Draft report

QUALITY ASSESSMENT OF BRAC HEALTH CENTRES

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November 1997

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EXECUTIVE SUMMARY

BRAC has implemented the Reproductive Health and Disease Control Programme (RHDC) in the northern and central regions of Bangladesh to improve health status of the people. Among the various components of the programme, BRAC health centre (BHC) is an important activity to reach basic and secondary health care to the community. This study assessed quality of the BHCs particularly with regards to structural elements and utilization of services. Nine of the 24 BHCs were purposively selected based on the duration of BHC establishment, cost recovery of BHCs and attendance of the patients. Data were collected in October 1997 through review of programme records, observation of the BHCs and interview of the BHC staff.

Findings revealed that among the patients who attended the BHCs, 74% were members of BRAC's village organizations (VOs). Attendance of the patients at the BHCs was affected by the length of health staff's presence at the BHCs, number of principal facilities available, education of paramedics, location of doctor's residence and involvement of shastho shebikas in patient referral. In the BHCs where medical doctors were present for 10-12 months, attendance of the patients was higher than that for 3-6 months. Similar findings were also observed in the presence of paramedics. When two types of services were delivered, average attendance per month at the BHCs was 464 (outpatient and delivery) and 585 (outpatient and laboratory), whereas it was 293 if only one type of service was available. In the BHCs where paramedics were highly educated, attendance of the patients was also high. Moreover, average attendance per month at the BHCs was 390 when the doctors' residence was attached to the BHCs compared to 310

when it was outside. Higher attendance was also observed when more than half of the patients were referred to the BHCs by the shastho shebikas.

Each BHC was located by the side of the paved road and not less than 10 km away from some villages. Out-patient services were offered to all BHCs, however, delivery services began in only two. Of the three laboratories available in the BHCs, only one had facilities to perform routine pathological tests for blood, stool and urine, and sputum test for tuberculosis. In the nine BHCs, sanctioned positions were observed to be occupied by the appropriate personnel. The medical officers (MO) in the observed BHCs obtained MBBS degree studying five years in the medical colleges ; six female paramedics had completed two years education at the university level obtained BA/B.Sc. degree whereas six male had HSC degree after completion of 12 years of schooling. Only one MO received training in clinic management and two in development management. None had ever received training in maternity care either during their internship in the hospital or in BRAC. All female and seven male paramedics received paramedic training in BRAC. Most family welfare visitors had training in pregnancy related care. Moreover, out of four lab technicians, only one received training in pathological tests and techniques.

Supply of equipment though found to be lower than the approved level it seemed adequate for the current out-patient activities of the BHCs. Unfortunately, emergency medical supplies were found only in two BHCs, one in the consultation room and the other in the store room. In the labour room, oxygen was available, but no nasogastric sucker was seen in the labour room. Only consultation rooms are separately available in the observed BHCs. Although space and ventilation were adequate in the consultation rooms of most BHCs, adequate light was available in only four. Of the two delivery rooms surveyed

adequate light and ventilation was observed in one. Only one labour room had attached toilet which was also being used by the out-patients. Moreover, BHC waste was found to be disposed of into open ground everywhere.

Concerning supervision, the regional managers were found to visit eight BHCs and sector specialists six BHCs in the previous month before data collection. In each BHC the MOs mentioned supervising the activities of the BHC staff through review of prescriptions and through informal discussion. Six male paramedics, two female paramedics and two female welfare visitors were found to maintain action plan for their monthly activities. While checking consistency between patient registers and prescription notes, diagnosis of the diseases was found to be similar in 84% of the cases. Of the patients who fulfilled the criteria for follow-up at home, only 48% were recorded in the follow-up registers. Of the patients who were recorded in the follow-up registers, about 79% were physically followed up at home. While reviewing prescriptions, very little information was written in the prescription notes. In most centres non-physicians were found to prescribe antibiotics.

Based on the findings, following recommendations were made to improve quality of the BHCs:

1. Supervisory system should be strengthened at the BHCs. The supervisors should be technically skilled to supervise the activities of their subordinates. Use of supervisory checklists would help supervisors give immediate feedback so the staff can amend their act accordingly.

2. Necessary training should be arranged for the staff to improve their performance, for example, arranging training for the medical doctors in clinic management and labour

management. Refreshers' training should be organized periodically. Post-training follow-up of the BHC staff needs to be emphasized.

3. Adequate note writing in prescriptions including referral note must be emphasized to improve opportunities for communication between health providers. A clear-cut instruction should be given both to medical doctors and paramedics as to how to write a useful prescription.

4. Record-keeping system needs to be improved as there exists inconsistencies in registers.

5. Emphasis must be placed on rational drug use to minimize unnecessary use of antibiotics and other medicine as practiced by medical doctors and paramedics. However, clinical guidelines should be made available to each staff and effective supervision must be ensured. Location of doctors' residence attached to BHC should also be considered for close supervision and enhanced interaction with staff.

6. As shastho shebikas' involvement in patient referral to the BHCs is crucial, increasing their incentives and recognition of work should be considered. Simultaneously, field supervisors should strengthen their liaison with shastho shebikas through informal discussion.

7. Reporting in disease profile should carefully be maintained. Occasionally only one diagnosis was recorded for each patient even though the patient was found to have multiple diseases.

8. Each staff should have orientation to BHC objectives and guidelines before starting their job.

9. Service facilities should be made available at each BHC as early as possible. With local initiative, some limitations can easily be overcome, for example, power supplies can be

made available through the use of generators; available houses can be rearranged for further service provision. Supply of emergency medicine and provision of services should be ensured at each BHC from the start of its operation.

10. Provision of hygienic toilet services and waste disposal should also be considered. Pertinent training should be arranged following a curricula that must contain details of environmental hazards of improper waste disposal and hygienic practices. More importantly, effective supervision must be concurrently ensured at the same field.

11. Emphasis should be placed on organizing subcentres to inaccessible population. However, if BHCs were inaccessible to VO members, they should be mobilized to accept services from the nearest health centres not always from the BHCs. Moreover, transportation between the BHCs and the referral centres (government hospital), particularly for the emergency cases must be considered.

QUALITY ASSESSMENT OF BRAC HEALTH CENTRES

ABSTRACT

This study assessed the quality of the BRAC Health Centres (BHCs) primarily with regard to structural elements and utilization of services. Nine of the 24 BHCs were purposively selected for the study based on the duration of its establishment, cost recovery and attendance of the patients. Data were collected in October 1997 through review of programme records, observation of the BHCs, and interview of the BHC staff. Findings revealed that service facilities were not yet available in each BHC. Even with the existing strengths of the program, lack of quality has been observed in various aspect of the BHC activities. Moreover, attendance of the patients at the BHCs was affected by the length of health staff's presence at the BHCs, number of principal facilities available, education of paramedics, location of doctor's residence and involvement of shastho shebikas in patient referral. In spite of regular visit of the supervisors to BHCs, supervisory neglect were evident in registers, records and prescriptions. This study concludes that there is a need to improve quality of the BHCs and thereby its service utilization by taking further measures.

INTRODUCTION

Quality of care had been neglected for years in the health policies of developing countries. However, in Bangladesh along with changes in the government health policies in the fourth five year plan, BRAC has addressed issues of quality in its health programme (1,2). BRAC, the largest national non-governmental development organization, established BRAC Health Centres (BHCs) in the northern and central part of Bangladesh to extend basic and secondary health care to the community (1). Services provided through these health centres are relatively new and so is the introduction of user fees to the community. While the government services are free of charge, most challenging for BRAC is the introduction of user fees. As the donor assistance has gradually been withdrawn from the developing countries, achieving financial sustainability has been impossible without charging user fees. (Quality of care, therefore, has been a serious issue of concern for the programme to enhance patient satisfaction which leads to increased utilization of health care and improved health status (3). As a consequence of better health, improved quality of health care ultimately reduces overall expenditures in health care(3,4).)

Applying Donabedian and Bruce's approach as widely used in other studies, the quality assessment has been addressed in the BHCs (5,6). The study on BHCs' quality assessment is a large one being conducted in two phases. Despite the structural elements having recognized as poor indicator of the quality, the first phase of the study assessed structural elements of the BHCs, because it is easier, faster and more objective oriented

(5,7)[1]. Implying structural assessment criteria, a study in rural clinics of Papua New Guinea revealed managerial weakness attributable to poor quality of care (8). Lack of functional capacity was evident in another study in outpatient clinics of the Philippines which in fact raised issues for correcting process defects (9).

A literature survey revealed paucity of information in the BHCs particularly with regard to quality of care. The present study, therefore, assessed quality of the BHCs related to structural elements, and utilization of services. Like other studies, this study also used various methods ranging from observation to review of programme records (10,11). Moreover, quality has been judged in the BHCs by using explicit criteria. Lessons learned from the study will be used to improve quality of the BHCs to enhance its acceptability to the community.

Organization of the BRAC Health Centres

Since 1972 BRAC has been working in Bangladesh, particularly in rural areas to improve the quality of life by implementing various development activities. Using its diverse experience from health interventions, in 1995 BRAC initiated BHCs in the northern and central part of Bangladesh. To date, of the 24 BHCs, 21 have been established in the Reproductive Health and Disease Control Programme (RHDC)[2] areas and three in the Rural Development Programme-Essential Health Care (RDP-EHC)[3]. Although health

[1] In the second phase, quality of service delivery and acceptability to the community have been addressed which reveal holistic picture of the health facilities, however, impact assessment has been avoided due to extreme costs.

[2] In 1991 comprehensive health care had been addressed in the Women's Health and Development Programme (WHDP). In 1995 WHDP changed its programme approach and evolved as RHDC. It primarily concentrates on BRAC's target group and aims to improve health status of the population by providing services through community-based care and through BHCs.

[3] The Rural Development Programme-Essential Health Care (RDP-EHC), a package of health care concerned primarily with preventive health services is extended to the community through RDP of BRAC. Using administrative and financial resources of the RHDC programme, BHCs have been established in RDP-EHC

services of the BHCs are available to the whole community, families of the members of BRAC credit programme, particularly women and children receive much more benefits from the BHCs.

The BHC is equipped with multiple services (12). However, due to various reasons, services are yet to start in each BHC. Services provided in the BHCs are: i) Out-patient services include treatment of common ailments, family planning, antenatal care service, immunization, etc.; ii) Obstetric care comprises of antenatal care, delivery services for normal labour and postnatal care; and iii) Laboratory services include routine tests for blood, urine and stool and sputum test for tuberculosis (TB). If patients are non-treatable in the BHCs, they are referred to government health centres for further care.

Medical and non-medical personnel are employed in the BHCs with particular responsibilities (12). A medical officer (MO) is accounted for the overall activities of a BHC. Two paramedics, a male and a female are assigned to work in the BHCs; they assist the MO, and also consult the patients. A week-long paramedic training is offered by the training unit of the Health and Population Division of BRAC to build the capacity of the paramedics. One family welfare visitor (FWV), posted in each BHC, is responsible for the obstetric care and occasionally help in out-patient services. Each FWV has training in obstetric care which they obtain during their diploma course. One lab technician is employed in each laboratory. One-month training in pathological tests is arranged for the lab technicians. A female attendant, posted in each BHC, is selected from among the

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areas in which basic and secondary services are given to the community. However, the shastho shebikas of RDP actively participate in social mobilization and service delivery at the community level.

community health workers; she welcomes patients and makes them feel comfortable in a new environment.

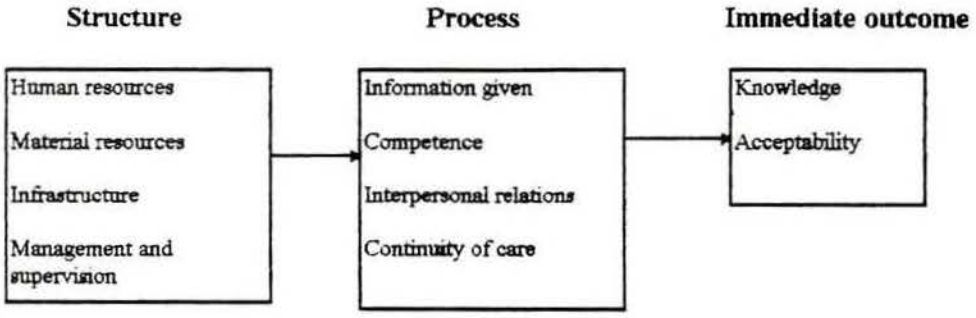
Supervision of BHC activities is carried out particularly by the regional managers, sector-specialists and MOs. In the community, social mobilization and follow-up of the patients are carried out by BRAC staff and the community health workers. The community health workers refer patients to the BHCs and receive little remuneration instead. The BHCs provide subsidized services to members of BRAC's village organization (VO)[4] and some poor non-VO members, but non-VO members receive services at relatively higher costs.

Conceptual framework

The study attempted to define quality by looking into a conceptual model that includes the structure-process-outcome trilogy. This model has been based on the framework formulated by Donabedian and Bruce. Such model was widely used in the studies of other developing countries. As the activities of BHCs are unlike others, quality of BHCs has been assessed by changing some elements of the framework. The framework is presented below.

[4]Village organisation is a primary organisation of rural development program of BRAC which consists of 20 members selected from the target population. Target population includes households having less than 50 decimals of land and a household member (12+ years old) who sells manual labour for at least 100 days a year for survival

Fig 1. Conceptual framework for BHCs



This paper emphasized on the structural elements in terms of human and material resources, infrastructure and management, and acceptability in terms of service utilization. Human resources included the number of personnel employed for providing services, their educational background and the number of training received. Material resources are the number of service facilities provided to the patients and the physical facilities. Programme management primarily focused on the supervisory system which includes visit to BHCs by regional managers and sectors specialists, supervision of BHC staff by medical officers, maintenance of record-keeping system, etc. The process and outcome elements are presented in the box but not discussed in this paper.

METHODS AND MATERIALS

This study was part of a larger study on the quality assessment of the BHCs planned to be carried out in two phases. The data were collected in the first phase of the study in BHCs located in Bogra, Dinajpur and Mymensingh region in October 1997. Nine of 24 BHCs were purposively selected assuming that an overall picture of the BHCs would be revealed. Eight BHCs were selected in the RHDC programme areas. The length of BHC establishment, cost-recovery of the BHCs and attendance at the BHCs were considered for sampling to have an equal distribution of the characteristics among the selected BHCs. In RDP areas, from amongst three BHCs, Lakmipur was selected based on its high cost-recovery and patient attendance.

Table 1. Selected BHCs in RHDC areas

BHC selected	Attendance at BHCs	Age of BHCs	Cost recovery
Bolior, Dupiaguri	>300	>2 years	>40%
Fashiitala, Barkandi	>300	<1 year	>40%
Kazipara, Kasnigonj	<300	>2 years	<30%
Parbotipur, Chechua	<300	<1 year	<30%

The investigators spent a day or two in each BHCs to gather data. Using a structured checklist (explicit criteria), data were collected through interview of BHC staff, review of the programme records and registers, and observation of the BHCs. Initially frequency table was made. Since no noticeable difference was observed between the centres data were merged together for further analysis.

Quality assessment in fact requires standards of care. Since the programme did not have any written standards of care, we judged the quality by comparing the data to

programme's targeted achievement and far more was assessed by looking at the level of care expected in the health centres as determined by literature review and discussion among the investigators. For instance, the programme is expected to provide all service facilities, such as out-patient services, obstetric care and laboratory facilities to each BHC. A consultation room would be expected to have adequate ventilation and light and a labour room emergency medical supplies.

FINDINGS

I. HUMAN RESOURCES

A. Staffing

Even with regular turn-over of the medical doctors in the BHCs, the sanctioned positions were observed to be occupied by the appropriate personnel. Positions of paramedics and family welfare visitors were also nearly filled in (Table 1).

B. Education

All the MOs in the observed BHCs were medical graduates; six female paramedics obtained BA/B.Sc. degree completed two years education at the university level whereas six male had HSC degree after completion of 12 years schooling. Eight FWVs obtained HSC/SSC degrees; six of them had diploma in nursing while two had FWV training (18-month diploma). Three lab technicians had B.Sc. degree. Most female attendants had no formal education (Table 2).

B. Training of the BHC staff

We were able to interview seven out of nine MOs. Only one MO received training in clinic management and two in development management from among the eight training mentioned by the BHC staff. The majority had had training in TB and leprosy control management (6), but a very few had training in clinical contraception (1) and menstrual regulation (1). In the BHCs the number of training varied among the MOs due to regular drop-out of trained doctors, recruitment of new doctors and organization of training at a particular time which may not always be availed to all. It is worth-mentioning that none of

the MOs had ever received training in maternity care either during their internship in the medical hospital or in BRAC (Table 3).

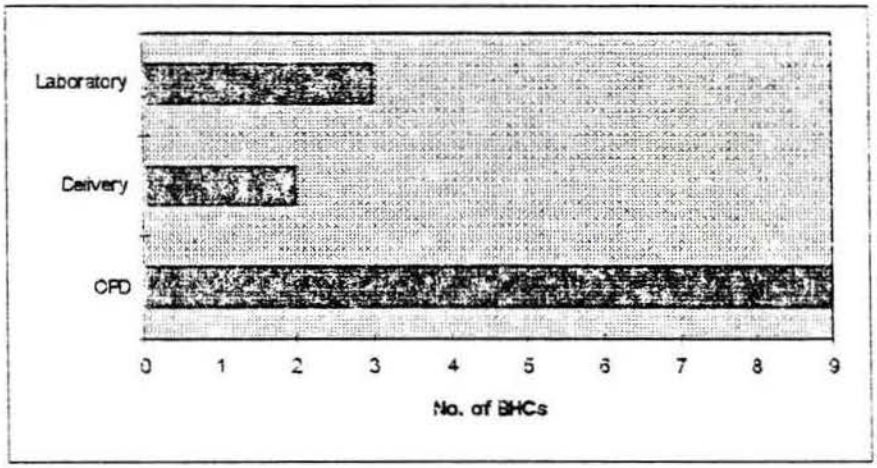
Paramedic training was given both to male and female paramedics. Two male paramedics not received paramedic training in the BHCs, were trained in the same field in Sulla and Manikgonj. Few of them had training in syndromic management of sexually transmitted diseases/Reproductive tract infections (STD/RTI) (2), clinic management (3), delivery case management (2) and menstrual regulation (2). Most family welfare visitors were trained nurse and likely to have knowledge about simple treatment; seven of them received training in pregnancy related care from BRAC. Unfortunately, out of four lab technicians, only one received training in pathological tests/techniques; the rest were trained earlier in techniques of sputum test for tuberculosis (TB). The BHC staff mentioned need for providing orientation to BHC guidelines at the beginning of their job.

II. MATERIAL RESOURCES

A. Service provision

In the nine BHCs, out-patient services were offered to all. However, delivery services were begun in two BHCs. Although laboratory facilities were likely to begin in all the BHCs, virtually only three BHCs were equipped with it.

Fig 1. Principal service facilities available at the BHCs



B. Equipment, IEC materials and laboratory tests

Supply of equipment though found to be lower than the approved level, it seemed adequate for the current out-patient activities of the BHCs. However, inadequate supply sometimes created problems. It has been found in a BHC that thermometer was not available as it had been taken away to a sub-centre; as a result, a patient with acute respiratory infection (ARI) came to the BHC was deprived of having her temperature recorded. Emergency medical supplies are invariably expected in the labour room. On physical verification, emergency medical supplies were found in the consultation room of one BHC and in the store room of another BHC. Of the two delivery rooms observed, only one had functioning sterilizer and no nasogastric sucker was available. Pathological tests, such as routine blood, stool and urine tests were started in one BHC. Information, education and communication (IEC) materials, such as posters, flipchart, booklets, pamphlets, were found in the BHCs but adequately[5] in five BHCs (Table 5).

[5] Adequate means availability of IEC materials on immunization, nutrition, hygiene practices, diarrhoea, family planning, pregnancy care, adolescent family life education, acute respiratory tract infections, tuberculosis, etc.

III. INFRASTRUCTURE

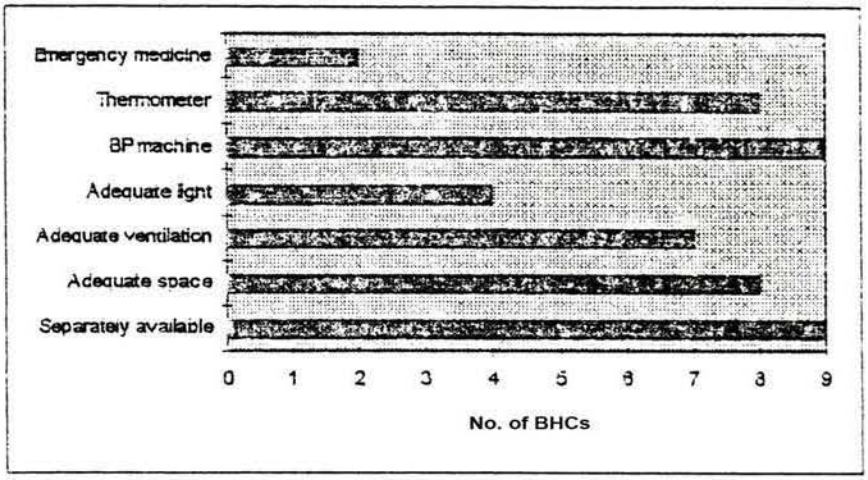
A. Location of BHCs

The BHCs were located by the side of the paved road and five were situated adjacent to bazaar. However, some villages in the programme areas were located at least 10 km away from the BHC which put a barrier to BHC accessibility. In the observed centres, distance between BHC and thana health complex was maintained at more than 6 km as per policy, but due to shift in policy distance would not be considered further. The distance of six BHCs was more than 16 km from the district or medical college hospital. Having no support for the transport, such a distance causes problem particularly to emergency cases. About half of the BHCs were located more than 2 km away from other government health facilities, such as family welfare centres and rural dispensaries (Table 6).

B. Status of the BHCs

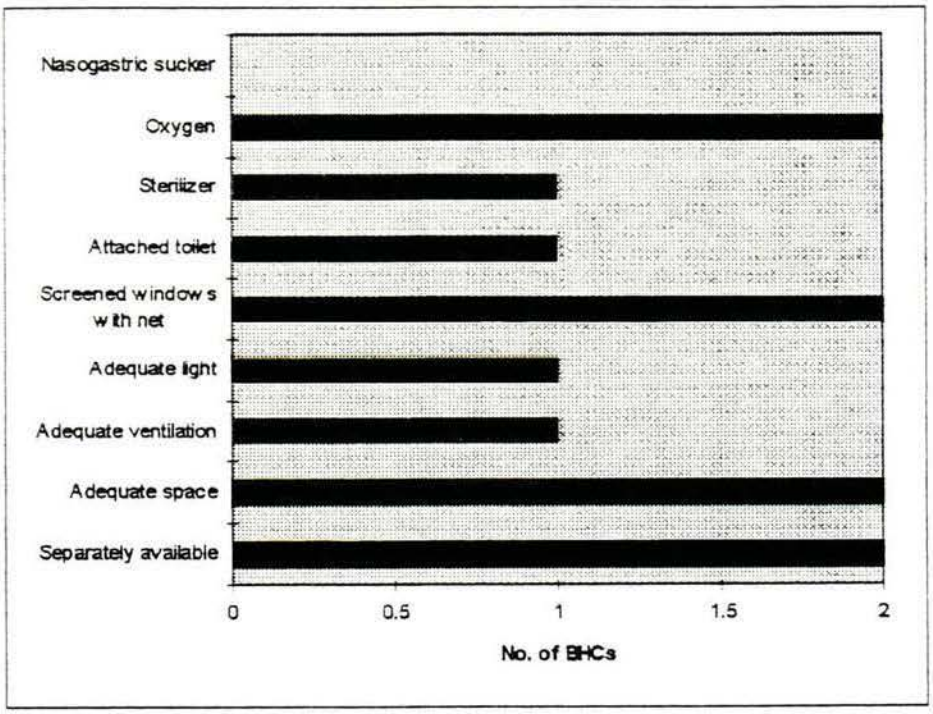
Only consultation rooms are separately available in the observed BHCs. Although space and ventilation were adequate in the consultation rooms of most BHCs, adequate light was available in only four rooms (fig 2). However, registration, waiting and counseling rooms were not separate in all observed BHCs. Adequate light and ventilation was quite variable in those rooms. Two BHCs also lacked power supply even with locally available electricity (Table 7).

Fig 2. Facilities available in consultation room



Delivery services were started in two BHCs. Of the two delivery rooms surveyed, adequate light and ventilation was observed in one. One has got attached toilet which was also being used by the out-patients (Table 7).

Fig 3. Facilities available in labour room



Of the 18 sanctioned dumping holes, 10 were available but four of them were found to be functional. Unfortunately, BHC waste was found to be disposed into open ground in all BHCs and the BHC staff seemed to be quite unaware of the environmental hazards. Eight toilets were seen in the BHCs, however, soap was available in only one (Table 7).

IV. SUPERVISION

The MOs did not maintain any monthly action plan for their activities. Although the others in the BHCs were liable to keep action plan, only 6 male paramedics and 4 FWVs were found to have action plan. The regional managers were found to visit 8 BHCs and the sector-specialists 6 BHCs in the preceding month. The MOs supervised the activities of the BHC staff through informal discussion. It has been observed only in one BHC that the MO actually checked prescriptions written by the paramedics and FWVs and allowed the staff to prescribe drugs in his presence.

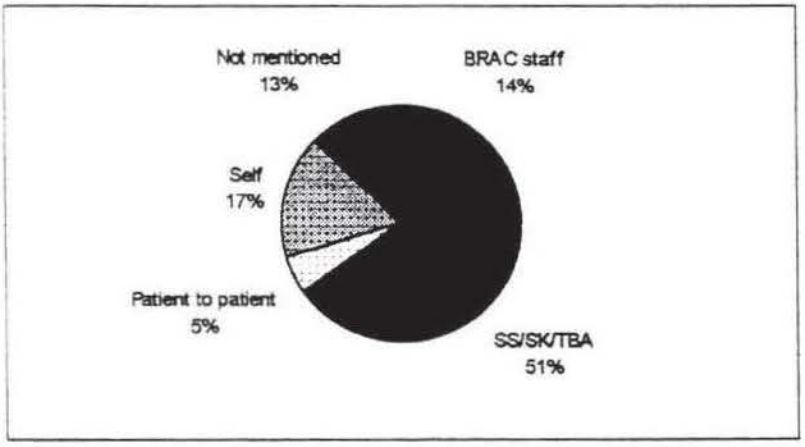
While checking consistency between patient registers and prescription notes, diagnosis of the diseases were found to be similar in 84% of the cases. Among the patients who fulfilled the criteria for recording in the follow-up registers, only 48% were recorded. Of the patients who were recorded in the follow-up registers, about 79% were physically followed up at home. Moreover, variation between monthly performance report and disease profile had still been observed in some BHCs even after the feedback in the last review meeting.

Besides, we looked at the prescriptions written by the MOs and other health staff. Very little information was written in the prescription, in most cases duration of symptoms was not even mentioned. Clinical diagnosis was made with little and sometimes with no clinical information in the prescription notes. Some errors were also observed in prescribing medicine. In most centres non-medical personnel were found to prescribe antibiotics. Misuse of antibiotics and other medicines was also observed. For example, an FWV prescribed both amoxycillin and cotrimoxazole for a simple respiratory tract infection. In certain cases, no consistency existed between the complaints and the

treatment, for example, a patient was treated with antihelminthics while diagnosis was secondary sterility and referral note was ignored in that prescription. Referral note was hardly found in any registers though it was noted in some prescriptions and referral slips.

More than half of the patients were referred to the BHCs by the community health workers, particularly shastho shebikas (Fig 4). On the contrary, about one-fourth of the patients attended the BHCs through self-motivation and patient-to-patient motivation.

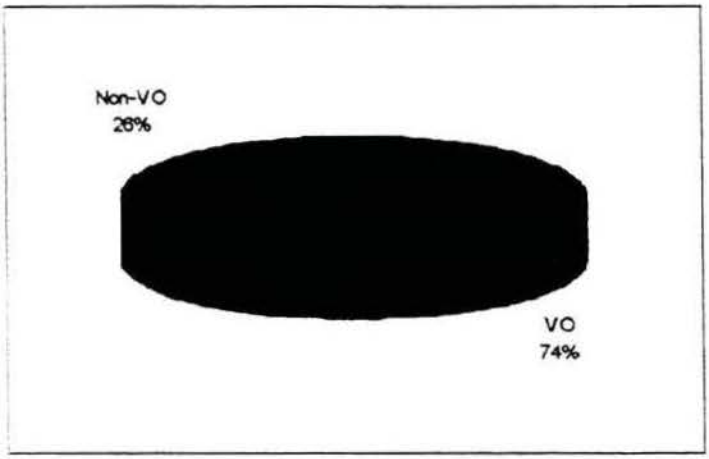
Fig 4. Patient referral to the BHCs by sources



V. UTILIZATION OF SERVICES

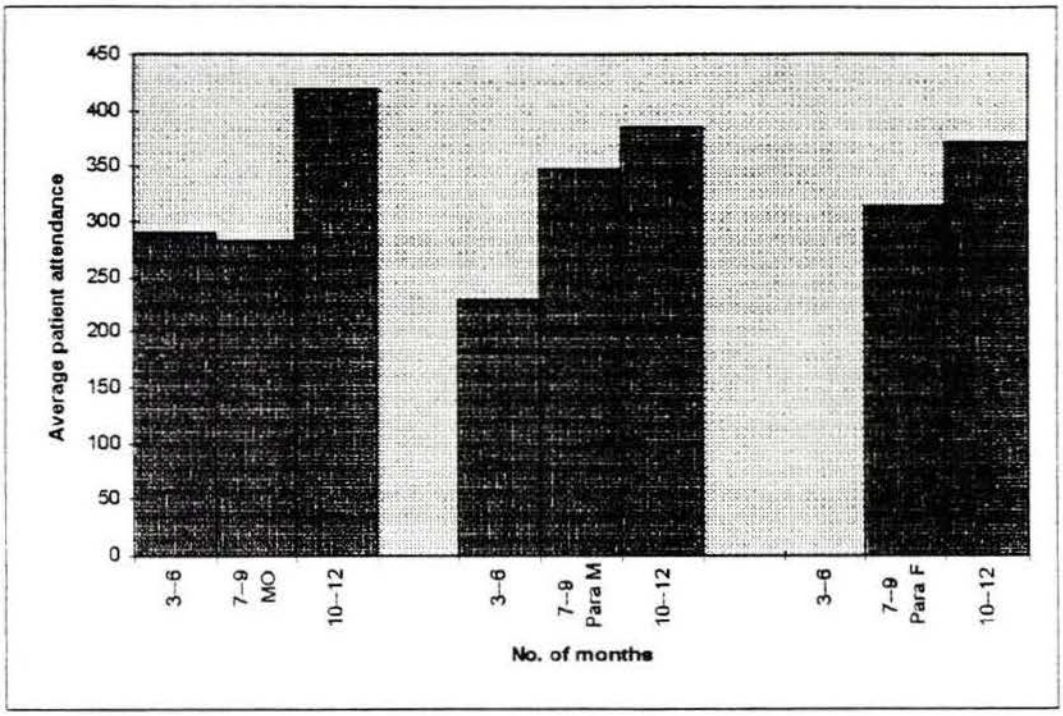
In all the observed BHCs, 74% of the patients were VO members (Fig 5). However, in one centre, almost half of the attendants were VO members.

Fig 5. Attendance of the patients at the BHCs by membership to VO



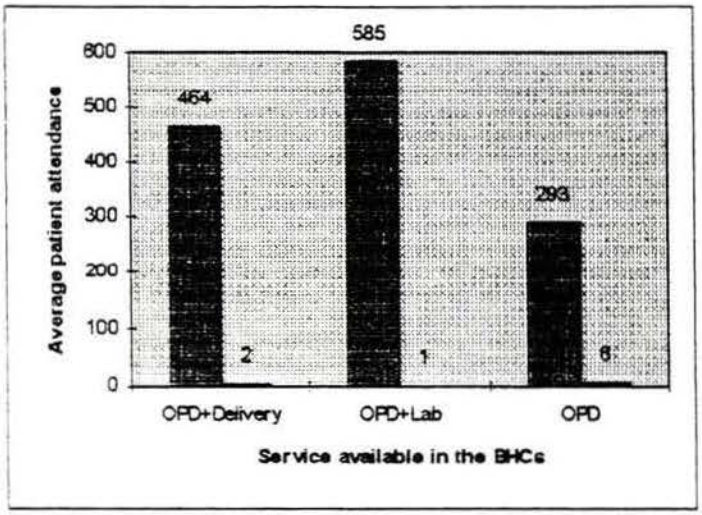
Presence of professionals in the BHC in terms of their length of stay affects attendance of the patients (Fig 6). In the BHCs where medical doctors stayed for 10-12 months, attendance of the patients was higher than that for 3-6 months. Similar findings were also observed in the presence of paramedics. However, the data failed to show an association between attendance of the patients and mere presence of MOs and paramedics at the BHCs.

Fig 6. Attendance of the patients at the BHCs by the length of stay of health providers



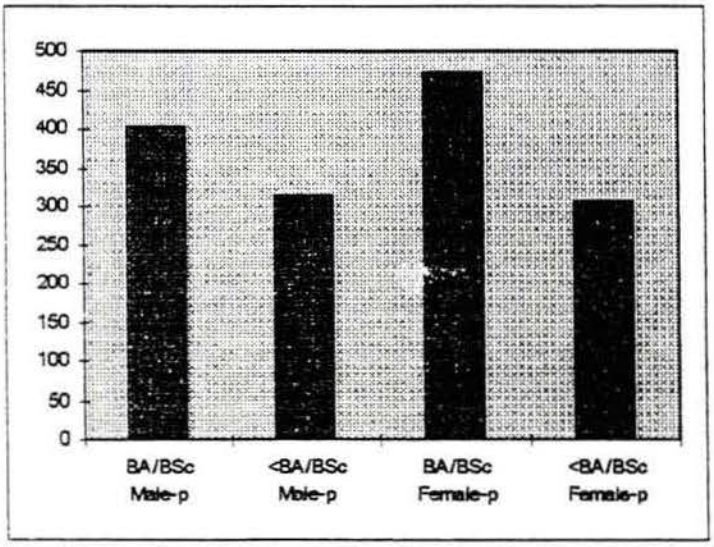
Attendance of patients at the BHCs was also influenced by the number of principal facilities available, education of the paramedics, location of doctor's residence and involvement of the shastho shebikas in patient referral. In two BHCs, attendance was 464 and 585 where number of services available were two, however, it was 293 where only

Fig 7. Attendance of the patients and the availability of the service facilities



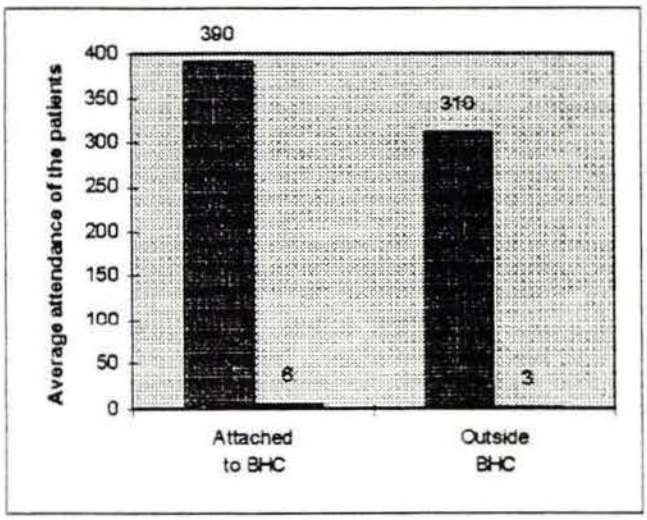
one service was available(Fig 7). Besides in the BHCs where paramedics had higher education, attendance of the patients was also high (Fig 8). Attendance of the patients at

Fig 8. Attendance of the patients and education of the paramedics



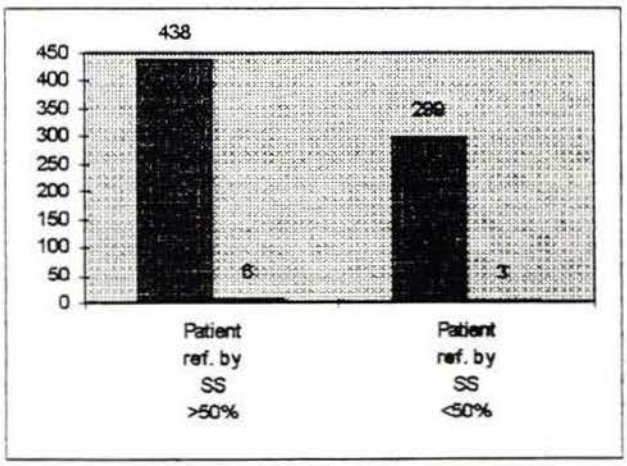
the BHCs was 390 when doctors' residence was attached to BHC but was 310

Fig 9. Attendance of the patients and location of the doctor's residence



when located outside (Fig 9). Moreover, attendance of the patients at the BHCs was found to be high when more than 50% of the patients were referred by the shastho shebikas (Fig 10).

Fig 10. Role of shastho shebikas in patient attendance



Discussion

Structure of the BHCs may not reveal the actual status because even with high quality structural elements, provision of services may not be of good quality. This study on the quality of the BHCs highlighted some strengths and problems of health centre set-up. The findings revealed association between service utilization and availability of service facilities, length of stay of the BHC staff, educational background of paramedics, location of doctor's residence and referral pattern of the patients.

Providing services through BHCs is an attempt to reach basic and secondary health care to rural community, particularly VO members. Service facilities planned to be provided were not yet available in all BHCs. Availability of more service facilities enhanced patient attendance at BHCs. Inadequate service facilities seemingly discourage patients to avail services, and therefore, enforce patients to seek health care elsewhere. Though services were likely to begin in each BHC by this time, physical constraints, such as scarcity of appropriate houses in the localities, inadequacy of health professionals, lack of power supplies, may limit its initiation in due time. Yet some limitations can easily be overcome with local initiatives, for example, power supplies can be made available through the generators or available houses can be rearranged for further service provision. However, one must think over alternatives to increase service facilities.

The sanctioned positions for health personnel in BHCs were nearly occupied even with regular turn-over of the medical doctors. However, length of stay of health staff in BHCs is far more important than their mere presence. More the length of stay of the MOs and paramedics at the BHCs, more were their influence on the increasing attendance

of the patients. Moreover, increased education of health staff causing enhanced attendance of the patients is likely to be due to the fact that education raises one's capacity of understanding the training courses more effectively and thus build up ability to offer quality services. Given that, educational background must be emphasized in recruiting BHC staff. Even though training of BHC staff did not seem to improve attendance of patients, it should also be considered. However, our experience showed that one-shot training did not improve performance of the health personnel (13). Therefore, apart from one-shot training we must emphasize on refresher's, and post-training follow-up.

Location of the BHCs near the paved road is an indication of convenient access. But some villages within the defined areas of the programme were located at least 10 km away from the respective BHC which put a barrier to its accessibility. Under such circumstances, it is unethical to mobilize VO members to attend the BHC in their respective territories. Therefore, either subcentres or mobile clinics should regularly be organized at the villages to make services more convenient and accessible. If not possible, from moral point of view, we at least mobilize the VO members to accept services from the nearest health centres but not to enforce them to avail inconvenient and inaccessible services of BHCs. Since distance is an issue between BHCs and referral centres, providing supports for transportation, particularly for emergency cases must also be considered.

In all the BHCs, rooms were available either separate or shared. Making separate room for each service may not be practical due to lack of appropriate building in rural areas. Considering environmental condition, consultation room was judged to be the best among all, though light was adequate only in four BHCs. Since patient examination requires sufficient light, its adequacy needs to be considered particularly in the consultation

and delivery room. Environment of other rooms did not receive equal importance. More than half of the counseling rooms did not have proper ventilation and light where neither the counselor would happily work with the clients nor the clients feel attentive to the advice of the counselors. Further the counseling room suffered from lack of adequate IEC materials. Even though supply of equipments was lower than what was approved, it did not seem to be inadequate for the present activities of the out-patient services, but inadequate for the obstetric care. Absence of emergency medical supplies and equipment is indicative of poorly equipped BHCs and essentially raises question whether it can deal with emergency situation. These issues should be carefully highlighted to improve the quality of BHCs.

The assessment also revealed some deficiency in waste disposal and hygienic practices. BHC wastes were still being dumped into the open grounds even after dissemination of the recent study findings on waste disposal (14). To cope with such a crisis, only training will not bring a solution to such problems. We must further ensure whether the trainers and the managers are convinced with the importance of training and contents of the curricula. The curricula must contain details of wastes including its effect on environment and more importantly, effective supervision must be concurrently ensured.

Lack of proper supervision was evident in record-keeping and prescription notes in spite of regular visits by the regional managers and sector-specialists to the BHCs. Paramedics deviating from standard medical practice is an indication of inadequate supervision and such practice could be harmful to patients and BRAC's reputation. Regular and close supervision should be emphasized to refrain from such practices.

Inadequate information in the prescription notes reduces opportunities for communication between health providers, and unnecessarily overburdens the health providers and the patients as well by repeating the same procedure. In such circumstances, effective supervision would help not only to improve in quality but also better in accountability to work. Doctors' residence attached to BHCs was also found to be important for patient attendance and is suggestive of close supervision of BHC activities. Hence in-house residence of the doctors should also be considered to have better supervision if feasible.

Shastho shebikas who are nucleus of BRAC's programme were quite intricately involved in mobilizing patient to BHCs. Involvement of the shastho shebikas in patient referral to BHCs reflects community involvement in social mobilization, close interaction with BRAC workers and effective supervision by BRAC management at the community level. The finding is quite optimistic; more the patients were referred by shastho shebikas, far better was the attendance of patients at BHCs. Vast network of BRAC participating in social mobilization is crucial to the success of BHCs. Therefore, involvement of the shastho shebikas by increasing their incentives and recognition might enhance utilization of BHC services.

PROGRAMME IMPLICATIONS

To enhance quality of the BHCs some suggestions are made in the light of the study findings:

1. Supervisory system should be strengthened at the BHCs. The supervisors should be technically skilled to supervise the activities of their subordinates. Use of supervisory

checklists would help supervisors give immediate feedback so the staff can amend their act accordingly.

2. Necessary training should be arranged for the staff to improve their performance, for example, arranging training for the medical doctors in clinic management and labour management. Refreshers' training should be organized periodically. Post-training follow-up of the BHC staff needs to be emphasized.

3. Adequate note writing in prescriptions including referral note must be emphasized to improve opportunities for communication between health providers. A clear-cut instruction should be given both to medical doctors and paramedics as to how to write a useful prescription.

4. Record-keeping system needs to be improved as there exists inconsistencies in registers.

5. Emphasis must be placed on rational drug use to minimize unnecessary use of antibiotics and other medicine as practiced by medical doctors and paramedics. However, clinical guidelines should be made available to each staff and effective supervision must be ensured. Location of doctors' residence attached to BHC should also be considered for close supervision and enhanced interaction with staff.

6. As shastho shebikas' involvement in patient referral to the BHCs is crucial, increasing their incentives and recognition of work should be considered. Simultaneously, field supervisors should strengthen their liaison with shastho shebikas through informal discussion.

7. Reporting in disease profile should carefully be maintained. Occasionally only one diagnosis was recorded for each patient even though the patient was found to have multiple diseases.

8. Each staff should have orientation to BHC objectives and guidelines before starting their job.

9. Service facilities should be made available at each BHC as early as possible. With local initiative, some limitations can easily be overcome, for example, power supplies can be made available through the use of generators; available houses can be rearranged for further service provision. Supply of emergency medicine and provision of services should be ensured at each BHC from the start of its operation.

10. Provision of hygienic toilet services and waste disposal should also be considered. Pertinent training should be arranged following a curricula that must contain details of environmental hazards of improper waste disposal and hygienic practices. More importantly, effective supervision must be concurrently ensured at the same field.

11. Emphasis should be placed on organizing subcentres to inaccessible population. However, if BHCs were inaccessible to VO members, they should be mobilized to accept services from the nearest health centres not always from the BHCs. Moreover, transportation between the BHCs and the referral centres (government hospital), particularly for the emergency cases must be considered.

ACKNOWLEDGMENT

The authors would like to thank Hasan Shareef Ahmed, Chief of Editing and Publication, Research and Evaluation Division, BRAC for editorial assistance.

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APPENDIX

Table 1. Staffing of the BHCs

	Sanctioned	NO. of BHCs	Posted
Medical Officer	9	9	9
Paramedics male	9	9	9
Paramedics female	9	8	10
FWV	9	7	9
Lab technician	9	3	4
PO/PA	9	3	3
Female attendant	9	9	9

Table 2. Education of BHC staff

Medical Doctors (9)	
-MBBS	9
Male paramedic (9)	
-BA/B.Sc.	3
-HSC/SSC	6
Female paramedic (10)	
-BA/B.Sc.	6
-HSC/SSC	4
Family welfare visitor (9)	
-BA/B.Sc.	1
-HSC/SSC	8
-Diploma in nursing	6
-Diploma in FWV training	2
Lab technician (3)	
-BA/B.Sc.	3
-HSC/SSC	1
Female attendant (9)	
-No formal education	6
-Primary	3

Table 3. Training of BHC staff

	No. of staff
Medical officer (7)	
-Clinic management	1
-Development management	2
-Clinical contraception	1
-Menstrual regulation	1
-Counseling	1
-Syndromic management of STD/RTI	2
-ARI management	3
-TB and leprosy control management	6
Paramedic Male (9)	
- Paramedic training	7
- TB and leprosy control management	1
- Syndromic management of STD/RTI	1
Paramedic female (10)	
- Paramedic training	10
- Syndromic management of STD/RTI	2
-Clinic management	3
-Pregnancy-related care	5
-Delivery case management	2
-Menstrual regulation	2
-ARI management	1
-Injectable contraceptive	1
-Emergency obstetric care	1
Family welfare visitor (9)	
-Pregnancy related care	7
Lab technician (4)	
-Pathological tests/ techniques	1
-TB tests/techniques	4

Table 4. Services provided in the BHCs

Type of services	Sanctioned	Available
Outpatient	9	9
Delivery	9	2
Laboratory	9	3

Table 5. Location of the BHCs

Distance	No. of BHCs
Close to paved road	9
THC	
≥ 6 km	9
< 6 km	0
FWC	
≥2 km	4
< 2 km	4
RD	
≥ 2 km	5
< 2 km	3
District hospital/Medical college hospital	
≥ 16 km	6
< 16 km	3
Bazaar	
Within	5
> 1 km	4
Village	
≥10 km	9

Table 6. Status of the BHC

Consultation room	
-Sanctioned	9
-Available	9
-Separately available	9
-Adequate space	8
-Adequate ventilation	7
-Adequate light	4
-Screened windows	9
-Adequate seats	9

Registration/ dispensing room	
-Sanctioned	9
-Available	9
-Separately available	2
-Adequate space	3
-Adequate ventilation	5
-Adequate light	5
-Screened windows	7
-Adequate seats	9
Waiting room	
-Sanctioned	9
-Available	9
-Separately available	5
-Adequate space	6
-Adequate ventilation	6
-Adequate light	6
-Screened windows	6
-Adequate seats	7
Counseling room	
-Sanctioned	9
-Available	8
-Separately available	1
-Adequate space	4
-Adequate ventilation	4
- Adequate light	4
-Screened windows	4
-Adequate seats	8
Laboratory	
-Sanctioned	9
-Available	3
-Separately available	3
-Adequate space	3
-Adequate ventilation	2
-Adequate light	2
Delivery room	
-Sanctioned	9
-Available	2
-Separately available	2
-Adequate space	2
-Adequate ventilation	1
-Adequate light	1
-Screened windows with net	2
-Attached toilet	1

Store room	9
-Sanctioned	7
-Available	4
-Separate	
Toilets	
-Sanctioned	18
-Available	8
-Separate for male patient	2
-Separate for female patient	1
-Joint male and female patient	2
-Shared with staff	3
-Soap available	1
Dumping hole for waste disposal	
-Sanctioned	18
-Available	10
-Functional	4
Power supply available	7

Table 7. Equipment, IEC materials and laboratory tests

	No. of BHCs
Out-patient department (9)	
-Inadequate supply of equipment as per approval	9
-BP machine available	9
-Thermometer available	8
-Aural speculum available	9
-Tongue depressor	8
-Torch light available	9
-Emergency medical box available	2
Delivery room (2)	
-Inadequate supply of equipment as per approval	2
-Sterilizer available	1
-Oxygen available	2
-Nasogastric sucker available	0
IEC materials (9)	
-IEC materials available and adequate	5
-IEC materials available but inadequate	4
Laboratory (3)	
-Sputum for AFB	3
-Blood for Hb, TC, DC and ESR	1
-Urine and stool for RME	1

Table 8. Supervision of the BHCs

	No. of BHCs
Action plan available in the observed month	
-Medical officer (8)	0
-Paramedic male (9)	6
-Paramedic female (10)	2
-FWV (9)	4
Supervision by RM	
-Visit in last 1 month	8
-Discussion with BHC staff	8
-Records and registers check	2
-Patient interview	2
Supervision by sector specialist	
-Visit in last 1 month	6
-Discussion with BHC staff	6
-Records and registers check	2
Supervision of staff by MOs	
-Discussion with BHC staff	9
-Close supervision of BHC staff	1

Table 9a. Maintenance of record-keeping system

	No. of cases observed	Similar
Consistency in diagnosis between registers and prescriptions	225	83.6 (188)
Follow-up patients recorded in the follow-up registers	225	47.6 (107)
Patients followed up at home who are recorded in the follow-up registers	107	79.4 (85)

Table 9b. Maintenance of record-keeping system

	No. of BHCs n=9
Number of patients in disease profile exceed the monthly performance report (MPR)	33.3 (3)
Number of patients similar in the disease profile and monthly performance report (MPR)	66.7 (6)

Table 11. Attendance of the patients at the BHCs by their status of VO and non-VO t

Attendance at the BHCs	
VO members	73.9
Non-VO members	26.1
Total	38785

Table 12. Attendance of the patients at the BHCs by the education status of paramedics

Education	No of BHCs (9)	Attendance of patients (avg. per month)
Male paramedics		
BA/B.Sc.	5	402
< BA/B.Sc.	4	314
Female paramedics		
BA/B.Sc.	3	473
< BA/B.Sc.	6	308

Table 13. Attendance of the patients at the BHCs by the presence of health personnel

	No. of centres (9)	Attendance of patients (avg. per month)
Presence of MOs		
3-6 months	1	290
7-9 months	3	282
10-12 months	5	419
Presence of paramedic male		
3-6 months	1	229
7-9 months	1	347
10-12 months	7	385
Presence of paramedic female		
3-6 months	0	
7-9 months	2	313
10-12 months	7	372

Table 14. Attendance of the patients at the BHCs by the principal facilities available and the location of doctor's residence

	No. of centres (9)	Attendance of patients (avg. per month)
Principal facilities available		
OPD and Delivery	2	464
OPD and Lab	1	585
OPD	6	293
Location of doctor's residence		
Attached to BHC	6	390
Outside BHC	3	310

Table 15. Patient referral to the BHCs

BRAC staff	13.8
SS/SK/TBA	51.2
Patient to patient	5.4
Self	17.0
Not mentioned	12.6
Total	3521

Table 16. Attendance of the patients at the BHCs by the referral pattern

Referred	No of BHCs (9)	Attendance of patients (avg. per month)
Patient referred by SS>50%	6	438
Patient referred by SS<50%	3	299

ব্র্যাক স্বাস্থ্য কেন্দ্রের গুণগতমানের মূল্যায়ন

কাওসার আফসানা, শাহ নূর মাহমুদ, এ এম আর চৌধুরী, ফজলুল করিম এবং সুহেলা হক খান

জনসাধারণের স্বাস্থ্যন্নোয়নের উদ্দেশ্যে ব্র্যাক দেশের উত্তর ও মধ্যবর্তী অঞ্চলে প্রজনন স্বাস্থ্য ও রোগ নিয়ন্ত্রণ কর্মসূচি শুরু করেছে। বিভিন্ন ধরনের কর্মকাণ্ডের মধ্যে ব্র্যাক স্বাস্থ্য কেন্দ্র উল্লেখযোগ্য। ব্র্যাক স্বাস্থ্য কেন্দ্র বর্তমানে সুস্বাস্থ্য নামে পরিচিত। সুস্বাস্থ্যের মাধ্যমে ব্র্যাক জনগণের মধ্যে প্রাথমিক ও মধ্য পর্যায়ের স্বাস্থ্যসেবা প্রদানের উদ্যোগ নিয়েছে। এ গবেষণার মাধ্যমে ব্র্যাক স্বাস্থ্য কেন্দ্রের গুণগতমান যাচাই করার চেষ্টা করা হয়েছে। স্বাস্থ্যকেন্দ্রের কার্যকাল, মূল্য উসুল (Cost recovery) এবং রোগীর উপস্থিতিকে সামনে রেখে সর্বমোট ২৪টি স্বাস্থ্য কেন্দ্রের মধ্য থেকে ৯টি কেন্দ্রকে গবেষণার জন্য নির্বাচন করা হয়। ১৯৯৭ সালের অক্টোবর মাসে কর্মসূচির রেকর্ড/রেজিষ্টার, সাক্ষাৎকার এবং পর্যবেক্ষণের মাধ্যমে এ গবেষণার জন্য তথ্য সংগ্রহ করা হয়েছে।

ফলাফলে দেখা গেছে, যে সকল রোগী স্বাস্থ্য কেন্দ্রে এসেছেন তাঁদের ৭৪% রোগী ব্র্যাকের গ্রাম সংগঠনের সদস্য বা তাদের পরিবারের সদস্য। রোগীর উপস্থিতি নির্ভর করে ব্র্যাক স্বাস্থ্য কেন্দ্রে কর্মীদের স্থিতিকাল, প্রধান প্রধান কী কী স্বাস্থ্যসেবা পাওয়া যায়, প্যারামেডিকদের শিক্ষা, ডাক্তারের আবাসস্থল এবং স্বাস্থ্য কেন্দ্রে রোগী পাঠানোর ব্যাপারে স্বাস্থ্য সেবিকাদের ভূমিকা। যে সকল কেন্দ্রে ডাক্তার একটানা ১০-১২ মাস কাল-পরিমাণ অবস্থান করছেন, সেখানকার রোগীর সংখ্যা, যেখানে একটানা ডাক্তার ৩-৬ মাস কাল-পরিমাণ আছেন তার চেয়ে বেশি। একই ফলাফল প্যারামেডিকদের বেলায়ও প্রযোজ্য। যেখানে দুই ধরনের স্বাস্থ্যসেবা (যেমন, বহির্বিভাগ ও প্যাথলজি/বহির্বিভাগ ও প্রসব) পাওয়া যায় সেখানে রোগীর গড়পড়তা উপস্থিতি ৫২৯ জন। অন্যদিকে যে সকল কেন্দ্রে শুধুমাত্র এক ধরনের (বহির্বিভাগ) স্বাস্থ্যসেবা পাওয়া যায় সেখানে রোগীর উপস্থিতি গড়ে মাত্র ২৯৩ জন। যেসব কেন্দ্রে ডাক্তারের আবাসস্থল স্বাস্থ্য কেন্দ্র সংলগ্ন, সেখানে রোগীর সংখ্যা গড়ে ৩৯০ জন, অন্যথায় তা ৩১০ জন। যেখানে স্বাস্থ্য সেবিকার মাধ্যমে শতকরা ৫০ ভাগের বেশি রোগী কেন্দ্রে এসেছেন সেখানকার রোগীর উপস্থিতির হারও বেশি।

প্রতিটি কেন্দ্র পাকা রাস্তার পাশে অবস্থিত এবং কোন কোন গ্রামের অবস্থান স্বাস্থ্য কেন্দ্র থেকে ১০ কি.মি. দূরে। যদিও প্রতিটি কেন্দ্রে বহির্বিভাগ চালু হয়েছে, কিন্তু প্রসবের

ব্যবস্থা রয়েছে মাত্র ২টিতে। কেন্দ্র সংলগ্ন ৩টি ল্যাবরেটরীর মধ্যে শুধুমাত্র ১টিতে রক্ত, মল-মূত্র ও সাধারণ পরীক্ষা শুরু হয়েছে। নয়টি কেন্দ্রেই অনুমোদিত পদে মোটামুটিভাবে উপযোগী কর্মী কর্মরত আছেন। প্রত্যেক ডাক্তার এমবিবিএস ডিগ্রীধারী, ১০ জনের মধ্যে ৬ জন মহিলা প্যারামেডিক বি.এ পাশ এবং ৯ জনের ৬ জন পুরুষ প্যারামেডিক উচ্চ মাধ্যমিক পাশ। ডাক্তারদের মধ্যে ১ জন ক্লিনিক ব্যবস্থাপনা এবং ২ জন উন্নয়ন ব্যবস্থাপনায় ট্রেনিং পেয়েছেন। সকল মহিলা এবং ৭ জন পুরুষ প্যারামেডিক ব্র্যাক থেকে প্যারামেডিকস ট্রেনিং পেয়েছেন। অন্য ২ জন পুরুষ প্যারামেডিক শাল্লা এবং মানিকগঞ্জে প্যারামেডিকস ট্রেনিং পেয়েছেন। সকল ফ্যামিলি ওয়েলফেয়ার ভিজিটর (FWV) ব্র্যাক থেকে প্রসব সম্পর্কিত ট্রেনিং পেয়েছেন। চার জনের মধ্যে মাত্র একজন ল্যাবরেটরী টেকনিশিয়ান প্যাথলজিকাল পরীক্ষার ট্রেনিং পেয়েছেন।

যদিও যন্ত্রপাতির পরিমাণ অনুমোদিত সংখ্যার চেয়ে কম, বর্তমান স্বাস্থ্য কেন্দ্রের কার্যক্রমের জন্য আপাতঃভাবে ঠিকই আছে বলে মনে হয়। নয়টি কেন্দ্রের মধ্যে, জরুরী ঔষধের সরবরাহ রয়েছে শুধুমাত্র ২টি কেন্দ্রে। এরমধ্যে একটিতে পাওয়া গেছে রোগী দেখার কক্ষে এবং অন্যটিতে স্টোর রুমে। প্রতিটি প্রসব কক্ষে অক্সিজেন আছে । প্রতিটি কেন্দ্রে শুধুমাত্র রোগী দেখার কক্ষ পুরোপুরি আলাদাভাবে আছে। প্রতিটি রোগী দেখার কক্ষে জায়গা ও বাতাস পর্যাপ্ত পরিমাণে রয়েছে কিন্তু পর্যাপ্ত আলো আছে মাত্র ৪টিতে। দু'টি প্রসবকক্ষে আলো-বাতাস পর্যাপ্ত রয়েছে। একটি কেন্দ্রে প্রসব কক্ষ সংলগ্ন বাথরুম আছে কিন্তু তা অন্যরোগীরাও ব্যবহার করে। এছাড়া প্রায় সকল স্বাস্থ্য কেন্দ্রের ময়লা-আবর্জনা উন্মুক্তভাবে ফেলা হয়েছে।

আঞ্চলিক ব্যবস্থাপকগণ তথ্য সংগ্রহের সময়কাল থেকে পূর্ববর্তী এক মাসে ৮টি ও সেন্টর স্পেশালিষ্টগণ ৬টি কেন্দ্র পরিদর্শন করেছিলেন। প্রতিটি কেন্দ্রে মেডিকেল অফিসার প্রেসক্রিপশন নিরীক্ষণ এবং সাধারণ আলোচনার মাধ্যমে কেন্দ্রের অন্য কর্মীদের কাজ পর্যবেক্ষণ করেন। ছয় জন পুরুষ প্যারামেডিক, ২ জন মহিলা প্যারামেডিক ও ৪ জন FWV-এর কাছে মাসিক কর্ম-পরিকল্পনা পাওয়া গেছে। রোগীর রেজিষ্টার এবং প্রেসক্রিপশনের সামঞ্জস্য পরীক্ষা করে দেখা গেছে যে, শতকরা ৮৪ ভাগ ক্ষেত্রে রোগ নির্ণয় সামঞ্জস্যপূর্ন ছিল। যে সকল এ্যান্টিবায়োটিক প্রদত্ত রোগীকে তাদের বাড়িতে ফলোআপ করার কথা, তাদের মধ্যে ৪৮% এর নাম রেজিষ্টারে লেখা হয়েছিল। যাদের নাম রেজিষ্টারে লেখা হয়েছিল, তাদের মধ্যে ৭৯% রোগীকে তাদের বাড়িতে গিয়ে

ফলোআপ করা হয়েছিল। প্রেসক্রিপশন পরীক্ষা করলে দেখা যায়, খুব সামান্য তথ্য লেখা আছে প্রেসক্রিপশনে। মাসিক পারফরমেন্স রিপোর্টের (MPR) রোগীর সংখ্যা এবং ডিজিজ প্রোফাইলের (Disease profile) রোগের সংখ্যা একই রকম দেখা গেছে ৬৬.৭% স্বাস্থ্য কেন্দ্রের ক্ষেত্রে। ফলাফলের আলোকে ব্র্যাক স্বাস্থ্য কেন্দ্রের গুণগত মান উন্নয়নের জন্য কিছু সুপারিশ করা হয়েছে। সেগুলি হলঃ

১। তত্ত্বাবধান প্রক্রিয়া আরও জোরদার হওয়া দরকার। স্বাস্থ্য কেন্দ্রর তত্ত্বাবধানের জন্য দক্ষ লোকবল প্রয়োজন। কেন্দ্র পর্যবেক্ষণের সময় তত্ত্বাবধান তালিকা (Supervisory check list) ব্যবহার করা উচিত যাতে সহকর্মীকে তৎক্ষণাৎ প্রয়োজনীয় ফিডব্যাক দেয়া যায় এবং তাতে তারাও সহজে সমস্যা বুঝতে পারেন।

২। কর্মীদের কর্মদক্ষতা বাড়ানোর জন্য প্রয়োজনীয় ট্রেনিং-এর ব্যবস্থা করা উচিত। এছাড়া রিফ্রেশার টেনিং এবং ট্রেনিং-উত্তর পর্যবেক্ষণ অবশ্যই করা উচিত।

৩। প্রেসক্রিপশনে বিশদভাবে অসুখ ও চিকিৎসার বিবরণ লেখা উচিত যাতে করে অন্য চিকিৎসকগণ রোগীর সমস্যা সম্বন্ধে বুঝতে পারেন। রেফারাল নোট প্রেসক্রিপশনের উপর লেখা উচিত।

৪। রের্কড ও রেজিষ্টারে সকল তথ্য সঠিকভাবে লিখে রাখা দরকার।

৫। ঔষধ-পত্র ব্যবহারের ব্যাপারে বিশেষভাবে লক্ষ্য রাখা দরকার। এ জন্য প্রতিটি কর্মীর নিকট ক্লিনিক্যাল গাইডলাইন থাকা দরকার এবং অবশ্যই চিকিৎসকের নিকটও। এখানেও তত্ত্বাবধানের ব্যবস্থার কথা মনে রাখতে হবে।

৬। স্বাস্থ্য সেবিকার ভূমিকার কথা মনে রেখে তাদের উৎসাহ ও কাজের স্বীকৃতি বাড়ানোর জন্য উদ্যোগ নেয়া উচিত। মাঠকর্মীদের স্বাস্থ্য সেবিকার সঙ্গে সম্পর্ক আরও জোরদার করা উচিত।

৭। ডিজিজ প্রোফাইলে সকল অসুখের উল্লেখ থাকা দরকার।

৮। প্রতিটি কর্মীর কাজে যোগদানের পরপরই ব্র্যাক স্বাস্থ্য কেন্দ্রের গাইডলাইনের উপর ধারণা দেয়া দরকার।

৯। ব্র্যাক স্বাস্থ্য কেন্দ্র শুরু হওয়ার সাথে সাথে প্রধান প্রধান স্বাস্থ্য সেবাগুলি থাকা দরকার।

১০। সুবিধাদিসহ স্বাস্থ্যসম্মত পায়খানা এবং ময়লা আবর্জনা ফেলার জন্য যথাযোগ্য ব্যবস্থা নেয়া উচিত।

১১। দূরবর্তী গ্রামগুলিতে সাব সেন্টারের মাধ্যমে সেবা দেয়ার কথা ভাবা উচিত। জরুরী রোগীকে হাসপাতালে নিয়ে যাওয়ার জন্যে পরিবহণের ব্যবস্থা করা দরকার।