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13. CEmOC 指定の郡病院及び DSF 対象郡の地図
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15. ローカルコンサルタント委託調査(Study on Maternal and Neonatal Child Health)
    ＊CD-ROM 版にのみ収録。
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付属資料1：コンサルタント調査日程

1st mission from 29 Nov to 26 Dec 2009

		Ms. Akiko HIRANO MNCH/Sector Analysis	Ms. Naomi IMANI MNCH/Institutional Analysis
29-Nov	Sun	Narita -> Bangkok TG641	
30-Nov	M	Bangkok -> Dhaka TG321 13:30	
1-Dec	T	**9:30** Meeting with JICA Office, SMPP	
2-Dec	W	**14:30** MoHFW, DGFP, DGHS, **16:00** Meeting with national consultants	
3-Dec	T	Site visit to Narsingdi, SMPP	
4-Dec	F	document review	
5-Dec	Sat	document review, **11:00** Saifur Rahman, Assistant Chief, M/O HFW	
6-Dec	Sun	**10:00** Dr. Khaled Islam, Senior Asst. Chief, (RHD, Unit) M/OHFW, Secretariat, **15:00~16:30** Meeting with DPs on MNH	
		17:00 Prof. Dr. Shaha Monir DG of DGHS @ DGHS	**16:30** Meeting with national consultants
7-Dec	M	**09:30** Dr. Jafar Ahmad Hakim, Director (MCH-Services) @ DGFP	
		14:30 Dr. Azad, Deputy Program Manager, (Community Clinic), @ DGHS	**11:20** Mr Md Zahir Uddin Babar, Director (MIS), LD (MIS services & Personnel-FP), DGFP **12:30** Dr. Md. Aminul Islam, Director (Admin) & Line Director (HRM), DGFP **14:45** Dr. A.K.M.Mahbubur Rahman, Line Director (Clinical Contraceptives), DGFP
		16:00 Dr. Borendronath Mandal, Director(PHC & ESD) @ DGHS	
8-Dec	T	**09:30** Director DNS, Mrs. Jahanara Begum, Director **12:00** Mr. Hafizur Rahman, Deputy Chief, Health Economics Unit, M/O HFW	
9-Dec	W	**13:00** Joint Chief Planning, Secretariat, MoHFW	**10:30** Dr. Khaleda, DPM (HRM), DGHS, **14:00** Mr. Abu Bakar Md Siddique, Chief Technical Manager, NEMEW(National Electro Medical Eduipment Maintainance Workshop), **15:30** Brig. General Md. Shahidul Haque Mallik, Director, Central Medical Stores Department(CMSD), DGHS
10-Dec	T	Document review	**09:30** Dr. AKS Mujibur Rahman, Line Dirctor Hospital,DGHS, **12:30** Ms Sabina Parveen, Assistant Director, Logistics & Supplies of DGFP
		15:30 Dr. Abul Monsur Director Planning, DGHS	
11-Dec	F	Documentation	
12-Dec	Sat	Documentation **15:30** Meeting with JICA	
13-Dec	Sun	**10:00** Dr. Jahangir, Care Bangladesh	
		18:30 Meeting with JICA	
14-Dec	M	**11:00** Ms. Fran McConville, Health Adviser & Ms. Shehlina Ahmed, DFID	**09:30** Mrs. Shuraiya Begum, Registerer-in-charge, Bangladesh Nursing Council(BNC), **11:00** Dr. Md. Aminul Hasan, DPM (Training), Hospital Unit, DGHS
		15:00 Meeting with JICA and local consultants	
15-Dec	T	**8:00** Dr. Afsana, BRAC	Document review
		14:00 Dr. Atef El Maghraby, MNH Project Coordinator, UNFPA	
16-Dec	W	**10:00** Dr. Nuzrul, Deputy PM, Demand Side Financing (DSF), DGHS, **PM** Field visit the UN joint project (MNH) to Mulvibazal	Document review
17-Dec	T	Field Visit to Mulvibazal	**18:00** Dr. Borendronath Mandal, Director(PHC & ESD)
18-Dec	F	Documentation	
19-Dec	Sat	Documentation	
20-Dec	Sun	**16:00** Dr. Nuzrul, DGHS	**10:00** Dr. Yasmin Rahman, DPM (Women Friendly Hospital), DGHS
21-Dec	M	**15:30~** Dr. Ishtiaq, Save the Children, **16:45~17:45** Dr. Ziaul Matin, UNICEF	**9:00** Dr. Jahir Uddin, Managing Director, FPAB Review of the field survey questionnaire for the local consultant
22-Dec	T	**10:00~11:00** Mr. Edward Thomas Espey (Ned), Country Director, Plan International **15:00** Dr. Nuzrul, DGHS	Field Visit to Brahmanbaria
23-Dec	W	**8:30** Meeting @ JICA	
		11:30 Meeting with ICDDR,B	Documentation
24-Dec	T	**11:00** TV conference @ JICA	
25-Dec	F	14:40 TG322 Dhaka -> Bangkok -> TG640 Narita	
26-Dec	Sat	Arrival in Japan	

2nd mission from 24 Jan to 13 Feb 2010

		Ms. Akiko HIRANO MNCH/Sector Analysis	Ms. Naomi IMANI MNCH/Institutional Analysis
24-Jan	S	arrival in Dhaka	
25-Jan	M	Meeting with mission members at JICA office	
26-Jan	T	AM JICA office meeting **13:00** National Neonatal Health Strategy Action Plan workhop	**15:00** Quality Assurance Cell, DGHS
27-Jan	W	Field trip to Jossore & Narail	Field trip to Bhola & Barisal
28-Jan	T		
29-Jan	F		
30-Jan	Sat	**10:00** PRDP workshop	Documentation
31-Jan	S	**9:30** Mission internal meeting	
		17:00 NIPORT training director	
1-Feb	M	**15:00** IMCI/DGHS programme manager, DGHS	Documentation
2-Feb	T	**9:00** WHO (turned out irrelevant) **10:00** EPI officer (GAVI/HSS), DGHS, **11:30** Community Clinic Project Additional Sectretary **16:00** CSBA Deputy Programme Manager, ESD/DGHS	**14:30** LLP at Planning, DGFP **16:30** LD Hospital, DGHS
3-Feb	W	**AM** Mission Internal Meeting	
		15:00 Assistant Chief, Planning Wing, **16:30** Community Clinic officer, Planning Wing	**14:30** LD, Planning, DGHS
4-Feb	T	AM Mission internal meeting,	
		16:00 NIPORT training director	**14:30** LD MCH DGFP
5-Feb	F	**AM** Mission internal meeting	
6-Feb	Sat	**PM** Mission internal meeting	
7-Feb	S	**8:30** Mission internal meeting, **11:50** Consultation meeting with DGHS and MoH officials, **15:30** JCC meeting	
8-Feb	M	**9:00** UNICEF interviews, **12:40** UN Joint Initiative NSC	**9:00** Meeting with JICA Country Representative **11:00** Internal Meeting
		15:00 Development Partner meeting @ JICA office, **17:00** Mission internal meeting	
9-Feb	T	**9:00** Mission internal meeting, **13:30** Report to JICA office, **15:15** Report to Japan Embassy, **16:00** Meeting with local consultants	
10-Feb	W	Review of local consultant's draft report	
11-Feb	T	**10:00** DGHS DSF officer, Telephone interviews with CC officer & ESD/RH officer	
		12:30 Mission internal meeting	
12-Feb	F	13:40 Leave Dhaka	
13-Feb	Sat	Arrive in Tokyo	

付属資料２：主要面談者リスト

１．バングラデシュ政府・関係機関

（１）保健家族福祉省

官房

Dr. Nargis , Additional Secretary, Community Clinic Program

Mr. Md Abdul Mannan, Joint Chief Planning

Mr. Saif Uddin Ahmed, Assistant Chief, Planning Wing

Dr. Saifur Rahman, Assistance Chief, Planning Wing

Dr. Khaled Islam, Sr. Asst. Chief, Human Resource Division

保健サービス局

Prof. Shah Monir Hossain, Director General, DGHS

Dr. Khaleda Begum, Officer on Special Duty, Human Resource Management, DGHS

Dr. Md. Abul Mansur Khan, Director Planning, DGHS

Dr. Barendra Nath Mandal, Director PHC & Line Director, Essential Service Delivery (ESD), DGHS

Dr. Md. Shamsul Haque, (New) Line Director, ESD, DGHS

Dr. Md. Nazrul Islam, Program Manager, RH/ESD, DGHS

Dr. A.K.S. Mujibur Rahman, Line Director, Improved Hosp. Services Management (IHSM), DGHS,

Dr. Md. Shah Jahan, Deputy Director, IHSM, DGHS

Dr. Md. Aminul Hasan, Deputy Program Manager, Training, IHSM, DGHS

Dr AKM Saidur Rahman, Deputy Program Manager, IHSM, DGHS

Dr. Md. Aminul Hasan, Deputy Program. Manager, Training, IHSM, DGHS

Dr. Yasmin Rahman, Deputy Program Manager, Women Friendly Hospital, IHSM, DGHS

Brig. General Md. Shahidul Haque Mallik, Director, Central Medical Store Depot, DGHS

Dr. Md. Saiful Islam, MO, QA Programme, DGHS

Dr. Adbul Mansur Khan, Line Director, Sector-wide Programme Management, DGHS

Dr. Mosaddeque Ahmed, Program Manager Integrated Management of Childhood Illness (IMCI), DGHS

Dr. Md. Altaf Hossain, Deputy Program Manager IMCI, DGHS

Dr. Md. Tajul Islam A. Bari, Deputy Program Manger EPI. DGHS

Dr. Humuyun Cabir, Deputy Program Manger CSBA, DGHS

Dr. K M Azad, Deputy Program Manager, Community Clinic, DGHS

家族計画局

Mr Md Zahir Uddin Babar, Director, Management Information System (MIS) & Line Director, MIS services & Personnel-FP, DGFP

Dr. Md. Aminul Islam, Director/ Administration & Line Director/HRM, DGFP

Mr. Syed Aliuzzaman, Asst. Chief, Planning, DGFP

Mr. Md. Mizanur Rahman FP Officer, Planning, DGFP

Dr. A.K.M.Mahbubur Rahman, Line Director, Clinical Contraception Service Delivery Programme, DGFP

Dr. Jafar Ahmad Harkim, Director MCH-services, DGFP

Mr. Shaiful Haque, Assistant Director, MIS Unit, DGFP

Ms. Sabina Parveen, Assistant Director, Foreign Procurement, Logistics and Supplies Unit, DGFP

その他

Mr. Md. Hafizur Rahman, Deputy Secretary, Health Economic Unit (HEU)

Mr. Md. Rafiqul Islam Khan, Deputy Secretary, HEU

Mr. A.B.M. Siddique, Chief, Tech. Manager, National Electro-Medical Equipment Maintenance Workshop & Training Centre (NEMEW)

Engr. Anwar Hossain, Head of X-ray section, NEMEW

Engr. M.A.Hannan Mia, Head of Electronics, NEMEW

Ms. Shuriya Begum, Registrar in charge, Bangladesh Nursing Council

Dr. Md. Aktor Hossain, Director Training, National Institute of Population Research and Training (NIPORT)

Mrs. Jahanara Begum, Director, Directorate of Nursing Services (DNS)

Ms. Farida Begum, National consultant-WHO, DNS

（２）Bramanbaria 県

Dr. Md. Nurul Amin, Civil Surgeon & Superintendent of DH (Acting)

Dr. Md. Jahangir Hossain, Deputy Director, DGFP

Dr. Musa, RMO, DH

Dr. Jabunnenesa Islam, Sr. Consultant-Obs/Gyn, Consultant-anesthetics, DH

Dr. Rais Uddin Ahmed, MO, MCWC

Dr. Abdul Kader, UH&FPO, Shorail UHC

Dr. Kowser Hossain Chowdhury, MO, Shorail UHC

（３）Moulvibazar 県

Dr. Parijat Kumar Peaul, Civil Surgeon

Dr. Azim Uddin, UH&FPO, Barolekha UHC

（４）Jossore 県

Dr. Md Salaudddin, Civil Surgeon

Dr. Nauda Dulal Biswcy, MO, MCWC

Dr. A. S. M. Abdun Razzaque, RMO, Chowgacha UHC

Dr. Md. Hoque, Consultant-Obs/Gyn, Chowgacha UHC

（５）Narail 県

Dr. Rezwanul Haque, Civil Surgeon

（６）Barisal 県

Dr. Anil Chamdra Datta, Civil Surgeon

Dr. Abdus Sattar Mio, Deputy CS

Dr. Shal Alamsharif, UH&FPO, Charfasson UHC

Dr. Md. Siddiq Rahman, RMO, Charfasson UHC

Dr. Nurul Islam, UH&FPO, Banaripara UHC

Dr. Jasimuddin Howkdar, PMO, Banaripara UHC

Dr. Monil Islam, MO/Anesthetist, Banaripara UHC

Md. Ziaul Ahsan, DSF Coordinator, Banaripara UHC

２．開発パートナー

Dr. Jahangir Hossain, Project Director-Health, CARE Bangladesh

Dr. Shamraj Arefin, Peoject Coordinator, MNH initiative, CARE Bangladesh

Dr. Md. Khairul Alam, Technical Coordinator, MNH initiative, CARE Bangladesh

Dr. Md. Ahsanul Islam, Project Manager Narsingdi, SMPP, CARE Bangladesh

Ms. Fran McConville, Health Adviser, DFID

Dr. Kaosar Afsana, Associate Director, BRAC

Dr. Atef Hussein El Maghraby, MNH programme coordinator, UNFPA

Dr. Imteaz Mannan, Project Director-Health, Save the Children US

Md. Rafiqul Islam, Manager, Operations, Barisal, Save the Children US

Dr. Md. Shohel Rana, Deputy Program Manager – MCHN, Barisal, Save the Children US

Dr. Ziaul Matin, Project Officer, Health and Nutrition Section, UNICEF

Ms. Mira Mitra, Health and Nutrition Section, UNICEF

Dr. Shumona Shafinaz, Health and Nutrition Section, UNICEF

Ms. Kazi Dil Afroza Islam, Health and Nutrition Section, UNICEF

Mr. Edward T. Espey, Country Director, Plan Bangladesh

Mr. Saiful Islam, Program Support Manager, Plan Bangladesh

Dr. S.M. Shahidullah, Project Manager, Plan Bangladesh

Dr. M A Quaiyum, Associate Scientist, ICDDR,B

Dr. Nafis AL Haque, Senior Research Investigator, ICDDR,B

Dr. Jahir Uddin Ahmed, Director General, Family Planning Association of Bangladesh

蒲　章則, WHO SEARO

３．日本関係者

（１）日本大使館

日田 春充　公使参事官

上原 孝史　公使参事官

吉田 明美　一等書記官

（２）JICA バングラデシュ事務所

戸田 隆夫　事務所長

長 英一郎　次長

古田 成樹　次長

牧本 小枝　所員

石井　克美　企画調査員

駒走　拓三　ボランティア調整員

Salma Akter, Program Officer

（３）SMPP 関係者

吉村　幸江　チーフアドバイザー

遠藤　亜貴子　専門家

横井　健二　業務調整員

Dr. Md. Tajul Islam, Technical Adviser

Mr. Mokubul Ahamed, District Coordinator

Mr. Sanwar Hossain, Administration & Finance Officer

Dr. Mabhuka Begum, QA Consultant

（４）青年海外協力隊

岡　隊員

志田　隊員

付属資料 3. 母子保健に関する指標

表１：新生児、乳児死亡率（BDHS2007）

Table 8.2 Early childhood mortality rates by socioeconomic characteristics

Neonatal, postneonatal, infant, child, and under-five mortality rates for the 10-year period preceding the survey, by background characteristics, Bangladesh 2007

Background characteristic	Neonatal mortality (NN)	Postneonatal mortality[1] (PNN)	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-five mortality ($_5q_0$)
Residence					
Urban	33	17	50	13	63
Rural	41	18	59	19	77
Division					
Barisal	31	19	50	23	71
Chittagong	34	20	54	27	79
Dhaka	38	18	55	14	69
Khulna	32	16	49	10	58
Rajshahi	46	12	58	14	71
Sylhet	53	31	84	25	107
Mother's education					
No education	47	24	71	23	93
Primary incomplete	35	23	58	19	76
Primary complete[2]	44	14	59	10	68
Secondary incomplete	39	10	48	13	61
Secondary complete or higher[3]	21	5	26	6	32
Wealth quintile					
Lowest	48	18	66	22	86
Second	44	23	67	19	85
Middle	40	23	63	22	83
Fourth	32	14	46	16	62
Highest	27	9	36	8	43

[1] Computed as the difference between the infant and neonatal mortality rates
[2] Primary complete is defined as completing grade 5.
[3] Secondary complete is defined as completing grade 10.

出所：Bangladesh Demographic and Health Survey 2007 より抜粋

表 2：熟練者による出産介助（SBA）率（BDHS2007）

Table 9.7 Assistance during childbirth

Percent distribution of live births in the five years preceding the survey by person providing assistance during childbirth, percentage attended by a medically trained provider, and percentage delivered by caesarean section, according to background characteristics, Bangladesh 2007

Background characteristic	Medically trained providers			Non-medically trained providers						Total	Percentage delivered by a medically trained provider	Percentage delivered by C-section	Number of births
	Qualified doctor	Nurse/ midwife/ para-medic/ FWV	CSBA	Trained TBA	Untrained TBA	Relatives/ friends/ neighbors	Other	No one	Missing				
Mother's age at birth													
<20	12.1	5.7	0.0	11.7	65.5	6.0	0.1	1.2	0.0	100.0	17.8	6.1	2,011
20-34	15.2	5.5	0.1	10.4	62.1	6.4	0.2	2.2	0.1	100.0	18.6	8.4	5,728
35-49	10.1	2.1	0.2	10.2	64.0	7.7	0.1	5.2	0.6	100.0	12.4	6.0	518
Birth order													
1	20.8	7.4	0.0	10.9	55.8	4.1	0.1	0.9	0.0	100.0	28.5	12.7	2,080
2-3	11.1	5.1	0.2	11.2	65.9	7.0	0.2	1.5	0.0	100.0	16.5	6.4	2,577
4-5	4.6	2.8	0.1	10.7	70.2	6.6	0.0	4.7	0.5	100.0	7.5	2.6	1,010
6+	1.9	1.4	0.1	8.9	70.0	11.9	0.0	4.9	0.9	100.0	3.4	1.1	420
Place of delivery													
Public sector	70.7	27.7	0.0	0.5	0.5	0.4	0.0	0.4	0.0	100.0	98.4	54.6	428
Private/NGO sector	88.9	10.5	0.0	0.1	0.0	0.1	0.0	0.4	0.0	100.0	99.5	67.5	459
Respondent's/other home	1.0	2.8	0.1	12.7	75.6	7.4	0.2	2.2	0.0	100.0	3.9	0.0	5,148
Residence													
Urban	26.1	10.4	0.1	11.5	46.2	5.9	0.0	1.7	0.0	100.0	36.7	15.9	1,249
Rural	9.2	3.9	0.1	10.7	66.9	6.9	0.2	2.1	0.1	100.0	13.2	5.4	4,809
Division													
Barisal	7.8	5.4	0.2	9.6	67.8	7.5	0.5	1.4	0.0	100.0	13.4	5.8	585
Chittagong	12.5	5.9	0.1	11.5	64.4	4.4	0.1	1.1	0.0	100.0	18.5	6.5	1,557
Dhaka	14.5	5.1	0.2	15.0	57.8	4.5	0.5	2.5	0.2	100.0	19.8	10.1	1,908
Khulna	16.8	9.8	0.0	5.8	62.5	4.5	0.0	0.6	0.0	100.0	26.5	9.7	578
Rajshahi	11.7	5.7	0.0	8.5	62.6	9.7	0.0	5.7	0.1	100.0	15.4	6.4	1,306
Sylhet	8.1	2.8	0.0	6.5	71.6	10.5	0.1	0.5	0.5	100.0	10.9	4.5	547
Mother's education													
No education	2.6	1.9	0.1	10.4	71.6	8.9	0.1	4.0	0.5	100.0	4.6	1.1	1,658
Primary incomplete	5.0	3.1	0.2	12.4	70.4	6.5	0.5	2.0	0.2	100.0	8.5	2.2	1,551
Primary complete[1]	7.5	5.5	0.0	7.9	70.1	7.6	0.0	1.8	0.0	100.0	12.6	5.7	565
Secondary incomplete	18.9	8.5	0.2	10.9	56.2	4.7	0.0	0.7	0.0	100.0	27.4	11.2	1,730
Secondary complete or higher[2]	38.1	9.2	0.0	11.0	37.8	3.1	0.2	0.5	0.0	100.0	47.3	25.7	757
Wealth quintile													
Lowest	5.5	1.5	0.0	9.0	70.8	12.0	0.0	5.2	0.2	100.0	4.8	1.8	1,567
Second	5.5	2.9	0.2	12.4	71.9	6.1	0.1	2.5	0.5	100.0	6.7	1.9	1,512
Middle	7.0	5.0	0.1	8.5	71.5	6.5	0.2	1.6	0.0	100.0	12.1	5.5	1,175
Fourth	15.2	7.2	0.0	14.6	57.8	5.2	0.2	1.7	0.0	100.0	22.5	8.5	1,149
Highest	39.4	11.5	0.5	9.7	36.0	2.6	0.2	0.5	0.0	100.0	50.9	25.7	1,056
Total	12.7	5.2	0.1	10.8	62.6	6.5	0.1	2.0	0.1	100.0	18.0	7.5	6,058

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation. Total includes 16 births with "other" for place of delivery, 7 births with information missing on place at delivery and 17 births with information missing on mothers' educational attainment

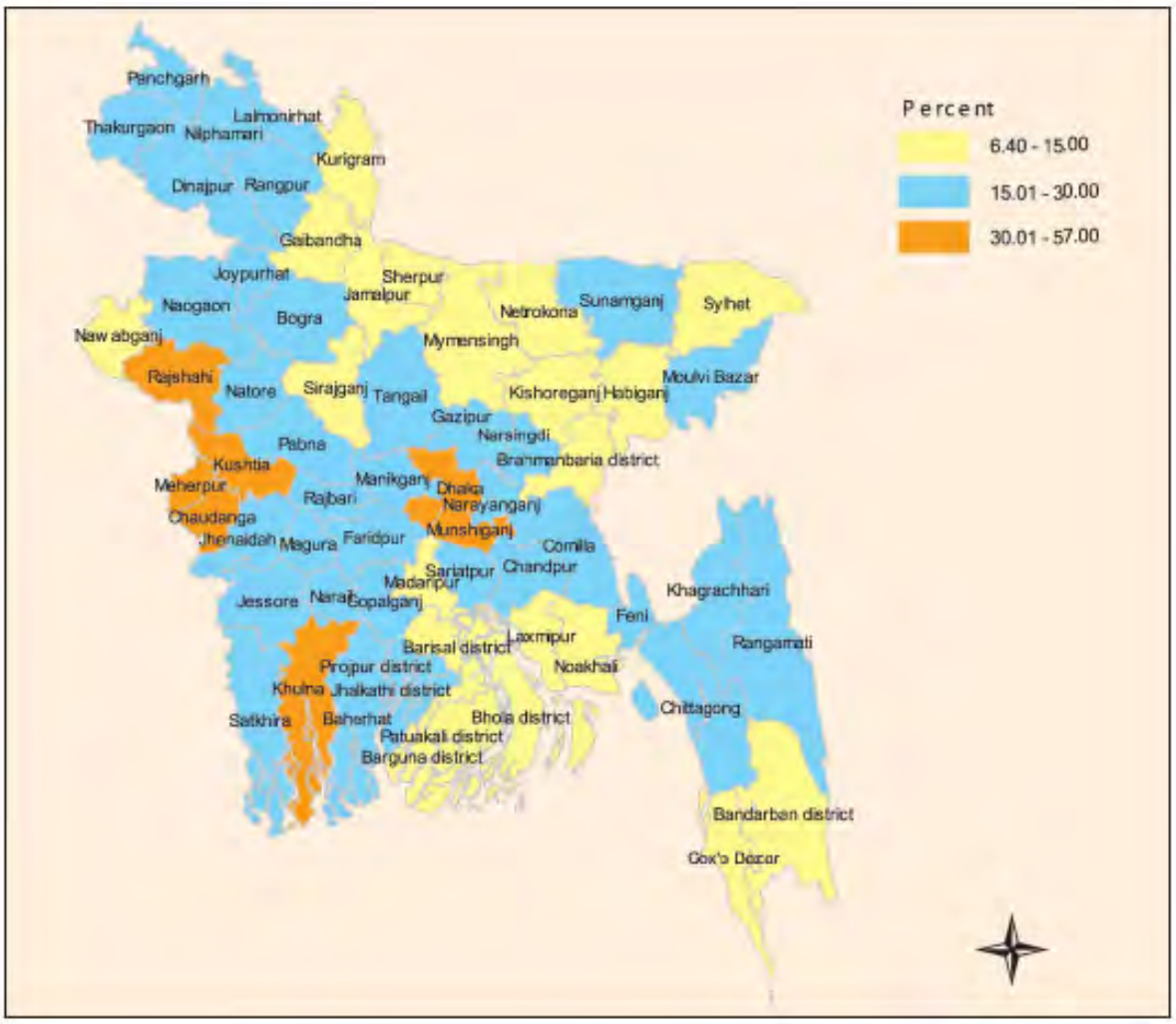
[1] Primary complete is defined as completing grade 5.

[2] Secondary complete is defined as completing grade 10.

FWV = family welfare visitor; CSBA = community skilled birth attendant ; TBA = traditional birth attendant

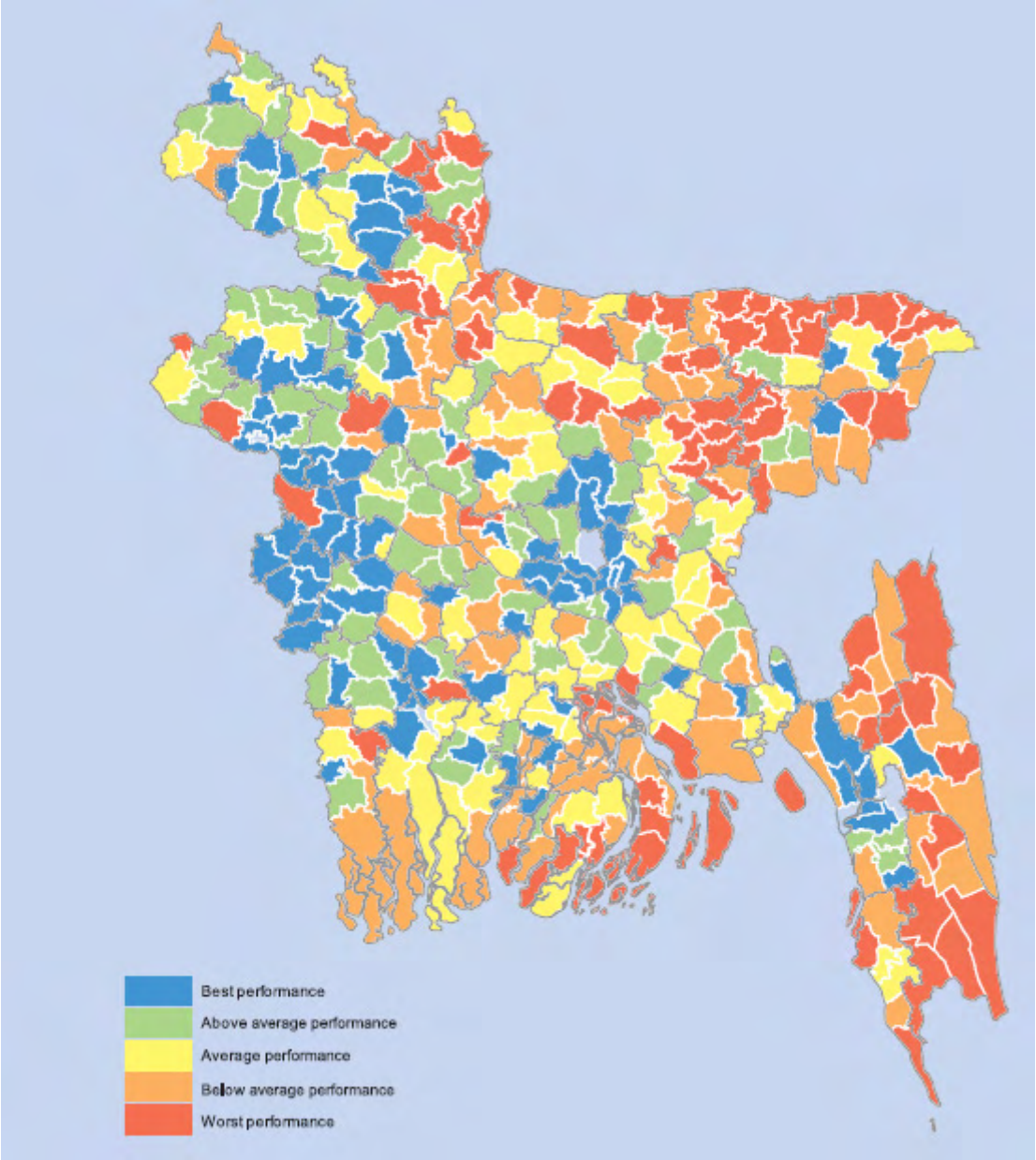
出所：BDHS2007 より抜粋

図 1：県ごとの SBA 率（MDG 2008（2006 年 MICS データ））



出所：MDG Progress Report 2008 から抜粋

図 2. 郡ごとの SBA 率（MICS 2009）



出所：Key findings of the Bangladesh Multiple Indicator Cluster Survey 2009 (preliminary report), 2010 から抜粋

表 3：分娩場所（BDHS2007）

Table 9.6 Place of childbirth

Percent distribution of live births in the five years preceding the survey by place of delivery, and percentage delivered in a health facility, according to background characteristics, Bangladesh 2007

Background characteristic	Health facility: Public	Health facility: Private/ NGO	Home	Other/ missing	Total	Percentage delivered in a health facility	Number of births
Mother's age at birth							
<20	7.6	6.6	85.5	0.2	100.0	14.3	2,011
20-34	7.0	8.1	84.4	0.4	100.0	15.2	3,728
35-49	4.0	6.9	88.4	0.7	100.0	10.9	318
Birth order							
1	11.3	12.6	75.8	0.3	100.0	23.9	2,050
2-3	6.4	6.6	86.7	0.3	100.0	13.0	2,577
4-5	2.5	2.7	94.3	0.5	100.0	5.2	1,010
6+	1.6	0.9	96.6	0.9	100.0	2.5	420
Antenatal care (ANC) visits[1]							
None	2.2	1.0	96.7	0.2	100.0	3.1	1,944
1-3	7.3	6.1	86.5	0.0	100.0	13.5	1,944
4+	18.2	27.9	52.9	1.0	100.0	46.1	1,011
Residence							
Urban	13.3	17.4	68.8	0.6	100.0	30.6	1,249
Rural	5.5	5.0	89.2	0.3	100.0	10.5	4,809
Division							
Barisal	4.6	4.9	90.5	0.0	100.0	9.5	383
Chittagong	7.6	6.0	85.7	0.7	100.0	13.6	1,337
Dhaka	7.1	9.8	82.8	0.3	100.0	16.9	1,908
Khulna	11.4	11.1	77.3	0.2	100.0	22.4	578
Rajshahi	6.6	6.6	86.5	0.3	100.0	13.2	1,306
Sylhet	4.0	4.2	91.4	0.4	100.0	8.2	547
Mother's education							
No education	1.2	1.4	97.0	0.4	100.0	2.7	1,658
Primary incomplete	4.5	2.1	93.1	0.2	100.0	6.6	1,331
Primary complete[4]	6.4	3.0	90.4	0.3	100.0	9.4	565
Secondary incomplete	10.7	11.0	77.7	0.5	100.0	21.8	1,730
Secondary complete or higher[5]	16.6	26.3	56.8	0.4	100.0	42.8	757
Wealth quintile							
Lowest	2.5	1.9	95.3	0.2	100.0	4.4	1,367
Second	3.7	1.6	94.4	0.4	100.0	5.2	1,312
Middle	5.5	3.4	91.0	0.1	100.0	8.9	1,173
Fourth	8.9	8.2	82.2	0.7	100.0	17.0	1,149
Highest	17.1	26.3	56.2	0.4	100.0	43.4	1,056
Total	7.1	7.6	85.0	0.4	100.0	14.6	6,058

Note: Total includes 7 births with information missing on number of ANC visits and 17 births with information missing on mother's educational attainment

[1] Includes only the most recent birth in the five years preceding the survey

[4] Primary complete is defined as completing grade 5.

[5] Secondary complete is defined as completing grade 10.

出所：BDHS2007 より抜粋

表 4：産前検診（ANC）率（BDHS2007）

Table 9.1 Antenatal care

Percent distribution of women age 15-49 who had a live birth in the five years preceding the survey by antenatal care (ANC) provider during pregnancy for the most recent birth, percentage receiving any ANC, and percentage receiving ANC from a medically trained provider, according to background characteristics, Bangladesh 2007

Background characteristic	Medically trained provider: Qualified doctor	Nurse/ midwife/ paramedic/ FWV	CSBA/ MA/ SACMO	Non-medically trained provider[1]	No one	Missing	Total	Percentage receiving: Any ANC	ANC from a medically trained provider	Number of women
Mother's age at birth										
<20	36.6	18.5	0.6	9.7	34.6	0.0	100.0	65.4	55.8	1,511
20-34	36.2	14.7	0.5	8.3	40.2	0.1	100.0	59.7	51.4	3,099
35-49	21.9	12.0	0.4	5.7	59.4	0.7	100.0	39.9	34.2	296
Birth order										
1	48.1	18.5	0.6	7.2	25.6	0.0	100.0	74.4	67.2	1,566
2-3	34.7	15.6	0.6	9.7	39.2	0.1	100.0	60.6	50.9	2,141
4-5	23.4	12.8	0.4	8.8	54.6	0.0	100.0	45.4	36.6	843
6+	13.4	10.9	0.1	6.8	68.3	0.6	100.0	31.2	24.4	355
Residence										
Urban	55.8	15.3	0.2	4.4	24.1	0.2	100.0	75.7	71.3	1,039
Rural	30.0	15.8	0.6	9.7	43.8	0.1	100.0	56.1	46.4	3,866
Division										
Barisal	30.8	12.2	0.6	8.7	47.5	0.2	100.0	52.3	43.7	313
Chittagong	40.3	11.7	0.4	7.9	39.7	0.0	100.0	60.3	52.4	1,030
Dhaka	35.1	12.7	0.4	8.5	43.0	0.3	100.0	56.8	48.2	1,556
Khulna	43.9	18.0	0.7	8.3	29.1	0.0	100.0	70.9	62.6	503
Rajshahi	29.2	25.3	0.5	9.6	35.4	0.0	100.0	64.6	55.0	1,118
Sylhet	35.1	10.6	1.2	7.5	45.6	0.0	100.0	54.4	46.9	384
Mother's education										
No education	15.2	13.1	0.5	8.2	62.9	0.2	100.0	37.0	28.7	1,282
Primary incomplete	23.6	17.2	0.6	10.2	48.2	0.3	100.0	51.6	41.4	1,056
Primary complete[2]	32.0	17.0	1.1	11.3	38.5	0.0	100.0	61.5	50.2	451
Secondary incomplete	48.9	17.3	0.4	8.6	24.8	0.0	100.0	75.2	66.6	1,453
Secondary complete or higher[3]	67.4	14.2	0.3	3.9	14.2	0.0	100.0	85.8	82.0	651
Wealth quintile										
Lowest	15.0	15.4	0.4	10.7	58.3	0.2	100.0	41.6	30.8	1,068
Second	19.3	16.7	0.3	11.1	52.4	0.2	100.0	47.4	36.3	1,045
Middle	30.4	17.1	0.4	11.0	41.1	0.0	100.0	58.9	48.0	932
Fourth	46.9	17.6	1.1	6.4	27.9	0.1	100.0	71.9	65.5	958
Highest	71.6	11.6	0.3	2.8	13.6	0.0	100.0	86.4	83.6	902
Total	35.5	15.7	0.5	8.6	39.6	0.1	100.0	60.3	51.7	4,905

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications is considered in this tabulation. Total includes 12 women with information missing on educational attainment

[1] Includes health assistant (HA), family welfare assistant (FWA), trained and untrained traditional birth attendants (TBAs), unqualified doctor, and other providers

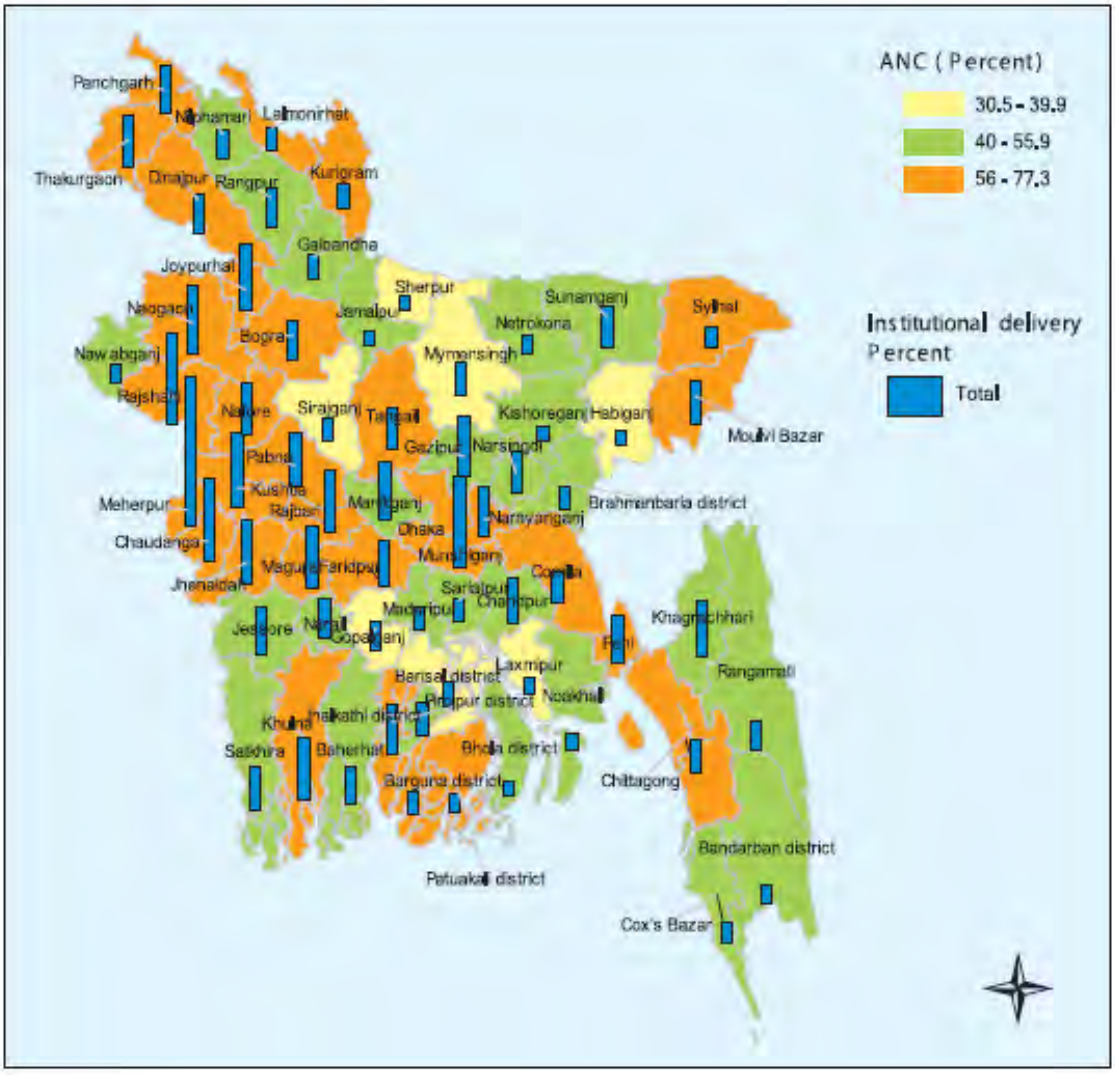
[2] Primary complete is defined as completing grade 5.

[3] Secondary complete is defined as completing grade 10.

FWV = family welfare visitor; CSBA = community skilled birth attendant; MA = medical assistant; SACMO = sub-assistant community medical officer.

出所：MDHS2007 から抜粋

図 3：県ごとの ANC 率（MDG2008（2006 年 MICS データ））



出所：MDG Progress Report 2008 から抜粋

表5：母親に対する産後検診（PNC）率（BDHS2007）

Table 9.8.1 Postnatal checkup: Women

Among women age 15-49 giving birth in the five years preceding the survey, the percent distribution by type of provider of the mother's first postnatal check-up for the last live birth, and the percentage receiving postnatal care from a medically trained provider, according to background characteristics, Bangladesh 2007

Background characteristic	Medically trained provider: Qualified doctor	Medically trained provider: Nurse/ midwife/ paramedic/ FWV	Medically trained provider: CSBA/ MA/ SACMO	Non-medically trained provider[1]	No postnatal checkup[2]	Total	Percentage receiving postnatal care from a medically trained provider	Number of women
Mother's age at birth								
<20	15.7	4.6	0.1	9.1	70.5	100.0	20.4	1,511
20-34	18.3	3.7	0.4	8.8	68.9	100.0	22.4	3,099
35-49	13.5	1.1	0.2	7.0	78.1	100.0	14.8	296
Birth order								
1	26.3	5.7	0.3	9.0	58.7	100.0	32.3	1,566
2-3	16.0	3.6	0.4	9.1	70.9	100.0	20.0	2,141
4-5	8.1	1.7	0.0	7.9	82.2	100.0	9.9	843
6+	6.2	1.5	0.2	7.5	84.6	100.0	7.9	355
Residence								
Urban	32.0	6.8	0.1	5.6	55.5	100.0	39.0	1,039
Rural	13.2	3.0	0.3	9.6	73.8	100.0	16.5	3,866
Division								
Barisal	14.0	2.8	0.8	8.2	74.2	100.0	17.6	313
Chittagong	18.5	4.4	0.6	9.8	66.7	100.0	23.5	1,030
Dhaka	18.2	4.1	0.1	6.1	71.5	100.0	22.4	1,556
Khulna	22.1	6.0	0.3	13.3	58.3	100.0	28.4	503
Rajshahi	14.5	2.9	0.0	9.3	73.3	100.0	17.3	1,118
Sylhet	13.9	1.9	0.3	9.5	74.3	100.0	16.2	384
Education								
No education	5.3	1.3	0.2	7.1	86.1	100.0	6.8	1,282
Primary incomplete	7.8	1.7	0.1	10.1	80.2	100.0	9.7	1,056
Primary complete[3]	11.3	3.5	0.3	10.7	74.2	100.0	15.1	451
Secondary incomplete	24.0	5.9	0.4	9.2	60.6	100.0	30.3	1,453
Secondary complete or higher[4]	45.2	7.6	0.4	7.7	39.1	100.0	53.2	651
Wealth quintile								
Lowest	6.0	1.4	0.3	7.1	85.3	100.0	7.6	1,068
Second	7.5	2.1	0.4	10.2	79.9	100.0	9.9	1,045
Middle	9.6	3.7	0.2	11.7	74.8	100.0	13.6	932
Fourth	22.0	5.4	0.2	10.8	61.6	100.0	27.6	958
Highest	44.6	7.1	0.3	3.9	44.1	100.0	52.0	902
Total	17.2	3.8	0.3	8.8	69.9	100.0	21.3	4,905

Note: Total includes 12 women with information missing on educational attainment

[1] Includes health assistant (HA), family welfare assistant (FWA), trained and untrained traditional birth attendants (TBAs), unqualified doctor, and other

[2] Includes women who received a checkup after 41 days

[3] Primary complete is defined as completing grade 5.

[4] Secondary complete is defined as completing grade 10.

FWV = family welfare visitor; CSBA = community-skilled birth attendant; MA = medical assistant; SACMO = sub-assistant community medical officer

出所：BDHS2007より抜粋

表 6：子供に対する産後検診（PNC）率（BDHS2007）

Table 9.8.2 Type of provider of first postnatal checkup: Children

Among women's most recent live births in the five years preceding the survey, the percent distribution by type of provider of the children's first postnatal checkup, and the percentage of children receiving postnatal care from a medically trained provider, according to background characteristics, Bangladesh 2007

Background characteristic	Medically trained provider: Qualified doctor	Medically trained provider: Nurse/ midwife/ paramedic/ FWV	Medically trained provider: CSBA/ MA/ SACMO	Non-medically trained provider[1]	No postnatal checkup[2]	Total	Percentage receiving postnatal care from a medically trained provider	Number of children
Mother's age at birth								
<20	16.7	4.2	0.2	10.7	68.3	100.0	21.0	1,511
20-34	19.1	3.6	0.3	9.3	67.6	100.0	23.1	3,099
35-49	12.9	1.4	0.2	5.9	79.6	100.0	14.5	296
Birth order								
1	27.1	5.4	0.3	10.9	56.3	100.0	32.8	1,566
2-3	17.2	3.4	0.4	9.7	69.3	100.0	21.0	2,141
4-5	8.3	1.8	0.1	7.9	81.9	100.0	10.2	843
6+	5.0	1.6	0.2	6.8	86.4	100.0	6.8	355
Residence								
Urban	32.6	7.3	0.0	5.3	54.7	100.0	40.0	1,039
Rural	14.0	2.7	0.3	10.7	72.3	100.0	17.0	3,866
Division								
Barisal	15.1	3.6	1.2	8.7	71.3	100.0	20.0	313
Chittagong	19.3	4.5	0.6	11.0	64.6	100.0	24.4	1,030
Dhaka	18.6	3.8	0.1	5.9	71.6	100.0	22.5	1,556
Khulna	25.0	5.5	0.3	16.5	52.8	100.0	30.7	503
Rajshahi	14.8	2.4	0.0	10.5	72.3	100.0	17.2	1,118
Sylhet	14.0	2.3	0.1	9.4	74.3	100.0	16.4	384
Mother's education								
No education	5.3	1.5	0.1	7.1	86.1	100.0	6.8	1,282
Primary incomplete	7.8	1.8	0.4	9.4	80.6	100.0	10.0	1,056
Primary complete[3]	12.2	3.7	0.3	11.3	72.4	100.0	16.3	451
Secondary incomplete	25.7	5.1	0.5	11.6	57.2	100.0	31.2	1,453
Secondary complete or higher[4]	46.3	7.8	0.1	9.0	36.8	100.0	54.2	651
Wealth quintile								
Lowest	6.2	1.6	0.2	7.6	84.4	100.0	8.0	1,068
Second	7.8	2.1	0.2	11.8	78.1	100.0	10.0	1,045
Middle	11.0	2.6	0.5	11.2	74.7	100.0	14.1	932
Fourth	23.8	5.3	0.3	12.7	57.9	100.0	29.4	958
Highest	44.7	7.3	0.3	4.1	43.6	100.0	52.3	902
Total	18.0	3.7	0.3	9.5	68.6	100.0	21.9	4,905

Note: Total includes 12 children with information missing on mothers' educational attainment
[1] Includes health assistant (HA), family welfare assistant (FWA), trained and untrained traditional birth attendants (TBAs), unqualified doctor, and other
[2] Includes women who received a checkup after 41 days
[3] Primary complete is defined as completing grade 5.
[4] Secondary complete is defined as completing grade 10.
FWV = family welfare visitor; CSBA = community-skilled birth attendant; MA = medical assistant; SACMO = sub-assistant community medical officer

出所：BDHS2007 から抜粋

付属資料 4. 母子保健指標に関する MDGs の達成状況

	Base/Year 1990/91	Current status	Target by 2015	Status of progress
Goal 4: Reduce Child Mortality				
Target 4.A: Reduce by two-third, between 1990 and 2015, the under-five mortality rate				
4.1 Under-five mortality rate (per 1000 live births)	146	67 (2009)	48	On track
4.2 Infant mortality rate (per 1000 live births)	92	45(2009)	31	On track
4.3 Proportion of 1 year-old children immunized against measles (%)	54	87.2 (2007)*	100	On track
Goal 5: Improve Maternal Health				
Target 5.A reduce by three quarters, between 1990 and 2015, the maternal mortality ratio				
5.1 Maternal mortality ratio, per 100,000 live births	574 (1990)	348 (2008)	144	Not achievable by 2015
5.2 Proportion of births attended by skilled health personnel (%)	5.0	24.4 (2009)	50	Not achievable by 2015
Target 5.B Achieve, by 2015, universal access to reproductive health				
5.3 Contraceptive prevalence rate (%)	39.7	59.0(2007)*	-	-
5.4 Adolescent birth rate, per 1000 women	77	59 (2007)*	-	-
5.5a Antenatal care coverage (at least one visit) (%)	27.5 (1993)	60.3 (2007)*	100	Will be close
5.5b: Antenatal care coverage (at least four visits) (%)	5.5 (1993)	20.6 (2007)*	100	Not achievable by 2015
5.6 Unmet need for family planning (%)	19.4 (1993)	17.6 (2007)*	-	-

出所：MDGs Bangladesh Progress at a Glance 2009 & MDG Bangladesh Progress Report 2008（* 印のデータ及び Status of Progress）から抜粋

付属資料 5. 母子保健に係る主な開発計画・保健政策・戦略の概要

主な開発計画・政策文書	概要	備考
6th 5 Year Plan 2011 – 2016 (fist draft)	母子保健対策が保健分野の優先課題であることに変わりなく、主要アプローチとして熟練介助（SBA）率の増加、緊急産科ケア設備拡充、コミュニティクリニック強化、保健行政強化の一環としての地方分権化（財政措置を伴うローカルレベルプランニング導入）推進などがあげられている。	ファーストドラフトの内容であり、最終案については未確認。
Health, Nutrition and Population Sector Programme 2003 – 2011	３つのコンポーネント。最優先目標：①妊産婦死亡率の低下、②出生率低下、③栄養失調の改善、④乳幼児死亡率低下、⑤結核やその他の疾患による影響軽減、⑥非感染症や事故の防止。母子保健のための主要対策として、妊産婦死亡率の原因となる 3 つの遅れに対応するため、緊急産科ケアの対応向上のための施設整備および医療サービス提供者能力向上、熟練者による介助率の向上、及びコミュニティ参加・動員、さらに、女性の権利保護・暴力からの保護などがあげられている。	元々2003-2010 年までの期間だったのが、2001 年（6 月）までプールファンドの予算の増減なく延期。
Next Sector Programme 2011-	（ドラフトコンセプトペーパーによると）重点課題：①保健・栄養・人口に関するサービス提供の促進、②サポートシステムと保健省の監督者（Stewardship）としての役割強化。具体的には、コミュニティクリニック（CC）を通じた PHC のワンストップサービスの提供、Upazila Health System 構築の基礎固め、また、母性保護サービス強化に関して、CC のマネージメント委員会をコミュニティ支援グループとして活用する。更に、地方分権化及びローカルレベルプランニング（LLP）に関しては、現在実施予定の LLP パイロットが成功すれば拡大する計画。	2010 年 1 月末に保健省がドラフトコンセプトペーパーを基に意見交換ワークショップを開催。2011 年 7 月からの実施を目指し、策定中。

National Health Policy 2008	ゴール：特に貧しい人々や女性・子供・老人を含む脆弱なグループの健康、栄養、家族福祉環境の持続的向上を目指す。目標：利用者中心の質の高い基礎的サービスの拡充と人々のニーズに応えるための持続的保健システムの開発。主な戦略：①保健サービス、特にPHC提供機能を強化し、郡病院、ユニオン保健センター、CCを整備、②政府の監督者（Stewardship）としての役割を強化、民間セクターとの連携推進。保健予算の上昇を目指し、国家予算の保健（HNP）分野への割合を現行の7%から段階的に2015年までに12%に増加する。また、民間セクターの投資や開発予算の増加も期待。M&Eについては、毎年保健省が年次レビューを作成し、5年ごとにポリシーは見直しされる予定。	最終承認待ち。
National Strategy for Maternal Health 2001	ゴール：妊産婦死亡及び疾病を減少する。基本方針：①妊産婦死亡率削減のための緊急産科ケアの強化、②合併症の早期発見・適切なレファラル実施のための基礎的産科ケアの提供、③女性の権利の推進、④サービスの質の確保。	2009年に改訂作業が開始。
National Neonatal Health Strategy and Guidelines for Bangladesh 2009	ゴール：政策、サービス利用率の改善を通して、新生児死亡率（2015年までに22/対1000出生数）及び疾病率の減少。主な目標：①証拠に基づく介入によるサービス提供改善、②全てのレベルのサービス提供者の能力強化、③母親とその家族の新生児ケアに対する意識を高める、④人材や資金などあらゆる資源の全体管理を向上、⑤コミュニティや市民社会を巻込み、活動を監督。特に、Maternal health careとの連携もあげられており、施設分娩の増加と全てのレベルでの緊急産科ケアの向上、地域助産師（Community based SBA：CSBA）の活用強化、母親と新生児の産後検診強化などをあげている。	Strategy の実施に向けて、幅広い開発パートナーの参加によるアクションプランの策定が進められている。

Bangladesh Health Workforce Strategy 2008	ゴール：人々の健康に対するニーズに応えるべく、公的・民間・NGO セクター及びドナーとの連携により、保健人材の開発を継続的に行う。 主要目標：①30 年間の保健人材マスタープランの作成を含む保健人材計画策定、②教育・訓練の質の改善、③保健人材の監督・規制、④採用・キャリア開発・維持計画整備、⑤保健省内の並行的活動の統一等による適切な人材育成、⑥PPP など。	
Adolescent Health Strategy 2006	ゴール：2010 年までに全ての青少年が充実したリプロダクティブヘルスを送るために必要な情報・教育・サービスにアクセスができる。 目標：①青少年のリプロ関連知識の向上、②青少年の親など責任者の行動・態度の改善、③青少年の若すぎる結婚や妊娠の減少、④青少年の HIV を含む性感染症の減少、⑤青少年に優しい保健サービスのアクセス向上、⑥青少年のリスクを伴う行動を抑制する環境整備。	
National Food Policy 2006	主目標：①安全で栄養価の高い食料の十分且安定した供給、②食料に対する社会・経済的アクセスの向上、③全ての個人―特に女性と子供―に対する十分な栄養の確保。PRSP での主要な課題でもあり、慢性的・一時的な食料不足の軽減と栄養失調の改善を目指す。	食糧・災害対策・救援省が主体となり、策定・運営。Plan of Action 2008-2015 が策定されている。
National Population Policy	人口増加率を低下させることが最重要課題の一つであり、“一人っ子政策”の導入を検討中。改訂中のためその他の詳細な内容は未確認。	現在改訂中
National Strategic Plan for HIV/AIDS 2004-2010 (incl. safe blood transfusion)	目標：①HIV 感染の予防、②HIV/AIDS の個人・社会に対する影響軽減、③性感染症の感染予防、④性感染症マネージメントの提供。輸血制度に関しては、バ国政府は国家輸血サービスを構築し、統一した高い品質のサービスを全ての地方の保健施設に提供・管理するとしている。	

出所：それぞれの文書から抜粋

付属資料 6. HNPSP の進捗

APIR2009 より HNPSP の優先目標・指標の進捗

優先目標	指標	ベンチマーク	成果	2011 までの目標値
MMR 減少	熟練者による出産介助割合	15.5 % (BDHS2004)	18% (BDHS2007)	43%
	対 1000 出生数周産期死亡者	3.2 (BMMS 2001)	2.75(ESD, HS2005)	2.4
出生率減少	一生のうちで女性が出産する数	3.00 (BMMS 2001)	2.7(BDHS2007)	2.2
人口増加率	年平均人口増加率（出産、死亡、移住者）	1.42% (MTBF 2008-11)	1.35%(MTBF 2008-11)	1.20%
栄養失調減少	59 か月から 6 歳までの低体重児（%）	50.9% (Child Nutrition Survey Bangladesh 2000)	46.3 (BDHS2007)	36%
	59 か月から 6 歳までの深刻な低体重児(%)	12.9% (同上 2000)	10.9 (BDHS2007)	<2%
5 歳未満死亡率減少	対 1000 出生数乳児死亡者	65.0(BDHS 2004)	52(BDHS2007)	37
	対 1000 出生数 5 歳未満死亡者	88.0(BDHS 2004)	65(BDHS2007)	52
HIV/AIDS、結核､マラリア等の負荷軽減	ケース発見 : 新規結核陽性患者の推定割合	38% (NTP 2003)	72% (NTP2007)	70%
	治癒 : DOTS により治癒した結核陽性患者の割合	83.7% (NTP 2003)	92% (NTP2007)	85%
	15-24 歳の妊産婦の HIV 感染率	<1%(IDU 以外のﾀﾞｯｶのﾊｲﾘｽｸｸﾞﾙｰﾌﾟは 4%) (5 次サーベイ 2004)	<1%(IDU 以外のﾀﾞｯｶのﾊｲﾘｽｸｸﾞﾙｰﾌﾟは 7%) (7 次サーベイ 2007)	<1%(一般人口)
主な非感染症の予防と治療	煙の出ないタバコ使用率（大人）	20.9% (WHO2004)	N/A	15%
	喫煙率（大人）	19.7%(WHO2004)	N/A	15%
	癌（子宮癌、乳癌、口腔癌）早期検診（自己）	N/A	N/A	30%(対象女性)
	高血圧発見	N/A	N/A	20%

付属資料 7. CEmOC 指定の郡病院リスト（太字・下線の郡病院が現在 CEmOC として機能、それ以外は未整備。備考のイタリック書体の病院は自己資金で CEmOC となった施設）

番号	県	郡病院名称	備考
1	Barguna	Betagi	Barisal Division
2		Pathorghata	
3	Barisal	Banaripara	
4	Bhola	Charfassion	
5		Monpura	
6	Jhalokhati	Nalchiti	
7	Perojpur	Motbarai	
8		Nazirpur	
9	Patuakhali	Bauphal	
10		Kalapara	
11	B.Baria	Bancharampur	Chittagong Division
12		Nasirnagar	
13		Sarail	
14	Bandarban	Lama	
15	Comila	Daudkandi	
16	Chandpur	Faridganj	
17		Matlab	
18		Sharasthi	
19	Cox's Bazar	Teknaf	Rama
20	Chittagonj	Banskhali	
21		Fatikchari	
22		Lohagara	
23		Miresharai	
24		Patia	
25	Feni	Porsuram	
26	Khagrachari	Paanchari	
27	Laxmipur	Ramgati	
28		Ramgonj	
29	Noakhali	Companigonj	
30		Hatia	
31	Rangamati	Baghaichari	
32	Dhaka	Dohar	Dhaka Division

33		Keranigong	Sawar, Dhamrai
34		Nawabgonj	
35	Faridpur	Alfphadanga	Boalmari
36		Bangha	
37	Gazipur	Kaliakoir	
38		Kaligonj	
39	Gopalpur	Kotalipara	
40		Tungipara	
41	Jamalpur	Dewangonj	
42		Sharisabari	
43	Kishoregonj	Bhairab	
44		Mithamoin	
45		Nikhi	
46		Karimgonj	
47	Madaripur	Shibchar	
48	Manikgonj	Harirampur	
49		Shibaloy	
50	Munshigonj	Serajdikhan	
51	Mymenshingh	Baluka	
52		Haluaghat	
53		Nandail	
54		Gafargaon	
55	Netrokona	Kalmakanda	
56		Kendua	
57	Narayangonj	Rupgonj	
58	Narshingdi	Monohordi	Palash, Raipura
59	Rajbari	Baliakanda	
60	Sharitpur	Bhederganj	
61		Goshairhat	
62		Zajira	
63	Sherpur	Jhenaigati	
64	Tangail	Gopalpur	
65		Madhupur	
66		Nagarpur	
67		shakhipur	

68	Bagerhat	Fakirhat	Khulna Division
69	Chuadangh	Almdanga	
70		Jibannagar	
71	Jeshore	Avoynagar	
72		Chowgacha	
73		jhikorgacha	
74	Harinakundu	Harinakunda	
75		Sailakupa	
76	Kustia	Bheramara	
77		Daulatpur	
78	Khulna	Batiaghata	
79		Dacope	
80		Dumuria	
81		Fultala	
82		Koyra	
83		Paikgacha	
84	Mehirpur	Gangni	
85		Mohammadpur	
86	Megura	Shalika	
87	Narail	Kalia	
88	Satkhira	Debhata	
89		Kalaroa	
90		Shyamnagar	
91	Bagura	Sonatola	Rajshahi Division
92		Sariakandi	
93	Chapainawabgonj	Nachole	
94		Shibganj	
95	Dinajpur	Birampur	
96		Birganj	
97		Ghoraghat	
98	Gaibandha	Gobindagonj	
99		Palashbari	
100		Sundarganj	
101	Joypurhat	Akkelpur	
102	Kurigram	Nageswari	

103		Roumari	
104	Lalmonirhat	Kaliganj	
105		Patgram	
106	Nilphamari	Jaldhaka	
107	Nature	Gurudaspur	
108		Lalpur	
109	Noogaon	Niamatpur	Atria
110		Patnitola	
111	Pabna	Bhangura	Sathia
112		Iswardi	
113	Panchangarh	Tetulia	
114	Rajshahi	Bagmara	
115		Charghat	
116	Rangpur	Kownia	
117		Mithapukur	
118		Chowhali	
119	Sirajgonj	Kazipur	
120		Shahjadpur	
121		Taras	
122	Thakurganj	Baliadanga	Pirgonj
123		Haripur	
124	Hobigonj	Azmirigonj	Shylet Division
125		Chunarughat	
126	Moulabibazar	Barolekha	
127	Sunamgonj	Dowara Bazar	
128		Jagannathpur	
129	Sylhet	Bianibazar	
130		Gopalgonj	
131		Joyantipur	
132		Kanaighat	
Total /CEmOC: 119			

出所：保健省 DGHS/ESD/RH の担当者からの入手データ

付属資料 8. Demand Side Financing (DSF)実施要領

＜資格基準＞
・当該ユニオンの定住者
・1 回目あるいは 2 回目の妊娠までで、2 回目の妊娠の前には家族計画実施
・事実上の土地未所有（0.15 エーカー以下）
・非常に低所得で不定期な収入または未所得（家族で 2500Tk/月未満）
・生産的資本なし（家畜、果樹園、リクシャやバンなど）

＜母親へのインセンティブ＞
・3 回の ANC、施設分娩或いは自宅分娩での熟練者による介助、1 回の PNC
・帝王切開を含む緊急産科ケア
・500Tk の交通費（一回 100Tk までで合計 5 回の施設訪問）
・500Tk のリファラル緊急交通費
・施設分娩者に対しては 2000Tk の母親や新生児に対する栄養食や薬費用
・500Tk 相当のギフトボックス（粉ミルク、タオル、石鹸、新生児の洋服等）

＜サービス提供者への支出・インセンティブ＞
（注：支出額の半分は郡の“Seed fund account”に払い込まれ、残りの半分がインセンティブとしてサービス提供者に支払われる。）

サービスの内容	全体額（Tk）	インセンティブ額（Tk）
資格のある女性の登録		10
2 回の ANC 血液検査	(35*2)=70	
2 回の ANC 尿検査	(35*2)=70	
3 回の ANC チェック	(50*3)=150	(25*3)=75
1 回の PNC チェック	50	25
通常分娩	300	150
医薬品	100	
合併症のケース		
鉗子分娩、プラセンタの手動除去、流産手術、吸引分娩	1000	500
子癇管理の医薬品	1000	
帝王切開	6000	3000

出所：Economic Evaluation of Demand-Side Financing (DSF) Program for Maternal Health in Bangladesh (Draft), 2010, GTZ

DSF 実施地域リスト（2009 年 12 月末現在）

	県	郡
１．現在実施中の地域（35 郡）	Barisal	Banaripara
	Patuakhali	Kalapara
	Pirojpur	Nazirpur
	Manikganj	Hariampur
	Faridpur	Bhanga
	Jamalpur	Sarishabari
	Kishoreganj	Tarail
	Narsingdi	Raipura
	Tangail	Sakhipur
	Shariatpur	Naria
	Madaripur	Shibchar
	Chittagong	Mirsarai
	Comillla	Daudkandi, Titas, Meghna
	Cox's Bazal	Ramu, Ukhiya, Teknaf
	Noakhali	Chatkhil
	Chandpur	Matlab-North
	Lakshmipur	Raipur
	Jossore	Chowgacha
	Khulna	Paikgacha
	Kushtia	Daulatpur
	Meherpur	Gangni
	Joypurhat	Khetlal
	Dinajpur	Khanshama
	Bogra	Shibgonj
	Gaibandha	Gobindhagonj
	Panchagarh	Debiganj
	Naogaon	Atrai
	Kurigram	Ulipur
	Sirajganj	Shahazadpur
	Habiganj	Baniachong
	Sunamganj	Sulla
２．2009/2010 年度開始予定の新	Shatkhira	Shamnagar
	Gopalgonj	Tungipara

規地域（10 郡）	Bagerhat	Fakirhat
	Rangpur	Gangachara
	Bhola	Charfashon
	Mymenshing	Haluaghat
	B-Baria	Bancharanpur
	Shunamganj	Jagannathpur
	Tangail	Mirjapur
	Shirajgonj	Chouhali
３．MNH プロジェクトでの実施予定地域（7 郡）	Thakurgaon	Haripur, Baliadangi
	Norail	Kalia
	Moulvibazal	Baralekha, Srimangal
	Jamalpur	Islampur, Dewanganj

出所：保健省 DGHS/ESD/RH の担当者からの入手データ

付属資料 9. チョウガサ郡病院モデル

●基本情報：50 床病院、3 人の産婦人科医（CS 手術は 2 人）と 1 人の麻酔医（＋病院長が麻酔医の資格あり）で、2009 年（1-11 月）、3204 の施設分娩（うち 767CS）を提供(県病院でも施設分娩は 2000 以下)。施設分娩率/ANC recipients は 2009 年には 72%、前年の 50%強から大きく上昇。

●特徴

（１）病院内スタッフが自らの使命・役割を認識し、コミュニティに対してより質の高いサービスを提供するという意識を持っている。

（２）地域内での資源活用―地方行政・コミュニティとの密なコミュニケーションにより協力体制を構築し、地方行政（Upazila・UP）から燃料・薬代、X 線フィルムや病院でのボランティアの手当、民間企業から携帯電話、コミュニティから廃棄物処理箱や人材（ボランティア）の提供などを受けている。

（３）病院発信でコミュニティとのリンケージを形成・強化しており、病院に対するコミュニティからの信頼及び協力関係を形成。

●特筆すべき主なサービス

①Non-clinical サービスを行う人（**ボランティア**）をコミュニティから採用。現在 9 名で、ほとんどは学生。受付、ANC での体重測定、EoC セクションでの患者のサポート的業務を実施。彼らへの手当（月 1000Tk）は地方行政から拠出されている。

②**保健教育**。患者や訪問者を対象に、院内ロビーや EPI セクション等病院内スペースで毎日異なるトピックの教育を実施。ANC 待合室では出産に関する情報提供。また地域の学校や専門学校などへも病院のスタッフが出かけて、保健教育やチョウガサ病院に関する情報の提供実施。

③**輸血ボランティア**グループ。輸血ボランティア制度を有しており、約数百名が登録。血液型も記録されている。輸血が必要な場合、呼び出しを受け、無償で血液を提供する。輸血の前には、血液のスクリーニング（基本 5 種類）が行われる。病院では血液バンクを入手したが、電力不足のため現在使用していない。

④小児セクション。小児患者はまずアシスタント医師が診察し、医師の診察・治療が必要な場合は院内の医者に送付。チョウガサ病院には小児科専門医はいないため、より深刻な場合は県病院などにリファー。

⑤**緊急携帯電話**。ER 担当医が携帯を保有、24 時間連絡可能。電話番号はコミュニティに知らされている。以前は病院独自で確保。現在は政府が支給を始めた。

⑥駐輪場管理をコミュニティに委託。利用料徴収により必要経費を確保しているため、病院の負担はなし。

⑦**業務確認ボード**。Non-clinical な業務について、壁に進捗ボードを掲げ、関係者全員が一目で業務の進捗を確認できる。

モデル普及計画（出所：Chowgacha Model Program Management Training モジュール）

訓練対象：郡保健家族計画官（UHFPO)、郡家族計画官（UFPO)、郡評議会長（Upazila chairman)、郡行政官（UNO)、県保健サービス局長(CS)、コミュニティの社会福祉活動者
実施計画：1 バッチにつき参加者 100 名、合計 2500 名をトレーニング予定
時期：2009 年 2 月 15 日から開始（以前の計画のため、修正が必要）
合計予算：約 13 百万 Tk

＜トレーニング内容＞

１．ゴール：郡病院において、質が高く、利用者にやさしい産科ケア、母子保健ケア、その他の基礎的保健サービスを提供するためにサービス提供者の態度を向上させる。

２．目標：

チョウガサ郡病院のモデルを参考に、各地域郡病院のサービス提供者を動機づけする。

病院関係者及び地域のリーダーとの間でチームスピリッツを醸成する。

病院管理において、官民連携を確立する。

３．トレーニング内容

各地域の保健指標の比較

チョウガサ郡病院のサービス

チョウガサ郡病院の管理

コミュニティクリニック管理

リーダーシップ

現地視察

アクションプラン

ワークショップ

４．トレーニング手法

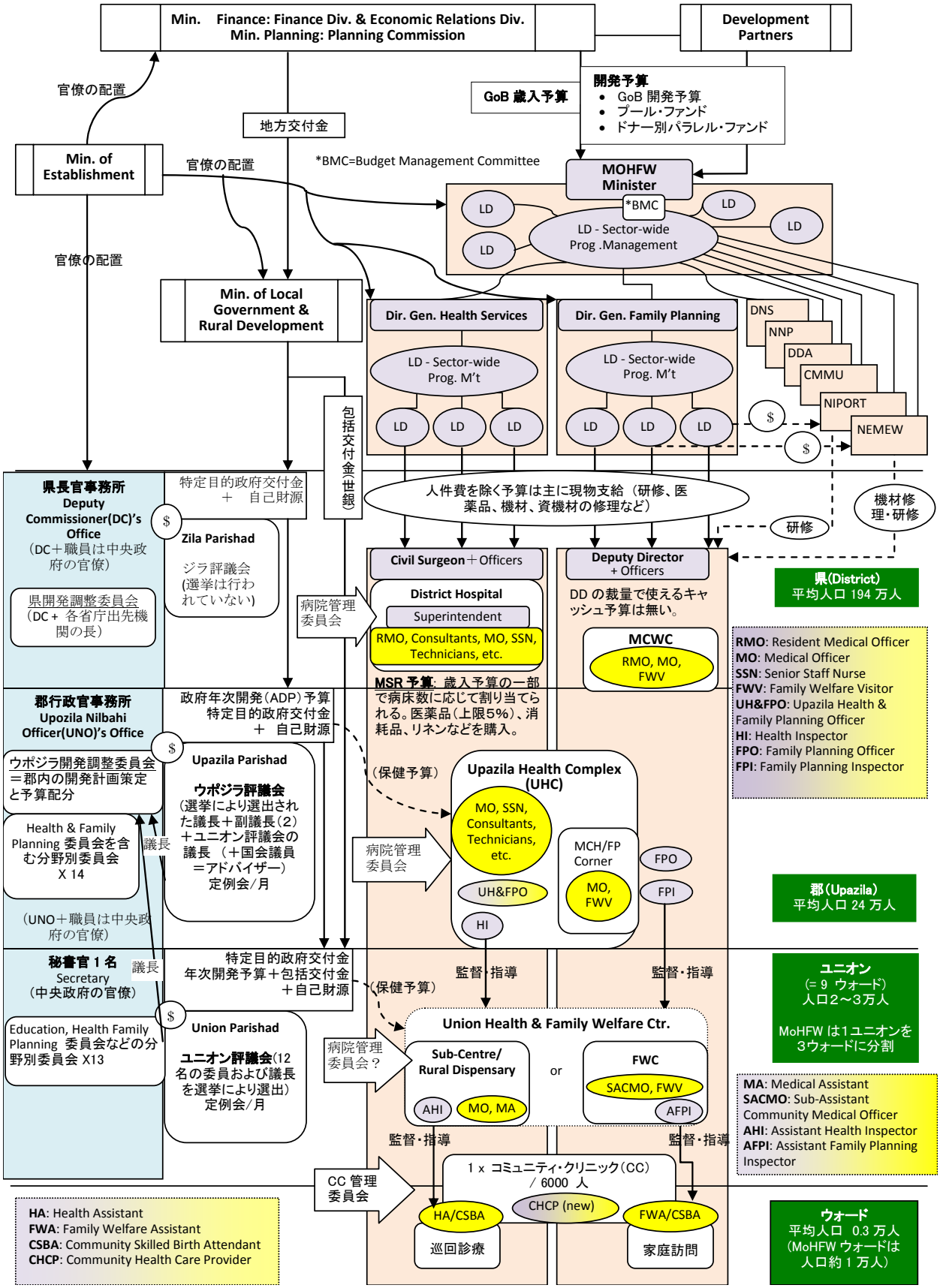
経験共有・実践的技術の開発（ﾌｪｰｽﾞ１）とワークショップ（ﾌｪｰｽﾞ２）を通じての訓練

ドラフトアクションプランの作成

モニタリング計画

トレーニング評価

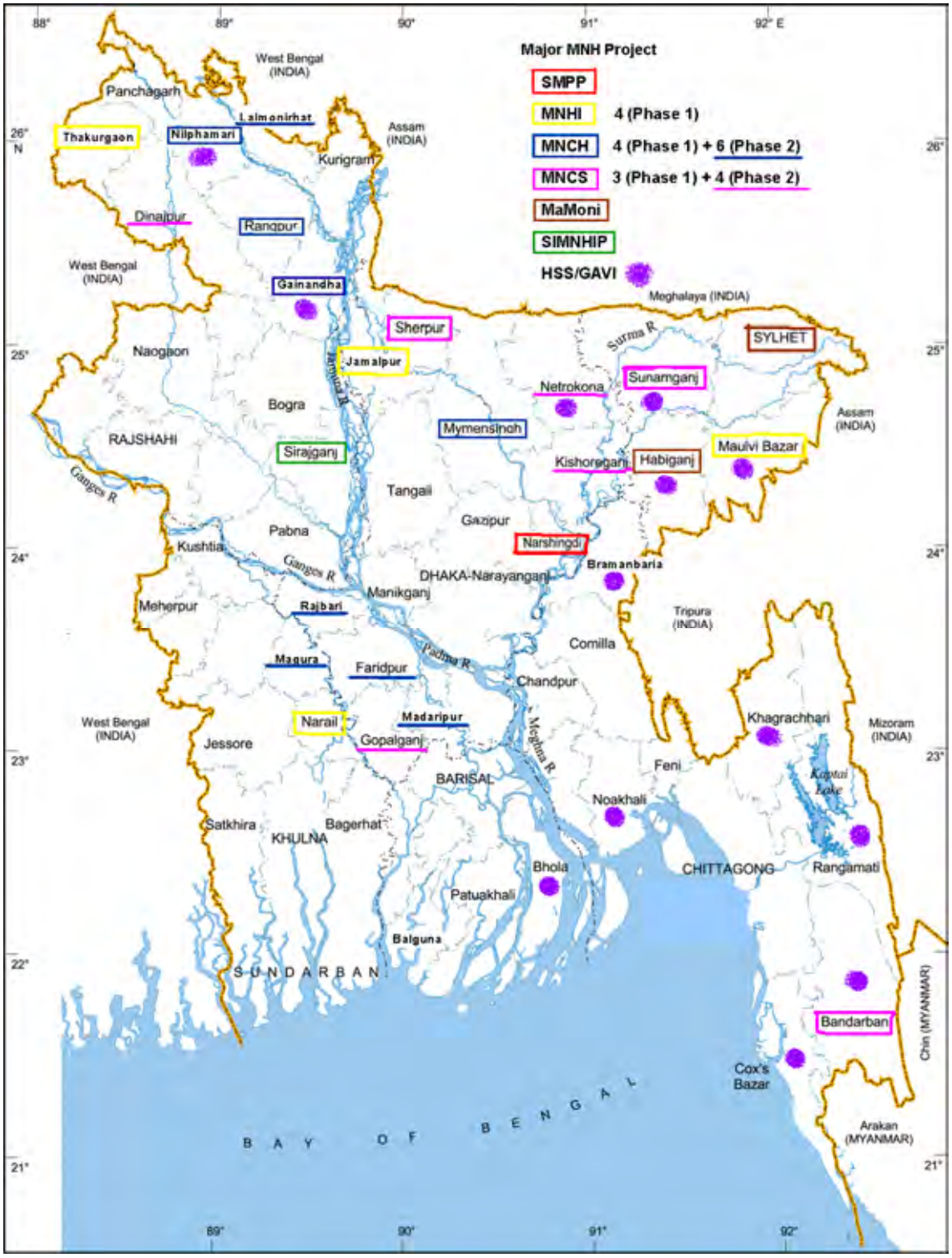
付属資料 10. 保健行政の概念図



付属資料 11. 援助協調 GoB-led HNPSP task groups リスト （2009 年 12 月現在）

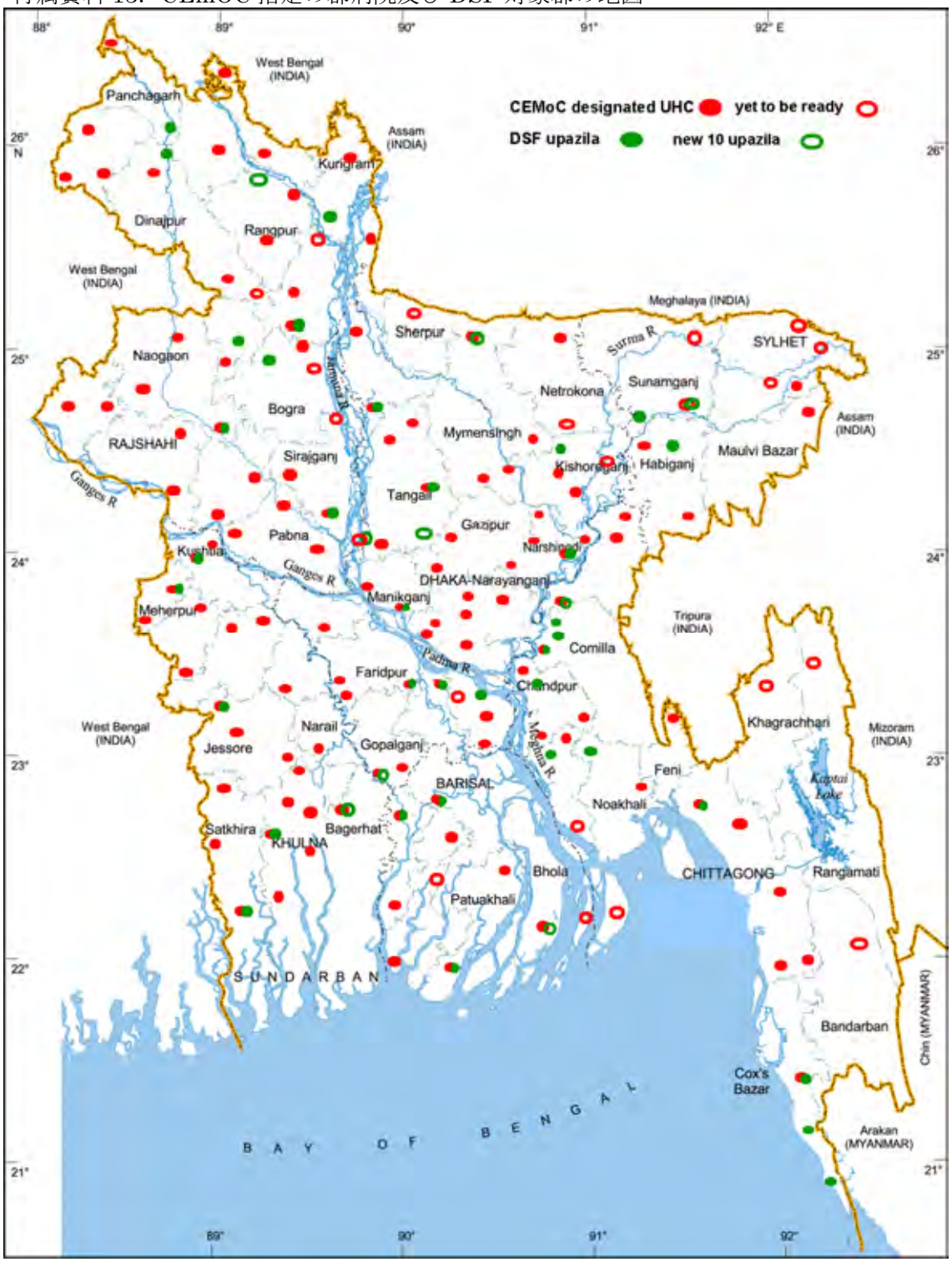
Sl.	Name of task group	GOB Chair	DP Lead partner	DP Members
1	HNP Forum	Secretary		All DPs + Selected members from Civil Society
2	HNPSP Coordination Committee	Secretary		Consortium Chair, WB
3	Monitoring and Evaluation	Joint Chief (Planning)	GTZ	WB, WHO, UNFPA, USAID, UNAIDS
4	Financial Management	Additional Secretary, Joint Secretary FM	WB	EC, EKN, DFID, (CIDA?)
5	Procurement	Additional Secretary, Joint Secretary Coordination	WB	USAID, KfW, UNFPA, CIDA
6	Nutrition	Joint Secretary Public Health	UNICEF	EKN, WHO
7	Diversification of Services Steering C.	Secretary	KfW	Sida, WB, (EC?)
8	Human Resources	Joint Secretary Admin	WHO	WB, JICA, AusAid, GTZ, DfID, CIDA
9	Gender, equity, voice	Joint Chief (HEU)	CIDA	DFID, Sida, UNFPA, GTZ, EKN
10	Health Financing Resource Group	Secretary, JC HEU	WB	WB, WHO, KfW/GTZ, EC, DFID
11	MNCH Forum / MNCH Task Group	DG, DGHS		UNICEF, JICA, WB,UNFPA, WHO
12	QA Task Group	DGHS		JICA, GTZ, UNICEF, WHO, UNFPA, OGBS, BRAC, EngenderHealth

付属資料 12. 主要 MNH プロジェクト地図



出所：現地調査結果を基に作成

付属資料 13. CEmOC 指定の郡病院及び DSF 対象郡の地図



出所：現地調査結果を基に作成

付属資料 14. 主要 MNH プロジェクト概要表　（出所：現地調査で収集した情報を基にとりまとめたもの）

Project Name	**Safe Motherhood Promotion Project**	**Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity (Joint GoB-UN MNHI)**	**Improving Maternal Neonatal and Child Survival**	**Accelerating Actions to Achive Millenium Development Goals 4 & 5 in Bangladesh " An Integrated Package of Maternal, Neonatal and Child Survival (MICS) Intervention"**	**MaMoni-Integrated Safe Motherhood, Newborn Care and Family Planning Project**	**Shahjadpur Integrated Maternal & Meonatal Health Intervention Project (SIMNHIP)**
Implementing Agency	**DGHS, DGFP**	**RH/DGHS, MCRH/DGFP**	**RH/ESD/DGHS, UNICEF**	**DGHS, UNICEF**	**JHPIEGO/Save the Children US**	**ICDDR,B**
Partners in implementation	**JICA, CARE**	**UNFPA, UNICEF, WHO, CARE, PHD, ESDO, DORP, MKP, WAVE Foundation**	**BRAC**	**ICDDR,B, PHD, Concern Worldwide, Bangladesh/VARD, Unnyan Sangha**	**Shimantik, FIVDB**	**PSF and other NGOs**
Funding Agency	**JICA**	**DFID, EC**	**AusAID**	**AusAID**	**USAID**	**AusAID**
Period	July 2006-June 2010	Jan 2007-Dec 2011	Oct 2008-Dec 2013	July 2008 – June 2011	Aug 2009- Jan 2014	Jan 2008-Dec 2011
Coverage	Narsingdi District	Phase 1: 4 districts (Thakurgaon, Jamalpur, Maulvi Bazar & Marail) Phase 2: not decided, 6 districts proposed.	Phase 1: 4 districts (Nilphamari, Rangpur, Gaibandha & Mymensingh), Phase 2: 6 districts (Lalmonirhat, Kurigram, Rajbari, Magura, Faridpur & Madaripur) TBC	Phase 1: 3 districts (Sherpur, Sunamganj & Bandarban) Phase 2: 4 districts (Netrokona, Kishoreganj, Gopalganj & Dinajpur)	Sylhet (7 upazilas out of 11) & Habigonj (all upazilas) districts	Shahjadpur upazila in Sirajgonj district
Target target population	2.3 million	NA	21 million	11 million in 7 districts	3.5 million (1.5 million in Sylhet & 1.8 in Habiganj)	600,000
Main Objectives	Maternal & Neonatal Health	Maternal & Neonatal	Maternal & Neonatal, IMCI UNICEF- supply side support BRAC- community support	Com-IMNCI + Maternal 1. Community promotion 2. Outreach based services 3. Facility based services	Maternal, Neonata & Child, FP ・Modified the previous project by adding MNH-FP services	Maternal & Neonatal ・community based intervention
Total Budget	4 Million USD	Phase 1: 5.3 Million USD, Total: 32 Million USD	UNICEF: 8.5 Million USD, UNICEF & BRAC: 48 Million USD	18 Million USD	13.5 Million USD	587,527 USD
Working mechanism with **private/NGO**	JICA contract with CARE	UNICEF contract with 6 NGOs for ComSS and HR based support. Some subcontract to local NGOs. Pilot (plan) – contracting of private practitioners to provide specialized services (better off) & services in more remote areas	UNICEF contract with BRAC.	Pilot (still plan) - contract with private facilities for better health services	Save the Children/US contract with local NGOs	ICDDR,B (covers training, research & logistics cost) in technical collaboration with existing NGO (Palli Shishu Foundation: PSF) who has a clinic providing BEmOC.
Guideline/Form produced	Referral slip, Maternal Death Audit format CmSS guidelines, LG manual	Violence against women (VAW) training manuals	Referral slip	Com-IMNCI guidelines		

Project Name	Safe Motherhood Promotion Project	Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity (Joint GoB-UN MNHI)	Improving Maternal Neonatal and Child Survival	Accelerating Actions to Achive Millenium Development Goals 4 & 5 in Bangladesh " An Integrated Package of Maternal, Neonatal and Child Survival (MICS) Intervention"	MaMoni-Integrated Safe Motherhood, Newborn Care and Family Planning Project	Shahjadpur Integrated Maternal & Meonatal Health Intervention Project (SIMNHIP)
Main components						
Management (LLP)	·Facility management	·Financing LLP (district & sub-district level)	·Facility management	·Miro-level planning	·Microlevel planning	-
	·MIS		·MIS	·National guidelines Dev. on com - IMNCI	·MIS	
	·Model Union approach	·DSF (7 upazilas)				
	·LLP→ drop	·MIS		·MIS		
Facility improvement	· Minor renovation, equipment supply, equipment repair	·All DH, MCWC & selected UHC – 24 hour EmOC, CmOC/BEmOC/first aid	·Improve EoC, newborn care, faciliy-based IMCI	·Minor renovation, logistic/drug supply, supervision, M&E at UHC, union sub-center	·Minor renovation/quality service/logistics at UHC, FWC, satelite & CC according to the assessment	-
		· Women Friendly Hospital Initiative (violence against women)	·Provision of health care providers (TBC)			
		·VCCT				
		·Provision of nurse/cleaner locally recruited				
CD of Health care providers	· Training on midwifery, EmOC, IPP, AMTSL, Newborn care, computer, Safe Motherhood	· According to need assessment for EmOC, infection control, CSBA, inter-personal skills etc, training will be done	·Training on EoC	·Training on com-IMNCI	·Training for formal and informal providers	·Training on EoC for UHC
	·Training and support for Private CSBA		· Training & utilization of private (NGO) CSBA	· Community health promoters, (only in Bandarban) community nurse	·While Sylhet utilizes Project community health worker, Habigonji utilizes govt. workers (HA/FWA)	·Recruitment and trainning of 32 NGO (PSF) CSBA and placing them where no GoB SBA and ANC services are available
Others		· Human Right-based intervention with creating a registration corner in the hospital where NGO staff provides counseling/advice for patients to ensure HR based service delivery and providers accountability				

Project Name	Safe Motherhood Promotion Project	Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity (Joint GoB-UN MNHI)	Improving Maternal Neonatal and Child Survival	Accelerating Actions to Achive Millenium Development Goals 4 & 5 in Bangladesh " An Integrated Package of Maternal, Neonatal and Child Survival (MICS) Intervention"	MaMoni-Integrated Safe Motherhood, Newborn Care and Family Planning Project	Shahjadpur Integrated Maternal & Meonatal Health Intervention Project (SIMNHIP)
Community based intervention						
Coverage/Beneficiaries	3 Upazilas (37,980 HHs)	All upazilas in 4 districts (phase 1)	4 districts (phase 1)	2 upazilas in Bandarban, 3 upazilas in Sumanganj, 2 upazilas in Sherpur (approx. 1.5 million population) (phase 1)	7 upazilas out of 11 in Sylhet, all upazilas in Habigonj, 3.5 million population in 2 districts	600000 population in 1 upazila
Main components	1. Community Support System (CmSS)	1. Formation of community group facilitated by NGO in link with CCMC to address BP, emergency preparedness, referral, awareness raising etc	1. Formation of MNCH committee for BP, facility mapping, emergency preparedness, transport cost support, blood donation list etc. BRAC staff deeply involved in activities i.e. member of blood donors	1. Formation of community groups in link with CCMC facilitated by NGO to address BP, preparedness, referral, ANC/PNC/ENC etc	1.Structured community mobilization to address transport, fund, early referral, male involvement in MNH-FP issues	1. Formation of community support group in link with CCMC to promote FP, birth planning/preparedness, referral, ANC/PNC utilization, maternal nutrition etc
	2. Community awareness raising on 5 danger signs and birth planning by Community change agents (CCA)	Each CCMC selects 3-4 community health volunteers (no financial incentive), who work in their designated area.	2. Provision of home based counseling and MNCH services by project hired community health care workers	2.Household counseling on ANC, ENC, newborn care by NGO promoters/volunteers (paid by project)	2. Household counseling in Sylhet by community health workers (NGO worker)	
	3. Collaboration with local government to improve quality of health services	2. Household counseling on ANC, PNC, ENC by community health volunteers	3. Provision of financial support, i.e. cost of medicines, procedure etc	3. In Bandarban, provision of service providers (Community nurses of PHD) in the community	3. Distribution of FP commodities and misoprostol to household	
			4. Trainining and supervision of TBA activity in the community		4. Training TBA on harmful practices, danger signs etc	
Input	Training, Orientation, Workshop, OJT	Training, Supply of vitamins/nutritious foods for mothers, Supply of dummy doll, message cards, ARI watch, modules for community health volunteers	Supply of drugs, pills/condoms, nutitiuous suppliments, Financial support, Training, Salary of community health care workers	Salary for promoters and service providers, Supply of drugs/logistics for service providers and mothers/newborns, Training, Supply of dummy doll with cloths, salter scale, thermometer to NGO promoters,	Procurement of misoprostol , Training, salary of health care workers in Sylhet	
Project staff distribution	NGO District: 1 Upazila: 2 Union: 8 (up to June 2009, 5 in 2010)	NGO District: 1 coordinator each Upazila: 1 coordinator each	NGO Upazila: 1 manager, 12 program organizers 1 PO per UHC, 2 training PO, Community: 1 community health worker (Shasthya Kormis) per 1500 H/H , 1 community health voluntee	NGO Upazila: 1 coordinator each Union: 3 community mobilizars each Community: 1 community health promoter per 200H/	**SC-US** District: 1 field manager, 5 technical managers, 2 program officers, **NGO Sylhet** District: 2 technical focal persons, 24 MIS officers, 2 TBA coordinators, Upazila: 7 team leaders, 24 field officers, 37 community mobilizers, 73 community supervisor mobilizers, 286 CHWs, **Habiganj** District: 2 coordinators, Upazila: 8 coordinators, 36 field supervisors, 24 technical officers,	Union: 1 medical manager (total 9 staff)
Implementing partners	CARE	CARE (Jamalpur & Nalail), PHD (Maulvibazar), ESDO (Thakurgaon) some of them subcontract to local NGO	BRAC	NGOs: PHD (Bandarban), Concern Worldwide (Sumamganj), Unnyan Sangha (Sherpur) 2 out of 3 NGOs subcontract to local NGOs	NGOs: Shimantik & FIVDB	Implemented by ICDDR,B
Budget	approx. 100,000 USD per year (contract amount with a NGO:CARE)	approx. 366,000 USD per year for 4 districts (contract amount with 3 NGOs including logistics)	approx. 40 million USD for 5 years (contract amount with BRAC) to be confirmed	approx. 700,000 USD per year for 3 districts (contract amount with 3 NGOs, but including drugs & other logistics) approx. 53,000 USD/year for community support group related activities	nearly 95 % of budget is for community intervention, which is around 13 million USD for 5 years for 2 districts	NA

付属資料 15：ローカルコンサルタント委託調査

Study on
Maternal & Neonatal Child Health

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Dhaka: March 2010

REPORT OF THE STUDY
ON
MATERNAL AND NEONATAL CHILD HEALTH

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Abul Barkat, *Ph.D*
Team Leader

Abbreviation

ADCC	Assistant Director, Clinical Contraception
AN	Anaesthetists
ANC	Antenatal Care
APH	Ante-partum Haemmorhage
AVD	Assisted Vaginal Delivery
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BF	Breast Feeding
CC	Community Clinic
CEmOC	Comprehensive Emergency Obstetric Care
CMMU	Construction Maintenance Managements Unit
CS	Civil Surgeon
C-Section	Caesarean Section
CSBA	Community Skilled Birth Attendant
CT	Copper-T/IUD
DDFP	Deputy Director Family Planning
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DPs	Development Partner(s)
DSF	Demand Side Financing
ECP	Emergency Contraceptive Pill
ENC	Essential Newborn Care
EOC/EmOC	Emergency Obstetric Care
FP	Family Planning
FPCST	Family Planning Clinical Supervision Team
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
Fy	Financial Year
GoB	Government of Bangladesh
Govt.	Government
HNPSP	Health Nutrition Population Sector Program
HEMA	It is a Private Agency/Company
HQ	Head Quarter
IMCI	Integrated Management of Childhood Illness
JICA	Japanese International Cooperation Agency
LLP	Local Level Planning
MCH	Maternal Child Health
MCWC	Maternal Child Welfare Centre

MIS	Management Information System
MNH	Maternal Neonatal Health
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MSR	Medical Surgical Requisites
NA	Not Available (Means that data not available)
NGO	Non-Government Organization
NHQ	National Head Quarter
NNP	National Nutrition Programme
NSMH	National Strategy for Maternal Health
NSV	Non Scalpel Vasectomy
OG	Obs/Gyne
OT	Operation Theatre
PPH	Post-Partum Hemorrhage
QAT	Quality Assurance Team
QCO	Quality Control Officer
QMS	Quality Management System
RD	Rural Dispensary
SACMO	Sub-assistant Community Medical Officer
SMPP	Safe Motherhood Promotion Project
TQM	Total Quality Management
TT	Tetanus Toxoid
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UHFPO	Upazila Health Family Planning Officer
UN	United Nations
UNFPA	United Nations Population Fund
VAW	Violence Against Women
WHO	World Health Organization
WRA	Women of Reproductive Age

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Executive Summary

In Bangladesh, Maternal Neonatal child Health is now a programme of national importance, although MNCH status continues to be a matter of serious concern. Maternal mortality rate is estimated at a range of 320-400 per 100,000 live birth and less than 50% women avail of even a single ANC visit[1]. Only 35% of pregnant women suffering from complications are receiving EmOC during delivery. Neonatal mortality now accounts for over 70% of overall infant death taking places during the first four weeks of life. Nearly 85% of the births take place at home. Pre-maturity, low birth weight, birth asphyxia, birth trauma and infections are the major causes of neonatal death[2].

Bangladesh government has been implementing the Health, Nutrition and population Sector Programme (HNPSP) since 2003. JICA supports the Ministry of Health and Family Welfare (MOHFW) in collaboration with UN Agencies and other development partners (DPs) in the implementation of HNPSP which covers nearly 90% of development projects under the Annual Development Programme of the government.

Prior to closing of the SMPP planned in July 2010, GoB has officially requested Japan for its continuous support in MNCH sector. In this connection, the study was conducted to find out strategic approaches for strengthening a health system in MNCH, which may be applied to a future project by JICA.

The core objective of the present study was to understand the current situation (MNCH) and to get an overview of constraints of MNCH programme in Bangladesh with a view to examine/explore the possibilities of extending JICA cooperation in MNCH-FP sector.

The `Study on Maternal and Neonatal Child Health was designed to collect information from five districts namely – Barguna, Bandarban, Jessore, Satkhira and Kurigram as agreed in a meeting held in Ministry of Health and Family Welfare chaired by the Joint Chief, attended by two Dy. Chiefs, Health and Family Welfare, Director MCH-FP DGFP office, DGHS representative, JICA representative/JICA consultants and two HDRC Consultants, prior to launching of the study in December 2009. There were two upazilas under each study district as follows:

Districts		**Upazilas**
Barguna	:	Patharghata and Betagi;
Bandarban	:	Lama and Ruma;
Jessore	:	Chowgacha and Jhikargacha;
Satkhira	:	Kolaroa and Debhata
Kurigram	:	Rajarhat and Nageswari

The research design was an assimilation of qualitative and quantitative methods. Data and information were collected from primary as well as secondary sources and Key informants interviews were held. The Key officials interviewed were Civil Surgeons-5, Deputy Director FP-5, Upazila Health and Family Planning Officer-10, Consultants Obs/Gynae-5, Medical Officers MCWCs-5, and also NGO Managers, Private Clinic/Hospital Service-providers.

[1] Community Support System for EmOC, Mira Mitra et al Health Nutrition section UNICEF, Oct, 2006.
[2] Lawn J E et al. 4 million neonat death: When? Where? Why? Lancet (neonatal survival); March 2005

An overview of the five study districts revealed Jessore had the largest number of union and population with density of 962 per km, whereas Bandarban has the smallest number of unions, populations with density of 67 per Km. All 10 upazilas (UHCs) have electricity, water connections and road communication.

The ***overall national policy framework*** particularly those related to health, social welfare, women development lack sharp focus on MNCH. Higher priority consideration for MNCH may rightly be given in all related national policies of the government.

The present ***study was designed to seek responses to 13-15 major issues.*** The ***Findings*** based on field responses recorded carefully are summarized below:

Maternal Neonatal situation, MNCH activities – Services were issues responded to by Civil Surgeons, DDFPs, UHFPOs, UFPOs, Consultants and MOs of MCWCs. Except Jessore, all have similar opinion, they rated MNH as poor/ unsatisfactory. Jessore case is a little better, - rated as somewhat satisfactory. **Two reasons** were identified for poor performance –

- ***One:*** Lack of awareness about MNCH services; the rural poor are unaware of how, where they are to available of the services;
- ***Two:*** Lack of manpower particularly trained doctors (MOs, Consultants), Nurses, FWVs, CSBA and others related to MNH service delivery.

Facilities providing MNCH services are mainly, District Hospitals, UHCs MCWCs, Union level upgraded FWCs/RDs, some community clinics and satellite clinics (limited service). For providing full-range of MNCH/BEmOC/CEmOC services, only a few are well-equipped at upazila level (UHCs 5 are providing CEmOC, remaining 5 BEmOC). Of the 5 MCWCs, Bandarban is providing EmOC and Jessore, Satkhira, Kurigram are providing CEmOC; Barguna at present is not in position to provide any of the two services because of absence of Anesthetist, Consultant/ MO Obs/Gynae and trained supporting staff.

Regarding ***Health-FP Workforce at 10 upazillas*** for MNCH service delivery, the status is that – Consultant OBs/Gynae, MO Obs/gynae, Anesthetist, trained FWV, CSBA/FWA posts both sanctioned and actual are far below the required number. Numerous vacant posts/ absence from place of posting are a major concern for program managers at all levels. None of the Field workforce works singularly in one area of activity as his/her job-responsibility cover a wide range of duties.

Status of Community Clinic (CC) appeared to some what confusing – it neither belongs to FP Department nor to Health Department, for either administrative or for operational purpose. **Dual control/management is going on**. Of the existing community clinics, nearly 75% are fully functional as reported by the Deputy Directors of FP. The Civil Surgeons of 5 districts are of the view that service delivery and monitoring of CCs are not yet upto the mark. Supervision of CCs by DDFPs is also quite weak. **They (CS/DDFP) are not fully aware of how many CCs are going to be built in future.**

About ***sources of income*** for FP-MCH facilities, most of the DDFPs replied in the negative. Scanty information about FP-MCH facilities and even of annual budget allocation for Dist FP programme was matter of great concern. UFPOs betrayed their ignorance. On the other hand, it was gathered from civil surgeon's office the ***budget for each bed*** of a 100-bed hospital is Tk.25,000/- and Tk.18,000/- for each bed of 31-bed and 51-bed hospitals.

Local level planning (LLP) is still at its nascent stage. Civil Surgeons reported that LLP is yet to be implemented in Barguna, Jessor and Satkhira. Two others, Bandarban, Kurigram have received a small amount of fund for LLP. DDFPs affirmed LLP except Jessore as his district is not a pilot for LLP. They (DDFP) said they get support from central authority/level. But for LLPs, UFPOs wanted budget allocation, support from Upazila Administration/ Upazila Parishad, training on LLP and feed back from central level.

Management Information System – is not yet fully equipped – technically or otherwise. DDFPs reported that information collected is partially computerized and partially manually compiled/recorded. Computer programming has not yet been developed; e-mail system and use of internet have to be developed. **Skilled manpower and shortage of equipment is blocking the digital way forward.** Monthly review meeting, staff meeting, discussion, exchanging written reports, monthly report/return, and sharing of information are done regularly.

Referral system prevailing in the Districts and at Upazilas vary from facility to facility and there is hardly any rigidity in the mechanism of referral. Usually, slip-system and then issuance of discharge paper, emergency slips, written chits, accompaning the client (by FWV/FWA) are in practice. Verbal referral to higher authority/facility is also on practice. It was revealed that consultants refer five types of patients to Government Medical College Hospitals which are – obstructed labour, Eclampsia, APH, PPH, retained placenta, hand prolapse and complications of abortion. Normally, complicated cases are referred to District Hospital from union FWCs, RD, UHCS by Medical Officers, FWVs, FWAs and private doctors, NGO doctors and others.

The Quality Management System (QMS) exists in all 5 districts and Upazilas as reported by DDFPs, MOs and UFPOs *but Civil Surgeons of Bandarban and Satkhira reported negatively.* Also UHFPOs of Lama and Ruma declined, again consultants had also negative views about quality assurance system. *The system appeared to be weak and fragile*. The task of quality assurance is maintained by checklist, routine inspection, and by Family Planning Clinical Supervision Team (FPCST). Regarding EmOC team's activity, Civil Surgeons expressed their ignorance, as they were not sure if the team had been formed in the EmOC run facilities. About EmOC team at the UHC, UHPOs of Betagi, Lama, Chougacha and Kalaroa reported in the positive.

In response to the question about sufficiency of ***supplies of emergency drugs*** to manage obstetric emergencies, the response was positive by 4 MCWCs – Borguna, Bandarban, Jessore and Kurigram but Satkhira said no. Satkhira MO explained that local fund is used to buy emergency medicine and *if this is exhausted, patients are asked to buy themselves*.

About **coordination between health and family planning** department's official, both side affirmed good cooperation and hardly there is any problem. They communicate regularly, have meetings attended by both partners. Again, with NGOs they also reported good communication and collaboration except Satkhira having some reservation. Also 50% UHFPOs expressed positive outlook about NGOs.

One of the questions was on ***barriers to MNCH not reaching the rural poor,*** the DDFPs and UFPOs identified the following factors – distance and geographical barrier, transport costs, unfriendly attitudes of the service providers, lack of awareness of the service receivers especially of the poor, acute shortage of trained/skilled doctors/anesthetists/staff for MNCH,

lack of drugs and necessary medical surgical requisites (MSR). The question, *what government can do or should do to improve EmOC service, the District Managers* were not very specific, nor explicit – they think the governments can do many things if the entire bureaucratic machinery is dynamic and efficient.

About the ***activity of development partners and NGOs*** the district and upazila level respondents have though a positive attitude, yet they are largely skeptical about their actual performance as partners in development. The general impression of CS, DDFPs, MOs, UFPOs and UHFPOs and others about NGOs and development partners (DPs)/donor agencies was that for success, or failure of a particular intervention(s) they (NGOs/DPs) are not accountable, can hardly be questioned. They are viewed as fair-weather friend and the fabric of relationship is still growing and confidence-building has to develop further. **As a matter fact, information collected about them was not enough to reach a conclusion.** Nevertheless, our understanding is that at national level the bilateral and multi-bi-relationship is much better and solid.

Good practices are not universally practiced- Barguna DDFP introduced team-work, while Bandarban DDFP – social mapping by Health Assistant, FWA, community support groups; Jessore introduced Award for 3 best (top) performers, stricture for lowest performer, feed-back session, cluster meeting etc.; Satkhira and Kurigram have not done anything as yet. They are pondering over the issue and intend to do something worthwhile.

In brief, about their ***future plan*** DDFPs, MOs and UFPOs have similar views – they are planning to –

- → Launch motivational campaign on greater access of rural poor for availing MNCH services;
- → Improve quality of service;
- → Raise GO-NGO collaboration & cooperation
- → Involve local Government bodies
- → Raise commitment of the service-providers and local community.

Private Clinic/Hospital Service Providers in four out of five study districts who had been providing basic or comprehensive EmOC, were identified and interviewed on - Facility profile, Staff force , Training in neonatal health, who also work at GoB facilities, list of MNH services being provided and Corresponding fees, EmOC Services, Referral of EmOC cases, Supplies and maintenance, Quality Assurance System, Services provided from January to November 2009, MNH services of the GoB, income and sustainability, and Suggestions for improvement.

At ***present, Bandarban district had no Private clinic/hospital capable of providing BEmOC/CEmOC services.*** EmOC services are available for 24 hours for 7 days a week in all of the clinics, except the 2 in Satkhira. Regarding the year of providing EmOC services all of them, except 1 in Jessore and 1 in Kurigram reported that such services were started in the year 2000 and afterwards. They reported of providing all the services in all the districts, except providing Assisted vaginal delivery in both the clinics of Satkhira. Regarding investigations done in their clinic, they reported of providing almost all except CT Scan, which is done only in Jessore.

Quality Assurance System in these private clinics did not appear to be quite sound and not meticulously pursued. However, *this issue needs further investigation*. About GOB assistance for MNCH services they reported in the negative and none of them are associated with DSF scheme of the government. About income and sustainability, all of them except one in Barguna reported that their clinics are not self-sustainable. They bank upon loans from the Banks.

The NGOs are Surjer Hashi Clinic (SHC) in four upazilas, Marie Stopes Clinic in three upazilas and Addin Hospital in one upazila. The number of clinics operated by the NGOs in each upazila varies between 1 and 5. Although there are some doctors (with out any MNH related training) reportedly provide services in a few upazilas, the number of trained in MNH paramedic nurse is alarmingly low. The health service delivering NGOs are providing a range of MNH services in eight upazilas out of ten. There are no NGO-delivered services in Lama and Ruma upazilas of Bandarban district. The health service-delivering-NGOs are providing: both in clinic and in community MNH services in eight upazilas out of ten. There are no NGO-delivered services in Lama and Ruma upazilas of Bandarban district. SHCs operating in Debhata upazila under Satkhira district and Rajarhat upazila under Kurigram district provide a limited range of in community services. *All Marie Stopes managers and manager of SHC at Rajarhat upazila informed about their intention to expand MNH services for the poor in the future.*

The clinics at Betagi, Jhikargachha, Chougachha *do not receive any financial* and/or in-kind assistance from government sources, except contraceptives. Other clinics receive some assistance. Different NGOs receive different amount of service charges for similar type of services. None of the NGOs/Clinics are financially sustainable, the financial support for SHCs come from USAID, Marie Stopes from UK, Grameen Phone and Marie Stopes Socity. The same for Addin Hospital remained incognito from the managers.

All the NGOs reportedly have their procurement, maintenance policies and MIS.

The ***most important observation is*** – intensive and extensive skill-based professional training of doctors, nurses, FWVs, FWAs/CSBA and all others related to MCH/MNCH service delivery ***must get high priority***. At the same time, awareness-building in the rural community to avail of the EOC services from the nearest centre should be launched seriously. Supportive supervision must continue uninterrupted. ***Lack of commitment to the assigned tasks, and knowledge gap at all levels, had been responsible for poor performance.***

Suggestions made by the field functionaries (both managers and service providers – technical and semi-technical) were numerous on various issues studied in the present exercise undertaken by MOHFW and JICA and accomplished by HDRC. Of the many suggestions for MNCH services reaching the rural poor, there is need for urgent attention on two –

- ***Launch robust advocacy campaign*** for motivation of rural poor to sensitize them of MNCH services and ***enlisting commitment of the community leaders*** for support to the needy mothers.
- ***Ensure posting/staying at the place of posting*** of sanctioned number of trained doctors, nurses, FWVs and Anesthetists working at different locations – Union, upazilla and District.

Limitations and risks – each study has some limitations and risks. The limitations of the present study are that, it could not deal with cross-cutting issues in detail and could hardly address or measure attitudinal issues, commitment level of key actors/stakeholders (Govt. DPs, NGOs, private entrepreneurs, civil society, local leaders and others) that influence implementation of current activities and also future expansion of MNCH program meaningfully. How far could we proceed – a question to be answered, perhaps, by more in-depth study(ies). The present study however, attempted to throw more light than before on answering some key questions. The study team was under the pressure of scarcity of time. Nevertheless, JICA-Consultants support was of great value in the successful completion of the study.

CHAPTER I
INTRODUCTION

1.1 Background

Bangladesh, small in area, large in population steeped in pervasive poverty has made commendable success in family planning but the national programme on Maternal, Neonatal and Child Mortality is still a serious health concern. Maternal mortality in Bangladesh is estimated at 320 per 100,000 and 44 per 1000 live births[3], whereas, neonatal, infant and child mortality are 37, 52 and 14 per 1000 live births. Neonatal mortality now accounts for over 70% of overall infant deaths taking place during the first four weeks of life. There is strong association between mother's education and under 5 children mortality. Still, 85% of the births occur at home. Again, 80% of maternal deaths due to pregnancy and child birth complication occur at home[4]. Only 18% births are attended by medically qualified provider. Additionally, trained traditional birth attendants assist in 11% deliveries. Around 43% of children under 5 are stunted, 17% are severely wasted and 41% are underweight[5]. Prematurity, low birth weight, birth asphyxia, birth trauma and infections are the major causes of neonatal death[6]. Inadequate access to skilled care at birth and lack of emergency obstetric care (EmOC) contribute to these maternal and neonatal mortality and morbidity. Additionally, poor quality of services precludes optimal utilisation of services.

Approximately 27 percent of teenage girls in Bangladesh are mothers and another 6 percent are pregnant with their first child. Thus, 33 percent of teenage girls have begun childbearing[7]. Maternal mortality in the rural areas is almost double the urban figure[8]. It is estimated that 35% of pregnant women suffering from complications are receiving EmOC during delivery.

Bangladesh government has been implementing the Health, Nutrition and Population Sector Program (HNPSP) since 2003. It has targeted to reduce infant mortality by 50% by now. In order to strengthen infant-child care more than 1500[9] union level Family Welfare Centres are being developed and equipped fully to provide Safe-motherhood, EmOC, Clinical contraception, Neonatal care and Adolescent health Care. It has also targeted to upgrade the Upazilla Health Complexes (UHCs) to provide comprehensive EmOC gradually.

1.2 Rationale of the Study

Japanese International Cooperation Agency (JICA) is implementing Safe Motherhood Promotion Project (SMPP) in Narshingdi since July, 2006. Prior to closing of the SMPP planned in July 2010, GOB has officially requested Japan for its continuous support in MNCH sector. In this connection, the study will be conducted to find out strategic approaches for strengthening a health system in MCH, which may be applied to a future project by JICA. It is expected that the survey, comprising of both quantitative and qualitative, will review the overall picture of MNCH sector in Bangladesh, suggest effective approaches to strengthen

[3] Bangladesh Maternal Health Service and Mortality Survey 2001, NIPORT. March 2002
[4] Mitra and Monira, UNICEF Booklet, Community Support System for EmOC, October 2006, UNICEF Dhaka.
[5] Bangladesh Demographic and Health Survey, 2007, NIPORT
[6] Lawn JE et al. 4 million neonatal death: when? Where? Why? Lancet (neonatal survival); March 2005
[7] Bangladesh Demographic & Health Survey (BDHS), 2007
[8] Sample Vital Registration System 2006, BBS 2008, Govt. of Bangladesh
[9] Directorate of Family Planning/Bangladesh Economic Review, 2006

the sector by reviewing various approaches and practices taken by GOB, NGOs, and development partners and by analyzing actual situation at district level, and draw the outline of the possible intervention that could be supported by JICA in MNCH sector after SMPP. It may be mentioned here that JICA also supports the Ministry of Health and Family Welfare (MoHFW) in collaboration with UN Agencies and other development partners (DPs) in the implementation of HNPSP which covers nearly 90% of development projects under the Annual Development Programme of the government.

1.3 Objectives of the study

The **overall objective** of this study is to understand the current situation and clarify the constraints of MNCH programme in Bangladesh and to examine the possibility of extending JICA cooperation in the sector.

The **specific objectives** of the study are to –

a. Review the overall picture of MNCH program in Bangladesh, including national policies, plans, related government orders, government management system/process, efforts made so far, progress and challenges remained.

b. Suggest effective MNCH approaches to strengthen Health system reviewing various approaches and practices taken by GOB, NGOs, and development partners including SMPP supported by JICA, and by analyzing actual situation at district level and below.

c. Draw an outline of the possible interventions to be supported by JICA in MNCH sector after SMPP.

CHAPTER II
METHODOLOGY AND IMPLEMENTATION

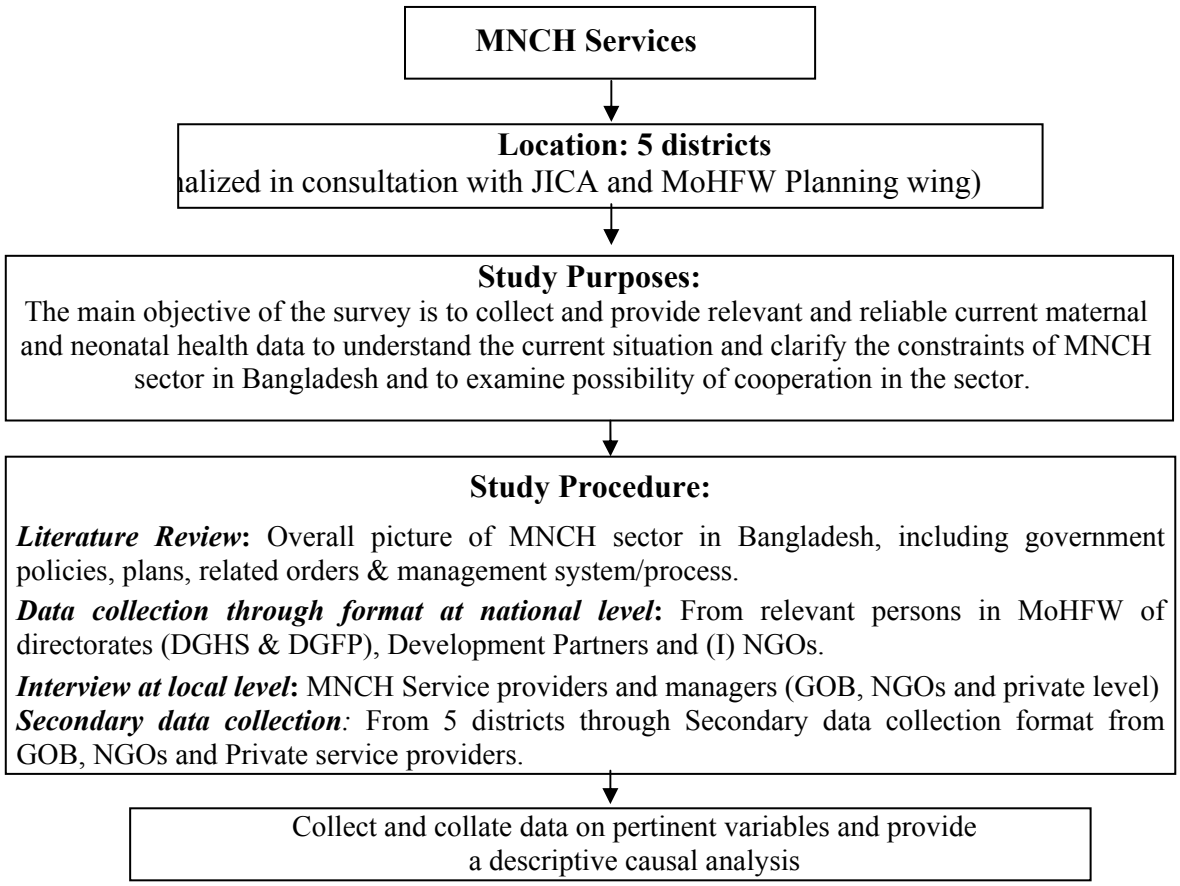
2.1 Study Strategy

The study was conducted by a joint team of international (Japanese) and national (Bangladeshi) consultants, and JICA Bangladesh Office and JICA Headquarters provided necessary guidance in the course of the study. Japanese team provided technical advice to the study and monitored the progress. They worked closely with the national consultants mainly at national level and sometimes in the field. The study covered 5 districts, as identified through consultation with MOHFW (Planning Wing), JICA and the Japanese team.

2.2 Study Design

Information was collected from 5 districts as agreed, namely, Barguna, Satkhira, Jessore, Kurigram and Bandarban through a questionnaire based on the understanding of current situation and future prospects. The total research design is an assimilation of qualitative and quantitative approach/study (Figure 2.1).

Figure 2.1: Research design of study on MNCH situation



A. Interviews

Interviews were conducted with Health and Family Planning Managers and MNCH Service Providers of Govt., NGOs and Private Service Providers at 5 districts. The persons interviewed were- Civil Surgeon, Deputy Director Family Planning, Consultant Obs/Gynae of District Hospital, Medical Officer of MCWC, UHFPO (2 per district providing Basic or Comprehensive EmOC services), UFPO (2 per district in same Upazillas), NGO Managers/ Service Providers (2 per district providing Basic or Comprehensive EmOC), and Private Service Providers (2 per district providing Basic or Comprehensive EmOC). In addition to the current activities relating to MNCH, their future plan was also asked to get an overview on the subject. Overall scenario of interview is depicted below in Box 1.

Box 1: Overall scenario of interview

- **Health and Family Planning Professionals of Govt. at district level-**
  - Civil Surgeon : 1 per district
  - Deputy Director Family Planning : 1 per district
  - Consultant, Gynae & Obstetrics of District Hospital : 1 per district
  - Medical officers of MCWC : 1 per district (Providing EmOC)
- **Health and Family Planning Professionals of Govt. at district level**
  - UHFPO : 2 Upazillas per district (Providing EmOC)
  - UFPO : 2 Upazillas per district
- **NGO and Private-**
  - NGO Managers : 2 per district (Providing EmOC)
  - Private Service Providers : 2 per district (Providing EmOC)

B. Secondary Data Collection

Secondary data was collected from Civil Surgeon and Deputy Director Family Planning office on General information, Human resources, Service statistics and related information through Secondary data collection sheet. Secondary data was also collected from District Hospitals, UHCs (conducting Basic or Comprehensive EmOC), UFPOs, MCWCs, NGOs, and Private Service Providers. These were the basis of quantitative data of this study.

2.3 Variables and Sources of Information

Following information were collected from Civil Surgeon, Deputy Director Family Planning, Consultant Obs/Gynae of District Hospital, UHFPO (providing Basic or Comprehensive EmOC), UFPO, Medical Officer of MCWCs, NGO Managers/ Service Providers (providing Basic or Comprehensive EmOC), Private Service Providers (providing Basic or Comprehensive EmOC). Focus was given to EmOC (Emergency Obstetric Care) and MNH related issues. In order to improve MNH services, distance from district, mode of communication from district HQ, human resources status, bed occupancy rate, number of CBSA, number of delivery conducted by CBSA, Community clinic situation, Local level planning, DSF program, Women friendly hospital status, NNP and IMCI program activities status, referral situation, and quality assurance status were also obtained to reveal the actual situation. Their suggestions for improvement of MNH services for the poor were also collected during interview.

Table 2.1: List of the variables and indicators by sources of information

Type of Variable(s)	Indicators	Source(s) of Information (*)
A. Health systems at district level		
1. Organizational arrangement and responsibility	1.1. Organizational arrangement and activities of health managers at district and upazila level	Civil Surgeon; DDFP; UHFPO; UFPO
2. Service delivery	2.1. MNCH related performance and process indicators by district	Civil Surgeon; DDFP; UHFPO; UFPO, Dist. hospital, MCWC, NGO, Private
	2.2. Number of B/C-EmOC in public health facilities, their population coverage, number of private health facilities and further expansion plan of B/C-EmOC services by district	Civil Surgeon; DDFP; UHFPO; UFPO, NGO
	2.3. Quality Management System (Monitoring of health facilities according to standards, EmOC Team, Quality Assurance Team etc.)	Civil Surgeon; DDFP; UHFPO; UFPO, Dist. Hospital, MCWC, NGO, Private
3. Health Workforce	3.1. Number of MNCH workforce by category	Civil Surgeon; DDFP; UHFPO; UFPO, Dist. Hospital, MCWC, NGO, Private
	3.2. Training	
4. Procurement (medical equipment, drugs and consumables)	4.1. Standard of specifications of Equipment, drugs and consumables	Civil Surgeon; DDFP; UHFPO; UFPO, Dist. Hospital, MCWC, NGO
	4.2. Budget allocation & expenditure	
	4.3. Procurement process	
	4.4. On-going improvement and future plan	
5. Institutional and financial arrangement for operation, renovation and maintenance of facility and equipment	5.1. Concerned organizations and their responsibilities	Civil Surgeon; DDFP; UHFPO; UFPO, Dist. Hospital, MCWC, NGO
	5.2. Budget allocation & expenditure	
	7.3. Current process	
	7.4. On-going improvement plan	
8. Budget of district and health facilities	8.1. Budget allocation and source of income of health facilities	Civil Surgeon; DDFP; UHFPO; UFPO; MO, MCWC
	8.2. User fees	
	8.3. Implementation of "Demand Side Financing"	
9. Local level planning Decentralization	9.1. Plan and progress	Civil Surgeon; DDFP; UHFPO; UFPO
	9.2. Working modality	
	9.3. Bottlenecks faced	
10.Community clinics	10.1. Situation of existing community clinics	Civil Surgeon; DDFP
	10.2. Future plan	
11.Referral system	11.1. Working mechanism	Civil Surgeon; DDFP
	11.2. Number of actual cases referred from upazila to district, district to regional/central levels	UFFPO; MO, MCWC; Civil Surgeon; DDFP
12.MIS (Management Information System)	12.1. Type of information collected	Civil Surgeon; DDFP
	12.2. Frequency of information collection	
	12.3. Information sharing between CS and DDFP	
C. Health Service delivery in 5 districts		
13. Service delivery by health facilities	13.1. MNCH related indicators	Civil Surgeon; DDFP; UHFPO; MO, MCWC, Private
	13.2. B/C-EmOC public health facilities information	
	13.3. Further expansion plan of B/C-EmOC services	
	13.4. Number of private health facilities by district	Civil Surgeon; DDFP
	13.5. Quality Management System	Civil Surgeon; DDFP; UHFPO; MO, MCWC, Private

Type of Variable(s)	Indicators	Source(s) of Information (*)
14. Health Workforce	-	Civil Surgeon; DDFP
15. Procurement system (medical equipment, drugs and consumables)	-	
16. Institutional and financial arrangement for operation, renovation and maintenance of facility and equipment	-	
17. Budget for sub-national level health facilities	-	Civil Surgeon; DDFP
18. Local level planning	-	Civil Surgeon; DDFP
19. Community clinics	-	UHFPO; UFPO
20. Referral system	-	Civil Surgeon; UHFPO; MO, MCWC
21. MIS	-	Civil Surgeon; DDFP; UHFPO; UFPO
22.Activities of develop-ment partners and NGOs	-	Civil Surgeon; DDFP; Private
25. Good practices (including GOB practices such as Chowgachha UHC)	25.1. Incentives	Civil Surgeon; DDFP; UHFPO; NGO Managers
	25.2. Hospital management	Civil Surgeon; DDFP; UHFPO; NGO Managers
	25.3. Quality Services	Civil Surgeon; DDFP;UHFPO; NGO Managers
	25.4. Equipment Maintenance	Civil Surgeon; DDFP;UHFPO; NGO Managers
	25.5. Demand creation / community involvement	Civil Surgeon; DDFP;UHFPO; NGO Managers
	25.6. Neo-natal care	Civil Surgeon; DDFP;UHFPO; NGO Managers
	25.7. Others	Civil Surgeon; DDFP;UHFPO; NGO Managers

2.4 Implementation

The implementation of the 'Study on Maternal and Neonatal Child Health (MNCH)' comprise of the following steps:

1. Contract Negotiation
2. Review concept, approaches and tools of SMPP
3. Review existing MNH mapping document
4. Discuss with JICA Bangladesh Office, Japanese consultant team and SMPP staff
5. Secondary data collection from existing project documents and study reports and documents produced by the GoB and other organizations.
6. Finalization of the study design and tools (Bengali and/or English)
7. Edit and finalize the questionnaire (GOB, NGOs, private clinics etc.)

8. Interviews to GOB, NGOs, private clinics etc.
9. Conduct secondary data collection
10. Data entry and compilation
11. Edit and clean the data
12. Analyze the data
13. Undertake comparisons among districts
14. Preparation of the draft report and submit to JICA Bangladesh Office
15. Finalization of the Report and submit to JICA Bangladesh Office
16. Present study findings at JICA and stakeholder meeting

2.4.1 Contract Negotiation

JICA, Bangladesh Office signed a contract with HDRC as the most suitable one. Professor Abul Barkat, Team Leader represented the organization as team leader of the study. All communications regarding this proposal were made with team leader.

2.4.2 Selection of 5 Districts for the Study

The most important and prime work of this study was selection of 5 districts for the study. It was done through a meeting in Ministry of Health and Family Welfare (Planning Wing) with Mr. Abdul Mannan, Joint Chief (Planning) in Chair in presence of representatives for both directorates (Health and Family Planning), JICA and HDRC Consultants/Professionals in early December. In addition to the time-bound list of work, there was several discussion-meetings and feed-back, and exchange of information between HDRC Consultants and JICA on issues of common concern. These engagements were fixed mutually.

2.4.3 Submission of Inception Report to JICA

An Inception Report was submitted to JICA Bangladesh by December 12, 2009 describing the methodology and detailed plan for Implementation Plan of the study, design and questionnaire.

2.4.4 Review Concept, Approaches and Tools of SMPP and Review Existing MNH Mapping Document and Eliciting Ideas

Review of concept, approaches and tools of SMPP and existing MNH mapping document was a major activity for definitions, interpretation of convention and eliciting ideas for the preparation of the draft data collection instruments. Then, meetings and discussions with JICA Bangladesh Office, Japanese consultant team and SMPP staff were done in order to understand the critical issues pertaining to the study.

2.4.5 Secondary Data Collection from Existing Project Documents and Study Reports and Documents Produced by the GoB and other Organizations

The procedural steps at this stage included: (a) Secondary data collection from existing project documents; (b) Obtaining of all relevant documents pertaining to the MNCH including EmOC and FP; (c) Obtaining of the copies of relevant study reports and documents produced by the GoB and other organizations. All the documents obtained were reviewed keeping the purpose of the study in mind.

2.4.6 Preparation of Draft Data Collection Instruments (English)

HDRC consultants prepared and submitted draft data collection instruments (DCIs) to JICA Bangladesh Office, Japanese consultant team and SMPP staff (Technical Committee) in line with the decisions of the consensus building meeting. The Technical Committee and HDRC Core team members worked jointly in the process of preparing the draft final versions of DCIs. The DCIs were submitted to JICA, Bangladesh for approval.

2.4.7 Edit and Finalize the Questionnaires

Then the questionnaire developed were edited and finalized after the decision of JICA, Bangladesh. After their reviewing the final data collection instruments prepared were translated into Bangali. Guidelines were developed for conduction of interviews and collect secondary data. In addition, guidelines helped them regarding how to reach those peoples and how to conduct interviews with them, what to do and what not to do, and how to face special situations.

2.4.8 Recruitment and Composition of Field Team

Qualified and experienced persons in the relevant field have been selected jointly by JICA and HDRC to do the job. There were 5 teams for field investigation in 5 districts each team consisted of two persons. Of the 2 persons, one interviewed Civil Surgeon, Deputy Director Family Planning (DDFP), Consultant, Obs/Gynae of district Hospital and 1 Medical Officer-MCWC and 2 UHFPOs, and another person collected Secondary Data from Civil Surgeon and DDFP office, and interviewed 2 UPFOs, 2 NGO Managers, and 2 Private Service Providers in each district. Before training of Field Investigators this was finally decided and all concerned informed.

2.4.9 Training

A 3-day training was provided. The training started on 25th December and ended on 27th December 2009. Trainers were professionally qualified in the relevant field. Training methodology was lecture, discussion, question-answer, practice session, and role-playing. During training, a discussion on date, time of departure/arrival, mode of transport, accommodation, etc. of Investigators/Quality Control Officer and others were finalized.

2.4.10 Data Collection from Field

All 5 teams moved out for travel to the selected five districts on December 28, 2009 and their work completed by January 4, 2010. They traveled by Bus/train to the destination and used local transport where necessary.

2.4.11 Quality Control Checks

A sound quality control system was developed to adequately monitor the quality of data collection. For this purpose, 2 Quality Control Officers (QCOs) was deployed. They constantly moved around the sample spots assigned to them and ensure quality data through: (i) field checking, and (ii) data monitoring. During their field checking, the Quality Control Officers performed re-interview, and check the data accuracy where necessary. Some of the reported no response items were also checked.

2.4.12 Analysis and Tabulation

The study is basically a qualitative one. However, some quantitative analysis was done for the data collected through Secondary data collection sheet.

Simple tables as well as multivariate tables were constructed including various indicators of the study. Relative importance of issues have been identified and analyzed so that specific interventions can be suggested by specific *upazillas*.

Qualitative Analysis: Since qualitative analysis played an important role to validate and supplement the quantitative data, information processing is directed toward 'deductive transcription' of qualitatively organized information into quantitative listing. We call this analysis plan a "qualitative-quantitative intersection".

Data/Information organization: The deductive transcription was reached through sorting information by qualitative vs quantitative, "addressed" vs "not addressed", pattern and magnitude of address. Gradually labelling, coding, editing, filtering, scaling, and *matricing* were done.

2.4.13 Draft Report Writing

Report writing constituted integration of relationships between variables and indicators of assessment; formation of general statements about relationships among categories, and interpretation of information in line with the objectives and requirements outlined in the ToR and other documents supplied for the study.

All the members of the core team were involved in data analysis and writing of the draft report. Findings from all the 10 data collection instruments were used in writing of report. The inception report has been submitted to JICA Bangladesh on January 12, 2010, and the draft on January 28, 2010.

2.4.14 Presentation of Findings to JICA Office and Stakeholders Meeting

Key findings will be presented to JICA Office and Stakeholders Meeting for their review and comments after submission of draft report. The date of presentation of study findings at JICA office/any suitable place (location) in a meeting with selected stakeholders and date of submission of final report to JICA Bangladesh will be decided jointly.

2.4.15 Finalization of the Report

Upon receipt of the comments from JICA as well as the comment and suggestion received during the presentation of key findings, they were reviewed thoroughly by the core team members, and necessary changes in the draft report were incorporated to finalize the report. This has been done.

2.5 Limitation

We are aware that each study has some limitations and risks. The limitations of the present study are that, it could not deal with cross-cutting issues in detail and could hardly address or measure attitudinal issues, commitment level of key actors/stakeholders (Govt. DPs, NGOs, private entrepreneurs, civil society, local leaders and others) that influence implementation of

current activities and also future expansion of MNCH program meaningfully. How far could we proceed – a question to be answered, perhaps, by more in-depth study(ies). The present study attempted to throw more light than before on answering some key questions.

In conducting the study it become transparent that the study originally designed **as one is not one, but two in one** and difficulties started in gathering information and data from various sources. Some sources were not easy to get information from and **were reluctant to divulge financial data and also their views on future plan.** Apart from this, getting responses to large questionnaires was not easy and as it appeared that knowledge gap or lack of time, or reluctance to respond hindered the process of investigation. However, facing problems of conducting a study is nothing new, nor unusual; the only thing that matters most is shortage of time. The study team was under the pressure of scarcity of time. Nevertheless, JICA-Consultants support was of great value in the successful completion of the study.

CHAPTER III
POLICY FRAME WORK VIS-À-VIS MNH PROGRAMME

The *national programmes on Health-Reproductive* Health-Nutrition-Family Planning singularly or in totality do not exist in isolation. Each of the programmes has multi-dimensional focus and calls for multi-disciplinary approach although strategies and policy objectives, in substance, may largely be identical or even dissimilar.

Ideally, the ***CONSTITUTION of Bangladesh*** is the root of all state/Govt. policies of national importance. The national policies should stem out of the ***CONSTITUTION of Bangladesh,*** as much as national programmes should be born out of the national policies and principles. In the same way, projects are usually supposed to germinate for development making a way forward, besides strengthening of the on-going programme efforts. Projects are of temporary nature, time-bound with specific objectives and targets. Programmes are of permanent nature, continue over time.

The national policies may be complementary, cross-cutting, reinforcing and also overlapping. In this context, National Health Policy (2000 AD), Bangladesh Population Policy (Oct. 2004), Bangladesh National Strategy for Maternal Health (Oct. 2001), on review may reveal strengths, weaknesses, challenges and opportunities for overall sectoral development nation wide. In order to understand the status of MNH in the policy framework of some high-profile national policies/strategies, close review of above noted policies was done.

As it appeared, *MNH did not enjoy the priority it deserved in the policies and from the policy-makers.* There existed lukewarm responses at policy and implementation level of both government and NGOs. Decision-makers and implementers are seized with myopic vision about **MNH which is still a low-profile activity.** A brief review revealed the followings.

The National Health Policy (2000 AD): The national health policy document began with a comprehensive introduction focused on – Health and Social well-being for all – a vision and mission to be achieved sooner or later (no strict time-line). Although, 15 main objectives and 32 policy principles of the national health policy included MCH/ Safe Motherhood, Nutrition and FP, **it did not specify anything (any programme intervention) about Neonatal health care.** It lacked in outlining strategies for various interventions which are doable and practical. An indication of 'how' to achieve the set goals or broadly, 'vision' to fulfill the mission "Health for All" was absent. In the policy document, there are however, strong elements of outburst of wishes of what should be done, but not what could be done within a reasonable time-frame. Any assumption that proper neonatal health care will be/could be absorbed within the domain of MCH interventions, may prove wrong and may not ensure adequate priority that it (MNH) rightly deserve. *The health policy framework may, in this context, warrant suitable revision.*

Bangladesh Population Policy (October, 2004): The national population policy objectives highlighted strategies for planned family life, good health, maternal infant-child care, nutrition and social well-being/welfare of the people and advocated multi-sectoral approach with community participation. But it (policy) **lacked in sharp focus on neonatal health care which could promote and strengthen programmes on infant-child care essential for**

establishing small family norm in the society. Due priority for mother and neonatal care in the policy was not given though it deserved as much importance as any other issue of national importance. The Bangladesh Population Policy, as it is understood, is under revision, would hopefully have higher priority dimension for MNH sub-sector.

Bangladesh National Strategy for Maternal Health (NSMH October, 2001): Maternal health strategy is an elaborate document for MCH activities focused more on maternal and child health **and less/least on neonatal care.** Absence of definite strategy(ies) for implementing specific programme measures for the well-being of the neonatal and lack of promotional efforts for "good practices" to be adopted/ensured by GO and NGOs, are hindering newborn health care. The national strategy on maternal health stated that "there is little recognition of the special needs of pregnant and lactating women and of the stress of these states on the women's health" (page 24 of NSMH, Oct, 2001). It is understood that MNH strategy formulation is in the offing. *One most important break-through is that awareness about MNCH services has increased substantially* both at grass root and higher management levels. **It is time for action.**

National Budget 2009-2010 of the Government of Bangladesh: The dimension of national budget 2009-2010 is one lakh thirteen thousand eight hundred nineteen crores (16.50% of GDP) only. While allocation for development budget is thirty thousand five hundred crores, the sector-wide allocation for Education, Health, Science and Technology is 23.50% which is not meager in view of the total resource envelop. The positive side is the promise for Sector/ Ministry/Division-wise allocation of fund for Women's Development. In the light of allocation for women's development, health, FP, Nutrition and Education, resource allocation for MNH care should given due priority not only in words but in action. Future Budget Speech of Finance Ministry may include this issue of national importance.

Annual Programme Review on HNPSP (Key Findings, Conclusions and Recommendations): The APR (dated 5th May, 2009) clearly stated that – "Bangladesh has only US $ 5 to spend from its own resources on health far short of the requirements for meeting the health MDGs. In a global economic crisis, the scope for increasing this will be limited, and Bangladesh will continue to need sustained and preferably increased aid flows". While global economic scenario is dismal, Bangladesh's optimism for liberal aid flow and internal resource mobilization efforts may not be very bright indeed.

In the overall policy framework of the government and in the government's multi-dimensional approaches and strategies for policy-actions on issues of national importance, the MNCH may appear quite small, but any lack of vision and missionary zeal to deal with this issue (MNCH) may have far reaching implications.

CHAPTER IV
AN OVERVIEW OF FIVE STUDY AREAS

Five study districts Barguna, Bandarban, Jessore, Satkhira and Kurigram are not totally homogeneous, nor heterogeneous in character (culture, tradition, way of living, literacy and thought-process) but each has similarities and dissimilarities with other, in various aspects of life and living. Bandarban is the only district of Chittagong Hill Tracts (CHT) among the five.

The health situation, MNH activities/services, human resources, facilities, access to available opportunities *are not even, nor equal*, besides quality of service delivery differing in various degrees in each location or outlet. In this context, findings by district (each five district) have been presented with available information collected from the field sources (both primary and secondary data).

4.1 Area and Population

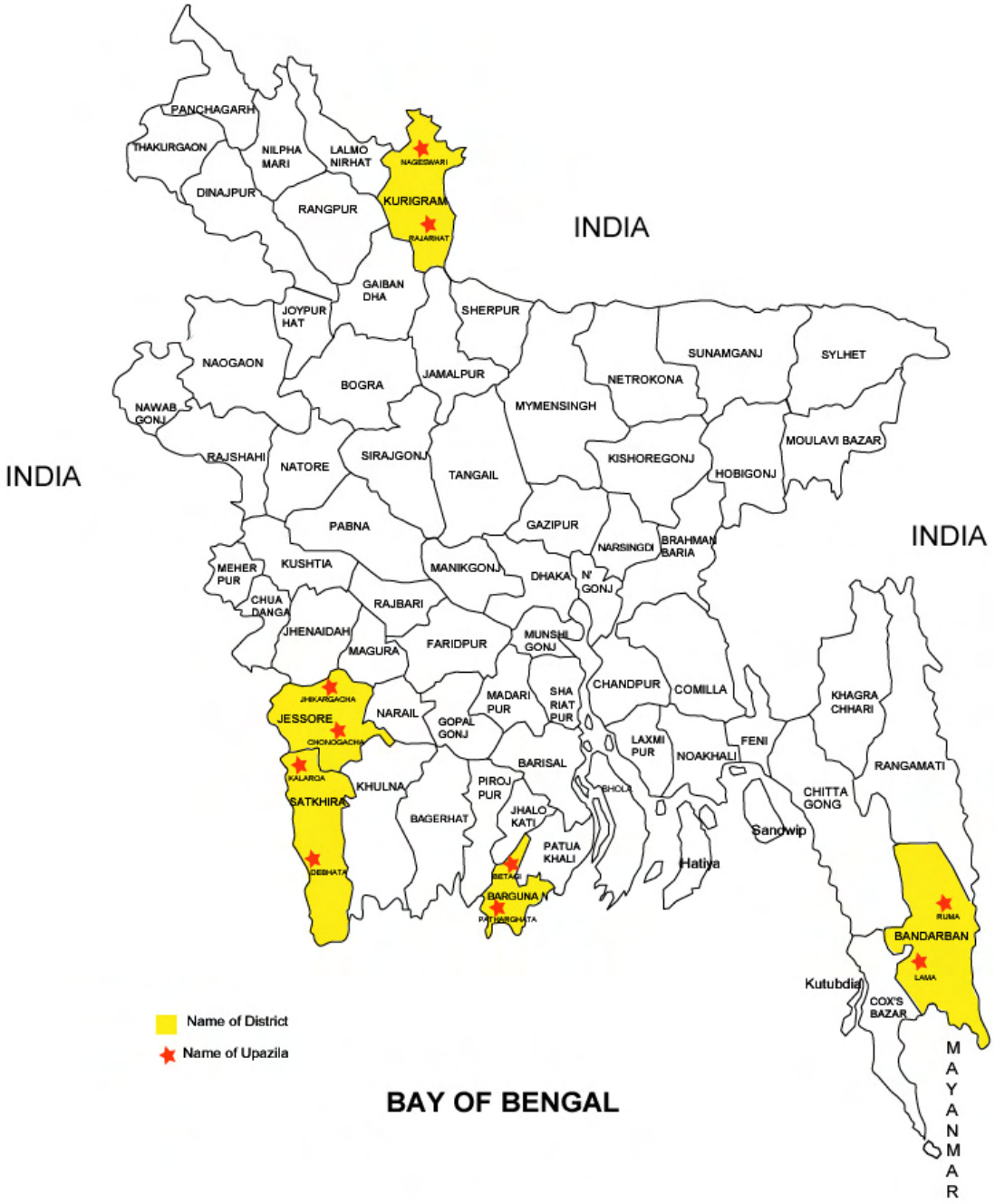
The five districts together have a population of 7,556,193 (as per Census 2001) and 82,44,161 as per field data (CS/DDFP office) in an area covering 15,031.65 sq.km. In terms of population, Bandarban district has the smallest in number (314,292 or 340,337) and Jessore district has highest number (2,584,801 or 2,795,822). In area, the district of Bandarban is the largest and Barguna is the smallest. The table below gives an overview of area and population size of five districts.

Table 4.1: Area, Upazila, Union and Population, density of each District

District	Area in sq. km.	Upazila #	Union #	Population Size		Density (as per Census 2001)
				As per Census 2001	As per report CS/DDFP office, 2009	
Barguna	183.31	5	38	884,036	896,946	462
Bandarban	4479	7	29	314,292	340,337	67
Jessore	2567	8	91	2,584,801	2,795,822	962
Satkhira	3858.33	7	78	1,930,164	1,984,493	478
Kurigram	2296.1	9	72	1,842,.900	2,226,563	768
5 Districts	15,031.65	36	308	7,556,193	8,244,161	NA

While Jessore has largest number of unions (91) and population with highest density of 962, Bandarban has smallest number of unions (29) and population (314,292) with density 67 per square kilometer (Census 2001). A map of Bangladesh showing distinctly five study Districts (MNH study) is provided for visual reference.

Map 4.1: Map of Bangladesh showing position of 5 study districts



4.2 Distance, Bed Capacity, Electricity and Water Supply

Distance and mode of transport from the District HQ to District Hospital, MCWCs, and different Upazila Health Complexes have been recorded in the present study. At the same time, information on the number of beds, electricity and water supply status was collected. This information are noted below.

- **Distance:** It appeared that almost in all cases the distance of District Hospital from District HQ is less than 0.5 km (walking distance), and MCWCs are also located at a distance of 0.5 km (Satkhira, Barguna) and at 1.0 km – 1.5 km in three other districts (Bandarban, Jessore, and Kurigram) with mainly Rickshaw as transport for road communication. In the case of UHCs, distance from District HQ, there exists wide variation and the range is quite big – from 1 Km (Bandarban Sadar UHC) nearest to 120 km (Naikhanchari) longest, and 115 Km Thanchi second longest in Bandarban district. All UHCs have road communication with bus service but in the case of Ruma and Thanchi upazilas of Bandarban district, boat (riverine communication) for transportation can be used.

- **Bed-Capacity:** All District Hospitals except Jessore have 100-bed facility and Jessore has 250-bed capacity. Again, 2 MCWCs (Barguna, Jessore) have 20-beds each and 3 other (Bandarban, Kurigram, Satkhira) have 10-bed capacity. The bed capacity of UHCs varies from 10-beds to 50-beds. 19 UHCs have 31-beds each, 9 UHCs have 50-beds each and 3 UHCs (Ruma, Rowangchari, Tala) have 10-beds each and 'no-bed' in two upazilas – Thanchi and Sadar of Bandarban district.

- **Electricity and Water Supply:** Regarding electricity and water supply, all UHCs are connected with electricity and water supply system, except ***Thanchi UHC of Bandarban where there is no electricity and no water supply line.*** It appeared that Thanchi upazila with 4 unions is most deprived/neglected being located at 115 km away from district HQ. Total picture of this upazila (UHC) seem to be quite dismal. In comparison, Keshobpur Upazila Health Complex (Jessore) seem to have much better condition. (See Annex Table 1a & 1b for details).

4.3 Human Resources at the Five Study Districts

- **In Barguna** it was reported, there are 35 MOs present in government hospitals (District Hospital, UHCs) including MCWCs though the sanctioned number of posts of MOs is 62. Amongst five UHCs, Betagi has no MO working nor any one is/was trained in OG and AN. Positions remain vacant. Again, the number of Nurses present (working) in the district is 51 against sanctioned strength of 83, and none of them is trained in EmOC/midwifery. Consultant posts shown was 6 and filled up/present number was 3. Consultant, AN post shown was 6 and presently working only 2. The posts of Consultant OG and AN (two posts) were shown at each UHC. The reported figure of sanctioned posts of all categories as noted above shown against District Hospital and UHCs was not verified.

- **In Bandarban district** as reported, number of MO present was 19 against sanctioned strength of 55. Of them, one MO is trained in OG and two are in AN. None of the trained MO, is present in any UHC. Only District Hospital has one MO OG and one MO, AN beside, MCWC has one MO trained in AN. In the district, a total of 43

Nurses against 77 sanctioned posts were present. Number of Nurses trained in EmOC/Midwifery was 14, only 9 of them working at District Hospital, 3 at UHC Lama, one at Ruma and one at Alikadam UHC. Against sanctioned post of 9 Consultants OG, only 2 are present and similarly only one Consultant AN out of 9 positions is presently working.

- **In the district of Jessore,** at present 59 MOs are in position against 124 posts, and number of nurses 207 against 202 posts. This is a bit unusual. Number of trained nurse in EmOC/Midwifery is 10. Consultant OG present 12 against 12 posts, and again Consultant AN present 9 posts (100% filled up and present). Number of MO trained in OG is 7 and MO trained in AN is 5 only. In terms human resource deployment, all UHCs seem to be almost on equal footing

- **Satkhira district has** 78 posts of MO filled up (present) against 197 posts, nurse in position 82 against 92 posts. Trained nurse (EmOC/midwifery) numbers 29 and 3 Consultants OG present against 7 posts, again 5 Consultants AN, are in position against 8 posts. Number of MO trained in OG is 4, trained in AN is 3 only. UHCs kolaroa and Debhata are in a better position in comparison to other UHCs in terms of deployment of manpower.

- **The district of Kurigram** has 32 MOs against 36 posts of which none in trained in OG, AN. Number of Nurse is 47 against 94 posts. There are 3 nurses trained in EmOC and 31 in midwifery. Presently, Consultant OG numbers 3 against 10 posts and Consultant AN numbers 2 against 10. Fulbari UHC has only 1 Consultant AN of the 2 present (in the district hospital 1+1 UHC Fulbari)

It is note worthy that the post (present and sanctioned) of Consultants OG/AN are usually shown in each UHC staffing pattern. It is likely that MOs trained in OG/AN are known as Consultants OG/AN at the UHC level. However, **the presence of a properly trained doctor (MO) in OG/AN at UHC level is critically important for MNH service delivery (BEmOC/CEmOC etc.).** The trained/not trained medical/paramedical personnel may be seen in the Table 4.2 on Human Resource status. Details may be seen in the Annex Table 2.

Table 4.2: Human resources status

Indicators (Category-wise district total #)		**Study Districts**				
		Barguna	**Bandarban**	**Jessore**	**Satkhira**	**Kurigram**
Medical Officer	In position #	13	19	59	78	32
	Sanctioned #	66	55	124	197	36
Medical Officer trained in OG	In position #	1	1	7	4	-
	Sanctioned #	5	-	7	-	-
MO trained in AN	In position #	0	2	5	3	-
	Sanctioned #	0	-	8	-	-
Nurse	In position #	51	43	207	84	47
	Sanctioned #	83	77	202	92	94
Nurses trained in EmOC/midwifery	In position #	0	14	10	29	34
	Sanctioned #	0	-	-	-	-
Consultant Obs./Gyne	In position #	3	2	12	3	3
	Sanctioned #	6	9	9	7	10
Consultant AN	In position #	2	1	9	5	2
	Sanctioned #	6	9	9	8	10

Source: Secondary data compilation format

4.4 Current EmOC Status (BEmOC, CEmOC or No EmOC)

All the 5 (five) District Hospitals provide CEmOC as designated. Among the MCWCs, Jessore, Satkhira and Kurigram MCWCs are providing CEmOC. They having 2 trained MOs (one trained in Obs/Gyn and another on Anesthesia). Bandarban MCWC is having 1 MO trained on Anesthesia and providing BEmOC. They asked for 2 sets of EmOC trained doctors for providing CEmOC.

Current EmOC status of 10 UHCs-

- In Barguna, Patharghata and Betagi UHCs provide no EmOC.
- In Bandarban, Lama provide First aid EmOC, and Ruma UHC doesn't provide no EmOC.
- In Jessore, Jhikorgacha and Choughacha UHCs provide CEmOC.
- In Satkhira, Kolaroa and Debhata provide CEmOC.
- In Kurigram, Rajarhat UHC provide First-aid EmOC and Nageshwari provide CEmOC.

Service delivery points		Designated status	Present situation (CEmOC/BEmOC/ no EmOC provided)	No. of CS in 2009 (Jan-Nov)	Reasons for not providing CEmOC/ BEmOC services as designated
District Hospital					
Barguna		CEmOC	CEmOC	213	NR
Bandarban		CEmOC	CEmOC	49	NR
Jessore		CEmOC	CEmOC	1148	NR
Satkhira		CEmOC	CEmOC	191	NR
Kurigram		CEmOC	CEmOC	102	NR
MCWC					
Barguna		CEmOC	No EmOC	0	No EmOC trained doctor
Bandarban		CEmOC	BEmOC	03	Need 2 sets of EmOC trained doctor
Jessore		CEmOC	CEmOC	122	NR
Satkhira		CEmOC	CEmOC	295	NR
Kurigram		CEmOC	CEmOC	68	NR
UHC					
Barguna	Patharghata	CEmOC	No EmOC	0	Lack of EmOC trained doctor and space
	Betagi	BEmOC	No EmOC	0	Lack of EmOC trained doctor
Bandarban	Lama	BEmOC	First-aid EmOC	0	Lack of EmOC trained doctor and other manpower
	Ruma	BEmOC	No EmOC	0	No cause mentioned
Jessore	Chowgacha	CEmOC	CEmOC	767	NR
	Jhikargacha	CEmOC	CEmOC	200	NR
Satkhira	Kolaroa	CEmOC	CEmOC	135	NR
	Debhata	CEmOC	CEmOC	83	NR
Kurigram	Rajarhat	BEmOC	First-aid EmOC	0	Lack of EmOC trained doctor and other manpower
	Nageshwari	CEmOC	CEmOC	33	NR

Note: CS= Caesarean Section; NR= Not required;
(Source for District Hospital : Consultant, Obs/Gynae Interview)
(Source for MCWC: MO, MCWC Interview, and Secondary Data Collection Format for No. of CS in Satkhira and Kurigram)
(Source for UHC: UHFPO Interview, and Secondary Data Collection Format for No. of CS in Satkhira Betagi, Patharghata, Ruma, Kalaroa, Debhata, Rajarhat and Nageshwari)

EmOC being an important component of MNH care is being implemented as a national wide program by both DGHS and DGFP. As designated, CEmOC should be provided at all the district hospitals, MCWCs and some of the UHCs, and BEmOC in other UHCs. However, the sad reality is that, due to lack of trained manpower, especially doctors trained in EmOC, and lack of proper policy for retaining those trained staff, a number those facilities are not providing EmOC at their designated level. Even the statistical section of Civil Surgeon's office and DDFP's office are not having proper data on their no. of EmOC trained staff and no. of EmOC services provided.

The consultants are of opinion that, all the gaps mentioned above should be filled in immediately through more training on EmOC, proper monitoring and devising system for retaining EmOC trained staff, and retaining accurate data at district and at national level, so that proper steps can be taken to make the EmOC program effective.

CHAPTER V
FINDINGS – ISSUES AND DISTRICT SITUATION

5.1. Situation of District Hospitals, Upazilla Health Complexes and Maternal and Child Welfare Centres

District Hospitals, Upazilla Health Complexes (UHCs) and Maternal and Child Welfare Centres (MCWCs) are the main places providing MNH services to the people. They are working under the supervision of Civil Surgeons and Deputy Directors of Family Planning (DDFPs). For assessment of situation of District Hospitals, UHCs and MCWCs, Civil Surgeons and DDFPs, the Consultants, Obs/Gynae, District Hospitals, Upazilla Health and Family Welfare Officers (UHFPOs) and Medical Officers, MCWCs were interviewed. Secondary data compilation formats were also used.

5.1.1 Situation of District Hospitals

District hospitals are important places at the district level for provision of MNH care. In this study, the situation of districts has been studied in terms of infrastructure, service provision and manpower in district hospitals. It has been observed that, only the Jessore district hospital is 250 bedded, and others are 100 bedded. And, in terms of their Bed occupancy rate Satkhira is the highest (149%) and Bandarban the lowest (60%).

As per manpower, actual number of nurses against their sanctioned post is highest in Jessore district hospital with 107 nurses against 114 posts, and Borguna district hospital the lowest with 18 nurses against 21 posts. Actual number of EmOC-trained nurses is highest (9) in Bandarban. In both Jessore and Kurigram district hospital there are 2 OB/GY Consultants. They are posted against 6 post in Jessore and 2 posts in Kurigram. However, the number of MOs present is highest (11) in Jessore against 13 sanctioned posts. Bandarban was the next, with 8 MOs present against 9 sanctioned posts.

Table 5.1: Situation of District Hospitals of 5 districts

Indicators	Barguna	Bandarban	Jessore	Satkhira	Kurigram
# of beds	100	100	250	100	100
Bed occupancy %	104	59.68	138.36	149.27	127.18
Actual # of nurses (# sanctioned)	18 (21)	24 (31)	107 (114)	37 (37)	22 (22)
Actual # of EmOC-trained nurses	NA	9	4	5	3
Actual # of OB/GY consultants (# sanctioned)	1 (1)	1(1)	2(6)	1(1)	2(2)
Actual # MOs (# sanctioned)	2(4)	8(9)	11(13)	3(6)	4(4)
Actual # MOs trained in Ob/Gy	1	1	4	0	0
Actual # MOs trained in AN	0	1	0	0	0
# OG admissions	1098	425	3204	1212	1078
# delivery conducted (incl. C-sections)	416	186	1335	663	415
# of C-section performed	213	49	1148	191	102
Blood transfusion available (numbers)	38	70	Yes (# NA)	125	Yes (# NA)
# obstetric referral (in)	286	0	4	27	1
# obstetric referral (out)	83	17	7	3	27

Note: NA= Data not available;
Source: Secondary data compilation format, and Interview of Consultant, Obs/gyn, District Hospital

Actual number MOs trained in Obs/Gynae were also highest in Jessore (4). In 2 other districts it was 1 and in others none of MOs were trained. Actual number MOs trained in Anesthesia were only 1 in Bandarban, and in other district hostitals there were no such trained MO.

As per performance, Obs/Gynae admission in last 11 months (Jan-Nov, 2009) reported by Obs/Gynae Consultants, was highest (3204) in Jessore in 11 months. It was only 425 in Bandarban and nearly one-third of Jessore in 3 other districts. Total delivery conducted (including C-sections) was 1335 in Jessore (highest) and it was only 186 in Bandarban. Number of Caesarean section performed was also highest (1148) in Jessore and lowest (49) in Bandarban. Blood transfusion available was available in all districts. The number of obstetric referral varied a lot by districts and there no such system to keep this data in district hospitals (Table 5.1)

5.1.2 Situation of Upazilla Health Complexes (UHCs)

Upazilla Health Complexes (UHCs) are the pillars of MNH clinical services at Upazilla level for provision of MNH care. Here, the situation of UHCs has been shown in terms of DSF, infrastructure, service provision and manpower. DSF was there in Chougacha upazilla only.

Among the 10 UHCs, Betagi, Lama, Ruma and Rajarhat are designated to provide BEmOC, and other 6 CEmOC. However, in actual, Lama and Rajarhat are providing 'First- aid EOC' and Betagi and Ruma 'No EOC' service. Among those designated to provide CEmOC (Patharghata, Jhikargacha, Chougacha, Kalaroa, Debhata and Nageshwari), 5 are providing CEmOC except. Patharghata is in fact is not providing any EOC care. The actual situation of EmOC has been reported by UHFPOs.

It has been reported by Civil Surgeon's office that, only Chougacha and Betagi UHCs are 50 bedded, and Lama UHC 10 bedded. Others are 31 bedded. And, in terms of their Bed occupancy rate Chougacha is the highest (172%), and Kalaroa below 50% in-spite of having CEmOC service. Both actual number of nurses and their sanctioned post is highest in Chougacha with 16 nurses against 17 posts. In Nageshwari the situation is worse, where the UHC providing CEmOC is running with 5 nurses against 13 posts. Actual number of EmOC-trained nurses varied from 0 to 4, and there was no data available about 4 of the UHCs in Civil surgeon's office on this issue.

Regarding manpower, all of the Civil Surgeon's office reported that they have 1 sanctioned post of OB/GY consultant for each of the 10 UHCs. However, in actual only 4 of them (Jhikargacha, Chougacha, Kalaroa, Debhata) had 1 OB/GY Consultants each. Actual number of MOs and their sanctioned post an anomaly was observed. In Kalaroa (31 bedded) there are 17 MOs against 32 sanctioned posts, whereas in 50 bedded UHC of Chougacha there were 6 MOs against 14 sanctioned posts. For Betagi they reported of 'no doctor' against their 14 posts. There were pairs of MOs trained in Ob/Gy and trained in Anesthesia in Jhikargacha, Chougacha, Kalaroa, Debhata and Nageshwari.

As per performance, number of Obs/Gynae admission in last 11 months (Jan-Nov, 2009) reported by UHFPOs, was highest in Chougacha (4543) and was much lower in other UHCs providing CEmOC. Total delivery conducted (including Caesarean sections) was 2285 in Chougacha (highest) and it is much lower in other UHCs. Number of Caesarean section performed was also highest (767) in Chougacha, which is much lower in other UHCs. All of those providing CEmOC conduct assisted vaginal deliveries. Blood transfusion available was

available in Jhikargacha, Chougacha, Kalaroa, and Debhata UHCs only. The number of obstetric referral varied a lot by UHCs as there is no such system to keep this data recorded in UHCs (Table 5.2)

Table 5.2: Situation of 10 selected Upazilla Health Complexes (UHCs) of 5 districts

Indicators	Barguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathargata	Lama	Ruma	Jhikar	Chougacha	Kalaroa	Debhata	Rajar	Neges
DSF (yes/no)	No	No	No	No	No	Yes	No	No	No	No
Designated CEmOC/ BEmOC	B	C	B	B	C	C	C	C	B	C
Actual situation CEmOC/BEmOC	No EOC	No EOC	First aid EOC	No EOC	C	C	C	C	First aid EOC	C
# of beds	50	31	10	31	31	51	31	31	31	31
Bed occupancy %	56	62	88.70	48	96	172	49.20	65.48	NA	NA
Actual # of nurses (# sanctioned)	6 (15)	9 (15)	6 (7)	4 (7)	10 (11)	16 (17)	10 (15)	10 (10)	7 (9)	5 (13)
Actual # of EmOC-trained nurses	0	0	3	1	NA	NA	3	4	NA	NA
Actual # of OB/GY consultants (# sanctioned)	0 (1)	0 (1)	0 (1)	0 (1)	1 (1)	1 (1)	1 (1)	1 (1)	NA (NA)	NA (NA)
Actual # MOs (# sanctioned)	0 (14)	2 (15)	3 (9)	1 (7)	9 (13)	6 (14)	17 (32)	10 (14)	NA (NA)	NA (NA)
Actual # MOs trained in Ob/Gy	0	0	0	0	1	1	2	1	NA	1
Actual # MOs trained in AN	0	0	0	0	1	1	1	1	NA	1
# OG admissions	163	239	134	13	1340	4543	968	NA	9	155
# delivery conducted (incl. C-sections)	65	74	48	13	47	2285	453	221	6	111
# of C-section performed	0	0	0	0	200	767	135	83	No	33
Assisted vaginal deliveries (yes/no)	No	No	No	No	Yes	Yes	Yes	Yes	No	NA
Blood transfusion available? (# cases if available)	No	No	No	No	Yes	Yes	Yes	Yes	No	No
# obstetric referral (in)	1	0	0	0	0	3	5	3	7	NA
# obstetric referral (out)	19	45	16	0	21	21	11	7	NA	7

Note: NA= Data not available;
Source: Secondary data compilation format and UHFPO's interview

5.1.3 Situation of MCWCS

The Maternal Child Health Programme (MCH) have national coverage. The programme is more or less comprehensive and depends heavily on Health as well as FP sector collaborative programme-inteventions. Bangladesh does not have an independent MNH or MCH/MNCH programme as many of the issues (of MNH) are cross-cutting/cross-sectored and broad-based to deal with. There is lack of attention to the overall needs of WRA and pregnant mothers. At present, MNH programme is being implemented in some pockets (areas) of Bangladesh. SMPP is an example. Table below gives picturesque figures of services provided at different MCWCs in the study five districts.

Table 5.3: Information on following services provided by MCWCs in 11 months (January to November 2009)

Data Heading		Barguna	Bandarban	Jessore	Satkhira	Kurigram
a.	No. of obs/gynae admission	24	204	600	1150	890
b.	No. of normal delivery conducted ph	9	2	162	814	494
c.	No. of Caesarean Section conducted	4	0	0	322	74
d.	No. of assisted vaginal delivery conducted	0	3	133	0	12
e.	No. of obs/gynae complications treated	22	207	484	60	NA
f	No. of obs/gynae referred patients received	0	0	57	14	NA
g.	No. of obs/gynae patients referred	7	2	97	11	44
h.	No. of blood transfusion services	0	0	7965	0	No blood transfusion facility
i.	No of in patients (in door)	545	3178	600	1136	NA
	No of in patients (out door)	24	207	1702	12446	NA
j.	Bed occupancy rate	12%	NA	23.35%	80%	NA

Note: NA= Not available
Source: District Deputy Director Family Planning Office and CS Office

It appeared that admission (obs/gynae) off patients is highest in Satkhira MCWC (1150 cases) and lowest in Barguna MCWC (24 cases only) during January to November, 2009. Similarly, normal delivery conducted was 814 cases in Satkhira, highest and lowest in Bandarban being 2 (two) cases only.

Overall, the services provided by MCWCs, the best/highest is Satkhira, then Jessore, Kurigram and lowest Barguna and second lowest is Bandarban. It is not clear why the number of obs/gynae referral cases (table column h) is Zero and Not available. 'Zero' and "Not available" is indicative of absence of service/system, or negligence in record-Keeping/ reporting. It may be noted that secondary data collected were not verified as there was no scope of doing so.

5.2 Responses of the Civil Surgeons

Civil Surgeons are the head of the authority in favour of Directorate of Health Services proving MNH and other health care services. In 5 districts 5 Civil Surgeons have been interviewed in course of the study.

5.2.1 Health Assistant and those Trained as CSBA

While they were asked about situation of the districts in terms of Health Assistants (HA) they reported that they are having 57.5% to 90.3% of the sanctioned post, only a few of them (9 to 56) are trained as CSBA (Table 5.4).

Table 5.4: Distribution of Health Assistant and those trained as CSBA by study districts provided by CS

District	Health Assistant			
	Sanctioned	Existing	% Existing against Sanctioned post	Trained as CSBA
Bandaban	144	130	90.27	14
Borguna	213	157	73.70	9
Jessore	358	246	68.71	24
Kurigram	335	201	68.84	9
Satkhira	325	187	57.53	56

In response to a query regarding **quality care of MNH services**, almost all Civil Surgeons, except Jessore feel that existing MNH services in their respective districts are not adequate to serve the need of community people. According to civil Surgeon of Jessore, MNH services in his district is up to the expectation of community people however, he thinks that concerned personnel related to MNH service should be more proactive.

In relation to **bottlenecks behind the quality of MNH services**, following points are mentioned by the Civil Surgeons.

- Lack of manpower in general and skilled personnel in particular
- Lack of community awareness on MNH services
- Economic limitation of most of the people, especially the poor for availing EmOC service provided at govt. facilities provided at lower cost
- Lack of required medical instruments
- Lack of modern diagnostic equipments
- Inadequate supply of medicines

- Inadequate number of service facilities
- Service centres are located at a long distance, particularly in CHT.
- Superstition regarding illness and health seeking behavior
- Lack of commitment of the services providers.
- Service providers are not always available at the centre.

It is evident from the above data that Quality assurance is in question in most of the UHCs. However, as we feel, lack of commitment, and inability to retain EmOC trained doctors is playing vital role here.

5.2.2 Source of Income of Health Facilities

Total health sector budget in the surveyed districts

Total health sector budget as reported by Civil Surgeons in the surveyed districts was highest for Jessore and lowest for Bandarban. For Kurigram the information was not available. The budget for each bed for 100 beds hospital (DH) was Tk. 25,000, and Tk. 18,000 for 31 bed and 50 bed hospitals (UHC).

Table 5.5: Reported total health sector budget (revenue + development + others) for the fiscal year 2009-2010 in the surveyed districts

District	Health sector budget in Taka
Bandarban	4,024,220
Borguna	10,120,000
Jessore	28,664,000
Kurigram	Not available
Satkhira	6,190,000

Allocation of budget for district hospital, upazila health complexes, and community clinics in each district.

In most of Civil Surgeon offices, detail information on annual budget is not available. Except Jessore, in most of districts reported total budget of the district is not consistent with the budget mentioned by different public health facilities (district hospital, upazila health complex, community clinic, etc.). Budget for UHC was not available in most of the Civil Surgeon offices. However, Civil Surgeon's office can spend 70% of its budget per bed for purchase of medicine through DGHS for purchase of medicine and 30% for other cost, as they reported. The allocation of health sector budget by district hospital, UHC and community clinic is given Table 5.6.

Table 5.6: Allocation of health sector budget by district hospital, UHC and community clinic

District	Allocation of budget (Fy 2009-2010)		
	District hospital	Upazila health complex	Community clinics
Bandarban	2,986,220	NA	NA
Borguna	5,000,000	4,868,000	NA
Jessore	16,250,000	12,414,000	NA
Kurigram	NA	NA	NA
Satkhira	2,500,000	3,690,000	NA

NA= Data not Available

Items covered by the budget

The Civil Surgeon of Borguna has mentioned that items like drugs, logistics and maintenance of equipments are covered by the budget he received. However, it is contradicted by the Civil Surgeons of Jessore and Satkhira. On the other hand, there is no information from Kurigram Civil Surgeon regarding the items that are covered by the budget. Similarly, collected information from Bandarban tells nothing on this matter.

Other sources of income besides the 'user fees'

Except Kurigram and to some extent Satkhira, other surveyed districts reported to have other sources of income in addition to user fees. Reported sources vary from place to place. Common sources are – donation from local wealthy persons, medicine companies, selling of tender schedules, leasing of pond, coconut tree, etc. Here leasing was meant for income from hire.

It is to note that none of the Civil Surgeons have mentioned about how to generate or mobilized for new source of income if current extra sources of income is not available.

Effort for generating/mobilizing of new source of income is lacking and it need much effort of UHFPOs and other service providers and support from the district authority. Community involvement is also highly important in this respect.

5.2.3 Challenges in providing EmOC services

The major challenges are as follows:

- Shortage of manpower in general and skilled manpower in particular.
- Frequent transfer of staff.
- Lack of appropriate staff (e.g., surgeon without anesthetist and vice-versa).
- Absence of ambulance, and Van is not available during need.
- Lack of blood bank facility hampers blood transfusion.
- Inadequate supply of medicine.
- Insufficient number of beds for labour cases.
- Low socio-economic condition of most of the patients does allow them to bear the expenses MNH services.
- Lack of adequate community awareness regarding MNH services.
- Lack of sincerity/commitment of the service providers (Sincerity/commitment means present at any time whenever needed for provision of EmOC service).

Reported solution to overcome the challenges

According to the Civil Surgeon of Kurigram, it is quite impossible to solve this issue without trained manpower. In Bandarban, Civil Surgeon blamed the existing policy of transfer and posting in CHT for shortage of staff. According to him, instead of 3 years, duration of posting in CHT should not be more than one year. This will encourage the staff to come and work willingly in CHT. However, the current practices to overcome the challenges are:

- Manage the problems by appointing skilled personnel from one centre to another and vice-versa.
- Try to manage the community clinics by existing manpower, since they can provide Obstetric First Aid and can inform people where to go during emergency.
- Encourage the staff to change their attitude in favour of the patients.

- Keep ready an up-to-date list of blood donors.
- Sensitize community people and local administration for their involvement.
- Request patient to buy required medicines.
- If the number of patients exceeds the numbers of beds then the patients who needs Caesarean section is usually transferred to higher centres.
- In case of power failure, patients are requested to meet the fuel price for the generator.

5.2.4 Role of Government to Improve the EmOC Service in Presence of Manpower Constraints

Most of the Civil Surgeons consider that it will be difficult for government to run the EmOC service properly without adequate number of trained staff. According to some, current size of the staff is half of the required amount. On this backdrop, following measures have been suggested by the Civil Surgeons where government can take necessary action to improve the EmOC.

- Frequent transfer is to be stopped.
- Local government is to be involved make people aware of EmOC problems and to generate fund for helping the poor.
- Community clinics are to be made functional and effective to provide Obstetric First Aid and can inform people where to go during emergency.
- Supply of medicine and equipments related to EmOC services is to be ensured.
- There must be a supportive and proper supervision of EmOC services.
- Sincerity and responsibility of all concerned staff should be raised.
- Initiatives to involve community.

Plan of action of the Civil Surgeons to improve the EmOC service in the district

The Civil Surgeon of Kurigram is struggling to minimize the problems of shortage of staff by tactful utilization of existing ones. Here tactful has been meant for distribution of the current no. of EmOC trained doctors in required facilities in pair (gyn/obs and aneasthesia). In Satkhira, Civil Surgeon is trying to provide EmOC training to the new doctors and nurses. However, he has given more emphasis to raise the number of Medical Officer and Anaesthetist. The Civil Surgeon of Jessore expressed his plan to replicate the ‘Chowgacha model’ to other upazilas, but how he will do that was not mentioned. In Bandarban, Civil Surgeon mentioned that as a head of the health sector of the district, he will write to higher authority to fulfil the posts lying vacant in his district. There was no response from the Civil Surgeon Barguna in this regard.

5.2.5 Local level planning

Local level planning (LLP) is yet to be implemented in Borguna, Jessore and Satkhira. However, Civil Surgeons of Kurigram and Bandarban have mentioned that local level planning has been implemented in their districts and they received a small amount of budget for the planning exercise. According to the Civil Surgeons, local level planning in their respective district was planned with the help a format send from Directorate General of Health Services. On the contrary, other than Kurigram and Bandarban, none has received any feedback from the central authority regarding implementation of LLP. On implementation of the local level planning, Civil Surgeon of Bandarban has mentioned about some problems as follows.

- Shortage of human resources.
- Lack transport to supervise the activities.
- Insufficient medicine.
- Shortage of logistics.
- Some of the UHC like Ruma has no staff quarter.

In response to the query whether they have requested for any item/budget for previous LLP and how much is allocated to them, none of the Civil Surgeons has acknowledged the receipt of that budget. The Civil Surgeon of Satkhira further added that as he did not receive any budget for LLP, he could not arrange the meetings as scheduled.

With regard to the steps required to improve the LLP, most of the Civil Surgeons have opined that it should be planned as per opinion/need of the local people and due authority is to be delegated to local body for its implementation. Moreover, in addition to technical support from central level, required budget, logistic, and manpower should be assigned with it.

5.2.6 Community Clinics

The Community Clinic is a facility located at the root-bottom of the community to provide primary health care services mostly. These are manned by health-FP staff and run under supervision of Management Committees. The number of CCs planned and constructed so far in 5 districts will speak about the present status of service delivery at grass root level, which as it appear is not yet up to the mark. Making the constructed CCs functional and constructing the number of CCs planned should be given more priority.

Table 5.7: Distribution of CCs by planned and actual number, problems regarding non-functioning of some CCs, and number of CCs has management committee at present

Districts	Number of (CC)			Reasons behind those CC, which are not functioning at present	Has management committee
	Planned	Constructed	Functioning		
Bandarban	55	55	29	• No electricity and water supply • No night guard/fixed staff	26
Barguna	119	105	94	• No electricity and water supply • Shortage of manpower • No suitable infrastructure • Inadequate medicine & furniture	105
Jessore	277	241	223	• Infrastructure and furniture not suitable	225
Kurigram	211	211	163	• HA and FWV not trained and they are overloaded with assigned works	138
Satkhira	213	213	175	• Shortage of skilled manpower • Inadequate supply of medicine	171

Source: Civil Surgeon's & DDFP office

Supervision of Community Clinics

In Jessore and Kurigram, community clinics are supervised by the Civil Surgeon while they visit upazilla for different purpose every month. On the other hand, in the rest of the surveyed districts, in addition to Civil Surgeon, community clinics are also supervised by UH&FPO, UFPO, HI, AHI, FPI at least one in a month.

Suggestion regarding improvement of performance and utilization of CCs

- Infrastructural renovation should be done in most of the CCs.
- CCs to be equipped with electricity and water supply.
- Should be kept open every day.
- Supply of medicine should be adequate.
- Recruitment of local people.
- There should a trained and fixed staff in each CC.
- Preparation of LLP with involvement of local community support group.
- All CCs should be linked with respective UHCs.
- Arrangement for EPI service specially advised by the CS of Jessore.
- Arrange of delivery services suggested by CS of Satkhira.

5.2.7 Referral System

Current referral system of the surveyed districts is public to public. According to the Civil Surgeons, existence of referral from public hospital/centre to private hospital/centre is almost nil.

In most of the districts, a referral slip describing a short history of patient's illness and treatment is used to refer the patient. However, in Bandarban and Kurigram, discharge certificate is used as a referral slip. Here they have meant that, patients has been admitted before being referred

All Civil Surgeon have reported that they receive the information on number and nature of referral uses between the health facilities. In most of the cases they receive such information through their routine monthly reports and in some cases in the monthly report of EmOC.

5.2.8 Private /NGO Hospitals/Clinics

The response of Civil Surgeons on private and NGO clinics have been sequenced. It has been observed that Satkhira and Jessore are having the highest number of private and NGO clinics providing MNH services and CEmOC services. Number of private including NGO hospitals and clinics are providing MNH services are shown in Table 5.8.

Table 5.8: Distribution of private/NGO hospital/clinic providing MNH and C-EmOC services

Districts	Providing MNH services		Providing C-EmOC service	
	Private Hospital/Clinic	NGO Hospital/Clinic	Private Hospital/Clinic	NGO Hospital/Clinic
Bandarban	1	4	NA	NA
Borguna	3	2	3	NA
Jessore	49	7	49	3
Kurigram	8	8	8	NA
Satkhira	66	2	66	1

NA= Data not available

According to the Civil Surgeons, all private including NGO hospital and clinics submit monthly report to Civil Surgeon Office regarding MNH services. Except, Bandarban, Civil

Surgeons largely monitor the standard of MNH services offered by the private/NGO hospital/clinic through intermittent visits. In Jessore, 'District Technical Team' monitors the standard of private/NGO hospitals providing MNH services. However, in Bandarban such practice of monitoring the standard of MNH services is absent.

Activity of Development Partners and NGOs

Regarding presence of any Development Partner and/or NGO working on MNH in their District all of them reported in positive. Borguna reported that Marie Stopes and Family Health Clinic are working and they provide ANC, PNC and FP. Bandarban reported GRAUS, NZ Ekota, Mohila Sommittee and BRAC are working and they provide ANC, PNC and BCC. In Jessore Ad-din, Marie Stopes, FPAB, PKS, BAVS and Rotary Health Centre are working and they provide ANC, PNC, FP, ECP, EPI and BCC. Only Ad-din, PKS, and Rotary Health Centre are providing Comprehensive EmOC among them. In Satkhira Smiling Sun is working and they are providing Comprehensive EmOC. Kurigram reported that Marie Stopes, Smiling Sun, RDRS, Kanchan Somittee are working who provide ANC, PNC and FP.
All of them reported that there is coordination/cooperation/collaboration with their programme, and all of the NGOs seeked support of Civil Surgeon's office in their MNH programme except for one NGO in Bandarban.

5.2.9 Quality Management System

DGHS's Quality Assurance System

There is a system of quality assurance in DGHS under a QA cell. They have QA manual and checklist for quality assurance. They train officials from Civil Surgeon and UHFPO on how to maintain and report on QA through use of that manual and checklist. They also visit field on requirement.

Analysis of Data

Analysis of data shows that in Bandarban, Satkhira and Kurigram districts, government health facilities do not follow any quality assurance (QA) checklist for their visit. In Borguna and Jessore districts, quality assurance (QA) checklist is practiced for government facilities. The Civil Surgeon of Jessore further stated that, daily monitoring of the centre is usually done by the respective in-charge of the centre. However, monthly monitoring of women friendly hospital is done by the person working there using a different tool. In Borguna the QA monitoring is not done regularly.

Persons Conduct Monitoring Visit to UHCs and CCs

In Borguna, UHCs are visited by Civil Surgeon and Medical Officer, whereas CCs are visited by Civil Surgeon, Upazila Health & Family Planning Officer, Upazila Family Planning Officer, Family Planning Officer, Health Inspector, Medical Officer, and Assistant Health Inspector. UHCs are visited intermittently (not regularly) and CCs are visited almost weekly.
In Jessore, UHCs are visited by Civil Surgeon, Deputy Civil Surgeon, and Public Health Nurse. On the other hand, CCs are visited by Health Superintendent, District Sanitary Inspector, EPI Supervisor, and Cold Chain Technician. In general such monitoring visits are carried out not less than once in a month and not regularly.

In Satkhira, UHCs are visited by Civil Surgeon, and Resident medical officer. On the other hand, CCs are visited by Health Inspector, and Assistant Health Inspector. According to Civil Surgeon, there is no specific time of such monitoring visits (not regular) to UHCs and CCs.

In Kurigram, available data shows that UHCs and CCs are visited by Civil Surgeon, Deputy Civil Surgeon, and Medical officer. Disaggregated data for monitoring of UHCs and CCs are not available in the field data sheet. Some one or two UHCs are visited every month (regularly).

In Bandarban, information regarding monitoring visit to UHCs and CCs was not available.

Concerning budget about the monitoring visits, almost all Civil Surgeons stated that there is no fixed budget for these monitoring visits, however they receive TA/DA for these visits as per existing rule of the country. Here TA means traveling allowance and DA means daily allowance. DA is applicable for night-staying during traveling.

External Monitoring Visits from Central Level

Except Satkhira, all Civil Surgeons acknowledge the external visits of their health facilities from central level. Analysis of data reveals that such visits are not originated from any particular section of the health department. All these reported visits were made by different persons from different sections of health department. Moreover, collected information is hazy as regard to the designation and working station of the external monitors. For instance, Project Manager, Director, Deputy Project Manager have visited Borguna health facilities during last year. Such types of external visits from central level are found to make once or twice in a year. In Bandarban, one person from Dhaka has visited the Sadar hospital in connection with EmOC services. During last National Immunization Day (NID), Director of ESD has visited the Lama UHC. Besides, UNICEF representative visits the UHCs intermittently. According to Civil Surgeon of Jessore, teams of different institutes from Bangabandhu Sheikh Mujib Medical University and Dhaka Medical College have visited health facilities at different times and assessed the quality of services in his areas. While in Kurigram, such type visits were done from central and divisional offices most administrative in nature. Analysis of data further discloses that these visits from central or regional offices are made without any specific format or checklist and not done at regular interval.

Status of EmOC team in Comprehensive/basic EmOC facilities

Every hospital or clinic providing EmOC service must have an EmOC team consisting of head of the hospital/clinic and the persons concerned with provision of EmOC services (doctors, nurses, operation theatre technicians, and ayas) who will meet on regular basis to discuss problems and its solve. As per statement of the Civil Surgeons of Bandarban and Borguna, regardless of basic or comprehensive, EmOC teams have not yet been formed at the EmOC run facilities in their districts. On the other hand, Civil Surgeon of Kurigram and Satkhira could not say whether EmOC teams have been formed in the EmOC run facilities or not. More so, the Civil Surgeon of Kurigram stated that if it is formed, right now he has no information about how many team has been formed. In Jessore, EmOC teams have already been formed in the facilities providing comprehensive and basic EmOC services. According to the Civil Surgeon, EmOC team meets regularly (without mentioning number of meetings held per month). In addition to regular meetings, respective team also involves in resolving problem, if any as well as reviews the records of death cases whether there was any breach of quality of care.

Status of Hospital Management Committee at District Hospital and UHCs

In Bandaban, Hospital Management Committees are yet to be formed. As regard to the other districts, all Civil Surgeons claimed that except one or two upazila in Kurigram, Hospital Management Committees have been formed in their respective District Hospital and UHCs.

Analysis of information in relation to the meeting of hospital management team pointed out that, other than Borguna, Civil Surgeons are not completely aware on that issue. In Borguna, a total of 9 meetings took place in last year up to November, 2009. Of them, 3 meetings took place at district hospital, 2 in Patharghata UHC, 3 in Betagi UHC and 1 in Bamna UHC.

5.2.10 Procurement, Maintenance System, Budget, MIS

Supply system: Civil Surgeons quite senior and are head of health services at district level. They are well aware of the difference between supply systems, like demand based and push-supply based. Civil Surgeons of 5 districts were asked about the supply system, whether it is demand based or push-supply based for medical equipment, drugs and consumables from the central level. In Borguna, Bandarban and Kurigram they were of opinion that it is both demand based and push supply based. MSRs are generally push supply based from CMSD. In Jessore and Satkhira they reported that it demand-supply based.

Regarding **local procurement of drugs or equipment** all of them except Satkhira reported that they can procure medicine, logistics and stationeries locally. Satkhira reported that they can't procure medicine locally. While asked about the **ceiling of local procurement budget**, only Borguna reported it as Tk.200,000. Others didn't report the limit quantitatively.

Arrangement/Mechanism for Renovation, Maintenance of Facilities and Equipment

The Civil Surgeons while asked about the arrangement/mechanism for renovation, maintenance of facilities and equipment informed that, at first they inform CMMU, in case of their failure they repair it locally. Civil Surgeon, Jessore informed that, they repair it locally for minor renovation.

While asked whether they have budget to procure maintenance and repair services locally all of them except Bandarban and Satkhira reported in positive.

Regarding whether they use NEMEW/DEMEW for repair of equipment all of them except Satkhira reported in positive. Satkhira reported NEMEW only.

As regards renovation and/or repair of buildings, all of them reported use of CMMU.

5.2.11 MIS Issues

The Civil Surgeons while asked what do you do with the health-related information received from the lower levels, like data entry and analysis on computer on monthly basis, etc. most of them reported receipt as hard copy. In Bandarban some of their upazillas don't have network, and in Kurigram they are suffering from shortage of skilled manpower.

Regarding how they send the information to divisional and central levels, they reported of sending both paper and email or web-based reporting. For how often do they report, they reported both monthly, weekly and daily. They didn't mention what they report.

For kind of problems they face in making timely reports, like internet connection, lack of data entry/compilation personnel, receiving timely information from upazilas or DHs, etc. Except Civil surgeon office Kurigram all of them mentioned of suffering from internet problem and lack of skilled operator.

Most of them share the information with their staff in monthly coordination meeting. They also consult during verbal discussion with upazila and union levels.

The Civil surgeon office utilized the data at the district level in various ways. Those mentioned were use for planning, use in display board, compare among upazillas, find out the problems, performance analysis and take measure accordingly.

5.2.12 Activity of Development Partners and NGOs

Regarding presence of any Development Partner and/or NGO working on MNH in their District all of them reported in positive. Borguna reported that Marie Stopes and Family Health Clinic are working and they provide ANC, PNC and FP. Bandarban reported GRAUS, NZ Ekota, Mohila Sommittee and BRAC are working and they provide ANC, PNC and BCC. In Jessore Ad-din, Marie Stopes, FPAB, PKS, BAVS and Rotary Health Centre are working and they provide ANC, PNC, FP, ECP, EPI and BCC. Only Ad-din, PKS, and Rotary Health Centre are providing Comprehensive EmOC among them. In Satkhira Smiling Sun is working and they are providing Comprehensive EmOC. Kurigram reported that Marie Stopes, Smiling Sun, RDRS, Kanchan Somittee are working who provide ANC, PNC and FP.

All of them reported that there is coordination/cooperation/collaboration with their programme, and all of the NGOs seek support of the government in their MNH programme except for one NGO in Bandarban.

5.2.13 Coordination

Coordination with Family Planning Department

All the Civil surgeons reported that they communicate and coordinate with DDFP and FP staffs through meeting and field visits. They also communicate verbally and through letters.

Regarding regular meeting with DDFP all of them reported in positive, except CS Jessore and Satkhira. These districts feel a need to establish a link with DDFP's office.

For bottleneck(s) in establishing stronger coordination with DDFP's the Civil Surgeons reported that they have some coordination at district level. But at Upazilla level coordination with UHFPO and UFPO is weaker. For stronger coordination they feel that health and family planning need to be integrated for accountability of the MNH activities, and for establishing validity of data.

Coordination with NGOs

While asked about the way Civil surgeons communicate and coordinate with NGOs, all of them except Satkhira reported that they have good communication with NGOs and they also attend regular monthly meetings. Civil surgeon of Satkhira reported that they can't arrange meetings and coordinate with NGOs due time constraint.

5.2.14 Good Practices (only in Jessore district)

Regarding good practices they reported as follows-

- Ensured some community support
- Innovative ideas
- Quality services
- Local initiative for garbage management
- DSF
- Women and Youth Friendly Hospital
- Good team work
- Donation by medical doctors
- Full time service
- Neat and clean
- Breast feeding corner
- Data analysis and use of it

5.2.15 Future Plan for MNCH Service

Reported future plans of the Civil Surgeons for improvement of MNH services are as follows:

- Take required steps for employment against the vacant posts.
- Raise the number of skilled personnel (through asking DGHS to send trained doctor and training of other category internally) and effective use of existing ones.
- Necessary measures (such as full time service, quality assurance, good team work, breast feeding corner, etc.) will be taken so that all EmOC service centers can provide their service effectively.
- Arrange trainings for the service providers.
- Raise the awareness of the community people regarding the benefits of MNH services.
- Community clinic committees would be made more proactive as regard to their effective/fruitful contribution to the society.
- Necessary measures will be taken to upgrade the community clinics.
- Try to bring all upazilla under C-EmOC coverage.

5.2.16 Suggestions for Improvement

Regarding suggestions for improving MNH and EmOC services to the rural poor people they mentioned the followings-

- Start providing Comprehensive EmOC services at all the UHCs.
- Ensure posting of pairs of doctors trained on Obs/Gynae and Anaesthesia at UHCs and MCWCs.
- Increase skilled manpower (doctors and nurses).
- Ensure supply of medicine and logistics.
- Ensure electricity for 24 hour at the Comprehensive EmOC centres.
- Introduce incentive or benefit for 24 hour service.
- Provide modern diagnostic facility according to felt need.
- Change mentality of service providers.

- Increase awareness on maternal and child health.
- Involve local govt.
- Boat ambulance to be arranged for rainy season for Bandarban.
- Provide resource for successful LLP.

5.3 Responses of Upazilla Health and Family Planning Officers

UH&FPOs are the supreme management persons for Upazilla Health Complexes (UHCs). In each of the 5 districts 2 UH&FPOs were interviewed (in total 10 UH&FPOs) to find out the situation of MNH services. They were asked questions on 13 issues.

5.3.1 MNH Activities

The UHFPOs were asked **whether their health complex provide some listed MNH services**, like ANC, PNC, FP-temporary methods, FP-permanent methods, Emergency contraception, MR, Normal Delivery, Assisted vaginal delivery, C-section and Neonatal care. It has been reported that 5 of the UHCs are providing Comprehensive EmOCs (Jhikargacha, Chougacha, Kalaroa, Debhata) and rest 5 Basic EmOCs. Their responses have been shown in Table 5.9.

Table 5.9: Whether these health complexes provide listed MNH services

MNH services (Y/N)	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
ANC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PNC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FP-temporary methods	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FP-permanent methods	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency contraception	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Delivery Normal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Assisted vaginal delivery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
C-section	No	No	No	No	Yes	Yes	Yes	Yes	No	Yes
Neonatal care	No	No	No	No	Yes	Yes	Yes	Yes	No	Yes
Others (Specify)										
NNP	No	No	No	No	No	Yes	No	No	No	No
IMCI	No	No	Yes	Yes	No	Yes	No	No	No	Yes

Source: Civil Surgeon's office & UHFPOs

Profile of UHCs has been collected through Secondary Data Collection Sheet of the districts. Among the 10 UHCs, only Betagi and Chougacha are having 50 beds. CEmOC is provided in Chougacha, Jhikargacha, Kalaroa, Debhata, and Nageshwari UHCs, and rest of the UHCs are designated to provide BEmOC services (see Annex Tables 1 to 3).

In reply to the specific reason of not providing CEmOC they mentioned of shortage of medical officer trained in gyane & anesthasia, shortage of skilled manpower, and their UHC is not CEmOC one. The details are shown in Table 5.10.

Table 5.10: Reasons of not providing specific services

Reasons	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
For not providing CEmOC										
Shortage MO in obs/ gyane & anesthasia	Yes	Yes	Yes	NR	NA	NA	NA	NA	NR	NA
Shortage of skilled manpower	Yes	Yes	Yes	NR	NA	NA	Yes	Yes	NR	NA
This is not a CEmOC centre	NA	NA	NA	NA	NA	NA	NA	NA	Yes	NA
For not providing clinical FP services										
Doctors and nurses not trained	NA	NA	NA	NA	NA	NA	Yes	Yes	NA	NA
This centre is not affiliated for clinical FP	NA	NA	NA	NA	NA	NA	Yes	Yes	NA	NA

Note: NR= Not responded; NA= Not applicable
Source: UHFPOs

Those reported in negative were asked regarding the **ways they plan to resolve the situation**. Regarding how do they plan to resolve the situation they mentioned- Prepare trained manpower, Will apply for more bed, Will discuss this problem in the divisional EmOC meeting, Take order from CS office, and some accountability will be established. Only Rajarhat reported that it is totally a Govt. policy level issue. See Table 5.11 for details.

Table 5.11: UHFPOs proposed plan to resolve the situation

How do you plan	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar-ghata	Lama	Ruma	Jhikar-gacha	Chou-gacha	Kalaroa	Debhata	Rajar-hat	Nege-swari
Prepare trained manpower	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
Will apply for more bed	No	Yes	No	No	No	No	No	No	No	No
Will discuss this problem in the divisional EmOC meeting	No	No	Yes	Yes	No	No	No	No	No	No
Order from CS office	No	No	No	No	No	No	Yes	Yes	No	No
Some accountability will be established	No	No	No	No	No	No	Yes	Yes	No	No
It is totally a Govt. policy level issue	No	No	No	No	No	No	No	No	Yes	No

Source: UHFPOs

5.3.2 Emergency Obstetric Care (EmOC) Services

Regarding whether the ***EmOC services*** (basic/comprehensive EmOC) reach the poor people in the community, all of the UH& FPOs reported in negative. Those reported in negative reported the following bottlenecks- MO-EmOC in pair (Obs/Gynae and Anesthesia) is not there, no trained manpower, no funding for EmOC service, shortage of trained staff, shortage of EmOC trained SSN, and shortage of equipment and medicine. Both 2 UHFPOs of Kurigram interviewed didn't mention any bottleneck. See Table 5.12 for details.

Table 5.12: Bottlenecks for reaching *EmOC services* (basic/comprehensive EmOC) to the poor people in the community

Bottlenecks	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
No trained manpower	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
No funding for EmOC Service	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
Shortage of trained staff	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
MO-EmOC in pair (Obs/ Gynae and Anesthesia) in not there	No	No	Yes	Yes	No	No	Yes	Yes	No	No
Shortage of EmOC trained SSN	No	No	Yes	Yes	No	No	Yes	Yes	No	No
Shortage of equipments and medicine	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No

Source: UHFPOs

While asked about **future plan for improvement of these EmOC services** for reaching the poor people they reported - solve shortage of trained manpower; train existing manpower; implement DSF program; increase awareness of people; increase public participation; sufficient medicine will be supplied; facility for pathological exam will be started; facility for blood transfusion will be started; and CC will be made functional. See Table 5.13 for details.

Table 5.13: Future plan for reaching the EmOC services to the poor poeple

Future plan for improvement	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Betagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Solve shortage of trained manpower	Yes	Yes	Yes	No	No	No	No	No	Yes	No
Train existing manpower	No	Yes	No	No	No	No	No	No	No	No
Implement DSF program	No	No	Yes	No	Yes	No	No	Yes	No	No
Increase awareness among people	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No
Increase public participation	No	No	No	No	No	No	Yes	Yes	No	No
Sufficient medicine would be supplied	No	No	No	No	No	No	Yes	No	No	No
Facility for pathological exam	No	No	No	No	No	No	Yes	No	No	No
Facility for blood transfusion	No	No	No	No	No	No	Yes	No	No	No
CC will be made functional	No	No	No	No	No	No	Yes	No	No	No

Most of the UHFPOs have no such future plan that can make the UHC functional to provide EmOC. This should be generated among them. Otherwise no support will be useful nor work efficiently.

5.3.3 Source of Income of Health Facilities

Primarily UH&FPOs were asked about the **sources of income of their UHC**. Most of them reported govt. allocated user fees only. However, Lama & Ruma of Bandarban district and Rajarhat of Kurigram district reported that they didn't mention such source of income. The UH&FPOs didn't mention of retaining any percentage of that user fee. See Table 5.14 for details.

Table 5.14: Sources of income of UHCs

Sources of income of UHC	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Betagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Govt. allocated user fees	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes

Most of them reported in negative when they were asked of any **source of income other than 'user fees'**. However, in Chougacha they mentioned of providing some Aya, Peon, and Guard to work as volunteer. They also provided Tk. 30,000 for Nurse, Receptionist and

Sweeper. The doctors helped them through contributing the fee they had earned from DSF program. Upazilla Chairman and UNO have direct contribution among the Community leaders. In Betagi, the UH&FPOs mentioned of leasing out the pond for fisheries and land for coconut trees. In Lama they mentioned of leasing out of land and selling fruits of trees within the UHC compound. In Jhikargacha, Union Parishard and Upazilla Chairman have provided volunteer to work as cleaner and to work as guard.

They were also enquired about how **new sources those can be explored or mobilized**. Although 4 of them reported in negative, in Lama they mentioned of leasing out the pond for fisheries, and in Jhikargacha they mentioned of community leaders, DSF fund, local govt., Rotary club, NGOs, bank and media (television) In Chougacha they mentioned of doctors community, those living outside country, industrialist, businessman, other departments of govt., and rich people. In Kalaroa and Debhata they mentioned of DSF fund and local govt. In Nageshwari, they reported of collecting fund from local rich people.

5.3.4 Local Level Planning (LLP)

The UH&FPOs were asked **whether they are implementing 'Local level planning'**. Only Lama, reported in positive on this. Lama has done it by making medicine supply regular and giving new ambulance. However, they didn't make any detailed report on it.

Regarding whether they are facing any **bottleneck during implementation of 'Local level planning'** Kalaroa and Debhata upazillas reported that they prepare but not get any response follow centre. In Lama they also reported almost the same except supply of medicine through it.

They were also interviewed in the previous LLP, what item/budget requested and what item/budget allocated, and what can be done to make it functioning efficiently. Both the 3 upazillas reported that they requested for fund, but didn't get it properly. Among them only Lama reported that fund had been allocated for medicine without carrying cost. Regarding what can be done to make it functioning efficiently, Kalaroa and Debhata reported of - lack of power of implementation, preparation of new project and getting fund, and lack of proper monitoring. Lama reported of taking steps from district level.

5.3.5 Community Clinics

While asked about the **number of Community Clinics those are functioning** in respective Upazila they reported of 9 clinics in Batagi, 19 clinics in Patharghata, 10 clinics in Lama, 4 clinics in Ruma, 24 clinics in Jhikargacha, 23 clinics in Chougacha, 13 clinics in Kalaroa, 13 clinics in Debhata, 13 clinics in Rajarhat, and 13 clinics in Negeshwari. See Table 5.15 below.

Table 5.15: Number of functioning Community Clinics

Number of Community Clinics functioning	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Betagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Numbers functiong	9	19	10	4	24	23	13	13	13	13

Then they were asked **whether poor people have access to community clinics for service**. Except, Batagi, Patharghata, Ruma and Jhikargacha all of them reported in positive. Regarding their plan for better utilization of Community Clinics all the 10 UH&FPOs reported 24 hour service, adequate number of trained manpower, repairing instruments, proper water and electrically supply, proper supply of medicine and Full time doctor.

5.3.6 Referral System

Regarding the **mechanism of referral system** for maternal and neonatal cases, the UH&FPOs mentioned - use of referral slip, discharge paper, use emergency slip, and writing in paper. Details of their responses on this has been shown in Table 5.16.

Table 5.16: Mechanism of referral for maternal and neonatal cases

Mechanism of referral	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Use referral slip	Yes	Yes	No	No	No	Yes	No	No	No	No
Discharge paper	No	No	Yes	No	No	No	No	No	Yes	Yes
Use emergency slip	No	No	No	No	Yes	No	No	No	No	No
Writing in paper	No	No	No	No	No	No	Yes	Yes	No	No

Source: UHFPOs

As to the **number of Maternal and Neonatal emergency cases referred out monthly** from their Upazilas to higher level hospitals, the UH&FPOs mentioned different numbers from 0 to 15. The details of their response have been presented in Table 5.17.

Table 5.17: Number of Maternal and Neonatal emergency cases referred out monthly average from Upazila to higher level hospitals

Number of referral	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Numbers of Maternal and Neonatal emergency cases referred monthly	7-10	5-7	10-15	No cases	1-9	9	2-7	2-3	5-10	8-10

5.3.7 Private Hospitals

The **number of private hospitals** providing MNCH services in their Upazillas the UH&FPOs reported different numbers varying from 0 to 16. Betagi, Lama, Ruma and Rajarhat don't have any private hospital. The numbers have been presented below in Table 5.18.

Table 5.18: Number of private hospitals providing MNCH services in Upazilla

Indicator	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Number of private hospitals providing MNCH services in Upazilla	0	1	0	0	3	3	16	4	0	1

Those reported of having private hospitals were asked regarding the **role they play in MNCH service provision**. They reported of different MNCH services that includes - ANC, PNC, MR, Normal delivery, and C-section. Their distribution by UH&FPOs is presented in Table 5.19.

Table 5.19: Role the private hospitals play in MNCH service provision

Indicator	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Role played by private pospitals	NA	ANC, PNC, C-section	NA	NA	ANC, PNC, MR, Normal delivery, C-section	ANC, PNC, MR	ANC, PNC, Normal delivery, C-section	ANC, PNC, Normal delivery, C-section	NA	ANC, PNC, Normal delivery, C-section

NA= Data not available

Regarding **how do they assess their service standard** if they have knowledge about it, almost all of the UH&FPOs didn't respond to it. They mentioned, good quality for care, all quality is good, medicine and service quality of care is low, and have no knowledge of it as the indicators. The full picture is presented in Table 5.20.

Table 5.20: How do they assess their service standard

Indicators	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Good quality for care	NA	Yes	NA	NA	NA	NA	NA	NA	NA	NA
All quality is good	NA	NA	NA	NA	NA	NA	NA	Yes	NA	NA
Medicine, and Service quality of care is low	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes
Have no knowledge of it	NA	NA	NA	NA	Yes	Yes	NA	NA	NA	NA

NA= Data not available

5.3.8 Quality Management System

Regarding Quality Management System the UH&FPOs were asked **whether there is any system of quality assurance** (QA) of services in their UHCs. Except in Lama and Ruma of Bandarban district all of the 8 UH&FPOs reported in positive on this question. Those reported in positive were asked regarding the system. They reported various system like- verbal order, though checklist, ensured by the doctors, ensured by UH& FPO himself, and women friendly hospital program. See Table 5.21 for details.

Table 5.21: What is the quality management system

Quality management systems	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Verbal order by supervising person	Yes	No	NA	NA	No	No	Yes	Yes	No	No
Though checklist	No	Yes	NA	NA	No	No	No	No	No	No
Ensure by the doctors	No	No	NA	NA	Yes	No	No	No	No	No
Ensured by UH&FPO himself	No	No	NA	NA		No	No	No	Yes	Yes
Women friendly hospital program	No	No	NA	NA	Yes	Yes	No	No	No	No

NA= Data not available

Those reported in positive were asked **how often are monitoring visits made** to UHC and CCs and how much is their budget for monitoring/supervision for this fiscal year. Regarding how often they had a number of responses. Regarding budget, all of them reported that there is no budget for this purpose. See Table 5.22 for details on how often.

Table 5.22: How often are monitoring visits made to UHCs and CCs

Quality management systems	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
How often monitoring visits are made	Monthly	Monthly	NA	NA	Daily/ Monthly	Daily/ Monthly	Some times	Some times	Not specific	Not specific

NA= Data not available

The UHFPOs were asked whether their health facilities receive **regular monitoring visits**. All of them except Kalaroa and Debhata others reported in positive on this issue. Those reported in positive were asked who comes for supervision, and whether they use specific format/checklist. See Table 5.23 for details.

Table 5.23: Regular monitoring visits for quality assurance

Whether health facilities receive regular monitoring visits for quality assurance	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Y/N	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes
Who comes for supervision	CS, DDFP	CS	-	-	CS, DCS, DGHS	CS, DCS, DGHS	-	-	CS, DCS, MOCS	CS, DCS, DD
Whether they use specific Format/checklist	No	No	-	-	No	No	-	-	No	No
How frequently are such monitoring visits made	Some-times	Some-times	-	-	Monthly	Monthly	-	-	Monthly	Monthly

5.3.9 EmOC team in UHCs

The UH&FPOs were asked whether there is an **EmOC team at their UHCs**. Only Batagi, Lama, Chougacha and Kalaroa reported in positive on this. Those reported in positive were asked how often do they meet and what do they do (besides meeting). See Table 5.24 for details of response.

Table 5.24: EmOC team at their UHC and their activities

EmOC team at their UHC	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Y/N	Yes	No	Yes	No	No	Yes	Yes	No	No	No
If yes, how often do they meet										
Regularly or ad-hoc base	Ad-hoc	NA	Ad-hoc	NA	NA	Ad-hoc	Ad-hoc	NA	NA	NA
What do they do (besides meeting)										
Try to provide EmOC	Yes	NA	NA	NA	NA	No	No	NA	NA	NA
Responding of their work	Yes	NA	NA	NA	NA	No	No	NA	NA	NA
Work according to decision	No	NA	NA	NA	NA	No	Yes	NA	NA	NA
Preparatory work	No	No	NA	NA	NA	Yes	No	NA	NA	NA

Note: EOC team meant a Committee/Team comprising of UH&FPO, MO-trained in EOC-obs/gynae, MO-trained in EOC-anesthesia, SSN trained in EOC, and OT technician. NA= Data not available

Recently, government has issued a circular to establish **Hospital Management Committees** for District Hospitals and UHCs. The UH&FPOs were asked whether such Committees have been established. All of them except Ruma and Rajarhat reported in positive on this. Those reported in positive were asked how many meetings of these committees took place this year (May-November' 09) in their district. No. of meetings varied from 0 to 4. See Table 5.25 for details of response.

Table 5.25: Hospital Management Committees for UHCs

Committees been established	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Y/N	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
How many meetings of these committees took place this year	3	2	0	NA	1	0	1	4	NA	1

5.3.10 Number of Health Workforce

The UH&FPOs were asked regarding the present number of maternal health and child health workforce by categories in their UHCs.

Table 5.26: Present number of MCH workforce by categories in UHCs

Categories of MCH workforce	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
# of MO present (no. posts)	0 (14)	2 (15)	1 (5)	1 (7)	9 (13)	9 (19)	17 (32)	10 (14)	4 ()	4 ()
# of Nurses present (# of Post)	9 (15)	6 (15)	6 (7)	4 (7)	10 (11)	16 (17)	10 (15)	10 (10)	4 (-)	4 (-)
# of Nurses trained in EOC/midwifery	0	0	3	1	*	*	3	4	0	0
# of Consultants OG (# of Post)	0 (1)	0 (1)	0 (1)	0 (1)	1 (1)	1 (1)	1 (1)	1 (1)	1	*
# of Consultants AN(#of Posts)	1 (1)	1 (1)	0 (1)	0 (1)	1 (1)	1 (1)	1 (1)	1 (1)	*	*
# of MO trained in OG (# of posts)	0 (1)	0 (1)	*	*	*	*	2 (2)	1 (1)	*	*
# of MO trained in AN (# of posts)	*	*	*	*	1 (1)	0 (1)	1 (1)	1 (1)	*	*

** Information not available*

5.3.11 Procurement, Maintenance System

For **Supply system** of medical equipment, drugs, medicine and consumables at the UHCs the UH&FPOs reported that this is demand based and supplied from district or central level. See Table 5.27 for details of response.

Table 5.27: Supply system of medical equipment, drugs, medicine and consumables at the UHC

Indicator	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Demand based and Supplied from District or Central level	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Regarding **arrangement of renovation and maintenance** of equipment and facilities the UH&FPOs reported - CMMU, MMED, CMSD, NEMEW, and locally. CMMU has reported as the authority by all of them, and in addition they reported others. Jhirkargacha, Chougacha and Nageshwari reported of performing it locally for small items. See Table 5.28 for details of response.

Table 5.28: Arrangement of renovation and maintenance equipment and facilities

Arrangements	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
With CMMU	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
With MMED, CMSD, NEMEW	No	No	Yes	Yes	Yes	No	No	No	No	No
Sometimes locally	No	No	No	No	Yes	Yes	No	No	No	Yes

5.3.12 Activity of Development Partners and NGOs

The UH&FPOs were asked whether there is any Development Partners and NGOs working on MNCH in their Upazila. Five of the UH&FPOs reported in positive on this. Those reported in positive were asked who are working in which place and in which field and is there any formal/informal working relationship with them for service delivery purpose. They reported of working the NGOs- Smiling Sun and Marie Stopes in Patharghata who report to them monthly and meet with them frequently to inform about their activities. GRAUS and NZ Ekota Mohila Somittee are working in Lama on MNH on awareness building among peoples. NZ Ekota Mohila Somittee have clinic there for providing health service from where they provide ANC, PNC, Normal delivery at home, and other primary health care services. FPAB and Ad-din are working in Jhikargacha and both of them provide ANC, PNC and FP temporary methods. Smiling sun and RDRS work in Rajarhat and provide ANC, PNC and FP temporary methods. Marie stopes, Smiling sun and RDRS work in Negeshwari, and GRAWS and provide ANC, PNC and FP temporary methods.

5.3.13 Good Practices (only for Jessore district)

Chowgacha UHC of Jessore has established them as the best UHC in Bangladesh who received this award 5 times. It is providing 24 hour CEmOC service with good quality and also a Women Friendly Hospital through some special activities with active participation of the service providers and community leaders. They have 3 pairs of service providers for 24 hour service, monthly monitoring on Women Friendly Hospital program is done and gaps identified. For quality assurance one person every day, ensure time bound visit of doctor, have garbage and waste management system, maintain good relation with local people's representative and local administration, arrange regular meeting with them, provide voucher for their contribution, doctors themselves also contribute regularly. Govt. has appreciated them several times and is now going to replicate this model in other areas of Bnagladesh.

The UHFPO, Jhikargacha of Jessore district was asked to mention the **similarities and dissimilarities** of this facility with those of Chowgacha. He reported that all services are similar. Regarding dissimilarities he mentioned the followings-Community involvement (not like Chowgacha), Familiar as a good delivery hospital (patients comes from other upazila not like Chowgacha), Local initiative - like Daily health education, Garbage management, Utilization of placenta (used as food of fish), Ownership of people's representative, DSF and Women friendly hospital, Good team work (staffs are more sincere and honest), Donation by the medical doctors, Staffs stay at service centre full time, Friendly environment, Neat and clean, Breast feeding corner, Data analysis and use of data, and Blood transfusion services.

He was asked how his UHC **manages to maintain equipment, ambulance and logistics** etc. In reply he reported that- it is small maintenance by them, if it is out of their ability, they seek assistance from DGHS.

While asked how he manages to provide **24-hour care**, he reported that now they have 2 pairs of service providers.

Regarding the **quality assurance system** followed in his facility he reported that each and every person is responsible for QA daily, they ensure it by the doctor during the time of round, and they have garbage and clinical waste management system.

In reply to **presence of a stakeholder committee** to support his UHC he reported that, Union Parishad provided manpower for UHC cleaning, Construction the office room and emergency room and some under commitment, and they informed these ase not like Chowgacha, since they didn't get any financial support directly from the stakeholders.

In response to how does he successfully **mobilize the community to support the UHC**, he reported that- Person to person motivation by staff under UH&FPO, Good relation maintained with local administration and also people representative and informing about their quality services are their ways.

Regarding the **keys to success** for providing quality services from their UHC he reported as follows- their performance is increasing day by day, they are a good team and a favorable working environment created, Their honesty, sincerity and responsibility, now his UHC is neat and clean, have skilled man power, ensure involvement of people representative, mind set up, attitude, good behavior, and finally, ensuring 24 hours services.

The researchers are of opinion that, the culture of 'Referral to govt. facilities' is slowing going to be abolished slowly and is being replaced by the private clinics. This should be changed through motivational activities among both service providers and service recipients. Quality of care and 24 hour service in govt. clinics should also be assured following the lessons learnt from Chougacha UHC.

5.3.14 Suggestions for Improvement

Regarding the suggestions of UHFPOs for improving MNCH and EmOC services targeting the rural poor people they reported –

- Deployment of EmOC pair of doctor
- Sufficient manpower
- Skilled manpower
- Training of manpower
- Trained CSBA
- Sufficient logistics
- Adequate medicine supply
- Awareness build up
- CC functioning by trained manpower
- Adequate need based supply
- Presence of functioning ambulance
- Electricity and water
- To include with DSF program

5.4 Responses of Deputy Director Family Planning (DDFP) and Upazila Family Planning Officer (UFPO)

5.4.1 Maternal Neonatal Health Situation

The Deputy Director, Family Planning is in charge of District FP-MCH programme and a key figure in the hierarchy of Health-FP administration. He acts as a coordinator as well as program manager of District FP-MCH program. He is responsible and accountable for proper management and implementation of district-level programme/projects/ interventions/ activities under development and non-development (revenue) budget of the government. He has to coordinate with NGOs and Private entrepreneurs contributing to FP-MCH-Nutrition

areas. As such, it was expected of him to be knowledgeable, cooperative and dynamic. In this background, an interview with him on relevant issues (MNCH-MCH-FP) was deemed necessary, useful and appropriate to have some light for assessing the possibilities of MNCH programme (such as SMPP or similar such interventions covering mothers and neonatals) expansion where it is needed most.

Findings are based on their responses. Also, UFPOs responses on the same issue/ question was reported in the following paragraphs.

On the issue MNCH, DDFPs were asked to assess the situation and describe briefly what they have found. Their assessment was as follows:

- ***DDFP Barguna*** - **reported** that MNCH status is **not quite satisfactory** for lack of trained manpower, vacant position of service providers and insufficient awareness about MNCH care and he said there is ample scope for improvement in MNCH.
- ***Bandarban DDFP*** **– described** the MNCH situation **as simply dismal**. Only the District Hospital provides CEmOC and MCWC providers BEmOC. Facilities of both Government/ non-government organizations are not fully capable of providing EmOC. Reasons as stated were:
  i. service-providers do not stay at the station for lack accommodation;
  ii. ignorance, lack of awareness and socio-cultural barriers stand;
  iii. Acute shortage of trained manpower for long.

- ***Jessore DDFP*** – **stated that** Jessore is **much better than any other districts** in MNCH service. He said Health Department actively cooperates in the delivery of EmOC. Choughacha upazila is a model upazila for MNCH and FP service. He evaluated health-FP staff as quite sincere and active. He reported that there is one 20-bed MCWC and of 83 FWCs, 32 are upgraded, and 7 RDs (union sub-centres) **provide MNCH service**.
- ***Satkhira DDFP's*** **– assessment of MNCH situation was not very positive**. He stated that of the two MCWCs in the district, only one is providing CEmOC. The reason is lack of trained doctor/Medical Officer. In fact there is no doctor posted in the other MCWC in question. He thinks without trained doctors' service, quality MNCH care can hardly be provided in the district.
- ***Kurigram DDFP*** – **reported that the main reason for poor quality as well as** deficient MNCH service is acute shortage of trained manpower, particularly shortage of MO (MCH). He also said that poverty, illiteracy and lack of awareness are factors influencing MNCH service delivery in the district. He rated the **MNCH situation as less than satisfactory**.

  To sum-up, the MNCH situation in four out of five districts is **rated as poor/ unsatisfactory.** In one (Jessore) district it was marked good and satisfactory.

  Two reasons are mainly responsible for not being able to up-grade performance to the satisfactory level:

One:	Lack of awareness of MNCH service delivery system and how to avail of the available services by the vast number of rural poor;
Two:	Lack of manpower particularly trained doctors (MOs/Consultant), Nurse/ FWVs and others related to delivery of MNCH services.

5.4.2 Status of MNCH Activities

Mainly three questions were addressed to assess the status of MNCH activities – how many/which facilities and who are providing MHH services, whether MNCH service is sufficient to reach rural poor people, and what is the future plan to improve MNCH. Table 5.29 presents the status at a glance.

Table 5.29: Facilities providing MNCH, and nos. FWAs, FWVs, CSBA under DGFP

Facilities providing MNCH Nos. of FWAs, FWVs		Five districts				
		Barguna	Bandarban	Jessore	Satkhira	Kurigram
MCWC #		1 (out of 2)	1	1	1	1
FWCs/RD #		22 (out of 2)	22	32 FWCs + 7 RDs	23	NA
Community Clinic #		NA	NA	NA	NA	NA
	Total	23	23	40	24	
FWVs #	Sanctioned	49	43	106	96	89
	Actual	42	106	95	70	59
FWAs #	Sanctioned	214	102	498	393	376
	Actual	202	90	443	360	335
FWAs trained as CSBA #		39	9	113	65	26

Source: DDFP office. NA= Data not available

DDFPs identified MCWCs and Union level FWCs and some RDs providing MNCH care, **whereas, UFPOs reported the community clinic also providing MNCH services.** The fact is that many CCs are not yet fully functional, not well-equipped, lack in manpower deployment (FWV[10]/FWA), but as it appeared from their (UFPOs) responses CCs do have potentials for delivering Basic EmOC partially. Enthusiastic respondents sometimes over-reported facts (actual).

Again, all DDFPs reported that service outlets for MNCH service are not adequate and not fully equipped to provide quality MNCH service, not reachable/accessible without incurring some costs, and majority of rural poor do not have birth emergency preparedness (BEP) and as such reaching the vast rural poor to provide needed service is still a far cry.

> DDFPs strongly recommended for awareness-building, skill-based/professional training, increasing manpower strength, and accountability of the service providers, besides effective strengthening of referral system and better utilization of CSBA. On this issue, UFPOs except Nageswari upazila, added increased supply of medicines as of great necessity; all FWAs be trained as CSBA, and FWAs should be better equipped.

5.4.3 Sources of Income for FP-MCH Facilities and Future for MNCH

There is **scanty information on sources of income** for FP-MCH facilities. Information provided by some DDFPs **could not be verified**. Negative responses (DDFPs) revealed ignorance, indifference and lack of interest about financial matters and on economic aspect of district FP-MCH programme. It may also be possible that they are quite reluctant to divulge

[10] FWV also attend CC on part-time basis (2-3 days a week) as reported by upazila level officials. There is no sanctioned post of a Family Welfare Visitor (FWV) for each CC, as yet.

any financial matters to anyone. Table 5.30 shows negative/dark side of the picture of the issue under consideration.

Table 5.30: Sources of income - FP MCH facilities (in Tk.)

Questions asked to DDFPs	Responses				
	Barguna	Bandarban	Jessore	Satkhira	Kurigram
What is the total budget (Rev + Dev) for the Dist. For Fy: 2009-2010?	Tk 2,910,229	No information	No information	Tk 2,395,710	No information
How much is allocated for MCWCs, FWCs and CCs?	No information	No information	No information	Tk 30,000 to 40,000	No information
What are the items (e.g. drugs, logistics, maintenance of equipments) covered under this budget?	No information	No information	No information	Emergency Medicine	No information
Are there any other sources of income besides "user fees" such as support from local government and personal donation?	No	No	No	No	No, Except sale proceeds
If 'yes' – what are they?	NA	NA	NA	NA	Sale proceeds of Condom
If 'no', what new type of income could possibly be generated/mobilized and how?	No possibility	Not known	Not known	Not known	Not known

FY = Financial year; Rev= Revenue, Dev = Development

On the same issue (sources of income for FP-MCH facilities) all UFPOs replied negatively (said 'no') to all questions asked.

The study team think that –
This state of lack of knowledge and awareness of programme-managers about financial matters is enough to send a shock-wave to higher management, but does it really matter to any one? It is urgently needed to activate thinking process, build-up awareness, enhance knowledge-level and finally infuse commitment to the task assigned, at all levels of the government.

5.4.4 Emergency Obstetric Care Service

It has been reported that under the DDFPs of Jessore, Satkhira, and Kurigram districts, MCWCs provide EmOC and no other service outlet under their administration/management control. The other two district level MCWCs provide BEmOC only[11].

The problems in continuing EmOC services as identified by the District DDFPs are mainly:

- Shortage of trained MO and absence MO (clinic),
- Electricity and water supply is irregular, or not available,
- Shortage of medicine and medical surgical requisites (MSR), and beds,
- Absence/shortage of Anesthetists.

Again, the DDFPs were of the view that MNCH are not adequately reaching rural poor people, who do not or can not avail of the services for many reasons. See Table 5.31 on barriers.

[11] It is to be noted that, Barguna MCWC is not at present in a position to provide any of the EmOC service – as reported MCWC, FWV.

Table 5.31: Barriers for not reaching MNCH in general to the rural poor

Districts	Barriers for not reaching MNCH to the rural poor
Bandarban	• Distance and geographical barrier • Transportation costs not affordable • Lack of awareness about the services
Barguna	• Attitude of the service providers not friendly • Lack of accountability of the field staff
Jessore	• Lack of motivation/awareness of the poor people • Neither staff needed are sufficient, nor many of them stay at the station • Lack of supervision of field staff
Satkhira	• Lack of trained/skilled staff/doctor/ anesthetists • Poverty
Kurigram	• Lack of trained/skilled staff/doctor/anesthetists • Lack of drugs and logistics

In coping with these problems, the District Managers were not adequately prepared nor much confident, and also they had a feeling of helplessness.

Regarding the question what government can or should do to improve EmOC service, the District managers were not very specific, nor explicit. They think government can give more supplies of necessities (MSR, equipment, and manpower) for this purpose.

Regarding the question of what are you doing or planning to do, as head of District, to improve EmOC – the responses by DDFPs are given in Table 5.32.

Table 5.32: Table what are the DDFPs doing/planning to do

Districts (DDFP)	What are you doing or planning to do to improve EmOC service as head of District: RESPONSES BY DDFPs
Barguna	• Field workers have been asked to inform locals about EmOC services and stay at the place of posting station[12]. • FWVs have been instructed to "refer" suitable cases to Hospitals/higher facilities for EmOC service.
Bandarban	• GO-NGO collaboration to be strengthened under the guidance of District Council/Committee. • Local leaders support for EmOC will be sought
Jessore	• We have started innovative initiatives like "cluster-meeting"[13] - DDFP
Satkhira	• In the areas where community clinics are established, manpower with necessary training will be posted, so that service delivery can be effectively ensured. "I will try my best for this/purpose" – DDFP Satkhira.
Kurigram	• "I have no plan so far. It is a national crisis, what can I do as a DDFP? "

5.4.5 Local Level Planning

Four districts except Jessore have affirmed LLP but were not emphatic about implementation. DDFP Jessore reported that, this district is not a pilot area for LLP. Other DDFPs said they receive help in LLP from central authority/DGFP's Planning Cell, Local Level Planning Unit. However, no 'feedback' is received in response to the local plan created. They also said they did not/do not face any problem in implementing LLP. One suggestion was that for

[12] 'Stay at the place of posting' means they should not leave the place of work, neglecting their duties, – and they should work/go around the communities for service delivery staying in and around their designated place of posting.

[13] 'Cluster-meeting' means simply group-meeting of a number of people grouped closely together who interact with each other on issues of common concern in a locality (3-4 unions as cluster).

implementing LLP effectively, DDFP needs manpower/human resource, logistics and some fund. It appeared that local level planning concept is good, but has not been taken seriously. **DDs feel that central level should play active role in strengthening LLP.**

Some UFPOs on the issue of LLP recommended for-

- Budget allocation for LLP in specific areas needed
- Support from Upazila Administration/Upazilla Parishad is a must
- Community participation and NGO support would be highly useful
- Training on LLP urgently needed
- Regular feed-back from central level must be ensured.

They expressed interest in LLP but lack in 'Know-how' of the subject. With support and guidance, DDFPs and UFPOs can do well in LLP. They are asking for resource.

5.4.6 Status of Community Clinics (CC)

Overall, the story of CC is a "tragi-comedy" in terms of operation, management and control. The status of Community Clinics of 5 districts may be gleaned from theTable 5.33.

Table 5.33: Status of community clinics

Districts	How many CC exist	How many fully functional	How many are not in full service	How many are planned to be built (new)
Barguna	105	79	26	14
Bandarban	55	29	26	Do not know
Jessore	297	225	71	Do not know
Sathkhira	213	171	42	Do not know
Kurigram	NA	NA	NA	NA

NA= Data not available

DDFP Kurigram's remark about Community Clinic (CC) is noteworthy. He said that CC is not a subject of DGFP. Evidently, he (DDFP) under administrative control of DGFP declined to take responsibility of CC, even partially. Regarding Community Clinic supervision by DDFP, the responses were as follows (Table 5.34).

Table 5.34: Supervision of Community Clinics by DDFPs

Districts	**How do you supervise CCs**
	Responses of DDFPs
Barguna	Not directly-but UFPO, MO, HFP, and FPIs (Family Planning Inspector).
Bandarban	Supervise personally once in a month (spot-visit)
Jessore	'When I visit upazila, I also visit CCs'. This is not done regularly but "sometimes"
Sathkhira	Supervision is done through FPIs, not personally
Kurigram	"I do not supervise" – DDFP

The implication is that owing to lack of regular (at regular interval) district-level supervision, the quality of care will remain neglected. From the district-level officials, not all CCs but at least a few CCs, are expected to be supervised with due diligence. Out of 5 DDFPs as reported, 2 are doing supervision of CCs personally/physically, but 2 are doing through their subordinate staff and one does not supervise CCs. It also appears that CC is not getting due importance from some programme-managers (DDFP) which may affect FP-MNCH programme in its totality. *Some CCs as reported to have management committee which must be made functional.*

It is our considered opinion that information and responses collected from DDFPs and UFPOs revealed CCs standing still on weak ground. The CC is not yet fully operational. With a strong support (if available) from the government, it may take more (say a couple of years) time and input to be more useful to the community. To justify the naming of "community clinic", community participation in its management is essential. Nevertheless, CC has vast potential to be the nearest and best service outlet for the rural people.

5.4.7 Referral System (Upazila level and below)

The question, what is the **mechanism/referral system of referring patients** including Maternal and Neonatal cases in your District, was asked to DDFPs and the responses were:

Type of mechanism	Yes/No	Districts DDFPs
Public – Public	Yes	Barguna, Bandarban, Jessore, Satkhira, Kurigram = 5 Districts
Public – Private	No Yes	Barguna, Bandarban = 2 Districts Jessore, Satkhira, Kurigram = 3 Districts
Private – Public	None	Record of such cases is not available
Use of Referral Slips	4 Districts have reported to using referral slips but Kurigram DDFP answered negatively	

There are three explanations on the type of mechanism for referral.

- **Public – Public referral meant:** CC/FWC→ UHC→ Dist. Hospital → Medical College Hospitals. This is initiated at the community level (Referrers are mainly FWVs or FWAs).
- **Public – Private:** As reported by UFPOs, MOs, FWVs this happens in case MCWC or UHC is found closed and is not in a position to provide specific service. Such cases are rare.
- **Use of Referral Slips:** Some DDFPs have reported that from the field (field staff/ FWC) to upazila (UHC) no referral slip is used, whereas, from MCWC to District Hospital/Sadar Hospital, Medical College Hospital, official referral slip is used.
- Regarding collection of report on the number and nature of referral cases from health facilities, the response was positive, but two DDFPs clarified their position, they got information from departmental monthly MIS report also.

The referral system from union level FWCs for MNCH cases to UHCs generally are –

Upazilas	System/Usages
Betagi	• FWAs or FWVs give prescription slip[14] and send the client/ patient to UHCs
Lama, Ruma, Kalaroa, Debhata, Rajarhat Nageshwari, Pathaghata	• Uses slips
Jhikargacha and Chowgacha	• FWV/FWA accompany the client:
Kalaroa	• Verbally refer to higher facilities:

It appears that there is no 'uniform' well-organized system for referral of cases (MNCH or for any other) to UHCs or to higher facilities.

[14] 'Prescription' – usually includes a brief note on patients condition/problem, medicine/treatment given and recommendation for better care at the higher facility. It differs with 'Slips'.

5.4.8 Quality Management System (QMS)

All districts (5) affirmed that QMS exist, and in response to all most same question/query on QMS for MCWC and FWC to ensure MNCH services, the following information were received from DDFPs and UFPOs. The system (may be called some kind of system) is maintained by the following tools –

- Field visit by programme-managers (DDFP, ADCC, MO-MCHFP)
- Upazila FP Committee members (supervise the program)[15]
- Checklist is practiced
- FPCST/QA Team provide supportive supervision[16]
- Monthly review meeting/staff meeting
- Routine inspection of quality and performance output.

But the fact remains, all these tools of QMS/monitoring are not universally applied by DDFPs, some are applied, some are not. Monitoring results are also shared/reported back and external monitoring is also carried out by FPCST. Nevertheless, regularity (at regular interval) of this monitoring and supportive supervision of upazila level and below activities and of MCWCs remains open to question.

About the question of budget provision (Do you have budget for monitoring/ supervision) the response from DDFPs was:

- Jessore : No
- Satkhira : Yes for supervisory officials (travel expenses)
- Kurigram : No budget
- Bandarban : No
- Barguna : Yes

Responses were somewhat confusing because "no budget" is partially correct, because for supervisory team/officials there is provision of travel expenses, but special allocation for monitoring/supervision may not be there.

The question EmOC team (Is there an EmOC team at the Comprehensive/Basic EmOC facilities) was responded by DDFPs differently. The position, as stated by them, is as follows.

DDFPs-

- Barguna : No.
-
- Bandarban : No
- Jessore : Yes, at MCWC
- Satkhira : No
- Kurigram : Yes, EmOC team in MCWC

Not to speak of the role of EmOC team but their presence at CEmOC/Basic EmOC facilities was not quite known to 3 District Managers (DDFPs), example – DDFPs Barguna, Satkhira,

[15] Upazila FP committee consists of upazila level officials of all Development Programmes with usually Upazila Parishad Chairman or otherwise, Upazila Executive Officer in the chair. UFPO is member-secretary.

[16] FPCSTQA: At district/upazila level, Family Planning Clinical Supervision Team for Quality Assurance is primarily responsible for supervision of clinical programme (FP-MCH), provide technical guidance to the doctors/paramedics for maintaining quality care.

Bandarban when asked about EmOC team said that 'no' such team was visible, and they had no knowledge of what they (EmOC team) do.

QMS is also in disarray, not in good shape, need to be streamlined. What is done, how, when and by whom to keep the QMS vibrant, not all clear. There seems to be more confusion in the system that could not be brought to surface by the present exercise/study.

5.4.9 Procurement and Maintenance System

Procurement

- About procurement system, both the system namely – pull/demand based and push-supply are currently in practice. Only Satkhira reported that push-supply is the main mechanism for procurement of goods and materials.
- All 5 DDFPs reported that all supplies are centrally procured, but in case of stock-out they (DDFPs) can procure some essential medicine and supplies for permanent FP/birth control methods from the local market.
- Normally, supplies are received, every month but Barguna DDFP said it is at every 2-3 months interval.

Maintenance

- About the arrangement/mechanism for renovation, and maintenance of facilities and equipment the DDFPs responded that –
- Upon requisition/report, the DDFP makes out a case and forward it to the Directorate of FP and CMMU for maintenance and renovation of facilities, and then CMMU according to available budget, take necessary action for the purpose;
- Regarding equipment and vehicles small repairing is being done by DDFP office. For bigger work, DDFP has to seek sanction of the central authority.

Maintenance/renovation/repairs are mostly central subjects – authority vests with the Directorate of FP and CMMU, only small things are (repairs/maintenance etc.) managed locally by DDFP & MCWCs.

5.4.10 Management Information System (MIS)

About MIS, DDFPs were asked two questions:

a. How do you manage health related information that you receive from the filed/facilities?
b. How do you share the information with your staff – what is the feedback system for higher level and below?

The response to the first question was common – all DDFPs said that information collected is partially computerized and partially compiled/recorded manually. Professional use of computer and programming have not yet been fully developed. DDFP Bandarban reported that 5 upazila FP offices have computer. *DDFP Kurigram informed that lack of skilled manpower is blocking the way forward.* The responses to the second question were also similar, they share information, give feedback in the District and upazill monthly coordination/staff meeting and through written report sent above and below. The UFPO also holds monthly review meeting in his office with Field Staff/workers (FWVs, FPI, FWAs/CSBA) for sharing information and feed-back. The UFPO sends monthly reports to DDFP office regularly on programme performance.

MIS needs special care, as it appeared, manual system persist and digital way of MIS yet to take roots down below.

5.4.11 Activity of Development Partners and NGOs

The activities of development partners (DPs) and NGOs as reported, in the areas of MNCH (partially or fully) may be observed from the table below, but the information collected from them (NGOs/DPs) was not enough to make any evaluative remark (Table 5.35).

Table 5.35: Development Partners and NGOs Present and Participating

Districts	Name of NGOs & DPs	Where they work	Brief activities
Barguna	• Marie Stopes Clinic • Family Health Clinic	In urban and rural areas -Do-	ANC and PNC, FP Services -Do-
Bandarban	• UNICEF • GRAUS (Grameen Unnyan Sangstha)	In urban and rural areas	ESP (Essential service Package) • Reproductive health • Communicable diseases • Child Health • Limited curative care • BCC
Jessore	• AD-Din • Marie Stopes Clinics • FPAB • Salvation Army • BAVS • Rotatary health centre	• At sadar upazila • ANC, PNC, ECP, FP methods, CEmOC, (normal, AVD and C-section) Neonatal care • MCH-FP (ANC, PNC, FP methods, Adolescent care services • FP (ANC, PNC, FP methods) • MCH-FP • MCH-FP (ANC, PNC, FP methods & NSV) • ANC, PNC, FP methods, CEmOC, C-section, AVD etc..	
Satkhira	• Smiling Sun • Marie Stopes • Satota	• Sadar Upazila • Urban areas planning to extend to rural areas • In urban areas	• MCH-FP services • ANC, PNC, FP services • FP Services
Kurigram	• Marie Stopes Clinic • Smiling Sun • RDRS • Kanchan Samity • Dhaldanga Bahumukhi Samaj Kallyan Samity • Friendship • Bora Bari Shamaj Unnyan Shangstha	• Both in urban and rural areas • Both in urban and rural areas • Both in urban and rural areas • Both in urban and rural areas • Both in urban and rural areas • Both in urban and rural areas • Both in urban and rural areas	• ANC, PNC, FP Services • FP services, also ANC, PNC • Multi-sectoral program + FP services • Development issues, literacy etc. • Development issues, literacy etc. • Development issues, literacy, FP service etc. • Development issues, literacy, FP service etc.

Source: NGOs, and DDFP office

Information on detailed activities in specific areas by these NGOs was not collected, and no validation of their responses could be made.

It was reported by DDFP Kurigram that these NGOs "do not provide CEmOC services". Regarding NGOs coordination with Government programme, all 5 DDFPs replied in the positive, and that DDFPs also hold meeting with them.

5.4.12 Coordination

As far as coordination with Health Department Officials is concerned, it was stated that DDFPs maintain coordination with them – over phone, meetings, personal contact and correspondences**. There is no problem** with regard to coordination with health officials.

DDFPs reported positively on the issue of coordination and found no problem. Meetings, rally, joint programme and supply of contraceptives take place with concerned NGOs. NGOs attend District FP Committee meeting at Deputy Commissioner's office.

5.4.13 Future Plan

Regarding future plan to improve MNCH service in the district especially for the rural poor, DDs responded as follows (Table 5.36).

Table 5.36: Future Plan

Districts	Proposed Action to Strengthen MNCH by DDFPs
Barguna	• Launch motivational campaigns for availing of MNCH service at the designated centres by the rural poor • Improve quality of service • Raise level of commitment in service providers
Bandarban	• Raise GO-NGO collaboration for better service delivery • Raise skill and motivation of service providers in the filed
Jessore	• Ensure better utilization of CSBAs in MNCH service • Establish stronger linkages with community to get their support and participation in MNCH service delivery system • Strengthen FWCs and hold frequently cluster meeting for effective both way communication
Satkhira	• Organize job-oriented training to build up skill of service-providers working in the filed • Organize awareness campaign to wake up the rural poor to get MNCH service from the nearest service outlets.
Kurigram	• Increase the number of CSBAs for facilitating safe-delivery and pre and postnatal care.

Source: DDFPs

The thinking of DDFPs and UFPOs do not vary much, and they seem to be on same boat, though their thinking-process on future planning is not well-organized.

5.4.14 Good Practices

The question asked was – 'what kind of innovative/good ideas or practices have you introduced in your district in order to improve services, if any'? The responses to the above question were as follows (Table 5.37).

Table 5.37: Good practices – innovative measures and suggestions

Districts	Innovative/good ideas introduced	Suggestions, if any
Barguna	• Team work introduced	• No further suggestion made
Bandarban	• Social mapping by Health Assistant and FWA supported by Community Support Groups[17] (FWA + HA+CSG) • They HA+FWA+CSG maintain ➢ Household no. ➢ Total pregnant women list ➢ Segregation ➢ Method/mix etc	• No further suggestion as of now.
Jessore	• Award for best 3 performers and lowest performer stricture/name displayed every month. Cluster-meeting: "We divided the upazila into different parts as cluster considering 3-4 unions for review of the whole MCH-FP programme where all upazila officers and concerned staff participated in the meeting. This is the special meeting for individual performance review and feed-back session and also plan of action for the next month" said DDFP. DDFP Jessore has no other suggestion, at present.	
Satkhira	• He has not yet introduced any innovative intervention.	• Peoples participation emphasized by DDFP • One or two persons residing in the CC area be trained to deliver basic services in order to enhance the quality as well as timely service close to the door steps. • Arrange for DSF Fund • Arrange for transport and improve communication • Involve Local Govt. in MNCH service
Kurigram	• He has not yet introduced any innovative measure	• Number of service providers be increased • Arrange for sufficient training of service providers • Launch stronger motivational and awareness-building campaign • Arrange transport for remote and 'char land' (large chunk of sandy lands). • Build-up infrastructure – FWCs/CC for every union/ward • Increase the number skill birth attendants (CSBA)

Source: DDFPs

It appears there are ideas for improving service delivery system but initiatives are lacking. It is, perhaps, not impossible to do something 'good', or innovative meaningfully in order to improve performance with quality service delivery with available resources, unless there is back-up support from Centre and/or local government bodies.

[17] Community Support Group is an informal local unit/body consisting of members (individuals) of the community who are basically social workers, work voluntarily in support of each other.

5.4.15 Status of Health-FP Workforce at 10 Upazilas of 5 Districts as Reported by UFPOs

The 10 upazilas of 5 districts have distinct position about health-FP workforce, facilities and services delivery **and they have clear opinion on MNCH reaching or not reaching the rural poor.** Because of differences and peculiarities upazila-wise positions have described in the tables below. It appeared from the responses by DDFPs and UFPOs that understanding on the same issue is not uniform, there are gaps in communication.

The status of workforce – be it called MNCH/MNCH, FP, Health or Health-FP meaning the same because existing workforce of each category deliver services related to MNCH, FP, Nutrition and Health with an integrated approach to HNPSP sector. **No field force work singularly on one area only.** Their job-description cover a wide range of activities.

Three questions were asked. **Number of MNCH force by categories, Number of sanctioned posts, and Actual numbers of FWVs, and FWAs. Table 5.38 shows the status as reported by 10 UFPOs of 5 districts.**

Table 5.38: Status of Health-FP Workforce at Upazila level, two upazilas of each 5 Districts

Categories of Health-FP Workforce	Barguna		Bandarban		Jessore		Satkhira		Kurigram		Total of 10 upazilas
	Betagi	Patharghata	Lama	Ruma	Jhikargacha	Chougacha	Kalaroa	Debahata	Rajarhat	Nageswari	
Categories and No. of Sanctioned post											
FWA	37	60	25	12	62	45	45	25	42	78	431
FWV	07	19	11	04	11	12	14	06	09	17	110
SACMO	NA	NA	NA	NA	11	NA	NA	NA	NA	NA	11
Actual Numbers											
FWA	35	58	21	10	58	34	41	22	32	64	375
FWV	05	18	08	03	09	07	09	05	07	12	83
SACMO	NA	NA	NA	NA	06	NA	03	02	NA	NA	11
CSBA (FWAs trained)	06	07	02	01	19	12	10	03	NA	NA	60

Note: The sanctioned post of FWAs in the Rajarhat Upazila is 33 and FWV 09, as reported by DDFP office; DDFP office Nageswari reported sanctioned post of FWV 16, FWAs 71. Thus there seems to be difference between DDFP, and UFPOs concerned.

UFPOs meant FWAs and FWVs as the main workforce for MNCH service, as FPI (Family Planning Inspector) perform supervisory role. Some of them (UFPOs) counted on SACMO as a member of MNCH service delivery force, but not others, and as such specific information was not available about them. It may be noted that there is difference between sanctioned number of posts and actual number in position. Above table shows that FWAs sanctioned number of posts is 431 against actual number in position are only 375 which is 87% total sanctioned posts. Then, FWVs sanctioned strength is 110 against in position (actual number) 83 which is 75.45% only in 10 upazilas under study.

All UFPOs recommended for training of FWAs in the course on CSBA in large number. They think community clinics have greater need of the services of FWAs trained as CSBA. All vacant posts should be filled up to optimize performance.

5.3.16 Facilities under UFPOs Jurisdiction Providing MNCH Services at Upazila Level and below

In reply to the question "Which facilities under your jurisdiction provide MNCH service"? The UFPOs identified the facilities, as follows (Table 5.39):

Table 5.39: Facilities providing MNCH services at upazila/Union/Ward level and below

Districts	Upazilas	Facilities at Union/Ward level and below for MNCH services
Barguna	Betagi Patharghata	• FWC, RD, Community Clinic (CC) • FWC, RD, MCH Unit of UHC
Bandarban	Lama Ruma	• FWC, Community Clinic • FWC, Community Clinic
Jessore	Jhikargacha Chougacha	• FWC/upgraded FWCs • FWC, RD
Satkhira	Kalaroa Debhata	• FWC, Community Clinic • FWC, Community Clinic
Kurigram	Rajarhat Nageswari	• FWC, RD, Community Clinic • FWC, Community Clinic, Satellite Clinic

In common, it was first FWC, then community clinic and RD. 'MCH Unit' as mentioned by UFPO Patharghata and Satellite Clinic by UFPO Nageswari are perhaps, exceptions. The responses by UFPOs were in contradiction with the responses made by some DDFPs. Example - one DDFP (Kurigram) said there is "no CC under DGFP". This response was verified. Community Clinics are jointly run by DGFP and DGHS staff – in fact, there exist some sort of dual control/or Joint management of these facilities. Another point is noteworthy about MNCH services. How Community Clinics which are not yet fully equipped/manned can deliver MNCH services fully or even partially? It was not believable that these facilities (FWCs, CCs, RDs etc as reported by UFPOs) provide full range of the following services. For response against the question, 'do they provide following services' the responses were as follows (Table 5.40).

Table 5.40: Do they provide following services: Responses by UFPOs

Services	Barguna		Bandarban		Jessore		Satkhira		Kurigram	
	Betagi	Patharghata	Lama	Ruma	Jhikargacha	Chougcha	Kalaroa	Debhata	Rajarhat	Nageswari
ANC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PNC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FP temporary method	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FP permanent method	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency contraceptives	**Yes**	**Yes**	**No**	**Yes**	**Yes**	**No**	**Yes**	**Yes**	**Yes**	**Yes**
T T	**Yes**	**Yes**	**Yes**	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
MR	**Yes**	**Yes**	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Delivery Normal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Assisted V. Delivery	**Yes**	**Yes**	**No**	**Yes**	**No**	**No**	**No**	**No**	**No**	**No**
C-section	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Neonatal care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Referral to other facilities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

The response was 'no' by all UFPOs on 'C-section'. In 7 upazilas 'Assisted vaginal delivery' was not being done. Two upazilas do not provide 'Emergency Contraceptives' and another two 'TT' (Tetanus toxoid). **All upazilas provide neonatal care referral service, ANC, FP temporary, FP permanent methods, Delivery normal services as reported by UFPOs.**

In response to another question – "Do you think the system of service delivery is sufficient for delivering MNCH care to the rural poor people – all 10 UFPOs said 'no' – not enough.

5.5 Responses of Consultant, Obs/Gynae, District Hospital

In each of the 5 districts, Consultant, Obs/Gynae of District Hospital were interviewed to know the situation of MNCH services prevailing there.

5.5.1 Emergency Obstetric Care (EmOC) Services

Regarding ***EmOC services*** all of them reported that they are providing Comprehensive EmOC services. Regarding ***whether hospital provide 24 hour Comprehensive EmOC*** services, all of them except Bandarban and Kurigram reported in positive. While asked about the ***reasons of not providing 24 hour Comprehensive EmOC services***, Bandarban and Kurigram, reported of a number of reasons as follows-Shortage of man power, Shortage of trained nurse, Shortage of MO-Anesthesia, C-section sets are not sufficient, MO-Obs/ gynae are not available, OT light focus is not sufficient, and Ayas and Sweepers are not sufficient.

The consultants were also asked about ***presence of an EmOC team***. Only Consultant, Obs/ Gynae of Jessore District Hospital reported that there is an EmOC team. But, while asked whether that team meet regularly, she reported in the negative.

5.5.2 Referral System

The Consultants, Obs/Gynae were asked regarding kind of MNCH cases are referred out to a higher-level hospital. Almost all of them ***reported of 7 problems/diseases of pregnancy***, as follows- Eclampsia, Obstructed labour, Prolonged labour, Placenta Previa, Renal failure, Post partum hemorrhage, and Rupture uterus. However, in Satkhira, they gave more emphasis on Post partum haemmorhage.

They were also asked regarding the ***hospital(s) they refer patients***. All of the Consultants reported of referring to nearest Govt. Medical College Hospital . Consultant Borguna reported of referral to Barisal Medical College Hospital, Bandarban to Chittagong Medical College Hospital, Jessore and Satkhira to Khulna and Dhaka Medical College Hospital, and Kurigram to Rangpur Medical College Hospital (Table 5.41).

Table 5.41: Hospital(s) where patients are referred

Hospital(s)	Borguna	Bandarban	Jessore	Satkhira	Kurigram
Barisal Medical College	Y				
Chittagong Medical College		Y			
Khulna Medical College			Y	Y	
Dhaka Medical College				Y	
Rangpur Medical College					Y

Source: Consultants obs/gynae

While asked about the ***types of case being referred in***, all of them reported 5 complications as follows- Obstructed labour, Eclampsia, APH, PPH, Retained placenta, Hand prolapse, and Complication of abortion. As to ***from whom/where are patients referred in***, they reported of FWC, RD, MO, RMO of UH&FPO, Private doctor, and Manager/doctor of NGO. While asked whether they have a ***formal referral mechanism*** with other government/private/ NGO facilities, only Consultants of Borguna and Kurigram reported in positive.

5.5.3 HR, Facilities and Supplies

The Consultants, obs/gynae were asked about the ***number of the EmOC providers*** in district hospitals. In terms of no. of Consultant, obs/gynae Jessore and Bandarban was better having 2 Consultants. In terms of all other staff, Jessore was better, except presence of EmOC trained nurse. The situation of human resources for providing EmOC service in district hospitals is presented in Table 5.42.

Table 5.42: Number of EmOC providers in district hospitals

District	Consultant (ob/gy)	Consultant (anes)	MO (ob/gy trained)	MO (anes.trained)	Nurse(EmOC trained)	Other related staff[18]
Borguna	1	0	0	1	3	0
Bandarban	2	1	1	1	9	9
Jessore	2	2	4	1	0	45
Satkhira	1	1	0	0	5	0
Kurigram	1	0	1	1	3	0

While asked, whether the OT is equipped for providing Comprehensive EmOC services and functioning or not, Consultants of all of the districts except Jessore reported in positive. They were also asked to provide a list of broken equipments of OT those are not repaired for more than a month. They provided a list where it seen that Jessore and Bandarban are suffering the most (Table 5.43).

Table 5.43: List of equipments out of order those are not repaired for more than a month

Districts	Name of equipment	Out of order since
Borguna	OT table	3 years
Bandarban	Anesthesia machine, Sucker machine, Electrical sterilizer	1 years
Jessore	OT table, OT light, Anesthesia machine, Sucker machine	1 Month - 1 year
Satkhira	Not out of order	-
Kurigram	Sucker machine	1 year

Regarding procedure for getting equipment repaired only Consultant, Obs/Gynae reported of writing letter to higher authorities. Rest of them didn't respond to this.

They were asked whether they have ***sufficient supply of emergency drugs to manage obstetric emergencies*** (such as, spinal anesthetics, GA, antibiotics, suture materials, infusions, oxytocin, etc.). All of them except Bandarban reported in negative on this issue. Those reported in negative were asked how often do you encounter stock-out situation. *Jessore reported of this situation 3 to 4 times a year. Other reported of suffering for 2 times a year.* As regards ***functioning of safe blood transfusion facility*** in their hospital all of them reported in positive.

5.5.4 Quality Assurance

Quality assurance is an important issue for providing MNCH services. The Consultants were asked whether there is any quality assurance system (periodic assessment with checklist, external assessment, etc.). All of them reported in negative on this. They (consultants) were also asked who provides supportive supervision for quality improvement. In Borguna and Satkhira they reported Civil Surgeon as this person. In Jessore the Consultant reported about Superintendent, DG Health, Director Hospital, and Divisional Director of Health Services,

[18] 'Other Related Staff' means supporting staff such as-Aya, MLSS (Peon), Sweeper, Cleaner, Driver of Automobiles and Guards.

Khulna Division. Others didn't report of anybody. Consultants of Bandarban and Kurigram although reported negatively about supportive supervision, yet they did not mention any bottleneck for this activity.

5.5.5 The Way Forward

The Consultants, Obs/Gynae of the 5 districts were asked whether they feel that more and more rural poor are accessing the MNCH services. The Consultants, Obs/Gynae of Jessore and Satkhira district reported in positive on this. The Consultants were asked about their suggestions for improving provision for and utilization of quality MNCH services including EmOC among the rural poor. All of them suggested- Free medicine for the poor, Ensure necessary equipments, Provision of 24 hours service, Increase skilled manpower, Solve the Communication problems, Build awareness, and Fill in vacant posts.

5.6 Responses of Medical Officers, MCWCs

In the five study districts five MCWCs in – one MCWC in each district, were brought under investigation to assess the MNCH situation in general and various other related aspects of the programme in particular; usually, each MCWC is headed by a Medical Officer, but in his/her absence FWV also holds the charge of the Centre. In two locations namely, Barguna and Bandarban FWVs are taking care of the MCWCs. As such, 3 MOs and 2 FWVs were interviewed by the Field team/Investigators for the study purpose.

Information on Six issues with 32 questions asked and data on 11 queries were collected from each centre. Issue-wise responses were recorded.

5.6.1 EmOC Services

Of the five MCWCs, Bandarban is providing EmOC and can not provide CEmOC for shortage of equipment in order. Jessore, Satkhira, Kurigram are providing CEmOC, Barguna at present is not in a position to provide any of the two, EmOC basic or EmOC comprehensive because of absence of Anesthetists, Consultant Obs/Gynae and supporting staff including trained FWV. For providing CEmOC pair of Anesthetists – Doctors (trained) is needed.

Regarding 24-hour service at the MCWCs, the responses were –

- Borguna and Bandarban districts reported 'no', - not possible 24 hrs service now
- Both Barguna and Bandarban reported actuate shortage of supporting staff/ paramedics for this purpose
- Barguna and Bandarban do not have residential facilities within the MCWC campus for FWVs and other related staff needed for 24 hrs service
- Jessore, Satkhira and Kurigram districts reported in the positive (yes) for 24 hrs service at MCWCs.
- Barguna, Jessore, Satkhira, Kurigram reported that EmOC Team exists
- Bandarban declined about the existence of EmOC team
- "Do they (EmOC team) meet regularly", Kurigram said 'no', but Jessore, Satkhira, Barguna and Bandarban said 'yes'.

The position of Barguna and Bandarban is, in comparison with other 3 districts (Jessore, Satkhira and Kurigram) is low/lower.

Shortage of trained manpower/lack of supporting staff, and particularly the absence of Anesthetists are problems blocking MNCH way forward. In fact, MNCH services are at risk without trained specialist. Support from higher authorities for the MCWC is a must to overcome the present crisis.

5.6.2 Referral System

a. All 5 district MCWCs in responses to the question, ***'what kind of MNCH cases are referred out to a higher level hospital***', identified the following:

- High risk mother – high blood pressure, pre-eclamsia cases, - high temperature
- Retained Placenta, perineal tear, rupture of membrane etc.
- Patients needing ICU services
- C-section with Athsma
- Excessive bleeding
- Obstructed labour/prolong labour
- Blood transfusion patients
- Severe pneumonia for neonates
- Patients guardians willing to go to higher facilities;

There is no noticeable difference in choosing/determining cases for referral amongst 5 MCWCs to higher facilities.

b. Again, the question was '***to which hospital do they (MCWCs) refer patients***', the response was –

- *Preferably, District Hospital/General Hospital located at the Dist. HQ;*
- *Nearest Medical College Hospital (Chittagong/Khulna/Rangpur)*

c. And then, the question – '***what kind of MNCH cases are being referred to MCWCs***' – they answered almost unanimously – the cases are generally –

- High blood pressure, Excessive bleeding, high temperature/fever;
- Retained Placenta, perineal tear, prolong labour, obstructed labour
- Unconscious mother/patient;
- Eclamsia
- Safe delivery (without problems)

d. In reply to the question- ***from where and who refer the patient to the MCWC,*** they (Respondents) reported as follows-

- Union FWC/CC – FWA/CSBA
- Upazila level MO MCH-FP
- District level from NGOs
- Private doctors
- Patient's guardians bring the patients directly to the MCWCs.

e. And finally **–** the question ***'do you have a formal referral mechanism with other government/ private/NGO facilities'* –** the responses were **–**

Districts	Yes / No	System
Barguna	Yes	Slip system
Bandarban	Yes	GoB prescribed referral form
Jessore	Yes	Slip/Prescription
Satkhira	No	No formal mechanism
Kurigram	Yes, but →	Formal referral mechanism established with DSF for Ulipur upazila only; anything else is informal.

Source: NGOs interview

It appears that referral mechanism is not well-established and not uniform and there is lack of urgency for doing this job seriously.

5.6.3 Human Resource, Facilities and Supplies

The ***status (in position) of manpower in the MCWCs providing EmOC*** may be seen from the Table 5.44.

Table 5.44: Human Resource status: Providers of EmOC

District	MO (ob/gy trained)	MO (anes. trained)	FWV (EmOC trained)	Other related staff for EmOC[19]
Barguna	1	1	4	0
Bandarban	0	1	3	5
Jessore	1	0	6	6
Satkhira	1	1	5	3
Kurigram	1	1	3	0

The present status of EmOC personnel is deplorable as the existing strength of skilled/trained manpower (in position) is not all satisfactory for quality service delivery. There is urgent need to fill-up vacant posts.

About the training of staff (MO/FWV) questions were asked (4 questions) and they (MO/FWV) replied which is noted in the Table 5.45.

Table 5.45: Reply to 4 questions to MO/FWV

Questions	Responses by: Five district MCWCs				
	Barguna	Bandarban	Jessore	Satkhira	Kurigram
How long was your in-service training?[20]	6 months	6 months	6 months	1 year	1 year
In which year were you trained?	2003	1990	1999	2001	2008
Do you feel confident enough to deal with obstetric and neonatal emergency situation?	Yes	No	Yes	Yes	Yes
Do you feel nurses in MNCH services are reasonably well trained in dealing with Emergency situation? Yes/No	Yes	Yes	Yes	No	Yes

There is need for more training and re-fresher training to update knowledge and skill level of MCWC staff for better service delivery and commitment to job responsibility.

About the question ***'whether the OT equipped for providing Comprehensive EmOC services'***, the reply was "Yes", but with a remark from Barguna MCWC FWV in-charge, that

[19] 'Other Related Staff' for EmOC' means: Aya, Sweeper, Cleaner, Record Keeper, Messenger, Peon, Driver and Security Guards.

[20] 'In-service' training meant refresher/retraining to up-date the knowledge level of the respondents (MO, FWV) and training was administered once.

– "C-section equipment two sets have not yet been opened after these were received"[21]. Regarding broken equipment not repaired for month or over a month, they said no equipment is broken now, except one Sucker machine at Kurigram MCWC lying broken for about a year.

Regarding the procedure for getting equipment repaired, there was no reply recorded from MCWC Barguna, Jessore, but Bandarban MCWC mentioned 'HEMA' a private firm doing the job on contractual basis; Satkhira MCWC reported that small repairs are locally managed, big/bigger ones referred to Assistant Director (CC) of District FP Office, for necessary action. Kurigram MO Clinic, MCWC reported that – 'Locally they cannot repair, about Sucker Machine issue, she informed it to higher authority, and then one sucker machine was supplied recently from central level".

It appears repairing is a problem since there is no system in place. There is no set guideline for the purpose, or even if there is any, this is not known to the MCWCs. The present condition (lack of system/procedure or lack of knowledge and practice of repairing job) is not at all favorable for smooth functioning of EmOC at the MCWCs.

Again, on question to, ***'do your have sufficient supply of emergency drugs to manage obstetric emergencies'*** – the response was "yes" by 4 MCWCs, Borguna, Bandarban, Jessore, Kurigram, but 'no' by Satkhira. Satkhira MO,MCWC explained that local fund is used to buy emergency medicines and if this is exhausted, patients are asked to manage by themselves.

While asked ***'do you have any fund to buy drugs, logistics or for maintenance of equipment from any sources'***, the response from all five MCWCs was "yes" – and three MCWCs-Bandarban, Satkhira and Kurigram reported that Tk.300,000/- to 400,000/- is their annual allocation. Two other MCWCs were not aware of the amount allocated to them. They were not sure about who is the highest approving authority for this fund – one said Line Director MCHFP, another said DGFP, another reported ADCC of the District FP office.

About functioning of blood transfusion facility at the MCWC, all of them replied negatively.

5.6.4 Quality Assurance (QA)

Regarding quality assurance system all five MCWCs reported positively.

About 'What is the mechanism of QA' – the responses were as follows.

Districts	Mechanism of each MCWC
Barguna	Checklist and supportive supervision by FPCST (no timeline mentioned)
Bandarban	Checklist and supportive supervision by FPCST (once a month)
Jessore	Daily assessment using tools and supportive external supervision by FCST on a quarterly basis and sometimes, by Assistant Director C.C of District FP Office on routine basis.
Satkhira	Checklist, routine supervision by ADCC, DDFP and supportive supervision by FPCST consultants every two months.
Kurigram	Checklist/monitoring checklist used by FPCST QA Team regularly – ADCC also make frequent visits; supportive supervision by DDFP and ADCC and sometimes by Divisional Director, FP

The answer to question **'whether QA mechanism is functioning',** was positive by all, and no bottleneck was reported.

5.6.5 Human Resources

[21] Reply/Response recorded in early January 2010.

In question to – **'what kind of subsidies/incentives do you receive for serving at this post, if any',** only Barguna reported in the negative. Others said "yes" for sterilization (Tk. 200 each case), for Copper-T/IUD insertion Tk.60, supporting staff get some remuneration/ incentives at varying rates. Also there is management cost of field level officials which are as follows:

- UFPO Tk. 75 for ligation client
- AUFPO Tk. 50 for ligation client
- AFWO MCHFP Tk.50 for ligation client
- FPI Tk. 50 for ligation client

(This information about management cost was given by MCWC Bandarban)

5.6.6 The Way Forward

The response to **'do you feel that more and more rural poor are accessing the MNCH services' –** all of them reported in the positive.

Suggestions made by them for improving MNCH are summarized below:

- Increase manpower strength
- Arrange for appropriate training/retraining of all categories of service-providers under MCWC
- Enhance facilities (physical, technical, logistics, and financial provisions) at the MCWC
- Fill up all vacant posts with highest priority/urgency
- Build up residential accommodation for MO MCH-FP and FWVs and other supporting staff where this facility is lacking to ensure 24 hrs service
- Arrange for suitable transport (example river ambulance for hard to reach upazilas such as Ruma, Thanchi) of Bandarban district
- Introduce Demand Side Financing (DSF) program gradually
- Strengthen Awareness program (BCC)
- Consider regular payment of over-time to staffs working beyond the call of duty
- Strengthen supervision and monitoring
- Streamline referral system under a set guideline and make it functional.

5.7 Responses of NGO Managers/Service Providers

5.7.1 Organizational Status

The study has found three NGOs providing health services in eight out of ten upazilas under the study. The NGOs are Surjer Hashi Clinic (SHC) in four upazilas, Marie Stopes Clinic in three upazilas and Addin Hospital in one upazila. In Bandarban, no such NGO clinic have been found. All the NGOs are registered and operating in the district comparatively long years. All the NGOs have their organizational mission statements. The number of clinics operated by the NGOs in each upazila varies between 1 and 5. The Clinics are mainly located in Sadar upazilas (upazila where the district headquarters is located), except SHC has clinic in Razarhat. The data reveal that the number of clinics that the NGOs operate nationwide is quite substantiating, except Addin Hospital who operates only 4 clinics (Table 5.46).

Table 5.46: Organizational Status of NGOs

Status	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
Legal Status										
Registered (R)/ Un-registered (U)	R	R	NA	NA	R	R	R	R	R	R
Operating in this district since	2008	2001	NA	NA	1985	1982	2003	2008	2008	DK
Organizational Mission										
To reduce maternal and neonatal health	No	No	NA	NA	Yes	No	No	No	No	No
Provide reproductive health services to adults and adolescents	No	Yes	NA	NA	No	Yes	Yes	No	No	Yes
Provide quality health service at lebour cost	Yes	No	NA	NA	No	No	No	Yes	Yes	No
Number of clinics they operate (in this district)	1	1	NA	NA	2	4	1	1	5	1
Location of clinics (upazilla)	Sadar	Sadar	NA	NA	Sadar	Sadar	Sadar	Sadar	Razar-hat	Sadar
Number of clinics operate nationwide	320	143	NA	NA	4	320	143	320	320	143

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS Marie stops clinic
Source: NGOs interview

It is worth mentioning that in 4 upazilas, there is no medical graduate available in running the service delivery (health service delivery program is run by paramedics or nurses), while in Nageswari, there is reportedly one doctor involved with the service providing (Annex Table 1). However, among all the doctors involved in service delivery, only 2 doctors are trained in the Obs/Gyne, none have the necessary training in the field of maternal and neonatal health (MNCH). The number of paramedic nurse trained in MNCH is also alarmingly low (Annex Table 2).

5.7.2 MNCH Services Provided by NGOs at Upazilas

The health service delivering NGOs are providing a range of MNCH services in eight upazilas out of ten. There are no NGO-delivered services in Lama and Ruma upazilas of Bandarban district. The services are grouped into two major groups: (a) in clinic, and (b) in communities (Table 2). In clinic services include: (i) FP, (ii) ANC, PNC, (iii) Neonatal care, and (iv) MR. People in NGO operated eight upazilas receive all these services. However, SHCs as are funded by USAID do not provide MR services. In contrary to most of the SHC clinics provide full range of in community services (including FP advice, increasing RH awareness, courtyard meeting on RH and circulating various messages). However the SHCs operating in Debhata upazila under Satkhira district and Rajarhat upazila under Kurigram district provide a limited range of the same (Table 5.47).

Table 5.47: MNCH services provided by NGOs scenario

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS			AH	SHC	MS	SHC	SHC	MS
What kind of non-clinical, MNCH-related services/activities do you have (eg. health education)										
Y/N	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
a. In clinic(s) FP-both	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
ANC, PNC	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Neonatal care	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
MR	No	Yes	NA	NA	Yes	No	Yes	No	No	Yes
b.In communities BCC Services	Yes	No	NA	NA	Yes	Yes	No	No	No	No
FP advice	No	Yes	NA	NA	No	No	No	Yes	No	No
Incensing Awareness	Yes		NA	NA	No	No	No	Yes	Yes	No
Courtyard Meeting	Yes	Yes	NA	NA	No	Yes	No	No	Yes	Yes
Circulate Message	Yes	No	NA	NA	Yes	No	Yes	No	No	No

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS= Marie stopes clinic

The following table is self explanatory and provides number of services by type (client/ patient visits) for each of the mentioned services during 2009 (Table 5.48).

Table 5.48: Service delivery statistics in NGO-delivered upazilas by types of services: 2009

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
ANC	4356	238	NA	NA	23291	1080	328	6327	6304	93
PNC	506	2	NA	NA	2892	457	3	747	1676	73
FP-temporary methods	10181	1254	NA	NA	1570	4374	1961	11779	46722	1500
FP-permanent methods	-	18	NA	NA	63	12	-	50	70	1
Emergency contraception	-	-	NA	NA	-	43	-	-	-	-
TT	1221	-	NA	NA	1585	848	-	7065	2885	-
MR	-	368	NA	NA	-	-	460	-	-	251
Delivery Normal	-	-	NA	NA	1011	75	1	131	85	-
Assisted vaginal delivery	-	-	NA	NA	-	-	-	-	-	-
C-section	-	-	NA	NA	1498	126	-	88	-	-
Neonatal care	80	2	NA	NA	-	-	-	201	85	-
Referral to other facilities	244	30	NA	NA	-	-	-	79	51	

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS= Marie Stopes Clinic

5.7.3 Future Expansion Plan of NGOs

The NGO managers and service providers were asked regarding their respective organizations having plans to expand and/or improve MNCH care services in future. Addin Hospital desires to expand their service delivery network through out the country. All Marie Stopes managers and manager of SHC at Rajarhat upazla informed about their intention to expand MNCH services for the poor in the future. The SHC at Betagi upazila has the intention to provide EMOC services in their clinic while MS at Patherghata upazila and SHC in Chougachha upazilas have the intention to convert their current clinic into full-fledged clinics, and MS clinic in Nageshawree upazila have the plan to start C-section (Table 5.49).

Table 5.49: Future expansion plans of NGOs

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
Expending Nation wide	No	No	NA	NA	Yes	No	No	No	No	No
MNCH Service for poor	No	Yes	NA	NA	No	Yes	No	Yes	Yes	No
Starting EmOc	Yes	No	NA	NA	No	No	No	No	No	No
Prepare full flanged clinic	No	Yes	NA	NA	No	Yes	No	No	No	No
Starting C-Section Service	No	No	NA	NA	No	No	Yes	No	No	Yes

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS= Marie stopes clinic

5.7.4 Cooperation with Government

The study revealed that the clinics at Betagi, Jhikargachha, Chougachha do not receive any financial and/or kind assistance from government sources, except contraceptives. Marie Stopes of Borguna reported of receiving some instruments for FP. However, the monetized amount donated by government has not been available during the field data collection (Table 5.50).

Table 5.50: Cooperation with Government agencies

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS			AH	SHC	MS	SHC	SHC	MS
1. Do you receive any assistance from GoB, financial or in kind?										
Y/N	No	Yes	NA	NA	No	No	Yes	Yes	Yes	Yes
a. If yes, What do you receive?										
Contraception	No	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes
b. How much (worth)? Tk. as per our requisition	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS= Marie stopes clinic

5.7.5 Service Charges by types

It is revealed that different NGOs receive different amount of service charges for similar type of services. The overall ranges for services vary sharply. Some NGO clinics include full and/or partial price for the drugs and contraceptives in the service charge. It is reportedly known that there are provisions for reducing/waiving the fees (service charges for the poor. See Table 5.51 and Annex Table 6 for details.

Table 5.51: Service Charges by type and by NGOs

Services	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
Registration (out-patient, in-patient)	5	10	NA	NA	30	20	10	50	20	10
ANC consultation	30	30	NA	NA	25	30	20	50	10	50
Tetanus immunization to pregnant women	10	-	NA	NA	25	10	-	-	10	-
Delivery (normal)	500	-	NA	NA	1499	1000	-	900	650	-
Assisted vaginal delivery	-	-	NA	NA	-	-	-	-	-	-
C-section	-	-	NA	NA	7130	8000	-	4000	-	-
PNC consultation	30	30	NA	NA	25	30	10	50	10	10
In-patient care (overnight stay) per night	-	-	NA	NA	-	-	-	-	-	-
Ultrasound	-	-	NA	NA	300	425	-	250	-	-
Blood transfusion	-	-	NA	NA	-	-	-	-	-	-
Lab tests	120	-	NA	NA	-	-	40	-	60	40
Others (Specify) ECG	-		NA	NA	100	-	-	-	-	-
Registration (out-patient, in-patient)	-	-	NA	NA	-	-	-	-	-	-
MR	-	600	NA	NA	-	-	500			

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS= Marie stopes clinic

5.7.6 Sustainability Issues

It is learnt from the respondents that none of the NGOs/Clinics except the Addin Hospital are financially sustainable. However, it is not clear that AH is fully and/or partly sustainable. The funding source for all SHC installation is USAID, while the Marie Stopes installations are funded from UK, Grameen Phone and Marie Stopes. The respondents from Ad Deen Hospital did not give any indication of funding sources, although it is felt that the same is not fully sustainable (Table 5.52).

Table 5.52: Financial sustainability Scenario of the NGOs

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathars	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
Y/N	No	No	NA	NA		No	No	No	No	
a. If not, who is giving you funds/commodities?										
USAID	No	Yes	NA	NA	No	Yes	No	Yes	No	No
UK	No	No	NA	NA	No	No	Yes	No	No	No
Grameen Phone	No	No	NA	NA	No	No	No	No	Yes	No
Marie Stopes	Yes	No	NA	NA	No	No	No	No	No	No

Note: AH= Addin Hospital, SHC= Surjer Hashi Clinic, MS Marie stops clinic , NA= Data not available

5.7.7 EmOC, Referral and Quality Management System

The study explored some relevant issues on EmOC, referral and quality management system. It is found that the EmOC, and referral services are not adequately developed. However, the NGOs have developed their own It has been reported that there exists a periodic internal quality assessment (QA) mechanism for each of them. The QA assessment is being reportedly done once during various duration of intervals; ranging between15 days and 180 days. The QA is reportedly made using check list and action plan format. (For details see Annex Table 7).

It is to note that some detailed information about procurement, maintenance and existence of MIS is presented in Annex Tables 8 and 9.

5.8 Response of Private Service Providers

The private service providers of districts providing Basic or Comprehensive EmOC were interviewed during the study. From each districts two such providers were interviewed. Except in the district of Bandarban private providers providing Basic or Comprehensive EmOC were found and interviewed. Thus, altogether 8 private providers were interviewed. See Table 5.53 for list of interviewees by district and name of clinics.

Table 5.53: List of private service provider interviewees

Districts	Name of interviewee	Name of clinic
Barguna	Dr. M.A. Khaleque	Doctors clinic
Barguna	Dr. Kamrul Islam	Central Hospital
Jessore	S.M.A. Islam Russel	Daratana Hospital
Jessore	Subrato Biswas	Ekota Hospital
Satkhira	Dr. AKM Nurul Islam	Farzana clinic
Satkhira	Dr. Md. Habibur Rahman	Anwara Memorial clinic & Diagnostics centre
Kurigram	Faruk Ahmed	Khan clinic
Kurigram	Md. Shamsul Alam	Kurigram clinic
Banadarban	NA	NA
Banadarban	NA	NA

NA= Data not available

They were interviewed on the issues - Facility profile, Staff force , Training in neonatal health, Who also work at GoB facilities, List of MNCH services being provided and Corresponding fees, EmOC Services, Referral of EmOC cases, Supplies and maintenance, Quality Assurance System, Services provided from January to November 2009, MNCH services of the GoB, Income and sustainability, and Suggestions for improvement.

5.8.1 Profile

Legal Status: The private providers were asked about their facility profile. Except one in Borguna all of them reported that, their facility is registered.

Established: Except one in Jessore and another one in Kurigram all of them reported that their facility have been established in 2000 and afterwards.

No. of beds: Their reported number of beds varied from 2 to 53. It was lowest in Borguna, and except in Kurigram they had no specific number of beds for MNCH.

Opening hours: Their facility is open for 24 hours, except in Satkhira.
See Table 5.54 for details.

Table 5.54: Status of facility

Status	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
1. Legal Status : Registered (R)/ Un-registered (U)	U	R	NA	NA	R	R	R	R	R	R
2. Established	2007	2005	NA	NA	2006	1999	2000	2007	1995	2005
3. No. of beds & beds for MNCH	10	2	NA	NA	40/0	53/0	20	10	30/4	10/3
4. Opening hours	24	24	NA	NA	24	24	8	8	24	24

NA= Data not available

5.8.2 Staff Force

Physicians: While the service providers were asked about their clinical and non-clinical staff force, they reported their number of physicians as 2 to 17. All of them reported of having at least one obs/gynae consultant in their facility. However, both the hospitals of Satkhira reported of not having any MBBS doctor with additional training in anesthesia.

Nurse-midwife: The total number of nurse-midwife they reported varied from 5 to 24, and both the clinics of Satkhira were unable to mention it. In Kurigram one of the clinics didn't have any nurse trained on EmOC or additional Midwifery. For further information see Annex Table 10.

Trained on neonatal health: Both the private clinics of Borguna, and one clinic of Kurigram reported of having doctor trained on neonatal health. Both the private clinics of Borguna and one clinic of Kurigram reported of having doctor with this training. See Annex Table 11.

Those who also work at GoB facilities: Only OB/GY consultants in in districts except Satkhira and MBBS with additional anesthetic training in all the districts were also working at GOB facilities. See Annex Table 12.

List of MNCH services being provided and Corresponding fees: All the private clinics reported of providing Normal delivery, Assisted vaginal delivery, and Caesarean section. However, both the 2 clinics of Satkhira didn't report of the fee of Assisted vaginal delivery. For Normal delivery the fee varied from Tk. 500 to Tk. 3500, for Assisted vaginal delivery it varied from Tk. 1500 to Tk. 4000, and for Cesarean Section it varied from Tk. 2000 to Tk. 9000 (Table 5.55).

Table 5.55: MNCH services being provided and Corresponding fees

MNCH services (Y/N)	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
ANC	200	200	NA	NA	NA	NA	50	50	free	100
PNC	200	300	NA	NA	NA	NA	50	50	100	100
FP-temporary methods	NA	NA	NA	NA	NA	NA	-	NA	free	NA
FP-permanent methods	NA	NA	NA	NA	NA	NA	200	NA	200	NA
Emergency contraception	NA	NA	NA	NA	NA	NA	NA	NA	150-200	NA
MR	1000	800	NA	NA	NA	NA	NA	NA	200	NA
Delivery Normal	4000	2000	NA	NA	1500	3500	1500	500	500	1500
Assisted vaginal delivery	4000	2000	NA	NA	4000	4500	-	-	1500	2000
Cesarean section	6000	3500	NA	NA	5000	9000	6000	4000	2000-3000	4000
Neonatal care	NA	300	NA	NA	NA	NA	150	100	200	100
Referral to other facilities	NA	NA	NA	NA	NA	NA	NA	NA	200	100
Others (Specify) D&C	NA	NA	NA	NA	NA	NA	500	500	NA	NA

NA= Data not available

It was observed that, support of private clinics on MNH care is 'nil' in district of Bandarban, and is also very low in Satkhira and the 'Sidor' affected areas of Borguna and other districts in their Upazilla level. Fees for different MNH services, especially CEmOC is out of reach of the poor and lower middle class peoples. There is no alternative for them as well.

5.8.3 EmOC Services

The private providers while about **EmOC services all of the clinics** reported of providing Comprehensive EmOC (CEmOC). While asked whether EmOC services available for 24 hours for 7 days a week all of the clinics, except the 2 in Satkhira reported of positive. Regarding the year of providing EmOC services all of them, except 1 in Jessore and 1 in Kurigram reported of starting such services in year 2000 and afterwatds (Table 5.56).

Table 5.56: Providing Basic or Comprehensive services

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
Providing Basic or Comprehensive services (B/C)	C	C	NA	NA	C	C	C	C	C	C
EmOC services available for 24 hours for 7 days a week	Yes	Yes	NA	NA	Yes	Yes	No	No	Yes	Yes
Since when providing such services	2007	2003	NA	NA	2006	1999	2000	2007	1995	2005

NA= Data not available

The private providers while asked to mention **whether they are providing the services listed below** at the moment in their facilities, they reported of providing all the services in all the districts, except providing Assisted vaginal delivery in both the clinics of Satkhira. Regarding investigations done in their clinic they reported of providing almost all except CT Scan, which is done only in Jessore (Table 5.57).

Table 5.57: At the moment the services provided in their facility

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
Parenteral antibiotics	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Parenteral anticonvulsants	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Parenteral Oxytosics	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Manual removal of placenta	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Removal of retained products	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Assisted vaginal delivery	Yes	Yes	NA	NA	Yes	Yes	No	No	Yes	Yes
Blood transfusion	Yes	Yes	NA	NA	No	Yes	Yes	Yes	Yes	Yes
Caesarean section	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes
Does you clinic have lab facility (Y/N)	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes

NA= Data not available

The numbers of MNCH services provided during January to November 2009 has been provided in Annex Table 13.

5.8.4 Referral of EmOC Cases

Regarding whether they receive referred cases from public facilities, all of them except Satkhira reported in positive. However, their response on facilities that refer patients to their clinic was not homogeneous, none of them reported of having any formal agreement with them. Numbers of obstetric cases referred out this year was reported by Satkhira and Kurigram only (Table 5.58).

Table 5.58: Referral situation of EmOC cases

Indicators	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
Receive referral cases from public facilities (Y/N)	Yes	Yes	NA	NA	Yes	Yes	No	No	Yes	No
Facilities that refer patients to their clinic										
Health worker	Yes	Yes	NA	NA	No	No	No	No	No	No
Quacks	No	No	NA	NA	No	No	No	No	Yes	No
Other patients	No	No	NA	NA	No	No	No	No	No	No
UHC	Yes	Yes	NA	NA	Yes	Yes	No	No	No	No
Whether have any formal agreement with them										
Y/N	No	No	NA	NA	No	No	No	No	No	No
Numbers of obstetric cases referred out this year	NA	NA	NA	NA	NA	NA	17	10	5	8

NA= Data not available

5.8.5 Supplies and Maintenance

The issue of supplies and maintenance was investigated through asking several questions to the private clinic managers/providers. Regarding presence of Ultrasound scanner and Anesthetia machine for OT all of them reported in positive. However, for Incubator, all of them except one clinic in Kurigram reported in negative. For where the machines are repaired in case of break down, they reported that Peoples come from Dhaka or nearly division. While asked from where they obtain drugs and other supplies, they reported from Dhaka, locally, and through representative of Medicine Company.

5.8.6 Quality Assurance System

For assessing the Quality Assurance System they were primarily asked whether they have periodic internal quality assessment. Except in 2 clinics of Jessore and 1 in Satkhira all of them reported in positive. Those reported in positive while asked how often mentioned daily, weekly and monthly, different answer in different clinics. Regarding availability of checklist and action plan format they reported in positive only for 2 clinics of Satkhira and I clinic in Borguna.

Those reported in negative in response to whether they have periodic internal quality assessment while asked how they ensure service standard all the three reported it through observation (Table 5.59).

Table 5.59: Quality Assurance System

Indicators	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
Whether they have periodic internal quality assessment	Yes	Yes	NA	NA	No	No	Yes	Yes	No	Yes
a. If yes, How often	Daily	Weekly	NA	NA	NA	NA	Weekly	Daily	NA	Monthly
b. Checklist and action plan format available	No	Yes	NA	NA	NA	NA	Yes	Yes	NA	No
c. If no, how the service standard is ensured										
Through asking patients	NA	NA	NA	NA	No	No	NA	NA	NA	No
Through observation	NA	NA	NA	NA	Yes	Yes	NA	NA	NA	Yes
Through medical team	NA	NA	NA	NA	No	No	NA	NA	NA	No

Regarding **any supervision from the government** (DGHS, CS office etc.) all of them reported in positive. In almost all cases it was Civil Surgeon office. As to the number of supervisions they received in 2009, the response varied from 0 to 4. However, clinics could not mention what do they check (Annex Table 14).

5.8.7 Assistance of GoB

Regarding **assistance of government for MNCH services** all of the private clinics reported in negative, and none of them are involved in DSF scheme of GoB. As to whether have any systematic cooperation/collaboration in MNCH with the GoB, only 1 private clinic in Borguna and 2 in Satkhira reported in positive. However, all of them find current relationship with the government authorities satisfactory.

All of them reported that they require manpower trained on MNCH, improved communication system, shortage of manpower and arrangement of medical instrument while asked their opinion about MNCH services of the GoB in their area.

5.8.8 Income and Sustainability

Regarding whether they feel the **service fees are affordable to rural poor people** all of them except 2 in Satkhira and 1 in Kurigram reported in negative.

On **sustainability issue** they were asked whether their hospital/clinic is self-sustainable. All of the clinics except 1 in Borguna reported that it is not self-sustainable. That clinic reported Bank loan as the source of financial assistance.

5.8.9 Suggestions for Improvement

The private clinic managers/service providers were asked about their suggestion to make MNCH services, particularly EmOC more accessible to and utilized by the rural poor in their district. All of them reported as follows-

1. Field workers should be provided training
2. Awareness among people should be increased
3. Communication should be improved
4. MNCH service should be provided at UHC
5. Service to be provided free of cost
6. Ambulance facility should there in all clinics.

5.9 Observation

1.1 ***Upazila Peculiarities:*** UFPOs and MOs, in some cases, are better informed; as an instance – in the case of Community Clinic Management and Operation, UFPOs have more knowledge and wider vision. Again, UFPOs have stronger stand on the training FWAs as CSBA. At upazila level definitions of basic terms and also functions of various facilities are not very clear.

1.2. ***District Peculiarities:*** Awareness and thinking about future plan seem to be hazy, not very clear. Local level planning has not yet got its roots and they (DDs) are not confident about the process of planning. The `know – how' of LLP is tremendously lacking. Most shocking was their ignorance about budget allocations (2009-2010 FY). DDFPs lack of interest in supervision of Community Clinics is matter of great concern. Also, shocking was the negative answer of 3 DDFPs about the role of EmOC team.

1.3. **On the training of doctors,** medics/para-medics and other related service-providers district and upazila level officials have identical and positive stand. They strongly feel that training for skill development and commitment to assigned job is a must.

1.4. **On Filling up of vacant posts** – they (District, upazila functionaries) strongly feel that all vacant posts must be filled with utmost urgency and the service-provider must stay at the place of posting.

1.5. **On knowledge gap -** the Deputy Directors (FP) knowledge gap/lack of interest in some areas (CC, MIS) is a matter of concern. Grooming of their guts as leader of FP-MCH programme in the district is the need of the hour.

1.6. **Meaningful coordination** - stronger coordination and supportive supervision of NGO – Private sector MNCH activities in a spirit of team work, should be considered with all seriousness.

1.7. **Development partners -** DPs should encourage local initiatives and provide technical support as well as material support not for perpetual dependence on them but for achieving gradual self-reliance. Capacity-building at local level should be the motive and objective of such support by DPs so that there is light seen at the end of the tunnel.

It is important to note that, NGO support on MNH care is 'nil' in district of Bandarban, and is also very low in the 'Sidor' affected areas of Borguna and other districts in their Upazilla level. It was observed that, most of the NGOs are working at Upazilla level for micro-credit only, and MNH care through them is a rare event.

CHAPTER 6
SUGGESTIONS

A good number of suggestions, or in other words, **recommendations,** have been made by field functionaries stationed at district and upazila level. These suggestions were noted by the Field Investigators during interview/discussion. These suggestions are aimed at improving MNCH as well as other health-FP related services for the overall benefit of the people in general and rural poor in particular.

These are summarized below:

- **Create more posts** of doctors, Nurses and other technical hands, such as Family Welfare Visitors for service to the rural areas of the country;
- **Fill-up all vacant posts** immediately;
- **Ensure posting of pairs** EmOC trained doctor (obs/gynae and Anesthesia).
- **Organize job-oriented training** to build-up skill of Service Providers in general and embark upon a well-organized training and re-training plan for doctors, Nurses, FWVs in MNCH care/(BEmOC/CEmOC) as appropriate to each category;
- **Arrange training in a massive scale** for FWAs who are eager and fit to undergo CSBA training;
- **Start providing Comprehensive EmOC** services at all UHCs.
- **Launch robust campaign for awareness-building** amongst the rural poor and BCC for enlisting stronger commitment of the community and community leaders on MNCH service delivery with quality;
- **Streamline referral system at all levels-union**, upazila, district levels and to higher facilities.
- **Encourage LLP and provide training to capture the 'know-how'** of LLP and provide needed resource for the purpose;
- **Encourage NGOs and Private sector initiatives**, provide supportive supervision/ technical guidance for quality assurance, also consider training of their concerned Service-Providers engaged in MNCH and related fields.
- **Activate local government bodies for stronger cooperation** with Health-FP-MCH officials in MNCH service delivery;
- **Streamline monitoring mechanism, provide necessary supplies** (computer facilities, e-mail-internet, etc) for MIS and Monitoring to go digital way forward.
- **Allocate fund for maintenance of facilities and equipment** on a routine basis locally
- **Strengthen union FWCs, upgrade them as centres of Excellence** gradually and organize frequent supervision of Community Clinics and consider posting of CSBA seriously.
- **Provide transport facilities for patients in need** of EmOC care.
- **Introduce incentives or benefits for 24 hrs service at** comprehensive EmOC Centres.
- **Encourage the culture of good practices locally** with support from the centre and local government bodies.
- **Encourage DPs to assist substantially** in a well-coordinated blanket-cover approach to MNCH programme for rural areas of the country.

References

1. Abul Barkat et al, Baseline Study on Increasing Access to Maternal Health Services for Poor Women in Rural Bangladesh, March 2006, Human Development Research Centre (HDRC).
2. Abul Barkat, et al, Study on Development of Urban Quality Assurance (QA) System, 2004, Human Development Research Centre (HDRC), Dhaka.
3. Bangladesh Bureau of Statistics – Bangladesh Population Census, 2001, Government of Bangladesh (Ministry of Planning/Statistical Division).
4. Directorate General of Health Services (DGHS), EOC Orientation Manual for Field Workforce on Prevention of Maternal Mortality, Reproductive Health Section (ESP), 2002, Ministry of Health & Family Welfare, Dhaka.
5. Directorate General of Health Services (DGHS), Protocol for Women Friendly Hospital, February 2005, Ministry of Health & Family Welfare and UNICEF, Bangladesh.
6. Economic Advisor's Wing, Finance Division Bangladesh Economic Review, June, 2006, Govt. of Bangladesh, Dhaka.
7. Finance Division, National Budget 2009-2010, Speech of Finance Minister June, 2009. Ministry of Finance, Govt. of Bangladesh.
8. Japan International Cooperation Agency (JICA), Newsletters – 7th – 11th edition on Safe Motherhood Promotion Project (SMPP) – a Technical Cooperation Project of the Ministry of Health & Family Welfare supported by Japan International Cooperation Agency.
9. Lawn JE et al 4 million Neonatal Death: When? Where? Why? Lancet (Neonatal Survival): March, 2005.
10. Ministry of Health and Family Welfare, Bangladesh Population Policy, October, 2004, Government of the People's Republic of Bangladesh, Dhaka.
11. Ministry of Health and Family Welfare, National Health Policy, 2000 AD. Govt. of Bangladesh, Dhaka.
12. Ministry of Women and Children Affairs, National Action Plan for Women's Advancement: Implementation of the Beijing Platform for Action (PFA), October 1998.
13. Mujadded Ahmed, Setara Rahman, A.B. Bhuiyan & Shameed Ahmed, Technical Standared and Service Delivery Protocol for EmOC, March, 2002, National Integrated Population and Health Program (NIPHP).
14. NIPORT, Bangladesh Demographic and Health Survey, 2007, National Institution of Population Research and Training, Ministry of Health & Family Welfare, Dhaka.
15. NIPORT, Bangladesh Maternal Health Service and Mortality Survey 2001, Ministry of Health & Family Welfare, Govt. of Bangladesh.
16. Planning Wing of MoHFW Annual Programme Review (APR) on HNPSP. Dated 5th May, 2009, Ministry of Health Family Welfare.

ANNEX I:
Tables

Table 1a: General Information about 5 Districts

Districts	Population	No. of upazilas	No. of unions	Electricity Yes/No	Water Yes/No	Distance from Dist. HQ (approx) in Km	Mode of communi-cation from Dist. HQ to each hospital
Barguna	896946	5	38	Yes	Yes	.5	Rickshaw
				Yes	Yes	45	Bus
				Yes	Yes	45	Bus
				Yes	Yes	1.5	Rickshaw
Bandarban	340337	7	29	Yes	Yes	0	On foot
				Yes	Yes	54	Bus & Boat
				Yes	Yes	54	Bus
				Yes	Yes	1	Rickshaw/ On foot
Jessore	2795822	8	91	Yes	Yes	2	Rickshaw
				Yes	Yes	28	Bus
				Yes	Yes	15	Bus
				Yes	Yes	1	Rickshaw
Satkhira	1984493	7	78	Yes	Yes	0	Rickshaw
				Yes	Yes	12	Bus
				Yes	Yes	12	Bus
				Yes	Yes	.5	Rickshaw
Kurigram	2226563	9	72	Yes	Yes	.5	Rickshaw
				Yes	Yes	28	Bus
				Yes	Yes	25	Bus
				Yes	Yes	.5	Rickshaw

Source: Secondary data compilation sheet (CS/DDFP office)

Table 1.b. No. of beds in District Hospital, MCWC and UHCs

Districts	Dist. Hospital	MCWC	UHCs							
			Amtali	Pathargata	Betagi	Bamna	NA	NA	NA	NA
Barguna	100	20	31	31	50	31	NA	NA	NA	NA
Bandarban	100	10	Lama	Ruma	Thanchi	Alikadam	Naikhongchari	Rowangchari	NA	NA
			10	31	0	31	31	10	NA	NA
Jessore	250	20	Bagarpara	Abhoynagar	Monirampur	Keshobpur	Jhikorgacha	Sharsha	Chougacha	NA
			31	50	31	50	31	31	50	NA
Satkhira	100	10	Kolaroa	Devhata	Tala	Ashasuni	Kaligang	Shamnagar	NA	NA
			31	31	50	31	50	50	NA	NA
Kurigram	100	10	Rajarhat	Ulipur	Chilmari	Rouwmari	Rajibpur	Fulbari	Nageshwari	Bhurungamri
			31	50	50	31	31	31	31	31

Source: Secondary data compilation sheet (CS/DDFP office)

Table 2: Status of Human Resources

District: Barguna

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas				
				Sadar	Amtali	Pathargata	Betagi	Bamna
# of MO present (# of MO post)	13 (66)	2 (4)	1 (1)	- -	4 (15)	2 (15)	0 (14)	2 (6)
# of Nurses present (# of Nurses post)	51 (83)	18 (21)	- -	- -	8 (16)	6 (15)	9 (15)	8 (10)
# of Nurses trained in EOC/midwifery	-	-	-	-	-	-	-	-
# of Consultants OG present (# of posts of consultants)	3 (6)	1 (1)	1 (1)	- -	1 (1)	0 (1)	0 (1)	0 (1)
# of Consultants AN present (# of consultants posts)	2 (6)	0 (1)	0 (1)	- -	0 (1)	1 (1)	1 (1)	0 (1)
# of MO trained in OG present	1	1	1	-	1	0	0	0
# of MO trained in OG (posts)	5	1	1	-	1	1	1	1
# of MO trained in AN	-	-	-	1	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Bandarban

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas						
				Sadar	Lama	Ruma	Thanchi	Alikadam	Naikhong chari	Rowang chari
# of MO present (# of MO post)	19 (55)	8 (9)	1 (2)	1 (2)	1 (5)	1 (7)	1 (6)	1 (5)	3 (7)	1 (7)
# of Nurses present (# of Nurses post)	43 (77)	24 (31)	- -	- -	6 (7)	4 (7)	0 (7)	2 (7)	4 (9)	3 (9)
# of Nurses trained in EOC/ midwifery	14	9	0	0	3	1	-	1	0	0
# of Consultants OG present (# of posts of consultants)	2 (9)	1 (1)	0 (1)	1 (0)	0 (1)	0 (1)	0 (1)	0 (1)	0 (1)	1 (1)
# of Consultants AN present (# of consultants posts)	1 (9)	1 ((1)	0 (1)	0 (1)	0 (1)	0 (1)	0 (1)	0 (1)	0 (1)	0 (1)
# of MO trained in OG present	1	1	-	-	-	-	-	-	-	-
# of MO trained in OG (posts)	-	-	-	-	-	-	-	-	-	-
# of MO trained in AN	2	1	1	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Jessore

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas							
				Sadar	Bagarpara	Abhoy-nagar	Moni-rampur	Keshob-pur	Jhikor-gasa	Sharsha	Chou-gasa
# of MO present (# of MO post)	59 (124)	11 (13)	- -	- -	4 (10)	8 (18)	7 (19)	7 (18)	9 (13)	6 (14)	7 (19)
# of Nurses present (# of Nurses post)	207 (202)	114 (107)	- -	- -	11 (11)	17 (17)	11 (11)	17 (17)	10 (11)	11 (11)	16 (17)
# of Nurses trained in EOC/ midwifery	10	4	6 (2) FWV	-	NA	NA	NA	NA	NA	NA	NA
# of Consultants OG present (# of posts of consultants)	12 (9)	6 (2)	- -	- -	1 (1)	1 (1)	1 (1)	0 (1)	1 (1)	1 (1)	1 (1)
# of Consultants AN present (# of consultants posts)	9 (9)	2 (2)	- -	- -	1 (1)	1 (1)	1 (1)	1 (1)	1 (1)	1 (1)	1 (1)
# of MO trained in OG present # of MO trained in OG (posts)	7 (7)	6 (4)	1 (1)	- -	NA NA	NA NA	NA NA	NA NA	NA NA	NA NA	NA NA
# of MO trained in AN present	5 (8)	0 (1)	1 (0)	-	1 (1)	0 (1)	1 (1)	0 (1)	1 (1)	1 (1)	0 (1)

NA= Data not available

Source: Secondary data compilation sheet (CS/DDFP office)

District: Satkhira

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas						
				Sadar	Kolaroa	Devhata	Tala	Ashasuni	Kali-gang	Sham-nagar
# of MO present (# of MO post)	78 (197)	3 (6)	1 (1)	- -	17 (32)	10 (14)	8 (32)	17 (39)	9 (21)	8 (32)
# of Nurses present (# of Nurses post)	84 (92)	37 (37)	1 (2)	- -	10 (15)	10 (10)	12 (15)	10 (11)	11 (11)	9 (15)
# of Nurses trained in EOC/ midwifery	29	5	-	-	3	4	3	5	4	5
# of Consultants OG present (# of posts of consultants)	3 (7)	1 (1)	- -	- -	1 (1)	1 (1)	0 (1)	0 (1)	0 (1)	0 (1)
# of Consultants AN present (# of consultants posts)	5 (8)	1 (2)	- -	- -	1 (1)	1 (1)	1 (1)	0 (1)	1 (1)	0 (1)
# of MO trained in OG present	(4)	-	-	-	(2)	(1)	-	-	-	(1)
# of MO trained in OG (posts)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
# of MO trained in AN present	3	-	-	-	1	1	-	-	-	1

NA= Data not available

Source: Secondary data compilation sheet (CS/DDFP office)

District: Kurigram

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas								
				Sadar	Rajarhat	Ulipur	Chil-mari	Row-mari	Rajib-pur	Ful-bari	Nages-swri	Bhurunga-mari
# of MO present (# of MO post)	32 (36)	6 -	1 -	- -	4 -	4 -	3 -	3 -	2 -	2 -	4 -	3 -
# of Nurses present (# of Nurses post)	47 (94)	22 -	2 -	- -	4 -	4 -	4 -	1 -	1 -	2 -	4 -	3 -
# of Nurses trained in EOC/midwifery	34	34	-	-	-	-	-	-	-	-	-	-
# of Consultants OG present (# of posts of Consultants)	3 (10)	2 -	- -	- -	1 -	- -	- -	- -	- -	- -	- -	- -
# of Consultants AN present (# of consultants posts)	2 (10)	1 -	- -	- -	- -	- -	- -	- -	- -	1 -	- -	- -
# of MO trained in OG present # of MO trained in OG (posts)	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
# of MO trained in AN present	-	-	-	-	-	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

Table 3: Status of Service Statistics about some Health, MNCH Programme Period: January to November 2009

District: Barguna

Indicators	District	Dist. Hospital	MC WC	Name of Upazilas with UHC				
				Sadar	Amtali	Pathar-gata	Betagi	Bamna
No. OG admissions	-	1073	268	-	44	239	163	20
No. delivery conducted (total including C-sections)	-	368	261	-	35	74	65	18
No. C-sections done	-	242	-	-	-	-	-	-
Blood transfusion services available	-	38	-	-	-	-	-	-
No. of referral cases (obstetric cases) received	-	281	-	-	-	-	1	-
No. of cases (obstetric) referred out to higher facilities	-	76	66	-	7	45	19	1
No. of indoor patients seen (all patients)	-	9942	238	-	4495	2875	1755	859
No. of outdoor patients seen (all patients)	-	101635	5510	46337	36777	29537	36760	36828
Bed occupancy rate	-	104%	12%	-	119%	62%	56%	55%
No. of CSBA present	39			7	18	7	6	3
No. of deliveries conducted by CSBAs	582			39	327	39	119	4
No. of FWC/RD	32			3 (7)	2 (5)	3 (&)	1 (5)	3
No. upgraded FWC	11			2	2	2	3	2
No. of FWC with FWV/ SACMO	24			6 (7)	3 (5)	6 (7)	4 (5)	3 (3)
No. of FWV present	45			18	8	18	5	4
# of FWV posts	55			19	11	19	7	5
No. of FWA present	202			58	52	58	35	20
# of FWA posts	214			60	57	60	37	22
No. of community clinic Constricted	105			27	37	27	14	8
No. of community clinics providing services	94			25	34	19	8	8
No. of community clinics planned services	116			38	37	19	14	8
DSF program	-			-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Bandarban

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC						
				Sadar	Lama	Ruma	Thanchi	Alikadam	Naikhong chari	Rowang chari
No. OG admissions	887	425	187	No	134	13	No	50	58	20
No. delivery conducted (total including C-sections)	548	186	190	No	48	13	No	No	47	16
No. C-sections done	52	49	No	No	No	No	No	No	No	No
Blood transfusion services available	Not available	Yes	No	No	No	No	No	No	No	No
No. of referral cases (obstetric cases) received	1	No	No	No	No	No	No	No	1	No
No. of cases (obstetric) referred out to higher facilities	52	17	2	No	16	No	No	2	12	3
No. of indoor patients seen (all patients)	16948	6096	-	No	42927	819	-	2925	2646	1223
No. of outdoor patients seen (all patients)	187742	15306	-	No	4083	9674	3521	28804	29256	6722
Bed occupancy rate	48.15%	70.38%	-	No	88.79%	48%	No	80%	56%	53%
No. of CSBA present	7 (14)			0 (2)	2 (5)	1	0	1 (4)	1 (3)	2
No. of deliveries conducted by CSBAs	136			0	41	34	0	20	28	13
No. of FWC/RD	22			5	9	2	1	1	2	2
No. upgraded FWC	10			3	2	0	1	1	1	2
No. of FWC with FWV/ SACMO	16			5	7	1	1	No	1	1
No. of FWV present	40			10	8	3	4	4	2	5
# of FWV posts	43			11	11	4	4	4	3	6
No. of FWA present	90			-	21	10	9	-	-	-
# of FWA posts	108				25	12	12	-	-	--
No. of community clinic Constricted	55			10	10	4	13	5	9	4
No. of community clinics providing services	29			5	10	3	3	3	3	2
No. of community clinics planned services	26			5	-	1	10	5	6	2
DSF program	No			No	No	No	No	No	No	No

Source: Secondary data compilation sheet (CS/DDFP office)

District: Jessore

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC							
				Sadar	Bagar-para	Avoi-nagar	Moni-rampur	Keshob-pur	Jhikore-gasa	Sharsha	Chou-gasa
No. OG admissions	11567	3207	550	-	48	1074	231	236	1340	334	4547
No. delivery conducted (total including C-sections)	7201	1935	444	-	39	640	131	236	473	199	3104
No. C-sections done	2630	1148	122	-	0	262	60	64	200	7	767
Blood transfusion services available	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No. of referral cases (obstetric cases) received	57	4 **	50	-	0	0	0	0	0	3	0
No. of cases (obstetric) referred out to higher facilities	337	7	89	-	6	44	34	06	21	21	109
No. of indoor patients seen (all patients)	81247	33084	7301	-	3659	6740	4655	5420	3963	4614	11811
No. of outdoor patients seen (all patients)	610612	166206	550	-	50674	63289	18376	61797	66033	63891	119797
Bed occupancy rate	101	138	24	-	92	108	112	86	88	90	172
No. of CSBA present	137*			11	9	16	27	24	23	14	13
No. of deliveries conducted by CSBAs	2880			368	161	615	518	312	573	215	118
No. of FWC/RD	84			14	8	7	16	7	10	11	11
No. upgraded FWC	32			4	4	4	4	4	4	4	4
No. of FWC with FWV/ SACMO	84			14	08	07	16	07	10	11	11
No. of FWV present	95			20	9	11	18	9	9	11	7
# of FWV posts	105			21	9	12	18	10	11	12	12
No. of FWA present	443			84	42	45	82	50	58	46	36
# of FWA posts	486			90	42	48	89	54	62	58	45
No. of community clinic Constricted	241			58	23	24	36	14	24	39	23
No. of community clinics providing services	223			57	23	24	36	14	24	24	23
No. of community clinics planned services	277			58	23	26	43	30	35	39	23
DSF program	Yes			-	-	-	-	-	-	-	Yes

Source: Secondary data compilation sheet (CS/DDFP office)

District: Satkhira

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC						
				Sadar	Kolaroa	Devhata	Tala	Asha-suni	Kali-gang	Sham-nagar
No. OG admissions	2863	880	1015	-	968	-	-	-	-	-
No. delivery conducted (total including C-sections)	4651	663	746	-	453	221	66	18	20	304
No. C-sections done	882	182	269	-	135	83	0	4	1	208
Blood transfusion services available	Yes	Yes	Yes	-	Yes	Yes	No	Yes	Yes	Yes
No. of referral cases (obstetric cases) received	102	56	10	-	5	3	7	4	5	12
No. of cases (obstetric) referred out to higher facilities	116	30	13	-	11	7	15	10	9	21
No. of indoor patients seen (all patients)	40572	13056	1015	-	10465	1986	3655	3077	986	6332
No. of outdoor patients seen (all patients)	1358022	172795	33239	-	58396	63072	46388	61980	42723	54729
Bed occupancy rate	9026	14993	4810	-	49..20	65.48	66.86	82.36	97.91	120.12
No. of CSBA present	65			-	11	2	6	16	15	6
No. of deliveries conducted by CSBAs	11944			899	2256	379	1606	1299	2540	2965
No. of FWC/RD	72			14	12	4	11	10	10	11
No. upgraded FWC	23			4	3	2	4	4	3	3
No. of FWC with FWV/ SACMO	18			7	0	2	5	1	1	2
No. of FWV present	71			19	10	4	14	7	11	6
# of FWV posts	96			20	14	5	15	13	16	13
No. of FWA present	359			68	42	21	62	54	56	56
# of FWA posts	393			71	45	25	65	59	64	64
No. of community clinic Constricted	213			38	21	14	36	33	32	39
No. of community clinics providing services	175			34	17	13	31	24	23	33
No. of community clinics planned services	213			38	21	14	36	33	32	39
DSF program	-			-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Kurigram

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC								
				Sadar	Rajarhat	Ulipur	Chil-mari	Row-mari	Rajib-pur	Ful-bari	Na-geswri	Bhurun gamari
No. OG admissions	7501	1078	697	-	26	615	128	361	9	120	155	23
No. delivery conducted (total including C-sections)	6097	414	639	-	16	429	35	116	6	41	111	20
No. C-sections done	1767	102	66	-	-	13	-	10	-	-	33	-
Blood transfusion services available	1	1	-	-	-	-	-	-	-	-	-	-
No. of referral cases (obstetric cases) received	87	1	85	-	-	-	-	-	1	-	-	-
No. of cases (obstetric) referred out to higher facilities	205	24	18	-	9	75	18	12	-	24	7	7
No. of indoor patients seen (all patients)	-	125	-	-	-	-	-	-	-	-	-	-
No. of outdoor patients seen (all patients)	-	380	-	-	-	-	-	-	-	-	-	-
Bed occupancy rate	-	125.48%	-	-	-	-	-	-	-	-	-	-
No. of CSBA present	-			-	-	-	-	-	-	-	-	-
No. of deliveries conducted by CSBAs	13261			1536	1135	1863	1045	1078	644	1142	3192	1626
No. of FWC/RD	59			7	2	8	2	2	1	5	7	5
No. upgraded FWC	27			4	2	4	2	2	1	4	4	4
No. of FWC with FWV/ SACMO	29			7	2	8	2	-	1	2	4	3
No. of FWV present	59			12	9	15	8	7	8	7	16	11
# of FWV posts	89			10	7	15	3	3	2	5	10	8
No. of FWA present	340			40	33	75	29	34	18	33	71	43
# of FWA posts	376			39	33	69	21	29	13	31	63	42
No. of community clinic Constricted	211			20	24	47	10	22	4	20	40	24
No. of community clinics providing services	163			15	24	47	10	10	4	20	23	10
No. of community clinics planned services	48			5	-	-	-	12	-	-	17	14
DSF program	1			-	-	1	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

Table 4: Some other related information

District: Barguna

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC				
				Sadar	Amtali	Pathargata	Betagi	Bamna
No. of private clinics	3			2	-	1	-	-
No. of private clinics providing Comprehensive EmOC	3			2	-	1	-	-
No. of private clinics providing basic EmOC	3			2	-	1	-	-
women friendly hospital project functioning in GoB/ NGO/ Private facility. Yes/No	-	-	-	-	-	-	-	-
NNP (national nutrition program) Yes/No	-	-	-	-	-	-	-	-
IMCI project activities present. Yes/No	-	-	-	-	-	-	-	-
Other relevant interventions (specify). Brief description	-	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Bandarban

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC						
				Sadar	Lama	Ruma	Thanchi	Alikadam	Naikhong chari	Rowang chari
No. of private clinics	No			No	No	No	No	No	No	No
No. of private clinics providing comprehensive EmOC	No			No	No	No	No	No	No	No
No. of private clinics providing basic EmOC	No			No	No	No	No	No	No	No
women friendly hospital project functioning in GoB/ NGO/ Private facility. Yes/No	No	No	No	No	No	No	No	No	No	No
NNP (national nutrition program) Yes/No	No	No	No	No	No	No	No	No	No	No
IMCI project activities present. Yes/No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes
Other relevant interventions (specify). Brief description	-	EPI, Malaria, TB	Malaria, Leprosy, Arsenic	Malaria TB,	Malaria, Leprosy, Arsenic	Malaria, Leprosy	Arsenic, TB	Leprosy, TB	Leprosy, TB	Malaria TB, Arsenic

Source: Secondary data compilation sheet (CS/DDFP office)

District: Jessore

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC							
				Sadar	Bagar-para	Abhoy-agar	Moni-rampur	Keshob-pur	Jhikor-gasa	Sharsha	Chou-gasa
No. of private clinics	49			23	0	6	2	6	3	6	3
No. of private clinics providing comprehensive EmOC	49			23	0	6	2	6	3	6	3
No. of private clinics providing basic EmOC	49			23	0	6	2	6	3	6	3
women friendly hospital project functioning in GoB/ NGO/ Private facility. Yes/No	-	-	-	-	-	-	-	-	-	-	-
NNP (national nutrition program) Yes/No	Yes	-	-	-	-	-	-	-	-	-	Yes
IMCI project activities present. Yes/No	Yes	-	-	-	-	-	-	-	-	-	Yes
Other relevant interventions (specify). Brief description	-	-	-	-	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Satkhira

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC						
				Sadar	Kolaroa	Devhata	Tala	Asha-suni	Kali-gang	Sham-nagar
No. of private clinics	66			41	-	2	3	4	10	6
No. of private clinics providing Comprehensive EmOC	66			41	-	2	3	4	10	6
No. of private clinics providing basic EmOC	66			41	-	-	3	4	10	6
Women friendly hospital project functioning in GoB/ NGO/ Private facility. Yes/No	4	1	1	2	-	-	-	-	-	-
NNP (national nutrition program) Yes/No	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
IMCI project activities present. Yes/No	yes	yes	-	No	No	No	yes	yes	yes	yes
Other relevant interventions (specify). Brief description	-	-	-	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

District: Kurigram

Indicators	District	Dist. Hospital	MCWC	Name of Upazilas with UHC								
				Sadar	Rajar-hat	Ulipur	Chil-mari	Row-mari	Rajib-pur	Ful-bari	Nage-swri	Bhurun-gamari
No. of private clinics	9			6	-	1	-	-	-	-	1	1
No. of private clinics providing comprehensive EmOC	9			6	-	1	-	-	-	-	1	1
No. of private clinics providing basic EmOC	9			6	-	1	-	-	-	-	1	1
Women friendly hospital project functioning in GoB/ NGO/ Private facility. Yes/No	No	No	No	No	No	No	No	No	No	No	No	No
NNP (national nutrition program) Yes/No	4	-	-	-	-	1	1	1	-	-	1	-
IMCI project activities present. Yes/No	28	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other relevant interventions (specify). Brief description	-	-	-	-	-	-	-	-	-	-	-	-

Source: Secondary data compilation sheet (CS/DDFP office)

Table 5: Staffing Pattern by Service Providers (only within the district)

Staff	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
CLINICAL:										
1. Physicians (total number)	-	-			2	6	-	4	-	-
OB/GY consultants	-	-			1	3	-	3	-	-
MBBS with additional EmOC training	-	-			-	-	-	1	-	1
MBBS with additional anesthetic training	-	-			1	3	-	-	-	-
2. Nurse-midwife (total number)	-	-			13	3	-	3	4	-
Nurse with additional EmOC training	1	-			4	-	-	3	1	1
Nurse with additional midwifery training	2	-			-	-	-	-	3	1
Other nurse	-	-			9	3	2	6	-	-
3. Lab. technicians	-	-			3	1	1	1	-	-
4. Field health worker	4	1			32	-	1	8	2	2
5.Other paramedics (specify)	-	2			-	-	-	-	-	-
NON-CLINICAL (pls specify)	-	-			-	-	-	-	-	-
Manager	1	1			3	3	1	1	1	1
Receptionist + Counter	-	-			10	1	-	-	-	-
Guar	1	1			3	1	1	2	1	-
Driver	1	1			3	1	-	-	-	-
Aya	2	-			17	1	-	5	-	1
Store	-	-			1	1	-	-	-	-
Councilor	1	1			-	-	1	1	1	1

Source: Secondary data compilation sheet (CS/DDFP office)

Table 6: Status of MNH Training among the service providers

Staff	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
CLINICAL:										
1. Physicians										
OB/GY consultants	No	No					No	2		
MBBS with additional EmOC training										
MBBS with additional anesthetic training										
2. Nurse-midwife										
Nurse with additional EmOC training					2	1			1	
Nurse with additional midwifery training										1
Other nurse		1						3		
3. Field health worker									1	
4.Other paramedics (specify)		1								

Source: Secondary data compilation sheet (CS/DDFP office)

Table 7: Issues related to existence of policies for assisting the poor

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Drugs or contraceptives free of charge										
Y/N	No	Yes			Yes	Yes	Yes	Yes	Yes	Yes
Existence of any schemes to reduce/waive fees for poor people										
Y/N	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
If yes, please describe										
50% discount	No	No			Yes	No	No	No	No	No
FP method free	Yes	Yes			No	Yes	Yes	Yes	Yes	Yes
Provide health care service after	No	No			No	No	No	No	No	No
Proper adjustment service through for care	No	No			No	No	No	No	Yes	No
Free service	No	No			Yes	No	No	No	No	No

Source: Secondary data compilation sheet (CS/DDFP office)

Table 8: EmOC, Referral and Quality Management System Related Issues in NGOs

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
	SHC	MS	NA	NA	AH	SHC	MS	SHC	SHC	MS
Have a fully equipped OT										
Y/N	No	No			Yes	Yes	No	Yes	No	No
At the moment, which of the following are performed in your facility										
Parenteral antibiotics	No	No			Yes	Yes	No	Yes	No	No
Parenteral anticonvulsants	No	No			Yes	Yes	No	Yes	No	No
Parenteral Oxytosics	No	No			Yes	Yes	No	Yes	No	No
Manual removal of placenta	No	No			Yes	Yes	No	Yes	No	No
Removal of retained products	No	No			Yes	Yes	No	Yes	No	No
Assisted vaginal delivery	No	No			No	No	No	No	No	No
Blood transfusion	No	No			No	Yes	No	Yes	No	No
Caesarean section	No	No			Yes	Yes	No	Yes	No	No
Places where you refer clients to, for the EmOC services beyond your capacity										
District Hospital					Yes	Yes	Yes	Yes	No	Yes
MCWC					Yes	No	Yes	Yes	No	Yes
Existence of formal agreement with them										
Y/N	No	No			No	No	No	No	No	No
Do women come for your EmOC services through referral, too										
Y/N	No	No			Yes	Yes	No	No	No	Yes
If yes, who refer them to you										
Village doctor	No	No			No	No	No	No	No	Yes
Pharmacy owner	No	No			Yes	Yes	No	No	No	Yes
FWV	No	No			Yes	Yes	No	No	No	Yes
SACMO	No	No			No	No	No	No	No	No
Do you feel your EmOC services are well utilized by rural poor people										
Y/N	No	No			No	Yes	No	Yes	No	Yes
If not, what are the barriers for them										
Costly	No	No			Yes	No	No	No	No	No
Doctor Room	No	No			No	Yes	No	No	No	No
Do you face any problems in provision of EmOC services										
Y/N	No	No			Yes	No	No	No		No
If yes, what are they										
Problem of space	No	No			Yes	No	No	No	No	No
Need more doctor	No	No			Yes	No	No	No	No	No
Needs Equipment	No	No			Yes	No	No	No	No	No
Existence of periodic internal quality assessment										
Y/N	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
If yes, How often (day)	30	15			15	90	30	1	90	180
Checklist and action plan format available (Y/N)	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
Do you receive monitoring visits by GOB officer(s)?										
Y/N	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
If yes, How often do they come										
Monthly	Yes	Yes					Yes	Yes	No	Yes
Quarterly	No	No			Yes	Yes	No	No	Yes	No
b. When was the last such visit by a GOB officer?										
05/2009	No	No			Yes	No	No	No	No	No
10/2009	No	No			No	No	No	No	Yes	No
11/2009	No	Yes			No	Yes	No	Yes	No	Yes
12/2009	Yes	No			No	No	Yes	No	No	No

NA= Data not Available; SHC= Surjer Hashi Clinic; MS= Marie Stopes; AH= Ad-din Hospital
Source: NGO clinic interview

Table 9: Procurement and Maintenance System in NGOs

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Procurement/supply system of medical equipment, medicines, reagent and consumables for your clinic (central or local, national or international procurement)										
Local	Yes	Yes			Yes	Yes	Yes	No	Yes	No
Central	Yes	Yes			Yes	Yes	Yes	Yes	No	Yes
National	No	No			No	No	No	No	Yes	Yes
International	No	No			No	No	Yes	No	No	No
What is your system in procuring maintenance and repairs for equipment and facilities?										
Localy	No	No			Yes	Yes	No	No	Yes	Yes
Central	Yes	Yes			Yes	Yes	Yes	Yes	No	Yes
Manager can spent up to Tk 4000	No	No			No	No	Yes	Yes	No	No
Manager can spent up to Tk 5000	Yes	Yes			No	No	No	No	No	No
Have faced situations in which certain services are not available for more than a week due to										
Stock out of supplies	No	Yes		No	No	No	No	No	No	Yes
Equipment failure	No	No		No	No	No	No	No	No	No
Other reasons	No	Yes		No	No	No	No	No	No	Yes
If yes, how frequently does it happen?		1 Month								1 Month

Source: NGO clinic interview

Table 10: MIS issues in NGOs

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	Batagi	Pathar	Lama	Ruma	Jhikar	Chou	Kalaroa	Debhata	Rajar	Neges
Kind of data do you keep in your MIS										
Soft copy	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Menual	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Whether submit any report to Upazila/District Officer	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes,										
To whom?										
Civil Surgeon	Yes	Yes			Yes	Yes	Yes	Yes	No	Yes
DDFP	Yes	Yes			Yes	Yes	Yes	Yes	No	Yes
DC	Yes	Yes			No	No	Yes	Yes	No	Yes
UFPO	No	Yes			No	No	No	Yes	Yes	
How often?										
Monthly	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
What information?										
Profile of patients	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes
Do you get any feedback from the government?	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes

Source: NGO clinic interview

Table 11: Staff force situation of private clinics

Staff	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
CLINICAL:										
1. Physicians (total number)	4	3	-	-	12	17	2	4	6	11
OB/GY consultants	1	1	-	-	1	3	1	2	2	3
MBBS with additional EmOC training	2	1	-	-	0	0	1	2	2	3
MBBS with additional anesthetic training	1	1	-	-	2	6	-	-	2	3
2. Nurse-midwife (total number)	5	5			24	21	-	-	6	6
2.1. Nurse with additional EmOC training	1	1			5	1	2	2	2	-
2.2. Nurse with additional midwifery training	2	-	-	-	-	1	5	1	2	-
2.3. Other nurse	2	4	-	-	-	7	-	-	2	6
2.4. Lab. technicians	1	1			5	6	4	1	2	1
2.5. Field health worker	-	-	-	-	2	2	2	-	2	-
2.6. Other paramedics (specify)	1	-	-	-	-	-	-	-	2	-
B. NON-CLINICAL (pls specify)									8	
Manager	1	2	-	-	3	4	-	-	1	1
Accountant	2	-	-	-	2	2	-	-	1	-
Aya	4	2	-	-	24	13	6	3	1	1
boy	-	-	-	-	2	10	-	-	1	1
Cleaner	1	-	-	-	-	17	1	1	3	1
gaud	-	2	-	-	6	-	2	1	1	1

Source: Private service providers (Providing EOC)

Table 12: Staff trained on neonatal health in private clinics

Staff	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
CLINICAL:										
1. Physicians (total number)										
OB/GY consultants	1	1	-	-	1	-	-	2	2	3
MBBS with additional EmOC training	2	1	-	-	-	-	-	-	-	-
MBBS with additional anesthetic training	1	1	-	-	-	-	-	-	2	3
2. Nurse-midwife (total number)	-	-	-	-	-	-	-	-	-	-
2.1. Nurse with additional EmOC training	1	1	-	-	-	-	-	-	2	-
2.2. Nurse with additional midwifery training	2	1	-	-	-	-	1	-	2	-
2.3. Other nurse	2	4	-	-	-	-	-	-	-	-
2.4.Lab. technicians	-	-	-	-	-	-	-	-	-	-
2.5. Field health worker	-	-	-	-	-	-	-	-	2	-
2.6. Other paramedics (specify)	-	-	-	-	-	-	-	-	2	-

Source: Private service providers (Providing EOC)

Table 13: Number of those who also work at GoB facilitiesin private clinics

Staff	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
CLINICAL:										
1. Physicians (total number)										
OB/GY consultants	1	1	-	-	1	3	-	-	2	-
MBBS with additional EmOC training	2	1	-	-	-	-	-	-	2	-
MBBS with additional anesthetic training	1	1	-	-	2	6	2	2	2	3
2. Nurse-midwife (total number)										
2.1. Nurse with additional EmOC training	-	-	-	-	-	-	-	-	1	-
2.2. Nurse with additional midwifery training	-	-	-	-	-	-	-	-	-	-
2.3. Other nurse	-	-	-	-	-	-	-	-	-	-
2.4. Lab. technicians	-	-	-	-	-	-	-	-	-	-
2.5. Field health worker	-	-	-	-	-	-	-	-	-	-
2.6.Other paramedics (specify)	-	-	-	-	-	-	-	-	1	-

Source: Private service providers (Providing EOC)

Table 14: Services provided from January to November 2009in private clinics

Items	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
No. of obs/ admission	132	370	-	-	354	311	31	47	170	124
No. of normal delivery conducted	19	72	-	-	23	7	1	10	40	0
No. of Caesarean Section conducted	105	220	-	-	309	101	54	23	126	116
No.of assisted vaginal delivery conducted	8	68	-	-	0	0	0	0	4	0
No. of obs/ complications treated	-	10	-	-	22	203	23	13	4	0
No. of obs/ referred patients received	65	120	-	-	0	0	0	0	50	0
No. of obs/ patients referred out	10	10	-	-	0	0	11	5	4	8

Source: Private service providers (Providing EOC)

Table 15: Any supervision from the government (DGHS, CS office etc.) in private clinics

System	Borguna		Bandarban		Jessore		Satkhira		Kurigram	
	1	2	1	2	1	2	1	2	1	2
Receive any supervision from the government	Yes	Yes	-	-	Yes	Yes	Yes	Yes	Yes	Yes
a. If yes, Who comes to your hospital/clinic for supervision										
CS	Yes	Yes	-	-	Yes	Yes	Yes	Yes	No	Yes
DGHS	No	Yes	-	-	No	No	No	No	No	Yes
Magistrate	No	No	-	-	No	Yes	No	No	No	No
Medical team of CS Office	No	No	-	-	No	No	No	No	Yes	No
Representative of CS	Yes	No	-	-	No	No	No	No	No	No
b. How many supervisions have you received in 2009	2	4	-	-	2	0	3	2	4	1
c. What do they check										
Cleanliness	No	No	-	-	No	No	No	No	No	No
Lab Instrument	No	No	-	-	No	No	No	No	No	No
OT Bed Problem	No	No	-	-	No	No	No	No	No	No
Service quality, quantity	No	No	-	-	No	No	No	No	No	No
Problem skill nurse and doctor	No	No	-	-	No	No	No	No	No	No

Source: Private service providers (Providing EOC)

ANNEX 2:
Data Collection Instruments

DCI-1

Study on Maternal and Neonatal Child Health

Key Informant Interview: Civil Surgeon

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

Japan International Cooperation Agency (JICA)
Bangladesh

Study Conducted by

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Website: www.hdrc-bd.com

December 2009

Issue 1: MNH situation

1. How do you assess the situation of maternal and neonatal health in this district (such as no. of facilities providing basic and comprehensive EmOC services, utilization of services, accessibility for the poor, maternal and neonatal deaths, awareness of community, etc. in the district)

Issue 2: MNH activities

1. How many government hospitals (district hospital, UHCs) do you have in this district? (obtain a list)
2. Which facilities are providing basic and comprehensive EmOC services?
    a. Basic EmOC -
    b. Comprehensive EmOC -
3. How many HAs do you have in your district?
    a. Total sanctioned HA posts
    b. Actual number of HA s
    c. Of which trained as CSBA?
4. Do you think with the way you are providing MNH services the rural poor people have access to MNH services of reasonable quality that they need?
    a. If no, what are the bottlenecks?
5. What is your future plan to improve MNH service in the district, especially for the rural poor?

Issue 3: Source of income of health facilities

1. What is the total health sector budget (revenue + development + others) of your district, for the fiscal year 2009-10: TK
2. How much is allocated for District Hospital, UHCs and community clinics?
3. What are the items (e.g., drugs, logistics, maintenance of equipment etc.) that are covered by this budget?
4. Are there any other sources of income besides 'user fees', such as support from local government, personal donation etc.?
    a. If yes, what are they?
    b. If no, how could new type of income be generated/mobilised?

Issue 4: EmOC services

1. What are the major challenges you face in providing EmOC services?
    a. How could you solve/address them?
2. Do you think the EmOC services are now accessible by the rural poor people?
    a. If no, what are the bottlenecks?
3. How do you think should/can the government do to improve the EmOC services, considering the current human resource constraints?
4. Is there anything you, as the head of the district, are doing, or plan to do to improve the EmOC services in the district?

Issue 5: Local level planning

1. Has the 'Local Level Planning (LLP)' been implemented in this District?
2. Who helped you in the process of developing the local plan?
3. Have you received any feedback or support in response to the local plan created from the Central level?
    a. If yes, what kind of support did you receive for implementation of the plan?
4. Are you facing any problem-in implementing the local plan created (other than lack of resources)?
    a. If yes, what are those?
5. What do you think should be done to improve LLP?

Issue 6: Community Clinics (the number of CCs (planned and actual) to be collected through the data collection sheet)

1. What are the problems for those CCs not fully functioning currently?
2. How many of the existing CCs have a management committee?
3. How do you supervise CCs?
4. What would you suggest to improve performance and utilisation of CCs in future?

Issue 7: Referral system

1. What is the mechanism (referral system) of referring patients in your District? Do you have any formal arrangements for the following:
    a. Public-public?
    b. Public-private?
2. What kind of tools is being used to facilitate effective referral at the moment?
3. Do you receive regular reports on the number and nature of referral cases between the health facilities?

Issue 8: Private/NGO hospitals/clinics

1. How many Private (including NGOs') Hospitals/clinics are there in your District offering MNH services?
    a. How many of them offer comprehensive EmOC services?
2. Do the private hospitals/clinics submit reports (especially related to MNH services) to you regularly?
3. How do you ensure their services are up to the standard?

Issue 9: Quality Management System

1. Is there any system of quality assurance (QA) of services for the government health facilities in the district?
    a. If so, what is the system?
    b. Do you use a tool for assessment, such as a checklist?
    c. Who in your office conduct monitoring visits to (1) UHC and (2) CC, if any?
    d. How often are monitoring visits to UHC and CC made?
    e. How much is your budget for monitoring/supervision for this fiscal year?
2. Do your health facilities receive any regular external monitoring visits for quality assurance (QA) from the central level?
    a. If so, who monitored the QA of the hospitals?
    b. Do they use specific format/checklist?
    c. How frequently are such external monitoring visits are made?
3. Is there EmOC team at the Comprehensive/basic EmOC facilities?
    a. If yes, how often do they meet? Regularly or ad hoc base?
    b. What do they do (besides meeting)?
4. Recently, government issued a circular to establish Hospital Management Committees for District Hospitals and UHCs. Have such Committees been established?
5. If so, how many meetings of these committees took place this year (January-November' 09) in your district?

Issue 10: Procurement, maintenance system, budget, MIS

1. What is the Supply system (Demand based or Push-supply based) of medical equipment, drugs and consumables from the central level?
2. Do you procure drugs or equipment locally?
    a. If yes, what items do you procure locally?
    b. How much (referring to the ceiling for local procurement, if any)?
3. What is the arrangement/mechanism for renovation, maintenance of facilities and equipment?
    a. Do you have budget to procure maintenance and repair services locally?
    b. Do you use NEMEW/DEMEW for repair of equipment?

c. Do you use CMMU for renovation and/or repair of buildings?

Issue 11: MIS

1. What do you do with the health-related information received from the lower levels? (eg, data entry and analysis on computer on monthly basis, etc.)
2. How do you send the information to the higher level (Division and central levels) – paper, email or web-based reporting?
    a. How often do you report?
    b. What kind of problems do you face in making timely reports, if any (eg. internet connection, lack of data entry/compilation personnel, receiving timely information from upazilas or DHs, etc.)?
3. How do you share the information with your staff? What is the feed-back system to lower levels?
4. How do you utilize the data at the district level?

Issue 12: Activity of development partners and NGOs

1. Are there any Development Partner and/or NGO working on MNH in your District?
2. If yes, who are those? Where do they work, what in brief are their activities.
3. Is there any coordination /cooperation /collaboration with your programme (formal or informal)?
4. Do they seek your support in their MNH programme?

Issue 13: Coordination

1. How do you communicate and coordinate with DDFP and FP staffs?
    a. Do you have regular meeting with DDFP?
    b. If not, do you feel a need to establish a link with DDFP's office?
    c. Are there any bottleneck(s) in establishing stronger coordination with them?
    d. How do you communicate and coordinate with NGOs? Do you have regular meetings with NGOs?

Issue 14: Good practices (Only for Jessore District)

1. Is there any other facility in your district providing services (such as, 24-hour EmOC care, high utilization, linked with stakeholders' committee etc.) like Chowgachha UHC?
2. If present, what are those?
3. What are the similarities and dissimilarities of these facilities with Chowgacha?
4. How do the Chowgacha and other UHCs manage to maintain equipment, ambulance and logistics etc.?
5. How do they manage to provide 24-hour care?
6. What quality assurance system is followed for these facilities?
7. How did you successfully mobilize the community to support the Chowgacha UHC?
8. What are keys to success for providing quality services at Chowgacha?

Issue 15: Good practices (all Districts except Jessore)

1. What kind of innovative/good ideas or practices do you have in your district that improves services, if any?

Issue 16: Suggestions for improvement

1. What are your suggestions for improving MNH and EmOC services to the rural poor people?

DCI-2

Study on Maternal and Neonatal Child Health

Key Informant Interview: DDFP

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

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Bangladesh

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December 2009

Issue 1: MNH situation

1. How do you assess the situation of Maternal and Neonatal Health in your District (example no. of facilities providing basic and comprehensive EmOC services, utilization of services, accessibility of service for the poor, maternal and neonatal deaths, awareness of community, etc. in the District)

Issue 2: MNH activities

1. How many facilities (MCWC and FWC) under DGFP are providing the MNH services in the district?
2. How many FWVs and FWAs are there in this district?
    a. The numbers of sanctioned posts (FWVs, FWAs)
    b. Actual numbers (FWVs, FWAs)
3. How many FWAs have been trained as CSBA so far?
4. Do you think the way you are providing MNH services is sufficient to reach the rural poor people?
5. What is your future plan to improve MNH service in the district, especially for the rural poor?

Issue 3: Source of income of FP-MCH facilities

1. What is your total budget (Revenue + Development + others) for the district for the financial year 2009-2010: TK?
2. How much is allocated for MCWCs, FWCs, Community Clinics etc?
3. What are the items (e.g., drugs, logistics, maintenance of equipment etc.) that are covered with this budget?
4. Are there any other sources of income besides 'user fees', such as support from local government, personal donation etc.?
    a. If yes, what are they?
    b. If no, what new type of income could possibly be generated/mobilized, and how?

Issue 4: EmOC services

1. Which of your facilities are providing:
    a. Basic EmOC services?
    b. Comprehensive EmOC services?
2. Is there any problem to continue providing EmOC services from the Centres?
    a) If yes, what are the problems?
    b) How do you solve/address them?
3. Do you think the EmOC services are reaching to the rural poor people?
    a. If no, what are the bottlenecks?
4. What do you think should/can the government do to improve the EmOC services?
5. Is there anything you, as the head of the district, are doing or planning to do to improve EmOC services in this distgrict?

Issue 5: Local level planning/ Decentralization

1. Are you implementing 'Local Level Planning (LLP)' in the District?
2. Who helped you in developing the LLP?
3. Have you received any feedback or support from the Central level in response to the local plan created?
    a. If yes, what kind of support did you receive?
4. Are you facing any problem to implement the LLP?
    a. If yes, what are those?
5. In the previous LLP, what item/budget requested and what item/budget allocated?
6. What can be done to improve LLP?

Issue 6: Community clinics

1. How many community clinics (CC) are there in the District under DGFP
    a. Existing CCs which are already providing full services
    b. Existing CCs which are not providing full services
c. CCs which are to be newly built
3. What are the problems for those CCs not fully functioning currently (the "b" in the question above)? How many of the existing CCs have a management committee?
4. How do you supervise CCs?
5. Could you say something about better utilization of community clinics in future?

Issue 7: Referral system

1. What is the mechanism (referral system) of referring patients including Maternal and Neonatal cases in your District?
    a. Public – public
    b. Public – private
2. Does the staff use any referral slip?
3. Do you receive regular reports on the number and nature of referral cases between the health facilities?

Quality 8: Quality Management System

1. Is there any system of quality assurance (QA) of services for the MCWC and FWC in the District?
    a. If so, what is the system?
    b. Do you use a tool for assessment, such as a checklist?

c. Who in your office conduct monitoring visits to (1) MCWC, (2) MC/FP unit in UHC, UHFWC and community clinics?
    d. How often are monitoring visits made?
    e. Do you have budget for monitoring/supervision?
    f. Are the monitoring findings reported back to you (using certain monitoring format)?

2. Do your health facilities receive any regular external monitoring visits from the central level?
    a. If yes, by who?
    b. Do they use specific format/checklist?
    c. How frequently are such monitoring visits made?

3. Is there an EmOC team at the Comprehensive/basic EmOC facilities?
    a. If yes, how often do they meet?
    b. What do they do (besides meetings)?

Issue 9: Procurement, maintenance system, budget, MIS

1. What is the Supply system (Demand based or Push-supply based) of medical equipment, drugs and consumables from the central level?
2. Is everything centrally procured?
    a. If yes, usually how long does it takes to get supplies, and how long it takes to distribute the same to various service outlets.
    b. If not, what are the items locally procured?
3. What is the arrangement/mechanism for renovation, maintenance of facilities and equipment?

Issue 10: MIS

1. How do you manage (i.e., computerize all the data or not) Health related information that you receive from the facilities and field?
2. How do you share the information with your staff? What is the feed-back system for higher level and below?

Issue 11: Activity of Development Partners and NGOs

1. Are there any Development Partner and/or NGO working on MNH in your District?
2. If yes, what are those? Where do they work, what in brief are their activities?
3. Is there any coordination with your programme (formal or informal)?

Issue 12: Coordination

1. How do you communicate and coordinate with Civil Surgeon and Health Staff? Do you have regular meeting with Health Deptt. Officials. Are there any bottleneck(s) in establishing strong coordination with them?
2. How do you communicate and coordinate with NGOs? Do you have regular meeting with NGOs?
3. Do they seek your support in their service delivery program?

Issue 13: Good Practices

1. What kind of innovative/good ideas or practices have you introduced in your district in order to improve services, if any?

DCI-3

Study on Maternal and Neonatal Child Health

Key Informant Interview: UHFPO

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

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Bangladesh

Study Conducted by

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Website: www.hdrc-bd.com

December 2009

Issue 1: Profile of the UHC
Collect the necessary statistical data as per the Date Collection Sheet"

Issue 2: MNH Activities

1. Does your UHC provide the following services:
   ANC, PNC, FP-temporary methods, FP-permanent methods, emergency contraception, MR, delivery (normal, assisted vaginal delivery, c-section), abstetric first aid, PNC, neonatal care, others (pls specify)
2. If not,
   a. What are the reasons for not providing the particular services?
   b. How do you plan to resolve the situation?

Issue 2: EmOC Services

1. Do the services (basic/comprehensive EmOC) reach the poor people in the community?
2. If no, what are the bottlenecks?
3. What is your future plan for improvement of these EmOC services?

Issue 3ource of Income of Health Facilities

1. What are the sources of income of your UHC?
2. Is there any source of income other than 'user fees'?
3. What new sources can be explored or mobilized?

Issue 4: Local Level Planning

1. Are you implementing 'Local level planning'?
2. If yes, how you are implementing this 'Local level planning'.
3. Are you facing any bottleneck in implementation? If yes, what are those?
4. In the previous LLP, what item/budget requested and what item/budget allocated?
5. What can be done to make it functioning efficiently?
6. If you are not implementing, have you any plan for 'Local level planning'.

Issue 5: Community Clinics

1. How many of the Community Clinics are functioning in your Upazila?
2. Do poor people have access to community clinics for service?
3. What is your plan for better utilization of Community Clinics?

Issue 6: Referral System

1. What is the mechanism of referral system for maternal and neonatal cases?
2. What is the number of Maternal and Neonatal emergency cases referred monthly from your Upazila to higher level hospitals?

Issue 7: Private Hospitals

1. What is the number of private hospitals providing MNH services in your Upazilla?
2. What role do they play in MNH service provision?
3. How do you assess their service standard (high, low, medium), if you have knowledge about it?

Issue 8: Quality Management System

1. Is there any system of quality assurance (QA) of services in your UHC?
   a. If so, what is the system?
   b. Do you use a tool for assessment, such as a checklist?
   c. How often are monitoring visits to UHC and CC made?
   d. How much is your budget for monitoring/supervision for this fiscal year?
2. Do your health facilities receive any regular monitoring visits for quality assurance (QA)?
   a. If so, who comes for supervision?
   b. Do they use specific format/checklist?
   c. How frequently are such monitoring visits are made?
3. Is there EmOC team at your UHC?
   a. If yes, how often do they meet? Regularly or ad hoc base?
   b. What do they do (besides meeting)?
4. Recently, government issued a circular to establish Hospital Management Committees for District Hospitals and UHCs. Have such Committees been established?a.
   - If so, how many meetings of these committees took place this year (January-November' 09) in your district?

Issue 9: Number of Health Workforce

1. What is the present number of Maternal Health and Child Health Workforce by categories in your UHC? [we shall get information from the data sheet. No need to collect from UHFPO]

Issue 10: Procurement, Maintenance System

1. What is the Supply system of medical equipment, drugs, medicine and consumables at the UHC?
2. What is the arrangement renovation and maintenance equipment and facilities?
3. Is the Health MIS in your UHC digital (computerize all data with network facility)
4. If not, what is done at present?

Issue 11: Activity of Development Partners and NGOs

1. Is there any Development Partners and NGOs working on MNH in your upazila?
2. If yes, who are working in which place and in which field and is there any formal/informal working relationship with them for service delivery purpose?

Should have the section of coordination with FP

Issue 12: Good practices (Only for Jessore District)

What are the similarities and dissimilarities of this facility with Chowgacha? **[Note: this question is not for UHFPO, Chowgacha]**

1. How do your UHC manage to maintain equipment, ambulance and logistics etc.?
2. How do you manage to provide 24-hour care?
3. What quality assurance system is followed for your facility?
4. Is there stakeholder committee to support your UHC?
5. If yes, how did you successfully mobilize the community to support the UHC?
6. What are keys to success for providing quality services from your UHC?

Issue 13: Suggestions for improvement

1. What are your suggestions for improving MNH and EmOC services targeting the rural poor people?

DCI-4

Study on Maternal and Neonatal Child Health

Key Informant Interview: UFPO

Basic Information
District: .....Upazila: .....
Name of Person Interviewed ……..……
Designation:……
Name of the interviewer: ……..…… Date of Interview: .....
Time of interview: From …… To…….

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Website: www.hdrc-bd.com

December 2009

Issue 1: MNH Activities

1 Which facilities under your jurisdiction provide MNH services?
2 Do they provide following services?
ANC= 1, PNC= 2, FP-temporary methods=3, FP-permanent methods=4, Emergency contraception=5, TT= 6, MR=7, Delivery Normal= 8, Assisted vaginal delivery= 9, C-section= 10, Neonatal care= 11, Referral to other facilities= 12, Others (Specify)
3 Do you think the system of service delivery is sufficient for delivering MNH care to the rural poor people?
4 If no, what are the bottlenecks?
5 How do you envisage MNH care should be delivered to rural poor people?

Issue 2: Source of Income of FP-MCH Facilities (FWCs)

1 What are the sources of income of MCWCs/FWCs under you?
2 Do they collect user fees?
3 Is there any source of income other than 'user fees'? Please specify.
4 Who decides how these local income is utilized?
5 How do you think new source can be mobilized/generated?

Issue 3: EmOC Services

1 Which facilities under your care are providing CEmOC, BEmOC?
2 Are there facilities that are supposed to be providing CEmOC or BEmOC but are not doing so
a If yes, what are the reasons?
3 Do you think the EmOC services are reaching the rural poor people?
4 If no, what are the bottlenecks?

Issue 4: Local Level Planning

1 Are you implementing 'Local Level Planning' (LLP)?
2 If yes, how are you implementing 'Local level planning'?
a Are you getting any support from government (or someone else) as a response to your plan
i) If yes, what are they?
b Are you facing any bottleneck in implementation of the plan created? If yes, what are those?
c What can be done to make LLP efficiently functioning?
3 If you are not implementing, have you any plan for 'Local level planning'?

Issue 5: Referral System

1 What is the mechanism of referral system from Union FWCs for MNH cases?
2 Where are they normally referred to?
3 Do they use referral tools such as referral slip?
4 What is the number of Maternal and Neonatal cases referred from FWCs to higher level institutions from Jan. to Nov. this year?

Issue 6: Quality Management System

1 What is the Quality Management System in place to ensure the MNH facilities under your care are providing services up to the standard?

Issue 7: Number of Health Workforce

2 What is the number of MNH Workforce by categories in your Upazila.
a The numbers of sanctioned posts (FWVs, FWAs)
b Actual numbers (FWVs, FWAs)
3 How many FWAs have been trained as CSBA so far?
4 In your assessment, are they providing necessary MNH services as expected by the system (given the increased workload due to population growth and addition of community clinics, etc.)

Issue 8: Procurement, Maintenance System

1 What is the Supply system (demand based and/or push supply based) of contraceptives, equipment, drugs and consumables.
2 What is the system for renovation and maintenance of facility and equipment for MNH care?
3 Do you have some fund that you could tap for local procurement of goods and services? If yes, how much?
4 Is the MCH-MIS in your Upazila digital (computerized data collection/network, etc.)?

Issue 9: Suggestions for Improvement

1 What are your suggestions for improving MNH including EmOC services targeting the rural poor people?

DCI-5

Study on Maternal and Neonatal Child Health

Key Informant Interview: NGO MANAGERs/Providers*

*** Choose NGOs active in MNH area, with clinical service provision, preferably with EmOC components**

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the Organization……
Address:
Contact number (phone):
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

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Study Conducted by

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December 2009

Issue 1: Organization							
1	Legal Status: Registered = 1, Un-registered = 2						
2	Operating in this district since (which year_____)						
3	Organizational Mission:						
4	How many clinics do you operate						
1	In this district (location)? # …….. Name of Upazila:						
2	Nation-wide? #.....						
5	**Staffing (**only within the district)						
1	Clinical (pls. indicate if any of them are trained in neonatal child health)						
SL	Category/qualification	Number	those trained in neonatal health	MNH-related training background			Number of those who also work at GoB facilities
				Length of course	contents	Training Institute	
A.	**CLINICAL:**						
1	**Physicians (total number :)**						
1.1	OB/GY consultants						
1.2	MBBS with additional EmOC training						
1.3	MBBS with additional anesthetic training						
2	**Nurse-midwife (total number:**						
2.1	Nurse with additional EmOC training						
2.2	Nurse with additional midwifery training						
2.3	Other nurse						
2.4	Lab. technicians						
2.5	Field health worker						
2.6	Other paramedics (specify)						
B.	**NON-CLINICAL (pls specify)**						
6	The number of beds (also specify the number of beds designated to MNH, if any) in the clinic/hospital .....Number.						
7	Service Hours of clinic/hospital: .....Hours						
Issue 2: MNH Activities							
1	What kind of non-clinical, MNH-related services/activities do you have (eg. health education)? Yes= 1, No= 2						
a	In clinic(s)						
b	In communities						
2	What kind of clinical MNH services do you provide: ANC= 1, PNC= 2, FP-temporary methods=3, FP-permanent methods=4, Emergency contraception=5, TT= 6, MR=7, Delivery Normal= 8, Assisted vaginal delivery= 9, C-section= 10, Neonatal care= 11, Referral to other facilities= 12, Others (Specify) ……						
3	Please provide the number of services provided (service statistics) for the above-mentioned services for Jan-Nov 09						
	Name of Service						Number
1	ANC						
2	PNC						
3	FP-temporary methods						
4	FP-permanent methods						
5	Emergency contraception						
6	TT						
7	MR						
8	Delivery Normal						
9	Assisted vaginal delivery						
10	C-section						
11	Neonatal care						
12	Referral to other facilities						
13	Others (Specify) …….						

4	What is your future plan for improving/expanding the MNH care services?	
Issue 3: Source of Income		
1	Do you receive any assistance from GoB, financial or in kind? Yes= 1, No= 2 If yes,	
a	What do you receive?	
b	How much (worth)?	
2	How much do you charge for the following services?	
	Type of Service	Amount Tk
1	Registration (out-patient, in-patient)	
2	ANC consultation	
3	Tetanus immunization to pregnant women	
4	Delivery (normal)	
5	Delivery (assisted vaginal delivery)	
6	Delivery (c-section)	
7	PNC consultation	
8	In-patient care (overnight stay) per night	
9	Ultrasound	
10	Blood transfusion	
11	Lab tests	
12	Others (Specify) ……..	
3	Are there any drugs or contraceptives you give out for free of charge? Yes= 1, No= 2	
4	Do you have any schemes to reduce/waive fees for poor people? Yes= 1, No= 2 If yes, please describe. …… ……	
5	Is your service provision self-sustainable financially? Yes= 1, No= 2	
a	If not, who is giving you funds/commodities? …… ……	
Issue 4: EmOC Services and referral (only for those that provide EmOC)		
1	Do you have a fully equipped OT? Yes= 1, No= 2	
2	At the moment, which of the following are performed in your facility: Parenteral antibiotics=1, Parenteral anticonvulsants= 2, Parenteral Oxytosics= 3, Manual removal of placenta= 4, Removal of retained products= 5, Assisted vaginal delivery= 6, Blood transfusion= 7, Caesarean section= 8	
3	Where do you refer your clients to, for the EmOC services beyond your capacity?	
a	Name of the facilities:	
b	Do you have any formal agreement with them? Yes= 1, No= 2	
4	Do women come for your EmOC services through referral, too? Yes= 1, No= 2	
a	If yes, who refer them to you?	
5	Do you feel your EmOC services are well utilized by rural poor people? Yes= 1, No= 2	
a	If not, what are the barriers for them?	
6	Do you face any problems in provision of EmOC services? Yes= 1, No= 2	
a	If yes, what are they?	
Issue 5: Quality Management System		
1	Do you have periodic internal quality assessment? Yes= 1, No= 2	
a	If yes	
1	How often ……day.	
2	Checklist and action plan format available? Yes= 1, No= 2	
b	If no, please describe how you ensure the service standard? Yes= 1, No= 2	
2	Do you receive monitoring visits by GOB officer(s)? Yes= 1, No= 2	
a	If yes, how often do they come?	
b	When was the last such visit by a GOB officer? ……..Month, ……..Year.	
Issue 6: Procurement and Maintenance System		
1	What is the Procurement/supply system of medical equipment, medicines, reagent and consumables for your clinic (central or local, national or international procurement)?	
2	What is your system in procuring maintenance and repairs for equipment and facilities?	
3	Have you faced situations in which certain services are not available for more than a week due to? Stock out of supplies= 1, Equipment failure= 2, Other reasons= 3	
a	If yes, how frequently does it happen? ……#	
	Issue 7: MIS	
1	What kind of data do you keep in your MIS (obtain a copy of the form, if possible)?	
2	Do you submit any report to Upazila/District Officer? Yes= 1, No= 2 If yes,	

a	To whom?
b	How often?
c	What information?
3	Do you get any feedback from the government? Yes= 1, No= 2
Issue 8: Governmental MNH service	
1	Are you involved in DSF of the GoB? Yes= 1, No= 2 (if any of the districts/upazila has the DSF scheme)
2	Do you have any systematic cooperation/collaboration in MNH with the GoB, including being a part of a committee/working groups or working with FWV/FWA/HA at the community level?
3	Do you find your current relationship with the government authorities satisfactory? Yes= 1, No= 2
a	Are there any changes you would like to see? Yes= 1, No= 2
4	What is your opinion about MNH services of the GoB in your area?
1	Quality
2	Coverage
3	Affordability
4	Others (Specify) ……..
Issue 9: Community-level activities	
1	Do you have non-MNH activity in the community, which are somehow linked to MNH? Yes= 1, No= 2 If yes:
a	Briefly describe the activities and how they relate to MNH
2	What kind of challenges do you face in community-level activity?
Issue 10: Suggestions for improvement	
1	What are your suggestions for improving MNH and EmOC services in particular for rural poor people in your area?

Thanks

DCI-6

Study on Maternal and Neonatal Child Health

Questionnaire for Interview with Consultant, Obs/Gynae of District Hospital

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

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Bangladesh

Study Conducted by

Human Development Research Centre (HDRC)
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December 2009

Issue 1: Emergency Obstetric Care (EmOC) Services

1. Does this hospital provide Basic EmOC/Comprehensive EmOC service?
   Basic EmOC=1, Comprehensive EmOC=2, No=3

a. If your answer was (BEmOC only), what are the constraints for not providing Comprehensive EmOC services?

---

b. If your answer was 3 (no EmOC), what are the constraints for not providing Basic Comprehensive EmOC services?

---

c. If the answer was 2 (CEmOC), Do you provide 24 hour care?

Yes=1, No=2

d. If No, What are the reasons?

---

2. Is there EOC team at this facility?
   a. If yes, do they meet regularly?

Issue 2: Referral System

1. What kind of MNH cases are referred out to a higher-level hospital?
2. To which hospital(s) do you refer your patients?
3. What kind of MNH cases are being referred in to this hospital?
4. From who/where are patients referred in?
5. Do you have a formal referral mechanism with other government/private/NGO facilities?

Issue 3: HR, facilities and supplies

1. Please provide the number of the following categories of providers your DH has:
   Consultant (ob/gy)____ MO (ob/gy trained)_____
   Consultant (Anesthesiology_____) MO (anesthetics trained)_____
   Nurse (EmOC trained) _____
   Other relevant staff for EmOC _____
2. Is the OT equipped for providing Comprehensive EmOC services and functioning?
   Yes=1, No=2
3. If you have broken equipment that is not repaired for more than a month, please list them below.

Name of equipment	Out of order since

a. Please describe the procedure for getting equipment repaired.

4. Do you have sufficient supply of emergency drugs to manage obstetric emergencies (such as, spinal anesthetics, GA, antibiotics, suture materials, infusions, oxytocin, etc.)?
   Yes=1, No=2

a. If no, how often do you encounter stock-out situation?

5. Is there functioning safe blood transfusion facility at this hospital?
   Yes=1, No=2

Issue 4: Quality Assurance

1. Is there any quality assurance system (periodic assessment with checklist, external assessment, etc.)?
   Yes=1, No=2

a. If yes, hat is the mechanism (self assessment, external assessment, tools used, frequency, etc.)?

---

2. Who provides supportive supervision for quality improvement? .....

   a. Is the mechanism functioning? Yes=1, No=2
   b. If not, what are the bottlenecks?

Issue 6: the way forward

1. Do you feel that more and more rural poor are accessing the MNH services?
2. What are your suggestions for improving provision for and utilization of quality MNH services including EmOC among the rural poor?

Collect Information on following services provided by hospital (average per month)
[if possible also collect cumulative figures for Jan to Nov 09]

a. No. of obs/gynae admission ……
b. No. of normal delivery conducted ph ……
c. No. of deliveries conducted
d. No. of Caesarean Section conducted……
f. No. of assisted vaginal delivery conducted……
g. No. of obs/gynae complications treated……
h No. of obs/gynae referred patients received……
i. No. of obs/gynae patients referred……
j. No. of blood transfusion services
k. No of out-patients and in-patients
l. Bed occupancy rate

Collect other data as per the data collection sheet

DCI-7

Study on Maternal and Neonatal Child Health

Questionnaire for Interview with Medical Officer Trained on EmOC at Upazila Health Complex

Basic Information
District/Upazila……
Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

Japan International Cooperation Agency (JICA)
Bangladesh

Study Conducted by

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December 2009

Issue 1: Emergency Obstetric Care (EmOC) Services

1. Does this UHC provide Basic EmOC/ Comprehensive EmOC service?
   Basic EmOC=1, Comprehensive EmOC=2, No=3
   a. If the answer to the above question was 1) What are the constraints for provision of comprehensive EmOC services?

   ---
   b. (if the answer to the question 1 was 3) What are the constraints for provision of Basic or Comprehensive EmOC services??

   ---
   c. (if the answer to the question 1 was 1 or 2)Do you provide 24 hour EmOC care?
   Yes=1 No=2
   d. If No, What are the reasons?
   ---
2. Is there EOC team at this facility?
   a. Do they meet regularly?

Issue 2: Referral system

1. **W**hat kind of MNH cases are referred out to a higher-level hospital?
2. To which hospital(s) do you refer your patients?
3. What kind of MNH cases are being referred in to this hospital?
4. From who/where are patients referred in?
5. Do you have a formal referral mechanism with other government/private/NGO facilities?

Issue 3: HR, facilities and supplies

1. Please provide the number of the following categories of providers your DH has:
   Consultant (ob/gy)____ MO (ob/gy trained)_____
   Consultant (Anesthesiology_____) MO (anesthetics trained)_____
   Nurse (EmOC trained) _____
   Other relevant staff for EmOC _____

2. Is the OT equipped for providing Comprehensive EmOC services and functioning?
   Yes=1 No=2
3. If you have broken equipment that is not repaired for more than a month, please list them below.

Name of equipment	Out of order since

   b. Please describe the procedure for getting equipment repaired.
4. Do you have sufficient supply of emergency drugs to manage obstetric emergencies (such as, spinal anesthetics, GA, antibiotics, suture materials, infusions, oxytocin, etc.)?
   Yes=1 No=2
   a. If no, how often do you encounter stock-out situation?
5. Do you have any fund to buy drugs, logistics or for maintenance of equipment from any source? If yes, what is the source? How much fund do you get annually? Who is the highest approving authority for this fund?
6. Is there functioning safe blood transfusion facility at this hospital?
   Yes=1 No=2

Issue 4: Quality Assurance

1. Is there any quality assurance system (periodic assessment with checklist, external assessment, etc.)?

   Yes=1 No=2

   a. If yes, What is the mechanism (self assessment, external assessment, tools used, frequency, etc.)?

   ---

2. Who is provides supportive supervision for quality improvement? .....
3. Is the mechanism functioning?

   Yes=1 No=2

   a. If not, what are the bottlenecks?

Issue 5: HR

1. What kind of subsidies/incentives do you receive for serving at this post, if any?
2. What kind of subsidies/incentives do you think are needed to encourage qualified providers (MDs, nurses, medical technicians) to work at upazila level and below?
3. How long was your in-service training on EmOC? In which year were you trained? Do you feel confident enough to deal with obstetric and neonatal emergency situations?
4. Do you feel nurses in MNH services are reasonably well trained in dealing with emergency situations?

Issue 6: the way forward

1. Do you feel that more and more rural poor are accessing the MNH services?
2. What are your suggestions for improving provision and utilization of the MNH services, including EmOC among the rural poor?

Collect Information on following services provided by UHC (average per month)
[if possible also collect cumulative figures for Jan to Nov 09]

a. No. of obs/gynae admission ……
b. No. of normal delivery conducted ph ……
c. No. of deliveries conducted
d. No. of Caesarean Section conducted……
f. No. of assisted vaginal delivery conducted……
g. No. of obs/gynae complications treated……
h No. of obs/gynae referred patients received……
i. No. of obs/gynae patients referred……
j. No. of blood transfusion services
k. No of out-patients and in-patients
l. Bed occupancy rate

Collect other data as per the data collection sheet

DCI-8

Study on Maternal and Neonatal Child Health

Questionnaire for Interview with Medical Officer, Trained on EmOC at Maternal and Child Welfare Centre (MCWC)

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……..

Study conducted for

Japan International Cooperation Agency (JICA)
Bangladesh

Study Conducted by

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December 2009

Issues 1: Emergency Obstetric Care (EmOC) Services

1. Does this centre provide Basic EmOC/Comprehensive EmOC service?

   Basic EmOC = 1 Comprehensive EmOC = 2 No = 3

   a. (if the answer to the above question was 1) What are the constraints for provision of Comprehensive EmOC services?

      ---

   b. (if the answer to the question 1 was 3) What are the constraints for provision of Basic or Comprehensive EmOC services?

      ---

   c. (if the answer to the question 1 was 1 or 2) Do you provide 24 hour care?

      Yes=1 No=2

   d. Is there EOC team at this facility?

Issue 2: Referral system

1. **W**hat kind of MNH cases are referred out to a higher-level hospital?
2. To which hospital(s) do you refer your patients?
3. What kind of MNH cases are being referred in to this hospital?
4. From who/where are patients referred in?
5. Do you have a formal referral mechanism with other government/private/NGO facilities?

Issue 3: HR, facilities and supplies

2. Please provide the number of the following categories of providers your DH has:

   Consultant (ob/gy)____ MO (ob/gy trained)_____
   Consultant (Anesthesiology_____) MO (anesthetics trained)_____
   FWCs (EmOC trained) _____
   Other relevant staff for EmOC _____

3. Is the OT equipped for providing Comprehensive EmOC services?

   Yes=1 No=2

4. If you have broken equipment that is not repaired for more than a month, please list them below.

   a. Please describe the procedure for getting equipment repaired.

5. Do you have sufficient supply of emergency drugs to manage obstetric emergencies (such as, spinal anesthetics, GA, antibiotics, suture materials, infusions, oxytocin, etc.)?

   Yes=1 No=2

   a. If no, how often do you encounter stock-out situation?

   6. Do you have any fund to buy drugs, logistics or for maintenance of equipment from any source? If yes, what is the source? How much fund do you get annually? Who is the highest approving authority for this fund?

7. Is there a functioning safe blood transfusion facility at this hospital? Yes=1 No=2

Issue 4: Quality Assurance

1. Is there any quality assurance system (periodic assessment with checklist, external assessment, etc.)?

   Yes=1 No=2

   a. If yes, what is the mechanism? (Self assessment, external assessment, tools used, frequency, etc.)?

2. Who provides supportive supervision for quality improvement? .....

3. When was the last visit by a supervisor from the central/regional level? How often do you receive such visit?
4. Is the QA mechanism functioning? Yes=1 No=2
   a. If not, what are the bottlenecks?

Issue 5: HR

1. What kind of subsidies/incentives do you receive for serving at this post, if any?
2. What kind of subsidies/incentives do you think are needed to encourage qualified providers (MDs, nurses, medical technicians) to work at upazila level and below?
3. How long was your in-service training on EmOC? In which year were you trained? Do you feel confident enough to deal with obstetric and neonatal emergency situations?
4. Do you feel nurses in MNH services are reasonably well trained in dealing with emergency situations?

Issue 6: the way forward

1. Do you feel that more and more rural poor are accessing the MNH services?
2. What are your suggestions for improving provision and utilization of the MNH services, including EmOC among the rural poor?

Collect Information on following services provided by MCWC (average per month)
[if possible also collect cumulative figures for Jan to Nov 09]

a. No. of obs/gynae admission ……
b. No. of normal delivery conducted ph ……
c. No. of deliveries conducted
d. No. of Caesarean Section conducted……
f. No. of assisted vaginal delivery conducted……
g. No. of obs/gynae complications treated……
h No. of obs/gynae referred patients received……
i. No. of obs/gynae patients referred……
j. No. of blood transfusion services
k. No of out-patients and in-patients
l. Bed occupancy rate

Collect other data as per the data collection sheet

DCI-9

Study on Maternal and Neonatal Child Health

Questionnaire for Interview with Private Service Provider (Providing EOC Service)

Basic Information
District…… Name of Person Interviewed ……..……
Designation: ……
Name, address, tel# of the hospital/clinic:…….
Name of the interviewer: ……..…… Date of Interview: ……..……
Time of interview: From …… To……...

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Bangladesh

Study Conducted by

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Website: www.hdrc-bd.com

December 2009

Issue 1: Facility profile:							
1	Legal Status: Registered = 1, Un-registered = 2						
2	The year in which the hospital/clinic was established .....Year.						
3	Number of beds (pls. specify if any beds are designated for MNH services) #.....						
4	Opening hours						
5	Staff force						
1	Clinical (pls. indicate if any of them are trained in neonatal child health)						
SL	Category/qualification	Number	those trained in neonatal health	MNH-related training background			Number of those who also work at GoB facilities
				Length of course	contents	Training Institute	
A.	**CLINICAL:**						
1	**Physicians (total no. :)**						
1.1	OB/GY consultants						
1.2	MBBS with additional EmOC training						
1.3	MBBS with additional anesthetic training						
2	**Nurse-midwife (total number:**						
2.1	Nurse with additional EmOC training						
2.2	Nurse with additional midwifery training						
2.3	Other nurse						
2.4	Lab. technicians						
2.5	Field health worker						
2.6	Other paramedics (specify)						
B.	**NON-CLINICAL (pls specify)**						

6	**List MNH services being provided and corresponding fees**	
	Name of Service	Fees
1	ANC	
2	PNC	
3	FP-temporary methods	
4	FP-permanent methods	
5	Emergency contraception	
6	MR	
7	Delivery Normal	
8	Assisted vaginal delivery	
9	C-section	
10	Neonatal care	
11	Referral to other facilities	
12	Others (Specify) …….	
7	At the moment, which of the following are performed in your facility: Parenteral antibiotics=1, Parenteral anticonvulsants= 2, Parenteral Oxytosics= 3, Manual removal of placenta= 4, Removal of retained products= 5, Assisted vaginal delivery= 6, Blood transfusion= 7, Caesarean section= 8	

Issue 2: EmOC services:	
1	Are you providing Basic or Comprehensive EmOC services in your clinic? (cross check with 1-6 above) Basic=1 Comprehensive =2 No=3
a	If yes, are the EmOC services available for 24 hours 7days a week? Yes= 1, No= 2
2	Since when are you providing such services? .....Year
3	At the moment, which of the following are performed in your facility: Parenteral antibiotics=1, Parenteral anticonvulsants= 2, Parenteral Oxytosics= 3, Manual removal of placenta= 4, Removal of retained products= 5, Assisted vaginal delivery= 6, Blood transfusion= 7, Caesarean section= 8
4	Does your clinic have lab facility? Yes= 1, No= 2
a	If yes, what investigations are done here?
b	If no, how far away is a lab facility?
Issue 3: Referral of EmOC cases	
1	Do you receive referral cases from public facilities?, Yes= 1, No= 2
a	If yes What are the facilities that refer patients to your clinic?

b	Do you have some formal mechanisms/agreement on referral with them?		
2	Do you refer patients to public facilities? Yes= 1, No= 2 If yes,		
a	To which facility do you usually refer the cases?		
b	Do you have some formal mechanisms/agreement with them? Yes= 1, No= 2		
c	How many obstetric cases have you referred this year?		
Issue 4: Supplies and maintenance			
1	Do you have the following equipment?	Yes= 1,No= 2	
a	Ultrasound scanner	1	2
b	Anesthetic machine for OT	1	2
c	Incubator	1	2
2	Where do you have the machines repaired in case of break down?		
3	Where do you obtain drugs and other supplies?		
Issues 5: Quality Assurance System			
1	Do you have periodic internal quality assessment? Yes= 1, No= 2 If yes		
a	How often		
b	Checklist and action plan format available? Yes= 1, No= 2		
c	If no, please describe how you ensure the service standard		
2	Do you receive any supervision from the government (DGHS, CS office etc.)? Yes= 1, No= 2 If yes,		
a	Who comes to your hospital/clinic for supervision?		
b	How many supervisions have you received in 2009? #		
c	What do they check?		
Issue 6: MIS and reporting			
1	Do you maintain hospital record for ANC, PNC, Obs admission, complications, delivery, C sections etc.? Yes= 1, No= 2		
2	Do you send monthly report to the government? Yes= 1, No= 2 If yes,		
a	To whom?		
b	How often?		
c	What information		
3	**Collect Information on following services provided by private hospital/clinic [Jan - Nov 09]**		
	Services provide	Number	
1	No. of obs/ admission ……		
2	No. of normal delivery conducted ……		
3	No. of Caesarean Section conducted ……		
4	No. of assisted vaginal delivery conducted ……		
5	No. of obs/ complications treated ……		
6	No. of obs/ referred patients received ……		
7	No. of obs/ patients referred out ……		
Issue 7: MNH services of the GoB			
1	Do you receive any assistance from GoB, financially and/or in kind? Yes= 1, No= 2 If yes,		
a	What?		
b	For how much?		
2	Are you involved in DSF of the GoB? Yes= 1, No= 2 (if any of the districts/upazila has the DSF scheme)		
3	Do you have any systematic cooperation/collaboration in MNH with the GoB, including being a part of a committee/working groups or having a systematic referral mechani Yes= 1, No= 2		
4	Do you find your current relationship with the government authorities satisfactory? Are there any changes you would like to see?		
5	What is your opinion about MNH services of the GoB in your area (quality, coverage, affordability, etc.)?		
Issue 8: Income and sustainability			
1	Do you feel the service fees (1-6) are affordable to rural poor people? Yes= 1, No= 2		
2	Do you have any mechanism to make it more affordable for the rural poor (fee waiver/reduction, installment, etc.)		
3	Is your hospital/clinic self-sustainable? Yes= 1, No= 2 If not,		
4	Who gives you financial assistance?		
Issue 9: Suggestions for improvement			
1	What do you suggest to make MNH services, particularly EmOC more accessible to and utilized by the rural poor in your district?		

Study on Maternal and Neonatal Child Health

DCI-10

Secondary Data Collection Format

Sl	Indicators	District	Dist Hosp	MCWC	Name UHC								
					1	2	3	4	5	6	7	8	9
1	**General Information**												
1.1	Population												
1.2	No. of unions												
1.3	Distance from the district HQ in km												
1.4	Communication from dist HQ												
1.5	No. of beds (100/50/31) with available infracture												
1.6	Electricity												
1.7	Water												
2	**Human resources:**												
2.1	No. MO present (no. posts)												
2.2	No. Nurses present (no. of posts)												
2.3	No. Nurses trained in EOC/midwifery												
2.4	Consultant OG: No present (No. of posts)												
2.5	Consultant AN: No present (No. of posts)												
2.6	MO trained in OG												
2.7	MO trained in AN												
2.8	Current EmOC status (BEOC, CEOC or no EOC)												
3	**Service statistics (Jan-Nov 09):**												
3.1	No. OG admissions												
3.2	No. dilivery conducted (total including C-sections)												
3.3	No. C-sections done												
3.4	Blood transfusion services available												
3.5	No. of referral cases (obstetric cases) received												
3.6	No. of cases (obstetric) referred out to higher facilities												
3.7	No. of indoor patients seen (all patients)												
3.8	No. of outdoor patients seen (all patients)												
3.9	What is the bed occupancy rate?												
3.10	No. of CSBA present												
3.11	No. of deliveries conducted by CSBAs												
3.12	No. of FWC/RD												
3.13	No. upgraded FWC												
3.14	No. of FWC with FWV/ SACMO												
3.15	No. of FWV present (no of posts)												
3.16	No. of FWA present (No of posts)												
3.17	No. of community clinic Constricted												

Sl	Indicators	District	Dist Hosp	MCWC	Name UHC								
					1	2	3	4	5	6	7	8	9
3.18	No. of community clinics providing services												
3.19	No. of community clinics planned services												
3.20	Is there DSF program?												
4	**Other information**												
4.1	No. of private clinics												
4.2	No. of private clinics providing Comprehensive EmOC												
4.3	No. of private clinics providing basic EmOC												
4.4	Is women friendly hospital project functioning in GoB/ NGO/ Private facility?												
4.5	Is there NNP (national nutrition program)												
4.6	Is there IMCI project activities present												
4.7	Other relevant interventions (specify)												

ANNEX 3:
LIST OF INTERVIEWEES

List of Interviewees

Name	Designation	Upazila	District
Civil Surgeon			
Dr. A. H. M. Zahirul Islam	Civil Surgeon		Barguna
Dr. Sarfaraj Khan	Civil Surgeon		Bandarban
Dr. Md. Salah Uddin Khan	Civil Surgeon		Jessore
Dr. Md. Ebadullah	Civil Surgeon		Satkhira
Dr Md. Tawfiqul Islam	Civil Surgeon		Kurigram
District Hospitals / Designation			
Dr Akber Hossain	Consultant Obs Gyane		Barguna
Umya Ching Marma	SSN		Bandarban
Dr. Md. Rabiul Islam	Jr. Consultant Obs Gyane		Jessore
Dr. Sankor Proshad	Consultant Obs Gyane		Satkhira
Dr. Mustafizur Rahman	Consultant Obs Gyane		Kurigram
District Family Planning Office			
Syed Alimuzzaman	Deputy Director Family Planning (In Charge)		Barguna
Dr. Ukkhey Win	Deputy Director Family Planning		Bandarban
Dr, Dilip Kumar Brama	Deputy Director Family Planning		Jessore
Mr. G.M. Moktar Hossain	Deputy Director Family Planning		Satkhira
Dr. Md Samsudduha	Deputy Director Family Planning		Kurigram
MCWC			
Zakia Sultana	FWV (In Charge) of MCWC		Barguna
Meli Prue	FWV (In Charge) of MCWC		Bandarban
Dr. Md Rafiqul Islam	Mo-MCHFP (Anesthetics of MCWC)		Jessore
Dr. Lipika Biswas	Mo Clinic		Satkhira
Dr. Marufa Akter Jahan	Mo Clinic, MCWC		Kurigram
UHCs			
Dr. Md Alamgir Hussain	Upazila Health &Family Planning Officer	Betagi	Barguna
Dr. Amal Chowdhury Roy	Upazila Health &Family Planning Officer	Pathargata	Barguna
Dr. Md Firujur Rahaman	Upazila Health &Family Planning Officer	Lama	Bandarban
Dr. Abdul Quaiyum	Upazila Health &Family Planning Officer	Ruma	Bandarban
Dr. Symol Krishna Saha	Upazila Health &Family Planning Officer	Chowgacha	Jessore
Dr. Md. Musarraf Hossain	Upazila Health &Family Planning Officer	Jhikargacha	Jessore
Dr. Md. Abdur Rahman	Upazila Health &Family Planning Officer	Kolaroa	Satkhira
Dr Md Abul Hossain	Upazila Health &Family Planning Officer	Debhata	Satkhira
Dr. M Billah Azad	Upazila Health &Family Planning Officer	Rajarhat	Kurigram
Dr. Upendra Nath Shil	Upazila Health &Family Planning Officer	Nageswary	Kurigram
Name	**Designation**	**Upazila**	**District**
Md Abdur Rab Sikder	Upazila Family Planning Officer In charge	Betagi	Barguna
Dr. Bizli Rani Bala Mitra	Upazila Family Planning Officer In charge	Pathargata	Barguna
Dr Anugtha Loo Mo	Medical officer (MCH-FP), also UFPO In charge	Lama	Bandarban
Dr. Santijoy Tanchanga	Upazila Family Planning Officer	Ruma	Bandarban
Md Shahidul Islam	Upazila Family Planning Officer	Jhikorgacha	Jessore
Md Nazrul Islam	Upazila Family Planning Officer	Chowgacha	Jessore
Suklal Baidya	Upazila Family Planning Officer	Kolaroya	Satkhira
Dr. Ranjit Kumar Roy	Medical officer (MCH-FP), also UFPO In charge	Debhata	Satkhira
Ashutosh Kumar Roy	Upazila Family Planning Officer	Rajarhat	Kurigram
Md Anwar Ali	Upazila Family Planning Officer	Nageswary	Kurigram
NGO			
Name	**Designation**	**Organization**	**District**
Md Ferdous Hossain	Manager	Mare Stops Mini Clinic	Barguna
Md Ataur Rahman	Manager	Surjer Hashi Clinic	Barguna

Farida Akter	Project Director	Surjer Hashi Clinic	Jessore
Shahina Yesmin	Deputy Manager	Addin Hospital	Jessore
Md Shafiqul Islam	Mini Clinic Coordinator	Mare Stops,	Satkhira
Md Shazzad Quadir Rana	Mini Clinic Coordinator	Mare Stops, UMC	Kurigram
Aleya Begum	Paramedic	Smiling Sun Clinic (Razarhat)	Kurigram
Private Hospital / Clinic Managers			
Dr. M.A. Khaleque	MBBS	Doctors Clinic	Barguna
S.M.A. Islam Russel	Director Admin	Daratana Hospital	Jessore
Subrato Biswas	Manager	Ekota Hospital	Jessore
Dr. AKM Nurul Islam	Chairman (AD)	Farzana Clinic	Satkhira
Dr. Md. Habibur Rahman	Chairman (AD)	Anwara Memorial Clinic & Diagnostic Center	Satkhira
Faruk Ahmed	Manager	Khan Clinic	Kurigram
Md. Shamsul Alam	Manager Director	Kurigram Clinic	Kurigram

ANNEX 4:
Members of the Study Team

Members of the Study Team

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Quality Control Officer

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JICA Field Team

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Dukul Barua	Ms Monjuara Khatun
AKM Mustafizur Rahman	

HDRC Field Team

Harunur Rashid	Anamul Hoq
Uttam Kumar Saha	Md Shakhawat Hossain
Ahsan Kabir	

Data Entry Operator

Md. Nurul Islam	Md. Abdul Hamid
Junnun Hasan	Md. Abdur Rahim

付属資料 16：収集資料リスト

１．バングラデシュ政府関係

(1) Action Plan for National Neonatal Health Strategies, Note for participants of the National Consultative Workshop - Discussion Draft for National Consultative Workshop, Jan-2010, MoHFW

(2) Adolescent Reproductive Health Strategy, 2006, MoHFW

(3) Annual Programme Implementation Report 2009, MoHFW

(4) Bangladesh Demographic and Health Survey 2007, 2009, NIPORT

(5) Bangladesh Health Facility Survey (Draft Final Report) 2009, Tulane Univ. SPHTM, AGPR

(6) Bangladesh Health Workforce Strategy 2008, MoHFW

(7) Bangladesh Maternal Health Services and Maternal Mortality Survey 2001, Dec 2003, NIPORT

(8) Bangladesh MDGs Progress Report 2008, Planning Commission

(9) Bangladesh National Strategy for Maternal Health 2001, Oct 2001, MoHFW

(10) Chowgacha Model Program Management Training Module (first draft), 2009, NIPORT

(11) Data of Affiliated Nursing Institute & College with Seat up to Nov. 17 2009, Bangladesh Nursing Council

(12) Demand Side Financing (DSF) maternal health voucher scheme, MoHFW & WHO and other DPs

(13) Draft Concept Paper, Framework of the Next Health Sector Program (July 2011- June 2016), 2010, MoHFW

(14) Enhancing contribution of nurse-midwives for midwifery services to contribute to the attainment of millennium development goals 4 and 5 - proposed strategic directions, Sep 2008, Directorate of Nursing Services & Bangladesh Nursing Council

(15) Guidelines on Patient Referral System (translated from Bengali), DGHS

(16) Health Bulletin 2009, MIS, DGHS, MoHFW

(17) HNPSP - Revised Programme Implementation Plan, 2008, MoHFW

(18) HNPSP Annual Programme Review 2009 - Aide Memoire, May 2009, MoHFW

(19) HNPSP Annual Programme Review 2009 - Main consolidated report, May 2009, Interdependent Review Team

(20) HNPSP Annual Programme Review 2009 - Technical Report, May 2009, Interdependent Review Team

(21) HNPSP Mid Term Review -Volume I Main Consolidated Report, March 2008, Independent Review Team

(22) HNPSP Mid Term Review - Volume II Technical Reports, March 2009, Independent Review Team

(23) HRD Data Sheet 2009, DGHS
(24) Key Findings of the Bangladesh Multiple Indicator Cluster Survey (MICS) 2009 (Preliminary Report), 2010, BBS & UNICEF
(25) Key Indicators on Report of Sample Vital Registration System 2008, Bangladesh Bureau of Statistics (BBS)
(26) List of 132 EmOC designated facilities under DGHS supported by UNICEF, ESD unit, DGHS
(27) List of DSF upazilas, ESD unit, DGHS
(28) List of Equipment for National Medical college Hospitals, 2008, Dhaka Medical College Hospital
(29) Manual for Planning and Budgeting, 2008, MoHFW
(30) Millennium Development Goals Bangladesh Progress at a Glance, 2009, BBS
(31) National Food Policy Plan of Action, Aug-2008, Food Planning and Monitoring Unit, Ministry of Food and Disaster Management
(32) (Final Draft) National Health Policy - An Update, Aug-2008, MoHFW
(33) National Neonatal Health Strategy and Guidelines for Bangladesh, Oct-2009, MoHFW
(34) National Strategic Plan for HIV/AIDS 2004-2010, National AIDS/STD Programme, MoHFW
(35) National Strategy for Accelerated Poverty Reduction II 2009-2011, Planning Commission
(36) Operational Plan (3rd revised), ESD, HNPSP, July 2003 - June 2011, Director, PHC and Line Director, ESD, DGHS
(37) Partnership Arrangements between the Government of Bangladesh and Development Partners concerning Support for the Implementation of the Health, Nutrition and Population Sector Programme (HNPSP)
(38) Report of Rapid Assessment of Demand Side Financing Pilot, Research Paper 35, Oct-2008, Health Economics Unit
(39) Revitalization of Community Health Care Initiatives in Bangladesh - Development Project Proposal, Nov 2009, MoHFW
(40) Social Sector Performance Surveys: Health and Family Planning, 2005, FMRP
(41) Study on HRD in Bangladesh as a Prelude to the HRH Master Plan 2010-2040, 2009, Dr. A.M.Zakir Hussain
(42) Steps Towards Change – National Strategy for Accelerated Poverty Reduction II (Revised) FY 2009-2011, 2009, General Economics Division, Planning Commission
(43) Table of Equipment (for primary level hospitals),2008, DGHS
(44) Table of Equipment/Instrument List for Secondary Level Hospital, DGHS (no date)
(45) Task Forces Reports on Human Resources Development in Health, Nutrition and Population Sector, 2003, MoHFW
(46) The State of Health in Bangladesh 2007: Health Workforce in Bangladesh, Bangladesh Health

Watch
(47) Utilisation of Essential Service Delivery Survey 2008: Provisional Findings, NIPORT

２．開発パートナー・その他関係資料

(48) Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction – Moulvibazar District Update, 2009, MoHFW, DFID, UN, EU
(49) Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction - Progress Report Jan - June 2009, 2009, MoHFW, DFID, UN, EU
(50) Bangladesh Medical Equipment Survey 2008, Simed International for World Bank
(51) Concept paper - Quality improvement for EmOC/Safe Delivery Services, SMPP/JICA
(52) Concept paper of Model Union Approach (draft), SMPP/JICA
(53) DMIS Support to MOHFW – Analysis Phase Report, 2009, EPOS Health Management/GTZ
(54) DMIS Support to MOHFW – Date Warehouse concept and development, GTZ Health Program (ppt), no date
(55) Economic Evaluation of Demand-Side Financing (DSF) Program for Maternal Health in Bangladesh – Draft, 2010, GTZ
(56) Final Report Short-term Expert community mobilization activities evaluation, 2009, C.D.C International
(57) Health Information System Assessment: Bangladesh Country Report 2009, Health Metrics Network
(58) MaMoni - Integrated Safe Motherhood, Newborn Care and Family Planning Project, USAID
(59) Maternal, Neonatal and Child Survival (Rural) - Proposal, BRAC
(60) MNH mapping: A mapping of Maternal and Neonatal Health Interventions in Bangladesh, Feb 2008, UNFPA
(61) MNH project/program information sheets by major development partners, 2009, JICA
(62) Model Union package of intervention and its achievement, SMPP/JICA
(63) Operational Guidelines on Community Support System in Bangladesh, 2008, JICA, CARE, MoHFW
(64) Reality Check Bangladesh, 2008, Sida
(65) Shahjadpur Integrated MNH Project- Newsletter Issue 1& 2, 2009, ICDDR,B
(66) Strategic Plan - Intervention in Char area of Narsingdi, SMPP/JICA
(67) Study on Maternal and Neonatal Child Health 2009 (draft report), HDRC
(68) UN Joint Project Proposal - Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction, 2007, UNFPA, UNICEF, WHO
(69) Workshop Report - Towards equitable health systems through community participation: Experience of community support system and community clinics, 2009, SMPP/JICA