

# Operations Research on ESP Delivery and Community Clinics in Bangladesh

---

---

## Site Selection for Community Clinics: A Field Experience

Ziaul Islam  
Sukumar Sarker  
Subrata Routh  
Barkat-e-Khuda  
Md. Mesbahuddin  
Md. Shahjahan

1999



**CENTRE**  
FOR HEALTH AND  
POPULATION RESEARCH



## The Centre

The Centre is a unique global resource dedicated to the highest attainable level of scientific research concerning the problems of health, population and development from a multi-disciplinary perspective. The Centre is an exceptional position to conduct research within the socio-geographical environment of Bangladesh, where the problems of poverty, mortality from readily preventable or treatable causes, and rapid population growth are well-documented and similar to those in many other developing countries of the world. The Centre currently has over 200 researchers and medical staff from 10 countries participating in research activities. The Centre's staff also provide care at its hospital facilities in Dhaka and Matlab to more than 100,000 patients a year and community-based maternal/child health and family planning services for a population of 100,000 in the rural Matlab area of Bangladesh. In addition, the Centre works closely with the Government of Bangladesh in both urban and rural extension projects, which aim at improving the planning and implementation of reproductive and child health services.

The Centre is an independent, non-profit international organization, funded by donor governments, multilateral organizations and international private agencies, all of which share a concern for the health problems of developing countries. The Centre has a rich tradition of research on topics relating to diarrhoea, nutrition, maternal and child health, family planning and population problems. Recently, the Centre has become involved in the broader social, economic and environmental dimensions of health and development, particularly with respect to women's reproductive health, sexually transmitted diseases, and community involvement in rural and urban health care.

The Centre is governed by a distinguished multinational Board of Trustees. The research activities of the Centre are undertaken by four scientific divisions: Clinical Sciences Division, Public Health Sciences Division, Laboratory Science Division, and Health and Population Extension Division. Administrative functions are undertaken by Finance, Administration and Personnel offices within the Director's Division.

B

# Operations Research on ESP Delivery and Community Clinics in Bangladesh

---

---

## Site Selection for Community Clinics: A Field Experience

Ziaul Islam<sup>1</sup>  
Sukumar Sarker<sup>1</sup>  
Subrata Routh<sup>1</sup>  
Barkat-e-Khuda<sup>1</sup>  
Md. Mesbahuddin<sup>2</sup>  
Md. Shahjahan<sup>3</sup>

<sup>1</sup> Operations Research Project, ICDDR,B: Centre for Health and Population Research

<sup>2</sup> Management Change Unit, Ministry of Health and Family Welfare,  
Government of the People's Republic of Bangladesh

<sup>3</sup> Programme Coordination Cell, Ministry of Health and Family Welfare,  
Government of the People's Republic of Bangladesh



**CENTRE**  
FOR HEALTH AND  
POPULATION RESEARCH

**ICDDR,B: Centre for Health and Population Research**  
Mohakhali, Dhaka 1212, Bangladesh

1999

ICDDR,B Special Publication No. 106

C

Edited by: M. Shamsul Islam Khan

Layout Design and Desktop Publishing: Jatindra Nath Sarker  
Subash Chandra Saha

**ISBN 984-551-203-8**

**ICDDR,B Special Publication No. 106**

© 1999. ICDDR,B: Centre for Health and Population Research

Published by  
**ICDDR,B: Centre for Health and Population Research**  
GPO Box 128, Dhaka 1000, Bangladesh  
Telephone: (880-2) 8811751-60 (10 lines); Fax: 880-2-8811568  
E-mail: [msik@icddrb.org](mailto:msik@icddrb.org)  
URL: <http://www.icddrb.org> and <http://www.icddrb.org.sg>

---

**Printed by: Olympic Products Printing & Packaging, Dhaka**

*d*



**Secretary**  
**Ministry of Health and Family Welfare**  
**Government of the Peoples' Republic of Bangladesh**

## Foreword

The Health and Population Sector Programme (HPSP) is aimed at providing a range of basic health and family planning services—Essential Services Package (ESP)—to the clients, especially the vulnerable and disadvantaged groups (children, women and the poor). A key component of the HPSP is the establishment of Community Clinics to provide ESP services. Both the integrated service-delivery package, Essential Services Package (ESP), and the strategy to deliver services from the static centres (Community Clinics) instead of routine domiciliary visits, are major shifts in the health services programme. It is, therefore, appropriate that in the process of implementation of these crucial systemic changes, research be undertaken to: (i) extensively document the operationalization process of the new service delivery system; (ii) monitor, analyze, and evaluate performance of the new system; (iii) identify problem(s) encountered in implementation of the new system; and (iv) suggest probable solution(s) for further refinement of the new system.

The Operations Research Project (ORP) of ICDDR,B: Centre for Health and Population Research is conducting an operations research—on request of MOHFW—on the ESP delivery and Community Clinics in three of its Project sites, namely, Abhoynagar thana of Jessore district and Mirsarai and Patiya thanas of Chittagong district. The research is conducted in collaboration with the Health and Family Planning Directorates of the Ministry of Health and Family Welfare (MOHFW). Early findings from the activities on orientation of the programme managers and other related persons on ESP and the site selection process for the Community Clinics were disseminated at a workshop held on August 31 and September 1, 1999. Both the activities are of critical importance in the operationalization of the ESP delivery. ORP experience which led to provision of new orientation to district and thana level programme managers, supervisors, service providers, and the community leaders on ESP and the new service-delivery system helped to clarify field-level issues related to the community's role in establishing Community Clinics. The resultant interaction between the government health delivery system and the local community representatives has set a unique precedent in Bangladesh of stakeholder participation in initiating reform of delivery of public service by the Government.

This publication documents the activities of ORP in facilitating the process of site selection for Community Clinics which have been carried out as part of the operations research on ESP delivery and Community Clinics. I recommend this document to the policy makers and programme managers so that they can apply the lessons learnt to improve implementation further.

  
M. M. Reza

E

## Acknowledgements

The Operations Research Project (ORP) is a project of the ICDDR,B: Centre for Health and Population Research that works in collaboration with the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, supported by the United States Agency for International Development (USAID).

This publication was supported by the USAID under the Cooperative Agreement No. 388-A-00-97-00032-00 with the ICDDR,B: Centre for Health and Population Research. The Centre is supported by the following countries, donor agencies and others which share its concern for the health and population problems of developing countries:

- Aid agencies of governments of: Australia, Bangladesh, Belgium, Canada, European Union, Japan, the Netherlands, Norway, Sri Lanka, Sweden, Switzerland, the United Kingdom, and the United States of America;
- UN agencies: International Atomic Energy Agency, UNAIDS, UNICEF, and WHO;
- International organizations: CARE Bangladesh, International Center for Research on Women, International Development Research Centre, Swiss Red Cross, and World Bank;
- Foundations: Ford Foundation, George Mason Foundation, Novartis Foundation, Rockefeller Foundation, and Thrasher Research Foundation;
- Medical research organizations: Karolinska Institute, National Institutes of Health, New England Medical Center, National Vaccine Programme Office, Northfield Laboratories, Procter and Gamble, Rhone-Poulenc Rorer, and Walter Reed Army Institute for Research-USA;
- Universities: Johns Hopkins University, London School of Hygiene & Tropical Medicine, University of Alabama at Birmingham, University of Göteborg, University of California at Davis, University of Maryland, University of Newcastle, University of Pennsylvania, and University of Virginia;
- Others: Arab Gulf Fund, Futures Group, International Oil Companies (Cairn Energy PLC, Occidental, Shell, Unocal), John Snow International, Pathfinder, UCB Osmotics Ltd., and Wander.

## Glossary

AC	Assistant Commissioner
ATFPO	Assistant Thana Family Planning Officer
AHI	Assistant Health Inspector
AOP	Annual Operational Plan
BCC	Behaviour Change Communication
CC	Community Clinic
ECNEC	Executive Committee of the National Economic Council
ESP	Essential Services Package
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GR	Geographical Reconnaissance
GOB	Government of Bangladesh
HI	Health Inspector
HA	Health Assistant
HPSP	Health and Population Sector Programme
ICPD	International Conference on Population and Development
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IUD	Intra-uterine Device
LD	Line Director
LGED	Local Government Engineering Department
MAU	Management Accounting Unit
MCH-FP	Maternal Child Health and Family Planning
MCU	Management Change Unit
MIS	Management Information System
MOU	Memorandum of Understanding
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
NGO	Non-Government Organization
ORP	Operations Research Project
PCC	Programme Coordination Cell
PIP	Programme Implementation Plan
THFPO	Thana Health and Family Planning Officer
THC	Thana Health Complex
TNO	Thana Nirbahi Officer
UHFWC	Union Health and Family Welfare Centre
UP	Union Parishad

# Contents

	Page
Abstract .....	v
1. Introduction .....	1
2. Background.....	2
3. Objectives .....	3
4. Methodology .....	4
5. Preparatory Activities (before the government guidelines were issued) .....	4
5.1 Orientation Workshops with GOB Officials and Field Workers.....	4
5.2 Participatory Planning Workshop at the Local-level with Thana Managers and Field Workers.....	4
5.3 Field Visits and Personal Contacts.....	7
6. Final Selection of Unions for the First Year (after the government guidelines were issued) .....	9
7. Site Selection Activities .....	10
8. Stock-taking Workshops/Meetings with Union Supervisors .....	14
9. Focus Group Discussions with Community Groups.....	15
10. Technical Assistance and Documentation .....	15
11. Important Observations .....	15
11.1 Community Group Issues .....	15
11.2 Procedural Issues .....	18
11.3 Structural Issues .....	22
12. Lessons Learned .....	22
13. Recommendations .....	24
References .....	26

## Contents (contd.)

Page

<b>Table 1.</b> Final selected unions for establishment of Community Clinics in 3 ORP thanas: first year, May 1999-June 2000.....	10
<b>Table 2.</b> Community Clinic profile in 3 ORP thanas.....	14
<b>Table 3.</b> Difference between the Community Clinics to be newly Constructed and the Community Clinics to be housed in the Union Health and Family Welfare Centre (UHFWC) .....	17
<b>Flow-chart A.</b> Steps Suggested by the MOHFW Guideline for Site Selection of Community Clinics.....	27
<b>Flow-chart B.</b> Steps followed by Thana Managers for Site Selection of Community Clinic .....	28

## Abstract

This paper has been prepared based on the field experience of the Operations Research Project (ORP) of ICDDR,B: Centre for Health and Population Research, in facilitating the process of site selection for Community Clinics at Abhoynagar of Jessore district and Mirsarai and Patiya of Chittagong district, during the period of October 1998 to August 1999.

Facilitation of the process of site selection for Community Clinics by ORP, with step-by-step documentation of related experience, was considered as one of the major components of the operations research on ESP delivery and Community Clinics. Activities related to site selection were conducted in collaboration with officials of the Ministry of Health and Family Welfare in accordance with government guidelines and the Programme Implementation Plan (PIP).

The general objectives of the operations research component on site selection for Community Clinics were: (a) orientation of government managers and providers at the district, thana levels and below, and community leaders on the new programme; (b) operationalization of Community Clinics with particular emphasis on site selection and other related issues of Community Clinic-based service delivery; and (c) documentation and dissemination of corresponding findings to suggest measures on further fine-tuning of related government guidelines and documents, as and when required.

Thana managers, union supervisors, and outreach field workers of the government health and family planning service delivery systems and community leaders were involved with facilitation activities so as to help them understand the issues and thereby expedite the process of site selection for Community Clinics.

The above objectives were attained through organizing briefing meetings, planning workshops, field visits and personal contacts, stock-taking meetings, focus group discussions and technical assistance.

This paper has generated several important observations on the site selection process and, thereby made some specific recommendations which are expected to streamline and accelerate the process of site selection for Community Clinics.

## 1. Introduction

The five-year plan (1998-2003) of the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, popularly known as HPSP (Health and Population Sector Programme), is a unique step toward sectoral reform. The organizational unification of health and family planning, decentralization of management, improved hospital management and promotion of NGOs and the private sector are the core issues of its reform agenda. It aims at achieving client-centred provisions and client-utilization of an Essential Services Package (ESP), plus selected services. The programme is intended to provide quality services with greater coverage and to promote financial sustainability. The general objectives of the programme emphasize reduction of maternal and child mortality, reduction of communicable diseases, unwanted fertility and decreasing the total fertility rate, as well as increasing life expectancy at birth, age-at-first pregnancy, nutritional status and healthy life-style of the population. It is estimated that an amount of US\$ 3,373.20 million would be spent to meet the expenditures of the programme. The HPSP has formulated the following five landmark strategies to achieve its objectives:

- a. Introduction of sector-wide management to replace a multiple project-driven approach to reduce inefficiencies and duplication of services in the health and population sector.
- b. Introduction of an Essential Service Package (ESP) to meet the client's needs with provision for greater service coverage, especially for women, children and the poor, in a cost-effective way.
- c. Establishment of Community Clinics as a static centre for ESP delivery at the grass-root level to gradually replace the home-visitation.
- d. Improvement of support services.
- e. Construction of the rest of the Union Health and Family Welfare Centres (UHFWC).

The Programme Implementation Plan (PIP) of HPSP was approved by the Executive Committee of the National Economic Council (ECNEC) on 28 June 1998. The Ministry of Health and Family Welfare (MOHFW) formally launched the programme on 1 July 1998. Despite the unprecedented flood of 1998 and its aftermath (mid-July-November 1998), the MOHFW has been relentlessly trying to implement the programme by adopting the Annual Operational Plans (AOP) of the different components of HPSP. The Ministry has simultaneously made necessary changes and amendments in its line functionaries and service modalities, especially at the national and thana levels. In addition to its existing set-up, the MOHFW has established three more associated bodies, namely Programme Coordination Cell (PCC), Management Change Unit (MCU), and Management Account Unit (MAU) to ensure a more focused

management of the upcoming issues relating to implementation of the programme. In view of the sector-wide management initiative of HPSP, some modifications have also been made in hierarchy by appointing Line Directors, Programme Managers, Deputy Programme Managers and Consultants. Advocacy workshops, fund disbursement, annual performance reviews, unification of MIS and BCC, preparation and distribution of comprehensive guidelines on the establishment of Community Clinics (CC) are some of the major activities that have already taken place (till August 1999). The unification of health and family planning personnel at the thana level and below and preparation of a new job description are also underway.

Amidst functional and organizational restructuring, the MOHFW is currently exercising its all-out efforts to expedite the process of operationalization of CCs across the country. These clinics will deliver the ESP to the community and will have a referral linkage with the UHFWCs and Thana Health Complexes (THC). The MOHFW has planned to establish one Community Clinic for each cluster of 6,000 population and as such, construction of 13,500 new Community Clinics are expected to be completed by 2003. However, for the first phase (May 1999 - July 2000), the target of construction is limited to 6,000 CCs. These clinics are designed to be established and operated jointly by the government and the community. A committee for site selection will be formed at the thana level, headed by the THFPO, for finalizing the site-selection procedure according to the MOHFW's guidelines. The community will select the site and donate five decimals of land on which the government will construct a building of 460 square feet floor space with provision for three rooms, one toilet and an attached tube-well. The community will constitute a committee (Community Group) to oversee the construction of the clinic and to look after the maintenance and security of the infrastructure. Besides construction of the building, the government will monitor services and provide technical supervision, medicines, equipment, furniture and manpower. These clinics will remain open on all working days (not less than 40 hours per week) and are to be served jointly by the Health Assistant (HA) and Family Welfare Assistant (FWA).

## **2. Background**

At present, the community level health and family planning service delivery system is dependent on two mechanisms: (i) home-visitation by the HA (once per month per household) and FWA (once bi-monthly per household) and (ii) makeshift satellite clinics/EPI outreach centres. Each field worker usually covers a population of about 5,000. This system is labour-intensive and costly. Moreover, the scope of service is limited with such a makeshift arrangement and home-visitation approach. It is reported that the frequency of the field worker's visits per household does not adequately meet the clients' need for healthcare as it is made once a month or less. Therefore, the time-gap between subsequent visits is quite long. Recent studies on consumer preferences

have shown that the rural people of Bangladesh want one-stop service. Also, in response to the ICPD (International Conference on Population and Development) resolutions, the Government is committed to offer a broader range of reproductive health services to its population. Availability of essential first-aid arrangement within the community is another basic healthcare need nearly missing in the present system at that level.

In view of the above-mentioned limitations of the home-based service delivery, the HPSP has proposed an integrated package of health and family planning services - ESP - which includes reproductive health, child health, communicable diseases, limited curative care and BCC as its core components. Community Clinics will be the permanent outlets and the first tier for ESP delivery at the community level. The other outlets for ESP delivery in rural settings are the UHFWCs and THCs. The service providers (HA and FWA) will be able to deliver more services on all working days, from these CCs, while the clients will also have easy access to one-stop service.

One of the mandates of the ORP's research on ESP delivery and Community Clinics is to facilitate the process of operationalization of CCs in its three field sites (Abhoynagar, Mirsarai and Patiya) and to provide feedback on lessons learned from operations research. These operations research activities were aimed at gathering more practical information on problems, constraints and probable solutions encountered during the process of implementation. Keeping this in mind, the process of operationalization of CCs is being documented by the ORP in a series of publications.

This paper is one of the documentation outputs of the facilitation efforts made by the ORP with regard to the selection of sites for CCs. Several critical areas of concern for policy-makers, planners and managers have also been identified.

### **3. Objectives**

The general objectives of the operations research component on site selection for Community Clinics were:

- orientation of government managers and providers at district, thana levels and below, and the community leaders on the new programme
- operationalization of CCs with particular emphasis on site selection, and other related issues of CC-based service delivery
- documentation and dissemination of corresponding findings to suggest measures for further refinement of related government documents and guidelines, as and when required.

### **4. Methodology**

The first step in operationalization of Community Clinics is to select appropriate sites. In the PIP of HPSP, several features relating to site selection have been described in

detail. In addition, the MOHFW has issued guidelines in April 1999 on the same and a circular in May 1999 detailing the steps of implementation. In light of these two documents (PIP and guidelines), the ORP made the following facilitation attempts (at Abhoynagar, Mirsarai and Patiya) before and after the guidelines were issued.

- a. Orientation workshops and briefing meetings;
- b. Participatory planning workshops;
- c. Field visits and personal contacts;
- d. Stock-taking workshops/meetings;
- e. Focus-group discussions; and
- f. Technical assistance and documentation.

It is notable that the MOHFW's guideline on establishment of CCs has suggested several specific steps to be followed for site selection (Flow-chart A). However, in reality, the thana managers had to readjust these steps with more practical choices (Flow-chart B).

## **5. Preparatory Activities (before the government guidelines were issued)**

The following preparatory activities (5.1-5.3) have been conducted at the ORP field-sites since October 1998 and were continued till the government guidelines were introduced in April 1999. The purpose of these activities was to motivate and prepare the GOB personnel and community leaders for the tasks they were expected to perform in connection with establishment of CCs. Different approaches, such as orientation and brain-storming sessions, planning exercises, field visits, interpersonal communications, etc. were adopted for this purpose. On completion of these preparatory activities, the government guidelines were followed step-by-step and the facilitation efforts were further strengthened until the finalization of site selection for the CCs was completed in August 1999.

### **5.1 Orientation Workshops with GOB Officials and Field Workers**

Selection of sites for CCs was a very crucial task of the whole intervention. Previous experience with regard to the site selection of UHFWCs suggests that the utilization of such centres by the community largely depends on the location of the clinics. Construction of the UHFWCs at inconvenient locations in the past has resulted in gross under-utilization of these facilities. This issue was a major concern, as perceived by the thana managers who suggested to undertake some preparatory exercises to identify optimal locations for the proposed CCs before actually doing the task. Moreover, establishment of a Community Clinic is an important step of the new national programme with many strategic changes in service delivery. One-stop shopping, clients' need-based services and community involvement are some of the major

changes that have been suggested in the HPSP with regard to CCs. In the backdrop of such new programme modalities and past experience with the UHFWCs, it was strongly felt that the concerned ESP officials, thana managers, field staff and community leaders should be sufficiently made aware of the new intervention on the basis of the PIP. A series of activities were, thus, undertaken at the thana and national levels since October 1998, involving the health and family planning field workers, supervisors, thana managers, community leaders, concerned Programme Managers and Line Directors. One of the major preparatory activities conducted was orientation workshop held with the thana-level managers and the community-level providers of the provisionally selected unions to sensitize them on the proposed intervention. Four unions in each of the above-mentioned thanas were chosen for the preparatory activities. These unions are covered by the ORP's longitudinal surveillance system. The details of the workshops are described elsewhere (a separate documentation on orientation—ICDDR,B special publication, 105). Orientation workshops were also conducted earlier, in November-December 1998 with concerned thana and district managers, ESP Programme Managers and Line Directors to build consensus on operational aspects of the intervention.

## **5.2 Participatory Planning Workshop at the Local-level with Thana Managers and Field Workers**

Planning workshops were held with the community-level health and family planning service providers (HA, FWA, FWV) and the union-level supervisors (HI, AHI, FPI) of the unions provisionally selected earlier for conducting preparatory activities (15-16 February 1999 at Abhoynagar, 7-8 March and 10-11 March 1999 at Mirsarai and Patiya respectively). The general objective of these preparatory workshops was to develop the capacity of GOB field personnel in identifying optimal locations for CCs. Thana level managers also participated at these workshops and shared their ideas in planning the selection of sites for Community Clinics. Union maps (mouza map/LGED map/Geographical Reconnaissance map) were collected from the LGED and AC-Land's office of the respective thanas. Information on population and household distribution (GR information), and information on the road communication network were also collected beforehand to help conduct the workshop. Maps were also used to assess the natural features, such as *khal/beel*, pond, paddy field, river, hill, *char*, etc. The population update, based on the 1997 GR (compiled by the concerned THC), was used for identification of the catchment population of Community Clinics.

These workshops were designed to allow participatory discussion and brainstorming exercises with field workers and managers. The ORP staff facilitated these workshops to attain the objectives and also participated in the discussions. A standard programme was followed in all three places (Mirsarai, Patiya and Abhoynagar). The facilitators made a brief presentation on the reorganized service delivery strategy in the HPSP and CCs to familiarize the participants about the concept

of ESP and design of Community Clinics (Box-1). This planning exercise was done, on a trial basis, through group work. Each group comprised of field staff of one union, who actively discussed and debated among themselves about the number of clinics per union, catchment population, and geographical features of the catchment area under the proposed CCs. Having decided upon the number of clinics (one for average 6,000 population) in each union, the catchment area of the clinic was marked. To define the catchment area, the workshop participants reviewed the distribution of dwelling houses (along with population) on the map, and then, defined a cluster of population ranging from 4,500 to 7,500 to be considered for one CC. An optimal location was, then, identified in the central place of each catchment area, considering the settlement of households, road communication and usual transportation habits of the dwellers.

### **Box 1. Basic Design of a Community Clinic**

- The Community Clinic is the basic unit (first level) of ESP delivery at the community level.
- One Community Clinic for an average of 6,000 population (range: 4,500-7,500).
- The clinic should be located in a centrally convenient location for the defined population.
- Location of the clinic should be considerably away from the graveyard/cemetery, crematory and riverbank.
- 80% of the population should live within a 30-minute walking distance from the Community Clinic.
- Services delivered by home visits will be gradually replaced by provision of services at the Community Clinic.
- A team, comprising of one FWA and one HA, will be the core service providers of the Community Clinic.
- Each team must have at least one female worker.
- Services will be made available on every working day.
- Limited domicilliary services will be offered by the Community Clinic workers to groups or individuals at risk, e.g., dropouts, handicaps, people living in remote areas etc.
- Existing satellite clinics and EPI outreach sites will be gradually reduced, keeping pace with the operationalization of the Community Clinic.
- FWV of the union will render services (IUD)/injectables) at a regular interval, i.e., at least once a month.

The UHFWC was considered as one of the CCs in each union. A tentative plan was made on how to explain the matter to the local community leaders (Union Parishad Chairman and Members) and how to approach the landowners for donation. Since the entire community was very familiar to the field workers, they were able to identify two or three potential land donors in the identified areas. The plan also included the initiation of the process of formation of a Community Group and identification of its potential members for each CC. This planning exercise enabled the GOB field workers to provide technical assistance to the community in the subsequent process of actual site selection.

### **5.3 Field Visits and Personal Contacts**

#### ***Field visits by workers and supervisors***

The field workers (GOB and ORP) and their supervisors paid numerous visits to their respective work areas to examine the validity of the aerial plan made in the planning workshops held at the thana level. During these visits, they verified the exact location of the provisionally identified sites, condition of the land, vicinity to the nearest dwelling houses, road communication, distribution of inhabitants around it, and finally, the interests of the community.

#### ***Personal contact with the community and land donors***

While checking with those characteristics of the tentatively selected sites for CCs through field visits, the field workers also approached some of the potential land donors to motivate them for donation of land. They discussed the matter formally/informally with the local opinion leaders and the Union Parishad Chairman and Members. These visits provided a good opportunity to interact with the local people who received some first-hand information about Community Clinic.

The GOB and ORP field workers discussed the purpose of the government plan with the potential land donors during their field visits (the briefing points are noted in Box 2). Through repeated contacts and intimate persuasion, the targeted landowners were ultimately motivated to donate land for the clinics. In most places, such interpersonal communications also helped the workers and the community to agree upon the most suitable sites for the clinics. Contrary to the apprehension that getting land in places adjacent to city areas would be difficult due to higher sale-value, the community was found quite enthusiastic and cooperative in donating land in all areas following satisfactory interactions with the workers.

## **Box 2: Briefing Points for Motivation on Community Clinic**

### For the benefits of clients

- One-stop shopping for health and family planning services
- The Community Clinic is open everyday, except holidays
- Extended range of services will be available
- The clinics are at the door-step of clients
- During clinic hours one can visit the clinic at his/her convenience
- There is no need to wait for a visit of the FWA or HA
- The FWV will provide services at the Community Clinics on fixed dates.

### For the community's participation

- The Community Clinics are meant for provision of services for the local community
- The community must participate in establishment and operation of Community Clinics, named so to recognize the community's participation
- Participation in establishment and operation of a Community Clinic would give a feeling of ownership to the community
- Donation of land for the Community Clinic is a gesture of community's participation in the effort
- Any member of the community may donate land for the clinic
- Donation of land may add dignity to the respectable member of the community as recognition of his/her charity.

### ***Personal contact with the UP Chairmen and Members: introduction of the government guidelines***

The government circular enclosed with the guidelines on establishment of Community Clinics for the first year was issued in May 1999. It suggested that a Thana Committee work on finalization of proposals on site selection for CCs. It further added that the Union Parishads must approve the proposals, and only then the sites to be proposed by the Thana Committee for construction of the clinic building. It is, thus, necessary for the UP Chairmen and Members to have clear understanding about CCs and the reformed service delivery strategy as a whole. Personal contacts and informal meetings with the UP Chairmen and Members were made to provide them with adequate information as available in the guidelines. During subsequent field visits, the field workers and supervisors availed of the opportunity to narrate the key features of an ideal location for a Community Clinic. Copies of the guidelines on establishment of Community Clinics were also circulated among them.

## **6. Final Selection of Unions for the First Year (after the government guidelines were issued)**

The aforesaid GOB circular enclosed with the guidelines on establishment of Community Clinics directed the THFPOs to constitute two committees: (i) a Thana Committee for site selection (one for each thana), and (ii) Community Group (one for each Community Clinic). Composition of each of these committees, their process of formation and the tasks to be performed were specified in the guidelines. It is suggested, in the guidelines, that the "Concerned UP Chairmen" would act as members of the Thana Committee. However, it is not clear about how the thana managers would select the 'Unions' beforehand and identify the "Concerned UP Chairmen." However, the number of CCs to be constructed in a union (worked out on the basis of projected population), and an allocation of a certain number of CCs to be constructed in a thana during the first year (May 1999-July 2000) were described in the GOB circular. It allowed the flexibility of selecting those unions that are completely covered by the allocated number.

However, after completing some initial exercises, thana managers provisionally selected those unions which match with the technical aspects (population-based planning) of the guidelines. The initial conditions, adopted by the THFPOs for selection of the unions, were based on: availability of good access to the area, adequate staffing, optimal geographical coverage and existence of a ORP surveillance system in the union. To confirm the selection of unions, the following approaches were tried by the THPOs, as the process was not spelled out in detail in the government guidelines.

1. A meeting of all Union Parishad Chairmen was convened by the concerned THFPO where the technical aspect of union selection and the most suitable unions to be selected for the first year were presented. The UP Chairmen and thana managers discussed the issue, and then approved some unions with or without any change. The Thana Parishad endorsed this selection later, at its regular meeting.
2. The THFPO, in consultation with other managers, field workers and the TNO, selected the unions found suitable as per the prefixed criteria, and then contacted respective chairmen to work with the Thana Committee for site selection. The Thana Parishad endorsed this selection later, at its regular meeting.

The appropriate approach for a particular thana was chosen by the concerned managers. Table 1 shows the list of the selected unions in the three ORP thanas.

**Table 1.** Final selected unions for establishment of Community Clinics in 3 ORP thanas: first year, May 1999-June 2000

<b>Abhoynagar</b>	<b>Mirsarai</b>	<b>Patiya</b>
Rajghat*	Dhum*	Kharana*
Paira*	Durgapur*	Baralia*
Baghutia*	Hinguli*	Dhalghat*
Sreedharpur*	Mirsarai*	Haidgaon*
	Moghadia	Asea
	Karerhat	Jungle Khain
	Saherkali	Kasiais
		Dakhsin Bhurshi
		Chhanhara
		Kelishahar
		Sobhan Dandi
		Habilas Dwip

\* Covered under longitudinal surveillance system

## **7. Site Selection Activities**

### ***Briefing meeting with UP Chairmen***

Formal briefing sessions were held at THC's with the UP Chairmen and members of the selected unions to discuss key features of the GOB guidelines (April-May 1999). All these meetings were initiated through the Thana Nirbahi Officer (TNO). As the TNO maintains routine official contact with the UP Chairmen in connection with various development projects, the organizers assumed that the UP Chairmen would respond more favourably to TNO's request for a meeting on CCs and this did occur. The THFPO, Thana Engineer of LGED, TFPO, ATFPO and the ORP officials were also present at the meeting. With the anticipation that the donated lands might need to be verified with regard to ownership disputes, the Assistant Commissioner (Land) was invited to the meeting. As expected, his involvement in the process led to a better understanding of government formalities regarding transfer of ownership of land, dispute-free certification, registration fees, mutation, etc.

Although the TNO had been assigned by the government to work as the appellate body for resolving disputes on site selection, his participation in the briefing sessions and similar meetings proved useful to generate a positive impact on agreement of the site selection. As a key personnel of the Thana Parishad, the TNO's familiarity

with the thana-level local government activities and the formal and informal community representatives helped in amicable resolutions of many related issues, e.g., inappropriateness of site proposals, and reconciliation of conflicting interests among the community leaders.

Presentations were made on the HPSP, ESP and Community Clinics by the ORP facilitators. The shift in service delivery strategy from a household-visitation approach to a static centre approach and formation of the Community Groups were also focused upon during the discussion. The UP Chairmen were substantially briefed on their role in implementing the programme, including active participation in establishment, maintenance and operation of CCs in their respective areas. The GOB's roles and responsibilities were also explained at the meeting. The criteria for site selection of CCs as prescribed by the government, were discussed in detail. The meeting attendees were informed about the number and location of provisionally selected sites, by the health and family planning field workers, in consultation with the community and the UP Chairman, according to the GOB guidelines. Questions were raised by the participants on different practical issues which were not addressed by the GOB guidelines (April-May'99). One of the vital questions raised was about who would pay for land registration fees. When asked about the matter, the PCC-MCU officials confirmed that the community would bear it. This message was, then, disseminated among the UP Chairmen and Members with 3 options suggested by the ORP to resolve the matter. These options for paying land registration fees include (1) land donor, (2) subscription from the community, and (3) any individual of the community. Many questions were also asked about the "modus operandi of the Community Group", which is not specified in the guidelines or PIP.

When the layout of the proposed clinic building was shown to the audience the participants expressed their serious concern about the semi-pucca structure of the facility. They argued that it would not be sustainable in the cyclone-prone areas if the rooftop is built of corrugated tin-sheets only. They suggested that the building should be fully pucca (brick-built with concrete roof) with MS angles and steel-made doors and windows. They also argued that there should be a provision for horizontal/vertical extension of the building in the future. The participants were critical about the proposed seating arrangement for the HA and the FWA at CCs. Instead of sitting side by side sharing a single table in one room, HA and FWA should sit in two separate rooms for maintaining privacy of clients, especially of females. The participants also suggested that provision for electrical wiring of the clinic building, fans, and security lights be made. They advised that toilets be built in two separate corners with the entrance facing outwards or that a provision be made for one toilet inside the building.

### ***Formation of Community Groups***

Community Groups, each consisting of 7-9 members, were formed for all CCs to be newly constructed. The GOB guidelines were followed for formation of Community

Groups. As mandated by the GOB guidelines on CC, the HI and FWV established the first official linkage with concerned UP Chairman for group formation. They were actively assisted by AHIs and FPIs (although their role in this matter was not mentioned in the guideline) and ORP workers. The UP Chairman took the lead role and assigned individuals he trusted to work with the group. The group members, in consultation with the concerned union supervisors (HI, AHI, FPI) and FWV, selected one Member-Secretary out of the two field workers (HA, FWA) and selected a President from among the remaining members. The male HAs were preferred as Member-Secretary and the land donor was preferred as President of the Community Group. The FWAs were rarely chosen as Member-Secretary. In some areas, the HA and FWA were assigned to work as Member-Secretary on rotation or separately in two different groups of the same union, as their job allocation in this respect was not separately written in the guideline.

#### ***Selection of sites by the Community Group***

After having threadbare discussion, the group members agreed upon the sites to be proposed for CCs. At the onset of the meeting, the group was apprised of the previous groundwork done jointly by the GOB and ORP field workers. The GOB and ORP workers extended necessary technical assistance to the group. The Community Group finally submitted a written proposal on the selected sites to the Union Parishad for its approval. The proposal from the Community Group was enclosed with a resolution, a map of the union showing the location of proposed sites along with necessary information, e.g., population of the catchment villages, mauza and plot numbers and area of the proposed land, etc.

#### ***Union Parishad meeting for approval of Community Clinic sites***

Special Union Parishad meetings were held to discuss the proposals submitted by Community Groups for site selection. Although the sites proposed by Community Groups were finally approved in most cases, there were disagreements in some cases regarding the location of some specific sites. In such situations, the Union Parishad advised the Community Group to submit alternate or revised proposals. The approved proposals along with resolutions and maps were given to the Thana Committee for site selection by the UP Chairman for taking necessary actions as required.

#### ***Thana Committee meeting for finalization of proposals***

The THFPO convened a follow-up meeting of the Thana Committee with the UP Chairman for finalization of the proposals. The meeting was attended, among others, by the Thana Engineer-LGED, TNO, AC (Land), TFPO, ATFPO and the ORP officials. The meeting reviewed all proposals recommended by the Union Parishad and these were cross-examined with the respective UP-Chairman. Transparency sheets, showing the location of CCs on union maps, were prepared for open discussion. The concerned UP Chairman was then individually requested by the Chair to justify the selection. It

appeared that some of the approved sites/proposals had faced disputes from the community (one such case was evidenced at Abhoynagar and six at Patiya). While four of the disputes could be resolved by the TNO and THFPO in consultation with the formal and informal community leaders, three are in the process of formal hearings by the appellate body (TNO). Other dispute-free proposals were unanimously accepted for submission to the Line Director (Construction), subject to completion of registration formalities by the Community Groups. It was observed that the Community Group and Thana Committee had to face a considerable political pressure from the beginning of the process. This was minimized tactfully by the UP Chairmen, TNO and THFPO.

In the first phase, fifty-four (54) sites have been finally selected in 23 unions of the 3 ORP thanas for establishment of CCs, of which two clinics will be established at cyclone shelters. Table 2 shows the total number of Community Clinics as planned in ORP thanas for the first year.

**Table 2. Community Clinic profile in 3 ORP thanas**

Thana	Union	Population	Community Clinics (CC)		
			In H&FWC	New CC	Total
Abhoynagar	Rajghat	34,131**	1	3	4
	Paira	15,999	1	2	3
	Sreedharpur	26,674	1 (RD)	5	6
	Baghutia	18,483	1	3	4
Mirsarai	Hinguli	33,131	1	4	5
	Dhum	19,000	1	2	3
	Durgapur	22,850	1	2	3
	Mirsarai	26,515	1	3	4
	Shaherkhali	17,821	1	2	3
	Moghadia	24,788	1	3*	4
	Karerhat	35,787	1	4*	5
Patiya	Baralia	15,944	1	2	3
	Dhalghat	19,556	1	2	3
	Haidgaon	10,308	1	3	4
	Kharana	15,386	1	1	2
	Asea	12,502	1	1	2
	Junglekhain	16,716	1	1	2
	Kasiais	10,517	1	1	2
	Dakhsin Bhurshi	11,755	1***	1	2
	Chhanhara	21,263	1	2	3
	Kelishahar	18,263	1	2	3
	Shovan Dandi	19767	1	2	3
	Habilas Dwip	21,255	1	3	4

\* No construction required; Community Clinics to be established at the cyclone shelters.

\*\*Some areas of this union are declared as municipal areas and, thus, left out of the planning for CCs.

\*\*\*UHFWC yet to be constructed; site for UHFWC is selected.

## **8. Stock-taking Workshops/Meetings with Union Supervisors**

On completion of site selection, stock-taking meetings were organized at the THC's with the union supervisors (HI, AHI, FPI) and FWV to learn of their experiences gained in site selection and Community Group formation. The supervisors mentioned that the Community Groups, so far constituted, were basically chairman-influenced. They

further added that the community was willing and able to donate land for Community Clinics, but their expectations were very high. The supervisors opined that preference was given to the male HA for the post of the Member-Secretary, in most of the Community Groups for convenience of the task. They also mentioned that the Community Groups should have a funding arrangement for doing maintenance work. The AHIs and FPIs expressed concern about their role ambiguity in the guideline in the process of Community Group formation and site selection.

## **9. Focus-group Discussions with Community Groups**

Focus-group discussions were held at the Union Parishad office with a Community Group at Paira union and another at Baghutia union of Abhoynagar thana during 22-23 August 1999. The Community Groups were found eager to pay for registration of the land when options were placed before them. Several members of the groups expressed their willingness to contribute to the same. The group members were adequately briefed about the Community Clinic and its functions, their roles and GOB's contribution, as detailed in the guidelines. In addition, the ORP-facilitators exchanged views with them on several critical issues not mentioned in the guideline. These include generation of fund for maintenance, terms of reference/modus operandi, security of the clinic and signing of a memorandum of understanding between the government representative and the Community Group. Some land donors wanted to know whether their names would be kept on display at the Community Clinic. It was felt that the Community Groups should have further technical assistance in shaping up its organizational capacity.

## **10. Technical Assistance and Documentation**

Necessary technical assistance was extended by the ORP to the thana managers, field workers and Community Groups in accelerating the site selection process. These include logistical support in organizing workshops and other meetings, basic support to the Community Group (in preparing union maps, holding group meetings, writing resolutions and proposals to the union parishad), field visits, linkage with PCC-MCU officials for review of key findings and feedback, as well as documentation of the process and dissemination.

## **11. Important Observations**

### **11.1 Community Group Issues**

#### ***Agreement with the Community Group***

The GOB guidelines on establishment of CCs (April 1999) envisages that the Community Groups would play specific roles in selection of sites, donation of lands,

and ensuring security and maintenance of the CCs, while the GOB inputs would include construction of the building, medical supplies, equipment, furniture and manpower. Both the GOB and Community Groups are expected to oversee the effective functioning of the CCs. It seems that this joint effort to promote CC would be better materialized if documented through an agreement. Hence, signing of an agreement (Memorandum of Understanding) between the Community Group and the GOB representative (THFPO/UP Chairman) on respective roles and responsibilities should be considered to help institutionalize this functional bondage and mutual obligations. Such an agreement would also endorse the Community Group in operating within a legitimate framework.

### ***Modus operandi of the Community Group***

- a. There should be a well-written modus operandi (or terms of reference) for the Community Group to make it efficient and sustainable. This would determine the rules of business especially related to:
  - the tenure of the groups
  - distribution of task
  - work plan
  - accountability
  - formation of a new group
  - termination factors of the members in case of death, resignation or incapacitation
  - incentive/disincentive (if possible)
- b. Funding arrangement for Community Group.

It is quite important to find out how the Community Group can generate funds for day-to-day and long-term maintenance expenditures. How much does it really need to meet the recurrent expenditure?
- c. Security arrangement for the CC by the group needs further examination.
- d. Ad-hoc arrangements to address these issues should be made available to operationalize the group. In-depth studies should be simultaneously conducted to explore workable solutions to these queries.

### ***New Community Clinics and UHFWC-based Community Clinics***

It has been stated in the GOB guidelines (April-May 1999) that the catchment population of UHFWC-based Community Clinic will receive services similar to a Community Clinic from the existing UHFWC and as such, construction of a new Community Clinic shall not be required for that population.

- a. A question, thus, arises as to whether the Community Group would be formed for the UHFWC-based Community Clinics? If not, there would be a clear inequality between the service recipients of the unions having both new CCs with Community Groups and UHFWC-based Community Clinic without a Community Group. This inequality becomes more evident in terms of maintenance expenditure that would be incurred by the Community Groups for new CCs, while no such expenditure is required for a UHFWC-based Community Clinic. It appears that, in a same union, several groups of inhabitants will have to bear the maintenance expenditure for their new CC, while one particular group of inhabitants does not need to bear the maintenance expenditure of their UHFWC-based Community Clinics (because the UHFWCs are fully maintained by the MOHFW).
- b. Besides maintenance, the Community Groups will have to look after security of the CCs. No such responsibility lies with the population expected to receive similar services from the UHFWC-based CCs. These issues (a+b) need to be clarified as these raised confusion among the villagers (Table 3).

**Table 3.** Difference between the Community Clinics to be newly constructed and the Community Clinics to be housed in the Union Health and Family Welfare Centre (UHFWC)

Sl. No.	New Community Clinic	UHFWC-based Community Clinic
1.	Community Group has defined roles and responsibilities	No such Community Group
2.	Maintenance and security are to be ensured by the Community Group	Maintenance and security are ensured by the government
3.	Land for construction of Community Clinic is to be donated by the community	Existing UHFWC will act as the Community Clinic. No new construction is proposed
4.	Staffing includes (HA and FWA) two personnel only	Staffing is different in number and category (more than two personnel with different backgrounds)
5.	Floor space is well-defined	Unclear

***Member-Secretary of the Community Group***

The Community Group members and the GOB union supervisors were confused regarding selection of the Member-Secretary of the Community Group. It is stated in the GOB guideline (April-May 1999) that either the HA or FWA would act as the Member-Secretary of the group. Such an option created some confusion, since both of

them are equally deserving. However, the concerned field staff settled the matter themselves by applying two methods: (1) placement of both the workers (HA and FWA) to act as Member-Secretary of a group by rotation, and (2) placement of one of the field staff members (HA) working in one group and the other (FWA) in another group of the same union. The third option could be that the Community Group to select one Member-Secretary out of the two field workers (HA/FWA) in the first Community Group meeting.

In most Community Groups, male HA-preference was observed for the post of Member-Secretary while FWAs and female HAs were selected for a very few Community Groups.

## **11.2 Procedural Issues**

### ***Selection of Unions***

The approved number of CCs to be constructed during May 1999-June 2000 is given in the GOB guidelines (April-May'99) for each thana separately, and the individual Thana Committee is supposed to work out the union-wise distribution of these CCs. Therefore, it is essential to select some unions in the first phase as it links the thana managers with the concerned UP Chairmen and Community Group formation. It was observed at the ORP field sites that the THFPOs had adopted the following two different types of strategies to select the unions for construction of Community Clinics during the first phase.

- a. After having open discussion with all UP Chairmen in the light of GOB guidelines, the most suitable unions were selected on the basis of consensus and the "concerned UP Chairmen" were included in the Thana Committee for site selection. This process of union selection was then endorsed by the Thana Parishad in its regular meeting (Mirsarai).
- b. The THFPO, in close consultation with the GOB field staff and the TNO, reached an agreement on selection of suitable unions and then contacted the respective chairmen to work with the Thana Committee for site selection. Suitability of unions was judged on the basis of good access to the area, adequate staffing, optimal geographical coverage and existence of a close monitoring system.
- c. The THFPOs, in both the approaches, took advantage of having the ORP's longitudinal surveillance system, and included the unions with surveillance in their selection for better monitoring.

### ***Influence of pressure groups***

Active support of elected representatives e.g., UP Chairman, Member and Member of Parliament, have truly helped in gaining community mobilization for this new initiative. However, in actual practice, the Thana Committee had to bargain with different

organized socio-political groups regarding selection of sites for CCs. Some influential people even applied pressure tactics to accept their offer of land which did not fulfill the conditions of the guidelines. The Thana Committee patiently resolved these problems mostly through repeated dialogue with their counterparts, involving the TNOs, UP Chairmen and local MPs. In some places, such reconciliation effort did not work, rather written objections/appeals were tabled, or untoward incidents happened. These events took a considerable time to settle down, and thus, delayed the process of site selection. However, the orientation activities conducted at the outset seemed to have resulted in the UP Chairmen being committed to the GOB guidelines.

### ***Land registration fees***

On several occasions, during orientation workshop/briefing sessions on ESP-Community Clinic at the field level, questions were raised about who would pay for registration of the donated land, as it is not clearly defined in the GOB guidelines (April-May 1999).

The issue was informally discussed with the PCC-MCU officials in May-June 1999. It was understood from the discussion that, to generate a sense of belongingness and participation among the people, the community should be pursued to bear the expenses of land registration. Accordingly, the following options were made by the ORP to help resolve the issue: (a) the land donor, (b) subscription from the community, and (c) any individual belonging to that community.

This message was quickly sent to the three ORP field sites, and the thana managers started pursuing the land donors, Community Groups and UP Chairmen to mobilize funds for land registration by adopting any of the aforesaid options. The attempt was fruitful in getting a positive response from the community. An amount of Tk.500-Tk.1500 was required for registration of each piece of land. An additional amount of Tk.200 was required for getting certified copies of land registration document in each case. However, the TNO and the AC-Land were requested by the thana managers and the community to examine the possibility of reducing this fee to a minimum amount.

### ***Low-lying land***

The community preferred mostly farmland for donation, which is usually a low-lying area. It appeared to be a common trend with only a few exceptions. The consideration of land value could be a possible explanation for this. However, in all the places, the community came forward for earth filling by voluntary labour and donation. The role of Union Parishad was very supportive in organizing this voluntary participation of the community.

### ***Greater involvement of the TNO/Thana Parishad and AC (Land)***

It was observed that the UP Chairmen and Members usually maintained a cordial relationship with the TNO in the interest of various development projects of the local government. On top of that, the TNO is the focal point of GOB's thana functionaries in the absence of the elected Chairman of the Thana Parishad. Therefore, it seems that the scope of TNO/Thana Parishad's involvement in the establishment of CCs should further be increased to create a greater influence on the UP Chairmen and Members. It is notable that the Thana Parishad was approached by the THFPOs for endorsement of the final selection of Unions, the procedure of which was not clearly described in the GOB guidelines.

The AC (Land), Sub-Registrar, and Tahshildar are the key people directly involved in the process of transfer of ownership of land, issuing dispute-free certificate, clearance of tax, mutation, etc. These documents are essential for the registration of land. It seems that inclusion of AC (Land) in the Thana Committee can help expedite the process of site selection.

### ***Thana Committee for site selection***

As the GOB-guidelines on CCs (April-May 1999) did not include the TFPO and the MO (MCH-FP) in the Thana Committee for site selection, they were found a bit displeased and were critical about the decision. On the other hand, the ATFPO, who has been officially assigned to work as Member-Secretary of the same committee, was in dilemma to cope with these changed circumstances. However, the THFPOs proceeded with care and caution to deal with this sensitive issue. The experience of good working relationships and mutual understanding indeed helped them to ease this tension. It is practically understood that a more congenial atmosphere would have been created by simply including the TFPO and the MO (MCH-FP) in the Thana Committee for site selection.

It was further observed that the Thana Committee and the Community Group really needed to consult with the AC (Land), Sub-Registrar and Tahshildar for certification on dispute-free land, transfer of ownership, mutation, and tax clearance. Therefore, these things would have been easier for them if the AC (Land) had been included in the Thana Committee.

### ***Scrutiny of proposals and documents by district managers***

The GOB guidelines suggested that the Thana Committee would send proposals, together with all necessary documents, directly to the Line Director (Construction)-cum-Joint Secretary (Coordination) of the MOHFW.

It would have been more prudent to have the proposals and documents scrutinized by the concerned district managers (Civil Surgeon or Deputy Director-Family Planning or both) before the final dispatch to the MOHFW.

Further involvement of the district managers, as and when required in the process of implementation seems to be very important.

### ***Pocket population***

In some places, a pocket of small and isolated population exists in a remote corner of the catchment area of a CC. These populations do not have good access to the existing health centres, and they need to be served by home visitation and satellite clinics/outreach centres. Careful consideration should be given to their needs when the phase-out of home-visitation is designed. Close monitoring and epidemiological surveillance should be continued in these areas to decide on phasing-out of those satellite/outreach centres.

### ***Inconvenient location of cyclone shelters***

In the cyclone-prone areas, the multipurpose cyclone shelters would be used as CCs. However, when the catchment population around the cyclone shelter were considered, it was found that some cyclone shelters were not located at a centrally convenient place and did not fit-in with the criteria of the guideline. Moreover, in some places, the cyclone shelters are being used as schools. In such situations, the community preferred to select an alternate site for construction of new clinic buildings. The MCU-PCC officials, who were consulted about the matter, suggested that if the concerned cyclone shelter is grossly deviated from the central location, an alternate site could be considered.

### ***Role of the FPI and AHI***

According to the GOB-guidelines on CCs (April-May 1999), the HIs and the FWVs have been assigned to initiate the formation of Community Groups by contacting with the UP Chairmen. However, the roles of FPIs and AHIs, have not been mentioned in the guideline. Despite their role ambiguity, FPIs & AHIs worked with HIs and FWVs throughout the process as directed by the THFPOs. Although it is implied by the current job description that the AHIs would work under the supervision of HIs, it is not applicable in the case of FPIs as they are not under the administrative control of the FWVs. It is felt that if FPIs and AHIs are officially assigned to work with HIs and FWVs by a subsequent GOB notification, the line functionaries at the union level would be further activated. Moreover, FPIs and AHIs should be actively considered for conducting mainstream BCC/MIS activities instead of fully depending on HAs and FWAs, who would be directly involved in Community Clinics' service-delivery.

### ***Existence of NGO clinics and Rural Dispensaries near Community Clinics***

There could be duplication of services in some places where NGOs are running similar clinics within the catchment area of a CC. The same possibility lies also with the Rural Dispensaries as well. Site selection of CCs should, therefore, be coordinated with the aforesaid NGO facilities and Rural Dispensaries.

### ***Preparation of thana and union maps***

It was observed that the thana and union maps were not readily available at the THCs. The health and family planning personnel working at the thana-level and below were not used to prepare such maps. However, as per requirement, some maps were collected from the thana LGED/AC-Land's office, while some other maps were prepared and supplied by the ORP field staff. The thana LGED/AC-Land's office could serve as a good source of these maps.

### **11.3 Structural Issues**

The physical structure of CC needs to be appropriate to the context of the climatic conditions of Bangladesh, such as nor-wester, monsoon, tornado, cyclone and flood. With that consideration, the rooftop of the building should be made of concrete (instead of corrugated tin-sheets) sloping on either side, if possible.

Two toilets may be constructed outside the building or adjacent to each room with entrance of the toilets facing outwards or provision for one toilet inside the building could be considered.

Provision for electrical wiring is necessary to install fans and security light in the clinic. Also, a partition may be built in the waiting room for convenience of female patients to sit more comfortably.

## **12. Lessons Learned**

The following lessons are learned during the facilitation efforts made by the ORP in selecting sites for the Community Clinics:

- Facilitation in the form of orientation and briefing sessions, planning workshops and focus-group discussions conducted at the thana and union levels with managers, field workers, UP Chairmen and Community Groups were found effective in mobilizing the community and capacity-building of the concerned government personnel.
- Contrary to prior apprehension, the community was found generally willing and able to donate land for CCs along with fees required for land registration. Community Groups, so far constituted, are basically UP Chairman-driven.
- When options were made available for the Community Groups for paying land registration fees, the reaction was positive on all occasions. Three options followed in this regard by the ORP worked well and received good response from the community. These were: (i) land donor, (ii) subscription from the community, and (iii) any individual of the community. The range of registration fees in Abhoynagar was Tk. 400-500 per piece of land. In Chittagong (Mirsarai and Patiya), it was Tk.1000-1500 per piece of land. An additional cost of Tk.200 is also involved for obtaining a certified copy of registration.

- Clarification is required on the procedure of union selection as it comes first in the process to identify the “concerned UP Chairman” for inclusion in the Thana Committee.
- The TNO has close working relationships with the UP Chairmen/Members in connection with various development projects. Therefore, the TNO’s involvement in the process of operationalization of the CCs can create a positive impact on the UP Chairmen/Members. Besides his role as appellate body, the TNO can play a critical role in resolving disputes regarding site selection, Community Group formation, etc. in an informal way. As an elected body of the Local Government, the Thana Parishad also appeared to be instrumental in the process.
- Information gaps, influence of local pressure groups, appeals and procedural short-comings of the GOB guidelines (on payment of land registration fees, procedure of union selection, role definition of TFPO, FPI and AHI and composition of Thana Committee) are probable reasons which might have delayed the process of site selection.
- Decision on formation of Community Groups for UHFWC-based and cyclone shelter-based CCs is required to maintain equality with other Community Groups already formed for the CCs to be newly built.
- The community actively participated in earth filling of the low-lying land by voluntary labour. In some places, the Community Group collected donations/subscriptions from the villagers for doing the same.
- Some pocket populations have been found, isolated from the existing health centres, due to the existence of natural barriers. Thus, they may not get easy access to the proposed CCs. They are presently dependent on home-visits by HA and FWA and satellite/outreach centres. These isolated populations need to be considered during phasing-out of doorstep services.
- Thana and union maps were not readily available at the THCs. Necessary maps were collected from the thana LGED/AC-Land’s office.
- When the proposed layout of the Community Clinic was discussed with the Community Groups and UP Chairmen, suggestions came in favour of having a concrete rooftop with provision of vertical/horizontal extension of the building for future. They also opined that two toilets may be built outside the building or kept attached to rooms on each side, keeping the entrance of the toilets outwards or one toilet may be built. Provision for electrical wiring for installation of fans and security lights, a separate waiting space for male and female patients and separate seating arrangements for HA and FWA were also requested.

## **13. Recommendations**

### **Specific Recommendations**

1. Orientation of the district and thana officials, union supervisors and service providers should be organized immediately to expedite the process of site selection.
2. Orientation/briefing meeting of the UP Chairmen and other community leaders should be organized to give them a clear understanding of the GOB guidelines.
3. Thana Committee on site selection for the CCs should be reconstituted to include TFPO, MO-MCH and AC (Land). Other officials may be co-opted, as deem fit.
4. Involvement of the LGED/AC (Land)'s office should be ensured in obtaining/preparation of thana and union maps.
5. AHI's and FPI's involvement in the process of formation of Community Groups should be mentioned in the government guidelines.
6. Involvement of Thana Parishad/TNO in the implementation process should be ensured.
7. In case of disputes, legal aid for the Thana Committee should be ensured.
8. A formal agreement (MOU) should be signed between the government/local government representative (THFPO/UP Chairman) and the Community Group on their roles and responsibilities.
9. Provision for minimum land registration fee and other ancillary costs (for obtaining certified copy of the deed) should be discussed and finalized with the relevant agencies.
10. There should be provision for options (land donor/subscription/any individual of the community) regarding payment of land registration fees.

### **Issues to be Resolved**

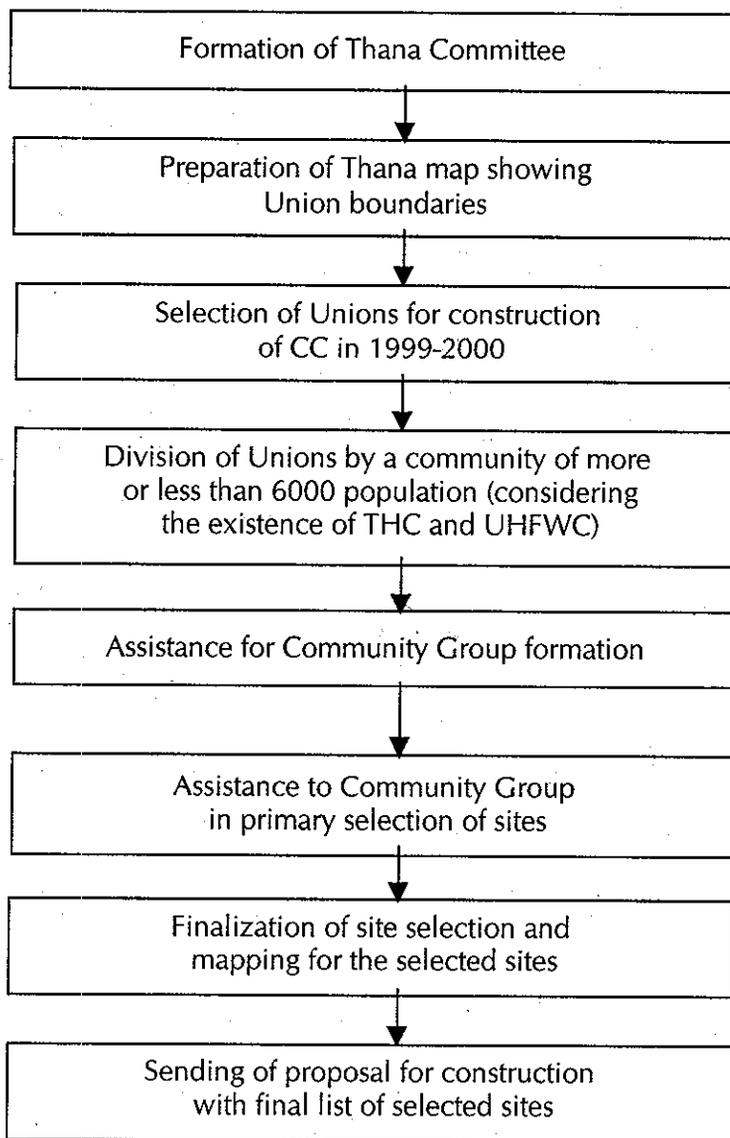
- a. Modification of the CC's layout be made, considering the climatic context and norms of rural life as follows:
  - Concrete rooftop, instead of corrugated tin-sheets, be considered.
  - Toilets to be built-in two corners with entrance facing outwards, or provision for one toilet inside the building be made.
  - Installation of a tube-well at a safe distance from the toilet inside the building be ensured.

- Provision for electric wiring be made.
  - Separate consultation tables for providers (HA, FWA) with seating arrangement in separate rooms may be considered.
  - Provision for horizontal extension of the building, waiting space in particular, be made.
- b. Involvement of district managers in monitoring and supervision of site selection and construction be ensured;
- monthly update from the THFPOs on site selection/construction to the District Managers,
  - feedback from the MOHFW to the District Managers on the national status of CC site selection/construction.
- c. Decision be given on display of the land donor's name at the CC.
- d. Development of a modus operandi for the Community Groups be considered.
- e. Some facilitation mechanisms be initiated to expedite appropriate implementation of the site- selection process.

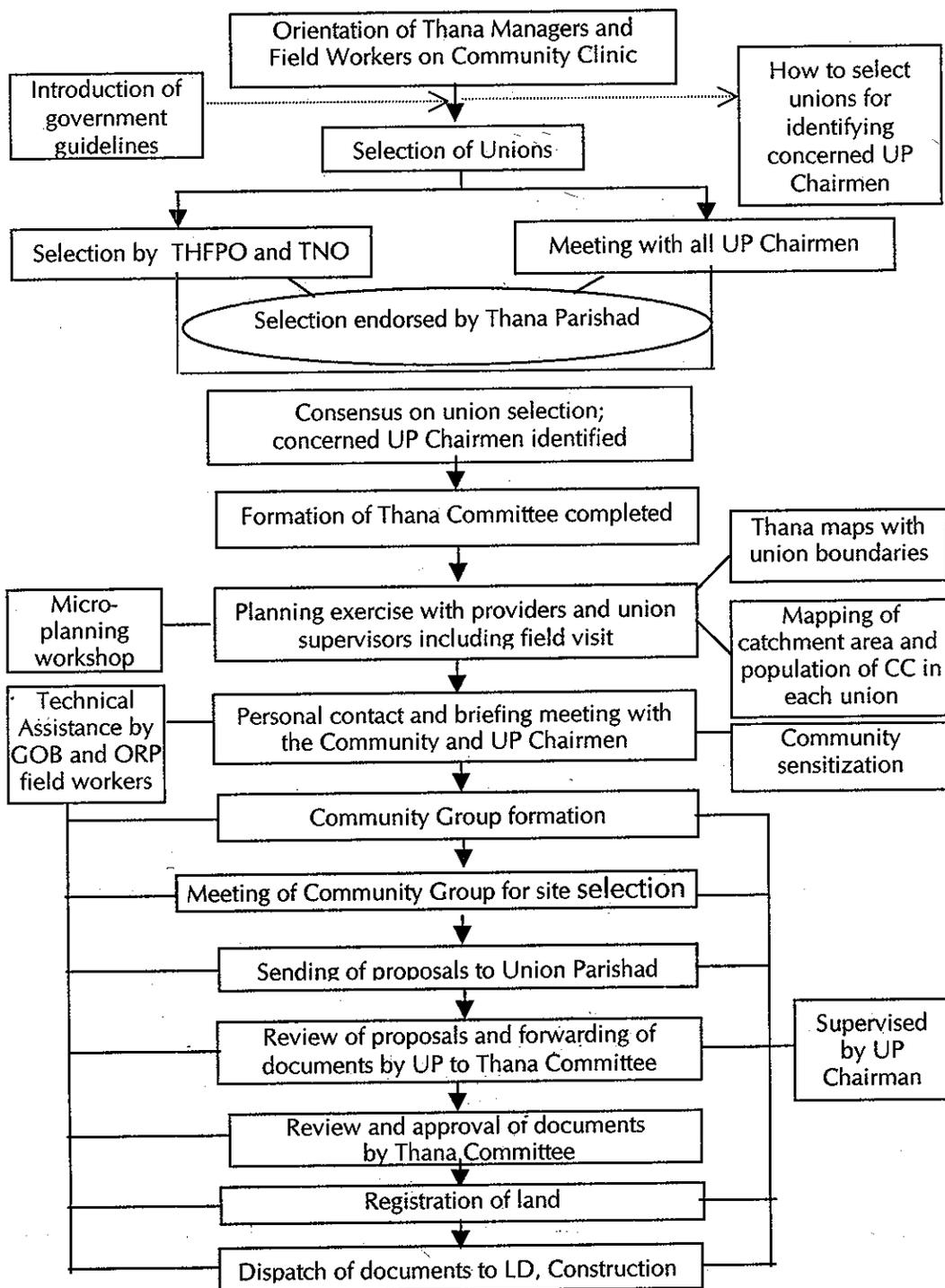
## References

1. Ministry of Health and Family Welfare. Health and Population Sector Programme (HPSP), 1998-2003: Project Implementation Plan, Part I and II. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 1998.
2. Ministry of Health and Family Welfare. Guidelines on Establishment of Community Clinics. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 1999.
3. Ministry of Health and Family Welfare. Circular on Establishment of Community Clinics. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 1999.

**Steps Suggested by the MOHFW Guideline for  
Site Selection of Community Clinics**



Steps followed by Thana Managers for Site Selection of Community Clinic



## MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. In 1982, the MCH-FP Extension Project (Rural) with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants.

Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, management information systems, and strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

The Centre and USAID, in consultation with the government through the Project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve the commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.

## The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to programme managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of underserved and population-in-need. There are various projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures. These cut across several Divisions and disciplines in the Centre. The Operation Research Project (ORP) is the result of merging the former MCH-FP Extension Project (Rural) and MCH-FP Extension Project (Urban). These projects built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. Together with the Environmental Health and Epidemic Control Programmes, the ORP provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. For one, the public health research activities of these Projects are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.

---



### **Operations Research Project**

Health and Population Extension Division

ICDDR,B: Centre for Health and Population Research

GPO Box 128, Dhaka 1000, Bangladesh

Telephone: (880-2) 8811751-60 (10 lines); Fax: (880-2) 8811568

E-mail: [misk@icddr.org](mailto:misk@icddr.org); URL: <http://www.icddr.org> and <http://www.icddr.org.sg>

3