REPORT ON COMMUNITY HEALTH CLINIC ASSESSMENT

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HELEN KELLER INTL

Sustainable Agriculture and Production Linked to Improved Nutrition Status, Resilience, and Gender Equity (SAPLING)

Report on Community Health Clinic Assessment

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LIST OF ACRONYMNS & ABBREVIATIONS

ANC	Antenatal care
ARI	Acute respiratory infection
BP	Blood pressure
CG	Community group
CHCP	Community health care provider
CSBA	Community skilled birth attendant
CSG	Community support group
EPI	Expanded program on immunization
FWA	Family welfare assistant
FWV	Family welfare visitor
GMP	Growth monitoring and promotion
GOB	Government of Bangladesh
HA	Health assistant
HKI	Helen Keller International
IFA	Iron-folic acid
HPNSP	Health, population and nutrition sector program
MCHN	Maternal and child health and nutrition
MCI	Mass casualty incident
MOCHTA	Ministry of Chittagong Hill Tracts Affairs
MOHFW	Ministry of Health and Family Welfare
OPL	Offset pit latrine
PL	Pit latrine
PNC	Postnatal care
SAPLING	Sustainable Agriculture and Production Linked to Improved Nutrition Status, Resilience, and Gender Equity
SBCC	Social behavior change communication
USAID	United States Agency for International Development
VAS	Vitamin A supplementation

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INTRODUCTION

On September 30, 2015, the United States Agency for International Development (USAID) awarded Helen Keller International (HKI) cooperative agreement No. AID-FFP-A-15-00010 to lead the pilot Development Food Security Activity (DFSA), Sustainable Agriculture and Production Linked to Improved Nutrition Status, Resilience, and Gender Equity (SAPLING) which is being implemented in collaboration with the Ministry of Chittagong Hill Tracts Affairs (MOCHTA). Under SAPLING, HKI, Catholic Relief Services, Caritas/Bangladesh, and three local implementing partners, (GRAUS, Toymu and Tahzingdong) are addressing food insecurity through an integrated, multi-sectoral approach that aims to sustainably improve nutrition outcomes for vulnerable populations, including women and children, and increase the resilience of households and communities to human-induced and natural shocks that threaten these outcomes. SAPLING is working with 104,331 participants from poor and extreme poor households, and those with children under two and/or adolescent girls, in all 24 unions and two *pourashovas* (municipalities) of five upazilas (sub-districts) of Bandarban District. These are Thanchi, Ruma, Lama, Rowangchari, and Bandarban Sadar, all of which have a high proportion of people living in extreme poverty, combined with high rates of stunting and undernutrition.

There are 70 community clinics in the SAPLING working area located in five upazilas of Bandarban District where basic health services such as antenatal care (ANC), growth monitoring, vaccination, Vitamin A supplementation (VAS) and other care are provided. Information on staffing, supplies and equipment, and services related to SAPLING's program areas has not been recently documented. The SAPLING project conducted an assessment of clinic operations in December 2019 in order to determine gaps and challenges to service provision for SAPLING participants. Trained data collectors used tablets to administer a pre-formatted questionnaire (see Annex 1) to visit each clinic and assess space, staffing, staff training, availability and use of water and latrines, equipment, supply of consumables (including medication), distance and modes of transportation for clinic catchment areas. Data consisted of both observation and questions asked of the clinic service providers.

Data were collected on tablets by experienced data collectors trained on the administered questionnaire. Data were synced and uploaded instantaneously to a secure online server when there was an internet connection or at the end of the day if there was not. The survey manager reviewed each survey upon completion to ensure accuracy in responses. Data were cleaned and analyzed descriptively using Stata v.14. Frequencies and percentages are reported for categorical variables and means for continuous variables.

Results are being used to inform SAPLING FY20 and proposed FY21 maternal and child health and nutrition (MCHN) programming. The Bandarban Civil Surgeon will also receive the report and SAPLING staff will discuss results to encourage the Ministry of Health and Family Welfare (MOHFW) to address identified gaps and challenges in service provision outside of SAPLING's scope. This assessment can be used by multiple stakeholders aside from SAPLING to fill gaps and provide a more sustainable and effective health care system in Bandarban.

RESULTS

COMMUNITY CLINICS AND CATCHMENT POPULATIONS

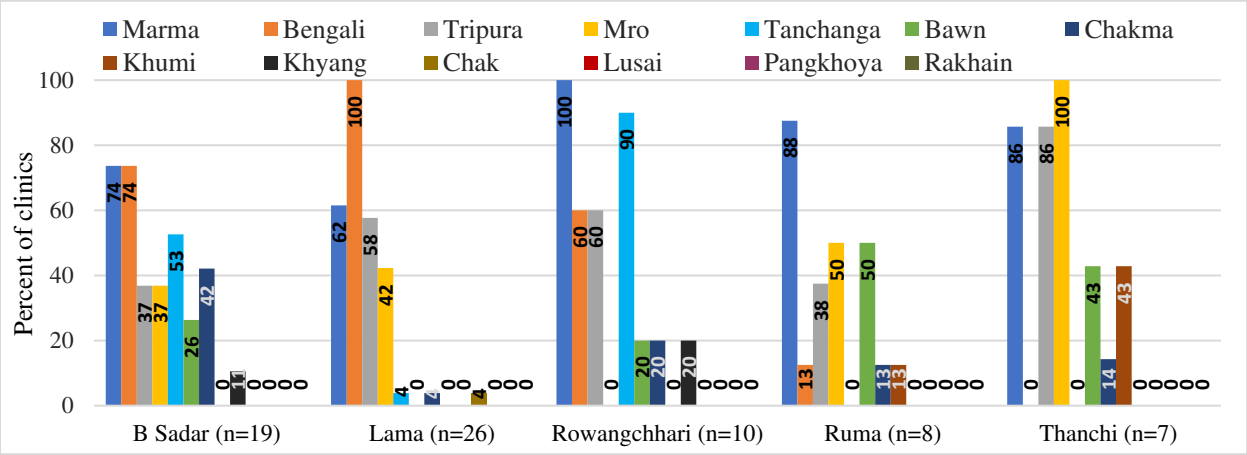
All 70 community clinics in the SAPLING working area were assessed. Table 1 summarizes the number of clinics surveyed along with their upazila (sub-districts) and union locations. Clinics have on average 13 para (villages) in their catchment areas, ranging from a mean of 17 para per catchment area in Lama, to 12 para in Thanchi, 11 para in Ruma, and 10 para per catchment area for each of the Bandarban Sadar and Rowangchari upazilas.

Table 1. Number of community clinics assessed by upazila and union

Upazila	Union	n
Bandarban Sadar	Bandarban Sadar	3
	Kuhalong	4
	Rajbila	4
	Suwalak	4
	Tankabati	4
	TOTAL	**19**
Lama	Aziznagar	5
	Faitang	4
	Fasyakhali	4
	Gajalia	3
	Rupshipara	3
	Sadar	3
	Sarai	4
	TOTAL	**26**
Rowangchhari	Alikhong	2
	Nowa Patang	3
	Rowangchhari	3
	Taracha	2
	TOTAL	**10**
Ruma	Paindu	3
	Remakri Pransa	1
	Ruma Sadar	4
	TOTAL	**8**
Thanchi	Balipara	2
	Remakri	1
	Thanchi	2
	Tindu	2
	TOTAL	**7**

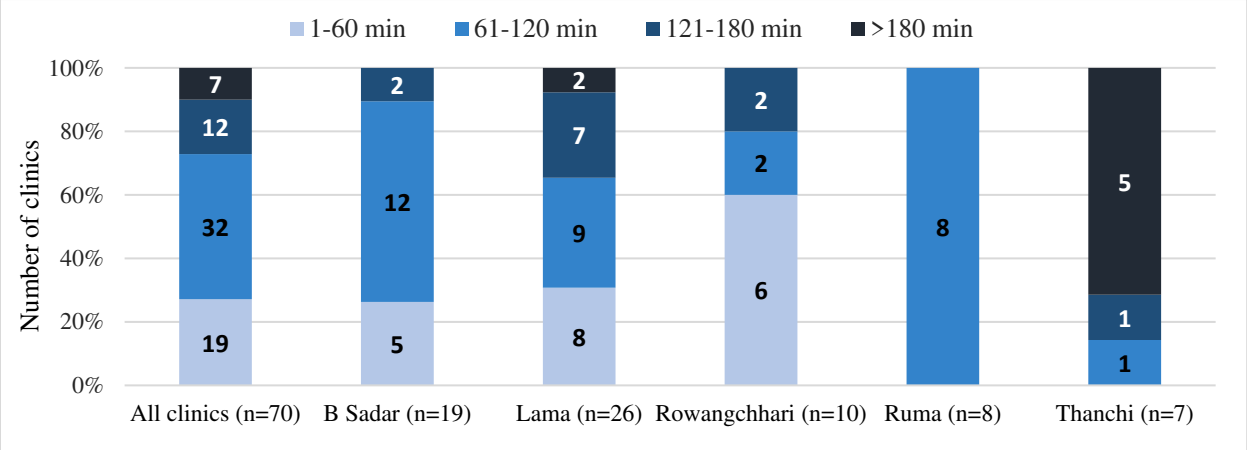
Each clinic was asked which ethnic groups are serviced in the clinic. These data were aggregated by upazila (Figure 1). In Bandarban Sadar Upazila, 74% of clinics say they serve patients who are Marma and Bengali, while 53% of clinics had patients who were Tanchanga, and 42% had patients who were Chakma, followed by 37% reporting Tripura and Mro patients, and 26% had Bawm patients. Data differ by upazila, with Lama clinics reporting 100% seeing Bengali patients, 62% with Marma patients, and 58% with Tripura patients. In Rowangchhari, 100% of clinics had Marma patients, 90% had Tanchanga, and 60% of clinics had Bengali and Tripura patients. In Ruma, 88% of clinics saw patients who were Marma, with 50% of clinics having patients who are Mro or Bawm. In Thanchi, 100% of clinics had Mro patients, while 86% had Marma and Tripura patients.

Figure 1. Percentage of clinics providing services to ethnic group, by upazila



Clinic staff were asked to report on how most patients travelled to the clinic and their transport times. More than 98% of clinics (n=69) said they are accessed only by walking. One clinic in Lama said patients arrive by auto rickshaw. The shortest mean travel time for all clinics was under ten minutes (data not shown). The longest reported travel time differs considerably by upazila (Figure 2), but the majority of clinics say the longest commute for patients is over 1 hour. In Rowangchhari and Ruma upazilas, the mean longest transit time is 1.5 hours, followed by Bandarban Sadar with a mean of 1.8 hours, Lama with two hours, and finally a mean of over four hours in Thanchi.

Figure 2. Longest reported transit/travel time to clinic, by upazila

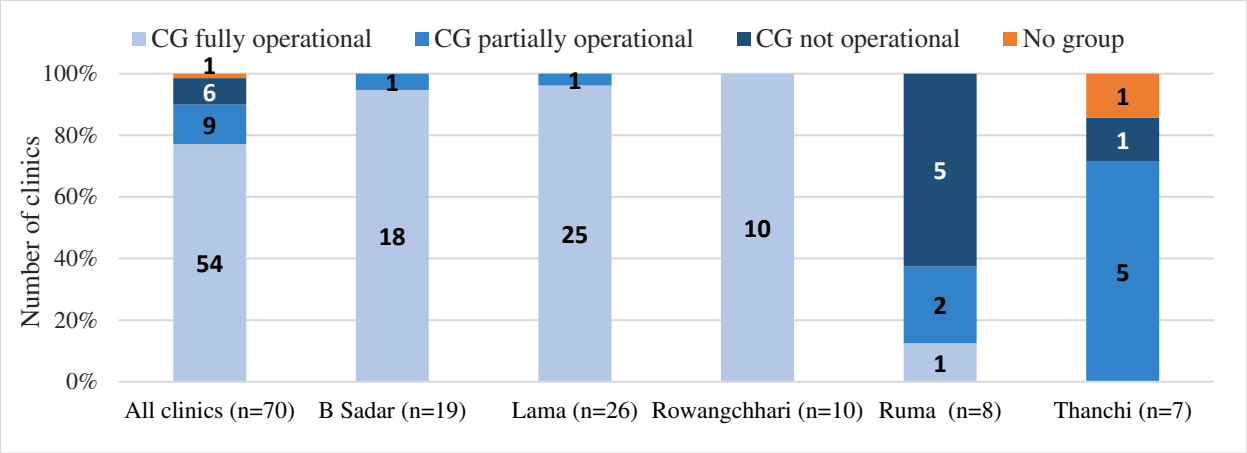


COMMUNITY GROUPS AND COMMUNTY SUPPORT GROUPS

Clinic staff were asked about the Community Groups (CGs) and Community Support Groups (CSGs) in their area. CGs are responsible for community clinic daily operations, monitoring of clinic functions, and fundraising for improvements in each clinic. CGs are mandated by the MOHFW and are the responsibility of the Civil Surgeon's Office and Upazila Health Complex. The CG should have nine to eleven members, with at least one-third membership reserved for women members and adolescent girls/boys and are led by the elected upazila member from the area. Other members include clinic staff, land owners and others in the community. CGs are required to meet monthly.

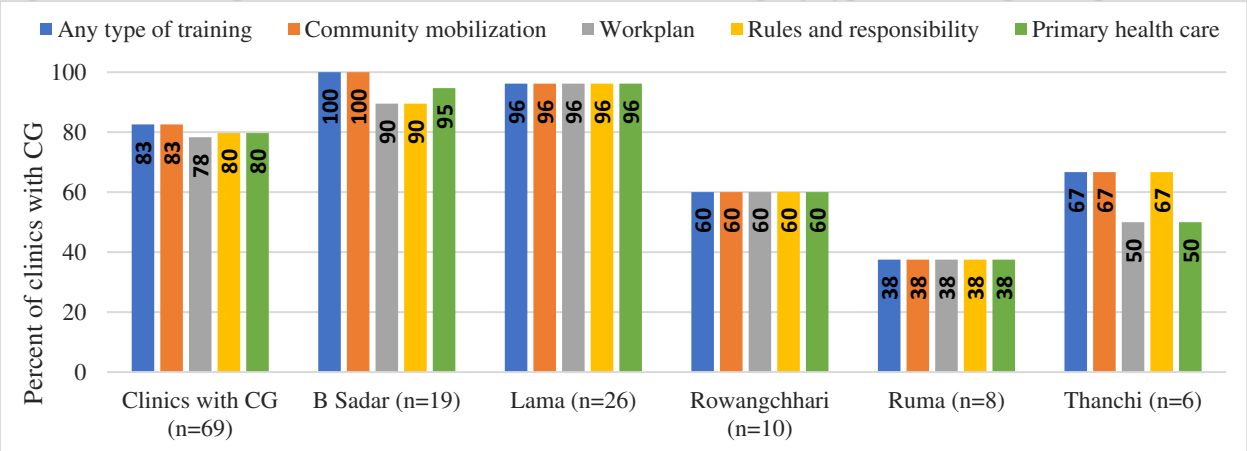
The survey asked about the existence and operation of the CGs. Almost all clinics in the areas (99%, n=69) said CGs had been formed with an average of 4.5 years since formation. Ninety-six percent of clinics with CGs (n=66) reported having 17 members and overall the ratio of mean number of female members to male members was six to eleven. Among all community clinics, 77% had fully operational CGs, meaning the group met 12 times or more in the past one year (Figure 3). Fewer clinics were partially operational, meeting less than 12 times a year, and not operational, saying they do not hold regular meetings. While CGs at clinics in Bandarban Sadar, Lama, and Rowangchhari were operating to expectation, 63% in Ruma were reportedly not operational and 71% in Thanchi were only partially operational, meeting on average only five times in the last year.

Figure 3. Operational status of community groups (CG) at clinic, by upazila



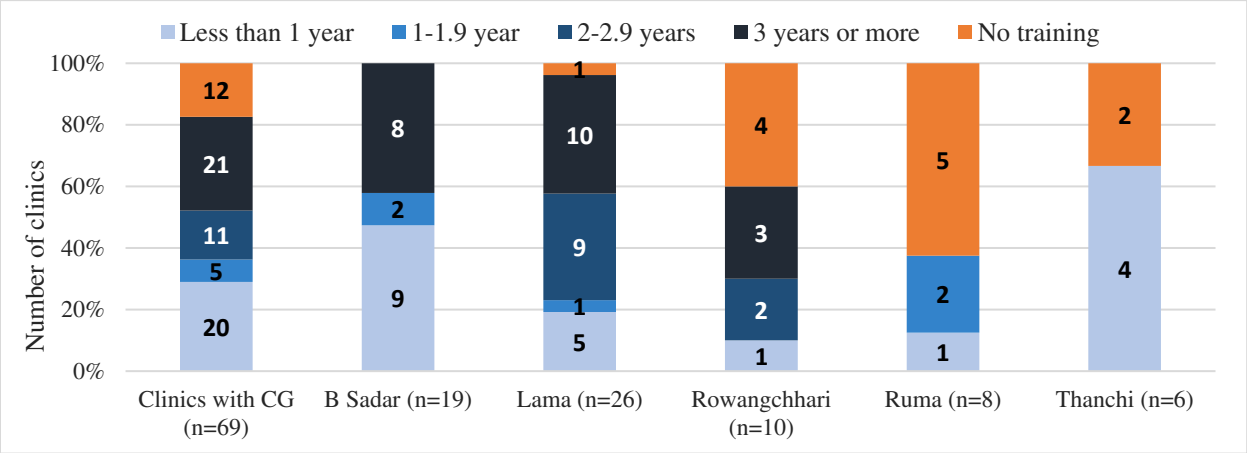
Training of CGs also differed considerably by upazila (Figure 4), with 100% of clinics with CGs in Bandarban Sadar (n=19) and 96% in Lama (n=25) reporting that their CG received any type of training, but only 67% in Thanchi (n=4), 60% in Rowangcchari (n=6), and 38% of CG groups in Ruma (n=3) receiving any training. Within each upazila, percentages of those receiving a training in different content areas did not differ; so that for the most part, if members received training, they received training in all of the mentioned categories. The main exception were CGs in Thanchi, where only 50% (n=3) reported receiving training in work planning or primary health care.

Figure 4. Percentage of clinics with CG who received training, by type of training and upazila



The survey also asked about the amount of time since training took place for CGs. In Bandarban Sadar and Thanchi upazilas, close to half or more of trainings took place within the past one year (Figure 5); however, in Lama and Rowangchhari nearly one-third of trainings were conducted three or more years ago. Rowangchhari and Ruma also had a sizeable proportion of clinics reporting no training of their CGs having taken place.

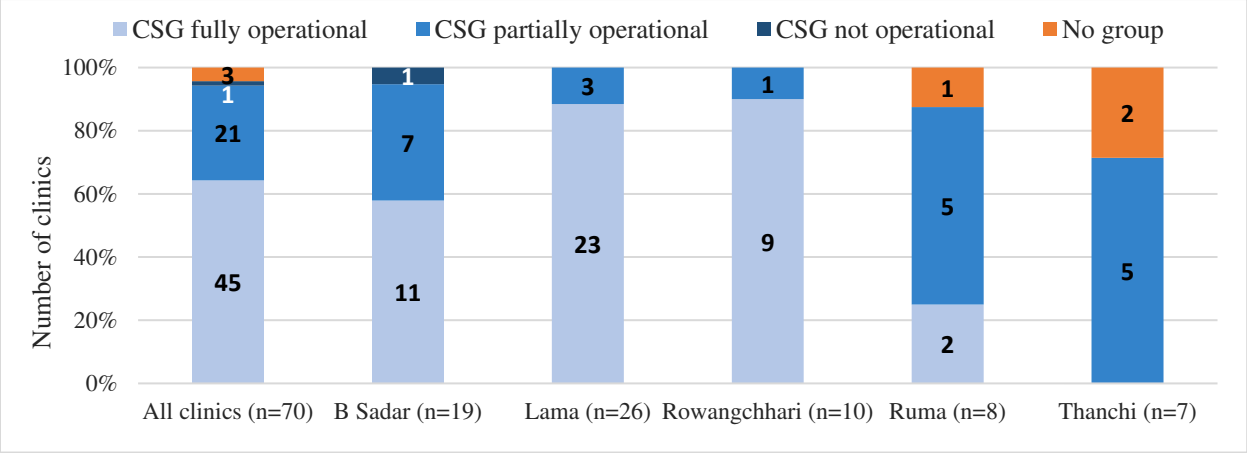
Figure 5. Time since last CG training, by upazila



Clinic staff were also asked about their CSGs, which promote the use of community clinic services and are charged with increasing community awareness about health issues. There are typically three CSGs per clinic catchment area with membership consisting of 13-17 community members who are at least one-third female. CSGs help the CG with clinic management along with making the community aware of services available at clinics and common health messages. CSG maintain quarterly meetings.

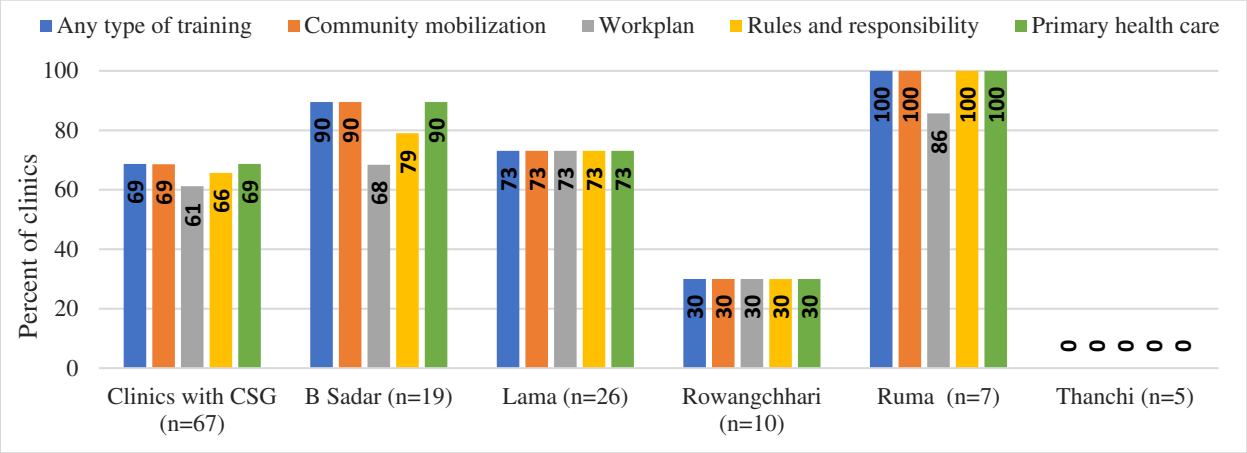
A wide range of responses were provided about the operationality of the CSGs in each upazila (Figure 6). No upazila had all of their CSGs operating fully, defined as meeting four or more times in the past year. Lama had the greatest number, with 23 of 26 fully functioning (89%), contrasting with Thanchi, where all groups were either partially operational (meeting three times or less in the past one year) or nonexistent. Ruma's CSGs were also predominately underperforming, with only two of seven existing groups fully operating to expectations.

Figure 6. Operational status of community support groups (CSG), by upazila



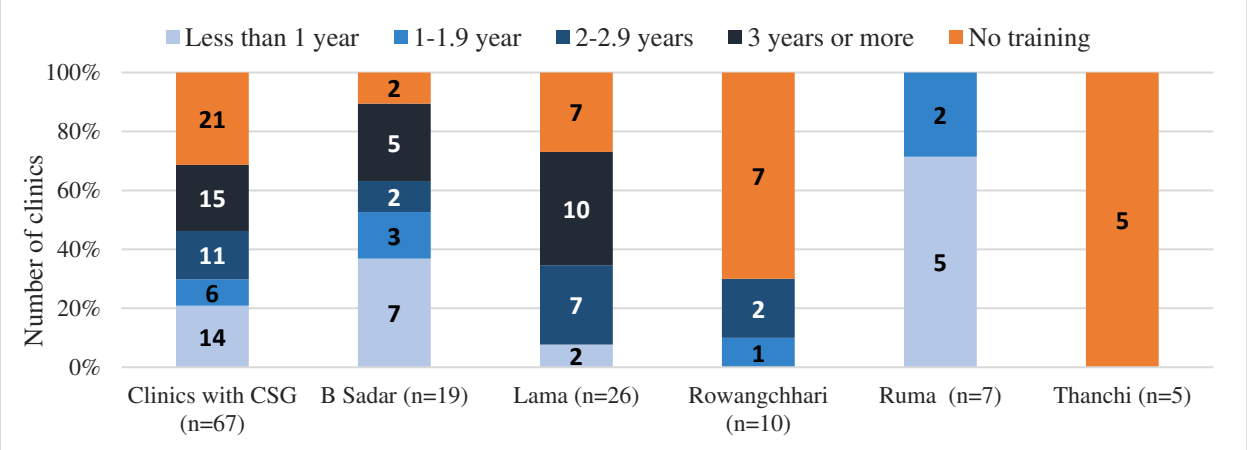
In the clinics with CSGs, the mean number of members was 16-17 in four of the five upazilas; notably, Ruma reported an average of 49 members per CSG. The membership of CSGs in Ruma were only one-quarter female on average, while the other four upazilas maintained a mean ratio of one-third women. When asked about the training of these CSG members, the receipt of required training varied considerably by upazila (Figure 7). As with the CGs, if a group received any type of training, they tended to have received all types; however, levels of training for the CSGs were lower overall, with the exception of Ruma where CSGs had received all training except for workplan training. Similarly, in Bandarban Sadar, only 13 of 19 clinics (67%) said their CSGs received training in work planning. In contrast, Thanchi CSGs had received no training and only a third of Rowangchhari's CSGs had received any kind of training.

Figure 7. Percentage of clinics with CSG who received training, by type of training and upazila



Time since training for CSGs differed from what was reported by CG groups (Figure 8); in contrast, more than 50% of CSG groups received training more than three years ago or had had no training. Bandarban Sadar, Lama, and Ruma were the only upazilas where any CSGs reported training in the last year.

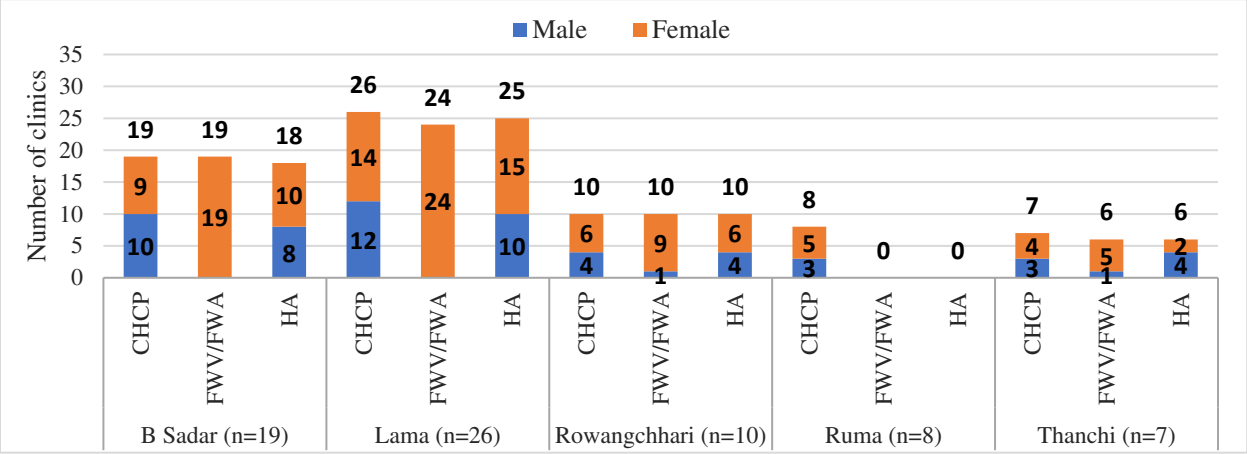
Figure 8. Time since last CSG training, by upazila



STAFFING AT COMMUNITY CLINICS

The survey asked about the availability and training of three types of staff at the community clinics: Community Health Care Provider (CHCP), Family Welfare Assistant (FWA) and Family Welfare Visitor (FWV), and Health Assistant (HA). All 70 clinics (100%) reported having CHCPs, who are trained medical professionals and the person in charge of the overall clinic operations. The majority of clinics reported the availability of FWA/FWV (n=59, 84%) who are part time assistants for the CHCP who work on alternate days and are responsible for Family Planning counselling and services, household visits, and satellite clinic visits. HA, who are responsible for conducting the expanded program on immunization (EPI), counselling, assisting Government of Bangladesh (GOB) health campaigns, and household visits also appear to be available (n=59, 84%). Figure 9 summarizes the availability of the staff across the five upazilas along with the sex of the staff. All clinics in Ruma reported not having FWV/FWA and HA staff.

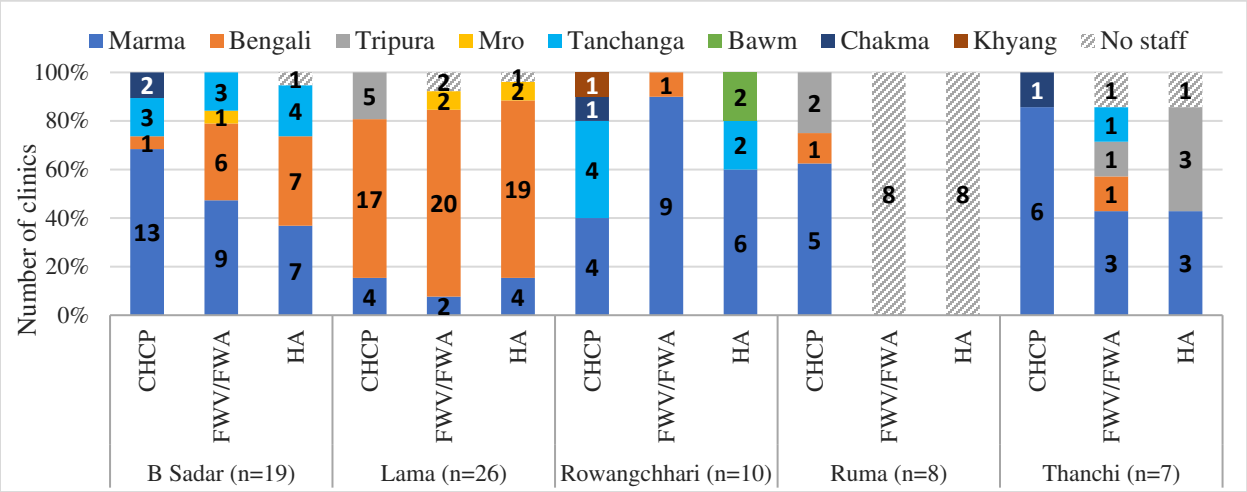
Figure 9. Number of clinics staffed with CHCP, FWV/FWA, and HA, and sex of staff, by upazila



Note: CHCP, Community Health Care Provider; FWV, Family Welfare Visitor; FWA, Family Welfare Assistant; HA, Health Assistant

Given the diversity of ethnic groups living in the five upazilas, the clinic assessment asked about the ethnic group of the staff working at the clinics and Figure 10 summarizes the ethnicity by type of staff. In Lama upazila all three types of staff were overwhelmingly Bengali and one-third of FWV/FWA and HA were also Bengali in Bandarban Sadar. The CHCPs in Bandarban Sadar were primarily Marma, as were the CHCPs in Thanchi and Ruma. Marma also represented a good proportion of FWV/FWA and HA in Rowangchhari and Thanchi. A number of Tanchanga staff were seen in Bandarban Sadar and Rowangchhari, and Tripura staff worked in Lama, Ruma, and Thanchi.

Figure 10. Ethnic group of clinic staff, by upazila

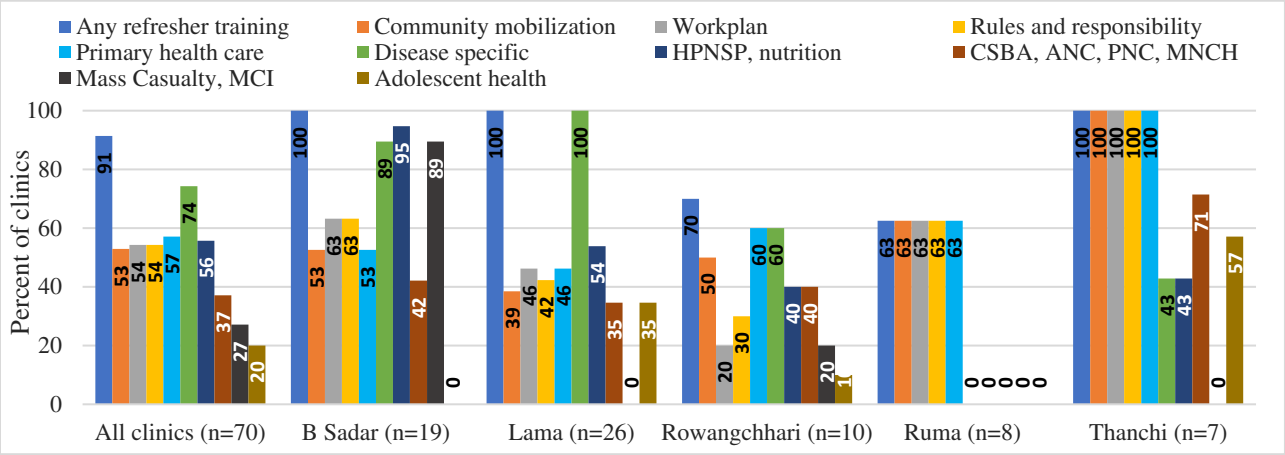


Note: CHCP, Community Health Care Provider; FWV, Family Welfare Visitor; FWA, Family Welfare Assistant; HA, Health Assistant

By in large, the ethnicity of the clinic staff represented the ethnic groups living in the catchment areas of the clinics. Bandarban Sadar clinics had the most discrepancies, with three CHCP, three FWV/FWA, and four HA having ethnic groups not found in the catchment areas of their respective clinics (data not shown). One clinic of the 19 had all three of the staff discordant with their clients' ethnic groups. In the other four upazilas, each had one clinic with a CHCP that was discordant with the catchment area, while FWV/FWA were discordant in only two clinics of Thanchi. HAs did not match their populations in two Lama clinics, one Rowangchhari clinic, and one Thanchi clinic. *Annex 2, Figures A-1 to A-5* show a detailed comparison of the ethnicity of the catchment population and the respective types of staff in each upazila.

The survey asked about refresher training provided to clinic health providers. Figure 11 shows recent training for the first designation CHCP, where all CHCP in Bandarban Sadar, Lama, and Thanchi have had some kind of refresher training. Seventy percent of CHCPs (n=7) have not had any refresher training in Rowangchhari and 67% in Ruma (n=5). The type of refresher training also differed by upazila with almost 90% of providers in Bandarban Sadar receiving training in various disease treatments, nutrition, and mass casualty treatment, while in Ruma and Thanchi few providers had received training in this, but most had received training in community mobilization, work planning, rules and responsibilities, and primary health care. Lama and Rowangchhari CHCPs most commonly reported refresher training was also disease specific training.

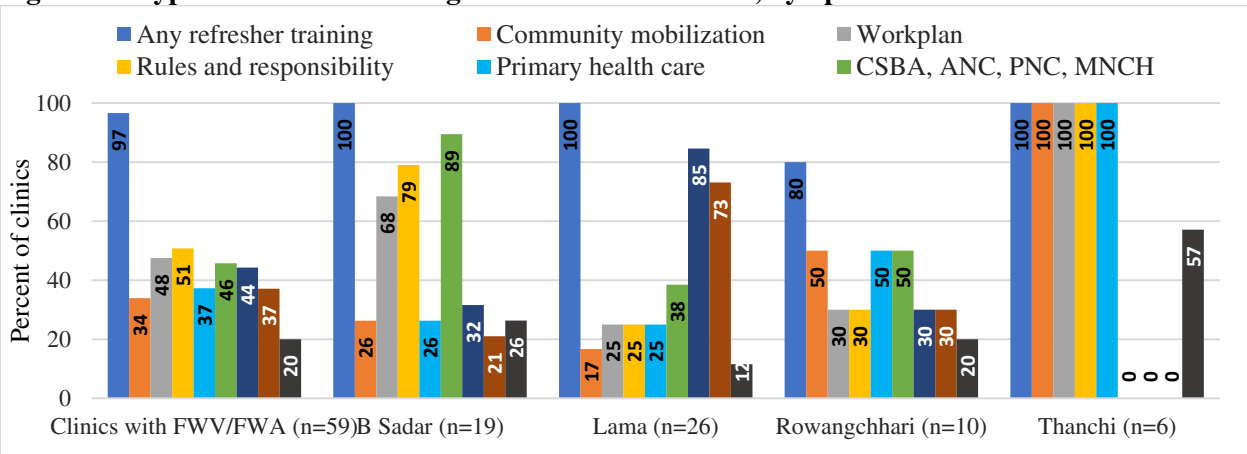
Figure 11. Type of refresher training for CHCP staff, by upazila



Note: HPNSP, Health population & nutrition sector program; CSBA, Community skilled birth attendant; ANC, Antenatal care; PNC, postnatal care; MNCH, Maternal, neonatal & child health; MCI, Mass casualty incident

Figure 12 details the most recent refresher training for FWV or FWA staff, although there is no mandated course content for FWV/FWA refresher training. Ruma upazila clinics reported no FWV/FWA staff and therefore are not shown in the figure. In three of the four upazilas shown, 100% of FWV/FWA staff received some type of refresher training, although this training differed considerably by content. In Bandarban Sadar, most training focused on maternal and child health services including community skilled birth attendants (CSBA), rules and responsibility, and work planning, while in Lama, staff were more likely to be trained on adolescent health and family planning. Thanchi clinics with FWV/FWA all had them receiving community mobilization, work planning, rules and responsibilities, and primary health care training.

Figure 12. Type of refresher training for FWV or FWA staff, by upazila

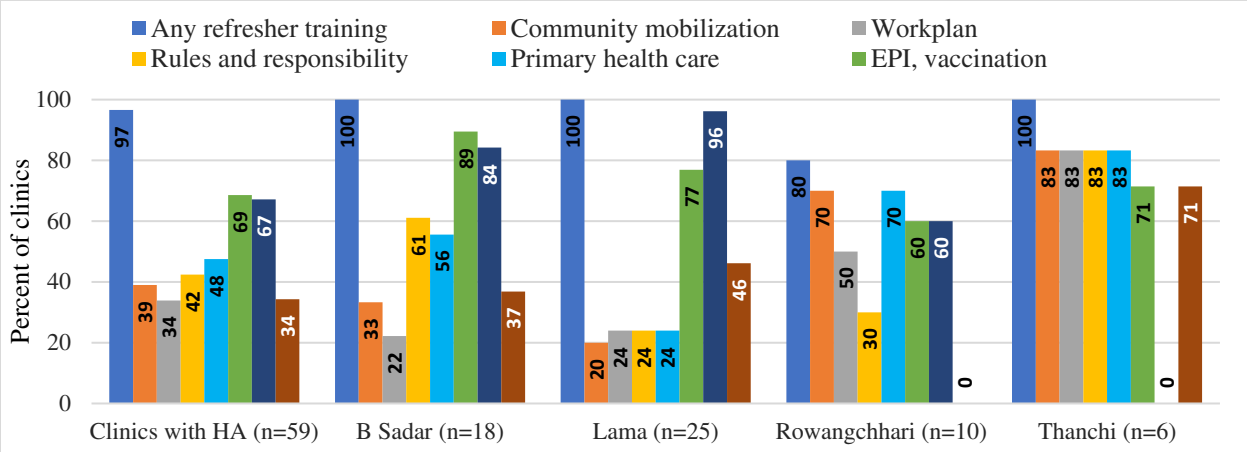


Note: No clinics in Ruma reported having FWV/FWA staff. CSBA, Community skilled birth attendant; ANC, Antenatal care; PNC, postnatal care; MNCH, Maternal, neonatal & child health; HPNSP, Health population & nutrition sector program.

Similar to training for FWV/FWA, all clinics with HAs in Bandarban Sadar, Lama, and Thanchi reported any type of refresher training for HAs, again with variation in content (Figure 13). Disease specific training was common in Lama and Bandarban Sadar, but not for HAs in Thanchi. Across the four upazilas, 60-89% of HAs also had EPI and vaccination training. In Rowangchhari and Thanchi,

orientation on community mobilization and primary health care were frequently reported. Again, no clinics in Ruma upazila reported having HAs.

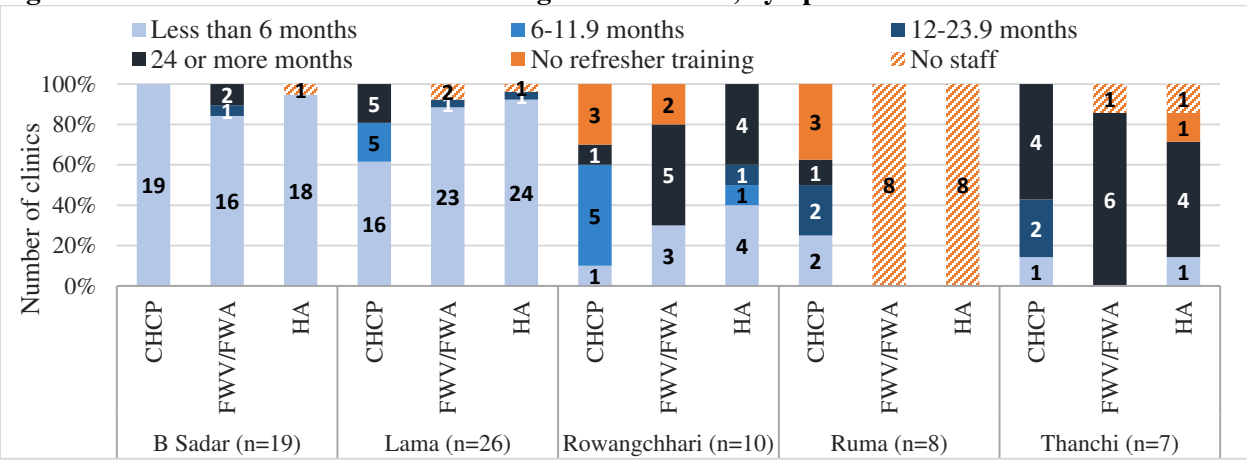
Figure 13. Type of refresher training for HA staff, by upazila



Note: No clinics in Ruma reported having HA staff. EPI, Expanded program on immunization; HPNSP, Health population & nutrition sector program;

Time since last refresher training was relatively similar for the three types of staff within an upazila, though training patterns differed from upazila to upazila (Figure 14). The vast majority of the community clinic staff in Bandarban Sadar and Lama upazilas participated in their most recent training within the last six months. In Thanchi, two years or more have passed since most staff were trained, and in Rowangchhari there was considerable variation in time across the clinics. Approximately 50-60% of CHCP and HA had their training refreshed within the last 12 months, but in some clinics CHCP and FWV/FWA staff said they never received refresher training. Similarly in Ruma upazila, half of CHCP had recent training and the other half had none. Across all upazilas and clinics, CHCP had the most recent refresher training—mean of 11 months since last training—compared to 16 months for both FWV/FWA and HA.

Figure 14. Time since last refresher training for clinic staff, by upazila

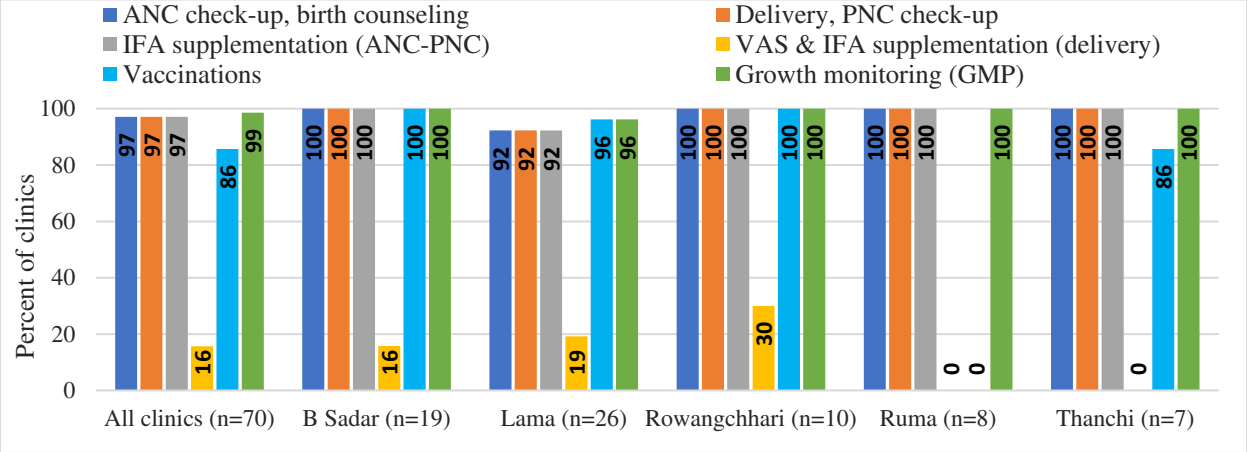


Note: No clinics in Ruma reported having FWA/FWV and HA staff; CHCP, Community Clinic Health Provider; FWV, Family Welfare Visitor; FWA, Family Welfare Assistant; HA, Health Assistant

SERVICES PROVIDED BY CLINICS

The survey asked the clinics what services related to MCHN they offer to their catchment populations, including the hours of services. All 70 clinics reported their working hours to be Saturday to Thursday; each work day they are open for six hours and service providers are available every day. Only one clinic in Thanchi upazila said that providers are unavailable on Sundays. During these service hours, nearly all clinics in all upazilas provide antenatal, delivery, and postnatal services (Figure 15), as well as growth monitoring and vaccinations. While the majority of clinics (n=68) provide iron-folic acid (IFA) supplementation during antenatal (ANC) and postnatal (PNC) check-ups, only 16 clinics across three upazilas provide IFA and Vitamin A supplementation (VAS) during delivery services. All eight clinics in Ruma said they do not offer IFA and VAS at delivery nor general vaccinations.

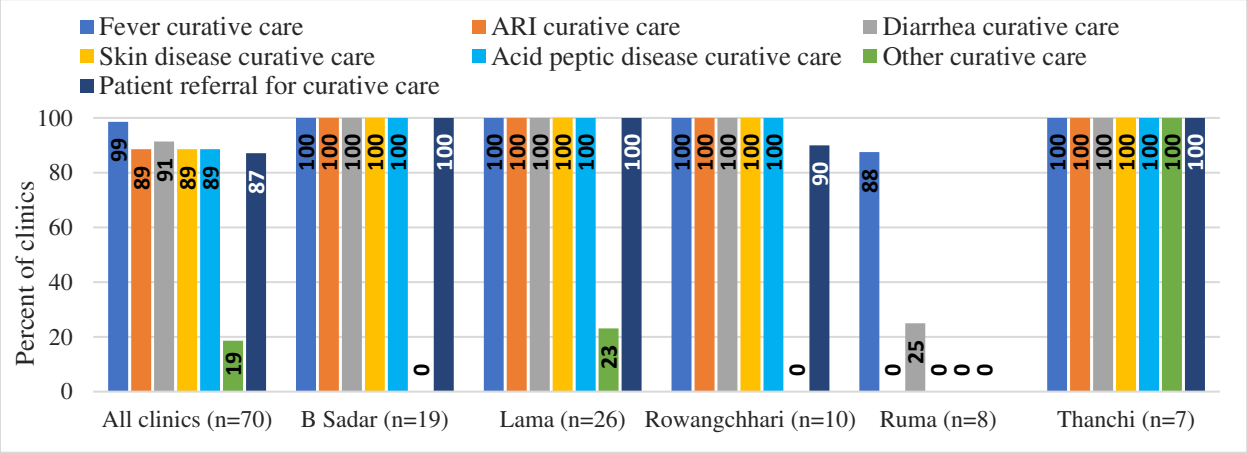
Figure 15. Percentage of clinics providing maternal and child health services, by upazila



Note: ANC, antenatal care; PNC, postnatal care, IFA, iron-folic-acid; VAS, Vitamin A supplementation; GMP, growth monitoring & promotion

The clinics also widely provide basic curative care services, especially for fever, respiratory infections, diarrhea, skin diseases, and acid peptic disease (Figure 16). Sixty one of the 70 clinics (87%) also refer patients for curative care they are unable to provide. Clinics in Ruma are the exception, providing limited curative care services for fever and diarrhea (7 and 2 clinics, respectively), and offering no extra curative care or referrals to patients who need additional treatment.

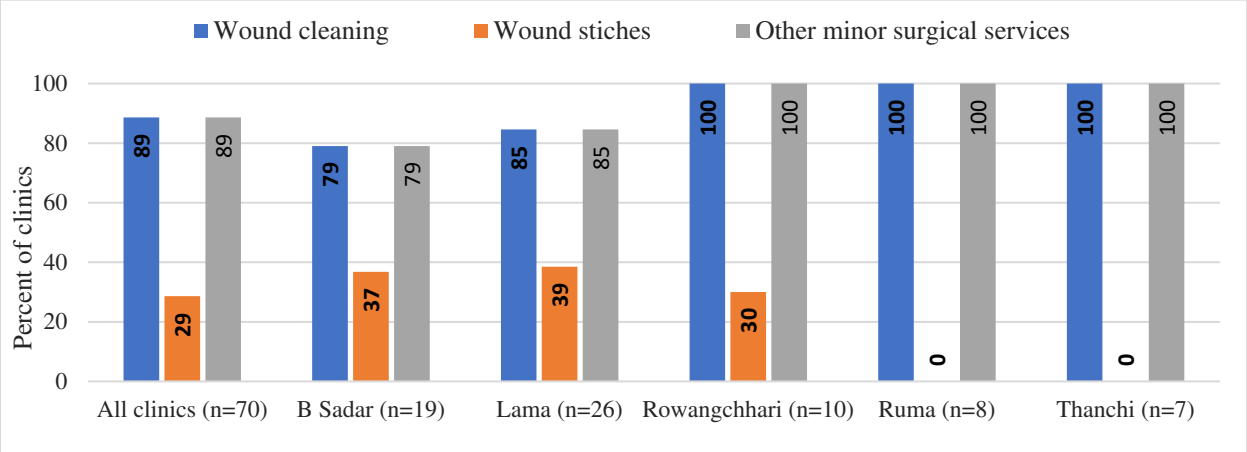
Figure 16. Percentage of clinics providing curative care services, by upazila



Note: ARI, acute respiratory infection

All clinics in Rowangchhari, Ruma, and Thanchi said they offer cleaning and other minor surgical services, and most in the other two upazilas (Figure 17). The ability to provide stiches for wounds was only mentioned by one-third of clinics in Bandarban Sadar (n=7), Lama (n=10), and Rowangchhari (n=3).

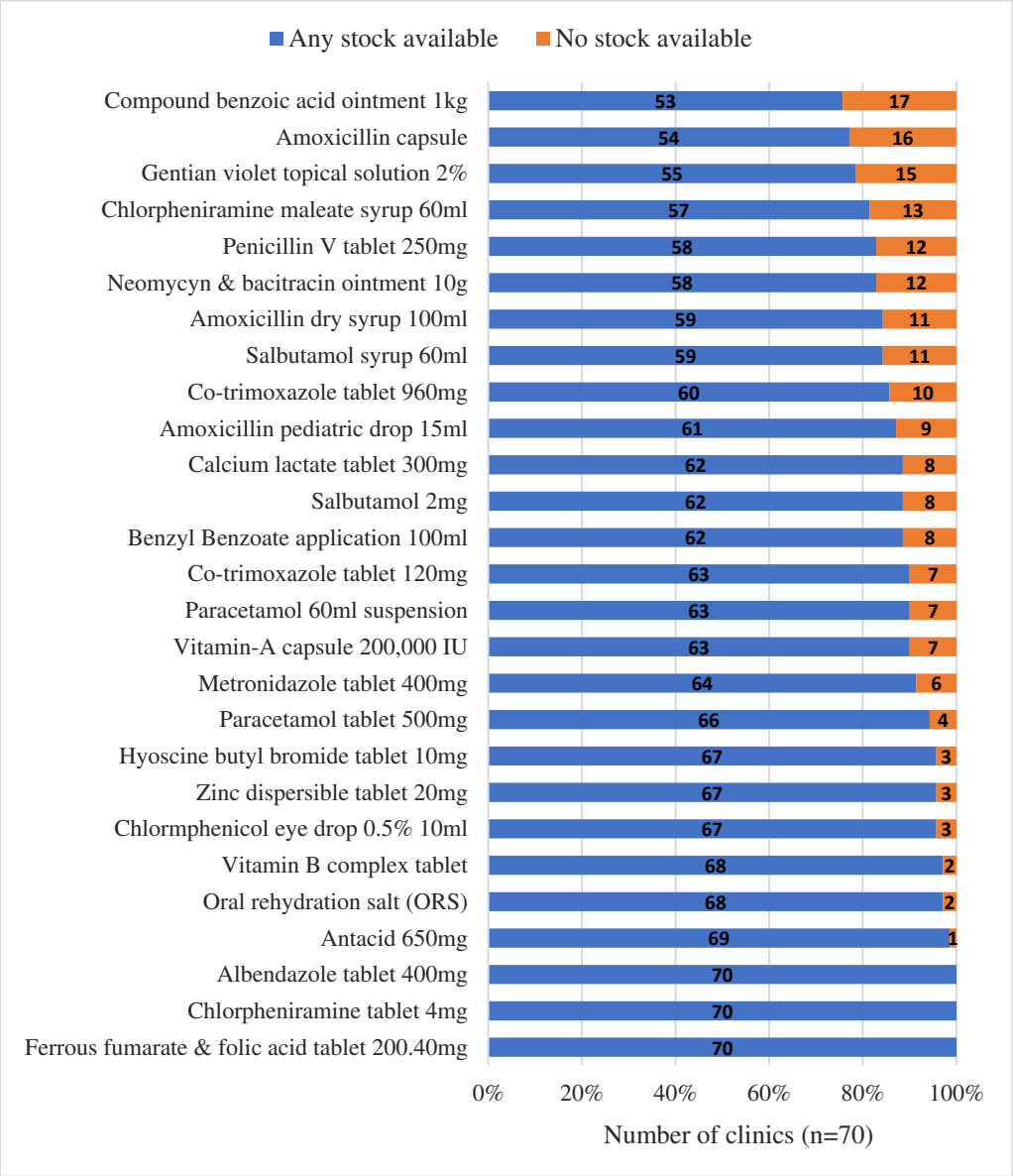
Figure 17. Percentage of clinics providing surgical services, by upazila



MEDICINE SUPPLIES IN CLINIC

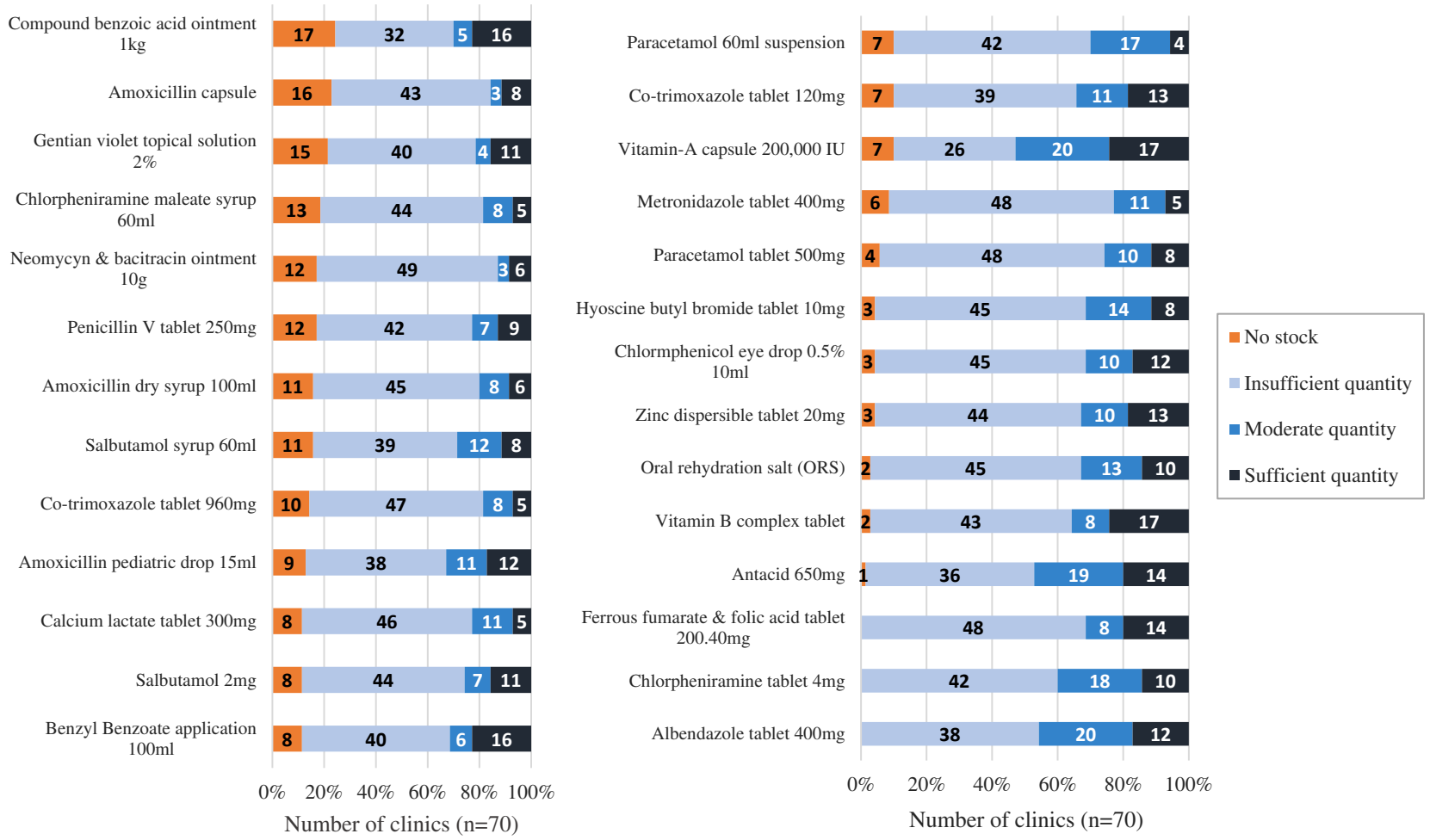
All 70 of the clinics reported that they dispense medicines and the survey assessed the availability of 27 essential medicines in each clinic. Overall, only 44% of all clinics (n=31) had any amount of the 27 medicines in stock, and another 16% (n=11) had 26 of 27 in supply. Figure 18 summarizes the availability of the essential medicines across all upazilas. All clinics had any stocks of IFA tablets, the antihistamine chlorpheniramine, and albendazole for anti-helminth treatment. More than 20% of clinics had stock-outs of gentian violet topical solution, amoxicillin capsules, and compound benzoic acid ointment. The majority of clinics had paracetamol to help treat fevers and oral rehydration salt for diarrhea. Notably, 90% of clinics had Vitamin A capsules available but only 16% said they provide this service at delivery or within 42 days after birth (GOB mandated times of receipt for post-partum mothers).

Figure 18. Number of clinics with any stock and no stock of 27 essential medicines



In addition to assessing the availability of medicines, the quantity of stock on hand was documented during the survey. Clinics were asked the quantity they were required to have on hand and enumerators counted and recorded the quantity that was available the day of survey. With these data, clinics were categorized as having 'sufficient quantity' of the medicine (76-100% of reported required quantity was counted in-stock), 'moderate quantity' (51-75% of required quantity in-stock), 'insufficient quantity' (less than 50% of required quantity in-stock), or no stocks available. Figure 19 summarizes the quantity of stocks on hand for the 27 medicines in all clinics. Less than a quarter of all clinics had sufficient quantities of any of the medicines the day of assessment. Only three medicines—albendazole tablets, antacids, Vitamin A capsules—were found in moderate to sufficient quantities in half of the clinics. For most drugs, 60-80% of clinics had insufficient or no quantity of the medicines.

Figure 19. Quantity of required medicine stocks on-hand in all clinics on day of assessment



The quantity and availability of medicine stocks varied considerably by upazila. Table 2 shows the percentage of clinics with sufficient quantity of medicines and Annex 2, Figures A-6 to A-10 detail the data for each upazila. Rowangchhari upazila had the most clinics with sufficient quantities of the 27 medicines, although, only two drugs had sufficient numbers in more than half of the clinics: IFA tablets and benzyl benzoate application. Seven medicines were stocked-out in at least one clinic in Rowangchhari and 19 had insufficient quantities in half or more of the 10 clinics. In Thanchi, 21 drugs were not found in sufficient quantity in any clinic, and 19 medicines had insufficient quantity in 50% or more of the clinics. Four medicines—Vitamin A capsules, Gentian violet topical solution, Neomycyn & bacitracin ointment, and amoxicillin pediatric drops—were stocked-out in at least one clinic. Vitamin A capsules were absent from all seven Thanchi clinics, which may explain why all the clinics said they did not provide VAS at delivery. Few clinics in Lama also had medicines in sufficient quantities and Lama clinics had the most stock-outs of drugs across all upazilas: 23 of 27 medicines were missing from at least one clinic. Half of clinics had no stocks of compound benzoic acid ointment, amoxicillin capsules, and chlorpheniramine maleate syrup. One-quarter to one-third were missing 12 additional medicines the day of survey.

Table 2. Percentage of clinics with 'sufficient quantity' of required medicines, by upazila

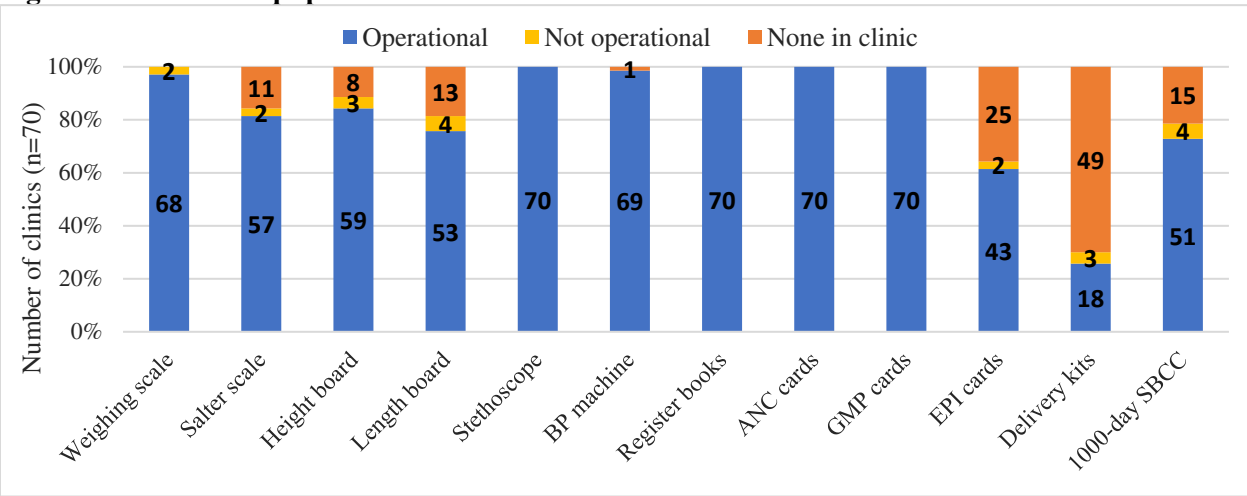
	Bandarban Sadar (n=19) %	**Lama (n=26) %**	**Rowang-chhari (n=10) %**	**Ruma (n=8) %**	**Thanchi (n=7) %**
Albendazole tablet 400mg	11	12	30	50	0
Antacid 650mg	32	4	40	38	0
Calcium lactate tablet 300mg	5	0	10	38	0
Chlorpheniramine tablet 4mg	11	8	40	13	14
Co-trimoxazole tablet 120mg	32	4	40	13	14
Co-trimoxazole tablet 960mg	16	4	10	0	0
Ferrous fumarate & folic acid tablet 200.40mg	16	12	60	25	0
Hyoscine butyl bromide tablet 10mg	11	12	0	38	0
Metronidazole tablet 400mg	0	8	20	13	0
Paracetamol 60ml suspension	5	4	10	13	0
Paracetamol tablet 500mg	5	8	30	25	0
Penicillin V tablet 250mg	21	4	20	25	0
Salbutamol 2mg	16	8	40	25	0
Vitamin-A capsule 200,000 IU	32	23	20	38	0
Vitamin B complex tablet	42	8	40	38	0
Zinc dispersible tablet 20mg	26	8	40	25	0
Amoxicillin dry syrup 100ml	16	4	20	0	0
Amoxicillin pediatric drop 15ml	26	4	40	25	0
Benzyl Benzoate application 100ml	26	8	60	38	0
Chlorpheniramine maleate syrup 60ml	16	4	10	0	0
Salbutamol syrup 60ml	11	4	20	25	14
Amoxicillin capsule	11	4	40	13	0
Chlormphenicol eye drop 0.5% 10ml	21	12	40	13	0
Compound benzoic acid ointment 1kg	5	15	40	0	100
Gentian violet topical solution 2%	11	12	0	13	71
Neomycyn & bacitracin ointment 10g	5	8	0	25	14

Enumerators also reviewed the expiration dates on the medicines in stock, recording the soonest expiration date. Across all 70 clinics and 27 essential medicines, only two instances of expired medications were found.

EQUIPMENT IN CLINICS

In addition to assessing the availability of medicine stocks, the clinic assessment examined the availability of equipment in the clinics, along with the operational status of the equipment. This included equipment for growth monitoring, delivery kits, and basic equipment such as stethoscopes and blood pressure (BP) machines. Delivery kits were missing from 70% of the clinics even though 97% of clinics said they offer delivery services (Figure 20). One-third of the clinics lacked EPI cards compared to 86% providing vaccinations. Length boards, salter scales, and 1000-day social behavior change communication (SBCC) materials were absent from approximately 20% of clinics. Overall, the majority of equipment present in clinics was operational.

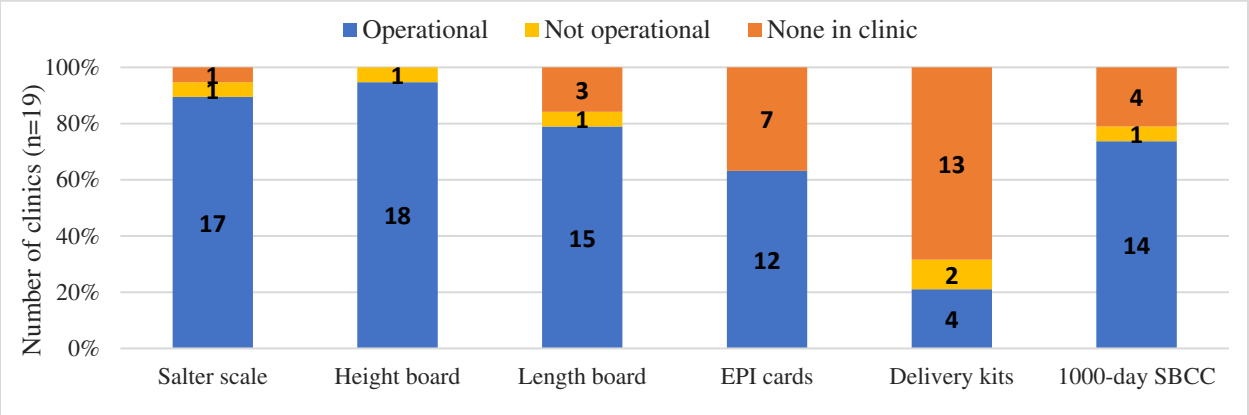
Figure 20. Status of equipment in all clinics



Note: BP, Blood pressure; ANC, antenatal care; GMP, growth monitoring & promotion; EPI, expanded program on immunization; SBCC, social behavior change communication

Figures 21 to 25 show the status of the six equipment most frequently missing or non-operational by upazila. In Bandarban Sadar, 13 of the clinics (68%) are missing delivery kits and another two (11%) are non-operational (Figure 21). Nearly 40% (n=7) of clinics are missing EPI cards. For the equipment not shown in the figure—weighing scale, stethoscope, BP machine, register books, ANC cards, Growth monitoring and promotion (GMP) cards—all were present and functioning on the day of survey.

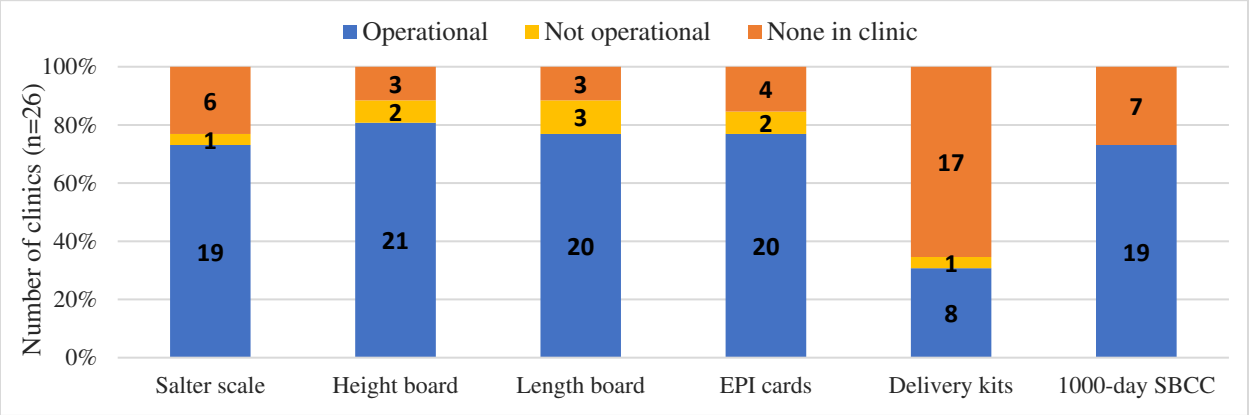
Figure 21. Status of select equipment in Bandarban Sadar upazila clinics



Note: EPI, expanded program on immunization; SBCC, social behavior change communication

Similar to Bandarban Sadar clinics, many clinics in Lama were missing delivery kits and EPI cards, along with 1000-day SBCC materials and salter scales (Figure 22). A few clinics noted that they have height and length boards and EPI cards, but they are non-operational. Additionally, 2 clinics in Lama (8%) reported non-operational weighing scales.

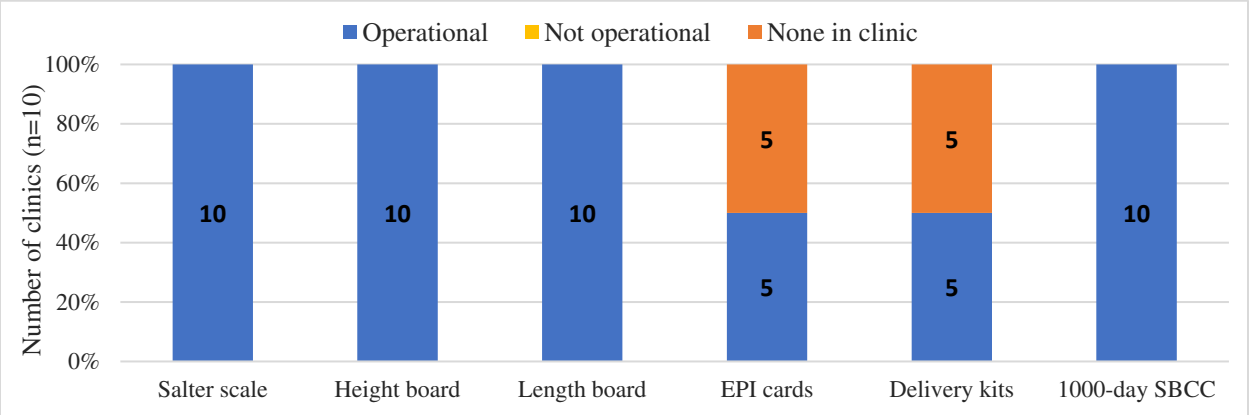
Figure 22. Status of select equipment in Lama upazila clinics



Note: EPI, expanded program on immunization; SBCC, social behavior change communication

In Rowangchhari, the only equipment not found in clinics was delivery kits and EPI cards. Missing from one clinic was also a BP machine.

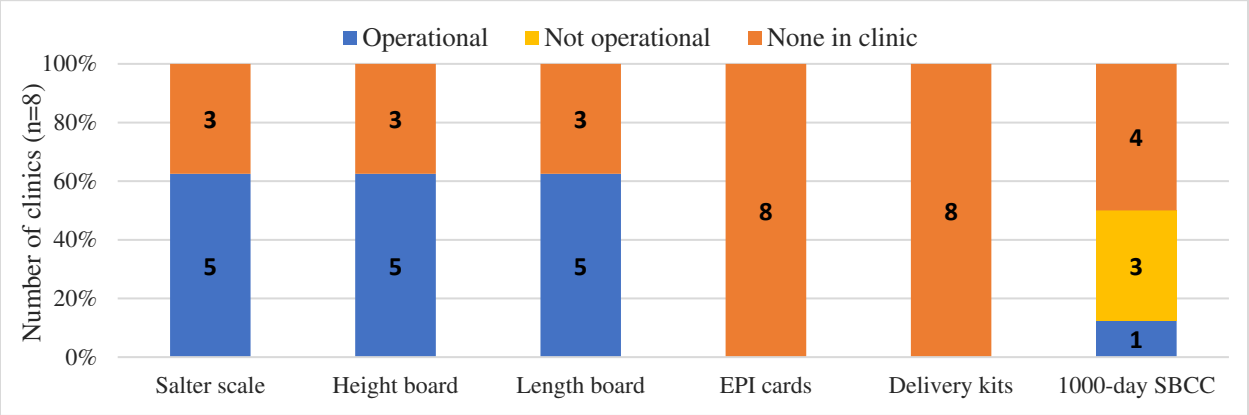
Figure 23. Status of select equipment in Rowangchhari upazila clinics



Note: EPI, expanded program on immunization; SBCC, social behavior change communication

In the eight Ruma clinics, missing equipment was commonplace (Figure 24). All clinics had no stocks of delivery kits and EPI cards, which may either be the result of or the cause of all clinics not providing delivery and vaccination services. The other equipment not illustrated in the figure were found and in good operation in all Ruma clinics.

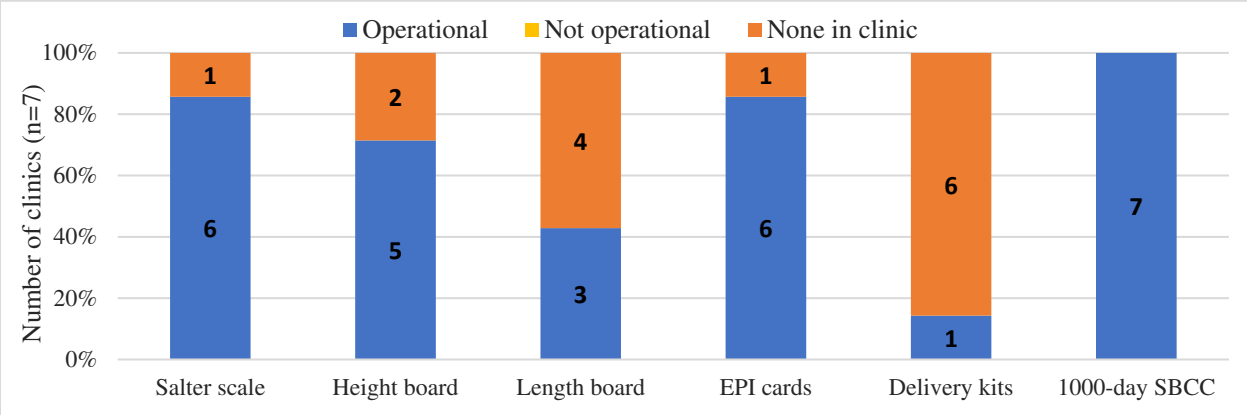
Figure 24. Status of select equipment in Ruma upazila clinics



Note: EPI, expanded program on immunization; SBCC, social behavior change communication

In Thanchi, equipment needed for growth monitoring was missing in a number of the seven clinics (Figure 25), even though 100% reported that they provide GMP services. All seven also said they offer delivery services, while six (86%) have no delivery kits in stock.

Figure 25. Status of select equipment in Thanchi upazila clinics

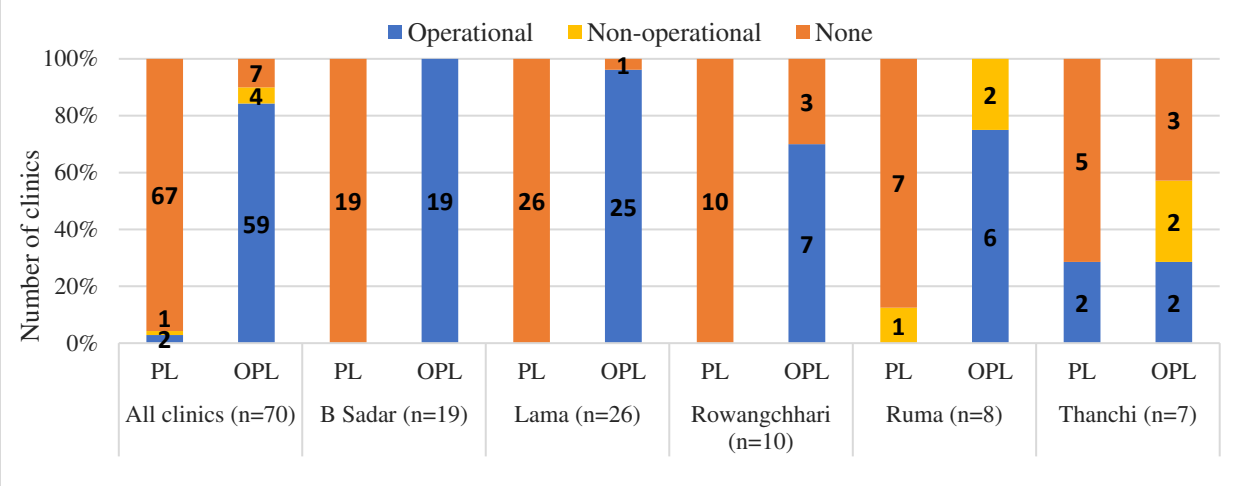


Note: EPI, expanded program on immunization; SBCC, social behavior change communication

WATER AND SANITATION FACILITIES AT CLINIC

The assessment of clinic equipment and operational status extended to the toilet and water facilities at the clinics. Enumerators examined the presence of pit latrines (PL) and offset pit latrines (OPL), with their observations summarized in Figure 26. OPLs were found in 80% (n=63) of clinics, with the majority in good operation. Three clinics each in Thanchi and Rowangchhari did not have OPLs, along with one in Lama. Overall, five of the 70 clinics (7%) had neither PLs nor OPLs: three in Rowangchhari, one in Thanchi, and one in Lama. Among the clinics with operational OPLs, all allow clients to use them except for three in Bandarban Sadar. Staff also use these toilet facilities in Lama, Rowangchhari, and Thanchi, while five clinics in Bandarban Sadar and five in Ruma say staff do not use them.

Figure 26. Toilet facilities and operational status in clinics, by upazila

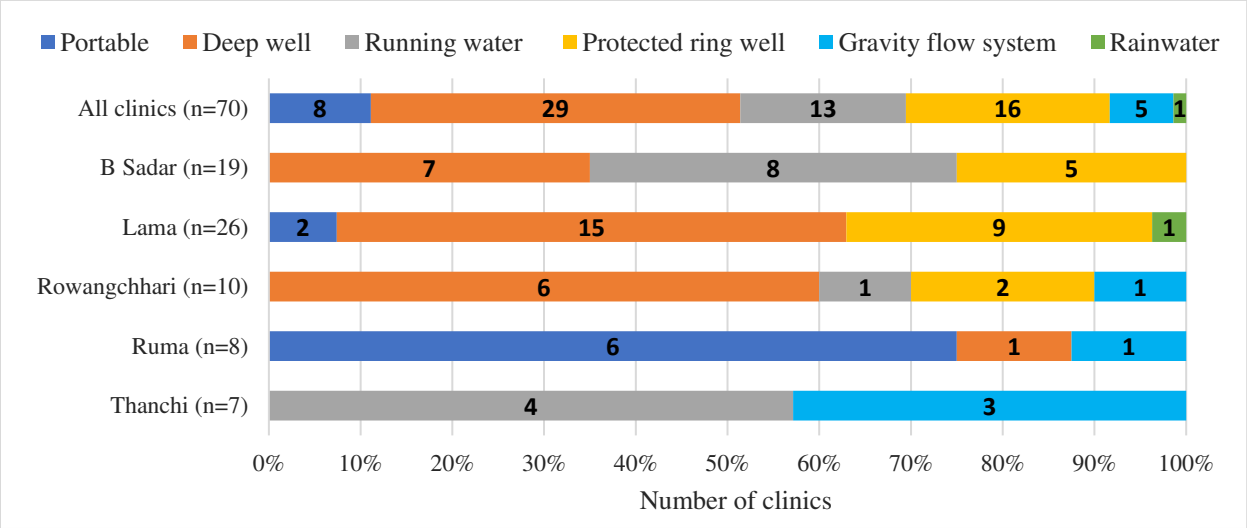


Note: PL, Pit Latrine; OPL, Offset Pit Latrine

Across the 70 clinics, six types of water facilities were observed. These included deep wells and protected ring wells, which were frequently observed in Bandarban Sadar, Lama, and Rowangchhari clinics (Figure 27). Gravity flow systems were seen in about half of Thanchi clinics, with the other half using running water from rivers, canals, or springs. Ruma clinics relied heavily on portable water, which is collected

outside or away from the clinic via water tanker, public taps, unprotected dug wells, or surface water like ponds or haors.

Figure 27. Water facilities in clinics, by upazila



Note: n=1 clinic in Bandarban Sadar reported running water & protected ring well; n=1 clinic in Lama reported portable & rain water

The water facilities in eight clinics were observed to be non-operational by survey enumerators. This includes five of the six portable water in Ruma, one of the observed deep wells in Bandarban Sadar, and two of the eight running water in Bandarban Sadar. Regardless of operational status, all clinics reported that their staff use these water facilities for handwashing. Three clinics said their water facilities are not used by clients for handwashing, including two in Rowangchhari and one in Bandarban Sadar.

CONCLUSION

This assessment of 70 community clinics in the SAPLING program area identified gaps in staffing, service delivery, and availability of equipment and medicine commodities that (likely) impact the quality of services provided to communities living in their catchment areas.

Nearly all clinics are fully staffed with CHCP, FWV/FWA, and HA, except for the eight clinics in Ruma upazila that reported no FWV/FWA and HA. By in large, staff ethnicity reflected the reported ethnicities of the clinics' respective catchment populations. Bandarban Sadar upazila had the most discrepancies, including one clinic where the ethnicity of all three staff types did not match their clients. While there is a provision for a quota of ethnic minority hiring in the Ministry of Family Planning, guidance is not provided for ensuring that staff ethnicity and language match the patient population. Finding qualified candidates in Bandarban is also a challenge. Training of these staff varied considerably by staff type, training content, and upazila. Nearly all staff had received any type of refresher training: 91% of CHCP, 97% of FWV/FWA, and 97% of HAs. However, there was no consistency in what these staff were trained on, whether related to clinic operations (work planning, roles and responsibilities, etc) or service provision (maternal and child health, disease specific, etc), or commonality across staff types or clinic location. For most staff, the refresher training was relatively recent, within the past 6-12 months.
The Family Planning Department at the District level is responsible for training after recruitment and refresher training. Refresher training is conducted in batches, so it is possible that staff who have not

received selected topics are in the queue; however, the length of time some staff have gone without training indicates that this process needs to be reviewed. Given the variation in refresher training, prioritization over what training is rolled out first is not clear.

CGs and CSGs that support the operation and community outreach of the clinics are present in all or most clinics, respectively. All areas have CGs, with sufficient numbers of members and meeting the expected male to female ratio. Three-quarters of CGs are fully operational, with most in Bandarban Sadar, Lama, and Rowangchhari upazilas. In Ruma, the majority are non-operational and in Thanchi most are partially operational, meeting less than the required frequency. Only 84% of clinics reported the formation of a CSG; most of their membership numbers met the quotas (though Ruma's had three times more members than expected), but female membership was lower than the mandated one-third. Overall, fewer CSG were operating fully compared to CG, but there were also fewer non-operational CSG. Similar to CGs, CSGs were operating best in Bandarban Sadar, Lama, and Rowangchhari. The pattern of reported refresher training was similar for CGs and CSGs in Bandarban Sadar and Lama, where staff were more likely to report any refresher training, but received a number of years ago. Refresher training was more variable in the other three upazilas. For example, in Ruma only one-third of CGs had any training, but 100% of CSGs had their training refreshed. Thanchi reported no training of their CSGs. Overall, refresher training was better for clinic staff compared to the CG and CSG. The Health and Family Planning Department is responsible for training CGs and CSGs, although the required timeframe, content or consistent plan for rolling out these trainings is not clear. It is unknown from the survey conducted how the three training categories relate to the respective group responsibilities.

All of the 70 community clinics serve a diversity of para and ethnic groups living in the catchment areas. However, with service providers who are not the same ethnicity as the catchment population, communication can be a major barrier to receiving health care. This may also mean even greater discrepancies as selected ethnic groups do not seek out care. Nearly all clinics are accessed by walking, often for long periods of time. All clinics reported they are open six days a week, six hour per day, with staff available every day. Despite this result, anecdotal information suggests that staff availability is not as prevalent as reported due to living outside of clinic areas in district or upazila towns. Clinics are almost universally reporting that they provide maternal and child health services like ANC and PNC check-ups, delivery care, IFA supplementation, growth monitoring, and vaccinations; however, anecdotally it does not appear that most community clinics have childbirth facilities. Curative care services are widely offered, as is wound cleaning. Notable gaps in clinic services include VAS and IFA supplementation at delivery and wound stitching. Ruma clinics were found to only be offering limited services; in addition to the gaps seen across all clinics, they also offered no vaccinations, no curative care for a wide variety of basic illnesses, and no referrals for the curative care they did not provide. It is unclear why services in Ruma are so limited.

The assessment of medicine stocks found that sufficient quantities of essential drugs are not being maintained at clinics. Less than half of all 70 clinics had any amount of the 27 medicines assessed, and less than a quarter of clinics had 'sufficient' quantities of any of the medicines. The vast majority of clinics had 'insufficient' quantities—50% or less of their required amount—in their clinics. Even basic/key medicines were in limited supply which creates challenges for clinics to fully provide the services offered. Thanchi and Lama clinics were found to have the most limited availability and quantity. In Thanchi, 21 of 27 drugs were not found in sufficient quantity in any clinic. Lama had the most stock-outs, with 23 of the 27 medications missing from at least one clinic. Of the stocks available, expired medicines were not a problem. Drug requisition is conducted based on demand and not on a regular schedule, so it could be that some of the low supply was due to waiting for there to be sufficiently low levels to initiate new procurement, but stock-outs would imply that there is still a problem with supply. The survey structure did not account for reasons why stocks are low or out.

Clinics also struggled with deficiencies in some basic equipment for providing care. Equipment for growth monitoring, like salter scales and height and length boards, were missing, especially in Ruma and Thanchi. EPI cards were missing or not useable in 37% of clinics, while useable delivery kits were unavailable in 74% of clinics, whereas 97% of clinics said they offer delivery services. This absence of kits was seen across all upazilas, including all eight of Ruma's clinics. Overall, if clinics possessed equipment, it was likely in good working order. Additionally, 69 of 70 clinics reported having operational stethoscopes, BP machines, register books, and ANC and GMP cards.

Toilet and water facilities were mostly available and in operational order, however any loss of toilet and water makes it impossible to maintain safe and hygienic health service provision. Five clinics were not observed to have PLs or OPLs, though it is unknown if they had other types of toilet facilities. In total, 90% (n=63) of all clinics had an OPL and four of those were non-operational: two each in Ruma and Thanchi. Water facilities, while available in all clinics, varied by type. Most upazilas relied on a combination of deep wells, running surface water, and protected ring wells. Ruma clinics mostly relied on portable water that has to be collected and brought to the clinic. These clinics, along with those relying on rainwater and running water, may be more susceptible to shortages of water for basic hygiene. Additionally, eight clinics had non-operational water facilities.

RECOMMENDATIONS

Recommendations culminating from the data collection and analysis will be provided to the Civil Surgeon in Bandarban District and the MOHFW, ranging from policy and guidelines to logistics and training issues.

- To enhance the overall oversight and functioning of clinics, revitalization of the CGs and CSGs to make them fully operational in all clinic areas is a priority. These groups are designed to support and monitor clinic functionality and are needed to increase both supply and demand for services.
- Standards for refresher training requirements and content should be established to maintain quality of provider care and ensure consistency of treatment and clinic management. Training content, frequency, staff to be trained and ensuring all training is relevant to responsibilities should be assured.
- Availability and sufficient supplies of stocks, including medicine and delivery kits should be assured in all areas. Supply chain management improvements require support.
- Faulty or missing equipment ensures that important health services are not performed. Equipment needs should be filled and non-operational equipment fixed or replaced.
- Health facilities require potable water and sanitation facilities for both staff and patients to provide services and reduce the spread of infectious diseases. All non-operational water and toilet facilities should be fixed and access to both for staff and clients is essential.
- Provision of equipment, staffing, training, and supplies should be consistent across all clinics in the district. Sizeable gaps and barriers to service provision were identified, particularly in more remote areas and clinics in Ruma upazila seemed particularly disadvantaged.
- Greater attempts to match the ethnicity of the service provider with the ethnic groups in the catchment area would enhance service provision and potentially increase the number of people seeking health services.
- Provision of equipped, trained, and available birth services at the community clinic are needed for safe pregnancy outcomes.

STUDY LIMITATIONS

There were several limitations to the study design and implementation that may have impacted results obtained. The survey was a cross-sectional design, taking place one time in each clinic at the end of

2019, so may not represent the actual situation across the year. Given the impact of COVID-19 on the area in recent months, conditions may also have changed. Operationality of CG and CSGs may be over-stated as the definition for functionality was only how often the groups meet, not the activities they are undertaking or the quality of those activities. Finally, transportation times for patients were asked of the providers, not of actual patients and asked only the shortest and longest commute times as it was not expected that providers would be able to estimate average transport for their patients.

ANNEX 1. QUESTIONNAIRE

Informed consent form

Introduction and purpose of the group discussion:

• Hello! My name is _____ and I am currently working in the SAPLING project, and in order to do our job better we would like to ask you some questions.

• We have selected you to discuss about Community Clinic (CC) and its activities. The purpose of this interview is to obtain information about the activities, services, facilities and related other issues of community clinic. It will help us to understand the status of the CC in this area and to better design the work SAPLING will do.

• Participation in this interview is voluntary and confidential. We will use the information to prepare reports. SAPLING will use this report to assess the progress and achievement of the project activities.

• This interview will take about……..minutes. Could you please spare some time for the discussion?

Please let me know if you have any question on the discussion.

QUESTIONS	CODING CATEGORIES	SKIP
May I begin the interview now?	Yes.....1 No…….. 2	→Complete the sample identification table and continue discussion. →Complete the sample identification table and go to **END**

সম্মতিপত্র

আসসালামু আলাইকুম/আদাব/নমস্কারঃ

• আমার নাম ..... I আমরা স্যাপলিং কর্মসূচীর বাৎসরিক নিরীক্ষা কাজের সাথে জড়িত।

• আপনার সাথে আজ আমরা এই কমিউনিটি ক্লিনিক ও এর কাজ সম্পর্কে আলোচনা করবো। এই আলোচনার উদ্দেশ্য হল এই কমিউনিটি ক্লিনিকের বিভিন্ন কাজ, সেবা, এবং এর সাথে সম্পর্কীত বিভিন্ন তথ্য সংগ্রই করা। এর ফলে আমরা এই ক্লিনিকের বিভিন্ন কাজ সম্পর্কে জানতে সহায়তা করবে যা স্যাপলিং প্রকল্পের কাজ রিভিউ করতে সহায়তা করবে।

• এই আলোচনায় অংশগ্রহণ সম্পূর্ণরূপে আপনার ইচ্ছার উপর নির্ভরশীল। এখানে আপনার দেওয়া তথ্য সম্পূর্ণ গোপন রাখা হবে। আপনার কাছ থেকে প্রাপ্ত তথ্য রিপোর্ট বা প্রতিবেদন তৈরিতে ব্যবহার করা হবে এবং এই প্রতিবেদনটি প্রকল্প কর্মকাণ্ডের অগ্রগতি ও অর্জন নিরূপণের জন্য ব্যবহার করবে।

• তথ্য সংগ্রহ করতে প্রায় ... মিনিট সময় লাগবে। আপনি কি এই সাক্ষাৎকারের জন্য কিছু সময় দিতে রাজি আছেন। আপনার কি এই জরীপ সম্পর্কে কোন প্রশ্ন আছে? কোন প্রস্ন থাকলে আমাকে জিজ্ঞেস করতে পারেন। এই প্রক্রিয়া নিয়ে যদি আপনার আর কোন প্রশ্ন থাকে তাহলে আপনি জনাব রোজেনা বেগম- ডিরেক্টর, মনিটরিং এন্ড ইভালুয়েশন-এর সাথে (+8801713036797) যোগাযোগ করতে পারেন।

1.1 আমি কি এখন সাক্ষাত্কার শুরু করতে পারি?	রাজি আছেন ..... 1 রাজি নাই 2	→sample identification table পূরন করে সাক্ষাৎকার গ্রহণ চালিয়ে যান। →sample identification table পূরন করে সাক্ষাৎকার গ্রহণ শেষ করুন।

Sample Identification (নমুনা পরিচিতি)

FINANCIAL YEAR: (অর্থ বছর) (2019-2020)	
Upazila (উপজেলা)	
Union (ইউনিয়ন)	
Ward (ওয়ার্ড)	
Name of Interviewer (ইন্টারভিউয়ারের নাম)	
Name of community clinic (কমিউনিটি ক্লিনিকের নাম)	

Catchment population and Ethnicity

সেবার অন্তর্ভুক্ত জনগোষ্ঠী এবং এথনিসিটি

No	Questions	Coding categories
q2_1	How many para of Catchment Area? (ক্যাচমেন্ট এরিয়ার মোট কতগুলি পাড়া আছে?)	
q2_1a	Name of Catchment Area's paras (ক্যাচমেন্ট এরিয়ার পাড়াসমূহের নাম)	
q2_2	How many ethnic communities receive services from this CC? (এই কমিউনিটি ক্লিনিক থেকে কতগুলো এথনিক কমিউনিটি স্বাস্থ্যসেবা গ্রহণ করে থাকে?)	
q2_3	Please ethnic communities দয়া করে এথনিক কমিউনিটির নাম উল্লেখ করুন	1= Bengali 2= Chakma 3= Marma 4= Tripura 5= Tanchanga 6= Mro 7= Lusai 8=Bawm 9= pangkhoya 10= Khumi 11= Chak 12= khyang 13= Rakhain 77= Others ১= বাঙ্গালি ২= চাকমা ৩= মারমা ৪= ত্রিপুরা ৫= থঞ্চঙ্গা ৬= ম্রো ৭= লুসাই ৮= বোম

		৯= পাংখয়া ১০= খুমি ১১= চাক ১২= খায়াং ১৩= রাখাইন ৭৭= অন্যান্য
q2_3ot	Please specify দয়া করে নির্দিষ্ট করুন	
q2_4	Mode of transportation to clinic ক্লিনিকের যাওয়ার যাতায়াত ব্যবস্থার ধরন	1=Rickshaw 2=Bi-cycle 3=Motor bike 4=Auto rickshaw 5=Motor car 6=Walk by foot 77= Others 1=রিক্সা 2=বাই সাইকেল 3=মোটর সাইকেল 4=অটো রিক্সা 5=মটরের গাড়ি 6=পায়ে হেটে 77= অন্যান্য
q2_4ot	Please specify দয়া করে নির্দিষ্ট করুন	
q2_5	What is the shortest transit time? কমিউনিটি ক্লিনিকে যেতে সর্বনিম্ন কত মিনিট সময় লাগে?	Minutes----- কত মিনিট....
q2_6	What is the longest transit time? কমিউনিটি ক্লিনিকে যেতে সর্বোচ্চ কত মিনিট সময় লাগে?	Minutes----- কত মিনিট....

CG : Community group (কমিউনিটি গ্রুপ/দল)

No	Questions	Coding categories
q3_1	Does a community group form? কোন কমিউনিটি গ্রুপ/ দল গঠন করা হয়েছে?	1= Yes ১= হ্যাঁ 0= No ০= না
q3_1a	If yes, date of formation? (কমিউনিটি গ্রুপ/ দল গঠনের তারিখ?)	Date..... তারিখ-----
q3_1b	Total number of members (কমিটির মোট সদস্য সংখ্যা)	Total number----- মোট সদস্য সংখ্যা----
q3_1c	Total Male members (মোট পুরুষ সদস্য কতজন?)	Male……...Number পুরুষ……সংখ্যা
q3_1d	Total female members (মোট নারী সদস্য কতজন?)	Female..……. Number মহিলা……সংখ্যা
q3_1e	how many ethnic groups represent in the group? (এই দলে কতগুলো এথনিক জনগোষ্ঠী প্রতিনিধিত্ব করে?)	many ethnic groups---- কতগুলো এথনিক জনগোষ্ঠী--
q3_1f	Whether members of the committee hold monthly meeting regularly (কমিটির সদস্যরা কি নিয়মিত মাসিক সভা করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q3_1g	How many meeting held in last 12 months?(গত বারো মাসে কতগুলো মিটিং অনুষ্ঠিত হয়েছে?	How many meeting.... কতগুলো মিটিং----

q3_2	Did this group receive any training (এই গ্রুপ/দল কি কোন প্রশিক্ষণ পেয়েছে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q3_3	What types of training? (কোন ধরনের প্রশিক্ষণ পেয়েছে?)	1=Community Mobilization 2=Workplan 3=Rules and responsibility 4=Primary health care 5=Others 1=জনগনকে উদ্বুদ্ধকরণ 2=কাজের পরিকল্পনা 3=দায়িত্ব ও কর্তব্য সম্পর্কে 4=প্রাথমিক স্বাস্থ্য সেবা 5=অন্যান্য
q3_4	When did they receive this training? (কখন এই প্রশিক্ষণ পেয়েছিল?)	Date – তারিখ–––

CSG: Community Support Group

No	Questions	Coding categories
q4_1	Does a community support group form? কোন কমিউনিটি সাপোর্ট গ্রুপ/দল গঠন করা হয়েছে?	1= Yes ১= হ্যাঁ 0= No ০= না
q4_2	Date of formation? (এই কমিউনিটি সাপোর্ট গ্রুপ গঠনের তারিখ?	Date – তারিখ–––
q4_3	Does this group functional? (এই কমিউনিটি সাপোর্ট গ্রুপ কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
q3_3b	Total number of members (: কমিটির মোট সদস্য সংখ্যা)	Total number..... সদস্য সংখ্যা---
q4_4	Total Male members (মোট পুরুষ সদস্য কতজন?)	Male……...Number পুরুষ……সংখ্যা
q4_5	Total female members (মোট নারী সদস্য কতজন?)	Female...……. Number মহিলা……সংখ্যা
q4_6	how many ethnic groups represent in the group? (এই দলে কতগুলো এথনিক জনগোষ্ঠী প্রতিনিধিত্ব করে?)	many ethnic groups---- কতগুলো এথনিক জনগোষ্ঠী--
q4_7	How many meeting held in last 12 months? (গত বারো মাসে কতগুলো মিটিং অনুষ্ঠিত হয়েছে?	How many meeting.... কতগুলো মিটিং----
q4_8	Did this group receive any training? (এই গ্রুপ/দল কি কোন প্রশিক্ষণ পেয়েছে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q4_9	What types of training? (কোন ধরনের প্রশিক্ষণ পেয়েছে?)	1=Community Mobilization 2=Workplan 3=Rules and responsibility 4=Primary health care 5=Others 1=জনগনকে উদ্বুদ্ধকরণ 2=কাজের পরিকল্পনা 3=দায়িত্ব ও কর্তব্য সম্পর্কে 4=প্রাথমিক স্বাস্থ্য সেবা 5=অন্যান্য
q4_10	When did they receive this training? (কখন এই প্রশিক্ষণ পেয়েছিল?)	Date – তারিখ–––

q5: Human Resources/Manpower

(কমিউনিটি ক্লিনিকের মানব সম্পদ)

Name of designation পদের নাম	Sex 1= male 2= Female 3= Third gender লিঙ্গ ১= পুরুষ ২= মহিলা ৩= তৃতীয় লিঙ্গ	1= Bengali 2= Chakma 3= Marma 4= Tripura 5= Tanchanga 6= Mro 7= Lusai 8=Bawm 9= pangkhoya 10= Khumi 11= Chak 12= khyang 13= Rakhain 77= Others ১= বাঙ্গালি ২= চাকমা ৩= মারমা ৪= ত্রিপুরা ৫= থঞ্চঙ্গা ৬= ম্রো ৭= লুসাই ৮= বোম ৯= পাংখয়া ১০= খুমি ১১= চাক ১২= খায়াং ১৩= রাখাইন ৭৭= অন্যান্য	Received basic training? 1= Yes 0= No প্রাথমিক প্রশিক্ষণ পেয়েছেন? ১= হ্যাঁ ০= না	Date তারিখ	Received refresher training? 1= Yes 0= No রিফ্রেসার প্রশিক্ষণ পেয়েছেন? ১= হ্যাঁ ০= না	Date তারিখ	Name of training প্রশিক্ষণের নাম 1=Community Mobilization 2=Workplan 3=Rules and responsibility 4=Primary health care 5=Others 1=জনগনকে উদ্বুদ্ধকরণ 2=কাজের পরিকল্পনা 3=দায়িত্ব ও কর্তব্য সম্পর্কে 4=প্রাথমিক স্বাস্থ্য সেবা 5=অন্যান্য
first designation (CHCP) (প্রথম কর্মকর্তা সংক্রান্ত তথ্য)							
second designation (FWV/FWA) দ্বীতিয় কর্মকর্তা সংক্রান্ত তথ্য							
third designation (HA) (তৃতীয় কর্মকর্তা সংক্রান্ত তথ্য)							

CHCP-Community Health Care Provider, FWV-Family welfare visitor, FWA-Family Welfare Assistant, HA- Health Assistant

Services provided from the CC (মডিউল ২: কমিউনিটি ক্লিনিক থেকে প্রদানকৃত সেবাসমুহ)

No	Questions	Coding categories
6.1	Does this CC provide dispense medicine services? (এই কমিউনিটি ক্লিনিক কি রোগীদের ঔষধ সরবরাহ করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
6.2	Does this CC provide GMP service? (এই কমিউনিটি ক্লিনিক কি জিএমপি সেবা প্রদান করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
6.3	Does this CC provide ANC and PNC service? (এই কমিউনিটি ক্লিনিক কি গর্ভ পূর্ববর্তী চেকাপ এবং গর্ভ পরবর্তী চেকাপ সেবা প্রদান করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
6.3a	I what type of ANC and PNC service (কোন ধরনের গর্ভ পূর্ববর্তী চেকাপ এবং গর্ভ পরবর্তী চেকাপ সেবা প্রদান করে।)	1= Antenatal Check up 2= Post Natal Check up 3= Pregnancy Counseling 4= Iron Folic Acid Supplementation ১= গর্ভ পূর্ববর্তী চেকাপ ২= গর্ভ পরবর্তী চেকাপ ৩= গর্ভবতীকালীন সময়ে পরামর্শ প্রদান ৪= আয়রন এবং ফলিক এসিড প্রদান
6.4	Does this CC provide vaccination service? (এই কমিউনিটি ক্লিনিক কি টীকা প্রদান করে?	1= Yes ১= হ্যাঁ 0= No ০= না
6.5	Does this CC provide child delivery service? (এই কমিউনিটি ক্লিনিক কি বাচ্চা ডেলিভারি সুবিধা আছে?)	1= Yes ১= হ্যাঁ 0= No ০= না
6.5a	If yes, what type of service related to child birth? (তাহলে সন্তান জন্মদান সম্পর্কিত কোন ধরনের সেবা প্রদান করে থাকে?)	1= Child birth 2= Birth counseling 3= IFA supplementation 4= VAS supplementation ১= সন্তান জন্মদান ২= সন্তান জন্মদান সম্পর্কিত পরামর্শ প্রদান ৩= আইএফএ সাপ্লিমেন্টেশন ৪= ভিএএস সাপ্লিমেন্টেশন
6.6	Does this CC provide limited curative care service? এই কমিউনিটি ক্লিনিক কি ছোট-খাট রোগের সেবা প্রদান করে?	1= Yes ১= হ্যাঁ 0= No ০= না
6.6a	What type of limited curative care service? এই কমিউনিটি ক্লিনিক কোন ধরনের ছোট খাট রোগের সেবা প্রদান করে?	1= Fever 2= ARI 3= Diarrhea 4= Skin diseases 5= Acid Peptic Diseases 6= Patient Referral 77= Others ১= জ্বর ২= এআরআই ৩= ডায়রিয়া ৪= চর্ম রোগ ৫=গ্যাস্টিক/আলসার ৬= রোগীকে অন্যত্র পাঠানো ৭= অন্যান্য
q6_6aot	If other, please specify. যদি অন্যান্য হয়, দয়া করে নির্দিষ্ট করুন	

6.7	Does this CC provide minor surgical facility service? এই কমিউনিটি ক্লিনিক কি ছোট-খাট অপারেশন করে?	1= Yes ১= হ্যাঁ 0= No ০= না
6.7a	If yes, what type of minor surgical facility services? কোন ধরনের ছোট অপারেশন করে থাকে?	1= Cleaning the wounds 2= Stitching the wounds 77= Others ১= ক্ষত পরিষ্কার করা ২= ক্ষত সেলাই করা ৩= অন্যান্য
q6_7ot	If other, please specify. যদি অন্যান্য হয়, দয়া করে নির্দিষ্ট করুন	

Module-3: Supplies and equipment

মডিউল ৩: উপকরন এবং সরঞ্জামাদি

No	Questions	Coding categories
7.1	Does this CC have weighing scale? এই কমিউনিটি ক্লিনিকের ওজন মাপার স্কেল আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.1a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.2	Does this CC have salter scale? এই কমিউনিটি ক্লিনিকের সালটার স্কেল আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.2a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.3	Does this CC have height board? এই কমিউনিটি ক্লিনিকের উচ্চতা মাপার বোর্ড আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.3a	Does this operational? যদি হ্যাঁ হয়, তবে এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.4	Does this CC have length board? এই কমিউনিটি ক্লিনিকের দৈর্ঘ্য মাপার বোর্ড আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.4a	Does this operational? (এটা কি কাজ করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
7.5	Does this CC have stethoscope? এই কমিউনিটি ক্লিনিকের স্টেথিস্কোপ যন্ত্র আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.5a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.6	Does this CC have blood pressure machine? এই কমিউনিটি ক্লিনিকের রক্তচাপ পরিমাপের ম্যাশিন রয়েছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.6a	Does this operational? (এটা কি কাজ করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
7.7	Does this CC have register books? এই কমিউনিটি ক্লিনিকে রেজিস্টার বই আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.7a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.8	Does this CC have ANC cards? এই কমিউনিটি ক্লিনিকে এএনসি কার্ড আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না

7.8a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.9	Does this CC have GMP cards? এই কমিউনিটি ক্লিনিকে জিএমপি কার্ড আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.9a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.10	Does this CC have EPI cards? এই কমিউনিটি ক্লিনিকে ইপিআই কার্ড আছে কি?	1= Yes ১= হ্যাঁ 0= No ০= না
7.10a	Does this operational? (এটা কি কাজ করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
7.11	Does this CC have delivery kits? এই কমিউনিটি ক্লিনিকে কি বাচ্চা ডেলিভারি সরঞ্জামাদি আছে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.11a	If yes, does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না
7.12	Does this CC have 1000-day oriented SBCC materials? এই কমিউনিটি ক্লিনিকে	1= Yes ১= হ্যাঁ 0= No ০= না
7.12a	Does this operational? এটা কি কাজ করে?	1= Yes ১= হ্যাঁ 0= No ০= না

sec8: Facility Service Time

পার্ট- IV: স্বাস্থ্য সেবা প্রদানের সময়

Days দিন	Working hours কর্মঘন্টা	q8_2: Availability of service providers (সেবা প্রদানকারীর উপস্থিতি) 1= Yes ১= হ্যাঁ 0= No ০= না
Saturday শনিবার		
Sunday রবিবার		
Monday সোমবার		
Tuesday মঙ্গলবার		
Wednesday বুধবার		
Thursday বৃহস্পতিবার		

q10: medicine stock (ঔষধের মজুত সংক্রান্ত তথ্য)

Generic Name **জেনেরিক নাম**	**Unit** **একক**	**In stock** 1=Yes 0=No **মজুদ** **১= হ্যাঁ** **২= না**			
			Supplied **সরবরাহ**	**In-Stock** **মজুদ**	**Earliest Expiration date** **মেয়াদ উত্তীর্ণের নিকটতম তারিখ**

Albendazole Tablet 400mg অ্যালবেনডাজল ট্যাবলেট ৪০০ মি.গ্রা	Tablet ট্যাবলেট				
Antacid 650mg অ্যান্টাসিড ৬৫০ মি.গ্রা	Tablet ট্যাবলেট				
Calcium Lactate Tablet 300mg ক্যালসিয়াম ল্যাক্টেড ট্যাবলেট ৩০০ মি.গ্রা	Tablet ট্যাবলেট				
Chlorpheniramine Tablet 4mg ক্লোরোফিনারামিন ট্যাবলেট ৪ মি.গ্রা	Tablet ট্যাবলেট				
Co-trimoxazole Tablet 120mg কো-ট্রিমোক্সাজল ট্যাবলেট ১২০ মি.গ্রা	Tablet ট্যাবলেট				
Co-trimoxazole Tablet 960mg কো-ট্রিমোক্সাজল ট্যাবলেট ৯৬০ মি.গ্রা	Tablet ট্যাবলেট				
Ferrous Fumarate and Folic Acid Tablet 200.40 mg ফেরাস ফিউমারেট অ্যান্ড ফলিক এসিড ট্যাবলেট ২০০.৪০ মি.গ্রা	Tablet ট্যাবলেট				
Hyoscine Butyl Bromide Tablet 10 mg হায়োসাইন বুটাইল ব্রোমাইড ট্যাবলেট ১০ মি গ্রা	Tablet ট্যাবলেট				
Metronidazole Tablet 400mg মেট্রোনিডাজল ট্যাবলেট 400 মি.গ্রা	Tablet ট্যাবলেট				
Paracetamol 60ml Suspension প্যারাসিটামল 60 এমএল সাসপেনশন	Bottle ট্যাবলেট				
Paracetamol Tablet 500mg প্যারাসিটামল ট্যাবলেট ৫০০ মি.গ্রা	Tablet ট্যাবলেট				
Penicillin V Tablet 250mg পেনিসিলিন ভি ট্যাবলেট ২৫০ মি.গ্রা	Tablet ট্যাবলেট				
Salbutamol 2mg সাল্বুটামল ১২ মি.গ্রা	Tablet ট্যাবলেট				
Vitamin-A Capsule 200000 IU	Capsule ট্যাবলেট				

ভিটামিন এ ক্যাপসুল ২০০০০০ আইইউ					
Vitamin B complex Tablet ভিটামিন বি কমপ্লেক্স ট্যাবলেট	Tablet ট্যাবলেট				
Zinc Dispersible Tablet 20 mg জিংক ডিসপারসিবল ট্যাবলেট ২০ মি.গ্রা	Tablet ট্যাবলেট				
Amoxicillin Dry Syrup 100ml অ্যামোক্সিসিলিন শুকনো ড্রাই ১০০ মিলি	Bottle বোতল				
Amoxicillin Pediatric Drop 15 ml অ্যামোক্সিসিলিন পেডিয়াট্রিক ড্রপ ১৫ মিলি	Bottle বোতল				
Benzyl Benzoate Application 100ml বেনজাইল বেনজোয়াট অ্যাপ্লিকেশন ১০০ মিলি	Bottle বোতল				
Chlorpheniramine Maleate Syrup 60 ml ক্লোরফেনিরামিন মালেতে সিরাপ ৬০ মিলি	Bottle বোতল				
Salbutamol Syrup 60 ml সাল্বুটামল সিরাপ ৬০ মিলি	Bottle বোতল				
Amoxicillin Capsule অ্যামোক্সিসিলিন ক্যাপসুল	Capsule ক্যাপসুল				
Chloramphenicol Eye Drop 0.5% 10 ml ক্লোরামফেনিকল আই ড্রপ ০.৫% ১০ মিলি	Vial বোতল				
Compound Benzoic Acid Ointment 1 kg কম্পাউন্ড বেঞ্জইক এসিড মলম ১ কেজি	Jar জার				
Gention Violet Topical Solution2% জেনো ভায়োলেট টপিকাল সলিউশন ২%	Vial বোতল				
Neomycyn and Bacitracin Ointment 10 g নিওমাইসিন অ্যান্ড ব্যাক্টেরিয়াম ১০ গ্রাম	Tube টিউব				
Oral Rehydration Salt (ORS) মুখে খাওয়ার স্যালাইন	Sachet স্যাশে/স্যালাইনের ছোট প্যাকেট				

q9: Community Clinic Observation (কমিউনিটি ক্লিনিক পর্যবেক্ষণ)

No.	Questions	Coding categories
9.1	Number of rooms in the CC কমিউনিটি ক্লিনিকের রুমের সংখ্যা	Number of rooms--- রুমের সংখ্যা----
9.2	Does this CC have pit latrine? (এই কমিউনিটি ক্লিনিকে কি পিট ল্যাট্রিন আছে?_	1= Yes ১= হ্যাঁ 0= No ০= না
9.3	q9: If yes, Does this pit latrine with water seal? (যদি হ্যা হয়, তবে কি এটি ওয়াটার সীল করা পিট ল্যাট্রিন?)	1= Yes ১= হ্যাঁ 0= No ০= না
9.3a	Are toilets operational? (টয়লেট কি চালু আছে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_3a_1	Does this toilet used by patients? (এই টয়লেট কি রোগীরা ব্যবহার করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_3a_2	does this toilet used by only staff? (এই টয়লেট কি শুধুমাত্র কর্মচারীরা ব্যবহার করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_4	Does this CC have offset pit latrine? এই কমিউনিটি ক্লিনিকে কি অফসেট পিট ল্যাট্রিন আছে?	1= Yes ১= হ্যাঁ 0= No ০= না
q9_5	Are toilets operational? (টয়লেট কি চালু আছে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_5a	Does this toilet used by patients? (এই টয়লেট কি রোগীরা ব্যবহার করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_5b	Does this toilet used by only staff? (এই টয়লেট কি শুধুমাত্র কর্মচারীরা ব্যবহার করে?)	1= Yes ১= হ্যাঁ 0= No ০= না
q9_6	What type of water facility is available in this CC? (এই কমিউনিটি ক্লিনিকে কোন ধরনের পানি ব্যবহারের ব্যবস্থা আছে?)	1= Portable 2= Deep well 3= Running water 4= Protected Ring well 5= GFS 77= Other (Please specify) ১= সহজে বহনীয় ২= গভীর কুপ ৩= প্রবাহমান পানি ৪= সুরক্ষিত রিং ওয়েল ৫= জিএফএস ৭৭= অন্যান্য নির্দিষ্ট করুন
q9_6a	Others (অন্যান্য)	
q9_6b	Does the water facility operational? (পানির এই ব্যবস্থা কি চালু আছে?)	
q9_6c	who use this for handwashing? (হাত ধোয়ার জন্য কে এই পানি ব্যবহার করে?)	

note: Thank you so much for your valuable time and effort.

(আপনার মূল্যবান সময় দেওয়ায় জন্য আপনাকে ধন্যবাদ।)

ANNEX 2. ADDITIONAL DATA FIGURES

Figure A-1. Ethnic groups served by clinics and of clinic staff in Bandarban Sadar Upazila

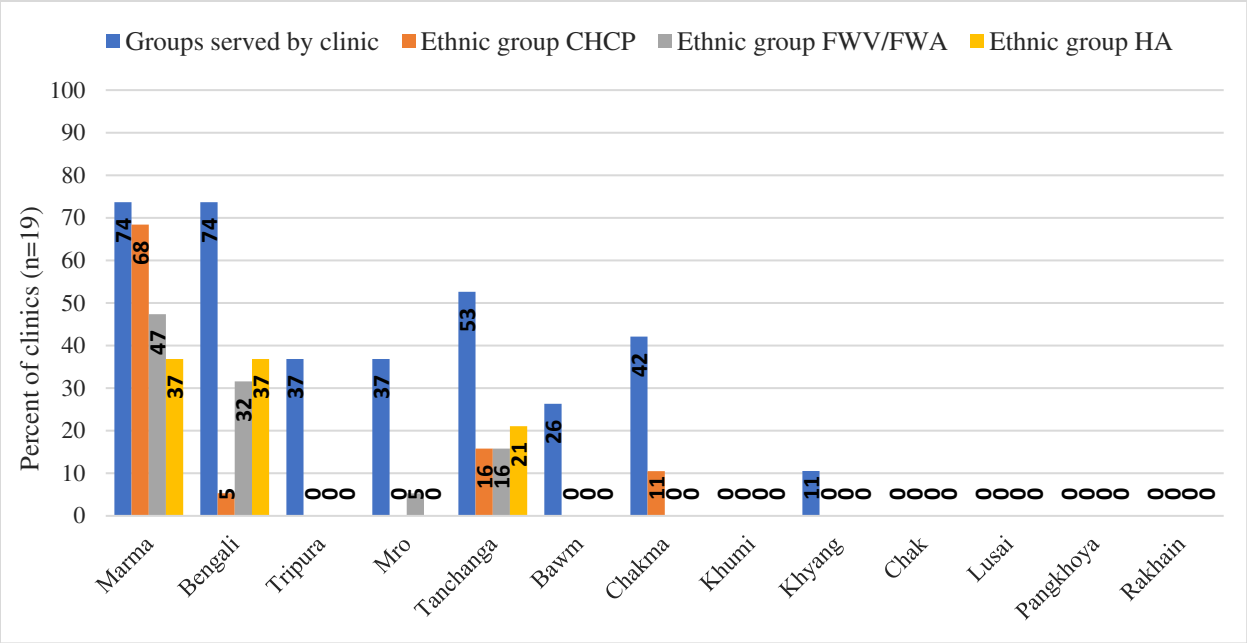


Figure A-2. Ethnic groups served by clinics and of clinic staff in Lama Upazila

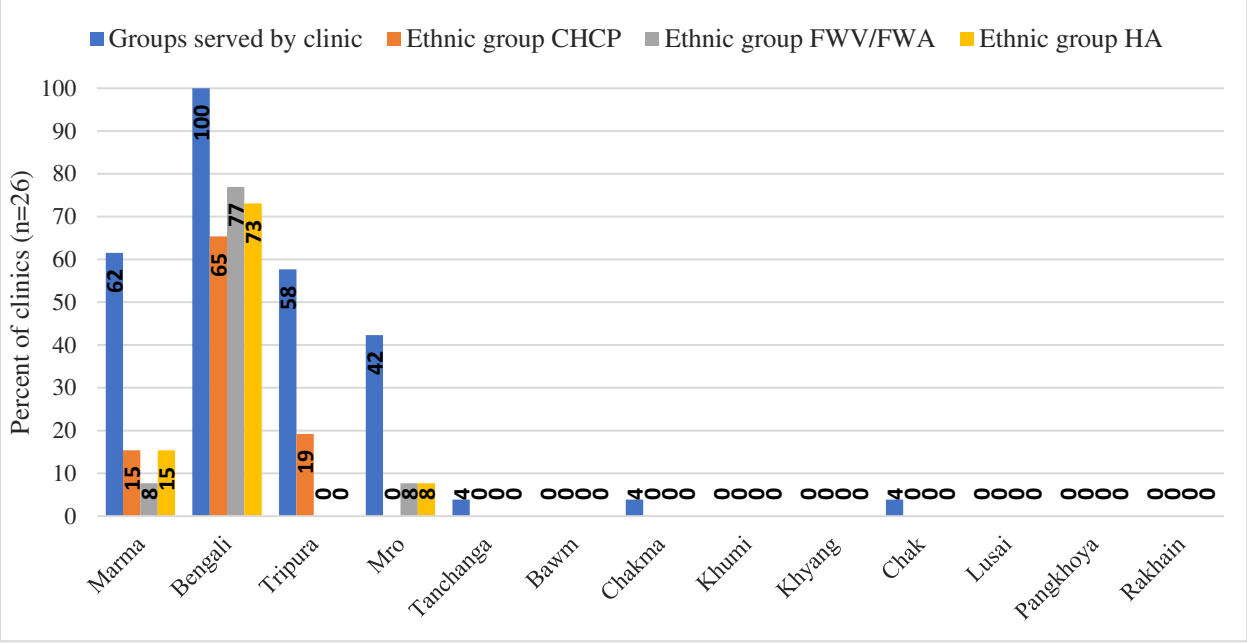


Figure A-3. Ethnic groups served by clinics and of clinic staff in Rowangchhari Upazila

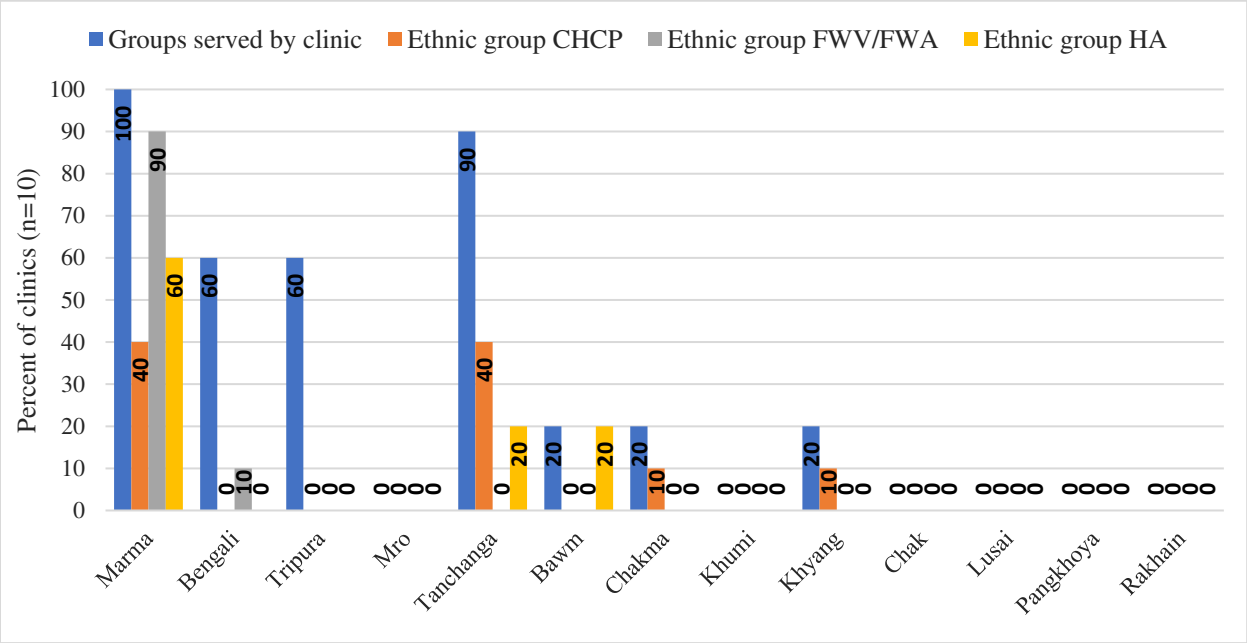
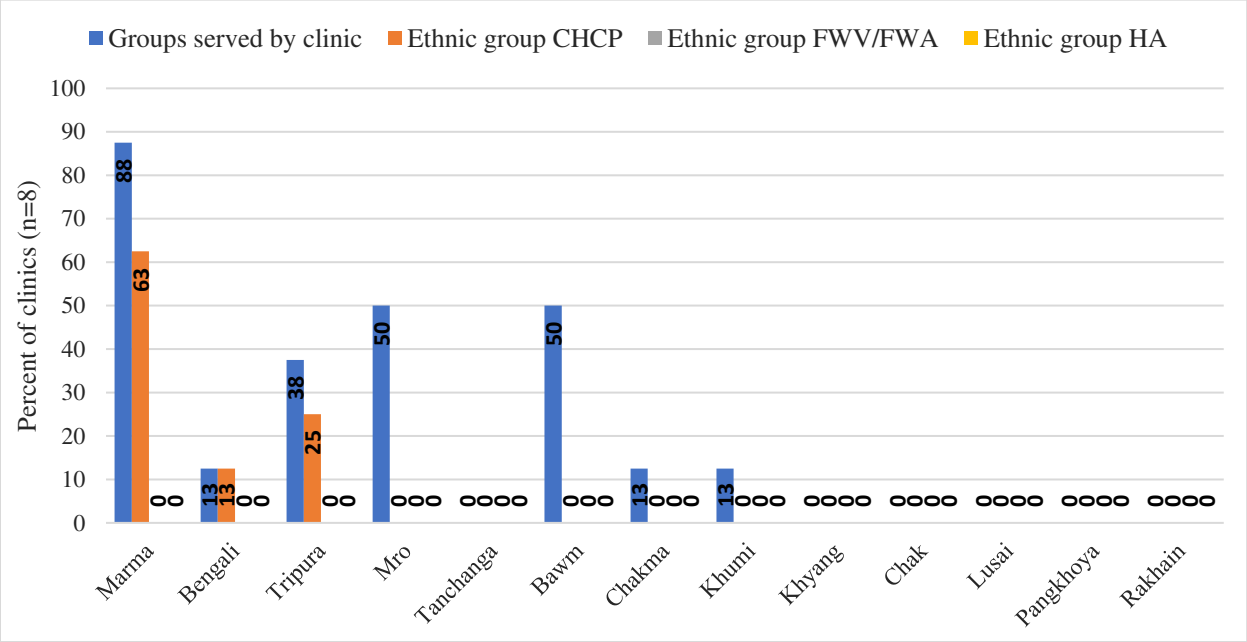


Figure A-4. Ethnic groups served by clinics and of clinic staff in Ruma Upazila



Note: No clinics in Ruma reported having FWA/FWV and HA staff

Figure A-5. Ethnic groups served by clinics and of clinic staff in Thanchi Upazila

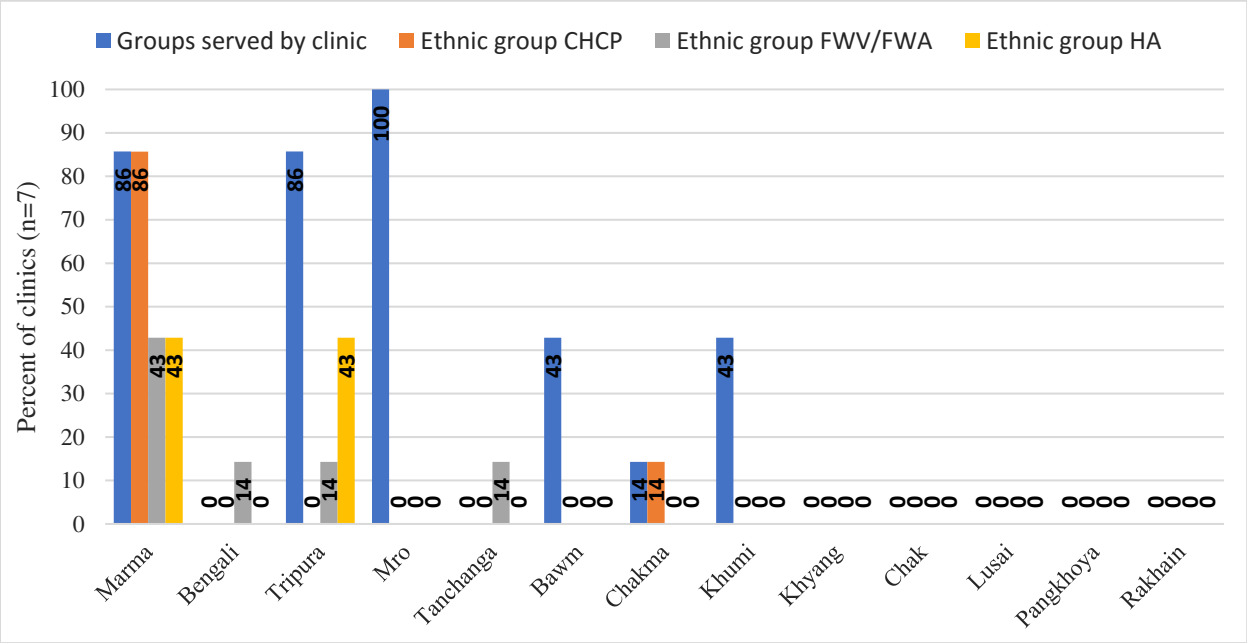


Figure A-6. Quantity of required medicine stocks in Bandarban Sadar clinics on day of assessment

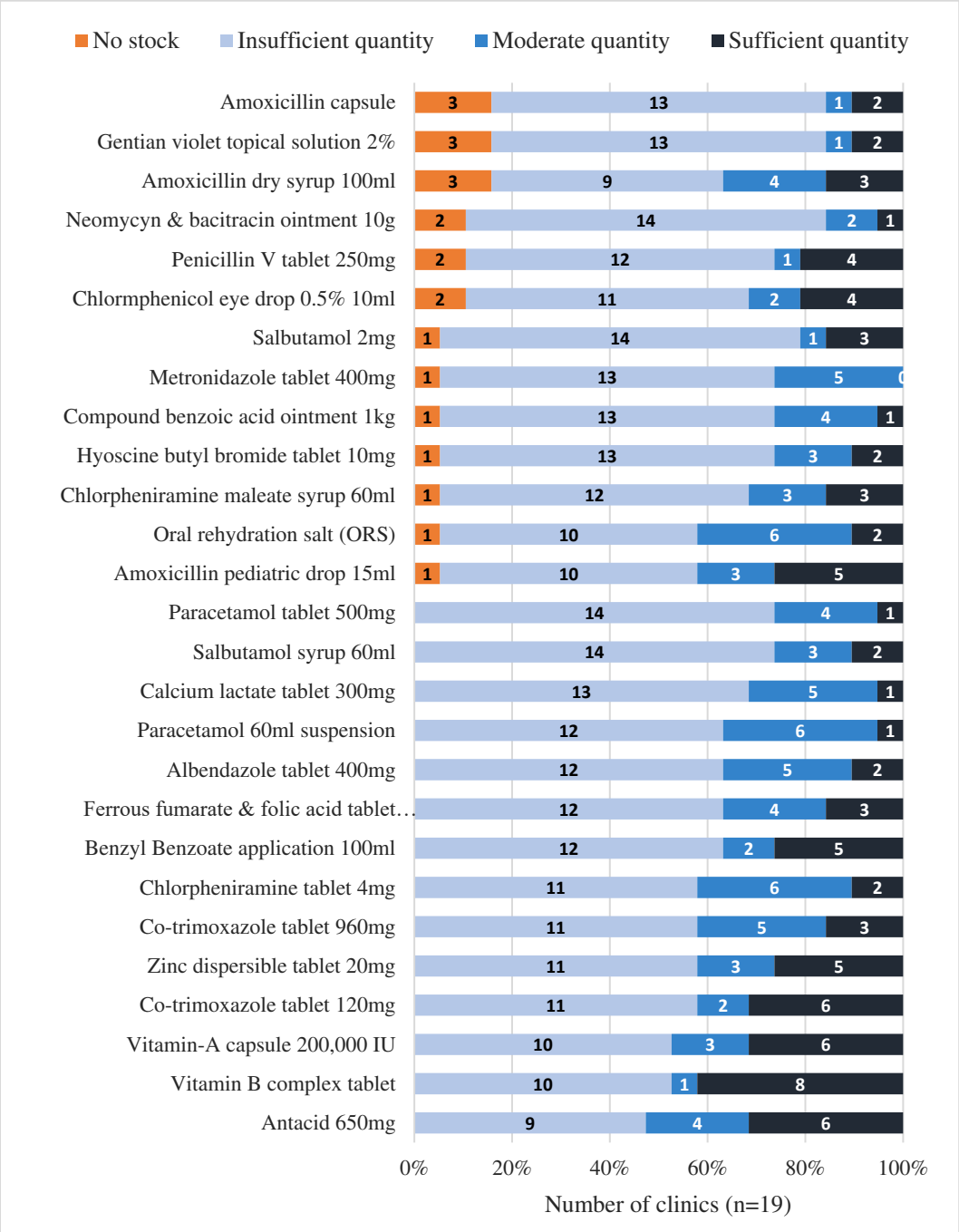


Figure A-7. Quantity of required medicine stocks in Lama clinics on day of assessment

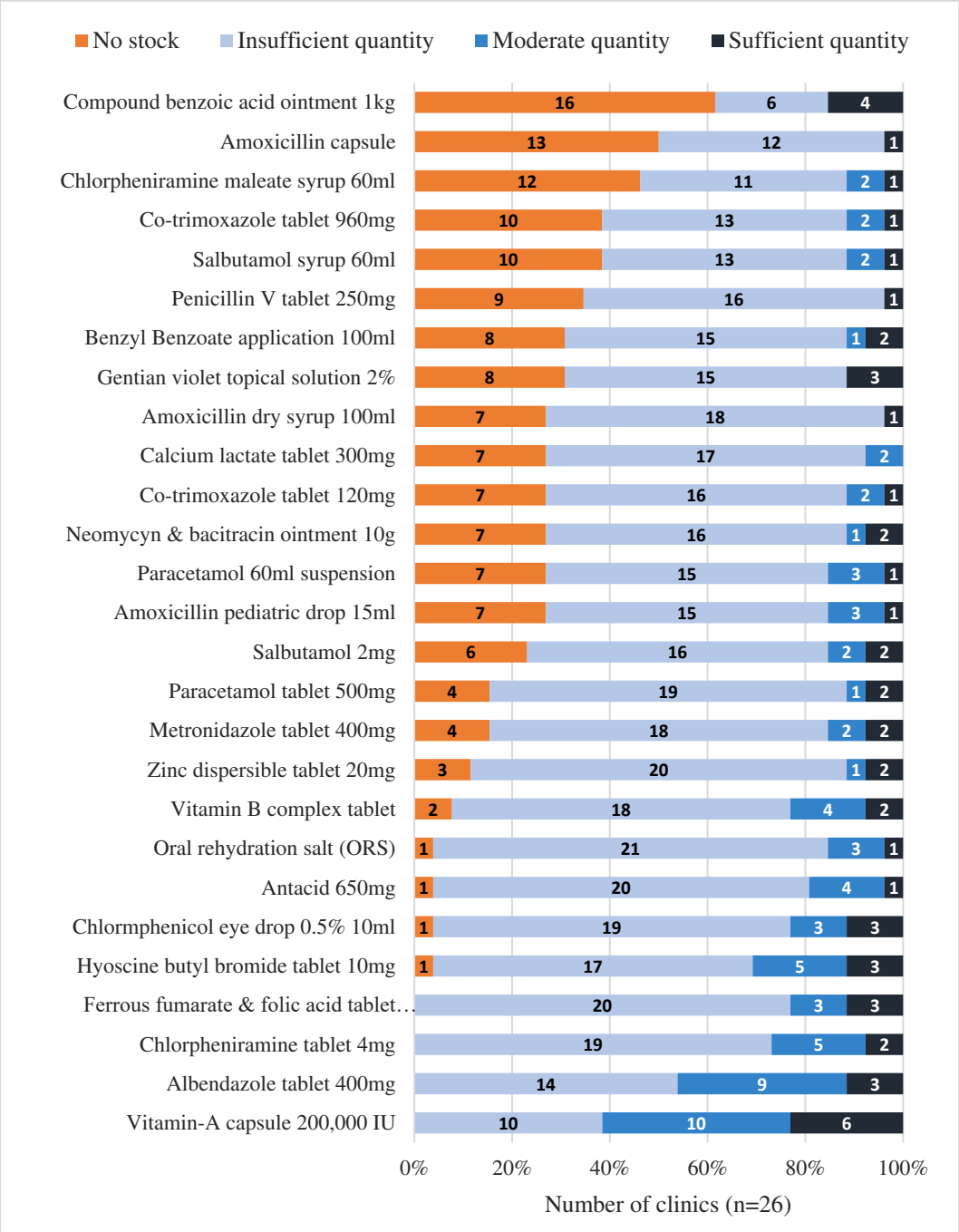


Figure A-8. Quantity of required medicine stocks in Rowangchhari clinics on day of assessment

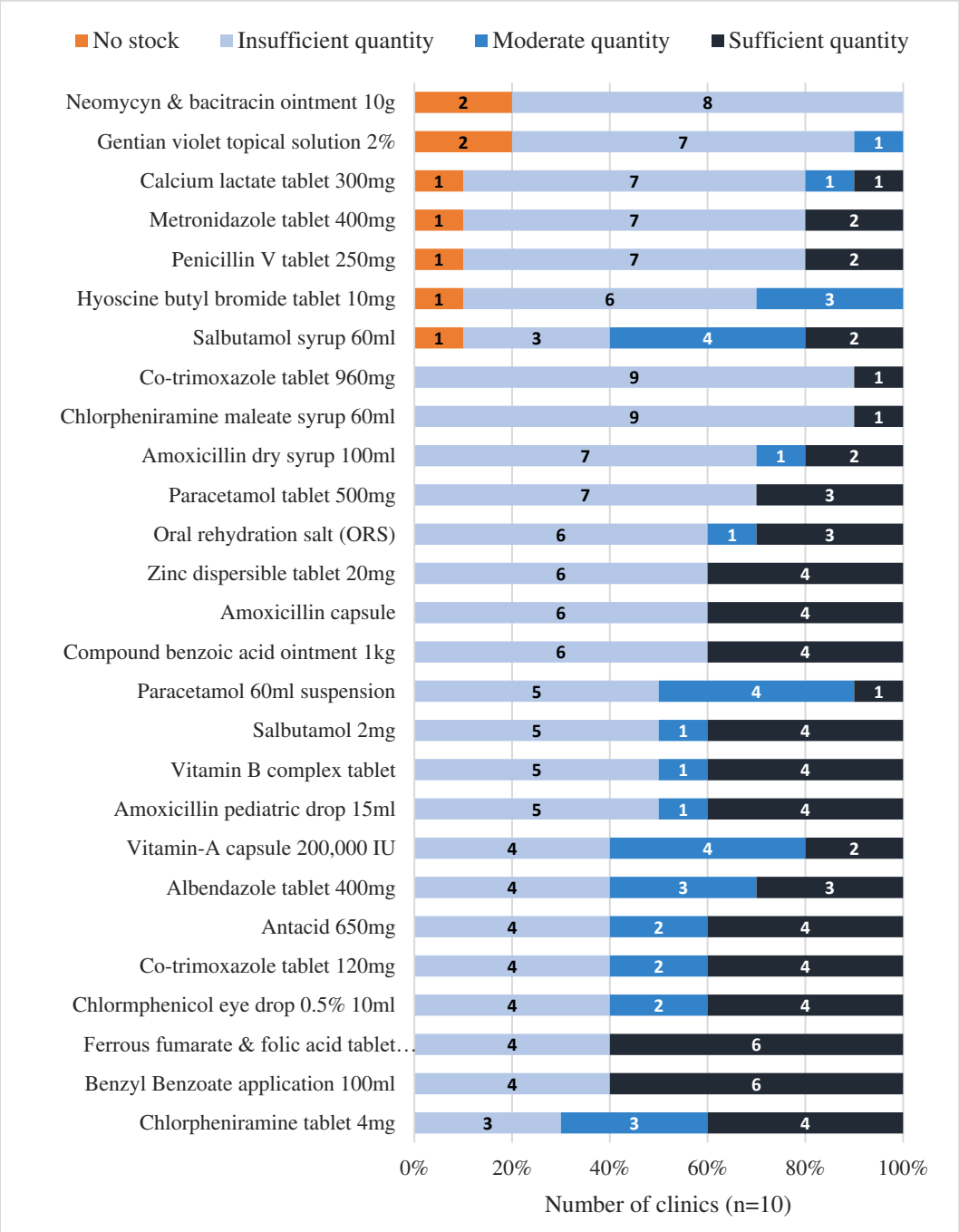


Figure A-9. Quantity of required medicine stocks in Ruma clinics on day of assessment

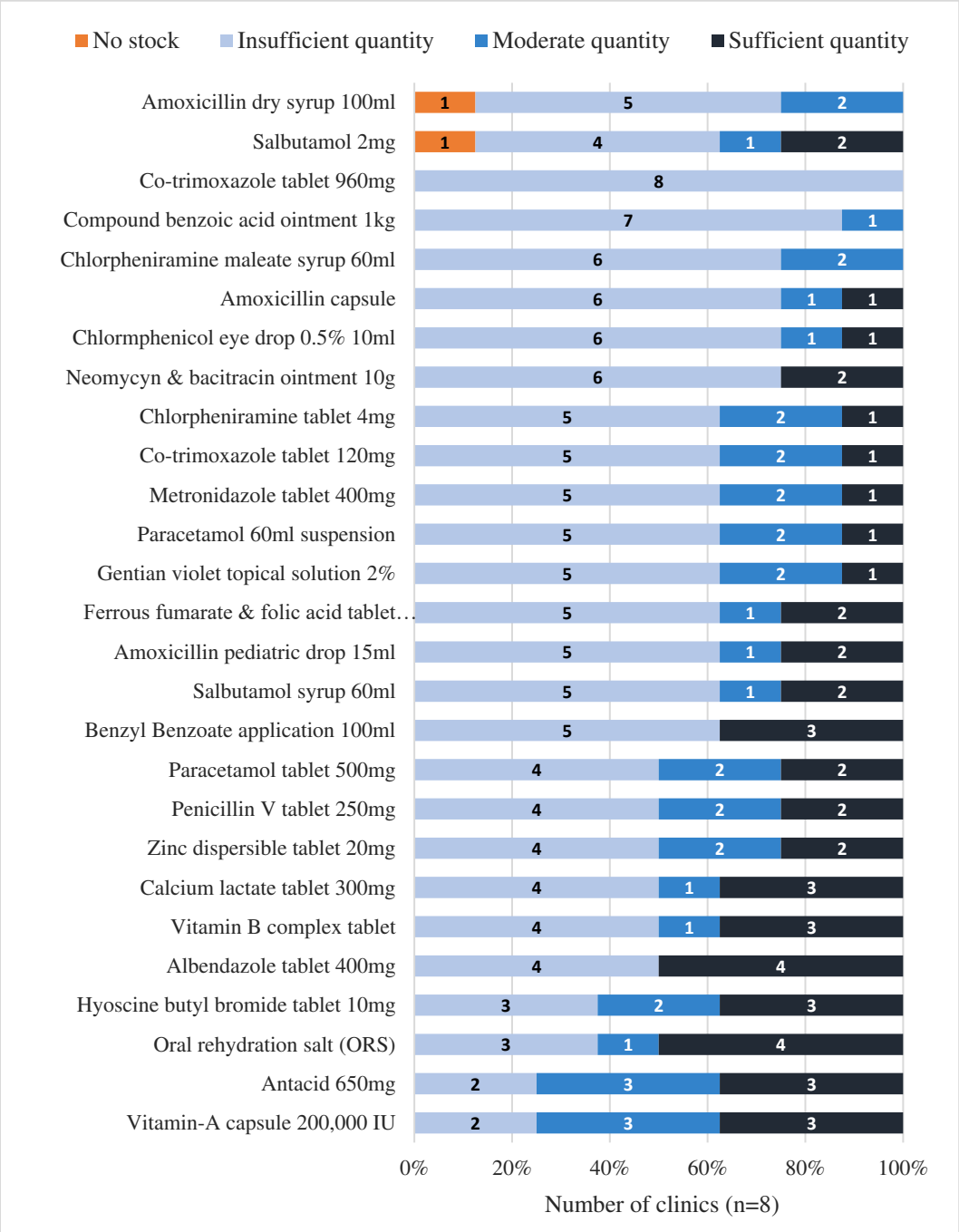
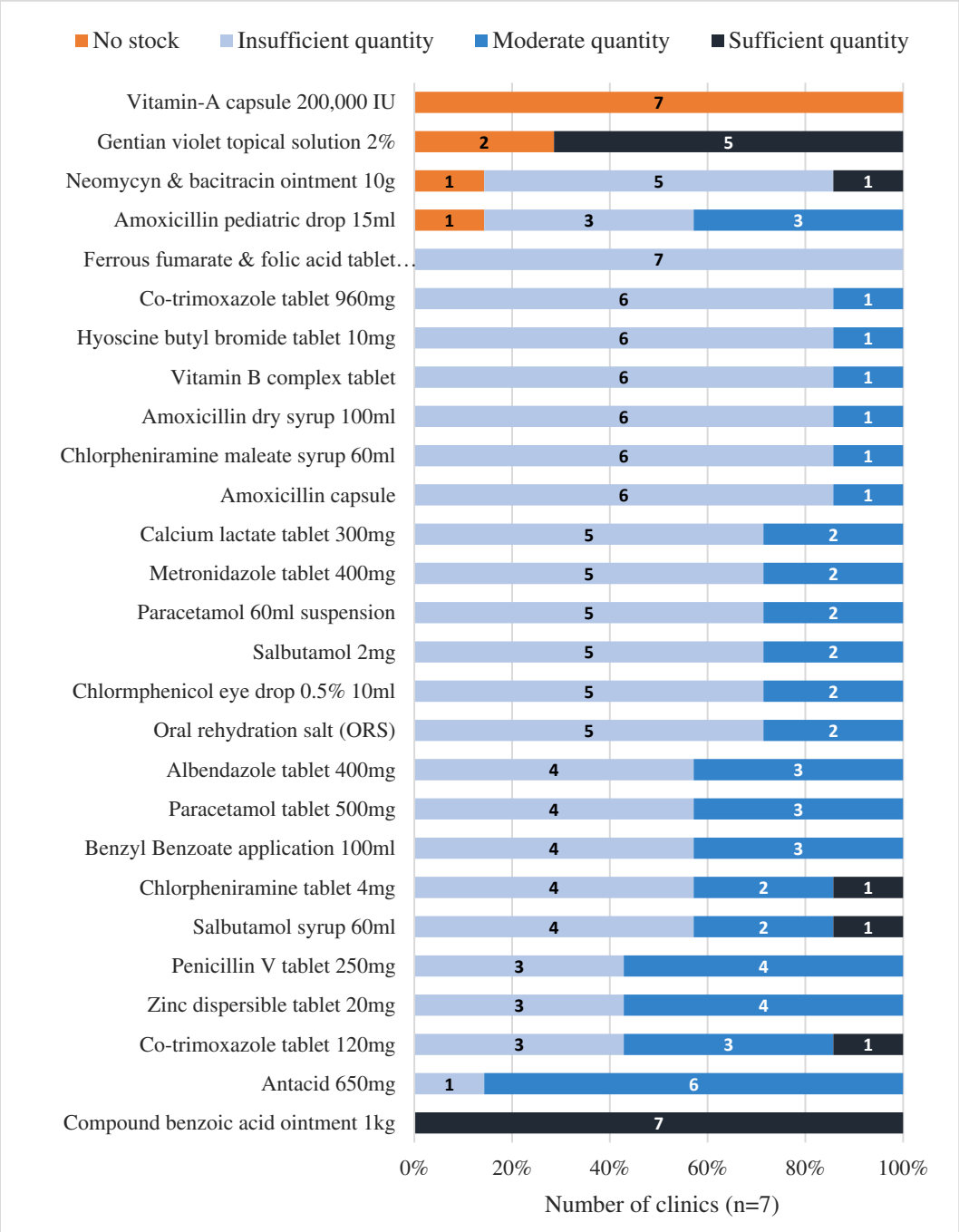



Figure A-10. Quantity of required medicine stocks in Thanchi clinics on day of assessment