

# Reaching Quality Services of BRAC Health Centers to the People

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September 1998

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## EXECUTIVE SUMMARY

BRAC has implemented the Reproductive Health and Disease Control (RHDC) program in the northern and central regions of Bangladesh to improve health status of the people. Among the various components of the program, BRAC health center (BHC) is an important intervention to reach basic and secondary health care to the community. This study was undertaken to assess the extent to which the quality services offered at the BHCs and the extent to which BHC services reached the community, and met clients' satisfaction and needs. Six of the 21 BHCs were purposively selected in RHDC program areas based on the duration of BHC establishment and its level of performance. Data were collected during April-May 1998 through review of program documents, observation of BHCs, client survey and focus group discussions (FGDs). For patient observation, 131 clients were selected purposively from six BHCs. By reviewing the program records, 471 patients who attended BHCs more than 7 days but less than 60 days prior to interviews were selected from the patient's registers. A total of 12 FGDs, seven with the clients and five with the non-users, were conducted in the program areas.

Findings reveal that structural elements of the quality have been improved in range of service provision, record keeping, availability of equipment and emergency medical supplies, and waste disposal. Maternity service for childbirth was started in 83% of the BHCs, which was 16% before 8 months. However, laboratory facilities were available in the 50% of the observed BHCs. Dumping holes for waste disposal available in nearly all the observed BHCs were functional. Poor quality was still observed in training and supervision. The number of training received was slightly increased, however, visits from the head office to the field were deteriorated than the earlier study findings.

Competence of the health providers was found to be inadequate by reviewing the prescriptions. In the prescriptions, duration of illness was mentioned by 35%, complaints-related systemic examination by 20% and specific diagnosis by 41% of the patients. Medicines were prescribed in only 3% of the cases from the BHC guidelines, and in 38% of the patients from the drug lists of the enlisted pharmaceutical companies. Moreover, half of the patients were prescribed vitamins. Only 13% of the patients were found to have received specific advice and 7% specific treatment.

Client provider relations seem to be very good but with a lack in communication, particularly among the medical officers. Gender bias and discrimination in relation to education were also observed among the medical officers. Information on the rules of drug intake was given to almost all the clients, but disease-related information was conveyed to a much lesser number of patients. Unfortunately, information on the side-effects of drugs was given to a very insignificant number of patients.

The study also reveals that the patient attendance of 1997-1998 was increased by 53% than that of 1996-1997. It has been estimated that only 6% of the ill persons in the operating areas of BRAC attended the BHCs in each month. Likewise, each month 26% of the ill VO members and 1% of the non-VO members were reached by BHC services. More than 90% of the patients attended the BHC more than once and more than 60% of the clients four times or more. With regard to source of treatment, 48% of the clients sought care only from BHCs and the rest from other formal and informal sectors. Even though community health volunteers' participation in patient referral was notable, their frustration for not receiving enough incentives was blamed to be due to competitive attitudes of BRAC staff in patient referral to BHCs.

Regarding access-related issues, it was found that the patient traveled an average distance of 8 kilometers to attend the BHC. Besides, the average time spent to reach the BHC was 53 minutes. In the BHCs, a patient spent an average of 47 minutes for receiving total health services. Considering low client flow to BHC, the time spent in first contact to physician (20 minutes) exceeded the consultation time (16 minutes) is suggestive of poor quality. In client survey, 95% of the patients reported that services provided at the BHCs were of good value for the costs, but in group discussions each female participant found cost as an obstacle to use BHC services. Nearly all the patients knew about the availability of treatment of common ailments in BHCs, but 55% knew about maternity services for childbirth and 30% about family planning services.

With regard to clients' satisfaction, 53% of the clients felt completely well and 36% felt better than earlier after receiving treatment. About 85% of the clients were found to be quite satisfied with the services, but concurrently 41% of the clients ranked quality of BHC services good. More than half of the patients appreciated good behavior of the BHC staff. Poor physical facilities, such as lack of toilets and drinking water were mentioned by 16% of the patients. To enhance acceptability of BHC services, 52% of the clients mentioned X-ray facilities, 24% surgical facilities and 14% lab facilities to be available at the BHCs.

Despite increased attendance of the patients, high client satisfaction and increased continuity of care at the BHCs, some issues need to be highlighted in order to improve the quality and acceptability of the BHC. Some suggestions are made in the light of the study findings:

## **Increasing quality of services offered at the BHCs**

### **1. Competence of the health providers**

- i) The program should address the importance of using clinical practice guidelines with algorithms and protocols for the diagnosis and treatment of diseases to improve the prescribing pattern of the BHC staff;
- ii) Continuous supervision and effective feedback must be ensured;
- iii) Continuing education program and training are important for improving competence of the BHC staff;
- iv) Provision of rewards and penalties can be considered in accordance with the performance of the health providers; and
- v) Reasons for physician's drop-out should be explored.

### **2. Client-provider relationship**

- i) Communicating strategies need to be improved among the BHC staffs, particularly medical officers; and
- ii) Staff's bias toward gender and social class, especially among medical officers should be explored.

### **3. Information given**

- i) Concerning medical ethics, patients should be informed of their disease, and side-effects of the drugs during consultation sessions; and
- ii) Attention should be given to proper organization of counseling sessions to meet client's needs

### Reaching services to the community and meeting clients' needs

- i) Social promotion of BHCs needs to be strengthened to inform the community about the available service facilities;
- ii) Facilities, such as X-ray, minor surgery and inpatient services including management of complicated delivery cases should be available to fulfill clients' needs;
- iii) Health insurance initiatives should be experimented soon at the BHC to address issues of equity;
- iv) Clients spending time in different service delivery points of the BHCs should be considered for the proper use of time.
- v) Provision of simple treatment at the village level should be considered, particularly for the remote villages; and
- vi) Incentives of the community health workers should be emphasized.

## ABSTRACT

This study was undertaken to assess the extent to which the quality services being offered at the BRAC health centers (BHCs) and the extent to which BHC services reached the community, and met clients' satisfaction and needs. Six of the 21 BHCs were purposively selected in reproductive health and disease control (RHDC) program areas based on the duration of BHC establishment and its level of performance. Data were collected during April-May 1998 through review of program documents, observation of BHCs, client survey and FGDs. The study reveals that patient attendance of 1997-1998 was increased by 53% than that of 1996-1997. It has been estimated that only 6% of the sick people in the operating areas of BRAC attended the BHCs in each month, of which 26% were members of village organization (VO) and 1% was non-VO members. As compared to earlier study findings, structural elements of the service quality of BHCs were improved in range of service provision, record keeping, availability of equipment and emergency medical supply, and waste disposal. Poor quality was still observed in the number of training provided, and supervision at the field level by the mid-level managers. Competence of the health providers was found to be inadequate by reviewing the prescriptions. Client provider relations seemed to be very good but communication, particularly of the medical officers lagged behind. Information on the rules of drug intake was given to almost all the clients but a very few number of patients were informed about disease and side-effects of drugs. With regard to perceived health status, 53% of the clients felt completely well and 36% felt better than earlier after receiving treatment. In spite of satisfaction of the 85% of clients with BHC services, 41% of the clients only considered service quality as good. Even though community health volunteers' participation in patient referral was notable, their frustration for not receiving enough incentives was blamed to be due to competitive attitudes of BRAC staff in referring patients to BHCs. Following suggestions were made to improve the quality and acceptability of the BHC: social promotion of BHCs needs to be strengthened; competence of the health providers and communicating strategies need to be improved; information on disease, and side-effects of the drugs should clearly be communicated to clients; and incentives of the community health workers should be emphasized.

## INTRODUCTION

### Background of the study

In Bangladesh three-fourths of the ill people seek health care from the informal health sectors with little or no substantial benefits (1). Moreover, more than half of the total household health care expenditure has been spent only in medicine, much higher in rural areas (1). In view of the unnecessary health expenditures, provision of efficient quality services has become a serious concern not only to improve health status but also to affect effective utilization of resources. Meeting demands of the people for efficient health care facilities, however, is difficult to be resolved only by the government. To complement government health services, along with the other non-governmental organizations (NGOs) BRAC, a national NGO, has initiated providing curative services through center-based approach (2). BRAC health centers (BHCs), therefore, have been established in the operating areas of BRAC to extend basic and secondary health care to the rural community, particularly the disadvantaged population (2).

Quality, however, is an important issue to be considered in the health care to provide efficient services not only to improve health status but also to enhance client satisfaction and thereby to improve the utilization of health care (3). Moreover, improved quality is likely to reduce overall costs because more the quality, more is the compliance with the treatment and continuity of care, which contributes to improved health status and ultimately minimizes health expenditures (4,5). Quality not only concerns with assuring quality at the center but also put efforts to reach services to the whole community.

In the developing countries, studies of quality are increasingly receiving attention for assessing performance of the health care (6-11). A recent study of BRAC that assessed the structural quality performance of the BHCs found poor quality particularly in training, supervision and record-keeping (12). Yet there remains more quality issues to be explored for improving the quality of the BHCs. Given that, the present study was undertaken to assess the extent to which the quality services offered at the BHCs and the extent to which BHC services reached the community, and met clients' satisfaction and needs.

#### **Operational process of the BHCs**

Using its diverse experience from the health interventions, in 1995 BRAC initiated BHCs in the northern and central part of Bangladesh. To date, of the 34 BHCs, 21 have been established in the RHDC program areas, and the rest in other health intervention areas of BRAC. Although health facilities of the BHCs are available to the whole community, members of BRAC's credit program, particularly women and children receive much more benefits from the BHCs.

BHCs are expected to be equipped with multiple services. However, due to various reasons, all services have yet to start in each BHC. Services provided at the BHCs are: i) Out-patient services include treatment of common ailments, family planning, antenatal care service, and treatment of sexually transmitted diseases and reproductive tract infections (STD/RTI); ii) Obstetric care comprises of antenatal, intranatal and post natal care; iii) Laboratory services include routine tests for blood, urine and stool, sputum tests and pregnancy test; iv) minor surgery; and v) menstrual regulation. If patients are not treatable in the BHCs, they are referred to the government health facilities for further care.



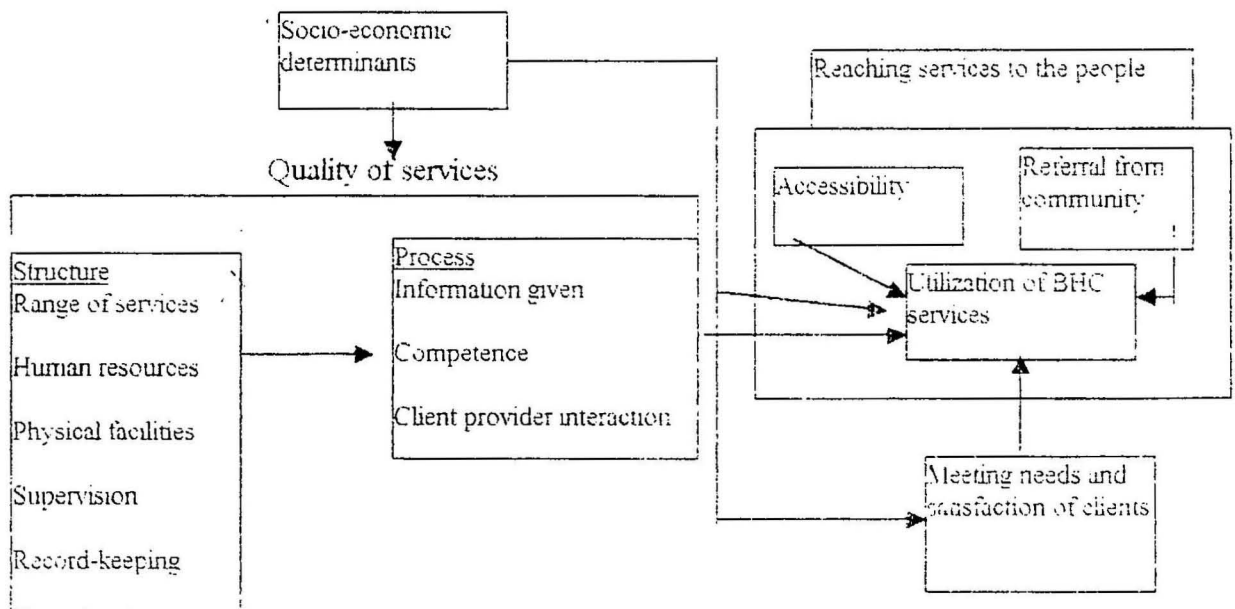
Medical and non-medical personnel are employed in BHCs with particular responsibilities. A medical officer (MO) is responsible for overall activities of a BHC. Two paramedics, one male and the other female assist the medical officers and also to treat patients. A 6-day paramedic training is being offered by the training unit of the Health and Population Division (HPD) of BRAC to enhance the capacity of the paramedics. One family welfare visitor (FWV), posted in each BHC is responsible for obstetric care and occasionally helps deliver the outpatient services. FWVs were experienced in pregnancy-related care, which was obtained during their nursing diploma nursing or FWV training provided by the GOB. The laboratory technician, employed in each laboratory has one-month training in certain pathological tests. Besides, a female attendant, selected from amongst the community health volunteers of BRAC, is posted in a BHC to look after the patients.

Supervision of BHC activities is carried out at the central and field level. At the field level, regional managers, sector specialists and medical officers are responsible for supervision. The management information system (MIS) and the quality assurance team continuously provide feedback to improve the quality of BHCs. In the community, BRAC staff and community health volunteers, particularly *shasthya shebikas* (SSs), carry out social mobilization and follow-up of the patients. The community health volunteers refer patients to the BHCs and receive little remuneration instead. The BHCs provide subsidized services to the members of BRAC's credit program and also to poor non-BRAC members. But well-off non-BRAC people receive services at a relatively higher price.

## CONCEPTUAL FRAMEWORK

In order to assess the quality of BHCs, a conceptual framework has been devised, primarily based on the Donabedian and Bruce's work on the quality of care, Norren and Vianen's malnutrition-infection and Chen and Mosley's child survival (13-16). Changes have accordingly been made in the framework to fit in the study objectives. In the graphic representation of the framework, it may not be possible to establish a direct relationship between variables in different boxes, but there remains some influence of one type of variables on the others.

Fig 1. Conceptual framework for the quality assessment of BHCs



The conceptual framework is based on three issues raised to fulfill the study objectives, which include whether the quality services being provided in the BHCs, and whether services reach the community and meet client satisfaction. Health facilities that

provide quality services and meet client satisfaction would ultimately influence utilization of the services. Utilization of services is also influenced by accessibility to BHCs, and referral of patients from the community. Further, socio-demographic variables affect utilization of services and client satisfaction.

Like many other studies, various approaches ranging from review of the program documents to client survey were used in the study to look into the issues of quality (17,18). Measurement of various elements of the framework has been summarized in the following table 1.

Table 1. Elements and indicators for the quality assessment of the BHCs

Elements	Indicators
<u>Socio-economic determinants</u>	
Age	Number of clients aged less or more than 30 years
Sex	Number of women and men clients attended the BHCs
Education	Number of clients had education or no education
Membership to BRAC	Number of clients had membership to BRAC or none
<u>Quality of services (Structure)</u>	
Range of services	Number of services offered to the BHCs
Human resources	Number of staff posted in each BHC Number of staff qualified for the position Number of training received by the BHC staff
Physical facilities	Location of BHCs Infrastructure of BHCs Availability of equipment, IEC materials, laboratory tests and emergency medical supplies
Supervision	Visits to BHCs by regional managers and sector-specialists in the preceding month Supervision by medical officers
Record-keeping	Maintenance of records and registers Consistency among registers and records

.....Continued

<u>Elements</u>	<u>Indicators</u>
<u>Quality of services (Process)</u>	
Information given	Percentages of patients given information on diseases and drugs
Competence	Prescribing pattern Client views about competence of BHC staff
Client provider interaction	Percentages of patients received greetings, friendly treatment, had two-way communication and maintained privacy
<u>Reaching service to community</u>	
<u>Utilization of BHC services</u>	
Patient attendance	Number of patients attended the BHCs
Continuity of care	Number of times patients attended the BHCs
Health care seeking pattern	Number of clients sought treatment from various sources
<u>Access</u>	Distance Travel time Service time Number of patients borne costs of BHCs Number patients aware of types of BHC services
Community role	Number of clients referred to the BHCs from various sources
<u>Meeting client's satisfaction and needs</u>	
Perceived health status	Number of patients perceived their health status
Client satisfaction	Number of patients satisfied with services Number of patients mentioned good/bad aspects of the BHCs Number of patients had suggestions to improve BHC services

## METHODS AND MATERIALS

### Sampling

The primary sampling unit for structural quality was the BHC, and for the process and outcome of service delivery was the client. The study was conducted in six BHCs, three from Mymensingh, one from Dinajpur and two from Bogra during April-May 1998. Six BHCs were purposively selected from among the 21 BHCs located in the RHDC program areas. The length of BHC establishment and level of performance (cost recovery and patient attendance) were considered for selection of the BHCs in order to have an equal distribution of background characteristics among the selected BHCs. From the six

Table 2. Selection of BHCs in RHDC areas according to its background characteristics\*

Selected BHCs	Age of BHCs	Patient attendance	Cost recovery
Boilor	>2 years	>300	>40%
Fashitala	<2 years	>300	>40%
Dublagari, Rangamati	>2 years	>300	<40%
Kashigonj	>2 years	<300	<40%
Chechua	<2 years	<300	<40%

\*Source: HPD, January 1997

BHCs, 131 clients were observed, primarily to assess the client-provider interactions. The 131 prescriptions were reviewed for assessing competence of the primary therapists. The sample were purposively selected from the patients complaining either of cough or abdominal pain and age ranged from 15-49 years with an equal distribution of sex. For the client survey, the sample size of 384 was calculated by assuming anticipated population proportion=50%, confidence interval=95%, level of significance  $P=0.05$  and  $s=0.10$ .

From the selected BHCs, 471 clients were randomly selected to effect the criteria of sample selection. Along with it, 12 FGDs were conducted among the clients and non-users to get their views about how to enhance the acceptability of the BHCs. Seven FGDs were conducted with the clients and five with the non-users.

#### **Data collection**

To measure the elements of the quality (table 1), different methods and sources of data collection were used to triangulate the information. Information was collected basically through following research methods:

- Observations of clinic conditions, and of client-provider interactions
- Structured interviews with clients
- Focus group discussions with clients and non-users
- Informal discussion with clients and non-users
- Reviews of records and registers
- Reviews of prescriptions

Observations of clinic conditions and reviews of programme records and registers were done. The investigators with the help of a medical practitioner reviewed prescriptions of all the observed patients to assess the technical competence of the primary therapists, either medical doctors or paramedics. The investigators also conducted FGDs with clients and non-users of BHCs and informally discussed with them. Trained field researchers interviewed clients to get their views about the BHC services and also observed client-provider interactions in the BHCs.

## Data analysis

Simple frequency tables were made to represent structural quality of the BHCs. Data on client survey and observation were analyzed by scoring and ranking different categories of variable. For some variable, simple 'yes' or 'no' response was considered, but for others, a composite variable was made, and then scored and ranked accordingly. For 'yes' response, a score of '2' and for 'no' response, a score of '1' was given. For example, to make a composite variable on 'satisfaction', three variables were added; it was considered 'good' when it scored six and, 'bad' when scored three, and 'fair' when scored four or five. Data on the competence of the health providers were judged by following BHC guidelines, paramedic's manuals and implicit judgements of the physicians. Relevant points were drawn from the FGDs to add more information and strengthen the findings.

## FINDINGS

### QUALITY OF SERVICES AT THE BHC

#### Range of services

Table 3 shows the extent of different services available in the observed BHCs. It was found that outpatient services were offered at all the BHCs. Maternity services for childbirth were presently available in 83% of the observed BHCs, but the previous study reported its availability in 22% of the BHCs (12). Although laboratory facilities are likely to be started in each BHC, only 50% of them were found equipped.

#### Human resources

##### *Staffing*

Table 4 presents the staffing pattern of all the BHCs and the extent to which the sanctioned posts were filled in. The sanctioned positions of each BHC were found to be occupied by the appropriate personnel except that of medical officers. Due to drop-out of the medical officers, their posts were vacant in two BHCs.

##### *Education*

The medical officers in the observed BHCs completed MBBS degree from the national medical colleges. Three of the six female paramedics had 14 years of schooling and the other three had 12 years. Of the six male paramedics, 2 had 14 years of schooling and the rest had 10-12 years. Eighty-three percent of the FWVs completed 10-12 years of schooling; one of them had special family welfare visitor-training<sup>1</sup> while the rest had

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<sup>1</sup>Family welfare visitor training is a 18-month midwifery course offered by the government institutions to develop skills to work in maternity care



diplomas in nursing<sup>2</sup>. All the three laboratory technicians completed 14 years of schooling.

Five of six female attendants had no formal education (table 5).

### *Training of the BHC staff*

Table 6 describes the extent to which the staff received training after starting work in the BHCs. Of the seven training mentioned, only 25% of the medical officers received training in clinic management and 50% in development management, TB and leprosy control management and counseling. None of them had training in clinical contraception and menstrual regulation. The number of training varied among the medical officers due to regular dropout and fresh recruitment, and also due to organization of training at a particular time, which may not be available to each of them. None of the doctors had ever received training in obstetric and gynecology either during their internship in the hospital or in BRAC.

The current paramedic training of the BHC was given to 67% of the male and all the female paramedics. The rest 33% of the male paramedics were trained in Sulla and Manikgonj health centers of BRAC a number of years ago. Besides, 67% of the male paramedics received training in TB and leprosy control management and 17% in counseling and development management. About 83% of the female paramedics were trained in pregnancy-related care and 50% in clinic management. Few of them had training in counseling (2), delivery case management (1), and menstrual regulation (1). Since most family welfare visitors were trained nurse, they were more likely to have knowledge about simple treatment. Besides, 33% of them had received training in pregnancy related care from BRAC and 33% in counseling. Each laboratory technician was trained in simple

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<sup>2</sup> Diploma in nursing is a 4-year course offered by the government recognized nursing institutions attached to a teaching hospital or a reputed hospital

pathological tests for blood, stool, and urine and sputum test for TB, and 67% of them in pregnancy test.

### **Physical facilities**

#### ***Location of the BHCs***

Location of the BHCs is presented in Table 7. All the BHCs were located near the main road and 83% were situated inside the bazaar. Some villages within the operating areas of the program were located 10 kilometers away from the BHC, which was also indicated by more than one-fifth of the clients (Table 35). During client survey, 42% of the patients indicated location of the BHCs as good and 25% as poor (Table 11). Sixty-seven percent of the BHCs were located more than six kilometers away from the Thana Health Complex and more than 16 kilometers away from the district/medical college hospitals. Having no supports for transport, such a distance causes problem particularly to emergency cases.

#### ***Infrastructure***

Infrastructure of the BHC buildings is summarized in Table 8. In the outpatient department of the observed BHCs, only waiting rooms were separately available, whereas consultation, registration, and counseling rooms were not. The survey results reveal that 54% of the patients were very much satisfied with the waiting place and 67% with the consultation room. Each BHC has its name written on the signboard with BRAC logo, and 62% of the clients clearly understood the signboard of BHCs (Table 10). Delivery rooms were separate but only one had attached toilet. Among the 12 sanctioned toilets of the BHCs, 83% were available; soap was found in 17% of the toilets. Of the 12 sanctioned dumping holes, 92% were available and functional. Although 87% of the BHCs were found to have

power supply, load shedding was a common problem in the BHCs due to inadequate power supply throughout the country.

*Equipment, Information, Education and Communication (IEC) materials and Laboratory tests*

All necessary equipment and IEC materials were available in the BHCs. Emergency medical supplies were found in the delivery room with oxygen and sterilizer. Unfortunately, nasogastric sucker was not seen in the delivery room. Pathological tests, such as routine blood, stool and urine were started in all the three laboratories and pregnancy tests in two (Table 9).

**Supervision**

Two of the four medical officers were found to have maintained monthly action plan for their activities. Besides, monthly action plan was maintained by 67% of the male paramedics, all the female paramedics and 33% of the family welfare visitors. The regional managers visited only 50% and the sector specialists 33% of the BHCs in the preceding month. The MOs were found to have supervised activities of the BHC staff through informal discussion (Table 11, 12).

**Record-keeping**

While checking consistency between patient registers and prescription notes, diagnosis of the diseases were found to be similar in 96% of the cases. Among the patients who have fulfilled the criteria for follow-up, only 58% were recorded in the registers. Of the patients who were recorded in the follow-up registers, about 82% were physically followed up at home. It has also been found that the number of patients recorded in the disease profile reports was found to exceed that in the monthly performance reports in 67% of cases

(Table 13, 14). Recording formats were not maintained in a like manner in all the observed laboratories.

### **Information given**

Any information related to complaints of the patients was considered as disease-related information regardless of its content. During observation of the consulting sessions, two-thirds of the patients were given disease-related information. Performance in providing disease-related information was better among the paramedics than the medical officers. It may have been due to that the paramedics were more caring to the patients whereas the medical officers still confined themselves to their own elitist mentality, not to expose much to the public. Rules of drug intake were discussed with 30% and side effects of drugs with 2.5% of the patients. Moreover, male and educated clients received more drug-related information than their counterparts in the consultation room. In client interviews, 30% of the respondents mentioned receiving disease-related information, 61% other information and 39% no information.

During drug dispensing, 90% of the patients were taught rules of drug intake with a little difference between performance of the family welfare visitors and paramedics. In survey, 77% of the clients were able to tell the rules of drug intake. Unfortunately, a very few patients were given information on side-effects of drugs both during consulting sessions and drug dispensing. The fact has also been revealed in client interviews where 99% of the patients stated that side-effects of drugs were not mentioned at the BHCs.

During observation, 10% of the clients were advised in the counseling room but not chosen on need basis. Health staff discussed few issues with the clients, particularly disease-related (16%), family planning (10%), hygiene (7%) and nutrition (6%). Half of

the BHC staff of recovering costs from drug sale. Likewise, ordering sputum tests for tuberculosis without following the program's criteria raised the same ethical concern.

Considering relationship with food intake, the primary therapists prescribed medicine appropriately in 17% of the clients; of them, the medical officers prescribed in 21% of the clients whereas the paramedics in 10% of the clients. Specific advice was given in 13% of the patients with a very little difference between the medical officers and the paramedics. Only 7% of the patients were specifically treated and the rest symptomatically. In client survey, treatment provided by the BHCs was considered good by 46% and fair by 40% of the clients (Table 21).

#### **Client-provider relationship**

Clients' interaction with different service providers has been summarized in Tables 22-32. While receiving the clients at the entrance of the BHCs, 96% of the clinic attendants were found to be friendly with the clients, and 87% also greeted them. Client-relationship with the paramedics and FWVs was very satisfactory as observed during registration. The paramedics did better than the medical officers during their consultations with the clients. All the paramedics were friendly with their clients during consultations whereas 88% of the medical officers showed friendly attitudes towards their clients. Likewise, 87% of the paramedics and 58% of the medical officers communicated with their clients during consultation sessions holding a difference of 30% between the two. Communication between clients and providers was not satisfactory during counseling sessions and drug dispensing. Gender differentials and preference to educated people were found during consultations with medical officers. In client survey, 67% of the clients considered their relationship with the primary therapists of the BHCs as good and 26% as fair. Besides,

the paramedics and the family welfare visitors used IEC materials during counseling sessions (Tables 15-18). In client interviews, 24% of the clients considered messages given in the BHCs as good (Table 21).

### **Competence**

Competence was primarily assessed by reviewing the prescribing pattern of the primary therapists of the BHCs, which were summarized in tables 19 and 20. It has been found that in writing prescriptions, duration of illness was mentioned by 35% of the primary therapists, of whom 26% were medical officers and 41% paramedics. Moreover, complaints related systemic examination was mentioned by one-fifth of the primary therapists in which paramedics performed better than medical officers. Moreover, 41% of the primary therapists specifically diagnosed the cases and 46% symptomatically. Among 41% of the specific diagnosis, the medical officers diagnosed 53% and the paramedics 34%. Laboratory tests were ordered by more than one-fourth of the primary therapists. Almost all the paramedics were found to have ordered sputum test for tuberculosis if the patient complained of cough, without following the ordering criteria of the programme.

Only 3% of the primary therapists followed the guideline of BHC while prescribing the medicine. In 50% of the clients, drugs were prescribed from the enlisted pharmaceutical companies. More than three-fourths of the clients received three to four medications for the disease. Besides, half of the clients received vitamin in which the medical officers prescribed for 30% and paramedics for 62% of the clients. It has also been observed that one patient received hormonal tablets for irregular menstruation. Prescribing three to four drugs per prescription and vitamins for a large number of patients raised not only a question of unethical prescribing pattern but also an unethical attempt of

relationship with the other BHC staff was considered to be good by 41% of the clients and fair by 58%.

## REACHING SERVICES TO THE COMMUNITY

### Utilization of BHC services

#### *Patient attendance*

Attendance of the clients at the BHCs is summarized in Table 33 and 34. Despite little overlapping of the months, an increasing trend in attendance was observed at the BHCs from 1996 to 1998. In 1996-1997, attendance per month was 359 whereas it was 550 in 1997-1998, which could be due to social promotion of BHC outpatient services, and organization of subcenters. More than 50% increase in BHC attendance in a year is inevitably optimistic for BHC's future. But in view of reaching BHC services to the community, it has been estimated that only 6% of ill persons in the operating areas of BRAC attended the BHCs in each month. Likewise, each month 27% of the ill VO members and 1% of the non-VO members were reached by the BHC services. Findings as such are perhaps despairing but essentially provide realities of the situation.

#### *Continuity of care*

The data on the continuity of care has been presented in Table 36. In client interview, the respondents mentioned the number of times they have attended the BHCs to get the treatment. About 61% of the patients attended the BHCs four or more times and 32% two to three times. Findings reveal that attendance of the same clients was much higher as opposed to that of the new clients. High continuity of care draws attention to two major dimensions. Firstly, client satisfaction relates to a better continuity of care, which is very

much positive. Secondly, the clients are perhaps not responding to the treatment provided by the health providers of the BHCs, which raise a serious concern of quality. Low attendance of new patients is attributable to low social promotion of BHCs.

### **Health care seeking pattern**

Among all the clients nearly half of them mentioned using only BHC services at present. Apart from it, one-fifth of the BHC clients also used health services from other formal health sectors. About 30% of the clients obtained health care from the informal health sectors. The findings reveal that more than half of the BHC clients used other health services along with BHC services. Analysis of the background characteristics shows that clients who were female, non-VO member, illiterate and ages more than 30 years used BHCs services more than their counterpart (table 37).

### **Accessibility**

#### ***Geographic access***

About two-thirds of the clients traveled a distance of more than 6 kilometers to reach the BHC (Table 38). The average distance of travel from BHC was found to be 8 kilometers. Moreover, the time needed to reach the BHC was averaged at 53 minutes (Table 39). In the FGDs, distance was identified as one of the major barriers to attend the BHC. The participants also looked forward to having doctors at their own localities and emphasized the fact that how easily they get access to village doctors. Typical comments were:

*Whenever you want, you get the village*

*doctor at your service. If BRAC could*

*provide services nearby, it will benefit us.*



### *Service time*

Table 40 summarizes the time spent in different service delivery points of the BHCs. It shows that of the 131 patients tracked, all were seen by the primary therapists; and on average, each patient spent 16 minutes with his or her physician. The least amount of time the patient spent was 5 minutes and the maximum was 40 minutes. The average amount of idle time spent by the patients was 14 minutes, with a minimum of 0 and a maximum of 90 minutes. The average length of time between the patient's arrival and first contact with a physician was 20 minutes, ranging from 0- 95 minutes. In a BHC, each patient spent an average of 47 minutes ranging from 20-140 minutes. Analysis of background characteristics reveal no age, sex and education differentiation in first contact to physician, idle, consultation and counseling time (Table 41).

In client survey, 84% of the patients considered waiting time and 99% considered consultation time as adequate (table 42). In the FGDs, the female clients explicitly stated that despite their other appointments or tasks they were mentally prepared to sacrifice time on the visiting day. One woman cited:

*There is no right or wrong time for waiting or consultation.*

*We have set our time and can spend the day for a good service.*

Men had no objection to time use of BHC services as opposed to the government health facilities that took long waiting hours, and were overcrowded.

### *Economic access*

During the survey, 95% of the clients mentioned that the service they received from BHC had good values for the cost that makes a comparable judgement with the cost of other health facilities (Table 43). About 92% of the clients bought medicine from the BHCs.

either fully or partially, and 81% bore the cost from their own resources. In the FGDs, the clients mentioned the importance of having more sophisticated services in the BHCs, such as x-ray facilities, and surgical, and inpatient services, which could save their money, and themselves from the hassles of going to a town.

### *Cognitive access*

In client interviews, the respondents were also found to be aware of different types of services offered at the BHCs (Table 44). About 99% of the clients knew about outpatient services, particularly treatment of common ailments; 55% mentioned about BHCs providing inpatient delivery care and 25% mentioned about laboratory facilities. Poor knowledge about the availability of delivery services indicates that social marketing of BHC services needs to be strengthened.

### *Referral of the patients from the community*

Review of program data for the previous three months shows that the community health volunteers referred 47% of the patients to the BHCs whereas BRAC staff sent 17% of the clients. However, during informal discussion, the SsS complained that BRAC staff refer their patient in order to show their involvement with the community. As a result, the community health volunteers get deprived of the incentives provided by the program. A very low proportion of patient-to-patient referral is suggestive of low social promotion of BHCs (Table 45).

## MEETING NEEDS AND SATISFACTION OF THE CLIENTS

### Perceived health status

Health status of the patient was measured by asking them about their feeling after having been treated by the BHCs (Table 46). About 53% of the patients said that they got completely well after the treatment and 36% felt better than before, however, 11% did not feel well. The variation in feeling could be due to chronicity of diseases and non-compliance with the treatment. Moreover, analysis of the background variable show that more female patients perceived their health status good than the male patients (Table 48).

### Client satisfaction

While the respondents were asked about their satisfaction with BHC services, 85% of them were found to be satisfied with it (Table 47). About 41% of the respondents ranked the quality of services as good and 48% as fair. Analysis of the background characteristics reveals that BHCs provided good quality services to male, educated and non-BRAC patients (Table 48).

Various reasons were mentioned by the clients in response to reasons for selecting BHCs. Due to motivation of shasthya shebikas, 47% of the clients selected BHCs for their treatment (Table 49). Availability of good health services was mentioned by 25% of the clients and BRAC staff's motivation by only 2% of the clients.

The respondents of the client survey also identified various good aspects of the BHCs: 53% of the clients mentioned good behavior of the staff, 32% low costs, and 25% good doctors offering services (Table 50). In the FGDs, each and every participant emphasized the good behavioral aspect of the BHC staff. They also mentioned that the

BHC staff clearly discussed the rules of drug intake, which is rarely done in other health care facilities.

In client survey, more than two-thirds of the patients were not able to tell the poor aspects of the BHCs (Table 51). However, 10% of the clients complained of joint sitting arrangement of both sex and 16% of poor physical facilities of the BHCs, such as lack of drinking water, poor toilet facilities, etc. Interestingly, in the focus group discussions, most of the participants identified the payment of user fees and medicine costs all at a time as a major problem. They also complained of paying service charge for each visit. The participants criticized the inability of the BHCs to handle complicated cases. A few of the clients complained of not admitting a delivery case to the BHC due to inadequate facilities. Lack of surgical facilities and inpatient services in the BHC was also identified as one of the poor aspects of the BHC. They argued:

*"If complicated cases cannot be handled in a BHC, then what is the point of going to the BHC? Because simple cases can be managed by the village doctors."*

*"BRAC's sisters spent so much time in motivating my relative to have her delivery in the center, but when she is in labor they refuse to treat her because they cannot handle such cases"*

Management of the difficult cases should have been a priority at the BHCs, otherwise why would people be motivated to move out of their own home?

### **Suggestions to enhance acceptability of BHC services**

Several suggestions came up in the client survey and focus group discussions for enhancing the quality of BHC services and patient attendance. In client survey, 52% of the clients emphasized the need of x-ray facilities and 24% of surgical facilities in the BHCs (Table 52). The need for eye treatment was particularly mentioned by 12% of the clients. During FGDs, the clients also demanded the availability of laboratory and indoor facilities in the BHCs. Moreover, the participants expressed their concern for payment system of BHCs. They specifically mentioned the generosity of the village doctors and the pharmacists for not taking service charges, and for selling medicine on credit. They made it clear that BRAC should start credit system for the poor people to pay off the expenses of BHC.

## **DISCUSSION**

In order to improve the quality of the BHCs the study looked into the extent to which the quality services offered at the BHCs, and the extent to which BHC services reached the community, and met client needs and satisfaction.

### **Quality of service**

A substantial improvement of the BHCs, particularly in the extent of service provision, record-keeping, availability of equipment and emergency medical supplies and waste disposal has been observed. Such an improvement in BHC performance could be attributed to increasing knowledge and skills of program personnel. Nevertheless, poor quality has still been evident in training and supervision. The number of training received by the staff was slightly increased than earlier, yet the remaining gaps need to be addressed. Due to regular doctor's turn over, the expected level of training among them has yet to

achieve. However, issues related to regular doctor's dropout must also be explored. Unfortunately, the present level of supervision by the mid-level managers at the field was deteriorated, probably due to their increasing central involvement. To provide further input to quality improvement of BHC, the present supervision system can be strengthened by creating self-supervision system<sup>3</sup> and by supervising activities of each other within the BHC.

Although structural elements are crucial to improve the quality of care, the strengths of ensuring quality in fact lies on technical competence and client-provider relationship. By and large client-provider interactions seem to be satisfactory in the BHC's, which was confirmed by triangulating information obtained from center observation, client survey and FGDs. However, true but unfortunate is poor interaction of medical officers with their patients, which is reflective of elitist mentality of modern biomedicine. Shifts in gaze from the patient, as a whole to disease only is one of the critiques of modern biomedicine. Evident male and education bias raises questions about the role of patriarchy. Patriarchy is so much ingrained in the roots of the society that even with BRAC's advocacy against gender and class discrimination and the awareness program on the related issues could not make a visible change in reality. Nevertheless, the program should emphasize on the importance of improving patient-provider interaction as well as looking at biomedicine from humanist perspectives.

Lack of quality was quite evident in technical competence of the health providers. Performance was not at all satisfactory in writing patient's history, complaints-related physical examinations and specific diagnosis of diseases in the prescriptions. Although the

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<sup>3</sup> In self-supervision, one can evaluate oneself by assessing the gap between "what is to be achieved" and "what has been achieved" and the factors contributing to create such gap.

medical officers performed better in making specific diagnosis than the paramedics, unfortunately their performance was rather bad in writing patient's history and examinations. Health providers deviated from following the protocols and the enlisted pharmaceutical companies in prescribing drugs is an area of concern, which need effective supervision. Moreover, over-prescription of drugs raised not only a question of unethical prescribing pattern but also an unethical attempt of the BHC staff of recovering costs from drug sale. Likewise, ordering sputum tests for tuberculosis without following program's criteria raised the same ethical concern. To improve technical competence of BHC staff, certain essential changes should be considered, such as use of clinical practice guidelines with algorithms and protocols for diagnosis and treatment of diseases, continuous effective supervision and feedback, and continuing education. Rewards and penalties could also be considered in accordance with the performance of staff.

Still remarkable in the BHCs was the dissemination of information on the rules of drug intake, which was also highly commended by the clients. However, low dissemination of information regarding disease itself and side-effects of drugs has been an indication of poor competence. Furthermore, poor performance has also been observed during counseling sessions. Now, the question may be raised, whether the health providers are doing so out of ignorance or on purpose, which needs to be explored. More importantly, concerning medical ethics, BRAC must seriously consider issues of informing patients, particularly about their disease and side-effects of drugs.

### **Reaching services to the community and meeting client needs and satisfaction**

Along with the strengths and weaknesses of BHC services, the increasing trend of patient attendance and continuity of care draws attention to an optimistic future of the BHCs. Even with the optimistic trend, the undesirable scenario is that only 6% of the ill persons in the operating areas were reached by BHC services and so were 26% of the VO members and a very negligible number of new clients. A high percentage of ill persons seeking health care from the informal health sectors do not mean that people were not much aware of what should be done. Authoritarian knowledge indeed plays a crucial role in human being's decision making power in seeking health care. In-depth studies should be considered in this regard. Social promotion of BHC services in the rural community should be emphasized to address the non-reached population and the regular clients as well. Furthermore, role of clients and community health volunteers in social promotion of BHC services is also crucial to social marketing of the BHCs. In this connection, incentives of the health volunteers must be ensured.

The reason people refrain from BHCs could be due to their diverse expectations from the BHCs. The perception among the community is that BRAC should provide services in supermarket approach, that is, goods are available under one umbrella. The needs that clients express to increase the acceptability of BHC services may not always be feasible, but with little more efforts, some requirements may be addressed. According to WHO, 90% of the radiological needs can be fulfilled by providing simple X-ray services at local health facilities. Providing basic radiological services at the BHC not only promote rapid diagnosis and better monitoring but also reduce costs for referral to larger, specialized hospitals. Meeting demands of the patients by increasing availability of service facilities



would further encourage patients to attend the BHCs. More importantly, to reach service to the community, partnership with the government (GO) must be emphasized, especially with regard to referral of the patients to a specialized care.

Despite clients' views that BHC services are relatively of low costs (indicated by an expenditures of Tk. 137.00 per patient in BHC which was far more lower than the expenditures of Tk. 430.00 per patient in rural government facilities), in the FGDs women voiced their concern about the costs (1, 19). Moreover, cost was of low priority among men. Gender relations in cost prioritization is indeed suggestive of economic inequality between women and men in the society. Nevertheless, one must think over as to how to meet patient's demands of launching a credit system for paying off expenses of BHCs. Hence, to address issues of health equity, health insurance system can only be experimented for the members of BRAC at the start, and based on the results, it may gradually be extended to reach the rest of the population. However, an alternative payment system for the hard core poor should also be explored.

Client's access to BHCs is likely to be constrained by geographical access. Although organization of subcenters at the village level may not be feasible in terms of costs and manpower, community needs can not always be measured in terms of costs. However, in the light of client demand, at least for treating common ailments a simplistic method of health service delivery can be arranged at the village level with the paramedics during their community visit. Use of community health workers' potential is also crucial to reach BHC services to the community. Furthermore, in future local health professionals can be integrated to community service delivery of BHCs after having additional training where necessary.

In rural areas clients are very much satisfied with the time spent in receiving BHC services due to their presupposed notions that health centers always consume long hours. The amount of time spent in different service delivery points of the BHCs depends on the clinic volumes, patient complexity and negligence of the health providers. The average time of 16 minutes spent in consultation sessions of BHC was adequate enough for a fair check-up of a patient. Yet the time spent in first contact to physicians was more than that in consultations. It, therefore, raises a question that despite low client flow at the BHCs, why it was so? It could be because the BHC staff were not careful to attend the patient on time. If it is so, the health providers should seriously consider such issues to minimize time wastage not only for them but also for their patients.

Along with the dynamism of the program, some flaws have been revealed in the study. However, a drastic change is not likely to be expected in the activities of BHCs at this hour. Although the findings reveal some realities of the BHCs, it should not be taken as conclusive. Initiatives of curative care with the involvement of health professionals in static facilities are fairly new in BRAC. Health providers of the BHCs have yet to be ready to adapt themselves to the new philosophy of BRAC. Unlike other medical system, the approach to reach people for health care is also very much challenging. To reach the community and meet client needs, quality of health care should not only be looked from the biomedical perspectives but cultural and gender-sensitivity of health care must also be considered.

## PROGRAM IMPLICATIONS

Despite increased attendance of the patients, high client satisfaction and increased continuity of care at the BHCs, some issues need to be highlighted in order to improve the quality of the BHCs and to reach services to the community and meet client needs. Some suggestions are made in the light of the study findings:

### **Increasing quality of services offered at the BHCs**

#### *Competence of the health providers*

- i) The program should address the importance of using clinical practice guidelines with algorithms and protocols for the diagnosis and treatment of diseases to improve the prescribing pattern of the BHC staff.
- ii) Continuous supervision and effective feedback must be ensured.
- iii) Continuing education program and training are important for improving competence of the BHC staff.
- iv) Provision for rewards and penalties can be considered in accordance with the performance of the health providers: and
- v) Reasons for doctor's drop-out should be explored.

#### *Client-provider relationship*

- i) Communicating strategies need to be improved among the BHC staffs, particularly medical officers; and
- ii) Staff bias towards gender and social class, especially among medical officers should be explored.

- i) Concerning medical ethics, patients should be informed of their disease, and side-effects of the drugs during consultation sessions; and
- ii) Attention should be given to proper organization of counselling sessions to meet client's needs

#### Reaching services to the community and meeting clients' needs

- i) Social promotion of BHCs needs to be strengthened to inform the community about the available service facilities;
- ii) Facilities, such as X-ray, minor surgery and inpatient services including management of complicated delivery cases should be available to fulfill clients' needs;
- iii) Health insurance initiatives should be experimented soon at the BHC to address issues of equity;
- iv) Clients spending time in different service delivery points of the BHCs should be considered for the proper utilization of time;
- v) Provision of simple treatment at the village level should be considered, particularly for the remote villages; and
- vi) Incentives of the community health workers should be emphasized.

#### ACKNOWLEDGMENTS

We would like to acknowledge our gratitude to the BHC staff of the RHDC program for their cooperation in executing our fieldwork. Thoughtful comments of Dr. Sadia A. Chowdhury, Director Health and Population Division (HPD), BRAC is acknowledged. We would like to thank Dr. Mursheed Chowdhury, consultant to HPD for his great help in data

analysis. Special thanks are due to field research team for their active participation in data collection. The editorial help of Mr. Hasan Shareef Ahmed, Chief of Editing and Publications of Research and Evaluation Division, BRAC is gratefully acknowledged.

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## APPENDIX

### I. Quality of services

Table 3. Services offered at the BHCs

Type of services	No. of BHCs	Sanctioned	Available (%)
Outpatient	6	6	100.0
Delivery	6	6	83.3
Laboratory	6	6	50.0
Minor surgery	6	6	50.0
Menstrual regulation	6	6	33.3
STD/RTI treatment	6	6	100.0

Table 4. Staffing of the BHCs

No. of personnel	No. of BHCs	Sanctioned	Posted (%)
Medical Officer	6	6	66.7
Paramedics male	6	6	100.0
Paramedics female	6	6	100.0
FWV	6	6	100.0
Lab technician	3	3	100.0
Female attendant	6	6	100.0



Table 5. Distribution of BHC staff by education

Personnel by qualification	Distribution of BHC staff (%)
Medical Doctors (4)	
MBBS	100.0
Male paramedic (6)	
14 years schooling	33.3
10-12 years schooling	66.7
Female paramedic (6)	
14 years schooling	50.0
10-12 years schooling	50.0
Family welfare visitor (6)	
14 years schooling	16.7
10-12 years schooling	83.3
Diploma in nursing	83.3
Diploma in FWV training	16.7
Lab technician (3)	
14 years schooling	100.0
10-12 years schooling	0.0
Female attendant (6)	
No formal education	83.3
Primary	16.7

\*14 year schooling : BA/BSc; 12 year schooling : HSC; 10 year schooling: SSC

Table 6. Distribution of BHC staff by training

Training	Distribution of BHC staff (%)
Medical officer (4)	
-Clinic management	25.0
-Development management	50.0
-Clinical contraception	0.0
-Menstrual regulation	0.0
-Counseling	50.0
-ARI management	75.0
-TB and leprosy control management	50.0
Paramedic Male (6)	
-Paramedic training	66.7
-TB and leprosy control management	66.7
-Development management	16.7
-Counseling	16.7
Paramedic female (6)	
- Paramedic training	100.0
-Pregnancy-related care	33.3
-Delivery case management	16.7
-Menstrual regulation	16.7
-ARI management	16.7
-Clinical contraception	16.7
-Counseling	33.3
-Clinic management	50.0
Family welfare visitor (6)	
-Pregnancy related care	33.3
-Counseling	33.3
Lab technician (3)	
-Pathological tests techniques	100.0
-TB tests/techniques	100.0
-Pregnancy tests	66.7

Table 7. Location of the BHCs

Distance from BHCs	No. of BHCs (%) N=6
Close to paved road	100.0
THC	
≥ 6 km	66.7
< 6 km	16.7
FWC	
≥ 2 km	33.3
< 2 km	66.7
RD	
≥ 2 km	50.0
< 2 km	50.0
District hospital/Medical college hospital	
≥ 16 km	66.7
< 16 km	33.3
Bazaar	
Within	37.3
> 1 km	16.7
Village	
≥ 10 km	100.0

Table 8. Infrastructure of BHC buildings

Infrastructure	No. of BHCs (%)
Consultation room	
-Sanctioned	6
-Available	100.0
-Separately available	87.3
Registration/dispensing room	
-Sanctioned	6
-Available	100.0
-Separately available	87.3
Waiting room	
-Sanctioned	6
-Available	100.0
-Separately available	100.0
Counseling room	
-Sanctioned	6
-Available	100.0
-Separately available	50.0
Laboratory	
-Sanctioned	3
-Available	50.0
-Separately available	50.0
Delivery room	
-Sanctioned	5
-Available	100.0
-Separately available	100.0
-Screened windows with net	100.0
-Attached toilet	20.0
Toilets	
-Sanctioned	12
-Available	83.3
-Soap available	16.7
Dumping hole for waste disposal	
-Sanctioned	12
-Available	91.7
-Functional	91.7
Power supply	
-Sanctioned	6
-Available	87.3

Table 9. Equipment, IEC materials and laboratory tests available in the BHCs

Equipment	No. of BHCs (%)
Out-patient department (6)	
-BP machine	100.0
-Thermometer	100.0
-Aural speculum	100.0
-Tongue depressor	100.0
-Torch light	100.0
-IEC materials	100.0
Delivery room (5)	
-Sterilizer	100.0
-Oxygen	100.0
-Nasogastric sucker	100.0
-Emergency medical supplies	100.0
Laboratory (3)	
-Sputum for AFB	100.0
-Blood for Hb, TC, DC and ESR	100.0
-Urine and stool for RME	100.0
-Pregnancy test	66.7

Table 10. Clients' views about location of BHCs and the building

	Distribution of clients (%) N=471		
	Good	Fair	Poor
Location of BHCs	42.9	32.1	25.0
Comfort in waiting place	54.4	43.5	2.1
Comfort in consultation room	66.5	32.9	0.6
Clarity of BHC sign	61.6	24.4	14.0

Table 11. Availability of action plan among the BHC staff

	Distribution of BHC staff (%)
Action plan available in the observed month	
-Medical officer (4)	50.0
-Paramedic male (6)	66.7
-Paramedic female (6)	100.0
-FWV (6)	33.3

Table 12. Supervision of the BHCs

	No. of BHCs (%) N=6
Supervision by RM	
-Visit in last 1 month	50.0
-Discussion with BHC staff	50.0
Supervision by sector specialist	
-Visit in last 1 month	33.3
-Discussion with BHC staff	33.3
Supervision of staff by Mos	
-Discussion with BHC staff	100.0

Table 13. Maintenance of record-keeping system

	No. of cases observed	Similar (%)
Consistency in diagnosis between registers and prescriptions	180	95.6 (172)
Patients recorded in the follow-up registers	180	57.8 (104)
Home visits to patients recorded in the follow-up registers	104	31.7 (35)

Table 14. Maintenance of record-keeping system

	No. of BHCs	(%)
Number of patients in disease profile exceed that of monthly performance report (MPR)	6	66.7 (4)
Number of patients similar in the disease profile and monthly performance report (MPR)	6	33.3 (2)

Table 15. Information given in consultation room (n=131)

Information	Medical officer (%) N=57	Paramedics (%) N=74	Total N=98
Information of disease	61.4	74.3	67.9
Rules of drug-intake	36.5	22.8	30.0
Side-effects of drugs	1.4	3.5	2.5

Table 16. Information given in drug dispensing room (n=125)

Information	FWV (%) N=56	Paramedics (%) N=61	Others (%) N=9	Total (%) N=125
Rules of drug intake	92.9	88.5	87.5	89.6
Side-effects of drugs	1.8	8.2	0.0	3.3

Table 17. Issues discussed in counseling room

	Distribution of patients (%) N=48
<u>Issues discussed</u>	
Disease-related	16.0
Family Planning	9.9
Hygiene	6.9
Nutrition	6.1
Pregnancy related care	1.5
Use of IEC materials	50.0

Table 18. Information given on diseases, rules of drug intake and side effects of drugs

	Distribution of clients (°o) N=471
<u>Information on disease</u>	
Disease-related information	29.9
Other information	60.7
None	38.6
<u>Rules of drug intake</u>	
Correct	77.3
Not correct	22.7
<u>Information on side-effects of drugs</u>	
Information provided	1.1
Not provided	98.9

Table 19. Competence of the primary therapists

	Medical officer N=38	Paramedics N=64	Total N=102
<u>Duration of illness</u>			
Mentioned	26.3	40.6	35.3
Not	73.7	59.4	64.7
<u>Complaints related systemic examination</u>			
Mentioned	10.5	26.6	20.6
Not	89.5	73.4	79.4
<u>Diagnosis</u>			
Specific	52.6	34.4	41.1
Symptomatic	47.4	45.3	46.1
None	0.0	20.3	12.7
<u>Lab tests</u>			
1	7.9	31.3	23.7
2	7.9	0.0	2.0
3	5.3	0.0	2.0
None	78.9	68.8	72.3



Table 20. Competence of the primary therapists

	Medical officers N=38	Paramedics N=63	Total N=101
<u>Guideline</u>			
Followed	2.6	3.2	3.0
Not	97.4	96.8	97.0
<u>Drugs from enlisted company</u>			
Followed	28.8	42.9	37.6
Not	76.2	57.1	62.4
<u>Medications</u>			
1	2.6	4.6	4.0
2	15.8	19.0	17.8
3	52.6	40.0	44.6
4	30.0	36.4	33.6
<u>Additional medicine</u>			
Vitamin	30.0	62.0	49.5
Iron	5.3	4.8	5.0
Hormonal preparation	0.0	1.6	1.0
None	65.8	30.0	43.5
<u>Relation with food intake</u>			
Appropriate	21.1	9.5	16.8
Not appropriate	71.1	73.0	72.2
Not applicable	7.8	12.5	11.0
<u>Advice</u>			
Specific	10.6	14.3	12.9
Non-specific	44.7	52.4	49.5
None	44.7	33.3	37.6
<u>Treatment</u>			
Specific	7.9	6.3	6.9
Symptomatic	92.1	93.7	93.1

Table 21. Client views about competence of primary therapists

	Distribution of clients (%) N=471		
	Good	Fair	Bad
<u>Primary Therapists</u>			
Treatment solving problems	45.9	39.9	14.2
Transparency of messages	23.8	36.5	39.7

Table 22. Client-TBAs interaction in waiting room

Client-TBAs interaction	TBAs (%) N=90	FWV (%) N=2	Total N=92
Greetings	86.7	100.0	93.4
Friendliness	95.6	100.0	97.8

Table 23. Client-provider interaction in registration room

Client-provider interaction	FWV (%) n=39	Paramedics (%) n=57	Others (%) n=6	Total (%) N=102
Greetings	100.0	94.7	100.0	98.2
Friendliness	100.0	100.0	100.0	100.0
Communication	84.6	94.7	100.0	93.1
Privacy	87.2	87.7	90.9	88.6

Table 24. Client-provider interaction in counseling room

Client-provider interaction	Paramedics (%)	FWVs (%)	Total (%)
	N=18	N=30	N=48
Greetings	96.7	94.4	95.6
Friendliness	100.0	100.0	100.0
Communication	53.3	72.2	62.8
Privacy	100.0	94.4	97.2

Table 25. Client-provider interaction in consultation room

Client-provider interaction	Medical officer (%)	Paramedics (%)	Total
	N=57	N=74	N=131
Greetings	73.7	75.7	74.8
Friendliness	87.7	100.0	94.7
Communication	57.9	86.5	74.0
Privacy	94.7	95.9	95.4

Table 26. Client-provider interaction in drug dispensing room

Client-provider interaction	FWV (%)	Paramedics (%)	Others (%)	Total (%)
	N=56	N=61	N=8	N=125
Friendliness	98.2	98.4	100.0	98.9
Communication	57.1	65.6	62.5	61.7
Privacy	89.3	90.2	75.0	84.8

Table 27. Client-TB.As interaction with background characteristics of the clients (n=92)

Patients' background	Greetings (%)	Friendliness (%)
Sex		
Male	86.4	95.5
Female	87.0	95.7
Age in years		
<30	88.5	92.3
>30	85.9	96.9
Education		
No education	83.3	96.7
Had education	93.3	93.3

Table 28. Client-Paramedics interaction during consultation sessions with background characteristics of the clients (n=74)

Patients' background	Greetings (%)	Friendliness (%)	Communication (%)	Privacy (%)	Information of disease (%)	Rules of drug intake (%)
Sex						
Male	82.4	100.0	85.3	94.1	76.5	38.2
Female	70.0	100.0	87.5	97.5	72.5	35.0
Age in years						
<30	76.0	100.0	84.0	96.0	76.0	36.0
>30	75.0	100.0	87.8	95.9	73.5	36.7
Education						
None	71.2	100.0	82.7	94.2	76.9	40.4
Had edu	86.4	100.0	95.5	100.0	68.2	27.3

Table 29. Client-MOs interaction during consultation sessions with background characteristics of the clients (n=57)

Patients' background	Greetings (%)	Friendliness (%)	Communication (%)	Privacy (%)	Information of disease (%)	Rules of drug intake (%)
<b>Sex</b>						
Male	75.9	89.7	65.5	100.0	62.1	27.6
Female	71.4	85.7	50.0	89.3	60.7	17.9
<b>Age in years</b>						
<30	87.5	93.8	56.3	87.5	56.3	31.3
>30	68.3	85.4	58.5	97.6	63.4	19.5
<b>Education</b>						
None	71.1	89.5	50.0	92.1	60.5	23.7
Had edu	78.9	84.2	73.7	100.0	63.2	21.1

Table 30. Client-paramedics interaction during drug dispensing with background characteristics of the clients (n=69)

Patients' background	Communication (%)	Rules of drug intake (%)	Side-effects of drugs (%)
<b>Sex</b>			
Male	71.4	85.7	10.7
Female	60.6	90.9	6.1
<b>Age in years</b>			
<30	52.9	88.2	11.8
>30	70.5	88.6	6.8
<b>Education</b>			
No education	69.0	87.8	8.2
Had education	50.0	91.7	8.3

Table 31. Client-FWVs interaction during drug dispensing with background characteristics of the clients (n=56)

Patients' background	Communication (%)	Rules of drug intake (%)	Side-effects of drugs (%)
Sex			
Male	77.8	92.6	3.7
Female	37.9	93.1	0.0
Age in years			
<30	66.7	85.7	0.0
>30	51.4	97.1	2.9
Education			
No education	56.8	91.9	2.7
Had education	57.9	94.7	0.0

Table 32. Client views about relationship with primary therapists and BHC staff

	Distribution of clients (%) N=471		
	Good	Fair	Bad
<u>Primary Therapists</u>			
Friendliness	67.3	26.3	6.4
Privacy	75.4	22.1	2.5
<u>BHC staff</u>			
Friendliness	41.4	57.8	0.8

## II. Reaching BHC services to the community

Table 33. Attendance of the patients at the BHCs by their membership to BRAC

Year	No. of BHCs	Attendance of the patients			
		Total	Average per month	VO members (%)	NVO members (%)
1996-97 (Sept-Aug)	9	38,785	359	73.0	26.1
1997-98 (Apr-Mar)	6	39,617	550	30.0	20.0

Table 34. Estimated morbidity and utilization of BHCs and other health sectors

	Population per area	*Estimated morbidity	Actual use of BHCs per month	Actual use of other health sectors
Total	1,50,000	10,020	550 (5.5)	9470 (94.5)
VO	25,000	1670	440 (26.3)	1230 (73.7)
NVO	125000	8350	110 (1.3)	8240 (98.7)

\*Calculated from the national statistics of morbidity estimated at 166.7 per 1000 population with a reference period of 14 days to 90 days, i.e., 75 days. As BHC use was calculated on a monthly basis, therefore, morbidity in a month was estimated at 66.8 per 1,000 population

Table 35. Comparison of estimated use of formal and informal health sectors and actual use of BHCs and other health sectors

Population	*Estimated use of formal health sector	*Estimated use of informal health sector	Actual use of BHCs	Actual use of other health sector
Total	2505	7515	550	9470
VO	418	1253	440	1230
NVO	2088	6262	440	8240

\*Estimated from the national statistics of use of formal (25%) and informal health sectors (75%) by sick persons

Table 36. Number of times clients attended the BHCs

No. of times	Distribution of clients (%)
	N=471
1	7.9
2-3	31.6
4-	60.5

Table 37. Health care seeking pattern of the clients by their background characteristics

	Distribution of respondents (%)			
	BHCs N=228	Formal health sector N=101	Informal health sector N=142	Total N=471
Sex				
Male	44.3	47.5	51.4	47.1
Female	55.7	52.5	48.6	52.9
Membership				
VO	42.5	35.6	45.1	41.8
NVO	57.5	64.4	54.9	58.2
Education				
Literate	40.4	40.6	35.2	38.9
None	59.6	59.4	64.8	61.1
Age in years				
<30	33.8	32.7	35.9	34.2
≥30	66.2	67.3	64.1	65.8
Total	48.4	21.4	30.1	100.0

Table 38. Distribution of the clients by their distance from BHCs

Distance (kilometer)	Distribution of clients N=471
1-5 (%)	35.9
6-10 (%)	42.7
>10 (%)	21.4
Mean	8.0

Table 39. Distribution of the clients by the time needed to reach BHCs

Time (min)	Distribution of clients N=471
≤30 (%)	35.5
30-60 (%)	42.9
>60 (%)	21.6
Mean	33.9



Table 40. Time spent in different service delivery points of the BHCs (n=131)

	Number of patients	Percent	Time spent (min)				Total
			Average	Median	Minimum	Maximum	
Consultation	131	100.0	16	15	5	40	2093
Registration	107	81.7	6	5	1	15	594
Medicine dispense	125	95.4	10	9	4	30	1307
Counseling	48	36.6	9	9	2	36	427
First contact to physician	131	100.0	20	15	0	95	2624
*Idle time	131	100.0	14	8	0	90	1811
Total service time	131	100.0	47	41	20	140	6212

\*Waiting for service

Table 41. Time spent in BHCs with background characteristics of the clients

Patients' background	First contact to physicians (min) N=131	Idle time (min) N=131	Consultation time (min) N=131	Counseling time (min) N=48
<u>Sex</u>				
Male	15.0	8.0	16.9	8.2
Female	15.0	10.0	15.1	9.3
<u>Age in years</u>				
<30	13.0	5.0	15.9	9.4
≥30	15.0	10.0	16.0	8.6
<u>Education</u>				
No education	15.0	8.0	16.9	8.2
Had education	16.0	10.0	15.1	9.3

Table 42. Clients' views about time spent in the BHCs

	Distribution of clients (%) N=471	
	Just	Not just
Waiting time	84.1	15.9
Consultation time	98.8	1.2

Table 43. Client views about cost

	Distribution of clients (%) N=471
Good value for the cost	94.5
Medicine bought	91.7
Cash spent from own resources	81.1

Table 44. Clients' knowledge about availability of services at the BHCs

Services	Distribution of clients (%) N=471
Treatment of common ailments	98.9
Treatment of TB	93.8
Delivery	55.0
Antenatal care	36.5
Family planning	30.1
Laboratory facilities	24.6
Menstrual regulation	8.3
Others	14.6

Table 45. Role of the community in patient referral to the BHCs

	Distribution of patients (%) N=4028
BRAC staff	16.6
Community health volunteers	47.0
Patient to patient	2.4
Self	18.2
Not mentioned	15.8

### III. Meeting needs and satisfaction of the clients

Table 46. Perceived health status after taking treatment

Perceived health status	Distribution of clients (%) N=471
Feeling well	52.7
Feeling better than before	36.3
Not well	11.0

Table 47. Satisfaction with services

Services	Distribution of clients (%) N=471		
	Good	Fair	Bad
Service quality of BHCs	40.8	48.4	10.8
Satisfaction with services	84.9	12.7	2.3

Table 48. Perceived health status, satisfaction with service and quality of service with background characteristics of the clients\*

Patients' background	Perceived health status	Satisfaction with service	Quality of service
	N=248	N=300	N=192
<u>Sex</u>			
Male	43.2	87.8	46.4
Female	61.0	82.3	35.7
<u>Age in years</u>			
<30	56.5	85.1	43.5
>30	50.6	84.8	39.4
<u>Education</u>			
No education	51.2	83.0	37.4
Had education	54.3	87.9	46.2
<u>Membership</u>			
BRAC	51.8	83.8	36.5
Non-BRAC	53.3	85.8	43.8

\* Clients who ranked perceived health status, satisfaction with service and quality of service as good

Table 49. Reasons for selecting BHCs

Reasons	Distribution of clients (%)
	N=471
Shasthya Shebikas' motivation	47.1
Availability of good health services	24.6
Neighbors' recommendation	11.9
Low cost	8.5
Family members' recommendation	3.0
VO members' motivation	3.0
BRAC staff's motivation	2.1
Close to home	4.0

\* Multiple responses considered

Table 50. Clients' views about good aspects of BHCs

Good aspects	Distribution of clients (%) N=471
Good behavior of the staff	52.7
Good physicians	24.8
Low cost	32.3
Cleanliness	23.4
Good treatment available	17.8
Sitting arrangement good	14.2
Good medicine available	11.0
Good atmosphere	10.2
Disciplined	7.6
Household visit	8.7

\* Multiple responses considered

Table 51. Clients' view about poor aspects of BHCs

Poor aspects	Distribution of clients (%) N=471
Don't know	68.4
Poor physical facilities	15.5
Joint sitting arrangement of both sex	10.4
Lack of surgical/indoor facilities	2.8
Lack of lab facilities	3.6
Can't buy medicine in credit	0.8

\* Multiple responses considered

Table 52. Clients' suggestions to provide more service in the BHCs to enhance patient attendance

	Distribution of clients (%) N=471
X-ray/ultrasonogram	51.6
Surgical facilities	23.6
Lab facilities	14.2
Eye treatment	12.1
Indoor service	5.5
ECG	3.8

\* Multiple responses considered

## জনসাধারণের মাঝে সুস্বাস্থ্যের মানসম্মত সেবা প্রদান : একটি সমীক্ষা

কাওসার আফসানা ও শাহ নূর মাহমুদ

জনসাধারণের স্বাস্থ্য উন্নয়নের লক্ষ্যে ব্র্যাক বাংলাদেশের উত্তর ও মধ্যবর্তী অঞ্চলে প্রজনন স্বাস্থ্য ও রোগ নিয়ন্ত্রণ কর্মসূচি শুরু করেছে। বিভিন্ন ধরনের কর্মকাণ্ডের মধ্যে ব্র্যাক স্বাস্থ্যকেন্দ্র বা সুস্বাস্থ্য উল্লেখযোগ্য। সুস্বাস্থ্যের মাধ্যমে ব্র্যাক জনগণের মধ্যে প্রাথমিক ও মধ্য পর্যায়ে স্বাস্থ্য সেবা প্রদানের উদ্যোগ নিয়েছে। এই গবেষণার উদ্দেশ্য ছিল সুস্বাস্থ্য কতটুকু গুণগত সেবা জনগণকে দিতে পেরেছে, কোন কোন সেবাগুলি জনগণের চাহিদা ও সন্তুষ্টি পূরণ করতে সক্ষম হয়েছে ইত্যাদি। স্বাস্থ্যকেন্দ্রের কার্যকাল, মূল্য উসূল এবং রোগীর উপস্থিতির হারকে বিবেচনা করে সর্বমোট ২১টি সুস্বাস্থ্যের মধ্য থেকে ৬টি সুস্বাস্থ্যকে গবেষণার জন্যে নির্বাচন করা হয়। ১৯৯৮ সালের এপ্রিল-মে সময়কালে কর্মসূচির রেকর্ড/রেজিস্টার, সাক্ষাৎকার, পর্যবেক্ষণ এবং ফোকাস গ্রুপ আলোচনার মাধ্যমে বিভিন্ন তথ্য সংগ্রহ করা হয়।

ফলাফলে দেখা গেছে, সুস্বাস্থ্যের কাঠামোগত বিষয়ে গুণগতমানের উন্নয়নের পাশাপাশি স্বাস্থ্য সেবাদানের সুযোগ-সুবিধার ব্যবস্থা, সঠিকভাবে রেকর্ড সংরক্ষণ, অত্যাবশ্যকীয় মেডিক্যাল যন্ত্রপাতি সরবরাহ এবং নিরাপদে বর্জ্য অপসারণের ক্ষেত্রেও উন্নতি সাধিত হয়েছে।

বাচ্চা প্রসব করানোর ব্যবস্থা বর্তমানে ৮৩% স্বাস্থ্যকেন্দ্রে প্রদান করা হচ্ছে যা ৮ মাস পূর্বে ছিল মাত্র ১৬% কেন্দ্রে। ল্যাবরেটরীর কার্যক্রম চলছে ৫০% স্বাস্থ্যকেন্দ্রে। আবর্জনা ফেলার জন্যে গর্ত এখন সবক'টি কেন্দ্রে চালু আছে। ট্রেনিং এবং তত্ত্বাবধায়নের ক্ষেত্রে গুণগতমান কিছুটা হ্রাস পেয়েছে।

প্রেসক্রিপশন নিরীক্ষণ করে স্বাস্থ্যসেবাদানকারীদের কর্মদক্ষতা যাচাই করে দেখা গেছে যে, রোগের স্থায়ীত্বকালের কথা উল্লেখ করা হয়েছে ৩৫%, রোগীর অভিযোগ অনুযায়ী স্বাস্থ্য পরীক্ষা করা হয়েছে ২০% এবং সঠিক রোগ নির্ণয় লেখা হয়েছে ৪১% প্রেসক্রিপশনের ক্ষেত্রে। আরো দেখা গেছে, সুস্বাস্থ্যের গাইডলাইন

অনুসরণ করে ঔষধ দেয়া হয়েছে মাত্র ৩% রোগীকে এবং ৩৮% প্রেসক্রিপশনে ব্র্যাক নির্বাচিত ঔষধ প্রদান করা হয়েছে। তাছাড়া, প্রায় অর্ধেক রোগীকে ভিটামিন প্রেসক্রাইব করা হয়েছে। মাত্র ১৩% রোগীকে সুনির্দিষ্ট উপদেশ এবং ৭% রোগীকে নির্দিষ্ট চিকিৎসা দেয়া হয়েছে।

স্বাস্থ্যকেন্দ্রে স্বাস্থ্যসেবাদানকারীদের সঙ্গে রোগীর সম্পর্ক বেশ ভালো। শুধুমাত্র মেডিকেল অফিসার ও রোগীদের সাথে যোগাযোগের ক্ষেত্রে আচরণগত দুর্বলতা দেখা গেছে। জেডার ও শিক্ষাগত বৈষম্যের ক্ষেত্রেও মেডিকেল অফিসারদের আচরণের তারতম্য লক্ষ্য করা গেছে। ঔষধ সেবনের নিয়ম-কানুন প্রায় সব রোগীকে জানানো হয়। কিন্তু রোগ এবং ঔষধের পার্শ্ব প্রতিক্রিয়া সম্পর্কিত তথ্য খুব অল্প সংখ্যক রোগীকে জানানো হয়েছে।

কলাফলে প্রকাশ পেয়েছে যে, রোগীর উপস্থিতি ১৯৯৭-৯৮ সনে ৫৩% বৃদ্ধি পেয়েছে। কিন্তু তা মোট জনসংখ্যার মাত্র ৬%। এর মধ্যে ২৬% ব্র্যাক সদস্য এবং ১% সদস্য নন। প্রায় ৯০% এর বেশি রোগী স্বাস্থ্যকেন্দ্রে একবারের বেশি এসেছিলেন এবং ৬০% এর অধিক রোগী চার বা ততোধিকবার স্বাস্থ্যসেবা গ্রহণ করে। প্রায় ৪৮% রোগী ব্র্যাক স্বাস্থ্যকেন্দ্র থেকে সেবা নিতে চেয়েছে বাকীরা অন্যান্য কেন্দ্র থেকে সেবা নিতে অগ্রহী। রোগীদের স্বাস্থ্যকেন্দ্রে প্রেরণ করার ক্ষেত্রে স্বাস্থ্য সেবিকারা গুরুত্বপূর্ণ ভূমিকা পালন করছেন। কিন্তু তারা হতাশ কারণ তারা ন্যায়া ইনসেনটিভ থেকে বঞ্চিত হচ্ছেন।

কলাফলে দেখা যায়, একজন রোগীকে গড়ে ৮ কি.মি. দূরত্ব অতিক্রম করে কেন্দ্রে আসতে হয় এবং এতে তার গড়ে ৫৩ মিনিট সময় ব্যয় হয়। কেন্দ্রে পৌঁছানোর পর পুরোপুরি সেবা পাওয়ার জন্য প্রতিটি রোগীকে গড়ে ৪৭ মিনিট সময় ব্যয় করতে হয়। যদিও ডাক্তার দেখাতে গড়ে ১৬ মিনিট সময় ব্যয় হয়। কিন্তু তা' স্বাস্থ্যসেবাদানকারীর সংস্পর্শে আসার সময়ের থেকে কিছুটা কম। গুণগতমানের ক্ষেত্রে তা মোটেও ভালোভাবে মূল্যায়ন করা হয় না। প্রায় সকল রোগীই জানেন যে, স্বাস্থ্যকেন্দ্রে সাধারণ রোগের চিকিৎসার ব্যবস্থা আছে। কিন্তু মাত্র ৫৫% রোগী বাচ্চা প্রসব করানোর ব্যবস্থা আছে বলে উল্লেখ করেছেন।



রোগীর সন্তুষ্টির ক্ষেত্রে দেখা যায়, ৫৩% রোগী সম্পূর্ণ সুস্থ হয়েছেন এবং ৩৬% রোগী আগের চেয়ে বেশি ভালো বোধ করছেন। প্রায় ৮৫% রোগী সুস্বাস্থ্যের সেবা পেয়ে সন্তোষ প্রকাশ করেছেন এবং ৪১% রোগী সুস্বাস্থ্যের গুণগতমানকে ভালো বলে মনে করেন। অর্ধেকের বেশি সংখ্যক রোগী ব্র্যাকের স্বাস্থ্যসেবাদানকারীদের ব্যবহারে সন্তুষ্ট। একইভাবে টয়লেট ও খাবার পানির অভাবের প্রসঙ্গ উল্লেখ করেছেন ১৬% রোগী। সুস্বাস্থ্যের স্বাস্থ্যসেবার মান বৃদ্ধির জন্যে ৫২% রোগী এক্স-রে ও ২৪% রোগী শল্য চিকিৎসা চালু করার ব্যবস্থা এবং ১৪% রোগী ল্যাবরেটরীর সুযোগ-সুবিধা উন্নয়নের জন্যে উদ্যোগ নিতে বলেছেন। তাছাড়া কিভাবে স্বাস্থ্যসেবা গরীব জনগণের মাঝে ঋণদানের মাধ্যমে দেয়া যায় এবং গ্রাম পর্যায়ে স্বাস্থ্যসেবা সবার দোরগোড়ায় পৌঁছানো যায় সে বিষয়ের প্রতি গ্রামের জনগণ আলোকপাত করেছেন।

ফলাফলের আলোকে সুস্বাস্থ্যের মান উন্নয়নের জন্য কিছু সুপারিশ করা হল। সে গুলি নিম্নরূপঃ

স্বাস্থ্যসেবাদানকারীদের কর্মদক্ষতার ক্ষেত্রে

- ক) প্রেসক্রিপশন সঠিকভাবে করার জন্যে সুস্বাস্থ্যে ক্লিনিক্যাল প্র্যাকটিস গাইডলাইন ব্যবহার শুরু করা উচিত। এই গাইডলাইন অনুযায়ী রোগ নির্ণয় ও চিকিৎসার যুক্তিপূর্ণ প্রণালী (Algorithm) ব্যবহার করতে হবে;
- খ) সার্বক্ষনিক তত্ত্বাবধান এবং কার্যকর সমালোচনা করার ব্যবস্থা নিশ্চিত করা দরকার;
- গ) সার্বক্ষনিক শিক্ষা কার্যক্রম এবং ট্রেনিং এর ব্যবস্থা থাকা প্রয়োজন;
- ঘ) কৃতিত্বের ভিত্তিতে পুরস্কার ও শান্তি দু'টোরই ব্যবস্থা থাকা দরকার;
- ঙ) ডাক্তারদের চাকুরী ছেড়ে দেওয়ার কারণ খুঁজে বের করা প্রয়োজন।

রোগী ও স্বাস্থ্যসেবাদানকারীর সম্পর্কের ক্ষেত্রে

- ক) সম্পর্ক উন্নয়নের জন্যে যোগাযোগের কলা-কৌশল নতুনভাবে গ্রহণ করা উচিত; এবং
- খ) জেন্ডার ও শিক্ষা বৈষম্যের কারণ উদ্ঘাটন করা দরকার।

তথ্য প্রদানের ক্ষেত্রে

- ক) রোগীকে তার অসুখ ও ঔষধের পার্শ্ব প্রতিক্রিয়া সম্পর্কে সঠিক তথ্য জানানো: এবং
- খ) উপদেশ সভা বা কাউন্সেলিং সেশন সুষ্ঠুভাবে পরিচালনার জন্যে আরো মনোযোগী হওয়া দরকার।

মাঠ পর্যায়ে স্বাস্থ্যসেবা পৌঁছানো ও রোগীর চাহিদা পূরণ সম্পর্কিত

- ক) সুস্বাস্থ্যের সেবা সামাজিকভাবে বাজারজাত করতে হলে জনগণের মাঝে এর সুযোগ-সুবিধা সম্বন্ধে ঢালাওভাবে প্রচার করা দরকার;
- খ) এক্স-রে, প্রাথমিক শল্য চিকিৎসা ও রোগীর অন্ত:বিভাগ চালু করাও যেমন দরকার তেমনি জটিল প্রসবসেবা প্রদানের ব্যবস্থা থাকা দরকার;
- গ) স্বাস্থ্যবীমা পদক্ষেপ পরীক্ষা করা উচিত;
- ঘ) রোগী ও স্বাস্থ্যসেবাপ্রদানকারীর সময়ের যথাযথ ব্যবহার নিশ্চিত করা প্রয়োজন;
- ঙ) গ্রামপর্যায়ে সাধারণ চিকিৎসা দেয়ার ব্যবস্থা সুনিশ্চিত করা; এবং
- চ) মাঠপর্যায়ের স্বাস্থ্যকর্মীদের ইনসেন্টিভের ব্যাপারটির প্রতি যথাযথ দৃষ্টি দেয়া প্রয়োজন।

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