

**COMMUNITY HEALTH CLINIC IN BANGLADESH:  
AN ASSESSMENT OF THE ESSENTIAL SERVICE PACKAGE (ESP) DELIVERY**

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**INTRODUCTION**

Health is a basic human right. One cannot imagine social development or sustained economic growth without health; the development process itself must also aimed at improvement of health and quality of life for all. No organisation or community can function properly when its population is not in good health, regardless of the causes. On the other hand, the need for partnerships between public and private in health has been recognised for many years. The challenge of developing a private sector which supports public policy goals is a major one. The move toward greater involvement with the private sector especially in the form of people's participation requires a sound understanding of which kinds of public-private mix will add value.

Bangladesh has made significant progress in recent times in many of its social development indicators, particularly in rural health services. This country has made significant achievements in providing Primary Health Care (PHC) since the Alma Ata Declaration in 1978. Concept of establishing Community Clinic (CC) is also based on principles of PHC to serve the greatest interest to the largest population. But some of this progress is uneven and there still exists inequalities between different groups and geographical regions.

**Background**

Bangladesh is one of the most densely populated and low income country in the world, has the highest percentage of people living in poverty in rural area. Success of public sector in providing health services to the rural Bangladesh was not up to the expectation of people. During 1996-2001, government planned to establish Community Clinic at the village level to extend PHC at the door step of the rural people all over Bangladesh. It was expected that where the community is involved, the programme would succeed to build a partnership of public sector facilities and providers with the community to address the health needs of the local population efficiently and effectively and to ensure long-term sustainability. It needs to be mentioned that CC is a unique example of Public Private Partnership (PPP) as all the CCs are constructed on community donated land, construction done by the government, medicine and all necessary logistics supplied by the government, service providers are employed by the government but managerial part is done both by the government and the community.

In this context the government planned to establish 18000 CCs and decision were taken to construct 13500 CCs and establishing CCs unit in 4500 existing health facilities at Upazila (Sub-district) and union level. 10723 CCs were constructed during 1998-2001 of which 8000 started functioning but due to change of government in 2001 CCs were closed and remained as such till 2009. Due to long 8 years of non-functioning and remaining uncared, 99 CCs were demolished due to river erosion and some other reasons.

### **Patient Satisfaction: Key to Success**

The Alma Ata declaration emphatically embraces community participation in health care and stresses the links between health and other sectors of society. As far as health care delivery is concerned, the key issues are access and affordability and ensuring its utilization.

The attitude of the health provider and patient satisfaction with treatment play a role in health seeking behaviour. The role of patient satisfaction is a crucial determinant for utilization and success of health care delivery system and its long term viability.

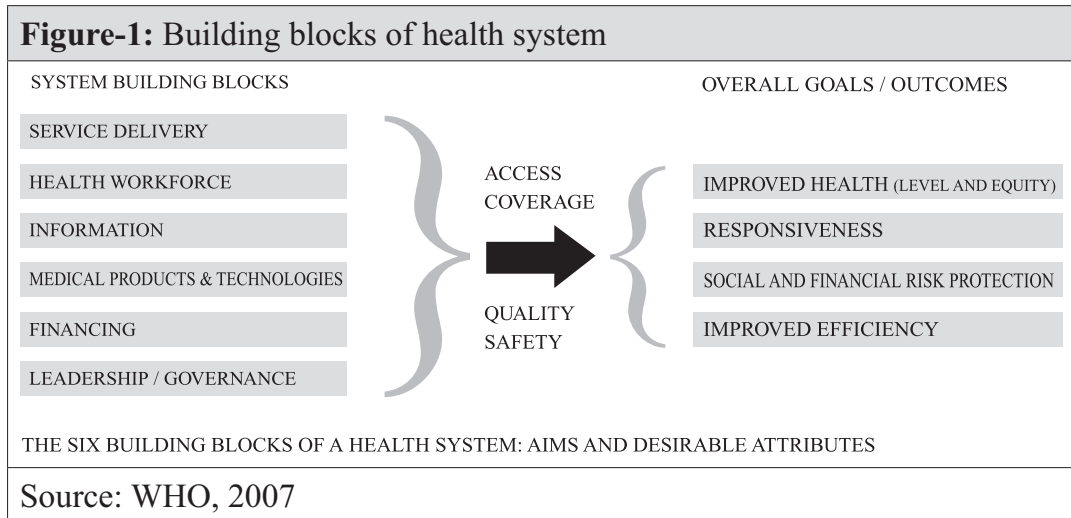
Studies in the developing world have shown a clear link between patient satisfaction and a variety of factor, among which service quality has been prominent (Rao, 2006: 414-421). This link is also important in the health care system of Bangladesh. Not only in the developing countries, the developed world also recognize the importance of patient satisfaction and his good perception on health care delivery services for long term viability and success of health care delivery system. Donabedian (1988) in his study ‘The quality of care: how can it be assessed?’ suggests that patient satisfaction may be considered to be one of the desired outcomes of care.

### **HEALTH SECTOR AND SERVICE DELIVERY**

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.

#### **Building Blocks of Health System**

According to the World Health Organisation (WHO), the health system is composed of six building blocks (Figure-1) that contribute to the strengthening of health systems in different ways to achieve its goals.

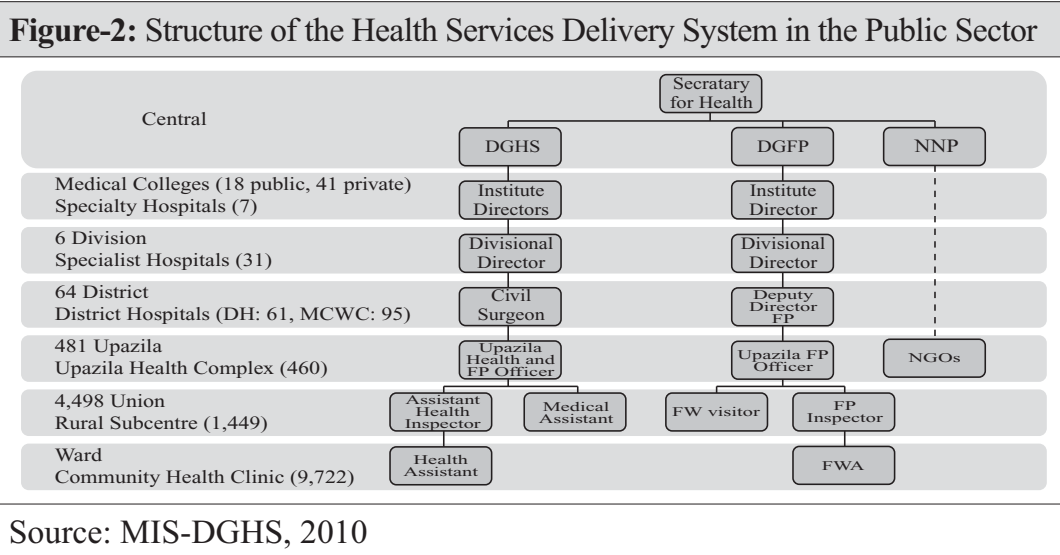


### Health Sector Organisation

In line with the general system of public administration in Bangladesh, the Ministry of Health & Family Welfare (MoHFW) management structure comprises of 2 main groupings, both headed by the Secretary under the leadership of the Minister. The executive agencies include Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP), each led by a Director General (DG) supported by Additional DGs, Line Directors and Hospital or Specialist Agency Directors. Both the directorates have separate management and delivery structures from national to union/ward level. Under the MoHFW there are several executive authorities and regulatory bodies. Revitalization of Community Health Care Initiatives in Bangladesh Community Clinic Project is one of them.

### Health Service Delivery

The MoHFW delivers health services directly through its own facilities under the direction of two separate executing authorities, the Directorates of Health Services and Family Planning. Figure-2 illustrates the public sector health services arrangements by administrative level.



### Health related Millennium Development Goals (MDGs)

The deadline for achieving the MDGs is 2015. Assessment is ongoing throughout the world to find the answer whether or not the countries made sufficient progress. Although much progress has been made, much more has yet to be achieved. The same is also true for Bangladesh. Table 1 shows the current position of Bangladesh in this regard.

<b>Table-1: Health related MDGs</b>	
<b>Goal</b>	<b>Targets</b>
Goal 1: Eradicate extreme poverty and hunger	Reduce by half the proportion of people who suffer from hunger
Goal 4: Reduce child mortality	Reduce by two thirds the mortality rate among under five children
Goal 5: Improve maternal health	Reduce by three quarter the maternal mortality ratio
Goal 6: Combat HIV/AIDS, malaria and other diseases	Halt and reverse the spread of HIV/AIDS, universal access to treatment for HIV/AIDS for all those who need Halt and begin to reverse the incidence of malaria and other major diseases
Goal 7: Ensure environmental sustainability	Reduce by half the percentage of people without sustainable access to safe drinking water and basic sanitation facilities

Source: Compiled from DGHS Health Bulletin, 2011.

## **Health Policy of Bangladesh**

Health care systems are dynamic; changing needs, new policy directions and medical developments may all necessitate health care-reform. As a result, it is quite difficult to place health-care systems into static compartments.

The first health policy of independent Bangladesh was proposed in 1990. During 1996-2001 government approved a policy on April 24, 2000 which includes establishing CC. The following government neither supported the policy nor scraped it. An outcome of the 2000 policy, on 6 March 2012 a 13-page new Health Policy 2011 was placed in National Parliament in line with the achieving MDGs, National Development Strategy and National Poverty Reduction Plan to ensure access to equitable health services to the poor (Rabbani, 2010).

## **Challenges of Health Care Service of Bangladesh**

Challenges of health care includes: the challenge of population growth, poverty, changes in the spectrum of diseases, insufficient budget and poor health knowledge.

In Bangladesh, demand for health care services increases as a result of steady population growth on the one hand and increasing awareness of poverty driven citizens and changing pattern of diseases on the other hand.

## **COMMUNITY CLINIC**

The Community Clinics are the public health care delivery centres at the grass root level to deliver the initial services of ESP. These CCs under the supervision of a unified management are to bring family planning, preventive health services and limited curative services closer to the population and to improve the efficiency of service provision, partly by replacing outreach services provided from a fixed point.

## **Background of Community Clinic**

Before introduction of Health and Population Sector Programme (HPSP) on 1st July 1998, the MoHFW used to have two separate cadres at all levels to provide and manage health and family planning services. But the clients could not obtain health, reproductive health and family planning services from the same service point. The separate service structure was an impediment for delivering the planned ESP because it had integrated health and family planning services. Therefore, the government decided to reorganize services by unifying health and

family planning services at upazila level and below. The establishment of CC – a one stop service delivery centre, is based on the experience of a pilot project at Abhaynagar in Jessore district and Mirersarai in Chittagong district (Sarker, 2001). After change of government in 2001, there was interruption of services of the CCs as the policymakers decided to shift from the concept of CC during 2002 to 2009.

### **Revitalization of Community Clinic: Top-most priority**

With the overwhelming mandate in the National Election held in December 2008, the current government took initiatives for revitalization of the CCs as the topmost priority project in health sector shortly after taking the oath on 6 January 2009. A project titled “Revitalization of Community Health Care Initiatives in Bangladesh” was approved by the Executive Committee of the National Economic Council (ECNEC) on 17 September 2009. Implementation period of the project is from 1st July 2009 to 30th June 2014. For about last two and half years 10,322 CCs are functioning and measures are already taken to strengthen them through increasing manpower and logistics.

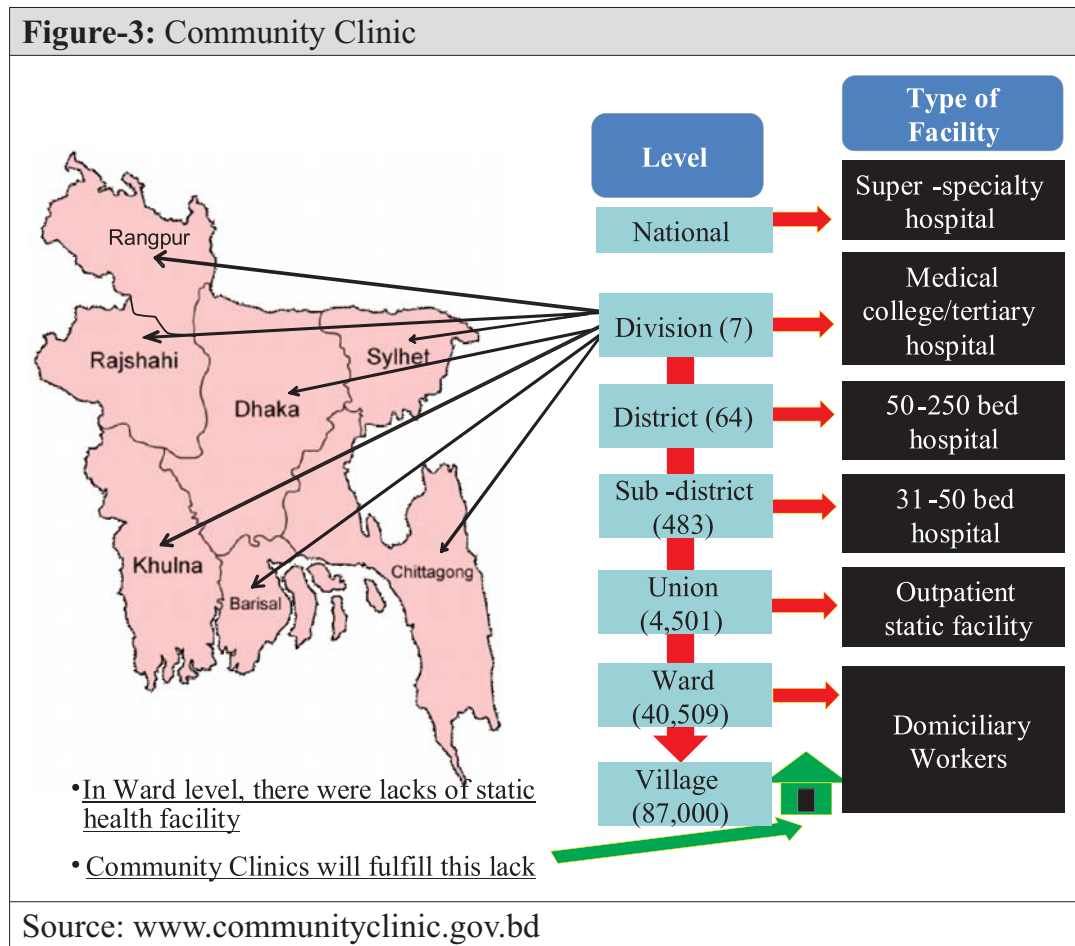
### **Rationale for Establishing CC**

In addition to the success of pilot project, government had the following view for establishing CCs:

- a. The public sector health services were unsuccessful in providing health and family planning care according to expectation of people. It was expected that where community is involved, the programme would succeed (www.Bangla2000.com, 2000).
- b. The CCs would provide ‘one stop’ community-level ESP services in a consistent location designed for easy access at the time of need and thus a much more comprehensive range of services could be provided (Programme Implementation Plan, MoHFW, 1998).
- c. CCs would replace labour intensive and costly health services with cost-effective extensive health and family planning services at one location (Routh *et al*, 1997).
- d. The studies on consumers’ preferences and the experiences of combined EPI outreach and Satellite Clinics had shown that the rural people of Bangladesh prefer one-stop provision of a package of Essential Services to address their basic health needs (Hasan *et al*, 1997).

### Community Clinic: A People Oriented PHC Approach

The decision of establishing CC at village or ward levels is to provide ESP to the rural people, particularly the poor at free of cost, in a consistent location designed for easy access at the time of need (Figure-3).



CCs are to provide services for around 6000 people, and it is envisaged that their location would make them accessible for 80% of the population within less than 30 minutes walking distance. One Health Assistant (HA) and one Family Welfare Assistant (FWA) have been posted in each CC to provide health and family planning services from 9 AM to 4 PM on all working days.

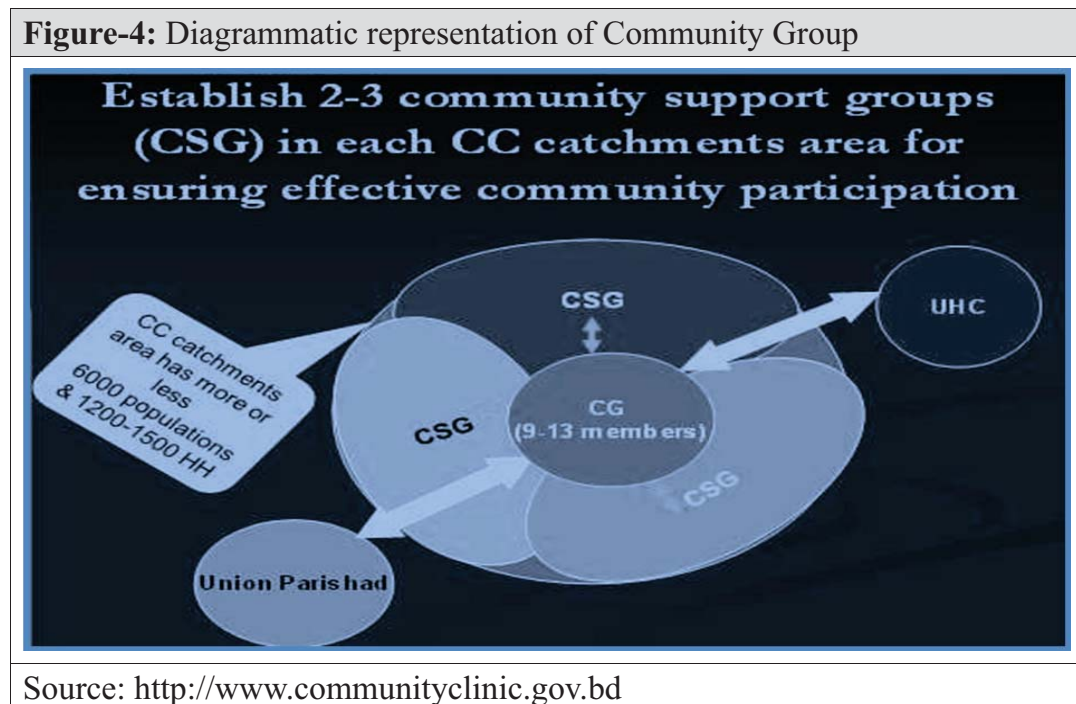
A doctor has been assigned to supervise the activities of each CC. All the necessary medicines are being provided in adequate amount to the CCs; initially, the package consisted of 25 items of drugs. However, depending on the need and reality, the package has been revised and extended to have 29 items. Table-2 shows details of medicine supplied to the CCs after revitalization.

<b>Table-2: Medicine supplied to CCs</b>					
Financial yr	# of items	Amount in Taka	Sent up to	Per CC/yr (Taka)	Remarks
2011-2012	29	103 crore	Upazila	99,000	By Dec'11
2010-2011	28	91 crore	Upazila	85,000	Supplied
2009-2010	25	58 crore	District	72,000	Supplied

Source: <http://www.communityclinic.gov.bd>

### Construction and Management

The design is simple - two rooms with drinking water and lavatory facilities and a covered waiting area. Funds for building the clinics were provided centrally, but communities are to donate land. This is planned to create the sense of ownership in the community. As shown in Figure-4 the CCs are managed by a body of local people, called Community Group (CG)



This is a 9 to 13-member management body, represented by different sectors of population from within the catchments areas of respective clinics. Four of the CG members are female. CG plays a vital role in the management of a CC through mobilizing community involvement, participation and ownership, ensuring the sustainability of the CC activities. The common responsibilities include day-to-day maintenance, cleanliness, security, local fund-generation and transparent use thereof, monitoring, evaluation and local planning for smooth functioning of the CC. Besides the CG, there exist three other support groups in the catchments area of each CC. Each support group comprises 10 to 15 members and works under the leadership of CG members. (DGHS Health Bulletin, 2011: 27).

### **Services provided from CC**

The major services that are provided from CC are as follows:

- a. Maternal and neonatal health care services
- b. Integrated Management of Childhood Illness
- c. Reproductive Health and Family Planning services
- d. Expanded Programme of Immunization, Acute Respiratory Tract Infection, Chronic Diarrhoeal Disease
- e. Registration of newly married couple, pregnant women, birth & death, preservation of Expected Date of Delivery
- f. Nutritional education and micro-nutrient supplements
- g. Health and Family Planning Education & counseling
- h. Identifications of other severe illnesses like TB, Malaria, pneumonia, life threatening influenza, obstetrical engineering and refer to higher facilities
- j. Identification of emerging & reemerging diseases & refer to higher facilities
- k. Other services as identified by GoB to be provided
- l. Treatment of minor ailments
- m. Establishing effective referral linkage with higher facilities

### The Community Clinic and ESP Services

In the reorganized service-delivery plan, the CCs will be the only major service-delivery outlet at the grassroots level to provide basic health and family-planning services (Normand, 2002). Nevertheless, limited home visits by the CC providers will still be continued as a back up to prevent dropout of critical services and to provide services for population with limited access.

MoHFW devised an ESP for phased implementation in Bangladesh. A key component was the development of the new ESP to meet the needs of the poor, especially in rural areas and particularly women and children. The elements of ESP are grouped into the following five areas:

- a. Reproductive healthcare
- b. Child health care
- c. Communicable disease control
- d. Limited curative care
- e. Behavior change communication

### Perceived Quality Care and Utilization of CC

Experiences in Bangladesh and also in China, Nepal and other countries provide growing evidence that the perceived quality of health care service has a strong impact on patterns. The low utilization of health care service to a large extent is due to consumers' perceptions of low quality of care.

Table-3 shows that as the time passes numbers of service seekers are increasing which indicates growing positive perceptions about quality of care in CC.

<b>Table-3: Utilization of CC after revitalization in 2009</b>				
Period	# of service seekers attended	# of service seekers referred	Average # of service seekers	Remarks
Jan'11-Dec'11	3,72,99,744	6,71,395	29	Health & FP Services
Jan'10-Dec'10	2,78,46,053	5,68,503	19	Health & FP Service
April'09-Dec'09	1,11,41,356	1,72,312	12	Health Services
Source: DGHS Health Bulletin, 2011				

## RESULTS

### Selective ESP Delivery

The following selective ESP delivery instruments are being assessed for the study requirement.

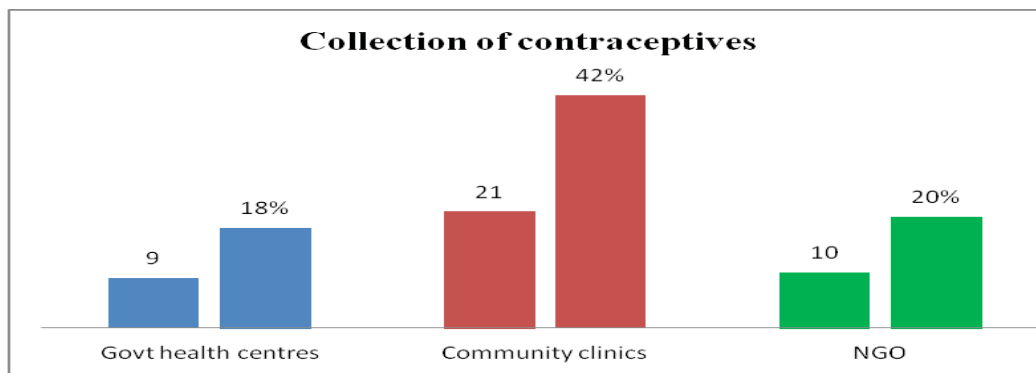
#### a. Utilization of CC for Immunization.

- (i) **Immunization to the children.** Seventy two percent of children were vaccinated from CC and rest were not vaccinated from the CC.
- (ii) **Tetanus immunization to pregnant mother.** Eighty six percent of pregnant mother had their vaccine during pregnancy from the CC.

#### b. Utilization of CC for Contraception.

It has been found that out of total 50 study sample 40 were using various contraceptives. Figure-5 shows collection of contraceptives.

**Figure-5:** Collection of contraceptives



Source: Author

#### c. Utilization of CC for Ante Natal Care (ANC).

Sixty six percent of mothers had the ante-natal care from the CC and the rest 17 did not receive that from CC.

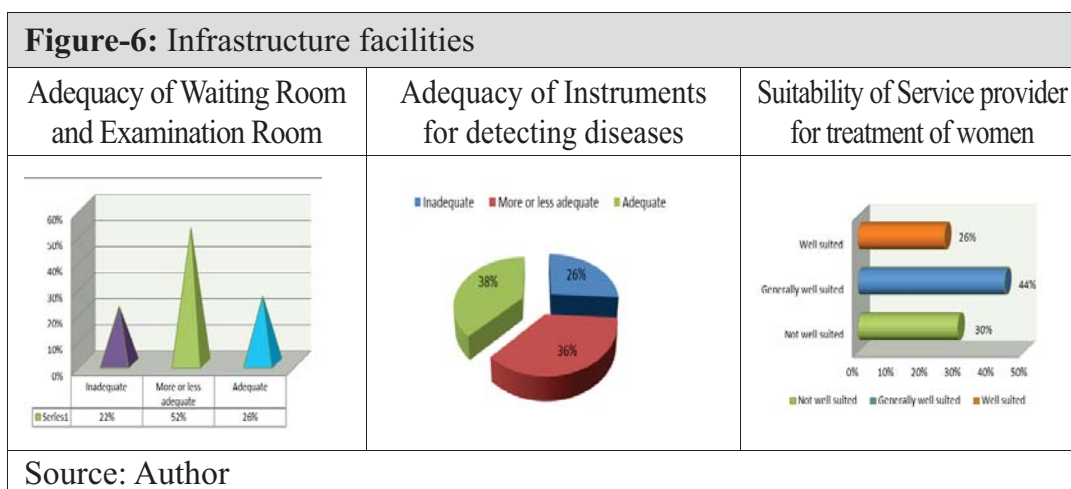
#### d. Utilization of CC for limited Curative Services

- (i) **Treatment of children for minor illness.** It has been observed that 62% of children treated in CC for minor illness and the rest 38% of were treated in other health facilities.
- (ii) **Treatment of family members for minor illness.** It was found from the frequency distribution that 66% of family members had their treatment for minor illness from the CC and the rest from other than CC.

### Support and Outcome

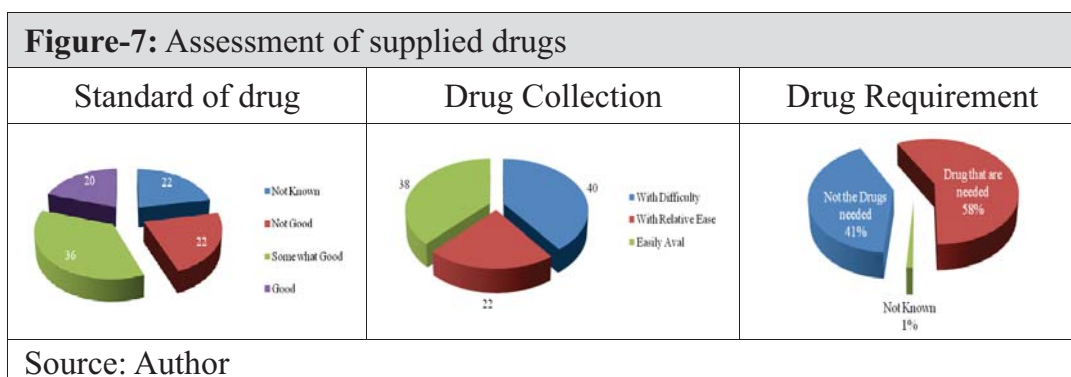
Supports for smooth functioning of the CC are being assessed in the form of infrastructure facilities, assessment of supplied drugs and community participation. On the other hand outcome was assessed on the basis of perceived quality of care provided by CC and satisfaction of clients.

- a. **Infrastructure facilities.** Following infrastructure facilities of CC were assessed and some of them are presented graphically in Figure-6 below.

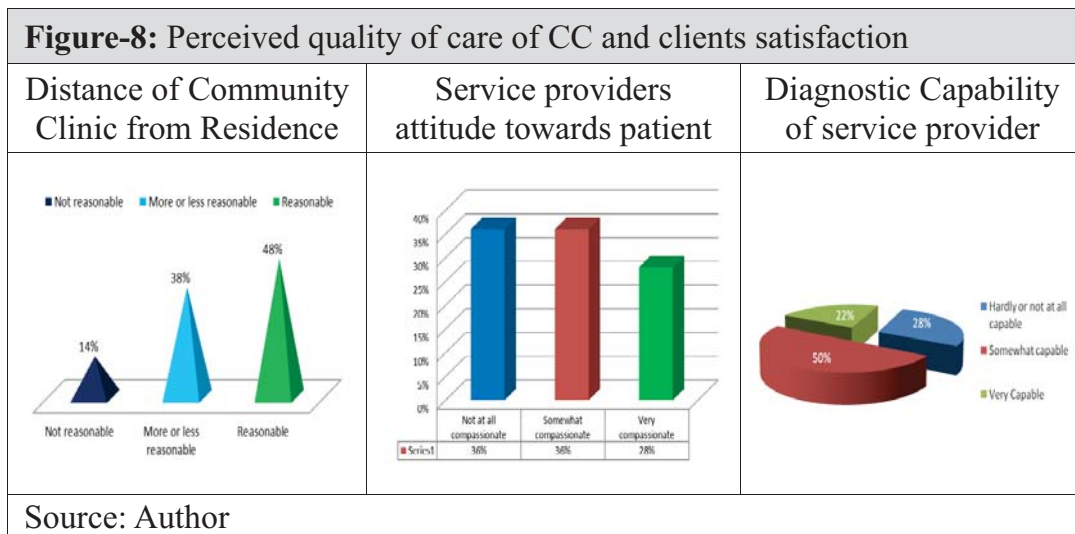


- (i) **Latrine facilities.** Though the CC is having two latrines within the building; but those were found non-functional.
- (ii) **Water and electricity supply.** In the reported CC there was no electricity and water supply. Tube well of the clinic was also not functioning.
- (iii) **Privacy.** Privacy to examine the female patients is available in CC.

- b. **Assessment of supplied Medicine.** Medicine that were supplied to the CC were being assessed by clients perception on Figure-7.



- c. Community participation.** It was observed that monthly meetings of CG were not convened regularly. Promotional activities by CG were also found unremarkable. CC under study was poorly constructed and not well maintained. There was no approach road, fencing and night guard. Standard of cleanliness of reported CC was not up to the mark. There was no citizen charter displayed in front of the clinic. CG has recently decided to collect nominal fees from the patient.
- d. Satisfaction of clients.** Perceived quality of care provided by CC and satisfaction of the clients were determined by using the following parameters: (Figure-8)



### Other Important Issues

Certain issues were unearthed during discussion with the key informants, which can be summarized as:

- a. Existence vulnerability of CC after change of political government.
- b. Role of media to accelerate people’s participation and utilization of services of CC.
- c. Establishment of ‘Community Trust’ will minimize the fund depletion; which will enhance sense of belongingness as well as will minimize vulnerability of discontinuation of CC after political regime change.

## CASE STUDY

Two elderly women were gossiping under the shade of a tree near the Mirergoan Community Clinic. They were holding some medicines in their hands. Researcher was passing by; he stopped at once and tried to listen their conversation, keep in mind the ethical limits. There was nothing personal, rather related to their recent experience of visiting the Community Clinic. Today they had to wait for a long to get the physician's advice and medicine, due to long queue. The long waiting hampered their daily routine of household duties. Nevertheless, they were happy due to compassionate behaviour of their known service provider, who seems to be from their same village. In their younger days they had to go to the nearest pharmacy at Shalna Bazar for their health problems and to get medicines, paying a considerable amount of money. At that time the road condition was not good. Now they are getting medicines at their door-step free of cost.

It came out from their discussion that the medicines that are being supplied from the clinic are very effective. Both of them had visited the clinic due to some health problems in the previous month also. They were narrating that their problems were addressed very efficiently with proper advice and medicine. One of them was bed-ridden, but within a couple of days she could start doing her daily work as usual.

## DISCUSSION

It was found in the previous study in 2002 that CCs were playing a very limited role in the delivery of ESP services for those most in need.

### Selective ESP delivery

ESP delivery is the key instrument of CC to achieve health related MDGs.

- a. **Utilization of CC for Immunization.** Immunization coverage among children was found to be significantly lower in study CC (72%) when compared with the national coverage levels (90%). It is probably due to persistent outrage services, activities of NGOs etc. Rate of immunization coverage in rural Bangladesh are widely depends on: proximity to health facilities, frequency of visit by health worker, respondent's mobility, media exposure, economic status of household, gender and order of child (Bhuiya, 1995: 304-311).

On the other hand it was encouraging that 86% pregnant mother had their TT vaccine from the CC. In Bangladesh Year wise Protection At Birth (PAB) coverage estimate in 2010 was 93% ([http://www.who.int/immunization\\_monitoring/data](http://www.who.int/immunization_monitoring/data)).

- b. Utilization of CC for Contraception.** Those who are using various contraceptives 42% of them have collected their contraceptives from the CC and rest from other facilities.
- c. Ante-Natal Care (ANC).** During 1998–2003, the ANC attendance rate rose from 57% to 70% in rural areas of Bangladesh, while it remained stable 96% in urban areas (Nikiema et al, 2010: 67–75). In a rural set up of CC it was found 66%, which is within range.
- d. Utilization of CC for limited Curative Services.** It was encouraging to notice that 62% children and 66% of family members received treatment from CC for minor illness.

### **Support and Outcome**

- a. Infrastructure facilities.** A mixed response was observed on adequacy of waiting room, examination room and instruments. Similar study on CC (Rahman, 2003) observed 50% of CC functioning in a clean environment. The others did not have either water supply or usable sanitary latrines.
- b. Assessment of supplied Medicine.** Aggregates of parameters used to assess clients perception of supplied medicine was found little frustrating.
- c. Community participation.** Monthly meeting and community financing is one of the important aspect to be addressed by CG. A study conducted by DGHS, (Hossain, 2009: 28) where 72% CG member identified lack of money as a problem. As per the policy directives written in CG Training Guideline, (Nargis, 2012: 35) decision was taken to collect fees from the patients to generate fund. In this study CC lack of promotional activity by CG were noticed.
- d. Satisfaction of clients.** Satisfaction in regards to the distance of CC from residence, diagnostic capability of the service provider, state of patient examination and recovery percentage of treated patients were found satisfactory. But all satisfactions were overshadowed by service provider's attitude towards patients. (36% not at all compassionate, 36% somewhat compassionate and rest 28% very compassionate).

It contradicts with the information gathered by case study. But by using ‘Triangulation methodology’ (Denzin, 1978) through FGD a conclusion was drawn that some attitude and behavioural problems are there among the service providers.

The CC under study is one of the CC which remained uncared and non-functional for long 8 years. After revitalization it’s performance to be praised worthy in rendering service to the marginalized people. ESP components those are more or less successfully delivered by the CC under study are enumerated in Table-4 below:

<b>Table 4:</b> Implementation status of ESP component in CC under study	
ESP Components	Status
Reproductive Health Care	Family Planning services i.e. distribution of temporary methods, TT vaccination
Child Health Care	EPI vaccination, distribution of ORS packets & Vitamin-A, Treatment of ARI, Common Cold, Fever etc.
Communicable Disease Control	No substantial contribution
Limited Curative Care	General trauma, Fever, Common Cold, Diarrhoea, Dysentery, PUD, Headache, Backache, General Weakness, Hookworm etc.
Behaviour Change Communication	Counselling on safe drinking water, sanitation, use of sanitary latrine, personal hygiene, ORS preparation and use, importance of vaccination etc.
Source: Author	

Service-support-outcome is interlinked. It is expected that more the support provided to a provision more outcomes can be achieved. On the other hand, difference of opinion in terms of perception may exist. But the smooth functioning and key to achieve the desired outcome from a CC is by enlarge depends on unified support from government as well as the community it belongs to.

## RECOMMENDATIONS

‘Do the right thing’ is what people need from the government support systems, but people also to be made responsible for their actions. CC is the flagship programme of the present government. Undoubtedly, it is a pro-people health initiative. If quality health services can be ensured near door-steps even

at the remotest corner of the country, people will spontaneously seek necessary service from the well trained care providers of the health facilities instead of the untrained traditional healers. It is expected that CCs will ensure provision of quality healthcare for the mass population of rural Bangladesh, particularly for the poor, vulnerable and the underprivileged and will contribute to the achievement of the health related MDGs within 2015. Following recommendations are proffered on the basis of the study findings:

### **General**

- A written assurance to be issued to the trained service providers at present working in CC to mitigate their fear of joblessness after termination of project.
- Health and Family planning sector are united at its two extreme. Administrative and functional unification at all stairs of health and family planning sector may extract more benefit in provision of service.
- Education, awareness and motivational strategies through media campaign are essentially needed for proper functioning and utilization of CC. Television and radio programme (including community radio), newspaper advertisement, poster, banner, billboard etc can be used. Local awareness programme through role play, drama, campaign etc may also be taken into consideration.
- Flexibility to be given to the land donor so that CC can be named as per his/her desire. If he/she is interested to give it in the name of his deceased father, mother or other relatives it should be encouraged. Because it will enhance emotional attachment of that donor to the clinic.

### **Community Group (CG)**

- CG should participate actively on promotional activities, which will definitely have a stronger impact on the rural population they belong to.
- To facilitate presence of maximum CG members, CG meeting can be arranged anytime of the day, not necessarily in the morning.
- To promote the utilization of CC, areas from where responses of people to visit the CC are less, representative from those areas can be co-opted in the CG.

- School children could be informed about services provided at the clinic by the CG. This would help the children influence their parents to receive services from the CC.

### **Training and Monitoring**

- Skill, knowledge and behavioural aspect of the health personnel should be improved through continued training programme.
- Regular monitoring especially on opening hour of CC and impact assessment of the CC to be carried out.
- As part of the community based training, medical students can be sent to the CC for On Job Training (OJT).
- There should be extensive operational research work through expert research team to see the utilization and progress of services and to find out the loop holes.

### **Capacity Building**

- Adequate supply of drugs and the availability of health personnel to be ensured.
- The services of CC was found more commonly utilized by the people with low socio-economic status and poor level of education, so the programme and approaches should be designed in a form which is more acceptable to them.
- Where electricity is not available, solar panels may be an alternative source. Water and lavatory facilities to be ensured.
- There should be good waste disposal system in CC.

### **CONCLUSION**

Community Clinic is a changing pattern of health care system, from a system where the public sector has predominated to a system where the people's participation is becoming increasingly important, poses new challenges to health services in Bangladesh. The government should be proactive in dealing with the issues ensuring involvement of all the stakeholders that might adversely affect the health benefits of the underprivileged segments of the populations. Functional CCs with adequate staff, supplies and logistics is required to be rapidly

institutionalized to improve the delivery of ESP, particularly for vulnerable women, children and marginalized population.

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22. [http://www.who.int/immunization\\_monitoring/data](http://www.who.int/immunization_monitoring/data)

**Interview/Discussion**

23. Professor Dr Sayeed Modassar Ali, Adviser to the Honourable Prime Minister for Health & Family Welfare, at Prime Minister's Office, 05 July 2012.
24. Professor Dr Khondhakar Md Shafayetullah, Director General of Health Services, at Directorate General of Health Services Office, Mohakhali, Dhaka-1212, 07 June 2012.
25. Dr. Makhduma Nargis, Additional Secretary & Project Director, Revitalization of Community Health Care Initiatives in Bangladesh, at BMRC Bhaban, Mohakhali, Dhaka-1212, 07 June 2012.

**Focus Group Discussions (FGD)**

26. FGD-1 with Community Group (Management Body of Community Clinic), at Mirergoan Community Clinic, 06 June 2012.
27. FGD-2 with Mother of Children < 2 years of age, at Mirergoan Community Clinic, 06 June 2012.

**Visit :**

28. Nandiora Community Clinic, Rajnagar Union, Moulovibazar, 21 March 2012.
29. Mirergoan Community Clinic, Kawaltia Union, Gazipur , 06 & 21 June 2012.

**Author**

*Brigadier General A K M Mustafa Kamal Pasha, ndc, MPH was born in Kishoreganj district on 22nd October 1963. After obtaining MBBS degree from Mymensingh Medical College he was commissioned in Bangladesh Army in February 1989 (Ante-date seniority February 1986). Later he has completed his Masters in Public Health in Epidemiology from National Institute of Preventive & Social Medicine in 2004.*

*During his service carrier he has served as MO, RMO, SMO & various Command & staff appointments in different medical units, Infantry Battalion, Inter-Services unit, Divisional & Army Headquarters and in Bangladesh Air Force. He was also deputed to Kuwait Armed Forces as Medical Officer of an Infantry Battalion. Before being detailed for the course NDC-2012 Brig Gen Pasha has been serving as Deputy Director General of Medical Services. He has attended many courses, seminars and workshop at home and abroad including 'Law of Armed Conflict (LOAC)' course in 2011 and workshop on 'Military Medical Ethical Dilemmas' in 2012 in Switzerland. He has visited many countries across the globe.*

*He is happily married and proud father of a daughter. His lady Yasmeen Khan obtained Masters in Social Welfare from Dhaka University who is an ex-teacher of Scholastica a leading English Medium School in Dhaka.*