবাচ্চাআসলেমহিলারাপরামর্শবাচিকিৎসারজন্যকোথায়যায়?

১৪.অনেকসময়দেখাযায়মহিলাদেরগর্ভেবাচ্চাআসেকিন্তুতারানানাপরিস্থিতিরকারনে   (যেমন-সাংসারিকবাঅর্থনৈতিককারনে)   তাদেরবাচ্চারাখাসম্ভবহয়না।আপনাদেরএইএলাকায়(community)তখনতারাকিকরে? সেক্ষেত্রেতারাকোথায়যায়? ওইখানেতারাকেনযায়? এগুলাআপনিকারকাছথেকেজানলেন?কেএইসিদ্ধান্তনেয়?

১৫.আপনারএইপর্যন্তকতবারগর্ভধারণহয়েছে? (বিবাহিতদেরজন্যপ্রযোজ্য)

১৬.এমনকিকোনঅবস্থাবাপরিস্থিতিহয়েছিলযে,   আপনারা   (স্বামী-   স্ত্রী)চাননিকিন্তুআপনারপেটেবাচ্চাচলেআসছিল।তখনআপনারাকিকরেছিলেন?

১৭.   যদিবাচ্চারেখেথাকেতবেএইপ্রশ্নটিপ্রযোজ্য,আচ্ছাএমনকিকখনোহয়েছিলযেআপনিগর্ভধারণকরেছেনকিন্তুআপনারাসিদ্ধান্তনিলেনযে,বাচ্চানিবেননা?কেনএইসিদ্ধান্তনিয়েছিলেন?তখনকিকরেছিলেন?

(Probe:কেউকিআপনাকেবাচ্চানারাখারকোনোপদ্ধতিসম্পর্কেবলেছিল? যদিবলে, তবেকিবলেছিল?)

১৮. এইসিদ্ধান্তনেয়ারসময়আপনারস্বামীরসাথেকোনপরামর্শকরেছিলেন?আপনারকি**(মতামত)** ইচ্ছাছিল?

(Probe:স্বামীরসাথেকোনঝগড়াবাঝামেলাহয়েছিল?)

১৯.এইসিদ্ধান্তনেবারসময়আপনারপরিবারেরঅন্যান্যদেরভূমিকাকেমনছিল?আপনারপরিবারেরঅন্যান্যসদস্যরাএইবিষয়েআপনাকেকিকিছুবলেছিল?

(Probe: পরিবারেরকারোসাথেঝামেলাহয়েছিলকি?)

২০.এইপরিস্থিতিতেআপনিকিপরামর্শেরজন্যকারোকাছেগিয়েছিলেন? যদিগিয়েথাকেতবেকারকাছে?

২১.আপনারএইবাচ্চানারাখারসিদ্ধান্তটা**পেটেবাচ্চাআসারকতদিন/সপ্তাহ**পরনিয়েছিলেন।তখনকিআপনারকোনোধরনেরশারিরিকবামানসিকসমস্যাহয়েছিল?

(গাইডলাইনেরপরবর্তীঅংশেMRএরসমার্থকশব্দহিসেবেউত্তরদাতারMRবিষয়কব্যবহৃতশব্দব্যবহারকরাহবে।লক্ষ্যণীয়বিষয়হলোকোনোভাবেইযেনInterviewer MRশব্দটাআগেব্যবহারনাকরেন।)

২২.আপনিMRকরাতেকোথায়গিয়েছিলেন?আপনিওখানেকেনগিয়েছিলেন? কেআপনাকেওখানকারকথাবলেছিল?

২৩.   আপনিযেদিনMRকরাতেগেলেনসেদিনেরকথাতোআপনারমনেআছে,তাইনা?সেদিনেরঅভিজ্ঞতারকথাকিআমাদেরকেএকটুবলবেন?

(Probe: সেদিনআপনারমনেরঅবস্থাকেমনছিল? আপনারসাথেকেগিয়েছিল?)

২৪.আপনিযেক্লিনিকেMRকরিয়েছেনওখানকারনার্স,আয়াবাডাক্তাররাআপনারসাথেকেমনব্যবহারকরেছিল?আপনারMRকরানোনিয়েতারাকিকোনকিছুবলেছিল?বলেথাকলেকিবলেছিল?

২৫.   আপনাকেযখনওটি   (OT)তেনেয়াহয়েছিলতখনআপনারকেমনলাগছিল?সেইসময়েরআপনারঅভিজ্ঞতাএকটুবলবেনকি?

[**Probe:**ভয়লাগছিলো, আপনিকিঘাবড়িয়ে (Nurves) গিয়েছিলেন?]

২৬.MRকরানোনিয়েকোনসমস্যাহয়েছিল?   সমস্যাহলেতাকাটিয়েউঠতেকতসময়লেগেছিল?এক্ষেত্রেডাক্তারবাপরিবারেরসদস্যরাকিসাহায্যকরেছিল?

(Probe: MRএরপরেকিআপনারকোনধরনেরশারীরিকএবংমানসিকসমস্যাহয়েছিল, বিস্তারিতজানুন।)

২৭.

MRকরারপরআপনাকেকিভাবেচলাফেরাকরতেহবেসেবিষয়েক্লিনিকথেকেকিছুকিবলাহয়েছিল?হলেকিবলেছিল?

২৮.আপনিMRকরেকবেবাসায়আসলেন?   এসময়আপনারপরিবারেরসদস্য (স্বামীওঅন্যসদস্য)আপনারসাথেছিলকি?

২৯. MRকরারকতদিনপরস্বাভাবিকজীবনেফিরেআসলেন?এসময়আপনারপরিবারেরসদস্যরা (স্বামীওঅন্যসদস্য) আপনাকেকিভাবেসাহায্যকরেছিল?

৩০.   MRকরারপরেআপনিকিবিশেষকোনপরিবারপরিকল্পনাপদ্ধতিনিয়েছিলেন?কেন ?এইবিষয়েআপনিতথ্যওপরামর্শকারকাছেপেলেন?

Perceptions of Service Quality

৩১.MRকরাতেগিয়েক্লিনিকেবাহাসপাতালেআপনাকেকতক্ষণঅপেক্ষাকরতেহয়েছে?

(Probe:হাসপাতালেযাবারকতক্ষণপরে MR করাহয়েছে।)

৩২.আপনিকিমনেকরেনএইহাসপাতালেযেভাবে MRকরানোহয়েছিলতারমানসন্তোষজনককিছিল?

৩৩.আপনিযেMRপেয়েছেনতাতেকিআপনিসন্তুষ্ট?

[Probe:ব্যক্তিগতঅভিজ্ঞতা, ডাক্তার-নার্সেরদক্ষতাকেমনএবংতাকিবাড়ানোদরকার, ক্লিনিকেরপরিবেশ- (ওটি, পোশাক, বেড), MRএরপুরোসময়কালেডাক্তারনার্সদেরব্যবহার।]

৩৪.আপনিকিঅন্যমহিলাদেরএইহাসপাতালেMRকরাতেপরামর্শদিবেন? হ্যাঁহলেকেন/ নাহলেকেন?

৩৫.MRচিকিৎসারকোনদিকগুলোআরোভালোকরাদরকারবলেআপনিমনেকরেন?

৩৬.   আপনিযারকাছথেকেMR   করিয়েছিলেনঐকাজেতারদক্ষতাকেমনবলেআপনিমনেকরেন? এইক্ষেত্রেতারকাজেরকোনদিকগুলোভালএবংকোনদিকগুলোতেদক্ষতাকমবলেআপনিমনেকরেন?

৩৭. যারকাছথেকেMR করিয়েছেনতারসেবাসম্পর্কেআপনারঅনুভূতিকেমন?

[Probe:পর্যাপ্ততা (কতটুকুসময়দেয়বাসবসময়পাওয়াযায়কি), দূরত্ব (MR Clinicথেকেবাসস্থানেরদূরত্বকতটুকু?), কার্যকারিতা, সীমাবদ্ধতাইত্যাদি]

৩৮. সেবাপ্রদানকারীরাMR সেবাগ্রহীতাদেরসাথেকেমনআচরনকরেবলেআপনিমনেকরেন? উদাহরণদিন।

৩৯. তাদেরসেবাগুলোকিআপনারকাছেপ্রশংসনীয়বলেমনেহয়? উদাহরণদিন।

৪০.MR সেবাপ্রদানপ্রোগ্রামেরগুরুত্বসম্পর্কেআপনিকিমনেকরেন?এইক্ষেত্রেMRসেবাপ্রদানকারীদেরকার্যকরঅবদানগুলোকি কি? আপনিকিএইপ্রোগ্রামেরকোনোনেতিবাচকদিকলক্ষ্যকরেছেন?

৪১.MR   সেবাপ্রদানকারীদেরকোনদিকগুলোভালোবলেআপনিমনেকরেন? উদাহরণদিন।কোনবিষয়গুলোএইসেবাকেভালকরতেসাহায্যকরছে?

(Probe:কোনউপায়ে, ঘটনাপ্রবাহ, ভালহওয়ারকারনগুলোকিকিইত্যাদি)

৪২.   আপনারকাছেএসেবারকোনদিকগুলোঅনেকসময়বাসবসময়ইভাললাগেনি? উদাহরণদিন।কোনকোনবিষয়গুলোএসেবাভালোনাহওয়ারজন্যদায়ীবলেআপনিমনেকরেন? উদাহরণদিন।

(বিদ্রঃযদিউত্তরগুলোস্বতঃস্ফূর্তভাবেনাআসেসেইক্ষেত্রেযখনউদাহরণগুলোদেয়াহবেতখনজানতেচেষ্টাকরবেনযে, এইক্ষেত্রেকোনদিকগুলোবাবিষয়গুলোকাজটিভালোবাখারাপতেপ্রভাবরাখে?)

Barriers and Difficulties

৪৩. MRকরানোনিয়েআপনারপারিবারিককোনসমস্যাহয়েছিল?

(**Probe:**পারিবারিকদোষারোপ, ঝগড়া-ঝাটিইত্যাদি।)

৪৪. ধর্মীয়কারনে MRকরাতেকোনসমস্যাহয়েছিল?হলেতাকেমন?

৪৫.আপনিযে MRকরিয়েছেনসেটাকিআপনারপরিবারেরবাইরেকেউজানে? জানারপরতারাআপনাকেকিবলেছিল?

(**Probe:**প্রতিক্রিয়াকিছিল?)

৪৬. MRকরাতেআপনারকোনপ্রতিবেশীসাহায্যবাবাধাদিয়েছিল?তাকিভাবে?

৪৭. MRকরাতেটাকাযোগাড়করতেকোনসমস্যাহয়েছিলকি?হলেকিভাবেটাকাযোগাড়করলেন?

৪৮.আপনিকিক্লিনিকেMRকরাতেগিয়েউপরোল্লিখিতসমস্যাগুলোছাড়াঅন্যকোনসমস্যায়পরেছিলেন?

Costs

৪৯.আপনারMRকরাতেকতখরচহয়েছিল?

৫০.MRকরাতেআপনারকিঅতিরিক্তকোনখরচকরতেহয়েছে?   যদিহয়েথাকে, তবেএইখরচেরব্যবস্থাআপনিকিভাবেকরেছিলেন?

(**Probe:**ঔষধ, টেস্ট/পরীক্ষা- নিরীক্ষা, যানবাহনএবংReferral এরজন্যখরচসমূহইত্যাদি)।

Referrals

৫১.MRকরানোরকোনReferralব্যবস্থাআছেকি? আপনাকেকিঅন্যকোথাওপাঠানোহয়েছিল? হলেকোথায়?

৫২.কিভাবেMRকর্মীরাReferকরেথাকে?রেফারেরপ্রক্রিয়াকি?

(**Probe:**কেন, কিভাবে, বিভিন্নধরনেরRefer প্রক্রিয়াসমূহ, slip দেয়কিনা,অন্যান্য।)

Mobile health

৫৩.মোবাইলেরমাধ্যমেআপনিকিকখনওMRকর্মীদেরকাছথেকেMRবিষয়কপরামর্শবাচিকিৎসানিয়েছিলেন?

(**Probe:**আপনিকেনকরেছেন, মোবাইলব্যবহারকেকিভাবেদেখেন।)

৫৪.মোবাইলএরমাধ্যমেযদিচিকিৎসাবিষয়কপরামর্শদেয়াহয়তাহলেসেটাকেমনহবে?

FGD Community Client Checklist

১।আপনাদেরএইএলাকারমানুষজনেরসাধারণতকোনধরনেরঅসুখ-বিসুখহয়েথাকে/ দেখাযায়?

২।অসুখ-বিসুখহলেবেশিরভাগমানুষপ্রথমেকারকাছেচিকিৎসানেওয়ারজন্যযায়?   এরপরেকোথায়যায়? কারপরামর্শেযায়?

৩।এইএলাকায়চিকিৎসাবিষয়কপরামর্শদিতেকারাআসে?   তারাকোনপ্রতিষ্ঠানথেকেআসে? কিধরনেরসেবা/তথ্যদেয়?এজন্যকিআপনাদেরকোনটাকাদিতেহয়?

৪।স্বাস্থ্যসেবাপেতেগিয়েকখনওকোনসমস্যায়হয়?

৫।গর্ভকালীনসময়েমায়েদেরকিকিধরনেরসমস্যাহয়? সমস্যারহলেকোথায়যায়? এবংএক্ষেত্রেকিকারওপরামর্শনেয়াহয়?

৬।অনেকসময়েদেখাযায়মা'এরগর্ভেবাচ্চাআসেকিন্তুতারানানাপরিস্থিতিরকারনে (যেমন-সাংসারিকবাঅর্থনৈতিককারনে) তাদেরবাচ্চারাখাসম্ভবহয়না।তখনতারাকিকরে? সেক্ষেত্রেতারাকোথায়যায়? ওইখানেতারাকেনযায়? এগুলাআপনিকারকাছথেকেজানলেন?
(Probe:আর্থিক, সামাজিক, পারিবারিক, সাংসারিক)

৭।বাচ্চানারাখতেচাইলেসেইসিদ্ধান্তটাকেনেয়? এক্ষেত্রেপুরুষদেরকিধরনেরভূমিকা/ সিদ্ধান্তথাকে?

৮।সিদ্ধান্তনেওয়ারসময়কাদেরসাথেপরামর্শকরে?
(Probe:আর্থিক, সামাজিক, পারিবারিক, বন্ধু-বান্ধব, আত্মীয়স্বজন)

৯।বিভিন্নপ্রতিষ্ঠানথেকেআপনারাযেচিকিৎসানেনএইচিকিৎসাগুলোপেতেমহিলাদেরকোনধরনেরসমস্যারসম্মুখীনহতেহয়? কিকিকরলেএসমস্যাগুলোকাটিয়েউঠাযাবে?

১০।যারাসেবাদেয়তাদেরসেবাকিআপনারাসন্তোষজনকবলেমনেকরেন? যদিভালোমনেকরেনকারনগুলোব্যাখ্যাকরেন? যদিমনেকরেনসেবারমানভালোহচ্ছেনাএরকারনগুলোব্যাখ্যাকরেন?

১১।আপনাদেরচিকিৎসারজন্যকোথায়বাকোনচিকিৎসাকেন্দ্রেপাঠায়?
(probe: ক্লিনিক, ডায়াগনস্টিকসেন্টার)
যদিযানতাহলেআপনাকেকোনখরচদিতেহয়? যদিহয়তাহলেতাহলেকিধরনেরখরচহয়/ খরচদেন?

১২।আপনারাযেচিকিৎসানেনএবংযারাআপনাদেরসেবাদেয়এরমধ্যেকোনধরনেরসমস্যাআছেবলেমনেকরেন-যদিসমস্যাথাকেতবেকিধরনেরসমস্যাআমাদেরবলবেন?

১৩।কিকিকরলেএইসমস্যাগুলোকাটিয়েউঠাযেতেপারেবলেআপনারামনেকরেন?
(Probe: চিকিৎসারমান)

১৪।স্বাস্থ্যসেবাপ্রদানকারীরাকিভাবেএলাকারস্বাস্থ্যসেবারসাথেজড়িতবলেআপনিমনেকরেন? আপনিকিএমনকোনকাজেরউদাহরণআমাদেরদিতেপারেন?

১৫।MR সেবাপ্রদানপ্রোগ্রামেরগুরুত্বসম্পর্কেআপনিকিমনেকরেন? এইক্ষেত্রেMR সেবাপ্রদানকারীদেরকার্যকরঅবদানগুলোকিকি? আপনিকিএইপ্রোগ্রামেরকোনোনেতিবাচকদিকলক্ষ্যকরেছেন?

১৬।MR সেবাপ্রদানকারীদেরসেবারকোনদিকটিআপনারকাছেভালমনেহয়েছে? কোনোউদারহনকিআমাদেরদিতেপারেন? সেবাটাভালদেয়ারক্ষেত্রেকোনবিষয়গুলোবেশিসহায়কবলেআপনারমনেহয়?
(probe:কোনঘটনাকিবলতেপারেন? ভালোসেবাপ্রদানেরকারনগুলোকিকি?)

১৭। এইসেবাপ্রদানেরক্ষেত্রেকোনবিষয়গুলোএকেবারেইভালনাবলেআপনিমনেকরেন? উদাহরনদিন।এইসেবাভালোনাদেয়ারক্ষেত্রেকোনবিষয়গুলোপ্রভাবফেলেবলেআপনারমনেহয়? উদাহরণদিন।

(বিদ্রঃযদিউত্তরগুলোস্বতঃস্ফূর্তভাবেনাআসেসেইক্ষেত্রেযখনউদাহরণগুলোদেয়াহবেতখনজানতেচেষ্টাকরবেনযে, এইক্ষেত্রেকোনদিকগুলোবাবিষয়গুলোকাজটিভালোবাখারাপহতেপ্রভাবরাখে?)

Perceptions of Service Quality

১৮.MR   স্বাস্থ্যসেবাপ্রদানকারীদেরদক্ষতাকেমনবলেআপনিমনেকরেন? এইক্ষেত্রেতারকাজেরকোনদিকগুলোভালএবংকোনদিকগুলোতেদক্ষতাকমবলেআপনিমনেকরেন?

১৯. সেবাপ্রদানকারীরাMR Clinicদেরসাথেকেমনআচরনকরেবলেআপনিমনেকরেন? উদাহরণদিন।

২০.তাদেরসেবাগুলোকিআপনারকাছেপ্রশংসনীয়বলেমনেহয়? উদাহরণদিন।

২১. এইসেবাআরউন্নতকরতেকিকরাদরকারবলেআপনিমনেকরেন?

Referrals

২২.আপনারজানামতেস্বাস্থ্যসেবা (MRসহ) দেয়ারক্ষেত্রেপর্যাপ্তReferralব্যবস্থাআছেকি?

২৩.কিভাবেস্বাস্থ্যসেবাপ্রদানকারীরাএইReferralএরব্যবস্থাকরেথাকে?

২৪.যখনকোনReferকরাহয়তখনকিকোনখরচদিতেহয়? কেসেখরচটাবহনকরেবাদেয়?

(probe:ভিন্নভিন্নঅবস্থারজন্যভিন্নভিন্নReferralপ্রক্রিয়া, উদাহরণদিন।)

২৫.Referralব্যবস্থারকোনদিকগুলোভালোএবংকোনদিকগুলোভালোনয়? কেন? উদাহরণদিন।

Mobile health

২৬.মোবাইলেরমাধ্যমেস্বাস্থ্যসেবাসম্পর্কেজানেন?

২৭.এইএলাকায়স্বাস্থ্যসেবাপ্রদানকারীরাকিমোবাইলেরমাধ্যমেস্বাস্থ্যসেবাদিয়েথাকেন? অন্যান্যস্বাস্থ্যসেবাপ্রদানকারীরাকিমোবেইলেরমাধ্যমেস্বাস্থ্যসেবাদিয়েথাকে?   কেনতারাএইপদ্ধতিব্যবহারকরে? মোবাইলেরমাধ্যমেস্বাস্থ্যসেবাদেয়াকেআপনারাকিভাবেদেখেন? সুবিধা-অসুবিধাসমূহ?

২৮.আপনারাকিস্বাস্থ্যসেবাপ্রদানকারীদেরকাছথেকেমোবাইলেরমাধ্যমেকোনোসেবানিয়েছেন?

## ANNEX 5: ROOT CAUSE ANALYSIS AND PROBLEM STATEMENTS

Root Cause Analysis for Limited Communication and Coordination with formal and informal providers in SRH
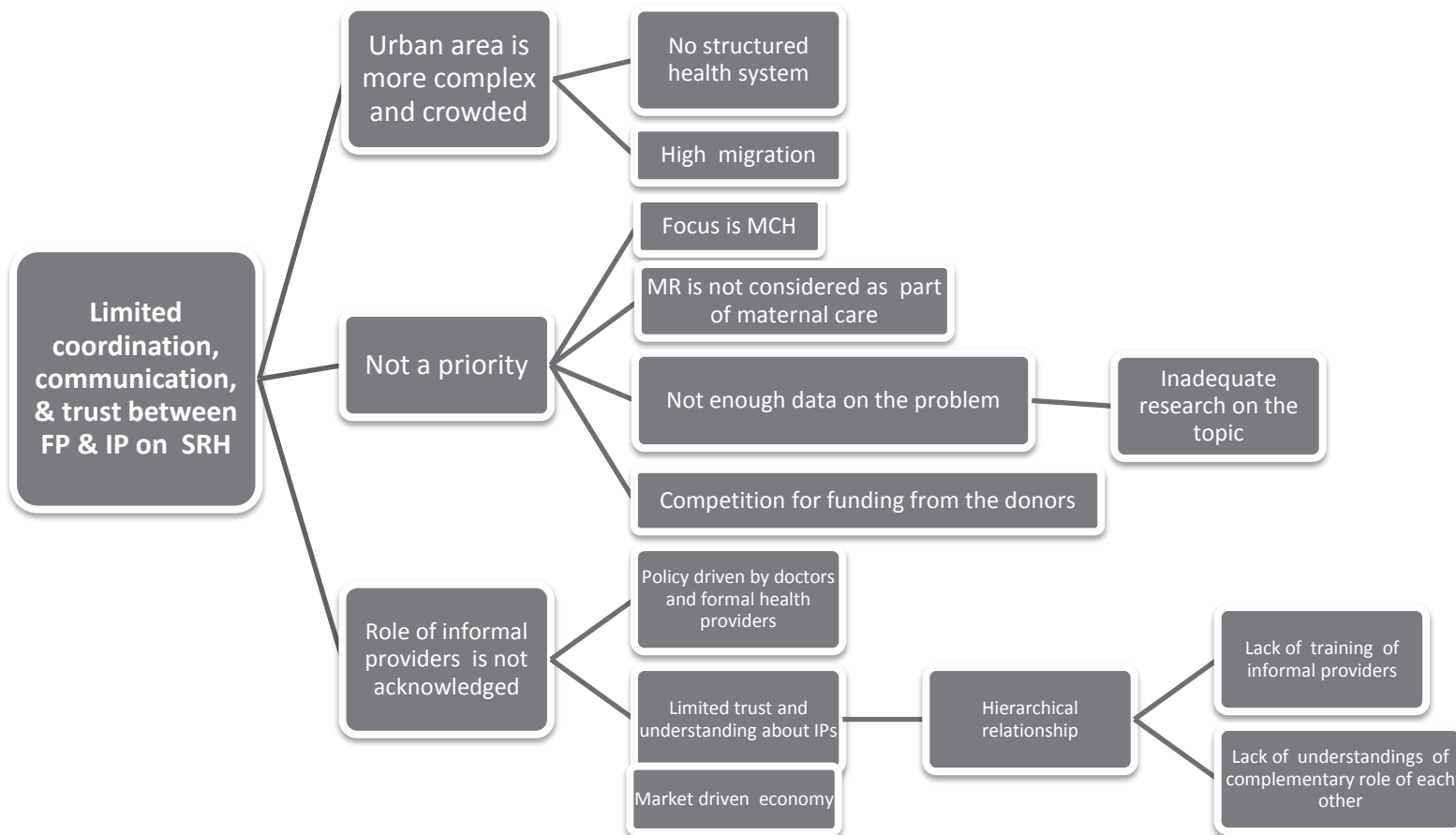
Root Cause Analysis for Women suffer from poor referral system that often makes them go for late treatment and the quality of care remains to be inconsistent.
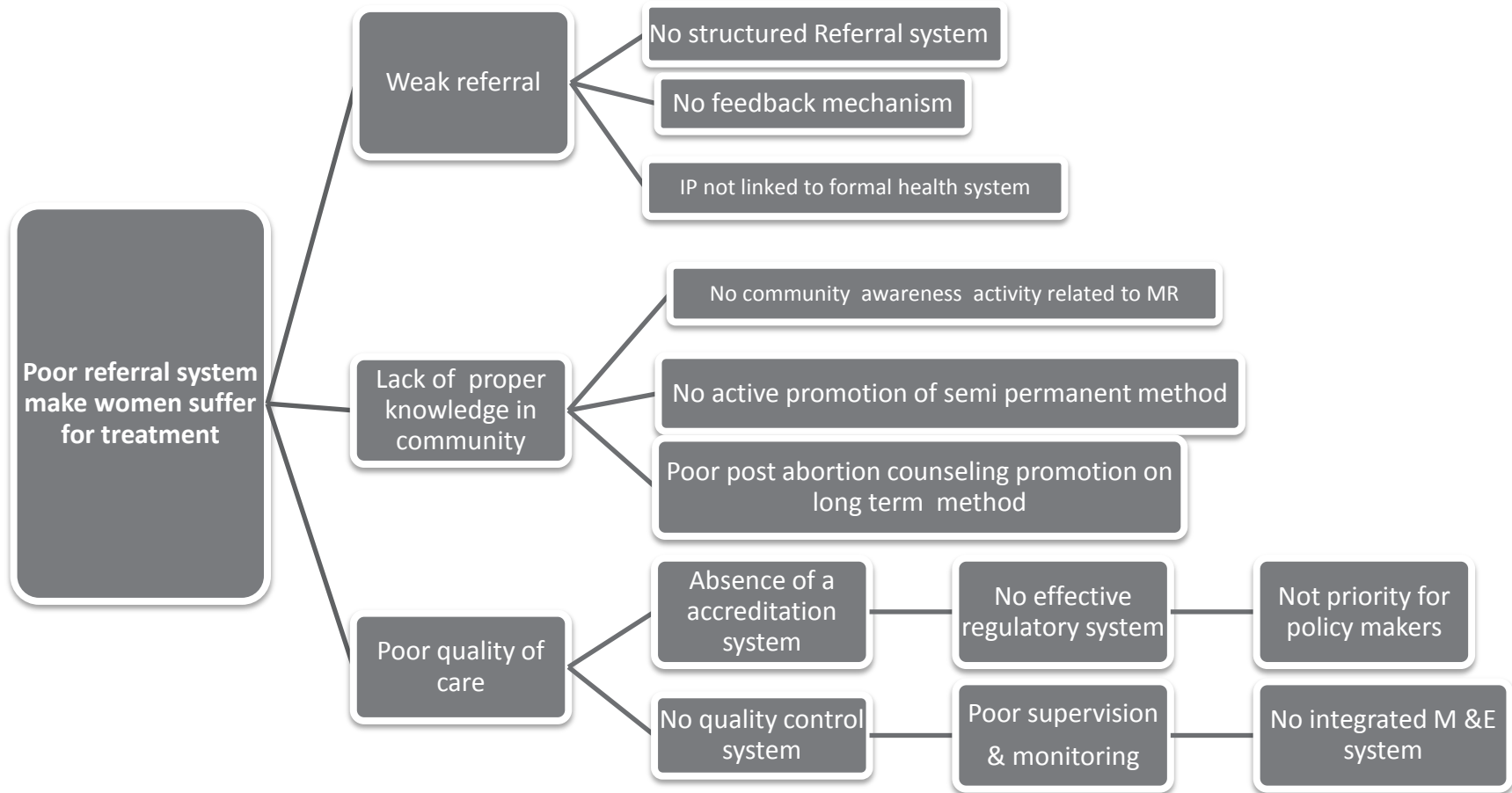
Root Cause Analysis for Poor Supervisory Mechanism
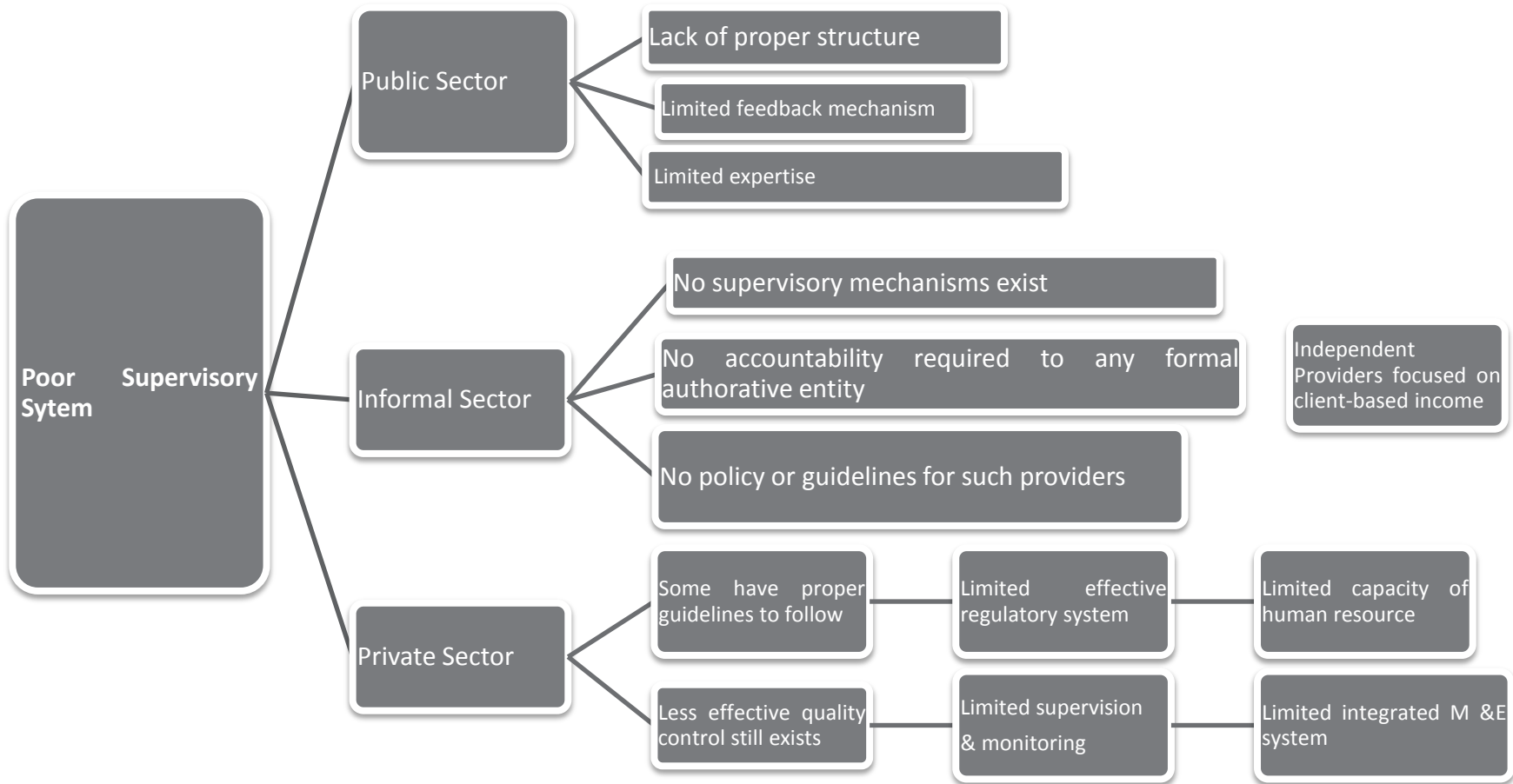
Codebook for Context Analysis (on MR related issues) Research, REACHOUT

1. **Age (**age of MR clients: IDI, age range of MR clients: KII**)**
2. **Sexual and Reproductive Health Service related issues**
a. Types of disease women face
b. Where do they go for women disease
c. Use of contraception method (e.g. decision making, kind of contraception methods etc)
d. Number of time conceive
e. Antenatal Service
f. Postnatal Service
g. Type of health service provider in community
h. Getting service in due time
i. Necessity of other services
j. Barriers and difficulties of using/taking family planning methods.
k. Cost of Services.

3. **MR Related Issues**
a. Community context (e.g. Cultural and religious, security, stigma and discrimination)
b. Community attitude to MR
i. Understanding and knowledge (e.g. MR health perception etc.)
ii. Health seeking behaviour - service utilisation [e.g. Seeking Advice to get MR Service, First Point of Contact, CTC Provider (Formal, Informal), Source of MR information (From whom, Where and How e.g. NGOs, Govt. Relatives, Neighbours, Friends etc.) Other Service Provider (Clinics/ Diagnostic Centre) etc.]
c. Reason of MR
d. Process of MR service
i. Decision making process of MR (General perception and client perception e.g. Self, husband, family and other etc.)
ii. MR Service Provider
iii. Counseling
iv. Referral system (e.g. Process of Referral (where, when and how), Cost of Referral, Positive areas of Referral, Negative areas of Referral, Follow up after referring etc.)
v. Follow up session
vi. Type of MR Service choice (e.g. General choice, Clients choice etc.)

vii.   Experiences of MR(e.g. physical and mental situation before and after MR; role of family member or other before and after MR, Experiences of the day of MR and self experiences etc)

e.   Perception of MR Service (Satisfaction and Dissatisfaction)

I.   Availability of MR service provider

II.   Behaviour of MR service provider

III.   Quality MR Service (e.g. Confidentiality, Evaluation of the service quality- Expertise, environment, proper instrument, duration of getting MR Service, Follow up session and counseling etc.)

IV.   Cost of MR (amount, source, difficulties faced, any other problem related arranging finance)

V.   Importance of MR service/ program

f.   Barriers and Difficulty of MR service

i.   Barriers and Difficulties of Providing MR service (e.g. Social Barriers, Political, Mistrust by Community, Low Income/ Earning, Family etc.)

ii.   Barriers and Difficulties of Taking/Getting MR service (e.g. Social Barriers, Political, Mistrust by Community, Low Income/ Earning, Family etc.)

g.   Policies about MR in our country context (e.g. existing policies- govt. or own institution, sufficient/ insufficient)

h.   Recommendations and suggestions.

4.   Technical methods (e.g. M health, credit for airtime, Perception on M Health, Cost of Providing M Health Service, Benefits of M Health, Disadvantages, Experience of M Health etc)

James P. Grant School of Public Health
BRAC University

Date: 26 August 2013

Ethics Reference No: *Please quote this ref on all correspondence*	30
Project Title:	**Context Analysis of Close to Community Providers and Quality of Menstrual Regulation Services in Bangladesh**
Principal Investigator:	Prof. Sabina Faiz Rashid
Co-Principal Investigator:	Prof. Malabika Sarker
Researchers	Showkat Gani, Bulbul Ashraf, Kuhel Islam, Salahddin Biswas, Yamin Jahangir, Nadia Chowdhury

Thank you for submitting your application which was considered by the James P Grant School of Public Health, BRAC University Ethical Review Committee (ERC). The following documents were reviewed:

1. Ethical Review Checklist
2. Research Proposal
3. Consent Form
4. Questionnaires

The Ethical Review Committee approves this study from an ethical point of view upon the addressing by the researchers of the concerns as raised by the ERC affiliates.

Approval is given for three years. Projects, which have not commenced within two years of original approval, must be re-submitted to ERC. You must inform ERC when the research has been completed.

Any serious adverse events or significant change which occurs in connection with this study and/or which may alter its ethical considerations must be reported immediately to the ERC.

Approval is given on the understanding that the 'Guidelines for Ethical Review' are adhered to.

Yours sincerely,

Dr. Syed Masud Ahmed
Professor
James P Grant School of Public Health,
BRAC University

ANNEX8: BACKGROUND INFORMATION OF THE IGD PARTICIPANTS

Sl. No.	Name of participants	Sex (1=Male, 2=Femal	Age (Years)	Occupation *	Are you involved activiely with social work or any organisation or club?	Para name (within	Moholl a	Ward	Thana

* 1=social work, 2=day labour (not agriculture), 3=factory worker, 4=service, 5=business, 6=rickshaw/van puller, 7=carpenter/master mason, 8=bus/tempo driver/helper, 9=restaurant worker, 10=small business, 11=household work, 12=students, 13= unemployed, others…………………….

Location of Data Collection

Name of Para (Outside):------------------------------Name of Para (Outside):-------------------Moholla :----------------------Union/Ward:-------------------

ANNEX 9: HEALTH RESOURCE MAPPING

Figure A. Health resource mapping of *Kallyanpur*slum, Mirpur, Dhaka
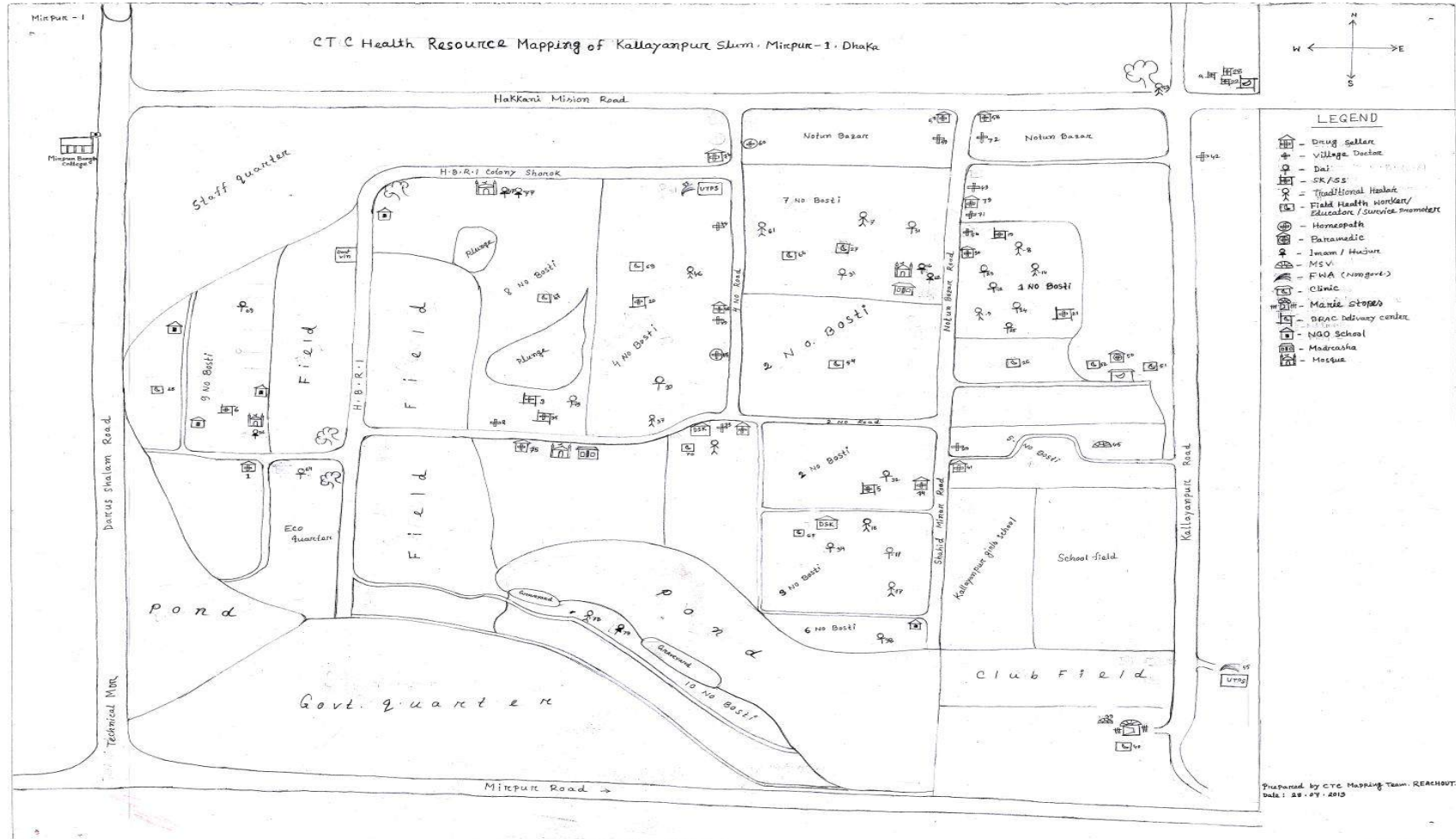
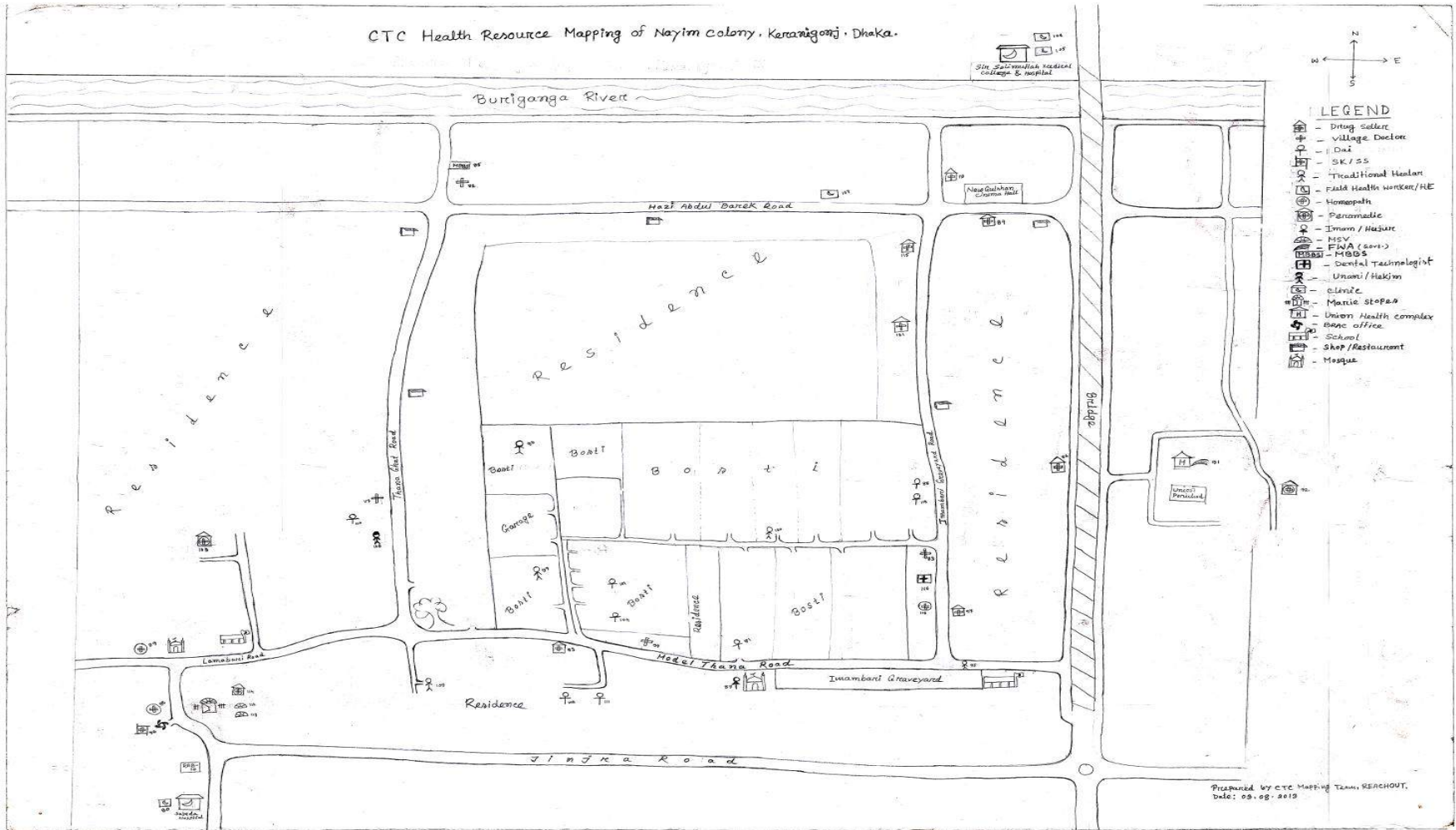Figure B. Health resource mapping of Keraniganj slum location, Dhak

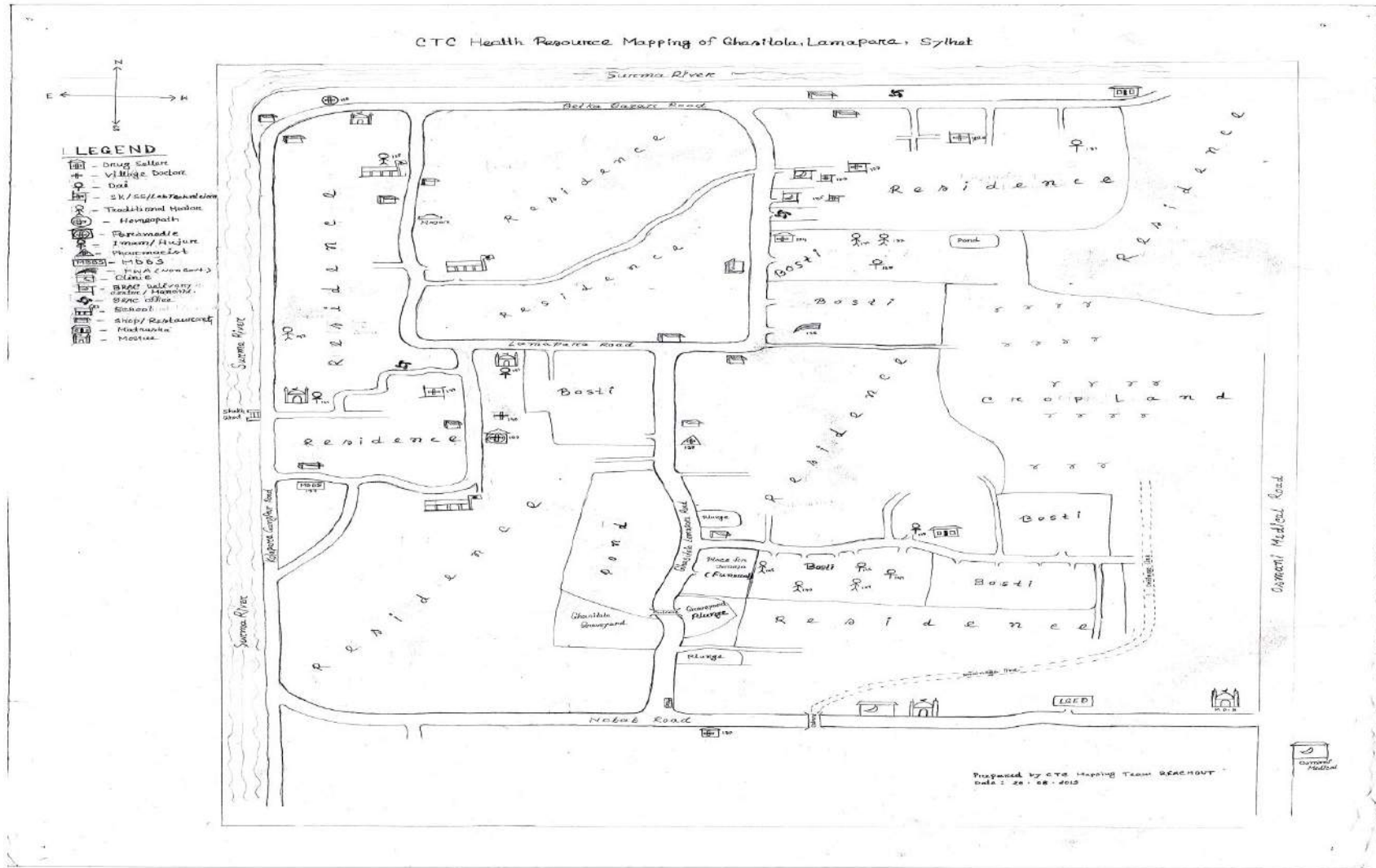Figure C. Health resource mapping of *Ghasitola* slum, Lamapara, Sylhet

Figure D. Health resource Mapping of *Lakkatura Tea Estate* area

CTC Health Resource Mapping of Lakkhatura Tea Estate, Sylhet.