Working Paper No. 34

Improving Availability of And Access to an Essential Services Package (ESP) in Urban Dhaka, Bangladesh

Findings from Mid-term Evaluation

MCH-FP Extension Project (Urban)
Health and Population Extension Division

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ICDDR,B
CENTRE
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Foreword

I am pleased to release these reports on urban Maternal and Child Health and Family Planning issues which are based on the operations research activities of the MCH-FP Extension Project (Urban) of the Centre. Over the years, the Centre has acquired a unique expertise on urban development matters that ranges from operations research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

This work has produced important findings on the health conditions and needs of city dwellers, particularly the poor and those living in slums. The research has also identified service delivery areas in which improvements need to be made to enhance effectiveness. Together, these research findings have been translated into interventions currently being applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with different ministries and agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.

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Last but not the least, we express our gratitude and appreciation to our reviewers especially Prof Robert E Black of Johns Hopkins and all those who have given critical comments and advice at numerous occasions.

Glossary

CPR	:	Contraceptive Prevalence Rate
IMR	:	Infant Mortality Rate
CMR	:	Child Mortality Rate
CBR	:	Crude Birth Rate
CDR	:	Crude Death Rate
UPS	:	Urban Panel Survey, ICDDR,B
MOHFW	:	Ministry of Health and Family Welfare
MCHFP	:	Maternal Child Health and Family Planning
PHC	:	Primary Health Care
NGO	:	Non-governmental Organization
EPI	:	Expanded Program on Immunization
DCC	:	Dhaka City Corporation
UEP	:	Urban MCH-FP Extension Project
ANC	:	Ante-natal Care
ARI	:	Acute Respiratory Infection
DDFP	:	Deputy Director Family Planning
FWV	:	Family Welfare Visitor
CWFP	:	Concerned Women For Family Planning
MO	:	Medical Officer
AHO	:	Assistant Health Officer
ZEO	:	Zonal Executive Officer
DFP	:	Directorate of Family Planning
BBS	:	Bangladesh Bureau of Statistics
GOB	:	Government of Bangladesh

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Executive summary

In order to improve availability of and access to essential health services, particularly in poor urban areas, the MCH-FP Extension Project (Urban) of ICDDR,B designed and implemented an intervention, by using an innovative methodology and a participatory planning process, to reorganize the current distribution of GOB and NGO primary health care (PHC) clinics at the zonal level of Dhaka City Corporation. This intervention was tested in Zone 3 and Zone 8 of Dhaka City Corporation. The methodology was based on locally available data e.g. inventory, mapping, service utilization and participatory planning workshops involving managers and decision makers of the organizations managing the facilities. Although the planning unit was ward, the objective was to improve utilization of individual clinics and to improve availability and access to services at the zonal level. The workshops for Zone 3 was held in August and that of Zone 8 in November 1996. The outcomes of these workshops were reorganization plans with recommendations for changes so that each ward has enough health resources to meet the essential health services needs. The workshops produced 14 similar recommendations for each zone. Attempts were made to implement changes according to the recommendations in the intervention sites. This report presents the findings from a mid-term evaluation of the intervention. The study period was April 1996- March 1997. The evaluation assessed the feasibility of local level reorganization using participatory methodology and the impact on service utilization.

Findings from the intervention indicate that although there were sufficient number of clinic-based health and family planning facilities in the GOB/NGO sectors , these were poorly distributed, and many of these were under utilized. A number of problems of distributions were identified in the intervention sites. The problems are as follows:

- Low utilization of EPI and FP centres in their current locations

- Deficiency of EPI / FP / curative service providers compared to needs in certain wards
- Gaps as well as duplications in coverage
- Irregular and sporadic locations of satellite clinics
- Referral among the multiple providers of services are weak

The study indicated that it is feasible to redistribute the facilities using the participatory methodology. So far 6 of the 14 specific recommendations for changes have been implemented in Zone 3. Four of these have been implemented by the NGOs and the other two by DCC. In Zone 8, seven of the 14 specific recommendations have so far been implemented. All have been implemented by NGOs. Changes that took place in Zone 8 was faster compared to that in Zone 3 because most of the facilities in Zone 8 are managed by the NGOs. Implementation of the recommendations by the NGOs is relatively easier perhaps due to flexibility and less administrative complexities than the GOB system. Experience from the intervention identified a number of strengths of the participatory planning methodology. The notable ones are as follows:

- Planning is done at the local level; the planning is participatory and based on consensus of the parties involved in service delivery
- Planning considers and addresses the requirement at the ward level where an elected representative and optimal population for local planning are included.
- Redistribution plan is based on the principle of needs, optimal use of existing resources and focuses on poor population

Findings on the effect of reorganization on utilization of services at the clinic and zonal level demonstrated significant improvement. This indicates that it is possible to improve the utilization of facilities through reorganization of the existing resources. However, changes often required support from the higher level of the organization concerned and can be time consuming.

The potential of the health department of City Corporations and municipalities must be strengthened to enable them to play a leading role in the application of this innovative methodology at the Zonal level.

Finally, further research and understanding of the following questions regarding the intervention are needed to ensure its smooth implementation:

- Is an external facilitating agency essential for planning and implementation of the reorganization methodology?
- What is the most effective way to inform the community about the changes that were implemented?
- Are the assumptions for calculations for service needs appropriate?

1. Background

A. Current Situation

The population explosion experienced in the cities of developing countries, like Bangladesh has resulted in dramatic increase in number of slums and squatter settlements with inadequate essential services. Current estimated population of Dhaka city is more than 5 million. About one third of them live in slums and squatter settlements. Though at the aggregate level the urban population appears to be healthier than in the rural area, the condition of the urban poor population in many respects is worse than their rural counterparts. This becomes evident from the significant intra-urban differentials in the health and family planning status. The urban slum population has lower rates of contraceptive use, immunization coverage, and use of antenatal care. There is higher contraceptive discontinuation, infant mortality and morbidity in this population (Table 1). In the urban slum, death in infancy were about 45% of all deaths in this population. Measles was responsible for 16% of child death (Baqui et al, 1995). Health care-seeking in this population is low. Even when care is sought, it is often delayed and done at the wrong place (for details see Appendix A). There is, therefore, a need to design an approach to urban public health services that specifically targets the poor communities.

Table 1: Intra-urban differentials in key health indicators

Indicator	Slum	Non-slum
Contraceptive Prevalence Rate (CPR)	50	58
Infant Mortality Rate (IMR)	100.7	91
Child Mortality Rate (CMR)	28.8	20.7
Immunization Rate <1 yr	58	77
Crude Birth Rate (CBR)	34.6	24.3
Crude Death Rate (CDR)	7.3	5.3

Sources: MCH-FP Extension Project (Urban), Urban Panel Survey 1995, 1996

The existing urban health service delivery system is characterized by the presence of multiple providers both in terms of number and type of services available (Annexure A, Figure 1). The Directorates of Health and Family Planning operate service facilities of a diverse range . Services are also provided by the local government bodies, i.e. City Corporations and municipalities. Another important feature of urban health services in Bangladesh is the role of the NGOs operating a number of maternal child health and family planning service facilities. However, the commercial sector holds the major share of service outlets in urban areas comprising pharmacies , private practitioners and clinics. The result is usually a relative abundance of service outlets. The Urban Extension Project (UEP) conducted a survey on urban health facilities in GOB, NGO and for-profit commercial sectors. Relatively large number of health and family planning facilities exist in Dhaka (Annexure A, Table 1). The entire city has almost 600 facilities comprising of EPI centres, MCH-FP centres , dispensaries, satellite clinics, hospital, and clinics. There are at least 66 health and family planning NGOs working in the DCC areas, operating a total of 184 facilities, with 555 field workers in addition to 72 from the Ministry of Health and Family Welfare (Majumder et al.1997) .

Though these facilities provide essential services, individual facilities usually offer a limited range of services, and many are single-purpose clinics, i.e. providing only EPI, or only FP, or only curative services, etc. The consequent fragmentation of services not only increases the cost of

Problems in Organization of Urban Service

a. Individual facilities offer limited range of services

b. Some areas have excess of facilities while others are under served due to improper location

c. Local-level coordination and effective cross-referral among neighboring facilities is limited

resulting in relative abundance, fragmentation, gaps and overlaps of services leading to:

i. Limited access to services
ii. Missed opportunities
iii. Increasing cost of service provision and utilization

providing these services but also limits access to these services as the opportunity costs for the clients go up. On the positive side, programme managers, in general, express a desire and willingness to expand the range of services. Staff at many of these facilities are either doctors or paramedics, and therefore, can be trained to provide a broader range of services.

The overall availability of essential services at the zonal (city administrative unit) level is high. However, due to inadequate planning and coordination, the spatial distribution of these facilities usually is not oriented toward needs of the specific areas. Consequently, in some areas many facilities, often providing similar services, are clustered while under-served areas exist elsewhere (Annexure A, Figure 2, 3). This results in geographic differences in availability and access to essential services, despite relative abundance of facilities. Consequently, many facilities are left under utilized.

There is also a lack of local-level coordination and effective cross-referral mechanisms between neighboring facilities that provide complementary services. Consequently, the needs of the clients that can be met by the set of facilities are not assessed at the time of the client visit, they are not referred to the appropriate facility. In facilities that provide more than one type of services, the opportunity provided by a client visit is often not taken advantage of to assess client needs and offer appropriate services and thus results in missed opportunities. In the current context the access to, availability and provision of essential services in urban areas have become an important development agendum for the government, donor and non-governmental agencies. In response to these needs, the Urban Extension Project (UEP) designed two related interventions to address the identified problems. The first intervention is intended to expand the range and to strengthen the quality of services delivered from urban primary care clinics through service delivery protocols. Results from this intervention will be presented in a separate report.

In the second intervention, the aim is to reorganize the current distribution of Primary Health Care Clinics of the GOB/NGOs at the zonal level of Dhaka City Corporation in order to improve availability of and access to essential health services, particularly in poor areas. The intention was to assess the feasibility of local- level reorganization of clinic-based urban PHC services and its effect on service utilization at the clinic as well as the zonal levels. This report deals with the second intervention.

B. Essential Services Package

Policy makers, program managers, providers, and donors agree on the need to focus efforts on moving the health and family planning system toward delivering a package of essential services. Operationally, this means that a minimum package of essential services can and should be identified based on health and demographic needs, feasibility of intervention and availability of resources. The Government of Bangladesh(GOB), however, in the health and population sector strategy have identified a broader package. The components selected in this intervention are part of the essential package that the government has already identified. The selective essential service package components have been identified on the basis of epidemiologic data and the availability and costs of effective services. Client preferences, based on explicit stated needs (Thwin et al. 1995), and current service utilization patterns have also been included as factors in the determination of the package. The following are the components that are being addressed by the intervention:

Selective Essential Services from Primary Health Care Facilities

Reproductive Health

* Family Planning:
  (i) Family Planning Education
  (ii) Contraceptive Services
  (iii) Management of Side-effects and Complications

* Safe Motherhood: (i) Antenatal Care
  (ii) TT Immunization
  (iii) Safe Delivery
  (iv) Postnatal Care

* Reproductive Tract Infections

Child Health:
(i) Child Immunization
(ii) Vitamin A Capsule Supplementation
(iii) Management of Acute Respiratory Tract Infection (ARI)
(iv) Management of Diarrhoeal Diseases
(v) Curative Care of other Common Diseases, Like Scabies, Worm Infestations
(vi) Promotion of Appropriate Infant Feeding

The purposes of this report are: (a) to describe the innovative methodology used for reorganizing the health facilities; (b) to assess the effect of the intervention on service utilization following implementation of the proposed changes.

2. Methodology

Description of the Intervention

This intervention was designed to reorganize the current distribution of PHC clinic network at the zonal level and to establish functional linkages among different facilities through a participatory process involving senior and field-level programme managers. The study period was April 1996-March 1997. The UEP designed an innovative methodology for planning the distribution of PHC facilities as a part of the intervention to increase availability of and access to essential services in the urban Dhaka. The intervention was tested in two zones of Dhaka City Corporation. Although ward was the unit of planning in this methodology with an average population of 40,000 (range 30,000-60,000), the objective was to improve utilization and access to services at the clinic and zonal level. The methodology for planning includes: assessment of current situation (inventory, mapping, services utilization), identification of needs and options for change and participatory planning process involving managers and decision-makers of organizations managing the facilities (see Annexure B for the study instruments). This was followed by monitoring implementation of the planning decisions at field level.

The objectives of this intervention were:(1) to develop and test a planning methodology to reorganize the current distribution health and family planning facilities of GOB and NGO" so that a clinic or a functionally-combined set of complementary clinics provides a package of essential services to a defined catchment population with focus on poor population;(2) to test the feasibility of the local-level reorganization using the planning methodology; and (3) and to assess the effect of reorganization on utilization of services at the clinic and the zonal level following reorganization of facilities.

Setting

This intervention was initially implemented in Zone 3 of Dhaka City Corporation (DCC). Then it was expanded to Zone 8 of DCC. Both the zones have an estimated population of about 450000. The area of Zone 3 is approximately 57.04 sq. miles while the area of Zone 8 is 97 sq. miles. Zone 3 has nine wards and Zone 8 has eight wards (Annexure A, Table 4 and Table 5). Zone 3 mainly comprises: Rayer Bazer, Hazaribag, Nowabgonj, Lalbag, Islambag, Bakshi Bazar, Azimpur while Zone 8 includes: Mirpur, Pallabi, Rupnagar,Vashantek, Chiriakhana, Botanical Garden, Manikdi Bazar, and Bauniabad.

Evolution of the Intervention

This intervention evolved in two stages. In the first stage a methodology to reorganize clinic-based PHC facilities of the GOB and NGOs was developed. The methodology comprises of the following steps:

(a) *Assessment of distribution of the health facilities*

A ward wise detailed inventory of GOB and NGO facilities was made in the intervention zones. The inventory not only identified a facility and mapped its location using Geographic information system software (Figure 1 and 2) but also collected information on staffing, services available, and utilization. The concept of 'location' is used for describing a situation in which different facilities share the same premises. A 'facility' is an individual entity administered by a specific service provider. The analysis of the distribution of clinic facility network in Zone 3 and Zone 8 revealed the following about how services were organized:

There are **41** Health and FP facilities in Zone 3 belonging to GOB and NGO sector (Annexure A, Table 6). There are altogether **23** service locations in the zone. Of these, **9** were offering broad range (FP/ANC/EPI/CURATIVE) of services. Another four of these locations offered services which were either deficient in FP/ANC or EPI component. Rest **10** locations were offering only one type of service. In Zone 3, EPI services are available from **16** locations, FP/ANC from **11** locations, and **17** locations were offering curative services.

There are **37** Health and FP facilities in Zone 8 belonging to GOB and NGO sector (Annexure A, Table 7). There are altogether **31** service locations in the zone. Of these, **10** were offering broad range (FP/ANC/EPI/CURATIVE) of services. Another **6** of these locations offered services which were either deficient in FP/ANC or EPI component. In the rest **15** locations, only one type of service was offered. In Zone 8, **nineteen** locations offeied EPI services and **18** locations offered curative services. The following table provides a comparative picture of how services were organized in GOB and NGO sectors :

Table 2. Organization of services by zone

Parameter	Zone 3	Zone 8
Total # of PHC facilities	41	37
Total # of service locations	23	31
Service locations offering broad range of services	9	10
Service locations offering FP, ANC and PNC services	11	21
Service locations offering EPI services	16	19
Service locations offering curative services	17	18
# of wards with inadequate service	4	4

(b) *Assessment of needs and availability of services by zone*

Estimation of the number of providers/clinics required by ward and by type of services, was made using a matrix prepared for this intervention. Essentially, the estimations were based on target population, proportion of the poor, and certain assumptions, like expected clinic utilization by services(Appendix B). Although ward was considered as a planning unit, the objective was to improve utilization of individual clinics and to improve availability and utilization of services at the clinic and the zonal levels. The estimations were done for 3 provider categories: EPI, FP/ANC, and curative services. For operational reasons, FP and ANC were treated together since these services were usually provided by the same provider. A number of assumptions were made to estimate the 'service needs' of each ward in terms of provider/clinic sessions. These assumption were supported by field experience and clinic utilization information collected during the intervention:

i) Target Population

- ❑ GOB and NGO facilities are primarily used by the poor, except for FP and EPI services .
- ❑ The proportion of the total population eligible for family planning is 18%. Under-5 and under-1 children account for 17% and 3 % of the population respectively.

ii) Poor Population

- ❑ On average, 30% of the urban population lives in slums. About 50% of the urban population is poor. The estimated proportion of poor population in each ward can be calculated using the formula: Total population X 5/3

The calculated needs for services in each ward was compared with the actual availability of services, and shortages or excesses of staff or services were identified (Annexure A, Table 8 and 9). Alternative options for addressing these problems were defined. The following table provides the summary of findings from the analysis:

Table 3. Ward-wise distribution of EPI, FP, ANC/PNC and curative services

Zone 8				Zone 3			
Ward	FP-ANC	EPI	CURATIVE	Ward	FP-ANC	EPI	CURATIVE
2	Inadequ	Inadequa	Inadequate	48	Inadequa	Excess Δ	Excess
3	Excess	Excess	Excess	58	Excess	Excess Δ	Excess Δ
4	Inadequ	Inadequa	Absence	59	Absence	Excess Δ	Excess
5	Excess	Adequate	Excess	60	Excess	Excess Δ	Excess
6	Excess	Excess	Excess	61	Absence	Absence	Absence
7	Absence	Excess	Absence	62	Adequate	Adequate	Adequate
8	Excess	Excess	Inadequate	63	Adequate	Adequate	Adequate
15	Excess	Inadequa	Adequate	64	Absence	Excess	Excess
				65	Excess	Excess	Excess Δ

" **Excess:** Current available services exceeds the calculated needs; "**Adequate**":Available services equal to the needs; "**Inadequate**": Available services are less than the calculated needs; "**Absence**": No services are available; " Δ" :Service is in "Excess" or "Adequate" but poorly utilized

© *Participatory planning by zone*

The findings were presented and discussed in two participatory planning workshops attended by decision-makers and local managers of organizations operating the facilities. The first workshop was held in August 1996 for Zone 3 while the workshop for zone 8 was held in November 1996. The workshops were organized by UEP. The objectives of the workshops were:

1. to analyze the current situation of clinic- based MCH-FP service delivery in the zones;
2. to formulate recommendations to reorganize the current distribution of GOB, DCC and NGO clinics so that a clinic or a cluster of clinics provides an essential package of services of appropriate quality;
3. to identify steps required for implementation of the recommendations;

The objectives of these recommendations were: to ensure that each ward had enough health resources to meet estimated essential service needs; increased availability of services in predominantly poor area; an increased number of locations where full range of services are available.

However, in Zone 8, an additional review meeting before the workshop was organized by the zonal authority. The meeting was attended by managers of NGO facilities. The majority of the service facilities of the zone belongs to NGO sector. The specific objective of this planning meeting was to share the options for modifications in the distribution of facilities based on the problems of current situation. The purpose was to make the concerned organizations aware of the option. This additional participatory planning process made the final workshop proceeding easier. Stage two of the intervention relates to the implementation of the workshop decisions in the intervention zones.

(d) *Implementation and monitoring by zone*

Following the workshops, the specific redistribution plans were further evaluated at the respective zonal health and family planning coordination committee meetings. There are ten zonal committees headed by Zonal Executive Officers. GOB/ NGO service providers and elected representatives are the members of the respective zonal committees. The aim of the committee is to link all local service providers and serve as a forum for local-level planning. The review process resulted in minor modification of some of the recommendations and defined following steps. The Project adopted two different strategies to follow up the implementation of recommendations after the zonal coordination committee meetings. In case of zone 3, UEP assisted DCC in implementing the agreed upon recommendations through active involvement in each and every step.

The facilitation process included:

(1) Circulation of the participatory workshop recommendations to the ward commissioners.

(2) Meeting with local ward commissioners and leaders to mobilize their support for the proposed changes.

(3) Raise the ward-specific recommendations in the ward health and family planning coordination committee meetings.

(4) Documentation of the experiences during implementation.

After the review of recommendations in the zonal health and family planning coordination committee in Zone 8, the Project assumed a role of monitor instead of active participation in the implementation process thereafter. The zonal health authority is actively monitoring the implementation of recommendations with concerned NGOs. DCC organized small group meetings to review the status of implementation of recommendations until the administrative problem evolved in DCC. UEP kept periodic contact with zonal health authority and concerned NGOs and noted the progress made in the implementation.

The schematic diagram in the following page outlines the various steps of the reorganization methodology.

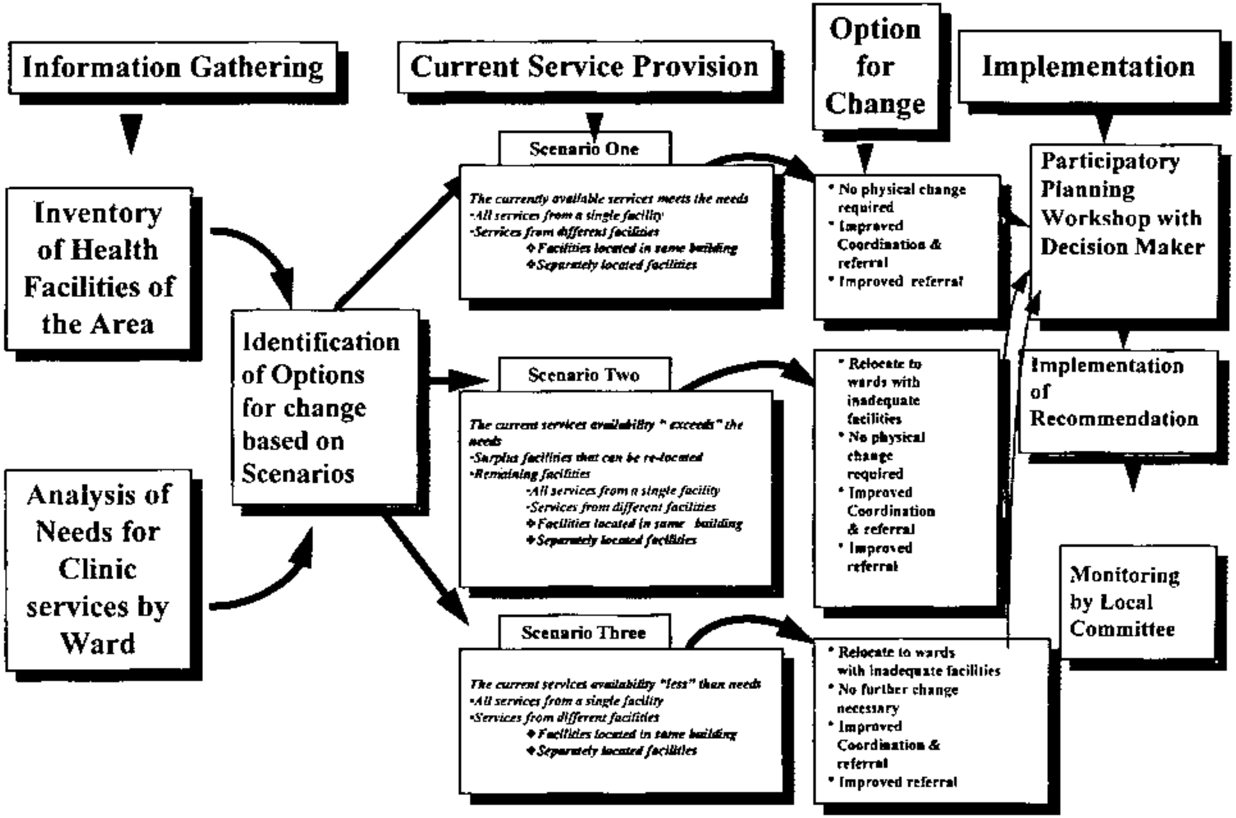
3. Evaluation method

This intervention is being evaluated on the basis of proportion of changes implemented and improvements in the availability of and access to essential health services at the clinic and the zonal level as measured mainly by service utilization. A non-experimental design with pre and post-test measurement was used. Based on the research questions the following indicators were measured through field-level data collection.

Table 4. Research questions

Is there increased availability of clinic based essential health services?
Is there increased utilization of static service delivery points?

Summary of Events in Reorganization Methodology



4. Findings

A. Findings from Zone 3

Fourteen specific recommendations were formulated by the managers and decision-makers of the zone. The following are the ward-specific recommendations from the participatory planning workshop held in August 1996 for Zone 3. Table 5 provides the current status of implementation as of March 1997. For details of the recommendations, please refer to Table 10, Annexure A.

Table 5. Extent to which clinic needs by ward are met in Zone 3

Service	Type of Problem	Recommendation	Implementation Status
EPI Services	One ward had no EPI service	Subject to availability of space DCC will provide service	No change has been initiated due to lack of suitable space. Space is commercially very valuable
	Two centres in two wards were poorly utilized in the current location	Number of days of operation per week of the centres will be reduced in the current locations and extend services to the under served area in the remaining days	Reduction in the operation /week in the current location and establishment of new centre in the under-served areas

Service	Type of Problem	Recommendation	Implementation Status
FP/ANC, PNC Services	In three wards, FP provider is not available	Overlapping and poorly utilized GOB-FP provider from wards with excess services will be relocated to FP -deficient wards. In one ward NGO will provide services	Needs of only one ward have been met by relocation of GOB-FWV from ward with excess providers. The need of the other ward yet to be met. Currently, these relocations are being processed by the DFP, Dhaka. Further action may require more time due to complex administrative process
	There is overlapping of FP providers in the GOB/NGO sectors in three wards. The GOB providers are poorly utilized in the current locations	Overlapping and poorly utilized GOB-FP provider from wards with excess services will be relocated to FP- deficient wards	Except one , planned relocation of the GOB-FP providers to the under- served areas yet to be done. Currently, these relocations are being processed by the DFP, Dhaka
	In one ward, FP provider sessions held are less than the need	One of the overlapping and poorly utilized GOB-FP provider from ward with excess services will be relocated to FP-deficient wards.	Planned relocation of an FP provider from ward with excess yet to be done

Service	Type of Problem	Recommendation	Implementation Status
Curative Services	In one ward there is no Curative services available	Subject to availability of space, an NGO will provide the service	No change has been initiated due to lack of suitable space
	In one ward, DCC dispensary is non-functioning at the current location. Two other DCC dispensaries are poorly- staffed.	Non-functioning DCC dispensary will be relocated to another ward. DCCdispensaries will be strengthened by deputed doctors from nearby MOHFW dispensaries	Planned relocation of the centre to revitalize, yet to be done

Increased availability of essential services

The following table describes the change in the organization of the facilities before and after reorganization at the zonal level. The concept of 'location' in the table describes a situation in which different facilities share the same premises, while a 'facility' is an individual entity administered by a specific provider. The parameter for comparisons were based on the service delivery scenario in urban areas by different providers:

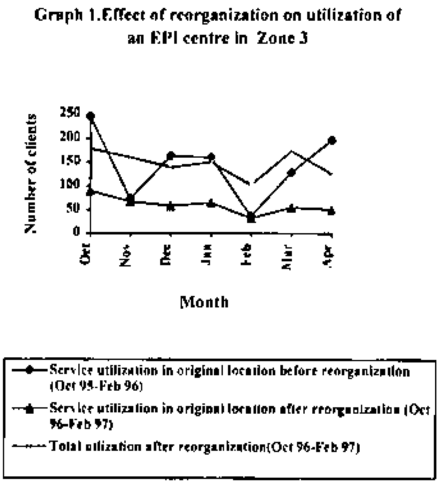
Table 6. Changes in the number of H&FP facilities in Zone 3

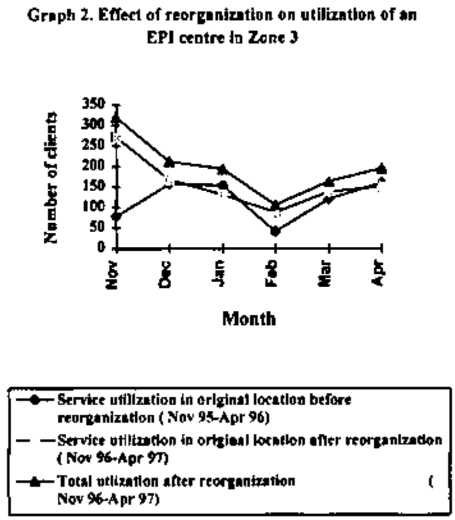
Parameter	Before Reorganization (Aug. 1996)	After Reorganization		
		Ist Qrt Oct 96	2nd Qrt Dec 96	3rd Qrt Mar 97
Total # of facilities in Zone 3	41	43	44	45
Total # of service locations in Zone 3	23	23	24	24
Service locations offering broad range of services	9	9	11	11
Service locations offering FP, ANC and PNC services	11	12	12	13
Service locations offering EPI services	16	17	18	18
Service locations offering curative services	17	17	18	18
# of wards with deficient services	4	3	3	2

Increased utilization of static service delivery points

In the following graphs utilization of clinics were compared by type of service. Data from comparable periods before and after implementation of the recommendations were compared to control for seasonality. The graphs below show the effect reorganization on utilization of two EPI centre . Utilizations before reorganization was considered poor due to improper locations. Number of clinic days per week, was reduced in two clinics in their locations. In the remaining days of the week, clinics operated in the under-served locations of their respective wards. Data indicate that the change in the operation of the clinic on the right resulted in insignificant changes in utilization in the original location than in the other. However, total utilization of the clinics in two locations shows marked improvement

Graph 1 &2



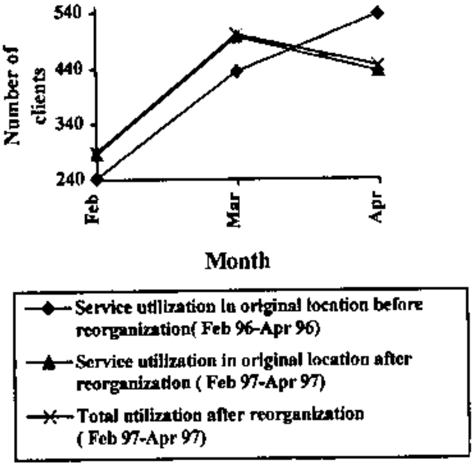


The following graphs represent the effect of reorganization on utilization of FP and curative services of an NGO clinic. As part of reorganization, additional FP and curative services were extended to the under served areas through a satellite clinic in an under-served area of the same ward. Utilization of the clinic in the original location was not affected significantly by the introduction of the satellite clinic. The graphs also show that total utilization of the FP and curative

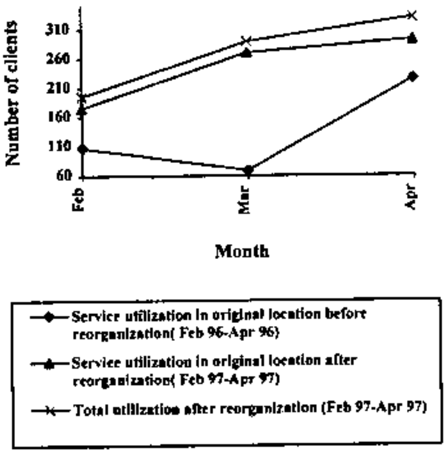
Services from the two locations (clinic and satellite clinic) with similar improvement, curative being more marked. However, there is slight reduction in the utilization of FP services in the month of April 1997 after reorganization which corresponds to the internal reorganization of the clinics by the providers.

Graph 3 & 4

Graph 3. Effect of reorganization on utilization of FP Service of an NGO Clinic in Zone 3



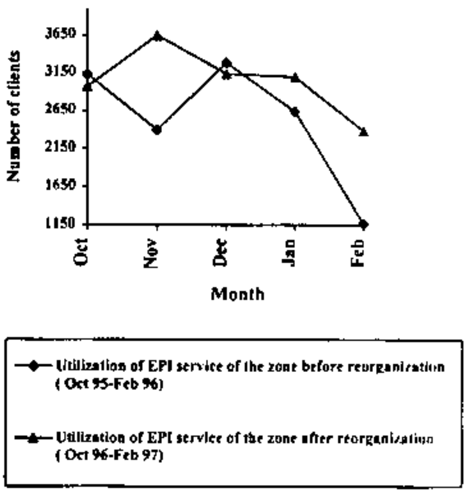
Graph 4. Effect of reorganization on utilization of curative Service of an NGO Clinic in Zone 3.



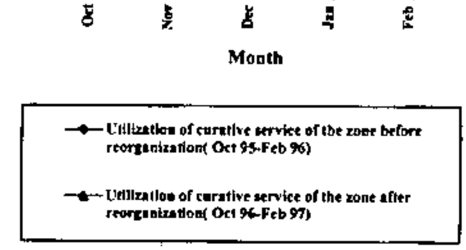
The graphs below represent the effect reorganization on utilization of EPI, FP and curative services at the zonal level. The EPI service utilization shows a rise and fall soon after reorganization followed by improvement. However, change in the curative service utilization was evident soon after reorganization. The improvement of family planning began early but had not become prominent until January 1997. This indicates that it is possible to improve utilization of services through proper distribution of existing resources as well as appropriate planning for new resources at the zonal level.

Graph 5 & 6

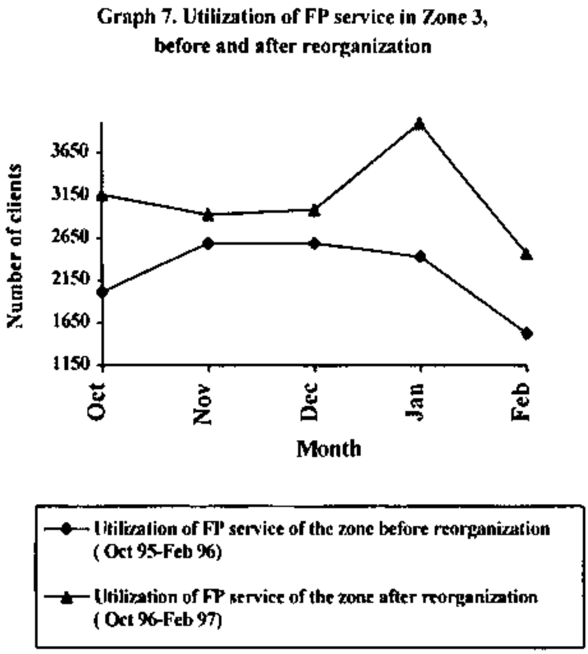
Graph 5. Utilization of EPI service in Zone 3, before and after reorganization



Graph 6. Utilization of curative service in Zone 3, before and after reorganization



Graph 7



B. Findings from Zone 8:

A total of fourteen ward- specific recommendations were formulated from the participatory planning workshop held in November 1996 for Zone 8. Table below describes the current status of the implementation of recommendations as of March 1997. For details of the recommendations, please refer to Table 11 of Annexure A.

Table 7. Extent to which clinic needs by ward are met in Zone 8

Service	Type of Problem	Recommendation	Implementation Status
EPI Services	In one ward, there is under served area due to locations of the facilities	One NGO will organize EPI session in the under- served area	No change has been initiated due to lack of initiative from responsible organizations
	In 3 wards, EPI service sessions held are less than the need.	Selected NGOs will provide the service through organizing new satellite clinics or adding the service to the existing satellite clinics	In two wards, EPI services are offered through satellite clinics; However, deficiency of another could not be addressed due to closure of an existing facility
FP/ANC, PNC Services	In one ward, FP provider is not available	GOB-FP provider from ward with excess service will be relocated to FP- deficient ward	No change has been initiated yet by the DFP, Dhaka. However, these relocations are currently being processed by DFP Dhaka
	There are under-served areas in one ward due to poor location of facilities	To extend FP service to under-served areas an NGO will organize satellite clinics	Under- served areas are served by organizing satellite clinics by the NGO
	Current number of FP provider session s is inadequate in one ward	An NGO will add FP/ANC service in an existing facility.	No change has been initiated due to closure of existing facility

Service	Type of Problem	Recommendation	Implementation Status
Curative Services	In 2 wards, curative services are not available	One NGO will provide curative service through new satellite clinics and another NGO will add the service in an existing facility	Curative services have been added in the satellite clinics in one ward but required sessions not being held. Deficiency of the other ward was not met due to closure of facility
	There is under served area in one ward due to poor location.	To extend curative service to under served areas an NGO will organize satellite clinics.	Under-served areas are served by satellite clinics organized by the NGOs as planned
	In one ward, curative service session is inadequate	An NGO will include the service in all the planned satellite clinics	Curative services have been added in the satellite clinics but required sessions are not being held

Increased availability of essential services

The following table describes the change in the organization of the facilities before and after reorganization at the zonal level.

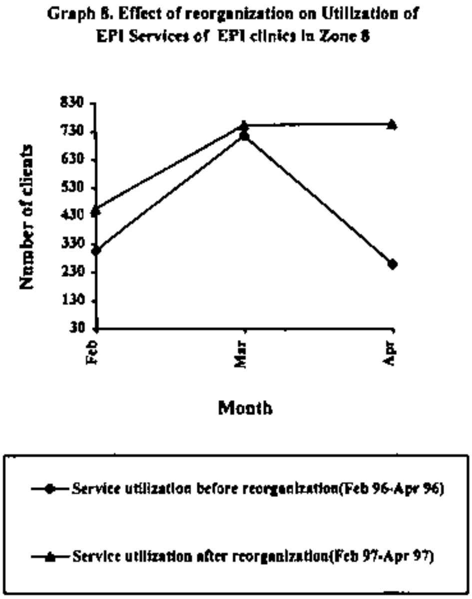
Table 8. Changes in number of H & FP facilities in Zone 8

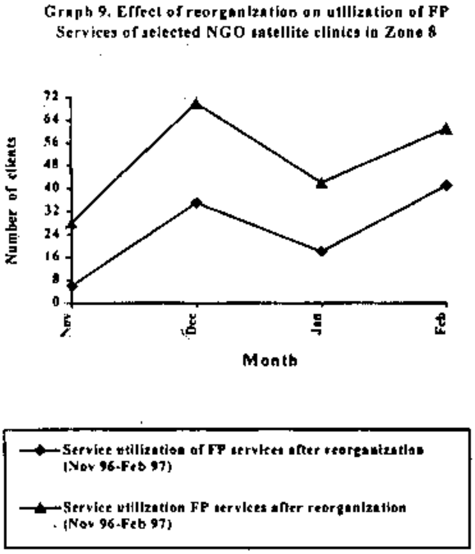
Parameter	Before Reorganization (Nov 96)	After Reorganization (Mar 97)
Total # of facilities in Zone 8	37	50
Total # of service locations in Zone 8	31	45
Service locations offering broad range of services (EPI, FP, ANC, PNC and Curative)	10	23
Service locations offering FP, ANC and PNC service	21	35
Service locations offering EPI services	19	32
Service locations offering curative services	18	32
# of wards with deficient services	4	3

Increased utilization of static service delivery points

Similar improvements were observed in Zone 8 with regards to FP, EPI and curative care utilization at the clinic and the zonal level. Graph 8 below shows the effect reorganization on utilization of EPI services in ward 15. As part of reorganization, additional EPI services were being offered by the different NGOs through satellite clinics in remote areas. The schedule of the satellite clinics was agreed upon among the organizations. The total utilization of EPI services of the ward has improved significantly after reorganization. Graph 9 shows the effect reorganization on utilization of FP services from selected NGO satellite clinics in ward 7. In particular situation , FP services were available from one satellite clinic and were less than the calculated needs. As part of reorganization, the recommendation was made to increase the number of satellite clinics instead of one satellite clinic as was the case before reorganization. This NGO is the only organization engaged in the delivery of FP-MCH services since June 1996 in this ward . Therefore, data from the same period after reorganization are considered in the graph for gross comparison. The graph does reflect definite improvement in the total utilization of FP services in the ward. It indicates that there was a demand for FP services in the areas and was met by reorganization

Graph 8 & 9

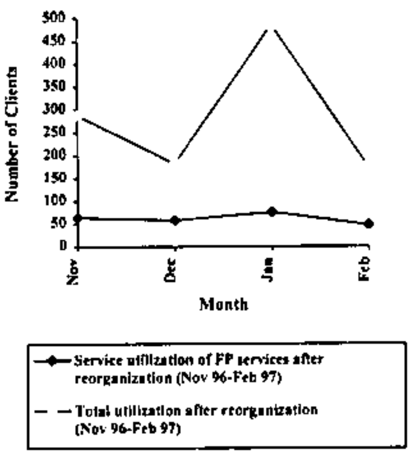




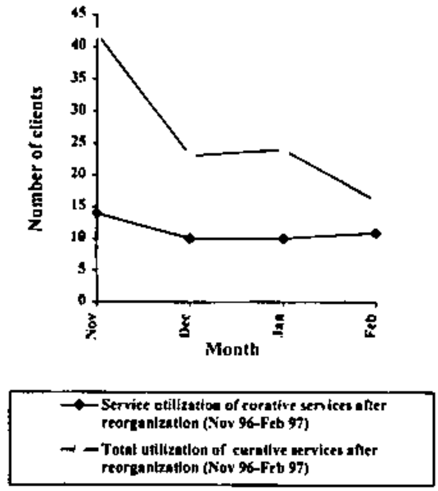
Graphs 10 and 11 show the effect reorganization on utilization of FP and Curative services of NGO satellite clinics. FP and curative services available were less than the calculated needs. As part of reorganization , the recommendation was made to increase the number of satellite clinics instead of one as it was the case before reorganization. This NGO is the only organization engaged in the delivery of FP and curative services since June 1996. Therefore data from the same period after reorganizations are considered in the graphs for gross comparison. The graphs do reflect definite improvement in the total utilization of FP and curative services. It indicates that there was a demand for FP services in the areas and was met by reorganization.

Graph 10& 11

Graph 10. Effect of reorganization on utilization of FP Services of NGO satellite clinics In Zone 8



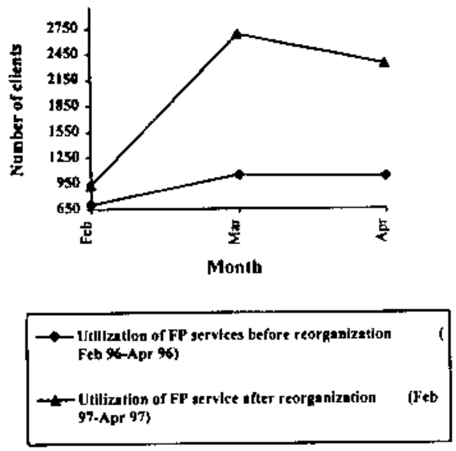
Graph 11. Effect of reorganization on utilization of curative service of NGO satellite clinics at in Zone 8



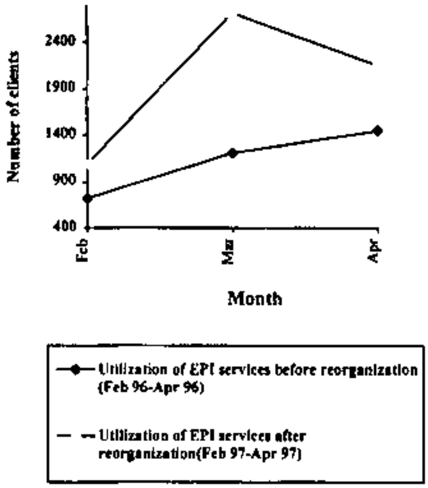
Graphs 12 and 13 demonstrate increase in the number of days of the clinic operation per week with the existing resources an effect on utilization of FP and EPI services offered from an large NGO MCH-FP centre. It was not part of the reorganization plan, but was done by the organization to address local need of EPI service and irregular holding of proposed satellite clinics by another NGO following recommendations of a reorganization workshop. Data from the graphs show that utilization of the MCH-FP centre has recorded improvement in the utilization of EPI and FP services.

Graph 12 & 13

Graph 13. Effect of reorganization on utilization of FP services of an NGOMCH-FP centre in Zone 8



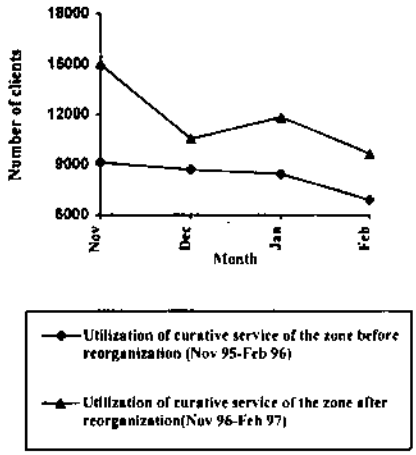
Graph12. Effect of Reorganization on utilization of EPI services of an NGO in Zone 8,



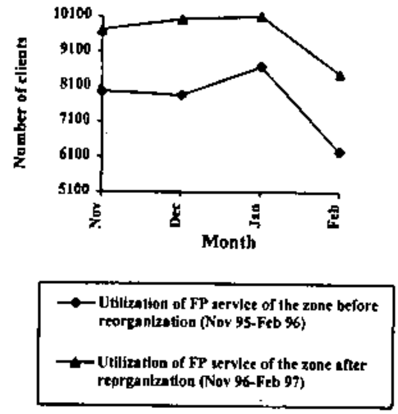
Graphs 14,15 and 16 represent the effect of reorganization on utilization at zonal level EPI, FP and curative services at the zone-level. The positive changes in utilization of all services are evident. This indicate that it is possible to improve utilization of services through proper distribution of existing resources as well as appropriate planning of the locations for new resources at the zonal level

Graph 14,15,

Graph 15. Utilization of curative service in Zone 8, before and after reorganization

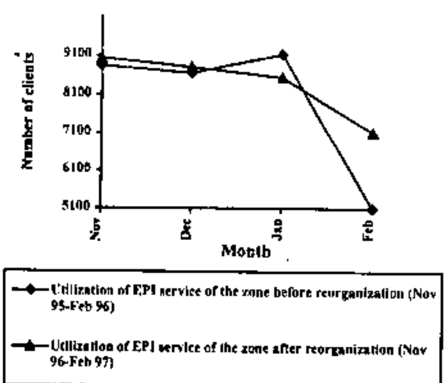


Graph 14. Utilization of FP service in Zone 8, before and after reorganization



Graph 16

Graph 16. Utilization of EPI, service in Zone 8 before and after reorganization



Comments on specific issues

So far six of the 14 specific recommendations have been implemented in Zone 3. Four of these have been implemented by the NGOs and the other two by DCC. In Zone 8, seven of the 14 specific recommendations have so far been implemented. All have been implemented by NGOs. Changes in Zone 8 took place faster compared to Zone 3, because most of the changes were related to establishment of satellite clinics by NGOs.

Effect of rational distribution of EPI services on utilization at the clinic level

Changes in the distribution of vaccination services in Zone 3 have extended availability in the under-served area. In addition the changes have resulted in improvement in utilization without additional resources. The current changes in service delivery show early signs of improvement in the overall service utilization from the clinics after reorganization (Graph 1 and 2). Although it may be argued according to graph 1, that the changes are not consistent in one of the reorganized clinics as the length of implementation may not have been adequate for the changes to stabilize. In Zone 8, deficiency of EPI services in two of the three wards was addressed by incorporating EPI services in the satellite clinics. As the planned of sessions were not being held in those satellite clinics, data on service use shows that changes are insignificant compared to those before reorganization. Further improvement can be expected with complete implementation of recommendations according to plans.

Analysis of findings from the utilization of services at the zonal level revealed that the reorganization had led to definite improvements in both the zones. This indicates that it is possible to improve utilization of services at the zonal level through proper distribution of existing resources.

Field findings also indicate that the process of reorganization has sensitized as well as enabled local organizations to to reorganize and to respond to local service needs on their own. This was revealed by the attempt made by a large NGO in Zone 8 to reorganize existing resources and expand services from one of its clinics to meet local need. This has been shown in graphs (12 and 13). This clearly demonstrates the willingness for optimum utilization of resources by organizations.

Extension of EPI, FP/ANC, and curative services to under-served and predominantly poor areas

Several satellite clinics were established by NGOs in the two zones. The intention was to extend EPI, FP/ANC, and curative services to identified poor areas. The service utilization at the concerned organizations shows that there has been an overall increase in the utilization of these services without affecting the utilization of the static clinics. This means that those clients who were not served before have been reached by the satellite clinics. Based on the current service utilization pattern, it is quite reasonable to assume that further improvement is expected if the satellite clinic sessions are held regularly.

Effort to address gaps and overlaps in FP/ANC services

An FP clinic was established by an NGO in one of the FP-deficient wards in Zone 3, Paediatric Hospital run by DCC. Monitoring data show that despite potential, the new FP service remained under utilized, perhaps due to lack of organized efforts to promote the clinic services in the community. Finally, the Directorate of family planning, Dhaka, has agreed to relocate one of the identified FWVs to the hospital. The remaining relocations will be considered in future by the Directorates.

Strengthening curative services

Most of the DCC-managed dispensaries are staffed only by untrained practitioners (pharmacist/compounders). As part of the reorganization, it was recommended that the DCC dispensaries be strengthened by deputed qualified physicians from nearby MOHFW dispensaries, but the change could not be implemented due to administrative procedures involved in relocation of GOB staff . Further support from higher authority was also necessary.

5. Discussion

The purpose of this intervention was to reorganize the current distribution of GOB/NGO health and family planning facilities at the Zonal level of Dhaka City Corporation to improve availability of and access to essential health services, particularly in poor areas, using an innovative methodology. The intention was to assess the feasibility of local level reorganization of clinic-based urban PHC service and its effect on service utilization at the clinic as well as at the zonal level.

Findings from the study strongly suggest that it is feasible to plan the distribution of GOB/NGO health and family planning facilities at the zonal level using this innovative methodology. There is also convincing evidence from service utilization data to suggest that participatory approach in reorganization of PHC facilities can result in improved utilization of services at clinic as well as at the zonal level. Moreover, it has been observed that there is considerable potential and willingness for more effective use of existing resources among the various urban service delivery partners. The willingness can be converted into actual actions through this innovative methodology.

However, all the recommended changes did not take place due partly to the fact that the length of implementation may have been too short to see all the changes planned and partly due to lack of prompt appropriate actions by the decision makers of the concerned organization at appropriate level. Field observation and discussion with concerned organization show that non-compliance with agreed upon decisions was partly because of complex administrative procedures, organizational ethos, and partly due to dwindling financial resources.

Findings from the study also indicated that a few of the changes were ineffective. This was perhaps due to the lack of effective mechanism to inform the potential users about the changes that were implemented. Monitoring data revealed that staff constraint and the current internal reorganization were the major obstacles in this regard.

Cost of Reorganization

At the backdrop of decreasing fund and increasing clientele, the major consideration of the reorganization methodology was to maximize the use of existing services and make the service delivery more efficient. The issue of reorganization can be looked into from various angles. The cost entails planning cost (inventory, mapping, participatory workshop) and cost of reorganized service delivery. Analysis of data from the evaluation revealed that implementation of recommended changes did not result in added/recurrent cost to the organization involved. New service centres (satellite clinics and EPI centres) are located in the properties owned by DCC, social organizations, clubs and no additional staff were required. However, the cost of planning can be considered a developmental cost. As an external agency UEP of ICDDR,B developed the planning methodology as part of conducting operations research. What is needed now is institutionalization of the planning mechanism within the system of city corporations and municipalities. This will eventually reduce the cost of planning for further attempts of reorganizations in other urban areas. Although cost is an important factor for reorganization, cost analysis to identify cost per service before and after reorganization is beyond the scope of the paper.

Factors in the Implementation of the Proposed Changes:

Data from the monitoring tools and follow-up discussion with providers in the intervention zones revealed factors that have played an important part in the implementation process. Some of the factors facilitated while others impeded the implementation. These factor may have acted independently or in combination with one another:

Factors facilitating the implementation of the intervention

- Willingness for change was high among the providers
- Support of the local health and family planning committees to implement specific recommendations was available.
- Cost of reorganized service delivery did not result in added/recurrent costs to the organizations concerned.
- The City Corporation, represented by the Zonal Executive Officer and Assistant Health Officer of DCC, was actively involved in the implementation process.
- UEP along with DCC and service provider organizations was Involvement in planning as well as in the implementation
- Some community leaders provided moral and logistics support.
- The partners were confident on the facilitating agency, i.e. UEP.

Factors impeding the implementation of the intervention

The review of the current status of implementation of the workshops recommendations highlighted a few factors that stood as obstacles to change. These are as follows:

- Some of the recommendations required decision at higher administrative levels involved in planning and service delivery of the organizations . Prompt decisions were not readily available due to complex bureaucratic systems.

- Organizational ethos and selective service preference of organizations sometimes did not match with the proposed changes and led to resistance in some facilities.
- Some organizations made changes without discussion at the zonal committees during implementation.
- Support from some of the local community leaders due to conflict of interest was not available.
- Suitable site for expansion of services was not available as spaces are commercially valuable.

Strengths of the Reorganization Methodology

The innovative methodology being tested has considerable strengths as outlined below:

- Planning is done at the local level, is participatory and based on consensus of the parties involved in service delivery.
- Redistribution plan is based on the principle of need, optimal use of existing resources and focuses on poor population.
- Planning considers and addresses the requirement at the ward- level; elected representative and and optimal population were a factor for local planning.
- Service-specific needs can be calculated from an easy-to- use matrix prepared for this and can be presented in an user-friendly manner.
- Planning was done based on data available at clinics.

6. Policy implications

Given the multiplicity of service providers in Dhaka city, the reorganization methodology tested in this intervention could be the basis for planning the distribution of GOB/NGO health and family planning facilities so that a clinic or a functionally combined set of complementary clinics provides a package of essential services to a defined catchment population.

The findings of the intervention suggest that reorganization methodology has potential to reduce the differences in access to poor with appropriate adaptation. Changes in organization with relatively decentralized authority are easier to implement than in the organizations where there is limited scope for local initiative. So, relative autonomy at the local level is a prerequisite for success of any reorganization effort. As reorganization alone cannot ensure improved utilization, there should be an effective mechanism identified to inform the community about the changes. Although involvement of local-level committees facilitated changes, concurrent support from higher level is also essential.

The potential of the health department of City Corporations and municipalities must be strengthened to enable them to play a leading role in the application of this innovative methodology at zonal level.

Finally, further clarification and understanding of the following questions regarding the intervention are needed to ensure smooth implementation:

- Is an external agency essential for planning and implementation?
- How can the community be involved at the planning stage?
- What is the most effective way to inform the potential user about the changes that were implemented?
- Are the assumptions for calculation of service needs appropriate?

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Annexure-A

Figure 1. The Urban Clinic-based Service Delivery System

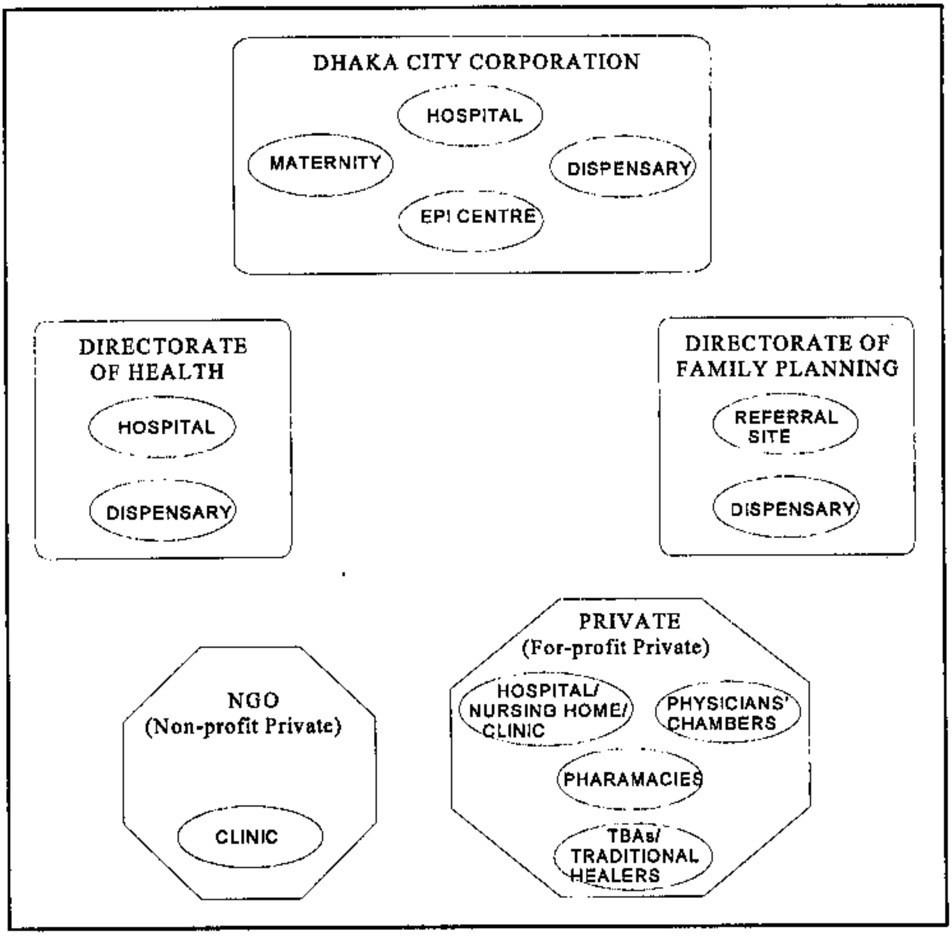

Figure 2: Zone 3 Map

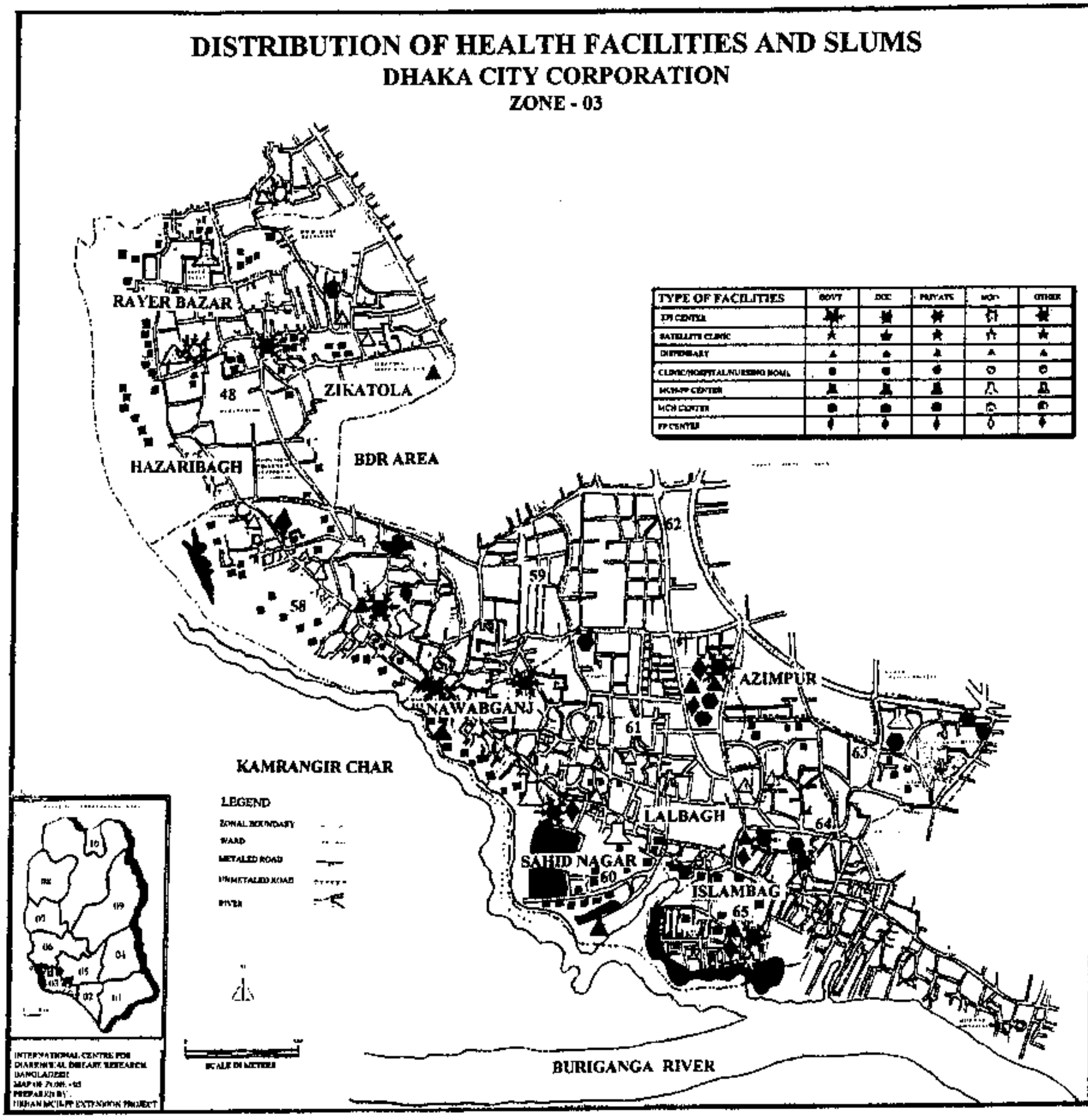

Figure 3: Zone 8 Map

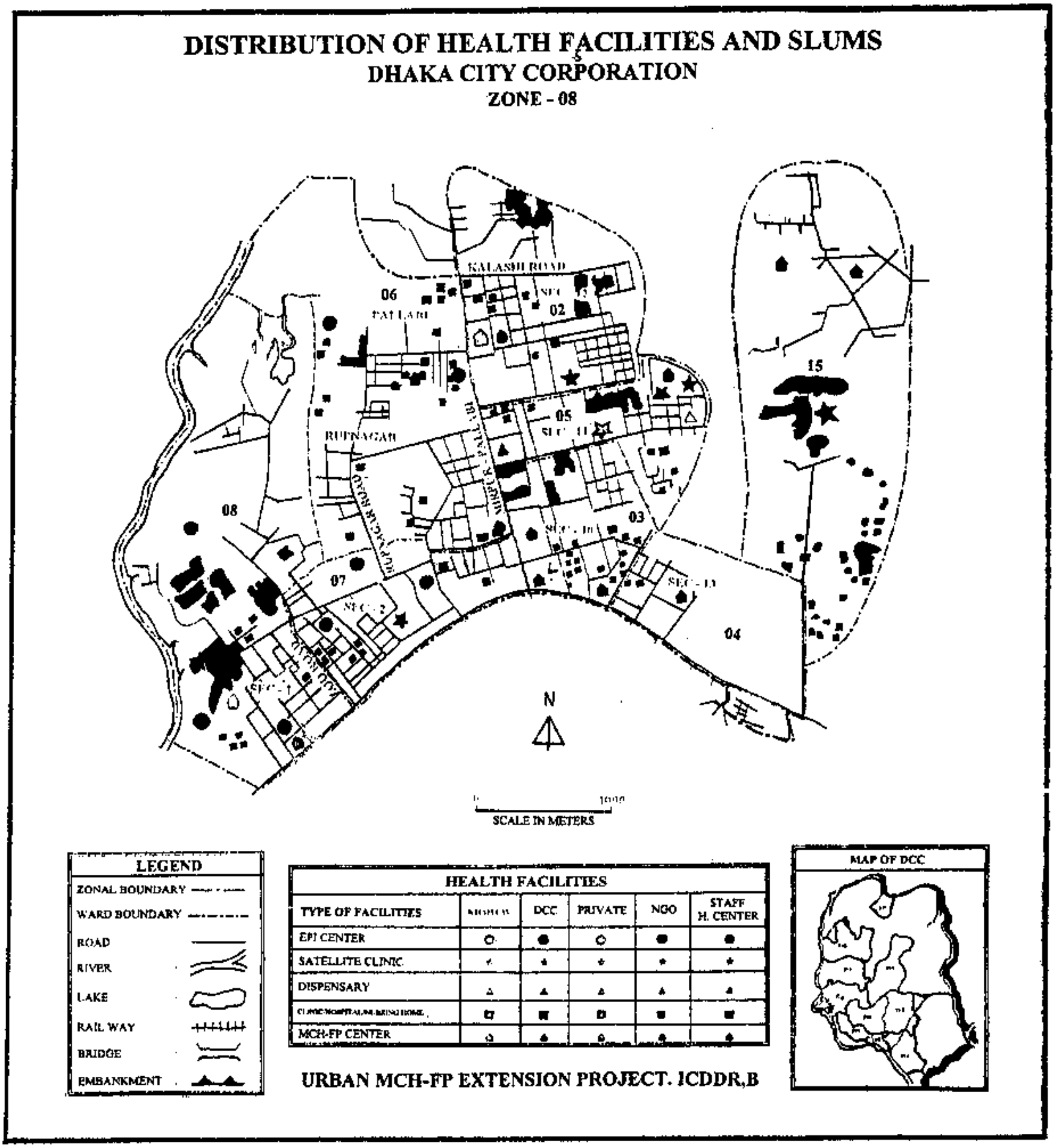

Table 1: Distribution of Health Facilities in Dhaka City

Type of Organization	EPI Centre	MCH-FP Centre	Dispensary	Satellite Clinic	Hospital	Clinic	Total
MOHFW	2	58	22	-	21	-	102
DCC	86	-	17	-	3	-	107
NGO	17	85	44	15	19	2	184
Private	1	-	05	-	40	125	176
Staff Health Centres	1	-	07	-	5	-	13
Total	107	143	95	15	88	127	582

Table 2: Services Available from Government and NGO Facilities in Zone 3 and 8

Zone 3			Service Provided				
Type of Facilities		#	FP	ANC/PNC	Delivery	EPI	Curative
MOHFW	MCH Hospital	1	1	1	1	1	1
	Dispensary	4	-	-	-	-	4
	FP Clinic	6	6	6	-	-	-
DCC	EPI Centre	9	-	-	-	9	-
	Dispensary	3	-	-	-	-	3
	Children's Hospital	1	-	-	-	-	1
CWFP	MCH-FP Clinic	4	4	4	-	3	4
	Sub-centre	2	2	2	-	1	2
Other NGOs (formal)		3	-	2	-	2	3
Non-profit Private		8	-	-	-	-	8
For- Private		7	-	-	7	-	7
Zone 8							
MOHFW	Dispensary	2	-	-	-	-	2
	FP Clinic	5	5	5	-		-
DCC	EPI Centre	7		-	-	7	-
NGOs	MCH-FP Clinic	17	17	17	-	12	12
	Sub-centre	5	5	5	-	2	3
O NGOs (formal)		1	-	-	-	-	1
Non-profit Private		1	-	1	-	-	1
For-profit Private		2	2	2	2	-	2

[1]Table 4: Zone 3 Basic Data: Total ,Slum and Poor Population

Ward	Ward Population			Slum Population			% of Ward Population			Poor Population (%) Extrapolated		
	Cen'91 a	Est'96 b	ADB'97 c	UVP '91 d	BBS '96 e	ADB '97 f	Cen '91 e/b	Est '96 f/c	ADB '96 g/d	Cen '91	Est '96	ADB '97
48	84525	100669	88977	9577	11240	6296	11	11	7	19	19	52
58	59884	71322	75013	13578	26269	18446	23	37	25	38	61	39
59	42725	50885	47384	3880	18499	7095	9	36	15	15	60	38
60	43625	51989	47794	12903	34982	22992	30	67	48	49	112	33
61	32328	38502	30024	6141	10894	1185	19	28	4	32	47	46
62	33863	40329	44028	2853	3132	6845	8	8	16	14	13	31
63	20221	24083	31424	2535	2487	3098	13	10	10	21	17	36
64	18061	21509	25205	652	1119	680	4	5	3	6	9	31
65	43727	52078	45095	34153	19972	30038	78	38	67	130	64	3
ZONE TOTAL	378959	451366	434944	86272	128594	96675	23	28	22	38	47	34

[1]Poor Population (%)calculated from 3:5 relationship between slum population and poor population in case of Census'91, Estimated 1996 while ADB 1997 data recorded from ADB report

[2]Table 5: Zone 8 Basic Data: Total ,Slum and Poor Population

Ward	Ward Population			Slum Population			% of Ward Population			Poor Population (%) Extrapolated		
	Cen'91 a	Est'96 b	ADB'97 c	UVP '91 d	BBS '96 e	ADB '97 f	Cen '91 e/b	Est '96 f/c	ADB '96 g/d	Cen '91	Est '96	ADB '97
2	64762	77130	95214	22072	30132	47549	34	39	50	57	65	20
3	54653	65091	62406	24315	12152	27317	44	19	44	74	31	26
4	25386	30243	53323	2720	5316	6501	11	18	12	18	29	73
5	46497	55377	54762	11732	32252	25620	25	58	47	42	97	23
6	59106	70395	95535	7446	20998	34194	13	30	36	21	50	22
7	39435	46967	59432	4830	9361	33983	12	20	57	20	33	8
8	52038	61977	76843	12554	24180	25559	24	39	33	40	65	34
15	53649	63895	72741	11679	35,400	28131	22	55	39	36	92	44
ZONE TOTAL	395526	471075	570256	97348	169791	228854	25	36	40	41	60	43

[2]Poor Population (%) calculated from 3:5 relationship between slum population and poor population in case of Census 1991, Estimated 1996 while ADB'97 data recorded from ADB report

Table 6: LIST OF GOB/NGO/PRIVATE H&FP FACILITIES DHAKA CITY CORPORATION , ZONE-3,

WARD	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/PNC	Cure	Deli-very
48	Out-door dispensary, Staff Quarter, Jigatola	MOHFW				✔	
	Rayerbazar Diba Jatna Kendra, 42 Jigatola	NGO				✔	
	EPI Centre, Rayer bazar, Comm. Office Dhaka.	DCC		✔			
	MCH-FP Centre, World Vision 46, Sonatan Gar.	NGO		✔		✔	
	MCH-FP centre, CWFP, 232/1, Sultangonj	NGO	✔	✔	✔	✔	
58	Gano Shastha Nagar Kendra, 21/23 Hazaribagh	NGO		✔		✔	
	EPI Centre, Hazaribagh Park, Hazaribagh	DCC		✔			
	MCH-FP centre, Hazaribagh Park	MOHFW	✔		✔		
	PHC Clinic, CWFP Hazaribagh Park	NGO	✔		✔	✔	
	Dispensary, Manik babur Dhal,Hazaribag	DCC				✔	
	MCH-FP Centre, Hazaribag samaj Unnayan Club	MOHFW	✔		✔		
	World Vision Sub-centre,Jalapara, Hazaribag	NGO				✔	
59	EPI Centre, Nowabgonj Commissioners office	DCC		✔			
	EPI Centre, Lalbagh Crescent Club, Lalbag	DCC		✔			
	Out-door Dispensary, Nawabganj Park	MOHFW				✔	

WARD	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/PNC	Cure	Deli-very
60	MCH-FP centre, CWFP, 269 J.S.Shaha Road	NGO	✔	✔	✔	✔	
	Zamila Khatun Maternity Clinic, 180 JNS Rd	NGO			✔	✔	✔
	MCH-FP centre, 139, JNS Road, Lalbagh	MOHFW	✔		✔		
	EPI Centre, 186, JNS Road, Amligola Park	DCC		✔			
61	Azimpur Day Care Centre, 6/9, Shaheb Bazar	Private				✔	
62	EPI Centre, Polashi Barak Azimpur	DCC		✔			
	MCH-FP Centre, Polashi Barak, Azimpur	MOHFW	✔		✔		
	Out-door Dispensary, Polashi Barak, Azimpur	MOHFW				✔	
	Azimpur Maternity Hospital, Azimpur	MOHFW	✔	✔	✔	✔	✔
	Out-door Dispensary, School H. Clinic. Azimpur	MOHFW				✔	
63	MCH-FP centre, CWFP, 18/1 Bakshibazar,	NGO	✔	✔	✔	✔	
	MCH-FP centre, Nawab Bagicha Club,Bakshibazar	MOHFW	✔	✔	✔	✔	

WARD	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/PNC	Cure	Deli-very
64	Chalkbazar Shishu Hospital, Chalkbazar	DCC				✔	
	EPI Centre, Chakbazar Shishu Hospital	DCC		✔			
65	EPI Centre, Syesta khan Community Centre	DCC		✔			
	MCH-FP Centre, Syesta khan Com. Centre,	MOHFW	✔		✔		
	Dispensary, Syesta khan Community Centre,	DCC				✔	
	Satellite Clinic, Badaler Club, Islambagh	CWFP	✔	✔	✔	✔	
	Dispensary, Islambagh Community Centre	DCC				✔	
	EPI Centre, Islambagh Community Centre	DCC		✔			
	MCH-FP centre, Islambagh Community Centre	MOHFW	✔		✔		

Table 7: LIST OF GOB/NGO/PRIVATE H&FP FACILITIES ,DHAKA CITY CORPORATION , ZONE- 8,

Ward	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/ PNC	Cur	Deli-very
2	Radda MCH-FP center, Section-12, Mirpur	NGO	✔	✔	✔	✔	
	MCH-FP center, Ward Commissioner Office	MOHFW	✔		✔		
	MFPP Satellite clinics	NGO	✔		✔		
3	Bangladesh Womens Health Coalition , Section-10, Mirpur	NGO	✔	✔	✔	✔	
	Progoti Samajkallan Prothistan, Section-10	NGO	✔	✔	✔	✔	
	Govt Outdoor dispensary, Section-10	MOHFW				✔	
	MFPP , Section-10	NGO	✔		✔	✔	
	Radda MCH-FP center,Section-10	NGO	✔	✔	✔	✔	
4	MCH-FP center , Janakallan clinic, Commissioner off.	MOHFW	✔		✔		
	EPI Centre, Progoti Samajkallan Prothistan, Sec-13	NGO		✔			

Ward	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/ PNC	Cur	Deli-very
5	Samajic Shasta Seba Kendro, Sec-11	NGO				✔	
	MCH-FP centre Samajic Shasta Seba Kendro,	MOHFW	✔		✔		
	Metropolitan satellite Clinic, Sec-11	MOHFW	✔	✔	✔	✔	
	Radda MCH-FP Centeer , Bauniabad.	NGO	✔	✔	✔	✔	
	Outdoor dispensary, Bauniabad Tinshed colony	MOHFW				✔	
	Proshika Shesta Seba Kendro, Section-11	NGO				✔	
	Bangladesh Womens Health Coalition Satellite clinics, Bauniabad	NGO				✔	
	MFPP Satellite clinic, Bauniabad	NGO	✔		✔	✔	
6	EPI Centre, Faizunessa Wokfa trust, Duaripara	DCC		✔			
	Manisha clinic, Pallabi	NGO	✔	✔	✔	✔	
	Manisha Satellite clinic, Pallabi	NGO	✔		✔		
	EPI center, Chalantika Club (Sias)	NGO		✔			
	BAPSA , Section-6.	NGO	✔		✔	✔	

Ward	NAME & ADDRESS OF FACILITIES	TYPE	FP	EPI	ANC/ PNC	Cur	Deli-very
7	EPI center, Rupnagar school	DCC		✔			
	EPI center, Rainkhola post office	DCC		✔			
	EPI centre Shaheen Pharmacy	DCC		✔			
	Monisha Satellite Clinic,	NGO	✔		✔		
8	EPI center, Uttar Bisil Janakallan Samittee	DCC		✔			
	EPI Centre, Mirpur-1.	DCC		✔			
	EPI center, Godaraghat Primary school	DCC		✔			
	MCH-FP center, Bisil Janakallan Samittee	MOHFW	✔		✔		
	Radda MCH-FP center, Section-1	NGO	✔	✔	✔	✔	
	Uttarayan Jano Kalyan Mohila Samity	NGO	✔		✔		
15	Progoti Samajkallan Prothistan , Manikdi Bazar	NGO	✔	✔	✔	✔	✔
	Dusta Nari - O- Shishu, Manikdi Bazar	NGO	✔	✔	✔	✔	
	Satellite clinics, PSKP, Manikdi	NGO	✔				

Table 8: Current needs and Availability and Utilization of services in Zone 3 Wards(August'96)

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
48	EPI	6	DCC EPI Centre	5	5.7
			CWFP	1	71.6
			World Vision	1	37.0
	FP/ANC	11	CWFP	6	7.1
			CWFP(Satellite clinic)	0.25	0.0
	Curative	5	DHS Dispensary	6	53.0
			CWFP	6	13.5
			CWFP(Satellite clinic)	0.25	5.1
			World Vision	6	63.0
58	EPI	4	DCC EPI Centre	5	22.9
			GK	1	9.5
	FP/ANC	7	CWFP	6	16.5
			DFP FP clinic (1)	6	13.5
			DFP FP clinic (2)	6	12.0
	Curative	7	DCC Dispensary	6	28.0
			CWFP	6	12.0
			GK	3	5.5
59	EPI	3	DCC EPI centre	4	9.8
			DCC EPI Centre	1	16.3
	FP/ANC	5			
	Curative	1	DHS Dispensary	6	83.0

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
60	EPI	3	DCC EPI centre	5	7.2
			CWFP	1	90.0
	FP/ANC	6	CWFP	6	27.4
			DFP FP Clinic	6	3.8
			Zamila Maternity	6	0.9
	Curative	7	CWFP	6	15.8
			Zamila Maternity	6	2.1
61	EPI	2			
	FP/ANC	4			
	Curative	4			
62	EPI	2	DCC EPI centre	5	5.0
			Azimpur Hospital	6	68.3
	FP/ANC	4	DFP FP Clinic	6	12.6
			Azimpur Hospital	6	-
	Curative	1	DHS Dispensary	6	48.0
			School Health Clinic	6	30.0
			Azimpur Hospital	6	-
63	EPI	1	CWFP	1	37.4
	FP/ANC	2	CWFP	6	11.0
	Curative	1	CWFP	6	16.0
64	EPI	1	DCC EPI centre	5	5.1
	FP/ANC	2			
	Curative	1	DCC Shishu Hospital	6	

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
65	EPI	3	DCC EPI centre (Islambag)	5	17.3
			CWFP(Satellite Cliinc)	0.25	7.9
			DCC EPI centre (Sayesta Khan)	5	16.1
	FP/ANC	6	CWFP(Satellite Clinic)	1	21.3
			DFP FP Clinic (Islambag)	6	18.5
			DFP FP Clinic (Sayesta Khan)	6	9.5
	Curative	13	CWFP(Satellite Clinic)	1	25.3
			DCC Dispensary (Islambag)	6	6.0
			DCC Dispensary (Sayesta Khan)	6	No Records

Table 9: Current needs and Availability and Utilization of services in Zone 8 Wards(November'96)

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
2	EPI	5	Radda MCH-FP Centre(Sec.-12)	3	109.1
	FP/ANC	10	Radda MCH-FP center (Sec-12).	5	77.3
			MFPP (Satellite clinic)	0.25	8.3
	Curative	9	Radda MCH-FP center	5	36.3
3	EPI	4	Radda MCH-FP Centre (Sec-10)	3	133.8
			Bangladesh Womens Health Coalition	5	5.5
			Progoti Samajkallan Prothistan (Sec-10)	3	5.47
	FP/ANC	7	Radda MCH-FP center (Sec-10)	5	179.6
			Bangladesh Womens Health Coalition	5	29.0
			Progoti Samajkallan Prothistan(Sec-10)	6	6.40
			MFPP	5	19.52
	Curative	4	Radda MCH-FP Center (Sec-10)	5	97.1
			Bangladesh Womens Health Coalition	5	27.2
			DHS Outdoor dispensary (Sec-10)	6	65.55
			Perogoti Samajkallan Prtothistan	6	30.73
			MFPP clinic	5	9.61
4	EPI	3	Progoti Samajkallan prothistan (NRU)	2	2.3
	FP/ANC	7	DFP FP clinic	5	1.7
	Curative	10			

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
5	EPI	3	Radda MCH-FP Center (Bauniabad)	3	27.9
	FP/ANC	6	DFP FP clinic	5	11.1
			MFPP Satelitte clinic	0.25	7.0
			Radda MCH-FP clinic (Bauniabad)	5	40.5
	Curative	3	MFPP Satellite clinic	0.25	3.2
			Radda MCH-FP center (Bauniabad)	5	17.60
			Proshika Shasta Seba kendro	6	3.76
			Samajik Shastho Seba Kendra	6	4.4
			B W H Coalition Satellite Clinic	1	20.19
			Bauniabad Tin Shade GoD	6	102.00
6	EPI	5	DCC EPI center	1	2.6
			Maneesa Clinic	6	1.89
			SIAS (Chalantika club) EPI center	1	1.79
	FP/ANC	10	DFP FP clinic	5	2.3
			Maneesa clinic	6	5.45
			BAPSA clinic	6	9.3
	Curative	6	Maneesa clinic	6	2.8
			BAPSA clinic	6	1.5
7	EPI	3	DCC EPI centre	2	6.6
			DCC EPI center	1	7.8
			DCC EPI center	1	8.59
	FP/ANC	6	Maneesa Sactellite clinics	0.25	1.3
	Curative	2			

Ward	Type of services	Sessions Required per Week	Service centre Available	Sessions held per Week	# of clients per Session
8	EPI	4	DCC EPI center	2	7.8
			DCC EPI center	2	9.38
			DCC EPI center	1	13.36
			Radda MCH-FP center (Sec-1)	3	114.96
	FP/ANC	8	DFP FP clinic	5	5.1
			Radda MCH-FP Center (Sec-1)	5	157.3
			Uttarayun Satellite clinics	0.25	2.11
	Curative	7	Radda MCH-FP center (Sec-1)	5	75.0
15	EPI	4	Progoti Samajkallan Prothistan (Manikdi)	1	13.6
			Dusta Nari	1	3.62
	FP/ANC	8	Progoti Samajkallan Prothistan (Manikdi)	5	16.5
			Dusta Nari-	5	3.97
			Progoti Samajkallan Prothistan Satellite clinics	0	0
	Curative	9	Progoti Samajkallan Prothistan (Manikdi)	5	2.5
			Dusta Nari	5	7.73
			PSKP Satellite Clinic	3	4.3

Table 10. Status of ward specific recommendations, Zone 3

Ward	Recommendation	Current Status
48	EPI centre of Ward 48 Commissioner's office is poorly utilized. It was recommended that the centre shall operate 3 days (Sat, Sun, Mon) instead of 5 days. Remaining 2 days (Tue, Wed) it will operate in an under- served area located near Beribadh Sonathon Ghar in a school building or the nearby NGO centre	This recommendation is yet to be implemented. DCC has been agreed to operate in the new location. Support from the NGO is needed
	Current number of FP providers in this ward is inadequate. There is excess of GOB/NGO providers of FP services in the adjacent ward 58. It is recommended that a poorly-utilized GOB- FWV from Hazaribag par, Ward 58 need to be relocated to the same spot of EPI centre near Beribadh of Ward 48	This recommendation is yet to be implemented. Relocation of FWV of GOB-is currently processed by Drector of Family Planning, Dhaka. Action in this regard may require more time
58	DCC dispensary at Manik Bbabur Dhal is inadequately staffed by only pharmacist trained to dispense drugs but not to treat patients. Zonal authority will take necessary steps to improve the services offered by the dispensary. If possible, one MO from health department or an NGO provider can be deputed to the dispensary to strengthen curative service	This recommendation is yet to be implemented. Support from the local commissioner is needed. This issue has been reviewed in the zonal committee meeting. Alternative site is being explored.

Ward	Recommendation	Current Status
59	EPI centre of Ward 59 Nabarun Club is poorly-utilized in the current location. It was recommended that the centre shall operate 2 days (Sat, Sun) instead of 4 days. Remaining 2 days (Mon,Tue) it will operate in an under-served area located at the GOB dispensary at Nowabgonj park.	This recommendation has been implemented. One new location with EPI services is available
	At present, there is no FP providers in this ward. There is excess of GOB/NGO providers of FP services in Ward 60. A poorly-utilized GOB-FWV from Amligola Park in Ward 60 can be relocated in the Nowabgonj dispensary at Nowabgonj park.	This recommendation is yet to be implemented. Relocation of FWV of GOB-FP is currently processed by DDFP, Dhaka. Action in this regard may require more time due to complex administrative procedure
60	EPI centre of Ward 60 at Amligola Park is poorly- utilized in the current location. It was recommended the centre shall operate 3 days (Sat, Sun,Wed) instead of 5 days. Remaining 2 days (Mon,Tue) it will operate in an under-served area located in the slums at Rajnarayan Dhar Road in the DCC community centre.	This recommendation has been implemented. One new location with EPI services is available
	Zamila maternity centre of formal NGO is poorly utilized but have several FP providers. It was recommended that GOB- FWV from the centre can be shifted to the Rajnarayan Dhar Road community centre. Alternatively, an NGO can set up a FP clinic to provide FP services 2 days /week as well as curative services	This recommendation has been implemented. One new location with FP/ANC, PNC services is available as well as broad range of services are provided

Ward	Recommendation	Current Status
60	Non functioning DCC dispensary at Amligola Park needs to be shifted to Rajnarayan Dhar Road community centre keeping the possession of the dispensary intact. If possible, one MO from health department can be deputed for providing curative service. Alternatively, curative service can be provided from an NGO clinic	This recommendation has been implemented. One new location offering curative service is available
61	At present, there is no EPI services available in this ward. Subject to the availability of space in Ward 61, EPI services one day/week will be provided by DCC	These recommendations are yet to be implemented. Suitable space is not available. Space in this ward is considered commercially very valuable. Support from the local commissioner is also needed
	At present, there is no FP services available in this ward. FP services will be provided by an NGO one day/week through its paramedic in the same site proposed for EPI	
	At present, there is no curative services available in this ward. In Ward 61, curative service will be provided by an NGO one day/week through its paramedic	
64	At present, there is no FP provider available in this ward. GOB-FWV from Ward 62 can be posted in the Shishu Hospital where there is already an EPI centre. Alternatively, an NGO can setup an FP clinic with assistance from Zonal authority	This recommendation has been implemented. GOB-FP provider has been officially relocated. However adequate space is not available. Support from the hospital authority is needed. One new location with FP/ANC, PNC services is available with broad range of services

Ward	Recommendation	Current Status
65	Service facilities of GOB/NGO are closely located. It was recommended that NGO-FP facility be shifted from the current location to a school. An NGO will do the needful	This recommendation has been implemented. Community has constructed a room for the centre to operate in the new location
	DCC dispensary at Sayestha khan Road and Islambag Bazar is inadequately staffed by only untrained practitioner(pharmacist/compounder) trained to dispense drugs but not to treat patients. Zonal authority will take necessary steps to improve the services offered by the dispensaries. If possible, one MO from nearby dispensary can be deputed for providing curative service in the Islambag dispensary	This recommendation is yet to be implemented. Support from DHS and DCC central authority is needed

Table 11. Status of Ward Specific Recommendations, Zone 8

WARD	Recommendation	Current Status
02	EPI sessions are less than current need in this ward. The only EPI centre is run by an NGO. It was recommended that another NGO will also organize one EPI sessions per week in their existing satellite clinics	This recommendation has been partially implemented. EPI services have been added in 2 new satellite clinics. However, instead of planned 4 sessions/month currently one session/month is being held
	Current satellite clinics of an NGO in this ward are held irregularly. It was recommended that the NGO will organize one session per week in the 4 satellite clinics of the ward instead of current schedule of one session /month	This recommendation have been partially implemented. FP/ANC services are being provided through 2 new satellite clinics. Instead of planned 4 locations and 4 sessions/month, currently one session/month are being held and are poorly-utilized. However, due to local need a large NGO expanded its clinic operation from 3 days to 5 days as part of their internal service reorganization

WARD	Recommendation	Current Status
	Current number of curative sessions in the ward is inadequate. It was recommended that curative services will be included in all the sessions of satellite clinics of an NGO currently being planned for this ward	This recommendation has been partially implemented. Curative services have been added in 2 new satellite clinics. However, instead of planned 4 locations and 4 sessions/month, currently one session/month are being held. Therefore, 2 locations will have broad range of services
04	There is a need to increase one session per week for EPI services as per current requirement. The group recommended that an NGO will organize 3 EPI sessions per week from December 1996 in NRU centre instead of current schedule of 2 sessions per week	These recommendations could not be implemented due to closure of operation of the centre due to fund constraints
	Current number of FP/ ANC providers in this ward is inadequate. So, it was recommended that an NGO will add FP/ ANC services with 3 FP/ANC sessions in NRU centre	
	At present, there is no curative service provider in this ward. It was recommended that an NGO will provide curative services in NRU centre with 3 curative sessions from December 1996.	

WARD	Recommendation	Current Status
05	There is no EPI centre in the western part of the ward . The EPI centre operated by NGO is far away from the target group of the western side of the ward. So, it was recommended that one EPI session per week will be organized by another NGO in a suitable site at western part of the ward by end of November 1996	This recommendation is yet to be implemented. No step has been taken by the organization in this regard
06	The group recommended that an NGO will organize all the existing satellite clinics of the ward one day per week on regular basis to cover remote areas of the ward	This recommendation has been partially implemented. There are 2 new locations with EPI , FP/ANC and curative services. However, instead of planned 4 sessions/month, currently one session/month are being held. Location of the new satellite clinics do not match the proposed locations. However, there are 2 new locations with broad range of services

WARD	Recommendation	Current Status
07	At present, there is no FP provider in this ward except infrequent satellite clinics held by an NGO. It was recommended that FWV from the GOB-FP clinic of Ward 5 be relocated (as Ward 5 has excess of providers) to a suitable site of the ward. It was decided that NGOs will contact with Ward Commissioner of the ward to find a suitable place for the DFP-FP clinic in the ward	This recommendation is yet to be implemented. Relocation of FWV of GOB-FP is currently being processed by DDFP, Dhaka. Action in this regard may require more time due to complex administrative procedure
	There is no curative service providers in this ward. The group recommended that an NGO will organize 4 satellite clinics in remote areas: one session/per week on regular basis to meet the curative service needs	This recommendation has been partially implemented. Four satellite clinics with EPI, FP/ANC and curative services are available. Therefore, 4 locations will have broad range of services. However instead of planned 4 sessions/month, currently one session/month is being held
	To bring services together it was recommended that 3 satellite clinics of an NGO can be merged with 3 EPI centre of DCC. Authority of Zone-8 and an NGO will merge the clinics by December 1996	This recommendation is yet to be implemented. Due to administrative problem in DCC, further action could not be taken

WARD	Recommendation	Current Status
08	To improve service utilization and bring services together the group recommended that the Godaraghat EPI centre of DCC can be relocated to . unused govt. building at Godaraghat from where an NGO can also operate one of their satellite clinic. Authority of Zone-8 and an NGO will to merge the clinics at the identified spot.	This recommendation is yet to be implemented. Due to administrative problem in DCC, no further action could be taken
	To extend FP and curative services to remote areas of the ward, it was recommended that an NGO will organize 4 satellite clinics (16 sessions per month) in this ward on regular basis	This recommendation has been implemented. Three satellite clinics with EPI, FP/ANC and curative services are available. Therefore, 4 new locations with broad range of services are available.
15	Current number of EPI sessions in this ward is inadequate. Moreover locations of the available services do not match the need. It was recommended that the satellite clinics including EPI sessions of this ward will be organized by theNGOs as per the agreed upon schedule	This recommendation has been partially implemented. Two new locations with FP/ANC services are available. EPI services have been added in 2 new satellite clinics and curative services in one. One new locations with broad range of services is now available

Appendix A

INTRA-URBAN DIFFERENTIALS IN THE HEALTH AND FAMILY PLANNING STATUS

a. **REPRODUCTIVE HEALTH:**

Family Planning: Contraceptive prevalence rate (CPR) is estimated at 54% for urban areas, (1993-94 Demographic and Health Survey), but CPR for women living in the slums was found to be only 50% (UPS 1996, ICDDR,B), much closer to the level of use in rural areas (43%). A large part of this difference is due to lower use among younger and low parity couples in the slums (Thwin/UNA, 1996).

Recent needs assessment studies carried out by UEP showed that though the ever use of modern contraceptives is high (70%), about a third of the ever users are not currently using a method (18). The drop out is 38% in the slum population compared to 31% in the non-slum population. Almost a third of all past users had discontinued due to side-effects.

Safe Motherhood: All pregnancies and births carry some health risk to the child as well as to the mothers. In the absence of proper obstetric care, many women die as a result of maternity and many more suffer from different morbidities related to pregnancy and delivery. The prevalence of pregnancy is higher in the slums compared to the non-slum population. Almost a quarter of these pregnancies are unwanted.

A proper ANC is important to detect early signs of diseases, or risk factors for pregnancy, followed by timely intervention where possible. The antenatal visit is also a good opportunity for providing messages on warning signs of pregnancy complications, safe delivery practice, child immunization, importance of proper diet, exclusive breast feeding, etc. At present, number of pregnant women seeking antenatal care in urban slums is about 55% and is lower than the rate in non-slum women (Antelman/IDSF, 1996).

The majority of maternal deaths occur around the time of delivery. Home deliveries by untrained women are almost universal in urban slum areas whereas, in non-slum areas, only a third of the deliveries are conducted by trained persons (check).

Reproductive Tract Infection: A survey of almost 3,000 rural women in Matlab found that almost 25% reported symptoms for RTIs (generally vaginitis), of whom over two-thirds had clinical and/or laboratory evidence of a infection. Data for the urban population is scanty. A study among urban MCH-FP clinic clients in Dhaka showed a high prevalence of RTIs and STDs.

b. CHILD HEALTH:

Infant mortality in urban slums is 100.7 per 1000 live births (Urban Surveillance System, ICDDR,B-1995), compared to the national urban and rural estimates of 91 per 1000 live births, in non slum (Urban Surveillance System, ICDDR,B-1995). In urban slums deaths in infancy were about 45% of all deaths in this population. A 54% of the infant deaths are due to a few preventable or treatable causes: tetanus, measles, respiratory infections, and diarrhoea. In Dhaka slums measles responsible for 16% of child death(Baqui et al, 95).The prevalence of diarrhoea and ARI among children is higher in the slums (Thwin/UNA, 1996).

Despite the tremendous success of the vaccination program in Bangladesh, the coverage in some hard-to-reach populations like the urban slums have remained low. 1995 data from the Urban Panel Survey of UEP shows that 54% of 12-23 month old children are fully immunized in the slum areas compared to 77% in the non-slum areas.

Previous studies in the slums of Dhaka have shown a high prevalence of stunting (48%) and wasting (13%) among slum children aged 6-24 months (Arifeen/UVP Seminar, 1993). Data from the Urban Surveillance System in Dhaka slums have shown that although breast feeding is almost universal, it is usually not exclusive (Arifeen/ASCON, 1994). Less than 10% infants beyond their 2nd month were exclusively breast fed in urban slums. Delayed and inappropriate weaning also appear to be a major problem.

The prevalence of chronic under nutrition in slums was low in Ist year of life but steadily increases to about 60% by the 3rd year of life. The prevalence of acute under nutrition is low in the Ist 6 months of life i.e. only 3%. However it increases rapidly thereafter to a peak in the 2nd year after which the prevalence declines(Baqui et al '95).

Annexure B

- **INVENTORY FORM FOR URBAN CLINICS:**

  This form will primarily be used during the preliminary exploratory visit to different urban clinics. Information obtained in this form will form the basis for further visits to selected clinics.

- **CLINIC VISIT FORM:**

  This form needs to be used in selected urban clinics based on the finding of the initial exploratory visits to obtain in-depth information to ascertain the potentials of integration, expansion, relocation and improvement of referral.

- **FP /EPI CLINIC UTILIZATION STATUS FORM:**

  This form will be used to obtain various service delivery data for at least a year as appropriate and available from service delivery documentation register(s)in the clinics.

- **HEALTH FACILITY INVENTORY FORM:**

  This form will primarily be used to document name and detailed location and range of services offered by the facilities within a ward boundary . This information will be used to develop ward wise health facilities map of the urban area concerned.

MCH-FP Extension Project, ICDDR,B
INVENTORY FORM for URBAN CLINICS
(self-administered)

___/___/_____

1. Name(exact):____ |__|__|__|__|

2.Location/address:____

3. Management: (✓)

Directorate of FP	
Directorate of Health Services	
City Corporation/ Municipality	
NGO ______________	
Private ______________	
Other ______________	

7. Services currently provided at the clinic and in the community: (✓)

Services		Clinic (✓)	Com (✓)	Day #
Family Planning:	Non-clinical			
	Inj			
	IUD			
	Norp			
	Tubect			
	Vasect			
	MR/Abort			
Antenatal Care				
Postnatal Care				
EPI				
Motivation/Counseling				
Delivery:	Normal			
	Caesarian			
General Treatment:	Male			
	Female			
	Children			

4. Fixed/Outreach Centre:_______

5. Working area:______________
Population served:____________
Eligible couple No. __________
Under 5 Children No.__________
Under 1 Children No.__________

6. ________ working days per __

8. Staffing:

Doctor:	Female	
	Male	
Nurse		
FWV/Paramedic	Female	
	Male	
Medical Assistant	Female	
	Male	
Field Worker	Female	
	Male	
Vaccinator	Female	
	Male	

MCH-FP Extension Project, ICDDR,B ___/___/_____

CLINIC VISIT FORM

- ❒ Location of the facility:(Details of location, Road Accessibility, Slum non Slum poor area)➤

- ❒ Physical Structure ➤
  Type of structure: Building/ Tin Shade/Club/Community Centre/Office/Rented/ Owned/Borrowed/Donated/Allocated

- ❒ Shared by➤

- ❒ Sharing the facility with➤

- ❒ Unused/Available space ➤

- ❒ Basic Training of Providers➤

- ❒ Scope of Expansion/ Relocation ➤

- ❒ Community Involvement/Interest in the facility➤

- ❒ Referral mechanism within and or neighboring facilities➤

(Please use additional page if necessary)

FP CLINIC/ EPI CENTRE UTILIZATION STATUS FORM

Name and Address of the clinic: **Ward#:** **Zone:**

MONTHS	ANC	PNC	Pill/Con	INJEC/CT	Other services	DPT (1,2,3)	Measles	TT (1-5)	Operation /week	Remark
Month 1										
Month 2										
Month 3										
Month 4										
Month 5										
Month 6										
Month 7										
Month 8										
Month 9										
Month 10										
Month 11										
Month 12										
TOTAL/Year										

OTHER SERVICES= General Health services,

Facility/Provider Needs by Population Size

Appendix B presents the basis of a matrix of provider/facility needs prepared for the intervention for a reference ward population and proportion of the poor. The estimation was done for 3 provider categories: EPI, FP/ANC, and curative services. For operational reasons, FP and ANC have been treated together since in almost all of these cases one provider is responsible for delivery of FP and ANC services from a clinic. The matrix was based on similar principle of calculations presented in appendix B to identify provider/facility needs for a combination of ward population and proportion of poor.

Thus the matrix was developed for the intervention as shown in appendix B , gives the minimum number **provider sessions** required per week to provide EPI, FP/ANC, and curative services separately as well as for FP/ANC and curative services, if provided by the same provider. It also provides estimated number of **providers needed** for each ward to provide required number of sessions (with a minimum of 1). The estimates are presented essentially for 3 different scenarios:

1. All services from the same facilities
2. Services from 2 types of facilities:
    - FP/ANC plus curative
    - EPI Only
3. Services from 3 types of facilities:
    - FP/ANC
    - EPI Only
    - Curative Only

In the model calculation in appendix B a population of 40,000 with 100% poor was considered as a situation in a reference ward. In order to derive the weekly clinic visits, estimated annual clinic visits by services was divided by the following :

- 48 (i.e. the number of weeks in a year minus 4 weeks off for holidays and other reasons), and

- 40 (i.e. the number of clients that can be served per session with a range 30-59, since estimated clinic sessions were rounded.)

For this ward the minimum weekly requirement for provider sessions are: 2 for EPI, 5 for FP/ANC, 10 for curative services, and 15 for FP/ANC and curative services together. This translates into 3 facilities providing all services, or 2 facilities, one offering FP/ANC and Curative services and another only EPI, or 1 facility offering FP/ANCand curative, another only curative services and another EPI only. The translation of required provider sessions to number of facilities assumes no sharing between facilities or wards, i.e. 3 facilities are needed for providing 15 sessions per week.

Matrix Use: Detail of the 24 page Matrix prepared for the intervention is beyond the scope of this paper. However it can be obtained from the authors.

Appendix B

Estimation of Clinic Needs for Essential Health Services at Primary Health Care Level in Urban Area

Population to serve:				40,000
ELCOS	18%			7,200
<5 Child	17%			6,800
<1 Child	3%			1,200
Prop. of Poor	100%			

Annual Clinic Visits By Services

CPR (expected	70%			
# of Users	13%		5,040	
Private Sources	50%		2,520	
From Clinics	50%		2,520	

Contraceptive Use			visits/y	
Pills	42% =	1058	4	4234
Cond	15% =	378	4	1512
Inj	9% =	227	5	1134
IUD	7% =	176	1.02	180
Perm	13% =	328	1	328
Trad	14% =	353	0	0

Total FP Visits/year			7387	
Total FP Visits/work day (48 weeks/6days)				26
Total FP Visits/work day (48 weeks/5days)				31
Ante-natal Care (Poop Population)				
Exp.# of Pregnacies/year	4%	1600		
Average # of ANC visits/pregnancy		3		
Expected # of ANC visits/year	50%		2400	
Total ANC contacts/week(48 wks)				50
Total ANC contacts/day (6 days)				8
Total ANC contacts/day (5 days)				10
Sick child visits (Poor Population)				
DIARRHOEA				
A Expected episode/child/year		4		
Expected cases /child/year		27200		
Expected utilization	20%	5440		
ACUTE RESPIRATORY TRACT INFECTION(ARI)				
B Expected episode/child/year		6		
Expected cases /child/year		40800		
Expected utilization	10%	4080		
Total sick child visits/year			9520	
Total sick child visits/work day (48 wks/6days)				33
Total sick child visits/work day (48 wks/5days)				40
Child EPI (Total Population)				
Exp.# of EPI contacts /child/year		4		
Total EPI contacts /year	90%		4320	
Total EPI contacts/week(48 wks)				90
Total EPI contacts/day (6 days)				15
Total EPI contacts/day (5 days)				18
Estimated other sick visits to the clinic	25%		10000	
Total sick visits/work day (48 wks/6days)				35
Total sick visits/work day (48 wks/5days)				42

Provider/Session Needs

Scenari Only multi-service clinics providing daily services (all)	
Total expected visits per work day (6 days), including daily EPI:	117
Number of providers needed (40/visits per day):	3
Scenari One type of clinics providing FP/ANC/Curative services 6 days/week and other clinics providing only EPI 5 days/ week	
Total expected visits per work day for non-EPI clinics:	102
Total expected visits per work day for EPI clinics:	18
Number of providers needed for FP/ANC/Curative:	3
Number of providers needed for EPI:	1
Scenari One type of clinics providing FP/ANC services 6 days/week and another clinic providing Curative services 6 days/week and another clinic provide EPI service 5 days/week	
Total expected visits per work day for FP/ANC clinics:	34
Total expected visits per work day for Curative clinics:	68
Total expected visits per work day for EPI clinics:	15
Number of providers needed for FP/ANC:	1
Number of providers needed for Curative:	2
Number of providers needed for EPI:	1

Minimum provider sessions required per week (40 visits/day):

EPI Only Clinic	2
FP/ANC & Curative Clinic	1
FP/ANC Only Clinic	5
Curative only Clinic	10
Curative only Clinic	10

Minimum Clinic(s) Need

EPI Only Clinic	1
FP/ANC & Curative Clinic	3
FP/ANC Only Clinic	1
Curative only Clinic	2

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. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, 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, a management information system, and developing 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.

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.

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:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Division has a long history of 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 the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; 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.

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