NATIONAL
THEMATIC FORUM
COMMUNITY CLINIC

Position Paper

Improving Service at Community Clinics

Introduction

This position paper is based on the experience of 'National Thematic Forum (NTF)' members who are working to strengthen civil society and government accountability mechanisms in Bangladesh. The National Thematic Forum is an apex body and a theme-based platform for civil society and grass-roots/local organisations. It provides an opportunity for civil society representatives, government actors, and other stakeholders to engage in discussion and formulate recommendations exclusively dedicated to citizens' priorities in Bangladesh. Platforms for Dialogue (P4D) is providing capacity building support to the forum.

This position paper asserts the NTF's position on improving community clinic services in Bangladesh. In this context, this position paper seeks to outline the nature of the problem that persists, provide some practical solutions to the problem, and state recommendations for different stakeholders on how they can contribute to improving services at community clinics in Bangladesh. This position paper is prepared based on data collected from both primary and secondary sources.

Health is now universally regarded as an important indicator of human development. Bangladesh is a signatory of the 1978 'Alma-Ata Declaration' and made a pledge to ensure 'Health for All' (HFA) in 2000 by providing Primary Health Care (PHC). However, by 1996, the results of relevant established indicators suggested that Bangladesh would not be able to fulfil such a pledge. One major cause was the unsatisfactory PHC for rural communities in Bangladesh, which accounted for the majority of the national population. PHC was found to be unavailable and inaccessible to people residing in rural areas, and there was a lack of community participation.

To address the issue and in order to easily provide accessible primary health services to local people living in rural areas, the then Government of Bangladesh in 1996 planned to establish Community Clinics (CC) (one CC for roughly every 6,000 people). In each CC, there was meant to be one Health Assistant (HA) and one Family Welfare Assistant (FWA) to provide health and family planning services on all working days from 9 am to 4 pm.

The government also sought to involve communities in the management and operation of the CCs by forming Community Groups (CGs) that could supposedly represent those living in the catchment areas of the CCs. Community Support Groups (CSG) were later added to further promote community engagement (Normand et al., n.d.). Health services provided at the CCs have unfortunately, not been as successful as many expected, and there are concerns over the quality of services provided at these community clinics.

During Covid-19, the healthcare system in Bangladesh has been struggling under immense pressure. Insufficient medical professionals and equipment, inexperience dealing with a pandemic, and above all, incompetence of public health management led to severe shortcomings. It is evident that the health service provided by community clinics has further deteriorated during the pandemic.

There has been a large gap between the demand and supply of tools and medical kits in clinics, and a large number of clinics have been shut down during the Covid-19 pandemic. It was also brought to light that due to lack of experience, the service providers prescribed more medicine to patients than required. It is also evident that the number of patients has almost doubled during the pandemic. Since the health providers were not prepared, they provided health services to patients in a haphazard manner.

Furthermore, the community clinics were not provided with adequate health protocols or sufficient budget to run the clinic efficiently. Thus, people in rural areas tend to go to larger towns to seek treatment since they cannot rely on the health services provided by their local clinics.

Besides the lack of medical supplies and medication, the physical infrastructure of community clinics is not up to the required standards to deal with a pandemic. The buildings are not well furnished, washroom facilities are substandard and without sanitizer, and there is no PPE or handwashing equipment.

Therefore, many people affected by the coronavirus tend to receive medicine from local doctors without requesting health services from community clinics. As people know there is a lack of necessary remedies for Covid patients at CCs, they actually lose their trust in community clinics, and they prefer seeking health services from Upazila or Zila hospitals.

Problems Related to Community Clinic:

Poor time management and insufficient/ intermittent medicine supply:
CCs are stipulated to remain open during regular working hours for six days a week. In reality however, many CCs remain closed, providing little to no service. While some clinics have available services, the quality of those services is well below the standard level. One acute problem is that the CCs do not have enough medical supplies and, as a result, the 30 types of medication that CCs should provide are simply unavailable (Normand et al, n.d.). Whilst some clinics have them available during working hours, others do not due to limited or intermittent supplies. More resources should be allocated to the clinics to purchase the needed medicine and equipment.

Poor quality of construction and inadequate facilities:
In contrast to Ministry guidelines, many community clinics are not easily accessible as they are located in low-lying areas without any proper roads. Many of them do not have electricity, safe water, proper toilet facilities, or other essentials. Most of them are also unsanitary and unsafe for patients. The operation and management of these clinics are poor since the responsible management committees have become defunct and there is a lack of state support and sponsorship (Sarker et al, 2000).

Inadequate capacity of Community Groups:
In most cases, Community Groups (CGs) were successfully established, but few of them are working properly. Members of the CGs opined that the clinics' service quality depended mainly on staff skills, staff availability, and medicine availability. They felt that they had little control over these factors and that, instead, the officials at the Union and Upazila levels were responsible. However, the poor cleanliness and maintenance of buildings were undoubtedly signs of weak CG leadership. Inadequate capacity-building initiatives for the CG and CSG cause inefficient CC management. Lack of proper training and accountability of CG group committee and support committee members. CGs also tend not to hold regular meetings, although government guidelines require them to meet monthly. CGs also fail to monitor the operation of the clinics, and some members of the CGs are not educated, thus lack the knowledge needed to run functional CGs and CSGs.

Poor monitoring, accountability, and supervision: Another study (NIPORT, 2011) finds that CC service utilisation remained low and that the routinely reported figures may have overstated the level of use. It also finds that, although CCs provided immunisation services, the quality of child and maternal health care was particularly low. There are poor mechanisms to monitor the operations and management of the CCs and, as a result, service providers are not held accountable. CHCPs were considered to be avoiding their duties and responsibilities; at times, CHCPs use their influence to evade problems. Poor monitoring and lack of coordination between the health department and family planning department create inconsistencies and planning shortcomings.

Apart from the above, other major problems include:

• There is no display of the Citizen's Charter at the CCs, so people do not know what CC services they are entitled to.
• As CC is a participatory initiative, CG has the authority to mobilise funds for CC from the local community in an agreed manner following the CC operational guideline. Most of the CCs are poor in 'fund mobilisation', however, and even though most of the CCs have their own Bank Account, they are empty. This clearly indicates that CC 'fund mobilization' is a major concern. Most of the CCs do not have any funds, though there is a provision to fundraise from the local community.
• There is also a shortage of basic medical equipment (e.g., BP, blood sugar measuring machine).
• Some Community Health Care Providers (CHCPs) do not provide medicine to patients, especially those who are poor and underprivileged.
• Some CC staff do not respect poor patients or treat them well.
• People in influential positions have been known to demand medicine from CCs that they do not necessarily require, but the clinics do not stop such practices.
• Water and sanitation crisis in community clinics causes premises to become unhygienic.
• Attendance of monitoring officers in CG and CSG committee meeting is low.
• There is no public hearing regarding community clinics at the grassroots level.
• As per the government guidelines, the service providers (HA/FWA) are to provide listed health and family planning services. These services are not rendered in some CCs.
• CGs also fail to monitor the operation of the clinics, and some members of the CGs are not educated, thus lack the knowledge needed to run functional CGs and CSGs.
• As per the government guidelines, the service providers (HA/FWA) are to provide listed health and family planning services. These services are not rendered in some CCs.

Consequences for the People and the Community

Due to the identified shortcomings, it is clear that people do not receive proper health services from CCs. Health services especially for mothers and children are inconsistent and patients do not have access to medicine when they need it. People have to go to distant, public and private hospitals for treatment, which results in wasted time and increased health risks. People are losing their trust in community health services and the Government is at risk to achieve its mandate for improving health services. CBHC faces challenges to improve the overall health status of rural communities by providing health care, family planning, and nutrition services with special attention given to the poor, marginalized people, and vulnerable groups.

National Level Initiatives to Improve Community Clinics

Community Clinics are one the Government of Bangladesh's flagship programs. It has contributed substantially to achieving Millennium Development Goal (MDG) four and five and will contribute more in reaching Sustainable Development Goal (SDGs) three. In 2009, the Government announced the Revitalisation of Community Health Care Initiatives in Bangladesh (RCHCIB) and revived the CC programme. The new programme aimed to establish and strengthen 18,000 community clinics throughout Bangladesh. Also, the Union Health and Family Welfare Centres (UHFWCs) and Upazila Health Complexes (UHCs) now serve to provide support to CC referrals in their respective Unions and Upazilas. From the beginning of Revitalisation of Community Health Care Initiatives in Bangladesh (RCHCIB), mainstreaming of the project had been thought of and implemented through the existing health system from the national to the sub-district level.

For this, an operational plan titled "Community Based Health Care" (CBHC), housed at Directorate General of Health Services (DGHS) under the 3rd sector program (HPNSDP) has been implemented since July 2011 in tandem with RCHCIB.

During the first three years, staff mostly received different types of local and overseas training, and in the fourth year, clinicians were provided with local training. Pay and allowances transferred from RCHCIB to CBHC as well during this time.

After the end of RCHCIB, all the Community Clinic activities have been conducted by CBHC. At the same time, abandoned Community Clinics have been repaired, and medicine, equipment, and all necessary medical supplies have been gradually provided. The number of functional clinics is increasing, and now, people are coming forward to support CCs with its activities. The main objective of CBHC is to improve the overall health status of rural communities by providing health care, family planning, and nutrition services with special attention given to the poor, marginalised people, and vulnerable groups. Establishing a functional link between public facilities at the union and upazila levels through community participation is key to improving services under CBHC.

Moreover, the community clinic represents the government's baseline healthcare infrastructure which now runs through public-private sector financing under the 'Community Clinic Health Support Trust Act 2018'. Meanwhile, the government also plans to build a 'Trust Fund' so that the programme may run smoothly in the long term. The health sector has developed at an increasing rate compared to past years, and the government has prioritised CBHC programmes in order to reach people at the local level. Section 10 of the 'Community Clinic Health Support Trust Act 2018' specifically mentions the inclusion of rural people to ensure functionality at the local level.

Local-Level Initiatives for Improving Community Clinics

A number of NGOs are Community Clinic partners. Most of them are supporting through community engagement which is paramount to increasing awareness of clinic services and citizens' rights. Recently, with the National Thematic Forums (NTF), P4D is engaging government officials, local leaders, and civil society actors to better coordinate and manage big policy issues with input from NTF members.

These members, who come from partner CSOs, Multi-Actor Partnerships (MAPs), and District Policy Forums (DPFs) bring local-level knowledge and experience to national policy making. This will not only ensure that first-hand knowledge is considered in these policy discussions, but it is also creating a bridge between earlier local-level interventions and the national dialogue on these issues. The NTFs have two groups each: a Core Group which constitutes the executive group members and a General Group which is made up of other participants from DPF districts.

NTF members at the district level are working closely with authorities to improve the service conditions of Community Clinics. NTF members have created space for the citizens to raise their voices in front of proper authorities, and as a result, some positive initiatives have been taken at the local level. For examples include:

• In Bagerhat, after raising concerns at the public hearing, the Deputy Director of Local Government issued a letter to 75 Union Parishads to allocate 20% of their health budget to regularly arrange Community Group (CG) and Community Support Group (CSG) meetings at Community Clinics. Now communities are more supportive, and recently in Bagerhat Sadar Upazila, community members from the Karapara Community Clinic area donated BDT 4,000.00 for different repairs.

• In Jamalpur, 22 midwives have been posted to support deliveries and pregnant women in the Community Clinics.

• The local health authority in Moulvibazar provided training to 28 CHCPs on an improved referral system and reformed 28 Community Groups.

• In Panchagarh, Union Health Inspectors have increased the frequency of clinic monitoring. Now, they are visiting each Community Clinic twice a week instead of once.

Policy Recommendations

The recommendations are made based on secondary review and the NTF's opinions. The important policy alternatives with respect to improving services at community clinics are as follows:

Recruit qualified Community Health Workers at the CCs: Community Health Workers at the CCs should have the skills to provide the designated Essential Service Package (ESP) at the village level.

However, many of the staff deployed to community clinics lack the necessary skills to do so. It is therefore necessary to recruit medically trained staff with the skills required to work in community clinics.

Ensure health workers' attendance at clinics: According to established policies, CCs should be open during normal working hours, six days a week. However, in most of the clinics, the health care professionals do not maintain regular hours. Worse, many clinicians are absent from their clinics for days on end. Enforcing regular attendance and maintaining normal working hours must be strictly monitored.

Maintain a regular supply of medicine and essential medical equipment: Though some medicine is provided, clinics often lack supplies or have intermittent deliveries. The supply of basic medical equipment is also inadequate in most CCs. A regular and sufficient supply of medication and basic medical equipment is necessary to ensure the smooth functioning of the clinics.

Develop and maintain proper clinic infrastructure: The quality of clinic buildings should be inspected and renovated as necessary. Basic facilities and cleanliness should be maintained so that the patients feel comfortable visiting the clinics. There should be electricity supplied to all clinics, and there ought to be clean toilets and clean water supply in all clinics.

Implement client-based tools for supervision, monitoring, accountability, and community engagement: It is imperative that clients be empowered to ask for effective and respectful care, irrespective of their ability to pay. Functioning, user-friendly accountability tools and mechanisms can produce regular reports, and using such reviews and reports to assess the quality and progress of the health care services at the community to national-level facilities should be institutionalised.

CC accountability, monitoring, and supervision mechanisms should be strengthened. An appropriate monitoring mechanism should be developed and followed to monitor the services at the clinics both vertically (i.e., from the higher authorities) and horizontally (i.e., from the community). Complaint boxes should be placed inside clinics, and the Citizen's Charter should be displayed at all CCs.

Strengthen capacity of the CGs and CSGs: The Community Groups and the Community Support Groups that are formed to ensure community participation in community clinic management are virtually non-functional. It is vitally important to reconstitute them with committed and active members from the communities where the clinics serve.

CGs and CSGs should actively monitor the services of the community clinics and should also provide the necessary support to the clinics to support smooth functioning. They should also be held accountable by the community people. In addition, the CGs should be held accountable by the UP. As an elected community representative and the head of the local government body, the UP Chairman may be assigned as the functional supervisor of CGs; he or she should also act as the advisor of the groups within the union.

Ensure Multipurpose Health Volunteer (MHV): Following the Community Based Health Care plan under DGHS, there is a scope to engage 5-7 Multipurpose Health Volunteers under each Community Clinic. Still, many of the community clinics are far behind in recruiting MHVs or utilising the MHVs as per their job description. Active MHVs are a significant factor to improving service quality and people's satisfaction with the community clinic's service.

Functional GO-NGO coordination and Public-Private Partnership (PPP) Mechanism: These coordination mechanisms are important, and both the GO and NGO officials have to develop a positive attitude towards collaboration to establish better conditions for CCs. Maintaining an open mind, welcoming ideas and opinions, and giving recognition of work among both counterparts is helpful to problem solve and increase mutual understanding. Introduction of a proper follow-up and monitoring system is necessary to ensure CC feedback is incorporated into the programs and help to remove systemic barriers to providing proper health service.

Resource mobilisation of community contribution for the clinics: It is recommended that the CGs should try to collect affordable subscription fees from local households. CGs can also approach wealthier families for clinic donations. An endowment fund could be created to accept voluntary donations. This fund may be used for further improvement of clinic services as well as providing financial support for poor patients for further treatment when they need it.

Awareness campaign about the services of the community clinics: Public awareness of the clinics needs to be raised and regular meetings should be held to improve the quality of the CCs.

Community members should be made aware of the services they can expect from the clinics including what medicine is available. They should come forward to ensure they receive standard services from the clinics. At the same time, they should also be aware that they have a role to play in maintaining the quality of the clinics as well as the services provided there. Larger groups of community members including teachers, religious leaders, and representatives of different groups, parents, and youth should also be made aware of CC services and involved in clinic affairs.

Some additional suggestions that have been made by the NTF members to improve services at community clinics include:

• Efficiently spending local funds allocated for the maintenance of the clinics,

• sending health care providers to visit villages to encourage villagers to seek health services from community clinics,

• creating the demand for services from the community clinics among the people so that they seek health services from community clinics in emergency situations and recruit midwives and other support staff for urgent maternity services,

• involving local NGOs in conducting committee meetings to ensure maximum attendance of members in the management of CCs,

• recruiting cleaning staff, security staff, and other support staff, and

• making special arrangements to obtain medicine in proportion to the population.

Given the constraints that the community clinics are already facing, it is not easy to improve the quality of service in the community clinics. Any real improvement will require a combined, concerted, and coordinated effort by all stakeholders. Based on the NTF experiences, the matrix below outlines recommended strategies with the responsible entity/entities to improve the quality of services at the community clinics in Bangladesh.

Strategies	Responsible Agencies /Organisations
• Recruiting qualified community health workers at the CCs	CBHC, DGHS
• Ensuring attendance of health workers at the clinics	UH & FPO, CG, CSG, LG
• Maintaining a regular supply of medicine and essential medical equipment	CBHC, CS Office
• Developing and maintaining proper physical infrastructure for the clinics and also in appropriate places	CG, CSG, LG, CBHC
• Strengthening monitoring and supervision	CG, CBHC, MOHFW

Strategies	Responsible Agencies /Organisations
• Strengthening capacity of the CGs and CSGs	CBHC, CSO, LG
• Ensure Multipurpose Health Volunteer (MHV)	CBHC, CG
• Functional GO-NGO coordination and Public Private Partnership (PPP) Mechanism	CBHC, CG, LG, Private Organisations
• Resource mobilisation of community contribution for the clinics	CG, CSG, LG, CSO
• Awareness campaign about community clinic services	CSO, MoH & FW, CG, CBHC

Note: CG: Community Group; CSG: Community Support Group; CSO: Civil Society Organization; LG: Local Government, CBHC- Community Based Health Care, MoH&WF: Ministry of Health and Family Welfare, UH&FPO- Upazila Health & Family Plan Officer.

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Photo: People are standing in a long queue to get health services from a community clinic.
Place: Mukkhait, Bagerha.

54% of CHCPs are women who are serving in community clinics across the country.

-CBHC, Directorate of Helath,
Department of Health Service, MoHFW.