Strengthening Union Level Facilities to Improve Institutional Delivery

A report of the national assessment of union level facilities in Bangladesh for their readiness to provide normal delivery care services

Directorate General of Family Planning
Ministry of Health and Family Welfare
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Foreword

I am delighted to learn that the final report of the national assessment of union level facilities is now ready for dissemination. As the country is moving onto the era of Sustainable Development Goals (SDGs), we are positioning ourselves to move towards universal health coverage. With large network of health care delivery institutions in the country, Bangladesh is well positioned to realize this ambition.

However, the primary level facilities, at the union level, play a particularly significant role in delivery an essential health package of preventive, promotive and curative services. In Bangladesh, we have three kinds of health facilities at the union level: rural health centers, union sub-centers, and union health & family welfare centers (UH&FWCs). These facilities are managed either by DGHS or by the DGFP. Irrespective of the managing agencies, all the union level facilities could provide the services identified in the essential services package.

The national level assessment conducted under the leadership of DGFP is an important step to identifying the level of readiness of these facilities to provide essential services, especially maternal and newborn care services. I am sure that the MOH&FW will use this information to develop and implement action plans for strengthening the union level facilities across the country as the primary health care facilities. The fourth HNP sector program offers a great opportunity to address the gaps identified through this assessment.

Finally, I would like to take the opportunity to thank USAID and the MaMoni HSS project for their financial and technical support for strengthening the union level facilities.

Dr. Habib Abdullah Sohel
Director – Primary Health Care and Line Director MNCAH
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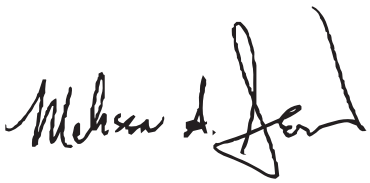
Foreword

Bangladesh can take tremendous pride in the achievements the country has made in the past decade in reducing maternal, newborn and child deaths. As the country steps into the post-MDG era with the ambition of moving towards universal health coverage, improving access to life-saving care for mothers and newborns during pregnancy, childbirth and the immediate postpartum period should remain a priority for years to come. It is quite evident that the norm in Bangladesh is clearly shifting from home deliveries to ensuring more skilled birth attendance at health facilities. As a result, now more than ever, the Bangladesh health service delivery systems needs to be better equipped to meet these increasing demands, with quality and equity in mind. Strengthening primary level health facilities across the country could be an easily-won strategy towards this objective.

I am pleased to share with you the report of the national level assessment conducted by the Directorate General of Family Planning, with the objective of strengthening the capacity of union level health facilities to provide life-saving care to mothers and newborns during delivery and at the time of birth. USAID, through its MaMoni Health Systems Strengthening project, provided financial and technical assistance to this effort. The assessment, which was conducted from April 2015 to February 2016, covered 4,461 union level facilities located in 4,550 unions across the country in order to create a database of all union level facilities in Bangladesh. The findings of the assessment provide very useful evidence for policy planners and program managers in the Ministry of Health and Family Welfare, as well as for development partners, to make informed decisions about the level of investments and support required to make these facilities functional, ultimately contributing to the implementation of the fourth Health, Nutrition, and Population Sector Program. As Ministry of Health and Family Welfare is developing the Program Implementation Plan, an incremental approach to strengthening these facilities should find a prominent place in the next health sector program.

I would like to congratulate the Directorate General of Family Planning on this important endeavor. I would also like to express my appreciation to the MaMoni Health Systems Strengthening project team, who provided expert and timely support in conceptualizing and implementing this assessment.



Melissa Jones
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Foreword

The Sustainable Development Goals have set ambitious health-related targets for mothers, newborns and children under the umbrella of Universal Health Coverage (UHC) by 2030. The Health Nutrition Population Strategic Investment Plan 2016-2021 of Government of Bangladesh has clearly articulated its longer-term aim of moving towards achieving UHC as targeted in SDGs. The Fourth HNP Sector Program also commits to expanding and strengthening the country's comprehensive Maternal, Neonatal, Child and Adolescent Health care approach (MNC&AH) as a priority and a crucial part of the government's efforts to incrementally reduce morbidity and mortality and to ensure the well-being of the population.

With the gradual shift of population norm from home deliveries to facility deliveries, and with the projected increases in population size, the demand for facility-based care around the time of birth is most likely to increase rapidly in the coming years. In order for the country to cope with this increase in demand, the share of deliveries happening at public health facilities need to increase many folds. There is a growing consensus that the union level facilities need to step up their efforts and increase their contribution to the overall facility deliveries. There has been a major gap of information about the current level of readiness of these facilities to meet this expectation. The assessment conducted by the Directorate General of Family Planning is an important step towards improving service delivery at this primary level of care. Strengthening the union level facilities will undoubtedly contribute to improving equity by enhancing access to the most marginalized rural populations.

Along with the increase in the utilization of services at this level, special attention need to be paid to improving the quality of care. Initiatives to address the gaps in the provision of care as well as the experience of care need to be implemented. The national strategic framework for quality improvement provides an excellent opportunity to extend the quality improvement efforts at this level. Enhancing local ownership, resource contributions and accountability mechanisms are also equally important.

On behalf of USAID's MaMoni Health Systems Strengthening Project, I would like to commend the Directorate General of Family Planning for prioritizing the union level facilities for improving maternal and newborn care in Bangladesh. I feel proud to be part of this initiative and delighted to be able to support the Ministry of Health and Family Welfare in its noble efforts to improve the lives of mothers, newborns and their families in Bangladesh.

Joby George
Chief of Party
MaMoni Health Systems Strengthening Project
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Preface

As we are coming close to the end of the third Health, Population and Nutrition Sector Development Program (HPNSDP 2011-16), the country has made commendable progress in reducing mortality rates among mothers and newborns. However, the rates continue to be high and there are significant inequities in the availability of life-saving services. This is an important unfinished agenda for the next sector programme. I believe that the health facilities at the peripheral levels, especially the union level facilities, need to be strengthened and supported to achieve our ambitions for ending preventable child and maternal deaths. There is also an urgent need to improve the utilization of the existing facilities and to improve the quality of care provided.

The national assessment of the union level health facilities on their readiness to provide normal delivery care services was designed to collect information from Union Health and Family Welfare Centers (UH&FWCs), Union Subcenters (USC) and Rural Dispensaries (RDs) in the country on their readiness to provide normal delivery care and essential newborn care services. I am very pleased to present the report of Strengthening Union Health and Family Welfare Centers to increase skilled attendance at birth assessment result on the availability, general preparedness and readiness of the union health and family welfare center.

We hope the report of the Strengthening Union Health and Family Welfare Centers to increase skilled attendance at birth assessment will be very useful to the planners, researchers, and policy makers to enhance the understanding of importance and to meet the monitoring and evaluation need for providing quality health services.

The assessment is the result of concerted effort, dedicated support and involvement of large number of institutions and individuals. I am deeply indebted and grateful to all those who contributed to the assessment. I would like to put on record my sincere appreciation for the members of the Technical Assistance Cell (TAC), MCH unit of DGFP, data collectors, data collection supervisors, the data processing team, RIC, PHD & Shimantik and particularly the assessment respondents. The U.S. agency for international Development (USAID), through MaMoni HSS project, provided financial and technical support for this assessment.

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Acknowledgements

This situational assessment collected essential information from every union level facility in the country on the status of providing care during pregnancy, child birth and through the immediate postpartum period. The assessment reveals the actual scenario of service availability at union level facilities, and has helped to establish an updated database of the facilities which exist at the union level. The findings are important to determine additional inputs and technical support required for strengthening these facilities to enable the provision of maternal and newborn care services on 24-hours a day, seven days a week basis. This assessment can be considered as the baseline database for the union level facilities of Bangladesh.

The MCH services unit of Directorate General of Family Planning and MaMoni HSS project conducted the assessment with funding from the U.S. Agency for International Development (USAID). Data was collected by the implementing partners of MaMoni HSS, namely Resource Integration Centre (RIC), Partners in Health Development (PHD) and Shimantik with supervision and technical oversight from the MCH Services Unit of DGFP and MaMoni HSS.

A large number stakeholders, including experts from government, nongovernment and international organizations as well as professionals who are knowledgeable about the health, nutrition and population sectors, contributed during designing and also during the assessment process by providing expert inputs. A Technical Assistance Cell (TAC) with representative from DGFP, DGHS, MaMoni HSS, Save the Children, UNFPA, OGSB, NHSDP, BRAC, Care, Population Council and Plan international – provided inputs from time to time. I would like to take the opportunity to thank all of them for their contribution. I offer my sincere appreciation to the MaMoni HSS team for their efforts and contribution throughout the course of this assessment and its successful completion.

The assessment findings were disseminated through seven divisional advocacy meetings with the divisional stakeholders. Their inputs were taken and also validation was done by them. This final report includes comprehensive analysis of the assessment findings and variety of interpretations. This will help the policy makers and the program managers to develop monitoring plan, design programs and prepare budget for next sector plan for improving maternal and newborn health care services in the country.

Finally, I would like to take the opportunity to thank USAID and the MaMoni HSS project for their technical and financial support for ending preventable child and maternal deaths in Bangladesh. In particular, I am grateful for the support provided for conducting this assessment and the initiatives for strengthening union level facilities.

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Abbreviations and Acronyms

ANC	Antenatal Care
AMTSL	Active Management of Third Stage of Labour
AHI	Assistant Health Inspector
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
CBHC	Community Based Health Care
CC	Community Clinic
CCSDP	Clinical Contraceptive Service Delivery Program
CEmONC	Comprehensive emergency obstetric and newborn care
CHW	Community Health Worker
CS	Civil Surgeon
CSBA	Community Skilled Birth Attendants
CSG	Community Support Group
CRVS	Civil registration and vital statistics
CYP	Couple Years of Protection
DDFP	Deputy Director Family Planning
DGFP	Directorate General Family Planning
DGHS	Directorate General Health Services
DNS	Director Nursing Services
EPCMD	Ending Preventable Child and Maternal Deaths
FeHA	Female Health Assistant
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
GOB	Government of Bangladesh
HA	Health Assistant
HBB	Helping Babies Breathe
HPNSDP	Health, Population, and Nutrition Sector Development Program
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illness
IPHN	Institute of Public Health Nutrition
LAPM	Long-acting and Permanent Method
LGD	Local Government Department
LMIS	Logistics Management Information System
MCH	Maternal & Child Health
MCHTI	Mother and Child Health Training Institute
mCPR	Modern Contraceptive Prevalence Rate
MCWC	Mother and Child Welfare Center
MNCH/FP/N	Maternal, Newborn and Child Health, Family Planning, and Nutrition
MNH	Maternal and Newborn Health
MOH&FW	Ministry of Health and Family Welfare
MOLGRD&C	Ministry of Local Government Rural Development & Cooperatives
MOU	Memorandum of Understanding
MPDR	Maternal and Perinatal Death Review
NGO	Nongovernment Organization
NHSDP	NGO Health Service Delivery Program

NIPORT	National Institute of Population Research and Training
NNS	National Nutrition Services
OGSB	Obstetric & Gynecological Society of Bangladesh
PHC	Primary Health Care
PHD	Partners in Health Development
PPIUCD	Postpartum Intra-Uterine Contraceptive Device
QI	Quality Improvement
RD	Rural Dispensary
RIC	Resource Integration Center
SACMO	Sub-Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Satellite Clinic
SCI	Save the Children International
SDP	Service Delivery Point
SDG	Sustainable Development Goal
TAC	Technical Assistance Cell
TOT	Training of Trainers
UEHFPSC	Union Education Health and Family Planning Standing Committee
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centers
UNO	Upazila Nirbahi Officer
UP	Union Parishad
UPHCSDP	Urban Primary Health Cater Service Delivery Programme
USC	Union Sub-center
USAID	United States Agency for International Development

Summary of key findings

The Directorate General of Family Planning (DGFP), Ministry of Health and Family Welfare (MOH&FW), with support from USAID's MaMoni Health Systems Strengthening (MaMoni HSS) project conducted a nation-wide assessment of the union level health facilities to determine the readiness of these facilities to provide round-the-clock normal delivery and essential newborn care services. Though the primary focus was on Union Health and Family Welfare Centers (UH&FWCs), other health facilities located at the union level, such as Unions Sub-centers (USC) and Rural Dispensaries (RDs) were also included in the assessment. The assessment was also intended to establish a comprehensive database of union level facilities covering the entire country.

Through this assessment a total of 4,461 union level facilities were identified, which includes 3,577 UH&FWCs, 797 USCs and 87 RDs. Among all the 4,461 union level facilities, 73 percent are managed by the Director General of Family Planning (DGFP) and the remaining 27 percent are managed by the Director General of Health Services (DGHS).Out of the total 4,550 unions in of the country, a total 529 unions do not have a union level health facility; but 185 of those unions have an upazila health complex (UHC) located in the union. A total of 358 unions do not have any health facilities.

A total of 3,131 UH&FWCs of DGFP 302 UH&FWC of DGHS are operating from own building and 157 USCs/RDs of DGHS are currently conducting deliveries. Thus, a total of 3,590 union level facilities are functioning as UH&FWCs. Among these facilities, FWVs are posted in 81 percent and 30 percent have FWVs residing in the facility. Sub-Assistant Community Medical Officers (SACMO) are posted at 71 percent facilities. Among the FWVs, 47 percent have undergone the six-months midwifery skills training conducted by DGFP, in addition to the eighteen months pre-service training; 78 percent have received training on newborn resuscitation package, called Helping Babies Breathe (HBB). Among essential supplies and equipment, blood pressure (BP) machines were available in good condition in 68 percent of the facilities; infant weighing scales were available in good condition in 56 percent of the facilities. In the year 2014, 59 percent of all UH&FWCs provided normal delivery care services. Forty-one percent of facilities did not conduct any deliveries in the year 2014. Management committee were formed in 52 percent of the facilities, of which 66 percent are active.

For the 3,590 facilities that are functioning as UH&FWCs, the assessment assigned scores against set criteria to determine the overall readiness of each facility to provide normal delivery and essential newborn care services. Based on the cumulative scores, each facility was grouped into categories A, B and C. The categorization indicates the overall readiness of the facilities to provide normal delivery and essential newborn care services and the level of inputs required to make them fully ready. Overall, 14 percent of them (489) are in category "A", which is defined as already functional or needs minimum resources to make them fully ready. A total of 69 percent of those facilities (2480) are in category "B", which will need medium to moderate level of inputs. A total of 17 percent (621) facilities are in "C" category, which means these facilities need major inputs in several areas, including physical renovation, staffing, supplies and equipment etc.

This assessment concludes that the union level facilities in the country have high potential to rapidly increase the provision of life-saving care to mothers and newborns around the time of birth.

The study recommends that:

- Majority of the union facilities can provide delivery care services with minor to moderate inputs. MOH&FW may prioritize the strengthening of those facilities that are in category A and category B for a phased implementation

- As the assessment suggests, vacancy of staff is not a major constraint. The focus needs to be more on appropriate deployment by posting the providers to facilities that are ready, training and ongoing competency development, ensuring that they reside at the facility and supportive supervision for performance enhancement need to be strengthened

- Many of the infrastructure gaps are minor in nature. It is possible to mobilize local level actions are required to address the gaps

- The assessment indicates that the UH&FWC management committees exists in majority of the facilities. These need to be strengthened for local ownership and oversight

- Management and supervision need to be strengthened to improve the performance of facilities that are “ready”

To accelerate the strengthening of these facilities, as evidenced by this assessment, it is recommended that the MOH&FW prioritize the activities delineated above and implement them across the health system of Bangladesh. These activities need to be implemented in a harmonized way to maximize the use of constrained resources. The MOH&FW may consider a phase-wise approach of expansion as it continues its strategic investment in facility-strengthening. A strong coordination mechanism is required at the level of MOH&FW to ensure that the efforts of different ministries, directorates and departments are coordinated to ensure the provision of infrastructure, human resources, equipment and logistics, local accountability and mobilization and information systems support to the union level facilities.

1. Background

1.1 Health service delivery system in Bangladesh

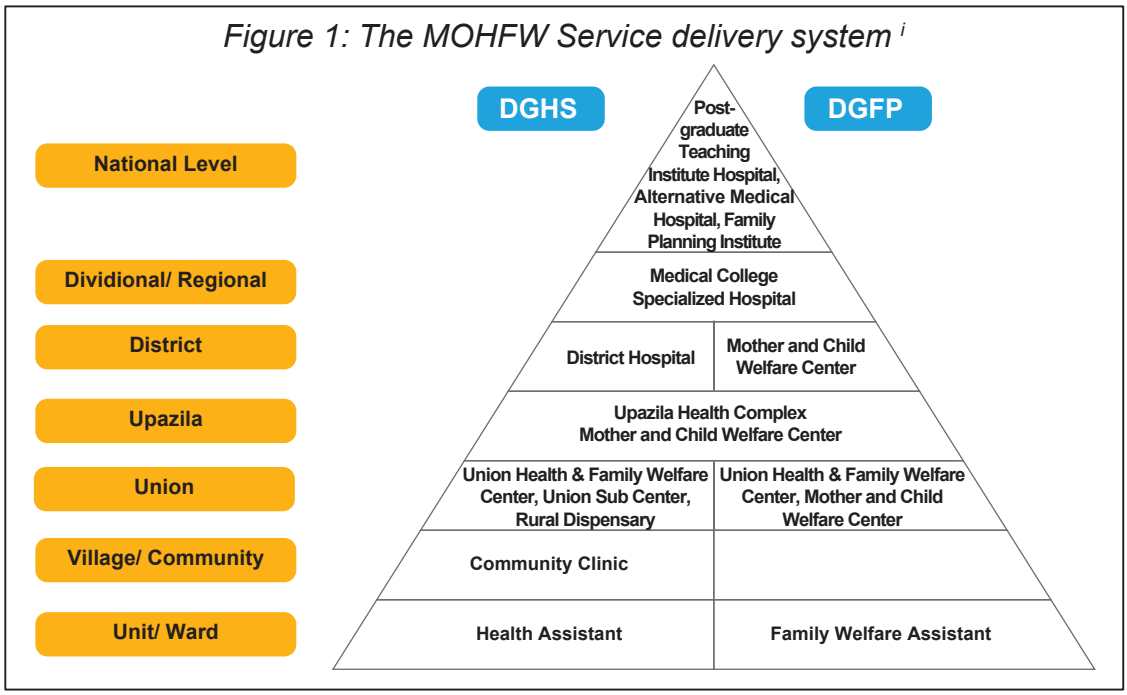
The formal health service delivery system in Bangladesh comprises of health institutions and providers in the public, private, non-profit and the informal sectors. The Ministry of Health and Family Welfare (MOH&FW) is the lead agency responsible for formulating national level policy, planning and decision making in the provision of health care. The private and informal sectors play a major role in the provision of services at all levels of care. The MOH&FW and its relevant regulatory bodies also have indirect control over the healthcare system of the NGOs and the private sector.

The Public sector

In the Public sector, health services are provided through two Directorates: The Directorate General Health Services (DGHS) and the Directorate General Family Planning (DGFP). The Community-based Health Care (CBHC) is providing essential services through a large network of Community Clinics (CCs) established across the country. The Directorate of Nursing Services (DNS) supports the service delivery through the various institutions. Other Directorates and Institutions provide regulatory, technical, logistical and management support for the public sector health care delivery system.

The Directorate General of Family Planning (DGFP) implements an MCH-based family planning program with an extensive network of health facilities, satellite clinics and domiciliary workers. The DGFP service outlets are situated all across the country. At the national level, DGFP manages to two national level institutions, which also serve as training centers. In addition, two model clinics are established at two medical colleges. At the district level, there are six model clinics attached to six medical colleges and MCH-FP clinics at 64 district hospitals, and 62 Mother and Child Welfare Centers (MCWC).At the upazila level, MCH-FP units are established at the Upazila Health Complexes (UHC) in 407 upazilas. In addition, 12 MCWCs are also functional at upazila level. There are approximately 3,500 Union Health and Family Welfare Centers (UH&FWCs) and 23 MCWCs located at union levels. The UH&FWCs are staffed by paraprofessionals such as a Medical Assistants (SACMO) and Family Welfare Visitors (FWVs) both trained in formal institutions. DGFP has deployed a total of 4,898 FWVs, and 2,322 SACMOs who are mostly posted at the union level[iii]. In addition to family planning services, the UH&FWC services ranges from antenatal care, safe delivery care, postnatal care and child health services. Currently UH&FWCs are moving towards provision of services on a 24-hours a day, seven days a week (24/7) basis. Over 30,000 satellite clinics are conducted at community level, including a few at the CCs, every month. Over 21,083 Family Welfare Assistants (FWAs) provide community-based family planning and basic MCH services across the country[iii].

Figure 1: The MOHFW Service delivery system [i]



The healthcare infrastructure under the Directorate General of Health Services (DGHS) comprises of six tiers: national, divisional, district, upazila (sub-district), union, and ward. At the national level, there are institutions both for public health functions as well as for postgraduate medical education/training and specialized treatment. The Civil Surgeon (CS) is the district health manager responsible for delivering secondary and primary-care services. In each district, there is a district hospital. Some district hospitals have superintendents to look after the hospital management. The primary care in the public sector is organized around the Upazila Health Complex (UHC) at sub-district level with in-patient and basic laboratory facilities, including 30-50 beds. The UHCs also coordinate and manage the service delivery for the whole upazila. At the union level, three kinds of health facilities exist: RDs, USCs and UHFWCs. Each union-level health facility under DGHS employs a medical doctor and a sub-assistant community medical officers (SACMO) among other staff. Mostly outdoor services are available at the union level. As of 2015, there are 4,684 SACMOs under DGHS. A large network of 13,394 Community Clinics have also been brought under the management of an Operational Plan under DGHS, which provides out-patient-based basic health care package. At the field level, there are 17,532 Health Assistants (HAs) who conduct home visits and provide preventive healthcare services, such as immunization. The HAs are supervised by Assistant Health Inspector (AHI)[iii].

Recently, some of the female HAs and FWAs have been trained as Community Skilled Birth Attendants (CSBAs) to provide skilled services in home delivery. As of 2015, there 7,858 registered CSBAs in the country[iii].

Private health sector

The private sector covers health services provided at hospitals, nursing and maternity homes; clinics run by doctors, nurses, midwives, and paramedical workers; diagnostic facilities (i.e., laboratories and radiology units); and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers. As of 2015, there are 4,280 registered private hospitals and clinics and 9,061 registered diagnostic centers in Bangladesh[iii]. The total number of beds in the registered private hospitals and clinics is 74,620[iii] . There are also traditional healers (*kabiraj, totka,* and faith healers like *pir/ fakirs*), homoeopathic practitioners, village doctors and finally, drugstores that sell allopathic medicine. There are also unregulated retail outlets which also diagnose and treat illnesses despite having no formal professional training.

NGO health programs

More than 4,000 NGOs, including international organizations, large national NGOs and hundreds of small and local NGOs are active in the health sector in Bangladesh. NGOs provide essential primary health care services through a nationwide network of static clinics, satellite clinics and community service providers. The NGO Health Service Delivery Program (NHSDP), a USAID-DFID funded network of approximately 25 NGOs deliver a broad package of maternal, child health and family planning services through more than 388 static clinics and about 10,000 satellite clinics serving about 20 million people all over Bangladesh. Similarly, BRAC has a large community-based network for delivering primary health care services including MNCS, nutrition and other services. The BRAC health program has approximately 97,000 *Shasthya Shebika* (SS) and 10,008 *Shasthya Kormi* (SK) who mainly supply preventive care and simple curative care services to women and children in rural areas and urban slums.

Health services in urban areas

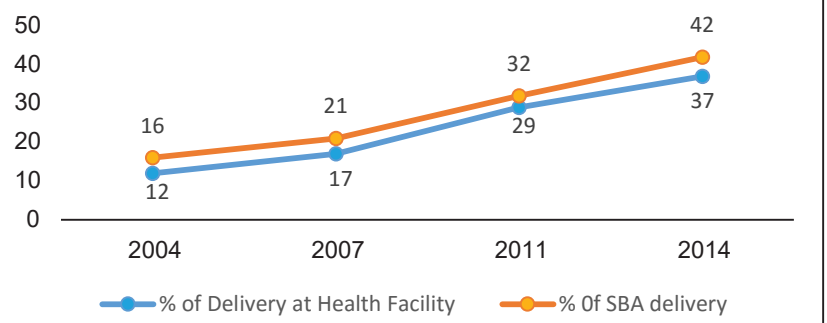
The Local Government Division (LGD) is mandated to provide health care services in urban areas. Since 1998, the LGD has been implementing the Urban Primary Health Care Services Delivery Project (UPHCSDP) in collaboration with the urban local government bodies and NGOs. The UPHCSDP delivers and expanded package of services through more than 150 health care centers. Twenty-five of these centers provide in-patient services that cover all city corporations and four municipalities of the country.

1.2 Maternal and newborn health situation in Bangladesh

Bangladesh has committed to End Preventable Child Maternal Deaths (EPCMD) by 2030. This commitment is in the spirit of achieving universal health coverage (UHC) and is in alignment with the Sustainable Development Goals (SDGs) and the priorities outlined in the Health Nutrition Population Strategic Investment Plan (HNPSIP 2016-2021) of the MOH&FW, Bangladesh[iv] . In order for the country to achieve SDG 3.1, maternal mortality will require significant reduction to 59 per 100,000 live births from the current level of 170 (per 100,000 live births). Similarly, while progress has been made in reducing neonatal mortality, from 37 to 28 per 1000 live births according to the Demographic and Health Surveys from 2007 and 2014, respectively, this progress has been slow. Increasing access to skilled attendance at birth (SBA) is one of the highest priority interventions that can contribute towards significant reduction of maternal and neonatal mortality and morbidity. In the past decade, the coverage of facility delivery has rapidly increased from 12 percent (DHS, 2004) to 37 percent (DHS, 2014). Yet, the contribution of the public sector has only increased marginally from seven percent to 13 percent. It is evident that there is a clear shift in the norm from home delivery to facility deliveries[v]. Yet ensuring access to facility delivery to the poor and marginal groups can increase only if the public sector strengthens and prioritizes efforts, especially in the rural and under-served areas by instilling equitable improvements in the coverage of interventions during the antenatal period as well as the care around the time of birth, including emergency obstetric and newborn care (EmONC). There is an urgent need to focus on a shift from deliveries at home to deliveries at health facilities with quality and equity.

Skilled attendance at birth in rural areas has been consistently lagging behind at national level, as shown in figure 2. With two thirds of the population in the rural areas, it is not possible to achieve the ambitions of universal health coverage, without improving access to life-saving services for women and children residing in rural and hard-to-reach locations[v]. Also, the progress has not been uniform. Across different income levels, geographical locations, between rural and urban population, there's a large disparity in utilization of SBAs. Recent heath facility assessment showed that readiness for quality basic MNH services in Bangladesh remains low – both at the public and the private sectors[vi].

Figure 2: Trends in facility delivery and SBA coverage in the last decade



1.3 Strengthening UH&FWC to increase coverage of skilled attendance at birth

The MOH&FW has several programs geared towards increasing SBA coverage. The more than 4,000 union level health facilities existing in the country present a unique opportunity to rapidly increase skilled attendance at birth. Since the unions typically cover 24,000-30,000 population, most facilities are located within 30-45 minutes from the farthest point of their catchment areas, and therefore, at a suitable location for women to come in for delivery. During the Health Population Nutrition Sector Development Program (HPNSDP 2011-16), DGFP has upgraded 1,441 UH&FWCs to provide both uncomplicated maternity care as well as basic obstetric services. Another additional 1,425 health facilities have been budgeted for up-gradation by the end of the third sector plan period.

The UH&FWCs are designed to contain at least two staff quarters, which means that the FWVs are available beyond routine service hours of 8:00 am to 02:30pm. All upgraded UH&FWCs have a designated delivery room, which is expected to be equipped to conduct normal deliveries and provide immediate and essential newborn care services. In other UH&FWCs there are separate rooms for insertion of Intra-Uterine Contraceptive Devices (IUCD).

The current human resource situation is also conducive for scaling up facility delivery services. The DGFP has recruited and posted FWVs in the majority of UH&FWCs. All FWVs have completed the eighteen months pre-service training conducted by DGFP through FWV Training Institutions (FWVTI) under the management of the National Institute of Population Research and Training (NIPORT). The curriculum for the pre-service training includes management of normal delivery care. In addition, DGFP conducts regular in-service training for FWVs to improve their midwifery skills, which is a six-months training program conducted at the Maternal and Child Health Training Institute (MCHTI), Dhaka. In addition, since 2003, the MOH&FW have also developed CSBAs, including FWAs and Female Health Assistants (FeHA) who are

certified by Bangladesh Nursing Council, and can serve from these facilities.

The design of UH&FWCs include at least two staff quarters, which means that the FWVs can be available beyond routine service hours. For UH&FWCs that do not have a delivery room, the room for insertion of Intra-Uterine Contraceptive Devices (IUCD) can be converted to conduct deliveries. For functional health centers with staff present and residential, this rearrangement is sufficient to introduce 24/7 availability of normal delivery care and essential newborn care.

1.4 Learning from experience: successful programmes in improving maternal and newborn health

The USAID funded MaMoni Health Systems Strengthening (MaMoni HSS) project supported the strengthening of the government owned UH&FWCs in under-served unions of Habiganj in Sylhet Division to provide normal delivery care services, along with life-saving essential newborn care on a 24/7 basis. Since 2012, the project supported physical renovation of the facility, including residence for the staff; deployed midwifery-trained paramedics on temporary basis; expanded the outreach of antenatal care services through well planned satellite clinics; established community-managed referral networks; applied clinical standards-based quality improvement initiatives; mobilized the support and oversight of local government institutions through Union *Parishad* and its Standing Committees; strengthened the UH&FWC Management Committees and mobilized community groups and volunteers to generate awareness and increase demand for the services provided at the UH&FWCs. In order to improve access to SBA services in remote and hard-to-reach communities, the project trained 48 local women in a six month private CSBA course accredited by the Bangladesh Nursing Council to increase coverage in hard to reach areas. This complemented the coverage of the government-supported CSBAs in the community.

Using the health facility records, the project monitored the pattern of utilization of antenatal care and delivery care services at these four upgraded UH&FWCs over a one year period (January – December 2014). In these unions, the project observed rapid increase in the utilization of antenatal care and SBA services in the catchment areas of these facilities. SBAs attended 67 percent of all deliveries in these unions (range 46-82 percent), including 40 percent at the UH&FWCs. The private CSBAs provided first antenatal care to 14 percent-17 percent women and conducted about 20 percent of total deliveries in their clusters. Government CSBAs conducted nine percent to 16 percent deliveries[vii]. The rapid increase in utilization of SBA services at the peripheral level is significant when compared with the very slow progress reported in the division (27 percent)[viii] and in the district (30 percent)[ix]. Private community skilled birth attendants and complemented the increase in coverage of skilled care at the community level, particularly in areas where health facilities were inadequate. According to unpublished data from the project, around 40percent of deliveries in MaMoni supported UH&FWCs occurred outside of the traditional 8:00 am – 2:30 pm service hours of the facilities. Running these facilities required two FWVs or paramedics deployed by the project, SACMO, two Ayas and other support staff. MaMoni HSS' experience also suggests that about 85 percent of the utilization of UH&FWC for delivery care is by families residing within 45-60 minutes of the facility.

" Population Council is providing technical assistance to the DGFP to implement an Operations Research project that tests the effectiveness of a model to provide round-the-clock normal delivery services in 24 UHFWCs in Chittagong and Munshiganj districts".

"As a part of the project, a situation analysis comprising a health facility assessment and provider survey was conducted. To explore the status of the UHFWCs in two intervention districts, a total of 174 facilities were assessed and a survey was conducted with 27 FWVs who provide normal delivery services at 24 intervention UHFWCs to understand their technical competence in terms of knowledge and capacities in providing round-the-clock normal delivery services. The report describes the outcome of this situation analysis activity"

"Several gaps in the existing capacity of UHFWCs for providing round-the-clock delivery services were identified through situation analysis. Necessary inputs are broadly described in five categories: physical infrastructure, human resources, equipment and supplies, management, and referral".

Population Council further describes in their 'Way forward' that "Limited availability of the FWV at the UHFWC (4 out of 6 working days), who is the only provider for conducting delivery services, is the key programmatic challenge to provide 24- hour normal delivery services from the UHFWC. Moreover, FWVs are not skilled to provide basic EmONC. The UHFWC requires a provider who should be adequately trained in midwifery care to address essential functions of EmONC and to make referral to the Upazilla Health Complex and higher-level facilities for complications management and cesarean deliveries. A new cadre of "midwife" can be created to address the maternal health care needs of the growing female population in rural areas".

Population Council also emphasiss that "There is no alternate to increase facility-based delivery in rural areas to reduce maternal health risks; therefore, it is necessary to strengthen UHFWCs with skilled human resources, service provision, logistics and supplies, and local level management".

Reference: Union Health and Family Welfare Centers in Chittagong and Munshiganj Are They Ready to Provide 24-Hour Normal Delivery Services? Population Council: 2015

The operation research conducted by DGFP with the technical assistance from population council reveals that physical infrastructure, human resources, equipment and supplies, management and referral are the areas to provide inputs to conduct round the clock normal delivery services from UH&FWCs.

Experiences from WATCH Project, Plan International

To address barriers in service delivery for mothers and children, Plan International Bangladesh introduced a project entitled "Women & Their Children's Health (WATCH)" from 2011 to 2015, covering five underserved sub-districts (Nilpahamari, Barguna, Lalmonirhut and Dinajpur) through a partnership with Government and the local NGOs. The main objective of this project was to increase utilization of facilities for MNCH services like antenatal care, safe delivery, postnatal care, obstetric first aid and newborn care. The project supported capacity building of the community, health care facilities and service providers. By the end of the first year of implementation, all 47 UH&FWCs in project working areas were ensuring 24/7 safe delivery services and timely referral.

WATCH made it possible by deploying two CSBAs in each UH&FWC under supervision of FWV, with some necessary renovation, and regular logistic supply including minimum pathological tests at the UH&FWC. The project also provided technical support for capacity building of service providers and management committees, regular monitoring, supportive supervision etc. Accountability of the providers was ensured by regularization and strengthening of UH&FWC management committees and the Union Education, Health and Family Planning Sub-Committees (UEH&FPSC). Moreover, their enhanced commitment and oversight role enhanced the utilization of UH&FWC for MNCH services. The experience showed that the optimal utilization of fully staffed and equipped UH&FWC can lead to improved health status of mother & children. The role of UH&FWC Management Committee , and local government are crucial in creating demand and ensuring availability of services in UH&FWC, leading to reduced maternal, newborn and child mortality and morbidity.

The Women and Their Children's Health (WATCH) project of Plan International has also demonstrated that UH&FWCs have huge potential to generate demand resulting into very high level of utilization for delivery care.

2. The assessment of service readiness of union level facilities

2.1 Purpose of the assessment

Now it is evident that the norm in Bangladesh is shifting from home delivery to delivery at facilities. In the last decade, facility delivery increased rapidly from 12 percent to 37 percent. Despite this substantial increase, the share of deliveries in public sector is very low, only 13 percent. There must be a threefold increase in public facility delivery in the next fifteen years to achieve the targets set for the SDG. The policy brief of Bangladesh Demographic and Health Survey 2014, has recommended a sharp increase in the public share to the total facility deliveries, to reach at least 20 percent by 2021. Therefore, special efforts are needed in the 4th sector program to attract more families to the facilities. The effort must include upgradation and strengthening of UH&FWC to provide 24/7 normal delivery care with proper infrastructure and quality of care.

It is important to understand the existing condition of all the union level facilities to determine the level of effort needed to make them functional. The problems at these facilities range from shortcomings of infrastructure, unavailability of water or electricity, unavailability of skilled human resources, absence of accountability and supportive supervision and gaps in quality of care. A number of these facilities were established many years ago while others have dilapidated due to water erosion and other environmental effects. To make these facilities function on a 24/7 basis, a comprehensive assessment develop an updated database was felt necessary. This assessment will help target resource planning and phasing for strengthening of each of the unions. A collaborative effort has been taken by the DGFP, with support from MaMoni HSS, to develop and implement an accelerated facility strengthening plan. The assessment of union level facilities throughout the country is the first step in this direction.

The objective of this assessment is to establish a national database of all union level health facilities in the country and to determine the service delivery readiness to provide normal delivery care and essential newborn care. The result of this assessment will be used to develop and implement an Accelerated Facility Strengthening Plan to rapidly increase the coverage of SBA by strengthening the union level facilities to achieve and exceed the target for the fourth sector program, the SDG and the target of ending preventable child and maternal deaths by 2030.

2.2 Types of union level facilities assessed

In 1972, the Government of Bangladesh introduced the concept of Thana Health Complex (THC) at the sub-district level and the government began to upgrade rural health centers to THC, which are now known as Upazila Health Complex (UHC). During the first five year plan (1973-1978), the state recognized the inadequacy of existing health facilities in respect of quality of care and quantity of resources. Thus, the government focused on creating and upgrading rural health centers and establishing more THCs. However, all the RDs were not upgraded. According to a government order, the remaining RDs under DGHS are also called UH&FWCs.

This assessment has included only union level facilities of MO&HFW, which provide MNCH services. All UHFWCs, USC, and RD were included. Larger facilities/ hospitals, urban centers/ clinics, traditional practitioners and private facilities were excluded.

Included	Excluded
All union level facilities located in rural areas • All UH&FWCs managed by DGFP • All UH&FWCs managed by DGHS • All union Sub-centers • All Rural Dispensaries	• *Paurasabha* Clinics located in *Paurasabaha* & City Corporations • All MCWCs and UHC located at union level • Private hospitals including informal service centers • Pharmacies

2.3 Methodology

2.3.1 Management and technical oversight

A Technical Assistance Committee (TAC) was formed to bring together a group of representatives from DGHS, DGFP and key stakeholders to guide the team on technical and implementation issues. The key responsibility of TAC was to provide necessary direction and information to the assessment team and facilitate communication with the districts. The committee members undertook field visits to oversee the process. The TAC was formed with following members and was chaired by Director MCH services, DGFP. The members included:

1. Representative, MCH services, DGFP
2. Representative, CCSDP,DGFP
3. Representative, Field Service ,DGFP
4. Representative, Planning ,DGFP
5. Representative, Director PHC, DGHS
6. Focal Point MaMoni-HSS
7. Project Director, Maternal Health, FP & N, MaMoni HSS
8. Senior Advisor Health Systems, MaMoni HSS
9. Other stakeholders from NGOs like Plan International, Care and Population Council

2.3.2 Development of assessment tool

The assessment tool was developed in consultation with technical specialists and experts from the DGFP and DGHS and other key stakeholders included in TAC. The tool was developed in Bangla. The major areas covered in the assessment tool were geographical details, human resources and training details, infrastructure of facility and residence for providers, availability of water and electricity, medical waste management system and the functioning of the management committees. The assessment tool was shared with the TAC and a pre-testing was done. The assessment tool is included in Annex A.

After finalization, the paper based tool was converted into a computer tablet (Tab) based tool with the technical support of MaMoni HSS as well as icddr,b team.

At the time of training, each member of the data collection team was provided with a Tab with the tool uploaded. Each Tab was assigned with a unique identification number which also helped to track the data collections of individual data collectors. GPS of the Tabs had been used to identify GIS coordinates of each union level facility. Response options were restricted by roll down menu, where possible. A screenshot of the Tab based tool is provided in Figure 3. The tool allowed the data collectors to capture images of service areas, residence and overall infrastructure of each facility using the Tab.

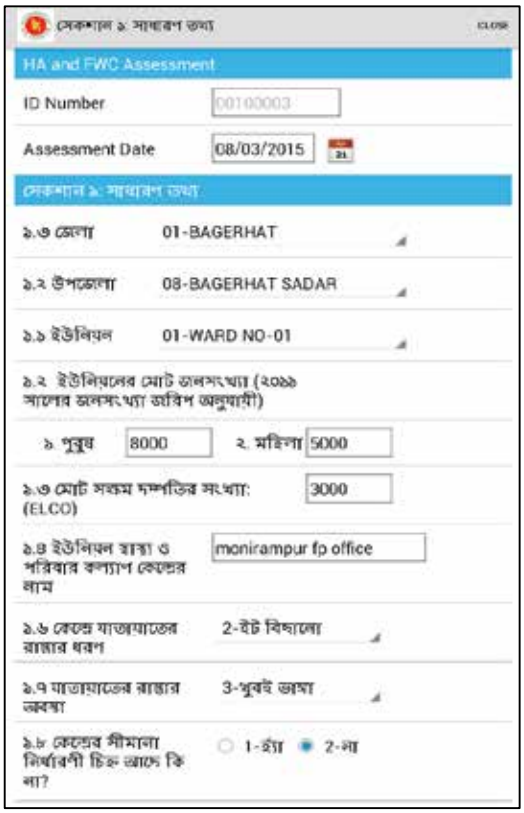


Figure 3: Screen shot of Tab-based tool

2.3.3 Pretesting

The Tab based assessment tool was tested for checking validity and feasibility of each of the queries. The draft tool was pre-tested in two unions in March 2015. During pre-testing the tool was examined for compatibility with infrastructure, staffing pattern, supplies and equipment of the union level health facilities. All findings from pre-test were reviewed and the tool was revised according to the field findings.

2.3.4 Training

MaMoni HSS trained a group of data collectors and supervisors recruited through the three local partners. A total of 45 data collectors and six supervisors were recruited. The training was of three days duration, with an additional for the supervisors to orient them on supervision skills and trouble-shooting. The main areas of the training included the use of Tab, assessment tool, all definitions related to the queries, data quality maintenance, supervision system and development of detailed plans for data collection, supervision and quality control.

All data collectors were trained on the coding, skip process as well as the process for uploading the data.

Refresher training was provided to data collectors and supervisors before starting data collection in each of the divisions.

2.3.5 Data collection

A list of all union level facilities was collected from relevant departments of DGFP and DGHS. At the district level, a list of union level facilities was collected from the Deputy Director of Family Planning (DDFP) and Civil Surgeons. At the upazila level, the list of union level facilities as well as the contact information of the service providers (FWV and SACMO) were collected from relevant upazila family planning officer (UFPO) and Upazila Health and Family Planning Officer (UH&FPO). At union level, the lists were cross checked with the union parishad chairmen to prepare a final list for conducting the assessment. The data collectors visited all facilities that were included in the final list and collected data using the Tab based tool. The data collection process mainly involved:

- Review of registers and records
- Interview with the service providers
- Observation of the environment, equipment etc.
- Capturing photographs of the service areas, residences and the overall facility structure

Division	Start of data collection	End of data collection
Barisal	12/04/15	14/06/15
Sylhet	12/04/15	06/06/15
Chittagong	14/06/15	20/09/15
Khulna	06/10/15	02/01/16
Rangpur	25/10/15	20/12/15
Rajshahi	20/12/15	31/01/16
Dhaka	04/10/15	31/01/16

The FWV and SACMO of each facility were the main source of information. In situations where one or both were absent, any staff assigned with the charge of the facility was interviewed. After completing the data collection, all information were checked and uploaded to the system by respective data collectors at the end of each day.

Field supervision was coordinated by MaMoni HSS local level NGO partners Resource Integration Center (RIC), Shimantik and Partners in Health Development (PHD). In addition, a dedicated supervisory team was formed by DGFP and MaMoni HSS for periodic visit and monitoring data collection exercise.

Each division required about two months for completing the assessment process (refer to the timeline in the box adjacent). Data collection in each division was conducted consecutively, only moving to the next division when data collection had been completed in the former division.

2.3.6 Supervision and quality control

Ten percent of all facilities in each district were re-assessed by the supervisor, using the same tool to check the validity and reliability of the information. After the data collectors completed the assessment, the supervisors randomly selected from the list to reassess some of the facilities. Since each Tab was coded individually, the assessor was not privy to the information collected during first assessment. Only the monitor from MaMoni HSS team could compare the information on SQL database to identify any inconsistencies. In the event of any major inconsistencies observed, the information was corrected after discussion with both the assessors.

During the data collection period, the supervisors met with data collectors on a monthly basis at the field level to identify issues and to resolve problems. MaMoni HSS, as well as DGFP officials from central level, conducted frequent visits to observe the data collection process. Issues arising or observed during these supervision visits were resolved during these field visits. A live dashboard was in place to view the data in real-time for enhancing quality control process. A password protected web link was accessible only to the central team in Dhaka for quality control.

2.3.7 Data analysis and report

All data were scored and stored in SQL data management software. A central data management team retrieved all data collected from each district after quality checking and finalization. A final cleaning process was done after importing the data into Microsoft Excel software. A detailed analysis plan was done by MaMoni HSS technical team. Divisional-level analyses were shared within the divisional management of DGHS and DGFP. After getting feedback and queries a comprehensive analysis was done for this report.

2.3.8 Validation

A few some discrepancies were observed about the management authority of some of the facilities. Since several facilities were included in both the lists provided by DGHS and DGFP, a re-validation of the management authority of the facilities became necessary. For revalidation, the assessment team used the list of union level facilities obtained from the central MIS departments of DGHS and DGFP to compare with the list prepared by the assessment. The supervisors went back to the districts to compare each facility. The team used several factors such as: which department the facility reports to, who posted the SACMO, which department clears the bills for that facility etc. to determine the actual management authority of some of the facilities. There are still a few facilities which are still included under the management authority of both DGHS and DGFP.

2.3.9 Limitations of this assessment

In a few cases it was difficult to get actual list of facilities from the respective districts. In a few other districts, information available from the national level mismatched with the details provided by the district/ upazila managers in terms of their name, number and management authority. These cases were dealt with on a case by case basis. Final determination was done by triangulating the field level information with the information available at the national level.

The information reported by the FWV and SACMO were primarily used for analysis for most variables, especially those relating to training and human resource. There were no additional processes followed to validate those information provided by these respondents. Information available from registers and records were extracted as available.

3. FINDINGS

3.1 General findings

The assessment identified a total of 4,461 union level facilities across Bangladesh. Of these, 3,590 UH&FWCs or USC/RD are conducting deliveries. Another 884 USC and 87 RDs also exist. A total 529 unions did not have a union level facility; but 171 of those unions had an UHC located within the same union. A total of 358 unions did not have any health facilities.

Availability of facility in the union

Bangladesh has a total of 4,550 unions, of which, 4,021 have union level facilities. Among the 529 unions, which do not have union level facilities, 171 have UHC. In total there are 358 unions which do not have a union level facility or an UHC.

Table 1: Distribution of unions by type of public health facilities available

Division	Total unions	Type of facility available in the union			Unions with no facility
		UH&FWC	USC/RD	UHC	
Barisal	352	258	42	17	35
Chittagong	947	703	97	32	115
Dhaka	1245	944	175	45	81
Khulna	574	473	54	17	30
Rajshahi	563	432	77	22	32
Rangpur	533	453	34	22	24
Sylhet	336	249	30	16	41
Total	**4,550**	**3,512**	**509**	**171**	**358**

Among the 4,021 unions that have a public health facility, 374 have more than one health facilities in the union; 3,512 unions have a UH&FWC and 509 unions have no UH&FWC but have an USC or a RD.

Location of facilities by division

Among the 4,461 facilities 28 percent are located in Dhaka division, seven percent each in Barisal and Sylhet Divisions, 20 percent in Chittagong Division, and 13 percent each in Khulna, Rajshahi and Rangpur Divisions.

Table 2a: Division wise distribution of union level facilities

Name of Division	Number of union level facilities	Facilities managed by DGFP	Facilities managed by DGHS
Barisal	313	242	71
Chittagong	887	660	227
Dhaka	1,243	893	350
Khulna	569	447	122
Rajshahi	582	391	191
Rangpur	573	419	154
Sylhet	294	223	71
Total	**4,461**	**3,275**	**1,186**

Facilities by management authority

Table 2b: Distribution of union level facilities by type and managing authority

Name of Division	UH&FWCs			USC	RD	Total union level facility
	Managed by DGFP	Managed by DGHS	Total UH&FWCs	Managed by DGHS		
Barisal	242	18	260	47	6	313
Chittagong	660	69	729	147	11	887
Dhaka	893	63	956	233	54	1,243
Khulna	447	35	482	87	0	569
Rajshahi	391	42	433	147	2	582
Rangpur	419	48	467	93	13	573
Sylhet	223	27	250	43	1	294
Total	**3,275**	**302**	**3,577**	**797**	**87**	**4,461**

Among the 3,577 UH&FWCs, 3,275 are managed by DGFP and 302 are managed by DGHS. In addition, there are 797 USCs and 87 RDs, which are managed by DGHS.

Table 2c: Distribution of union level facilities by ownership of the building

Divisions	DGFP			DGHS					Total
	UH&FWC			UH&FWC	USC		RD		
	Own building	Union Parishad building	Rented	Own building	Own building	Rented	Own building	Rented	
Barisal	239	3	0	18	45	2	6	0	313
Chittagong	640	16	4	69	141	6	11	0	887
Dhaka	844	40	9	63	222	11	53	1	1243
Khulna	430	13	4	35	86	1	0	0	569
Rajshahi	369	10	12	42	142	5	2	0	582
Rangpur	407	8	4	48	93	0	13	0	573
Sylhet	202	19	2	27	41	2	1	0	294
Total	**3,131**	**109**	**35**	**302**	**770**	**27**	**86**	**1**	**4,461**

The Table 2c above shows that 109 UH&FWCs of DGFP, out of the total 3,275, are operating from Union *Parishad* building and 35 are operating from a rented building. Among the 1186 DGHS managed centers there are 28 union level centers that are operating from rented houses and which do not have any permanent structure.

For further analysis, we have included all UH&FWCs that are operating from an owned building and all USCs and RDs that are presently conducting deliveries. They are labeled as "**union level facilities that are functioning as UH&FWCs"**. The total number of such facilities is **3,590.** Table 2d below provides the details of facilities that are included in the detailed analysis.

Table 2d: Distribution of union level facilities that are functioning as UH&FWCs

Divisions	DGFP	DGHS			Total
	UH&FWC	UH&FWC	USC	RD	
Barisal	239	18	14	2	273
Chittagong	640	69	14	1	724
Dhaka	844	63	39	11	957
Khulna	430	35	22	0	487
Rajshahi	369	42	35	0	446
Rangpur	407	48	10	2	467
Sylhet	202	27	6	1	236
Total	**3,131**	**302**	**140**	**17**	**3,590**

**All the UH&FWCs are considered (except those are operating from union parishad and rented buildings)*
*** For USC & RD, those conducting deliveries are considered (except those are operating from union parishad and rented buildings)*

3.2 Readiness of union level facilities equipped for or conducting normal delivery services

This section analyzes the readiness of UH&FWCs to provide delivery care services, against seven pre-requisites that are considered essential for providing delivery care services.

3.2.1 Categories of union level facilities designed to or conducting normal delivery services

The 3,590 UH&FWCs were grouped into three categories based on the cumulative scores they achieved from the assessment. The scores were assigned based on the critical elements required for providing normal delivery care and essential newborn care services at the facility. These included elements such as: the availability of FWV, midwifery skills training status of FWV, availability and condition of the delivery room, availability and condition of equipment, presence of medicines and essential supplies, availability of running water, usable toilet facility etc.

For ease of categorization, the assessment areas were divided into 7 sections. Sections were:

a) Approach road
b) Human resource availability
c) Mideifery skills training of staff
d) Physical infrastructure of facility
e) Availability of equipment
f) FWVs residence and
g) Availability of delivery room

Scores were assigned for each section according to the importance in relation to 24/7 delivery. Selected important areas were chosen for categorization, considering the priority areas for 24/7 delivery, as presented in the Table 3 below. This Table presents categorization criteria and the resources required. The Table below summarizes the variables used for categorization and the interpretation for each category of facility.

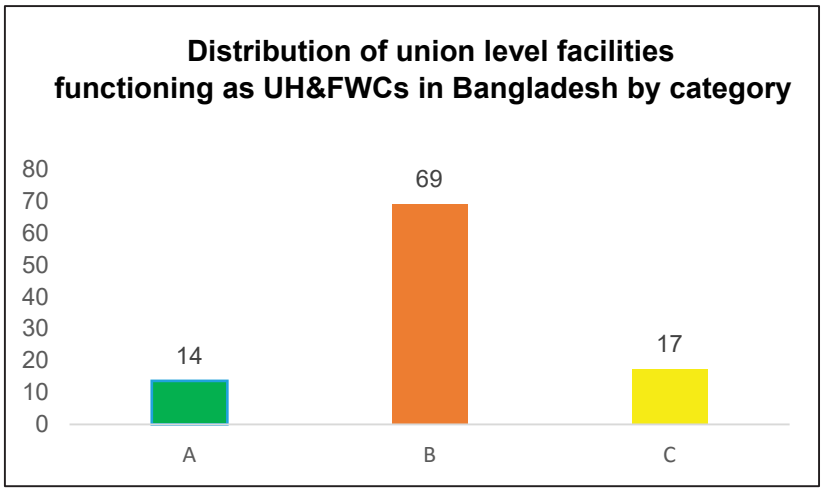
Table 3: Summary of the elements considered for categorization of facilities

Criteria	**A:** **No input required**	**B:** **Minor to moderate inputs required**	**C:** **Major inputs required**
Approach road	Easy access by any kind of vehicles (Van/ rickshaw etc.)	Accessible but condition is not good (*non-tarmac*, uneven road)	Road condition is extremely bad or no road. Vehicles cannot approach
Human resource availability	All service providers are available (FWV SACMO, Aya etc.)	Most of the service providers specially FWV is available	FWV not available
Training of HR	FWV trained in midwifery skill	FWV needs midwifery skills training	-
Infrastructure of the facility	Facility needs minor or no renovation	Facility needs minor to some renovation	Facility needs major renovation
Availability of delivery facilities	Labor or delivery table, water supply in handwashing space, electricity etc.	Available but not in usable condition	Not available
FWVs residence	Available and livable	Need minor or to some renovation	Need major renovation (toilets/ electricity etc.)

After posting all the scores, an aggregate score was calculated for each facility. Based on the aggregate scores, each facility was categorized into A, B or C, as indicated below:

- Aggregate Score between 201 and 301 = Category A
- Aggregate Score between 101 and 200 = Category B
- Aggregate Score below 100 = Category C

Figure 4: Distribution of union level facilities functioning as UH&FWCs by Category



Overall 17 percent facilities (Range: 10-22 percent) are in Category C, which means that these facilities need major physical renovation and investment on the infrastructure of the facility as well as residence for FWVs. Sixty-nine percent of facilities (Range: 65-75 percent) fall into Category B, which require minor to moderate level of inputs. These facilities may require some renovation of physical infrastructure and other inputs such as running water, electricity, staff placement/training, provision of minor equipment or supplies etc. The Category A facilities accounted for 14 percent of all facilities functioning as UH&FWCs (Range: 11-25 percent). These facilities are either already functional or need minimum resources to become fully functional.

Table 4: Distribution of number of union facilities functioning as UH&FWCs by category and by Division

Division	Total	Category A		Category B		Category C	
	N	n	%	n	%	n	%
Barisal	273	41	15	187	68	45	16
Chittagong	724	101	14	482	67	141	19
Dhaka	957	101	11	647	68	209	22
Khulna	487	63	13	333	68	91	19
Rajshahi	446	61	14	327	73	58	13
Rangpur	467	63	13	350	75	54	12
Sylhet	236	59	25	154	65	23	10
Total	**3,590**	**489**	**14**	**2,480**	**69**	**621**	**17**

Please refer to Annex B for a detailed information on district-wise distribution of facilities by category.

3.2.2 Population coverage

The population coverage for facilities ranges from 23,640 in Barisal Division to 30,364 in Dhaka Division. The lowest population coverage is under Azimpur UH&FWC in Chittagong district covering only 2,475 population and the highest coverage is under Sultanganj UH&FWC in Dhaka district covering 80,000 population. Fifty-six percent facilities cover more than 25,000 people and 44 percent cover more than 25,000 people.

Table 5: Distribution of union level facilities functioning as UH&FWCs by population coverage

Division	Number of union level facilities	No. of facilities covering <10,000 population	No. of facilities covering 10,001-20,000 population	No. of facilities covering 20,001-30,000 population	No. of facilities covering >30,000 population
Barisal	273	5	95	107	66
Chittagong	724	41	118	271	294
Dhaka	957	23	244	370	320
Khulna	487	5	142	229	111
Rajshahi	446	5	47	198	196
Rangpur	467	4	62	231	170
Sylhet	236	1	31	125	79
Total	**3,590**	**84**	**739**	**1,531**	**1,236**

3.2.3 Infrastructure

This section analyzes the condition of physical structure, including availability of electricity, water supply, hygiene and sanitation requirements for it to be able to provide safe delivery services. Among the 3,590 union facilities, 1810 are one-storied buildings, 1,684 are two-storied buildings and 96 are three-storied buildings. Additionally, a total of 109 UH&FWCs are located in Union *Parishad* building and 35 are located in rented buildings which are excluded from this analysis.

Table 6: Division wise distribution of union level facilities functioning as UH&FWCs according to type of structure

Name of Divisions	Total number of facilities	One-Storied	Two-storied	Three-storied
Barisal	273	131	140	2
Chittagong	724	368	330	26
Dhaka	957	454	465	38
Khulna	487	230	242	15
Rajshahi	446	250	191	5
Rangpur	467	283	179	5
Sylhet	236	94	137	5
Total	**3,590**	**1,810**	**1,684**	**96**

3.2.3.1 Physical Structure

The physical structure is important not only for providing quality services, but also to motivate the health care providers and to attract clients/patients to receive services. This section describes the current condition of the physical structure of the union level facilities, including the condition of the toilets, availability of safe water, and hygiene and sanitation facilities.

Table 7: Condition of physical infrastructure of union level facilities functioning as UH&FWCs

Name of Divisions	*Total number of facilities	FWVs room available in good condition[1]		Delivery room available in good condition[2]		Delivery table available in good condition[3]		Spot light available in good condition[4]		Space for hand washing in delivery room in good condition[5]		Toilet available in good condition[6]	
	N	n	%	n	%	n	%	n	%	n	%	n	%
Barisal	273	60	22	68	25	117	43	39	14	97	36	104	38
Chittagong	724	241	33	247	34	192	27	64	9	290	40	305	42
Dhaka	957	249	26	263	27	335	35	101	11	290	30	334	35
Khulna	487	167	34	154	32	210	43	77	16	171	35	171	35
Rajshahi	446	95	21	105	24	206	46	57	13	178	40	171	38
Rangpur	467	135	29	145	31	177	38	75	16	173	37	140	30
Sylhet	236	98	42	98	42	104	44	38	16	87	37	105	44
Total	**3,590**	**1,045**	**29**	**1,080**	**30**	**1,341**	**37**	**451**	**13**	**1,286**	**36**	**1,330**	**37**

** (both DGFP and DGHS center excluding those operating from union parishad and rented buildings and among USC and RD which provide normal delivery service)*
1: No repair required i.e. wall, floor, ceiling, window, door and electricity wiring are fine in the FWVs room.
2: No repair required i.e. wall, floor, ceiling, window, door and electricity wiring are fine in the Delivery room.
3: No repair required.
4: Light is functional.
5: Separate space for hand washing with available water i.e. pipe supplied water available.
6: One toilet is considering of union level facilities with no repair required i.e. wall, floor, ceiling, window, door, electricity wiring, water and sewerage line in good condition.

Information was collected on the condition of the building including walls, roof, window, approach road, delivery room, toilet, electricity, water supply etc. Thirty percent (30 percent) of the union health facilities had delivery room and 29 percent of FWVs rooms in good condition indicating that the facility's infrastructure is good. Availability of at least one toilet is considered in this analysis. Thirty seven percent (37 percent) facilities have at least one toilet functional. Water supply for hand washing is available in the delivery rooms of 36 percent of union level health facilities. About 66 percent of the facilities have good approach road.

3.2.3.2 Electricity supply

According to Bangladesh Health Facility Survey 2015, the definition of regular electricity supply suggests that the electricity supply will be provided from a central power grid and power supply should not be interrupted for more than two hours in a week. By this definition, regular supply of electricity is available only in 28 percent of UH&FWCs.

In this assessment, we considered a facility as having electricity supply available if it has any of the four sources of supply of electricity - government supply, solar power, generator or an IPS. Among the 3,590 union level health facilities equipped for conducting deliveries, about 70 percent of the facilities have electricity supply. Khulna and Rajshahi has the highest percentage (77 percent) of electricity supply available and Sylhet has the lowest (62 percent). Among these facilities which have electricity supply, most of them have government supply (98 percent) and a very few facilities are provided with solar, generator or IPS. A considerable proportion of union facilities (30 percent) do not have supply of electricity.

Table 8: Availability of electricity and water supply at union level facilities functioning as UH&FWCs

Name of Divisions	Total number of facilities *	Electricity available[1]		Water supply available[2]	
	N	Number	%	Number	%
Barisal	273	198	73	157	58
Chittagong	724	507	70	395	55
Dhaka	957	651	68	417	44
Khulna	487	373	77	236	48
Rajshahi	446	343	77	242	54
Rangpur	467	311	67	190	41
Sylhet	236	146	62	121	51
Total	**3,590**	**2,529**	**70**	**1,758**	**49**

** (both DGFP and DGHS center)*
1 Electricity by Govt. Solar, Generator or IPS
2 Piped supply of running water

Among the A category facilities, about 70 percent facilities have electricity supply. In B category and C category the percentages are 69 percent and 40 percent respectively. But a lot of A and B category facilities reliable electricity supply still need to be provided.

3.2.3.3 Water supply

This assessment suggests that about 49 percent of the union level health facilities are provided with piped water supply. Only Barisal, Chittagong and Rajshahi divisions have water supply provision in over 50 percent of the facilities. On the other hand in Dhaka and Rangpur division, a major proportion of the facilities (almost 60 percent) lacks proper piped water supply. Among the centers which had proper water supply, over 50 percent of the facilities still do not provide normal delivery service.

3.2.3.4 Staff residence

In terms of condition of the residence, only 21 percent of union level facilities have residence in good condition, where at least one bedroom and one toilet are in good condition. Interestingly, even in this 21 percent residences, only 42 percent of FWVs (323 out of 771) are currently staying at the residence provided.

Table 9: Status of FWV residence at union level facilities functioning as UH&FWCs

Name of Divisions	Total number of facilities	Residence available in good condition for FWVs*		FWV currently residing at the residence	
	N	Number	%	Number	%
Barisal	273	59	22	40	68
Chittagong	724	164	23	94	57
Dhaka	957	185	19	68	37
Khulna	487	126	26	32	25
Rajshahi	446	82	18	27	33
Rangpur	467	88	19	19	22
Sylhet	236	67	28	43	64
Total	**3,590**	**771**	**21**	**323**	**42**

**Master bed room and toilet in good condition considered as residence available in good condition*

Compared to facilities in categories B and C, nearly double the number of Category A facilities have delivery rooms and FWVs rooms in good condition. Similarly hand washing facilities, toilets and residences are in better condition in A category facilities.

Table 10: Comparison of infrastructure between A category facilities with all union level facilities functioning as UH&FWCs

	Total number of UH&FWC		Total number of A category UH&FWC	
	N=3,590		N=489	
	n	%	n	%
Approach road in good condition	2,376	66	380	78
FWVs Room available in good condition	1,045	29	294	60
Delivery room available in good condition	1,080	30	313	64
Separate space for hand washing in delivery room in good condition	1,286	36	357	73
Toilet available in good condition	1,330	37	319	65
Residence available in good condition for FWVs	771	21	220	45
Electricity available	2,529	70	465	95
Water supply available	1,758	49	426	87

3.2.4 Human resources

As per the staffing norms, each union health facility has provision of a medical officer (MO), SACMOs, FWV, Aya and Night guard/MLSS who provide health services. Only outpatient services are available at union level facilities. For the purpose of analyzing the readiness for delivery care, the analysis has focused on the status of FWV, SACMO and support staff.

The assessment shows that 81 percent of union level health facilities which are functioning as UH&FWCs have FWVs posted. In addition, FWVs were available in many more facilities at the time of assessment. This is due to local staffing arrangements such as deputations, additional charge etc. Thus, a total of 95 percent union level facilities that are functioning as UH&FWCs had FWV available at the time of assessment. SACMOs were posted to 71 percent union level health facilities and additional seven percent had SACMO available through other arrangements. Availability of Aya and MLSS were 73 percent and 70 percent respectively.

Table 11: Status of human resources at union level facilities functioning as UH&FWCs

Name of Divisions	No of facilities	FWV Posted [1]		FWV available [2]		FWV resided in the center [3]		SACMO Posted [4]		SACMO available [5]		Aya available [6]		MLSS available [7]	
	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Barisal	273	238	87	264	97	127	47	199	73	221	81	194	71	195	71
Chittagong	724	596	82	700	97	269	37	488	67	543	75	502	69	445	61
Dhaka	957	773	81	923	96	265	28	741	77	794	83	709	74	702	73
Khulna	487	377	77	454	93	106	22	346	71	403	83	351	72	353	72
Rajshahi	446	356	80	412	92	106	24	376	84	398	89	326	73	331	74
Rangpur	467	366	78	436	93	96	21	296	63	323	69	369	79	361	77
Sylhet	236	188	80	234	99	105	44	104	44	128	54	159	67	130	55
Total	**3,590**	**2,894**	**81**	**3,423**	**95**	**1,074**	**30**	**2,550**	**71**	**2,810**	**78**	**2,610**	**73**	**2,517**	**70**

1: Only regular FWVs are considered.
2: All FWVs are considered.
3: FWV resided in the center.
4: Only regular SACMOs are considered.
5: All SACMO are considered.
6: All Aya are considered.
7: All MLSS are considered.

The DGFP has been providing additional six-month midwifery skills training to FWVs as an in-service training to improve their skills in managing labor and delivery. This training is conducted at the MCHTI Azimpur, Dhaka and Mohammadpur Fertility Services Training Center (MFSTC), Dhaka. FWVs who have already completed the 18 months basic training and served at least for two years at a union level facility are eligible to receive this training.

The assessment shows that FWVs in 47 percent of union level facilities functioning as UH&FWCs had undergone the midwifery skills training. In 78 percent of union level facilities, the FWVs have received training on Helping Babies Breathe (HBB) training. For training on PPFP and nutrition the percentage is 39 percent and 46 percent respectively.

Table 12: Training status of FWV posted at union level facilities functioning as UH&FWCs

Name of Divisions	No of facilities	FWV available		FWVs received training in midwifery skills		FWVs received training in HBB		FWVs received training in postpartum FP		FWVs received training in nutrition	
	N	n	%	n	%	n	%	n	%	n	%
Barisal	273	264	97	129	47	207	76	131	48	152	56
Chittagong	724	700	97	370	51	562	78	384	53	393	54
Dhaka	957	923	96	425	44	737	77	287	30	343	36
Khulna	487	454	93	221	45	375	77	152	31	258	53
Rajshahi	446	412	92	208	47	360	81	122	27	126	28
Rangpur	467	436	93	194	42	384	82	167	36	206	44
Sylhet	236	234	99	133	56	180	76	142	60	156	66
Total	**3,590**	**3,423**	**95**	**1,680**	**47**	**2,805**	**78**	**1,385**	**39**	**1,634**	**46**

3.2.5 Availability of equipment and supplies

Among the 3,590 union level facilities, 79 percent centers have useable adult stethoscope, 68 percent have blood pressure (BP) measuring machine available in good condition, 56 percent have baby weighing machine in usable condition and 74 percent centers have HBB logistics in usable condition. The other essential equipment and supplies assessed are presented in Table 13 below:

Table 13: Equipment & supply at union level facilities functioning as UH&FWCs

Name of Divisions	No of facilities	Adult stethoscope		BP Machine		Baby weighing scale		Kidney tray		Scissors		Umbilical cord clamp or tie		HBB* logistics		Artery Forceps	
		available in good/ useable condition															
	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Barisal	273	194	71	148	54	140	51	261	96	244	89	64	23	159	58	104	38
Chittagong	724	495	68	404	56	309	43	655	90	627	87	161	22	462	64	337	47
Dhaka	957	749	78	646	68	479	50	914	96	862	90	210	22	762	80	885	92
Khulna	487	436	90	388	80	325	67	471	97	461	95	135	28	409	84	450	92
Rajshahi	446	411	92	346	78	318	71	429	96	419	94	159	36	383	86	421	94
Rangpur	467	409	88	379	81	322	69	449	96	428	92	144	31	364	78	436	93
Sylhet	236	145	61	131	56	109	46	202	86	189	80	55	23	111	47	82	35
Total	**3,590**	**2,839**	**79**	**2,442**	**68**	**2,002**	**56**	**3,381**	**94**	**3,230**	**90**	**928**	**26**	**2,650**	**74**	**2,715**	**76**

**1 bag, 0 and 1 size 2 mask available and in good condition consider.*

The BHFS 2014 showed that more than 80 percent of all Bangladesh health facilities have a stethoscope and blood pressure apparatus scale available. In contrast, a child scales were found in only 29 percent of facilities. Only a quarter of all facilities (35 percent excluding CCs) have all of the following six basic items of equipment: stethoscope, thermometer, blood pressure apparatus, adult scale, child scale/infant scale, and light source[v].

3.2.6 Status of management committees

By engaging members of the local community, such as the local leaders, elites, especially women in the management of UH&FWCs, the acceptance and utilization of services as well as the overall ownership and management of these facilities could be improved. The MOH&FW has promoted the establishment of a 15 member management committee for union level facilities, with the Union *Parishad* Chairman as the Chair and MO or SACMO as the Member Secretary. The Vice Chairperson is a respected elected women ward member of the Union *Parishad*. This committee is expected to ensure the quality of services and take necessary steps to mobilize resources to meet the needs. The committee is expected to meet once in every two months.

Table 14: Status of management committee at union level facilities functioning as UH&FWCs

Name of Divisions	No of facilities	Facilities management committee exists		*Active committees among the existing management committees	
	N	n	%	n	%
Barisal	273	192	70	141	73
Chittagong	724	443	61	325	73
Dhaka	957	403	42	234	58
Khulna	487	175	36	96	55
Rajshahi	446	285	64	184	65
Rangpur	467	297	64	207	70
Sylhet	236	73	31	53	73
Total	**3,590**	**1,868**	**52**	**1,240**	**66**

** Meetings held in last six months with documented minutes of the meeting.*

The assessment found that a total of 1,868 union level health facilities have management committee (52 percent). Only 66 percent committees of these are active, which means they had held at least one meeting in the last six months, as verified by records such as minutes of the meetings. Barisal division has the highest proportion of management committees (70 percent) and Sylhet division has the lowest (31 percent).

3.2.7 Current status of delivery care service provision

Table 15: Status of delivery care services at union level facilities functioning as UH&FWCs (as reported by service provider)

Name of Divisions	No of facilities	Facilities providing any delivery care services		Facilities providing delivery care on 24/7 basis	
	N	n	%	n	%
Barisal	273	151	55	97	36
Chittagong	724	353	49	178	25
Dhaka	957	560	59	186	19
Khulna	487	244	50	80	16
Rajshahi	446	211	47	51	11
Rangpur	467	240	51	68	15
Sylhet	236	161	68	89	38
Total	**3,590**	**1,920**	**53**	**749**	**21**

The assessment looked at the number of deliveries conducted at the union level health facilities during the full calendar year of 2014. A total of 76,103 deliveries were conducted in 1920 union level facilities in calendar year 2014. The average number of deliveries per union level facilities that are functioning as UH&FWCs is 39 and the range is 0 to 1,578.

Overall, 53 percent union health facilities are conducting some deliveries at the facility. Only 21 percent of facilities are providing services on a 24 hours a day, seven days a week (24/7) basis. 47 percent centers are not providing any delivery services that is “0” deliveries in a year. Among the 53 percent union level health facilities, where delivery services are available, 39 percent are providing it on a 24/7 basis.

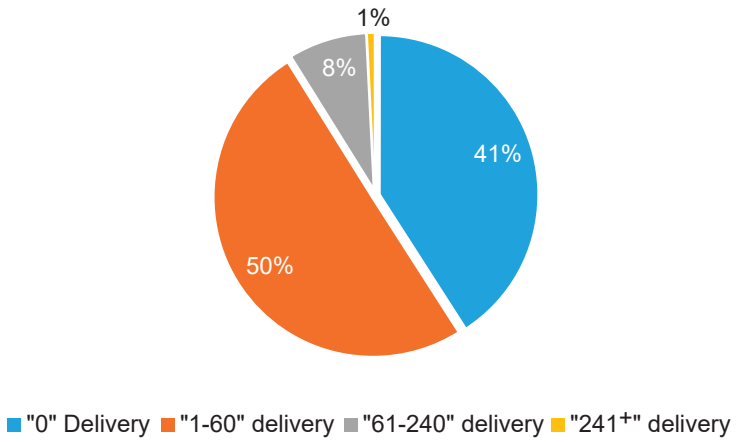
The Table 16 below has grouped the union level facilities that are functioning as UH&FWCs according to the performance of normal deliveries. Group 1 conducting “1-60” deliveries in a year, which means on an average 0 – 5 deliveries per month, Group 2 having “61-240” deliveries in a year, which means on an average 5^{+} - 20 deliveries per month and Group 3 having “241^{+}” deliveries in a year, which means on an average 20+ deliveries per month. Among all the union level facilities 50 percent are in Group 1, eight percent are in Group 2 and less than one percent centers are in Group 3.

Table16: Provision of delivery care services at union level facilities functioning as UH&FWCs (as reported through MIS)

Name of Divisions	No of facilities	Facilities conducting delivery in 2014							
		"0" delivery		"1-60" delivery		"61-240" delivery		" 241+" delivery	
	N	n	%	n	%	n	%	n	%
Barisal	273	131	48	122	45	19	7	1	0
Chittagong	724	392	54	255	35	70	10	7	1
Dhaka	957	383	40	522	55	51	5	1	0
Khulna	487	195	40	276	57	16	3	0	0
Rajshahi	446	127	28	284	64	30	7	5	1
Rangpur	467	161	34	216	46	81	17	9	2
Sylhet	236	80	34	127	54	24	10	5	2
Total	**3,590**	**1,469**	**41**	**1,802**	**50**	**291**	**8**	**28**	**1**

Among the 3,590 union level facilities that are functioning as UH&FWCs, only 28 are performing at least 241 or more deliveries in a year.

Figure 5: Provision of delivery care services at union level facilities functioning as UH&FWCs



3.3 Detailed analysis of service readiness and current provision of services

In order to better understand the factors that may be hindering the provision of delivery care services through UH&FWCs, a detailed analysis was conducted combining multiple variables, such as:

a. Availability of delivery room in good condition
b. Availability FWV trained in midwifery skills
c. Residential status of the FWV
d. Availability of FWV residence in good condition

3.3.1 Delivery room in good condition with FWVs trained in midwifery skills

A well trained FWV can provide better quality services to the community if the infrastructure especially the delivery room is in good condition and is well equipped. A total of 1,080 union level facilities (30 percent) have good delivery room available in good condition. Only 15 percent of all UH&FWCs (n=523) have both "delivery room in good condition and at least one FWV who has received the six-month midwifery skills training". This also means, more than half of the UH&FWCs that have a delivery room in good condition, do not have a FWV posted with midwifery skills training. The Table 17 below summarizes the presence of these two factors in combination in facilities working as UH&FWCs.

Table 17: Distribution of union level facilities functioning as UH&FWCs having delivery room in good condition and FWVs trained in midwifery skills

Name of Divisions	No of facilities	Delivery room available in good condition		Facilities with FWVs trained in midwifery skills and delivery rooms in good condition	
	N	n	%	n	%
Barisal	273	68	25	26	38
Chittagong	724	247	34	132	53
Dhaka	957	263	27	115	44
Khulna	487	154	32	72	47
Rajshahi	446	105	24	59	56
Rangpur	467	145	31	68	47
Sylhet	236	98	42	51	52
Total	**3,590**	**1,080**	**30**	**523**	**48**

3.3.2 Performance of union level facilities having delivery room in good condition with FWVs trained in midwifery skills

About one-fourth of the facilities that are functioning as UH&FWCs and have a delivery room in good condition (n=130) did not conduct any deliveries in the year 2014, despite having delivery room in good condition and a FWV posted with midwifery skills training. The highest number of "0" delivery is in Chittagong division (42 percent). Only 1.7 percent union level facilities conducted more than 240 deliveries in 2014. Rajshahi division (5 percent) has the highest number of facilities conducting >241 deliveries in 2014; Dhaka and Khulna divisions have none.

Table 18: Performance at union level facilities functioning as UH&FWCs having delivery room in good condition and FWVs trained in midwifery skills

Name of Divisions	Centers with ready delivery room and FWVs trained in midwifery skills		Performance in 2014							
			"0" delivery		"1-60" delivery		"61-240" delivery		"241+" delivery	
	n	%	n	%	n	%	n	%	n	%
Barisal	26	10	5	19	12	46	8	31	1	4
Chittagong	132	18	56	42	51	39	22	17	3	2
Dhaka	115	12	23	20	80	70	12	10	0	0
Khulna	72	15	14	19	53	74	5	7	0	0
Rajshahi	59	13	11	19	40	68	5	8	3	5
Rangpur	68	15	12	18	43	63	12	18	1	1
Sylhet	51	22	9	18	35	69	5	10	2	4
Total	**523**	**15**	**130**	**25**	**314**	**60**	**69**	**13**	**10**	**2**

3.3.3 Union facilities functioning as UH&FWCs having delivery room in good condition and FWVs trained in midwifery skills who reside at the center

It is well known that if the FWV resides at the center, the community will have greater confidence about the availability of services at the facility and hence the utilization will also be high. The assessment shows that only 211 union level health facilities are having the ready delivery room with trained FWVs who resides at the facility, which is only 6 percent among the total 3,590 union level health facilities.

Table 19: Union facilities functioning as UH&FWCs having delivery room in good condition and FWVs trained in midwifery skills reside in the facility

Name of Divisions	No of facilities	Facilities having delivery room in good condition and FWVs trained in midwifery skills residing at the facility	
	N	n	%
Barisal	273	17	6
Chittagong	724	53	7
Dhaka	957	56	6
Khulna	487	22	5
Rajshahi	446	18	4
Rangpur	467	21	4
Sylhet	236	24	10
Total	**3,590**	**211**	**6**

3.3.4 Performance of union level facilities in different situation

Having good delivery room with a FWV who resides at the residence of union level facility is a positive situation for performing normal delivery services at the center compared to a situation when FWV is not residing in the facility. Only six percent of the union level facilities are having delivery rooms in a good condition as well as FWVs posted and residing in the facility.

Table 20a: Performance of union facilities functioning as UH&FWCs having delivery room in good condition and FWVs trained in midwifery skills residing at the facility

Name of Divisions	No of facilities	Facilities having ready delivery room with FWVs trained in midwifery skillsresiding at the facility		Performance in 2014							
				"0" delivery		"1-60" delivery		"61-240" delivery		"241+" delivery	
	N	n	%	n	%	n	%	n	%	n	%
Barisal	273	17	6	1	6	9	53	6	35	1	6
Chittagong	724	53	7	9	17	27	51	16	30	1	2
Dhaka	957	56	6	6	11	39	70	11	20	0	0
Khulna	487	22	5	1	5	19	86	2	9	0	0
Rajshahi	446	18	4	1	6	12	67	3	17	2	11
Rangpur	467	21	4	2	10	13	62	6	29	0	0
Sylhet	236	24	10	3	13	18	75	2	8	1	4
Total	**3,590**	**211**	**6**	**23**	**11**	**137**	**65**	**46**	**22**	**5**	**2**

Table 20b: Performance of union level facilities functioning as UH&FWCs based on key characteristics as reported in 2014

Facility characteristics	Number (%)*	Median number of deliveries in 2014
Having delivery room in good condition	675 (32)	20
Having delivery room in good condition and FWV resides in the facility	321 (15)	25
Having delivery room in good condition, FWV trained in midwifery skills and FWV resides in the facility	198 (9)	32

**Only within 2120 UHFWCs that reported delivery in 2014*

Above Table indicates the union facilities are able to perform better when FWVs reside at the center whether she is trained or untrained.

To understand the association or degree of necessity of above factors for better performance of union facilities, we looked at the statistical associations (Chi-squire). It shows that the presence of good delivery room and presence of FWVs at residence is significantly associated with better performances (as measured by number of deliveries).

Table 20c: Association between enabling factors for better performance of union level facilities that are functioning as UH&FWCs in 2014

Facility characteristics	Number of facilities reported delivery in 2014 (%)	Number of facilities that conducted more deliveries than the average number of delivery in 2014 (%)	Degree of association (p-value)
Having delivery room in good condition	675 (32)	331 (49)	0.10
Having delivery room in good condition and FWV resides in the facility	321 (15)	157 (49)	0.00
Having delivery room in good condition, FWV trained in midwifery skills and FWV resides in the facility	198 (9)	98 (50)	0.00

Regular posting of FWVs, completion of midwifery skills training of FWV and their residence in the facility, improves the performance in terms of number of deliveries conducted at the facilities by many folds.

4. Conclusions and recommendations

This assessment concludes that the union level facilities in the country have high potential to rapidly increase the provision of life-saving care to mothers and newborns around the time of birth. There are several union level facilities, both under DGFP and DGHS, that have all the basic elements for conducting normal vaginal delivery services, yet they are not currently providing such services. This is an important missed opportunity and “low hanging fruit” for increasing deliveries at health facilities.

The assessment concludes that:

- Majority of the union facilities can provide delivery care services with minor to moderate inputs, such as renovation of physical infrastructure, deployment or midwifery skills training of FWV or ensuring the availability of essential equipment and supplies
- In order to ensure availability of key staff, the deployment according to need and readiness of facilities, competency development, supportive supervision and ensuring that they reside at the facilities need to be the main focus.
- Many of the infrastructure gaps are minor in nature. It is possible to mobilize local level actions and resources to address the gaps
- UH&FWC management committees need to be strengthened for local ownership and oversight
- Management and supervision need to be strengthened to improve the performance of facilities that are “ready”

To accelerate the strengthening of these facilities, the MOH&FW needs to prioritize the following activities to implement across the health system of Bangladesh. These activities need to be implemented in a harmonized way to maximize the use of constrained resources. The MOH&FW may consider a phased approach of expansion as it proceeds with investing on the strategy. A strong coordination mechanism is required at the level of MOH&FW to ensure that the efforts of different ministries, directorates and departments are coordinated to ensure the provision of infrastructure, human resources, equipment and logistics, local accountability and mobilization and information systems support to the union level facilities.

4.1 Use of the categorization of facilities for prioritization of infrastructure development

For the sake of synchronized implementation, the facilities that are functioning as UH&FWCs will be grouped in to the following three categories, based on the extent of anticipated physical renovation and other inputs required.

Category A: These facilities meet most of the requirements to provide normal delivery services. Several of these facilities already have physical space, essential equipment and trained staff to provide delivery services and are already conducting some deliveries. However, some of these facilities will require additional renovation or physical improvements, such as residence for staff, running water. Equipment and furniture may need repair or replacement. In addition, these facilities may need additional staff to ensure availability of round the clock services. **The total number of these facilities is in category A is 489.**

Category B: Majority of the UH&FWCs are in this category Additional inputs will be required to renovate the staff residence and to ensure water supply and electricity. Also, additional staff, equipment and basic furniture will be required in these facilities. **The total number of facilities in this category is 2,480.**

Category C: These facilities require major inputs for renovation and upgrade. **The total number of facilities in this category is 621.** All these facilities will require major inputs for physical renovation, procurement of new equipment and furniture and additional staff to provide round the clock services. Among these, 85 percent of these facilities are located more than five kilometers away from the nearest UHC and 93 percent are located more than ten kilometers from the nearest district hospital. This means that the residents under their catchment areas do not have adequate access to life-saving essential services. These facilities need to be prioritized for making major investments in renovation of physical infrastructure.

Even though strengthening category C facilities would require major investments, it is critical to focus on these facilities to improve equitable access. Only in 15 percent category C facilities, the UHC is available within 5km distance. At least 85 percent category C facilities neither have a district hospital nor a UHC within five km distance. This means that the population residing in the catchment areas of the remaining 85 percent category C facilities have to travel more than 5km to get to a facility. Hence, these facilities need to be prioritized while planning for investments in category C facilities. In addition, there 109 UH&FWCs are operating from Union *Parishad* buildings and 35 are in rented buildings (Table 2c). Infrastructure development for these facilities need to be prioritized.

In addition there are 358 unions without any health facilities (Table 1). The MOHFW need to prioritize these unions for establishment of new union level facilities. A total of 737 unions have USC or RD that are not conducting deliveries. DGHS should prioritize these facilities to make sure that they are upgraded to UH&FWCs. Staff trained in midwifery skills, such as the new diploma midwives, should be posted to these facilities under the management of DGHS.

4.2 Human resources

Currently, only one FWV is posted or sanctioned to most of the UH&FWCs to provide normal delivery services. The same FWV is also responsible for conducting eight satellite clinics in a month, in addition to family planning and other service provided at the UH&FWC. In facilities that provide round the clock delivery services, it is essential to add the position of one more FWV. Both the FWVs should also be able to reside at the facility. In addition, one full-time Aya and one full-time cleaner are proposed for each facility to ensure assistance to the FWV during delivery and to maintain adequate cleanliness of the facility. We propose a few immediate and long-term steps to address the human resources gaps:

Immediate:

- Deploy one residential FWV and one SACMO in all union level facilities. This may require recruitment of additional FWVs
- Relocate CSBAs temporarily to UH&FWCs to provide ANC and delivery care where necessary (if utilization is high or FWVs are not available)
- Consider deployment of newly licensed midwives on a priority basis to facilities where FWVs are not posted
- Negotiate temporary arrangement with NGO programs to deploy trained and certified paramedics, privately trained CSBAs, cleaners to assist FWVs as part of district/ upazila level plans
- Work with Union Education, Health and Family Planning Standing Committees and Union *Parishad* for recruiting cleaners through local fund.

Intermediate to long term:

- Expedite midwifery skills training of newly recruited FWVs
- Plan for recruitment of additional FWVs to be deployed to union level facilities that are conducting more than 20 deliveries a month and functioning on 24/7 basis
- Assess the feasibility of upgrading eligible FWVs to midwives meeting the standards set by International Council of Midwives.

4.3 Training, supportive supervision and quality assurance

MOH&FW needs to ensure all existing FWVs receive refresher training and newly recruited FWVs have undergone the in-service midwifery skills training. The following managers could be assigned at different levels to provide supportive supervision and necessary clinical/technical support to ensure service quality.

- District: Assistant Director- Clinical Contraception (ADCC)
- Upazila: Medical Officer- Maternal and Child Health (MO-MCH), Medical Officer-Mother and Child Welfare Center (MO-MCWC) and Senior FWV
- Additional technical/supervisory support: District/ upazila Quality Improvement Committees

The FWVs need to receive basic training followed by rotating attachment at District Hospitals and MCWC for one week every six months. In addition, the quality improvement committees established at the district and upazila levels should provide guidance and supervision support to union level facilities to implement quality improvement initiatives.

4.4 Furniture, equipment and supplies

Depending on the category of the facility, the requirements may vary. All facilities will require essential items such as delivery table, one patient bed, instrument trolley, spot lights, BP machine, weighing scales, newborn resuscitation equipment, delivery sets, sterilization equipment, generator for power back up etc. Furniture may need be newly procured or repaired. The items could include examination table, table and chairs for FWV room, almirah and shelves. Additional items such as buckets, waste bins etc. will also be required to ensure cleanliness and appropriate waste management. Recently 1,734 facilities of DGFP got delivery tables from government.

4.5 Referral

In coordination with DGHS, Line Director- Maternal, Child, Reproductive, and Adolescent Health (LD-MCRA&H) of DGFP will establish a referral system to ensure timely referral of the complicated cases from UH&FWCs to appropriate UHC, DH or MCWC. This system will include proper and timely assessment, transport, and communication network, prompt availability of referral level care, follow-up and documentation. Emergency helplines at UHCs will be activated to provide necessary support to the families. Lessons from BRAC and MaMoni HSS will be considered to engage community groups especially to facilitate notification and local transport. The referral linkages between CCs and union level facilities need to be strengthened. Since the CCs are providing some antenatal services, and since they are located closer to communities, they can encourage more mothers to use the union level facility for normal delivery care.

4.6 Engagement of the local government and local community

The MOH&FW needs to work in close collaboration with the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C) and particularly with the Local Government Division to engage the decentralize LG institutions to strengthen UH&FWCs. The Union *Parishads* must:

- Allocate budget to support minor repair and maintenance cost (e.g. security guard), and
- Conduct local level advocacy and ensure community engagement
- Provide oversight and support to the functioning of the UH&FWCs, including accountability of the service providers

MOHFW will initiate a dialogue and develop a coordination mechanism with the MOLGRD&C to ensure that the:

- Deputy Commissioners (DCs), Upazila Nirbahi Officers (UNOs) and Upazila Chairmen are aware of the initiative and provide all necessary support the Union Parishads,
- Community engagement through members of the UPs, CGs and CSGs,
- Local management support through the UH&FWC Committees and oversight through Union Education, Health and Family Planning Standing Committees.
- UPs mobilize local resources through their respective funds to cover expenses like employment of security guard or cleaner for the facility, build access roads and support waste management.

At local level, the health and family planning workers will work with different community groups to increase community awareness and engage the groups to extend maximum support to the pregnant mothers in accessing ANC, safe delivery, and postnatal care services from the facilities. NGOs may be requested to facilitate the community mobilization activities in the unions.

4.7 Other supportive activities

The interventions to strengthen the union level facilities will also rely on complementary and supplementary functions of other tiers and partners of the health system. The MOH&FW will generate support from other sectors in local resource mobilization.

Role of the community clinics

MOH&FW has established 13,094 CC, which are unique additions to the service delivery organization of Bangladesh health systems. CCs must provide regular antenatal care services, identify complications of pregnancy (e.g. pre-eclampsia), ensure referral and promote delivery at 24/7 union level facility. The CSG and CG should mobilize the community and identify community pockets with barriers to care seeking and address them.

Support from Development Partners/NGO programs

Several projects/initiatives operated by development partners and NGOs have demonstrated significant success in increasing SBA coverage through strengthening union level facilities and other related health systems activities. MOH&FW should solicit their support and develop a coordination mechanism to ensure optimal utilization of their potential. This will be done at the central as well as at local levels.

MOH&FW may convene workshops with all relevant stakeholders to receive support from each of them towards this strategy.

Strengthening the information systems

The health information systems of DGHS and DGFP need to be strengthened to allow tracking of all mothers from pregnancy through childbirth and postnatal/newborn period. In this direction, the registers of the FWVs have been simplified into a combined maternal and newborn health register. This new MNH register need to be rolled out to all union level facilities, including those under the management of DGHS. It is also recommended that the recording and reporting system should be automated using electronic tools. Tracking of individual union level facilities for the provision of MNH care could be made possible by using electronic MIS systems.

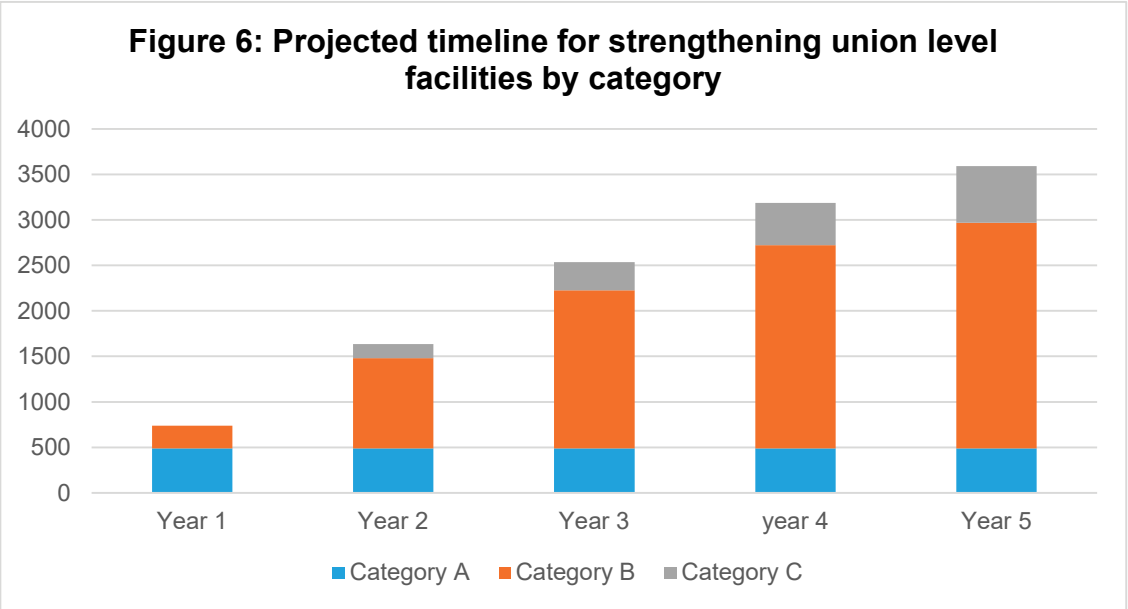
5. Projected benefits of strengthening the union facilities

The fourth HNP Sector Program (HNPSIP 2017-2021) has set a target to reduce the maternal mortality ratio (MMR) to less than 90 per 100,000 live births by the year 2030. The corresponding increase in other maternal health and reproductive health services are required to reach this goal, including the target of 65 percent births to be attended by skilled birth attendants by the year 2021. As per BMMS 2010, the MMR reported for 2010 is 194. The UN report of 2013 projected that the MMR has declined to 170 in 2013. Further decline in MMR in Bangladesh will require accelerated measures to improve the coverage and quality of skilled birth attendants, particularly in the rural and low-performing areas. Substantial investments in strengthening union level facilities to provide round the clock services for conducting normal deliveries is a quick win for Bangladesh, as the unmet need for maternal health services is particularly high in rural areas. Below is an analysis of potential benefits of strengthening the union level facilities for providing skilled assistance at birth.

According to MOH&FW Health Bulletin 2015, the average population of a union in Bangladesh is 34,748. It is estimated that each union will have 774 births per year. As per BDHS 2014, only 42 percent deliveries are assisted by SBAs. The majority of these SBA deliveries happen at private or NGO health facilities (about 22 percent) and public sector referral facilities (about 13 percent). Less than one percent occurred at home with a SBA. Approximately five to seven percent took place at union level facilities.

Based on experiences from different districts in Bangladesh, it is expected that the utilization rates will rapidly increase once client-friendly and high quality services become available round the clock at the union level facilities. If Bangladesh can implement a phased implementation of an accelerated plan, all 3,590 union level facilities can provide normal delivery care services. We propose to prioritize category A and B facilities in the first year, followed by gradual strengthening of the remaining facilities. The Figure 6 below shows a proposed timeline for strengthening the various categories of facilities during the next HNP sector plan period.

Figure 6: Proposed timeline for strengthening of UH&FWCs by category



Based on past experiences from projects such as MaMoni HSS and WATCH, it is established that the utilization of MNH services will rapidly increase when the union level facilities provide regular and predictable services with quality. Overall, it can be expected that the total number of deliveries occurring at union facilities could increase several folds from 76,103 reported in 2014. In order for the country to achieve the target of 65 percent SBA coverage by 2021 set in the draft of the fourth sector program, the public sector share has to increase to at least 20 percent by 2021[v]. This will be possible only if the union level facilities contribute at least half of those public sector facility deliveries. With the current trends indicating a rapid increase in the proportion of deliveries in the private sector, along with the facility deliveries in other public sector facilities (UHC, DH, MCWC, medical colleges) and at NGO managed facilities, this would be sufficient to achieve over 65 percent SBA coverage across the country by 2021[v].

In addition, the ancillary services, such as antenatal care and postnatal care family planning services will rapidly increase, which will also contribute to reducing maternal mortality. It is also expected that the identification of complications related to pregnancy, labor and postnatal period will also improve significantly. Small improvements are expected for deliveries by SBA at home, due to the overall efforts to train more CSBAs in the country, the improvements in antenatal care provide by the FWVs as well as the improvements in community awareness and behaviors. The services of CSBAs and the FWVs will also improve prompt identification of complications and referral to upazila and district level facilities in the public and private / NGO sectors. If the program could adequately focus on improving the quality of care, corresponding improvements could also be expected in the coverage of various life-saving maternal health interventions, such as Active Management of Third Stage of Labour (AMTSL), prevention and management of eclampsia and pre-eclampsia, prevention and management of post-partum hemorrhage, management of pre-term labor using antenatal corticosteroids etc.

Annex A: Assessment Tool

Union Health & Family Welfare Centre (UH&FWC)
Assessment Questionnaire

Questionnaire ID | | | |

Facility Code | | | | | | |

Assessment Date:
_____

Assessment Start Time:
_____

Assessment End Time:
_____

Assessment done by:

Signature:
_____

Name:
_____

Designation:
_____

Organization: _____

Cell number:
_____

Questionnaire checked by:

Signature:
_____

Name:
_____

Designation:
_____

Organization: _____

Cell number:
_____

Instruction
Introduce yourself & explain why are you here
(The purpose is to evaluate whether the union facility can be developed into a quality mother & child health care center; so that the center can provide 24/7 delivery service along with other services)

Section 1: General information

1.1.0 Division: _____1.1.1 District: _____ 1.1.2 Sub-districtt_____1.1.3 Union: _____

1.2 Total population of the Union 1.Men_____ 2.Women _____ Total: _____

1.3 Number of eligible couple :(ELCO) _____

1.4 Name of UH&FWC_____

1.5 GPS Coordinate: Latitude (N) _____ ^{0} _____' _____ " Longitude (E) _____ ^{0} _____' _____ "

1.6 Road pattern to go to the facility: 1. Kaccha Rasta 2. Brick's road 3. Concreate road
4. Cement road 5. River 6. Others, mention_____

1.7 Road condition for communicating: 1. Good (Easy to go by CNG, Auto-rickshaw or Van can come easily)
2. Not good
2.1 Badly Broken 2.2 others

1.8 Whether boundary clearly demarcated? 1. Yes 2. No → go to 1.10

1.9 Type of boundary demarcation present? 1. Boundary wall 2. Wired fence 3. Others, write specifically
_____

1.10 Signboard and citizen charter present? 1. Yes 2. No

Section 2: Management of the center

2.1 Name of the respondent (1): _____ 2.2 Designation: _____

2.3 Name of the respondent (2)_____ 2.4 Designation: _____

2.5 The center is under which directorate? 2.5.1 DGFP 2.5.2 DGHS

2.6 How far is the facility from the district hospital: _____ k.m.

2.7 Whether any management committee exists for the center? 1. Yes 2. No → go 2.10 3. Don't know→ go 2.10

2.8 Was any meeting held of management committee in last 6 months? 1. Yes 2. No →go 2.10

2.9 Meeting date: 1. ___/_____/_____ 2. _____/_____/_____
3. _____/_____/_____ 4. _____/_____/_____

	Dry session	Rainy session
2.10 Name of the village farthest from the facility		
2.11 Distance from the farther village to the facility? (in Km.)		
2.12 What kind of transport is usually used to come to the facility from that place?	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____
2.13 Approximately how much time it takes to reach to the facility (minutes)	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____

Section 3: Staff information

Designation	Employee present (Number)	Remarks (Attached, Deputation on center, employed in other place/ not applicable etc. specify)
3.1 Medical officer		
3.2 Sub Assistant Community Medical Officer		
3.3 Family Welfare Visitor		
3.4 Pharmacist		
3.5 Aya		
3.6 Security guard/ MLSS		
3.7 Others, write specifically		

Section 4: Information about training of caregiver

Whether service provider received the below mentioned training?	Sub Assistant Community Medical Officer	Family Welfare Visitor
4.1 Training on midwifery skills	1. Yes 2. No 3. Not applicable	1. Yes 2. No 3.Not applicable
4.2 Field Training on nutrition	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.3 ARH training	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.4 IMCI	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.5 Helping Babies Breathe (HBB)	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.6 LARC	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.7 LAPM	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.8 MR/ PAC	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.9 Postpartum family planning	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.10 Misoprostol to prevent PPH	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.11 Injectable contraceptives	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.12 Infection prevention	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable
4.13 Others (if any)	1. Yes 2. No 3.Not applicable	1. Yes 2. No 3.Not applicable

Section 5: Structure of the facility

5.1 Infrastructural pattern: 1. one storied building UH&FWC □ Tin-shed □ concrete roof
2. Two storied building UH&FWC
3. Three storied building UH&FWC
4. Union Parishad building
5. Rented building

5.2 When was the center repaired last? _____ / don't know

5.3 Are the following room/supplies available?		Room/supply condition/(Record appropriately after observation)
5.3.1 Room for Medical Officer	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.2 Room for Sub Assistant Community Medical Officer.	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.3 Room for Family Welfare Visitor	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.4 Room for IUD/ Delivery/ Operation.	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.5 Room of IUD insertion/After delivery care	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.6 Room for FPI & HI	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.7 Room for FWA & HA	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.8 Waiting room for patient & health education.	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.9 Pharmacy / medicine preserve & distribution room	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.10 Toilet 1	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.11 Toilet 2	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.12 Toilet 3	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.13 Toilet 4	1. Yes 2. No	1. Good 2. Repair needed, specify (floor, wall, roof, painting, electricity connection, door, window, furniture, others)
5.3.14 Electricity connection available.	1. Yes 2. No	
5.3.15 If yes, Source of electricity connection	1. Government supply 2.Generator 3. IPS 4. Solar	
5.3.16 Water supply available	1. Yes 2. No	
5.3.17 Sources of water for daily work?	1. Piped supply 2. Tube well 3. Shallow well 4. Well 5. Pond 6. Others, mention_____	
5.3.18 Sources of drinking water?	1. Pipe supply 2. Tube well 3. Shallow well 4.Well 5. Pond 6. Filter 7. Bought water 8. Others, mention _____	
5.3.19 Is there sewerage system?	1. Yes 2. No	

d

5.4 Are the following supplies available in the room of medical officer?		**Furniture/supply condition/remark (Record appropriately after observation)**
5.4.1 One secretarial table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.2 One chair with handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.3 Two chairs with handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.4 One patient examination table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.5 One stair	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.6 One cabinet	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.7 One shelf	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.4.8 One stool	1. Yes 2. No	1. Good 2. Repair needed, specify _____

5.5 A**re the following supplies available in the room of sub assistance community medical officer?**		**Furniture/supply condition/remark (Record appropriately after observation)**
5.5.1 One half Secretarial table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.2 One chair with handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.3 Two chair without handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.4 One patient examination table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.5 One stair	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.6 One *almirah*	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.5.7 One shelf	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.5.8 Stool	1. Yes 2. No	1. Good 2. Repair needed, specify _____

5.6 A**re the following supplies available in the room of Family welfare visitor?**		**Furniture/supply condition/remark (Record appropriately after observation)**
5.6.1 One half Secretarial table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.2 One chair with handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.3 Two chair without handle	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.4 One patient test table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.5 One stair	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.6 One *almirah*	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.7 One shelf	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.6.8 One stool	1. Yes 2. No	1. Good 2. Repair needed, specify _____

5.7 Are the following supplies available in the IUD/Delivery room?		Furniture/supply condition/remark (Record appropriately after observation)
5.7.1 One IUD table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.2 One operation table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.3 One labor table	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.4 A delivery table with mattress & pillow covered with rubber	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.5 One spot light	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.6 one trolley to keep instrument	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.7 One almirah	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.8 One stool	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.9 Separate place for hand washing with water supply	1. Yes 2. No	1. Good 2. Repair needed, specify _____
5.7.10 Adult stethoscope	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.11 Adult weighing scale	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.12 BP Machine	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.13 Fetal stethoscope	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.14 Baby weighing scale	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.15 Collection tubes appropriate for urine samples	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.16 Container for placenta	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.17 Kidney Tray	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.18 Kellys long placental forceps, 2	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.19 Scissors	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.20 Umbilical cord clamp and/or tie	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.21 HBB logistics (1 bag, 0 & 1 size mask, sucker)	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.22 Drape or blanket to cover mother	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.23 Laboratory equipment/ supplies for conducting hemoglobin and urine tests	1. Yes 2. No (if yes then go 5.7.22.1/2/3 & If no then go to number 5.7.23)	1. Good 2. Unfit for use, specify_____
5.7.23.1 Lancet	1. Yes 2. No	
5.7.23.2 Urostick	1. Yes 2. No	
5.7.23.3 Tall Quist	1. Yes 2. No	
5.7.24 Syringes and needles	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.25 Thermometer	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26 Delivery kit	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.1 Gallypot	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.2 Sponge Holding forceps	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.3 Artery forceps	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.4 Scissors	1. Yes 2. No	1. Good 2. Unfit for use ,specify_____
5.7.27 Pregnancy detection kit	1. Yes 2. No	1. Good 2. Unfit for use ,specify_____
5.7.28 DDS kit	1. Yes 2. No	1. Good 2. Not sufficient , specify_____
5.7.29 Oxygen cylinder with oxygen	1. Yes 2. No	1. Good 2. Unfit for use, specify_____

5.7.23.1 Lancet	1. Yes 2. No	
5.7.23.2 Urostick	1. Yes 2. No	
5.7.23.3 Tall Quist	1. Yes 2. No	
5.7.24 Syringes and needles	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.25 Thermometer	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26 Delivery kit	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.1 Gallypot	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.2 Sponge Holding forceps	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.3 Artery forceps	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.7.26.4 Scissors	1. Yes 2. No	1. Good 2. Unfit for use ,specify_____
5.7.27 Pregnancy detection kit	1. Yes 2. No	1. Good 2. Unfit for use ,specify_____
5.7.28 DDS kit	1. Yes 2. No	1. Good 2. Not sufficient , specify_____
5.7.29 Oxygen cylinder with oxygen	1. Yes 2. No	1. Good 2. Unfit for use, specify_____

5.8 **Are the following supplies available in the IUD insertion and after delivery care room?**		**Furniture/supply condition/remark (Record appropriately after observation)**
5.8.1 Two delivery bed with rubber mattress & pillow	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.8.2 Bed sheet, pillow cover, pillow net	1. Yes 2. No	1. Good 2.Not usable, specify_____
5.8.3 Two iron/wood cot	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.8.4 Two bed side locker	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.8.5 One saline stand	1. Yes 2. No	1. Good 2. Unfit for use, specify_____
5.8.6 Two stool	1. Yes 2. No	1. Good 2. Repair needed, specify_____

5.9 A**re the following supplies available in the pharmacy / medicine preservation and distribution room?**		**Furniture/supply condition/remark (Record appropriately after observation)**
5.9.1 One half secretary table	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.9.2 One handle chair	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.9.3 Two shelf	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.9.4 Two almirah	1. Yes 2. No	1. Good 2. Repair needed, specify_____
5.9.5 One medicine distribution table	1. Yes 2. No	1. Good 2. Repair needed, specify_____

Section 6: Residential arrangement for caregiver:

6.1 Residential arrangement for Medical Officer? 1. Yes 2. No → go 6.3
6.1.1 Residence situated: 1. At the top of the center 2. Beside of the center 3. Others write specifically_____
6.1.2 Roof of the residence: 1. Tin -shed 2. Concrete roof
6.1.3 Whether the residence have the separate boundary fence/ wired fence or not? 1. Yes 2. No

6.1.4 Condition of the boundary fence/ wired fence: 1. Good 2. Repair needed, specify_____
6.1.5 Whether Medical Officer reside in the residence at the facility? 1. Yes 2. No 3.Not applicable
6.1.6. Why the MO does not reside in the residence at the facility? 1. Insecurity 2. Electricity problem 3.Water problem 4.Residence condition bad 5. Her residence is close to UH&FWC 6. Others

6.2 Are the following facilities available in the house?		**Condition/remark (Record appropriately after observation)**
6.2.1 Master bed	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.2.2 Common bed	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.2.3 Living & dining room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.2.4 kitchen	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.2.5 Toilet	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.2.6 Electricity available (If available then whether electric fitting, light fan work properly or not, write detail)	1. Yes 2. No	
6.2.7 if available then sources of electricity supply	1. Government supply 2.Generator 3. IPS 4. Solar	
6.2.8 water supply available in kitchen & toilet	1. Yes 2. No	
6.2.9 Source of water supply	1. Pipe supply 2. Tube well 3. Shallow well 4. Well 5. Pond 6. Others, mention_____	
6.2.10 Source of drinking water?	1. Pipe supply 2. Tube well 3. Shallow well 4.Well 5. Pond 6. Filter 7. Bought water 8. Others, mention _____	

6.3 Residential arrangement for Sub Assistant Community Medical Officer? 1. Yes 2. No → go 6.5
6.3.1 Residence situated: 1. At the top of the center 2. Beside of the center 3. Others write specifically_____
6.3.2 Roof of the residence: 1. Tin -shed 2. Concrete roof
6.3.3 Whether the residence have the separate boundary fence/ wired fence or not? 1. Yes 2. No

6.3.4 Condition of the boundary fence/ wired fence: 1. Good 2. Repair needed, specify_____
6.3.5 Whether SACMO reside in the residence at the facility? 1. Yes 2. No 3.Not applicable (position is vacant)
6.3.6. Why SACMO does not reside in the residence at the facility? 1. Insecurity 2. Electricity problem 3.Water problem 4.Residence condition bad 5. Her residence is close to UH&FWC 6. Others

6.4 Are the following facilities available in the house?		Condition/remark (Record appropriately after observation)
6.4.1 Master bed room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.4.2 Common bed room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.4.3 Living & dining room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.4.4 Kitchen	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.4.5 Toilet	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.4.6 Electricity available (If available then whether electric fitting, light fan work properly or not, write detail)	1. Yes 2. No	
6.4.7 if available then sources of electricity supply	1. Government supply 2.Generator 3. IPS 4. Solar	
6.4.8 water supply available in kitchen & toilet	1. Yes 2. No	
6.4.9 Sources of water supply	1. Pipe supply 2. Tube well 3. Shallow well 4. Well 5. Pond 6. Others, mention_____	
6.4.10 Sources of drinking water?	1. Pipe supply 2. Tube well 3. Shallow well 4.Well 5. Pond 6. Filter 7. Bought water 8. Others, mention _____	

6.5 For FWV residence is available or not? 1. Yes 2. No → Go section 7

6.5 .1 Residence situated 1. Above floor of the center→ 2. Beside of the center 3.Others, specify_____

6.5 .2 Roof of the center 1. Tin -shed 2. Concrete roof

6.5.3 Whether the residence have the separate boundary fence/ wired fence or not? 1. Yes 2. No

6.5.4 Condition of the boundary fence/ wired fence: 1. Good 2. Repair needed, specify_____

6.5.5 Whether FWV reside in the residence at the facility? 1. Yes 2. No 3.Not applicable (position is vacant)

6.5.6. Why FWV does not reside in the residence at the facility? 1. Insecurity 2. Electricity problem 3.Water problem 4.Residence condition bad 5. Her residence is close to UH&FWC 6. Others

6.6 Are the following facilities available in the house?		Condition/remark (Record appropriately after observation)
6.6.1 Master bed room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.6.2 Common bed room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.6.3 Living & dining room	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.6.4 Kitchen	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.6.5 Toilet	1. Yes 2. No	1. Good 2. Repair needed, specify_____
6.6.6 Electricity available (If available then whether electric fitting, light fan work properly or not, write detail)	1. Yes 2. No	
6.6.7 if available then sources of electricity supply	1. Government supply 2.Generator 3. IPS 4. Solar	
6.6.8 water supply available in kitchen & toilet	1. Yes 2. No	
6.6.9 Source of water supply	1. Pipe supply 2. Tube well 3. Shallow well 4. Well 5. Pond 6. Others, mention_____	
6.6.10 Source of drinking water	1. Pipe supply 2. Tube well 3. Shallow well 4.Well 5. Pond 6. Filter 7. Bought water 8. Others, mention _____	

Section 7: Information related to delivery services

7.1 Whether normal delivery service provide from the facility? 1. Yes 2. No

7.2 Has the facility been upgraded? 1. Yes 2. No

7.3 Who provides normal delivery care? 1. Family Welfare Visitor 2. Government CSBA

3. Others, write specifically _____

7.4 Is delivery care services provided seven days in a week, day-night 24 hour (24/70)? 1. Yes 2. No

7.5 Date of upgrading the facility:_____/_____/_____

7.6 Total number of deliveries conducted at the facility during the full one year period (January to December 2014) Do record from MIS form-3											
Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014

7.7 List of government & non-government organization in the union which provide normal delivery service:

Centre Name	**Who provides normal delivery service (doctor, paramedic, CHCP, others)**	**Organization**	**Whether 24/7 normal delivery service provide or not? (yes/not)**

Section 8: Waste management system of the facility:

8.1 Whether incinerator present for destroying general/solid waste like (saline bag, syringes and needles, cotton, medicine packet, used hand gloves) etc.? 1. Yes 2. No,

How is general/solid waste usually destroyed by the facility? (write details)

_____
_____

8.2 Dumping pit for infectious wastes (liquid wastage that remains after delivery, like placenta etc.) (a hole with 5 fit wide 6.5 fit deep with a bricks wall covered by a cement made lid. Is 3-inch wide & 6 fit height plastic pipe attached to the lid)? 1. Yes 2. No,

How infections waste usually destroyed by the facility? (write details) _____

_____
_____

Section 9: Information of referral hospital/center

□ Upazila Health Complex (UHC)

Estimated distance(km):_____

Mode of transport:_____

How much time it takes to reach (hours): _____

How much it costs to reach (taka):_____

□ Mother & Child Welfare Centre (MCWC)

Estimated distance(km):_____

Mode of transport:_____

How much time it takes to reach (hours):_____

How much it costs to reach (taka):_____

□ District General /Sadar Hospital

Estimated distance(km):_____

Mode of transport:_____

How much time it takes to reach (hours):__

How much it costs to reach (taka):_____

□ Medical College Hospital

Estimated distance(km):_____

Mode of transport:_____

How much time it takes to reach (hours):__

How much it costs to reach (taka):_____

□ Others

Name:_____

Estimated distance(km)_____

How to go:_____

How much time it takes to reach (hours):__

How much it costs to reach (taka):_____

Section 10: List of CSBA working in the Union:

Serial no:	Name of CSBA	Designation	Government/NGO/Private, etc. please mention	Working area		How many delivery conducted in last 3 month	
				Ward Number	Unit Number		Do not Know

ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রে মানসম্মত মা ও শিশু স্বাস্থ্য সেবা প্রদানের মূল্যায়ন প্রশ্নপত্র

Questionnaire ID | | | |

Facility Code | | | | | | |

Assessment Date: _____	
Assessment Start Time: _____	
Assessment End Time: _____	
Assessment done by:	*Questionnaire checked by:*
Signature: _____	Signature: _____
Name: _____	Name: _____
Designation: _____	Designation: _____
Organization: _____	Organization: _____
Cell number: _____	Cell number: _____

নির্দেশিকা

আপনার পরিচয় দিন এবং আগমনের কারণ ব্যাখ্যা করুন

(আগমনের কারণ হচ্ছে, এই কেন্দ্রটিকে একটি মানসম্মত মা ও শিশু স্বাস্থ্য সেবাদান কেন্দ্রে রূপান্তরিত করা যায় কিনা, যাতে করে এই কেন্দ্রটি থেকে অন্যান্য সেবার পাশাপাশি ২৪/৭ স্বাভাবিক প্রসবসেবা প্রদান করা যায় সে ব্যাপারে মূল্যায়ন করা)

সেকশান ১: সাধারণ তথ্য

১.১.০ বিভাগ: _____১.১.১ জেলা: _____ ১.১.২ উপজেলা _____ ১.১.৩ ইউনিয়ন: _____

১.২. ইউনিয়নের মোট জনসংখ্যা ১। পুরুষ _____ ২। মহিলা _____ মোটঃ _____

১.৩ মোট সক্ষম দম্পতির সংখ্যা ঃ (ELCO) _____

১.৪ ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রের নাম _____

১.৫ GPS Coordinate: Latitude (N) _____ ^{0} _____ ' _____ " Longitude (E) _____ ^{0} _____ ' _____ "

১.৬ কেন্দ্রে যাতায়াতের রাস্তার ধরণ: ১. কাঁচা রাস্তা ২. ইট বিছানো ৩. পিচ ঢালা ăÿ

৪. সিমেন্টের পাকা রাস্তা ৫. নদী পথ ৬. অন্যান্য, উল্লেখ করুন _____

১.৭ যাতায়াতের রাস্তার অবস্থা: ১. ভাল (প্রধান সড়ক হতে সিএনজি অটোরিক্সা বা ভ্যান গাড়ী সহজেই কেন্দ্রে আসতে পারে)

২. ভাল নয় :

২.১ খুবই ভাঙা ২.২ অন্যান্য

১.৮ কেন্দ্রের সীমানা নির্ধারণী চিহ্ন আছে কিনা? ১. হ্যাঁ ২ না→ সেকশন ১.১০-*এ যান*

১.৯ কী ধরণের সীমানা নির্ধারণী চিহ্ন আছে? ১ বাউন্ডারী দেয়াল ২. কাঁটাতারের বেড়া ৪. অন্যান্য, নির্দিষ্ট করে লিখুন _____

১.১০ সাইনবোর্ড এবং সিটিজেন চার্টার আছে কিনা? ১. হ্যাঁ ২ না

সেকশান ২: কেন্দ্র ব্যবস্থাপনা

২.১ উত্তর দাতার নাম (১): _____ ২.২ পদবী: _____

২.৩ উত্তর দাতার নাম (২): _____ ২.৪ পদবী: _____

২.৫ কেন্দ্রটি কোন অধিদপ্তরের আওতাধীন? ২.৫.১. পরিবার পরিকল্পনা অধিদপ্তর ২.৫.২. স্বাস্থ্য অধিদপ্তর

২.৬ জেলা সদর হাসপাতাল থেকে কেন্দ্রটির দূরত্ব: _____ কি. মি.

২.৭ কেন্দ্রটি পরিচালনার জন্যে কোন ব্যবস্থাপনা কমিটি আছে কিনা? ১. হ্যাঁ ২. না→ ২.১০-*এ যান* ৩. জানা নাই→ ২.১০-*এ যান*

২.৮ গত ৬ মাসে ব্যবস্থাপনা কমিটির কোন সভা অনুষ্ঠিত হয়েছে কিনা? ১. হ্যাঁ ২. না→ ২.১০-*এ যান*

২.৯ সভা অনুষ্ঠিত হওয়ার তারিখ: ১. _____/_____/_____ ২. _____/_____/_____

৩. _____/_____/_____ ৪. _____/_____/_____

	শুকনা মৌসুমে	বর্ষা কালে
২.১০ কেন্দ্রটি থেকে ইউনিয়নের সবচেয়ে দূরের গ্রামের নাম		
২.১১ ইউনিয়নের সবচেয়ে দূরের স্থান থেকে কেন্দ্রটির দূরত্ব কত? (কি.মি)		
২.১২ ইউনিয়নের সবচেয়ে দূরের স্থান থেকে এই কেন্দ্রে আসতে সাধারণত কী ধরনের যানবাহন ব্যবহার করা হয়	১. _____ ২. _____ ৩. _____	১. _____ ২. _____ ৩. _____
২.১৩ ঐ স্থান থেকে এখানে আসতে আনুমানিক কত সময় লাগে (মিনিট)	১. _____ ২. _____ ৩. _____	১. _____ ২. _____ ৩. _____

সেকশান ৩: কর্মকর্তা ও কর্মচারীবৃন্দের তথ্য

পদবী	বর্তমানে কর্মরত (সংখ্যা)	মন্তব্য (সংযুক্ত, ডেপুটেশনে এই কেন্দ্রে/অন্যত্র কর্মরত/প্রযোজ্য নয় ইত্যাদি উল্লেখ করুন)
১.১ মেডিকেল অফিসার		
৩.২ উপসহকারী কমিউনিটি মেডিকেল অফিসার		
৩.৩ পরিবার কল্যাণ পরিদর্শিকা		
৩.৪ ফার্মাসিস্ট		
৩.৫ আয়া		
৩.৬ এমএলএসএস/নিরাপত্তা প্রহরী		
৩.৭ অন্যান্য, নির্দিষ্ট করে লিখুন		

সেকশান ৪: সেবা প্রদানকারীর প্রশিক্ষণ সংক্রান্ত তথ্য

সেবাপ্রদানকারী নিম্নলিখিত প্রশিক্ষণ পেয়েছেন কী?	উপসহকারী কমিউনিটি মেডিকেল অফিসার	পরিবার কল্যাণ পরিদর্শিকা
৪.১ Training on Midwifery Skill	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.২ Field Training on Nutrition	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৩ ARH Training	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৪ IMCI	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৫ Helping Babies Breathe (HBB)	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৬ LARC	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৭ LAPM	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৮ MR/ PAC	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.৯ Postpartum Family Planning	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.১০ Misoprostrol to prevent PPH	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.১১ Injectable contraceptives	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.১২ Infection Prevention	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়
৪.১৩ Others (if any)	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়	১. হ্যাঁ ২. না ৩. প্রযোজ্য নয়

সেকশান ৫: কেন্দ্রের স্থাপনা

৫.১ অবকাঠামোভেদে স্থাপনার ধরণ: ১. এক তলা বিশিষ্ট ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র, □ *টিনশেড* □ *পাকা ছাদ*

২. দুই তলা বিশিষ্ট ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

৩. তিন তলা বিশিষ্ট ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

৪. ইউনিয়ন পরিষদ ভবন

৫. ভাড়া বাড়ি

৫.২ কেন্দ্রটি কত সালে সর্বশেষ মেরামত করা হয়েছে? _____/ *জানা নাই*

৫.৩ কেন্দ্রটিতে নিম্নলিখিত কক্ষ/সরবরাহ আছে কিনা?		**কক্ষ/সরবরাহের অবস্থা/ (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫.৩.১ মেডিকেল অফিসারের কক্ষ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.২ উপসহকারী কমিউনিটি মেডিকেল অফিসারের কক্ষ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৩ পরিবার কল্যাণ পরিদর্শিকার কক্ষ?	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৪ আইইউডি/ডেলিভারী/ অপারেশনস কক্ষ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৫ আইইউডি ইনসার্শান ও ডেলিভারী পরবর্তী শুশ্রূষা ওয়ার্ড (২ বেড)	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৬ এফপিআই ও এইচআই এর কক্ষ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৭ এফডব্লিউএ ও এইচএ এর কক্ষ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.৯ স্বাস্থ্য শিক্ষা/রোগীদের বসবার প্রসস্থ স্থান	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.১০ ফার্মেসী/ঔষধ সংরক্ষণ ও বিতরণ কক্ষ?	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, অন্যান্য)
৫.৩.১১ টয়লেট ১	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, পানির সংযোগ, পয়ঃ নিস্কাশন লাইন, অন্যান্য)
৫.৩.১২ টয়লেট ২	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, পানির সংযোগ, পয়ঃ নিস্কাশন লাইন, অন্যান্য)
৫.৩.১৩ টয়লেট ৩	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, পানির সংযোগ, পয়ঃ নিস্কাশন লাইন, অন্যান্য)
৫.৩.১৪ টয়লেট ৪	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন (মেঝে, দেয়াল, ছাদ, পেইন্টিং, বিদ্যুৎ সংযোগ, জানালা দরজা, পানির সংযোগ, পয়ঃ নিস্কাশন লাইন, অন্যান্য)
৫.৩.১৫ কেন্দ্রে বিদ্যুৎ ব্যবস্থা আছে কিনা?	১. হ্যাঁ ২. না	
৫.৩.১৬ *বিদ্যুৎ ব্যবস্থা থাকলে*, বিদ্যুৎ সরবরাহের উৎস কী	১. সরকারি সরবরাহ ২. জেনারেটর ৩. আইপিএস ৪. সোলার	
৫.৩.১৭ সার্বক্ষণিক পানি সরবরাহ ব্যবস্থা	১. হ্যাঁ ২. না	
৫.৩.১৮ দৈনন্দিন কাজের জন্য পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. অন্যান্য, উল্লেখ করুন _____	
৫.৩.১৯ খাবার পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. ফিল্টার ৭. কেনা পানি ৮. অন্যান্য, উল্লেখ করুন _____	
৫.৩.২০ পয়ঃনিষ্কাশন ব্যবস্থা আছে কিনা	১. হ্যাঁ ২. না	

৫.৪ মেডিকেল অফিসারের কক্ষে নিম্নলিখিত আসবাবপত্র/সরবরাহ আছে কিনা?		**আসবাবপত্র/সরবরাহের অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫.৪.১ ১টি সেক্রেটারিয়েট টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.২ ১টি হাতলওয়ালা চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৩ ২টি হাতলছাড়া চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৪ ১টি রোগী পরীক্ষার টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৫ ১টি রোগী পরীক্ষার টেবিলে উঠার সিড়ি	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৬ ১টি আলমারী	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৭ ১টি সেলফ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৪.৮ ১টি টুল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৫. ৫ উপসহকারী কমিউনিটি মেডিকেল অফিসারের কক্ষে নিম্নলিখিত আসবাবপত্র/সরবরাহ আছে কিনা?		**আসবাবপত্র/সরবরাহের অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫. ৫.১ ১টি হাফ সেক্রেটারিয়েট টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.২ ১টি হাতলওয়ালা চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৩ ২টি হাতলছাড়া চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৪ ১টি রোগী পরীক্ষার টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৫ ১টি রোগী পরীক্ষার টেবিলে উঠার সিড়ি	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৬ ১টি আলমারী	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৭ ১টি সেলফ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫. ৫.৮ ১টি টুল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৫. ৬ পরিবার কল্যান পরিদর্শিকার কক্ষে নিম্নলিখিত আসবাবপত্র/সরবরাহ আছে কিনা?		আসবাবপত্র/সরবরাহের অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)
৫.৬.১ ১টি হাফ সেক্রেটারিয়েট টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.২ ১টি হাতলওয়ালা চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৩ ২টি হাতলছাড়া চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৪ ১টি রোগী পরীক্ষার টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৫ ১টি রোগী পরীক্ষার টেবিলে উঠার সিড়ি	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৬ ১টি আলমারী	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৭ ১টি সেলফ	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৬.৮ ১টি টুল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৫.৭ আইইউডি/ডেলিভারী কক্ষে নিম্নলিখিত সরবরাহ আছে কিনা?		সরবরাহের অবস্থা/ মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)
৫.৭.১ ১টি আইইউডি টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.২ ১টি অপারেশন টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৩ ১টি লেবার টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৪ রাবার-আচ্ছাদিত ম্যাট্রেস ও বালিশ সহ ১টি ডেলিভারী টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৫ ১টি স্পট লাইট	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৬ ১টি যন্ত্রপাতির ট্রলি/যন্ত্রপাতি রাখার টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৭ ১টি আলমারী	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৮ ১টি টুল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.৯ হাত ধোয়ার পৃথক এলাকা ও সেখানে সার্বক্ষণিক পানি সরবরাহ ব্যবস্থা	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৭.১০ Adult stethoscope	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১১ Adult weighing scale	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১২ BP Machine	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৩ Fetal stethoscope	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____

৫.৭ আইইউডি/ডেলিভারী কক্ষে নিম্নলিখিত সরবরাহ আছে কিনা?		সরবরাহের অবস্থা/ মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)
৫.৭.১৪ Baby weighing scale	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৫ Collection tubes appropriate for urine samples	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৬ Container for placenta	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১ Kidney Tray	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৭ Kellys long placental forceps, 2 nos	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৮ Scissors	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.১৯ Umbilical cord clamp and/or tie	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২০ HBB logistics (1 bag, 0 & 1 size mask, sucker)	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২১ Drape or blanket to cover mother	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২২ Laboratory equipment/ supplies for conducting hemoglobin and urine tests	১. হ্যাঁ ২. না (উত্তর হ্যাঁ হলে ৫.৭.২২.১/২/৩ এ যেতে হবে এবং উত্তর না হলে ৫.৭.২৩ এ যেতে হবে)	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২২.১ Lancet	১. হ্যাঁ ২. না	
৫.৭.২২.২ Urostick	১. হ্যাঁ ২. না	
৫.৭.২২.৩ Tallquist	১. হ্যাঁ ২. না	
৫.৭.২৩ Syringes and needles	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৪ Thermometer	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৫ Delivery kit	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৫.১ Gallypot	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৫.২ Spong Holding foreceps	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৫.৩ Artery Forceps	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৫.৪ Scissors	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____

৫.৭ আইইউডি/ডেলিভারী কক্ষে নিম্নলিখিত সরবরাহ আছে কিনা?		**সরবরাহের অবস্থা/ মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫.৭.২৬ Pregnency detection kit	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৭ DDS kit	১. হ্যাঁ ২. না	১. পর্যাপ্ত ২. পর্যাপ্ত নয়, নির্দিষ্ট করে লিখুন _____
৫.৭.২৮ Oxygen cylinder with oxygen	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____

৫.৮ আইইউডি ইনসার্শান ও ডেলিভারী পরবর্তী শুশ্রূষা ওয়ার্ডে নিম্নলিখিত আসবাবপত্র/সরবরাহ আছে কিনা?		**আসবাবপত্র/সরবরাহের অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫.৮.১ রাবার-আচ্ছাদিত ম্যাট্রেস সহ রোগীর বিছানা, ২টি	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৮.২ পর্দা, বেডশিট, পিলোকভার, বালিশ ও মশারী	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৮.৩ ২টি আয়রন / কাঠের কট	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৮.৪ ২টি বেড সাইড লকার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৮.৫ ১টি স্যালাইন ষ্ট্যান্ড	১. হ্যাঁ ২. না	১. ভাল ২. ব্যবহারযোগ্য নয়, নির্দিষ্ট করে লিখুন _____
৫.৮.৬ ২টি টুল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৫.৯ ফার্মেসী/ঔষধ সংরক্ষণ ও বিতরণ কক্ষে নিম্নলিখিত আসবাবপত্র/সরবরাহ আছে কিনা?		**আসবাবপত্র/সরবরাহের অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৫.৯.১ ১টি হাফ সেক্রেটারিয়েট টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৯.২ ১টি হাতলওয়ালা চেয়ার	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৯.৩ ২টি র‍্যাক	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৯.৪ ২টি আলমারী	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৫.৯.৫ ১টি ঔষধ বিতরণ টেবিল	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

সেকশান ৬ঃ সেবাদানকারীদের আবাসন ব্যবস্থা :

৬.১ মেডিকেল অফিসারের বসবাসের জন্য বাসার ব্যবস্থা আছে কিনা? ১. হ্যাঁ ২. না → ৬.৩ এ যান

৬.১.১ বাসার অবস্থানঃ ১. কেন্দ্রটির উপর তলায়→ ২. কেন্দ্রটির পাশে ৩. অন্যান্য, নির্দিষ্ট করে লিখুন _____

৬.১.২ বাসার ছাদঃ ১. টিনশেড ২. পাকা ছাদ

৬.১.৩ বাসার পৃথক বাউন্ডারী দেয়াল/কাটাতারের বেড়া আছে কি না? ১. হ্যাঁ ২. না→

৬.১.৪ বাউন্ডারী দেয়াল/কাটাতারের বেড়ার অবস্থাঃ ১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৬.১.৫ মেডিকেল অফিসার এই বাসায় থাকেন কিনা? ১. হ্যাঁ→ ২. না ৩. প্রযোজ্য নয় (পদটি শূন্য)→

৬.১.৬ কেন থাকেন না? ১। নিরাপত্তার অভাব ২। বিদ্যুতের সমস্যা ৩। পানির সমস্যা ৪। বাসার অবস্থা ভাল নয় ৫। নিজের বাসা কাছে ৬। অন্যান্য

৬.২ বাসায় নিম্নলিখিত সুবিধাগুলো আছে কিনা?		**অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৬.২.১ মাষ্টার বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.২.২ কমন বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.২.৩ লিভিং ও ডাইনিং রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.২.৪ রান্না ঘর	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.২.৫ টয়লেট	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.২.৬ সার্বক্ষণিক বিদ্যুৎ ব্যবস্থা (বিদ্যুৎ ব্যবস্থা থাকলে প্রতিটি কক্ষে ইলেকট্রিক ফিটিংস-এর অবস্থা, বাল্ব/টিউব লাইট, ফ্যান ঠিক মত কাজ করে কিনা তা বিস্তারিত লিখুন)	১. হ্যাঁ ২. না	
৬.২.৭ *বিদ্যুৎ ব্যবস্থা থাকলে*, বিদ্যুৎ সরবরাহের উৎস কী	১. সরকারি সরবরাহ ২. জেনারেটর ৩. আইপিএস ৪. সোলার	
৬.২.৮ রান্নাঘর ও টয়লেটে সার্বক্ষণিক পানি সরবরাহ ব্যবস্থা	১. হ্যাঁ ২. না	
৬.২.৯ দৈনন্দিন কাজের জন্য পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. অন্যান্য, উল্লেখ করুন _____	
৬.২.১০ খাবার পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. কেনা পানি ৭। ফিল্টার ৮. অন্যান্য, উল্লেখ করুন _____	

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৬.৩ উপসহকারী কমিউনিটি মেডিকেল অফিসারের বসবাসের জন্য বাসার ব্যবস্থা আছে কিনা? ১. হ্যাঁ ২. না → ৬.৫ এ যান

৬.৩.১ বাসার অবস্থান: ১. কেন্দ্রটির উপর তলায় ২. কেন্দ্রটির পাশে ৩. অন্যান্য, নির্দিষ্ট করে লিখুন _____

৬.৩.২ বাসার ছাদ: ১. টিনশেড ২. পাকা ছাদ

৬.৩.৩ বাসার পৃথক বাউন্ডারী দেয়াল/কাটাতারের বেড়া আছে কিনা? ১. হ্যাঁ ২. না

৬.৩.৪ বাউন্ডারী দেয়াল/কাটাতারের বেড়ার অবস্থা: ১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৬.৩.৫ উপসহকারী কমিউনিটি মেডিকেল অফিসার এই বাসায় থাকেন কিনা? ১. হ্যাঁ ২. না ৩. প্রযোজ্য নয় (পদটি শূন্য)

৬.৩.৬ কেন থাকেন না? ১। নিরাপত্তার অভাব ২। বিদ্যুতের সমস্যা ৩। পানির সমস্যা ৪। বাসার অবস্থা ভাল নয় ৫। নিজের বাসা কাছে ৬। অন্যান্য

৬.৪ বাসায় নিম্নলিখিত সুবিধাগুলো আছে কিনা?		**অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)**
৬.৪.১ মাষ্টার বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৪.২ কমন বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৪.৩ লিভিং ও ডাইনিং রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৪.৪ রান্না ঘর	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৪.৫ টয়লেট	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৪.৬ সার্বক্ষণিক বিদ্যুৎ ব্যবস্থা (বিদ্যুৎ ব্যবস্থা থাকলে প্রতিটি কক্ষে ইলেকট্রিক ফিটিংস-এর অবস্থা, বাল্ব/টিউব লাইট, ফ্যান ঠিক মত কাজ করে কিনা তা বিস্তারিত লিখুন)	১. হ্যাঁ ২. না	
৬.৪.৭ *বিদ্যুৎ ব্যবস্থা থাকলে*, বিদ্যুৎ সরবরাহের উৎস কী	১. সরকারি সরবরাহ ২. জেনারেটর ৩. আইপিএস ৪. সোলার	
৬.৪.৮ রান্নাঘর ও টয়লেটে সার্বক্ষণিক পানি সরবরাহ ব্যবস্থা	১. হ্যাঁ ২. না	
৬.৪.৯ দৈনন্দিন কাজের জন্য পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. অন্যান্য, উল্লেখ করুন _____	
৬.৪.১০ খাবার পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. কেনা পানি ৭। ফিল্টার ৮. অন্যান্য, উল্লেখ করুন _____	

৬.৫ পরিবার কল্যাণ পরিদর্শিকার বসবাসের জন্য বাসার ব্যবস্থা আছে কিনা? ১. হ্যাঁ ২. না → সেকশান ৭ এ যান

৬.৫.১ বাসার অবস্থান: ১. কেন্দ্রটির উপর তলায়→ ২. কেন্দ্রটির পাশে ৩. অন্যান্য, নির্দিষ্ট করে লিখুন _____

৬.৫.২ বাসার ছাদ: ১. টিনশেড ২. পাকা ছাদ

৬.৫.৩ বাসার পৃথক বাউন্ডারী দেয়াল/কাটাতারের বেড়া আছে কিনা? ১. হ্যাঁ ২. না→

৬.৫.৪ বাউন্ডারী দেয়াল/কাটাতারের বেড়ার অবস্থা: ১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____

৬.৫.৫ পরিবার কল্যান পরিদর্শিকা এই বাসায় বাসায় থাকেন কিনা? ১. হ্যাঁ ২. না ৩. প্রযোজ্য নয় (পদটি শূন্য)

৬.৫.৬ কেন থাকেন না? ১। নিরাপত্তার অভাব ২। বিদ্যুতের সমস্যা ৩। পানির সমস্যা ৪। বাসার অবস্থা ভাল নয় ৫। নিজের বাসার কাছে ৬। অন্যান্য

৬.৬ বাসায় নিম্নলিখিত সুবিধাগুলো আছে কিনা?		অবস্থা/মন্তব্য (সরেজমিনে পর্যবেক্ষণ করে যথাযথ পর্যবেক্ষণ রেকর্ড করুন)
৬.৬.১ মাষ্টার বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৬.২ কমন বেড রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৬.৩ লিভিং ও ডাইনিং রুম	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৬.৪ রান্না ঘর	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৬.৫ টয়লেট	১. হ্যাঁ ২. না	১. ভাল ২. মেরামত করা প্রয়োজন, নির্দিষ্ট করে লিখুন _____
৬.৬.৬ সার্বক্ষণিক বিদ্যুৎ ব্যবস্থা (বিদ্যুৎ ব্যবস্থা থাকলে প্রতিটি কক্ষে ইলেকট্রিক ফিটিংস-এর অবস্থা, বাল্ব/টিউব লাইট, ফ্যান ঠিক মত কাজ করে কিনা তা বিস্তারিত লিখুন)	১. হ্যাঁ ২. না	
৬.৬.৭ *বিদ্যুৎ ব্যবস্থা থাকলে*, বিদ্যুৎ সরবরাহের উৎস কী	১. সরকারি সরবরাহ ২. জেনারেটর ৩. আইপিএস ৪. সোলার	
৬.৬.৮ রান্নাঘর ও টয়লেটে সার্বক্ষণিক পানি সরবরাহ ব্যবস্থা	১. হ্যাঁ ২. না	
৬.৬.৯ দৈনন্দিন কাজের জন্য পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. অন্যান্য, উল্লেখ করুন _____	
৬.৬.১০ খাবার পানি সরবরাহের উৎস কী	১. পাইপে সরবরাহ ২. টিউব ওয়েল ৩. শ্যালো ওয়েল ৪. কুয়া ৫. পুকুর ৬. কেনা পানি ৭। ফিল্টার ৮. অন্যান্য, উল্লেখ করুন _____	

সেকশান ৭: প্রসবসেবা প্রদান সংক্রান্ত তথ্য

৭.১ এই কেন্দ্র থেকে স্বাভাবিক প্রসবসেবা প্রদান করা হয় কিনা? ১. হ্যাঁ ২. না

৭.২ এই কেন্দ্রটিকে মানোন্নীত সেবা কেন্দ্রে রূপান্তরিত করা হয়েছে কিনা? ১. হ্যাঁ ২. না

৭.৩ কে স্বাভাবিক প্রসবসেবা প্রদান করে থাকেন? ১. পরিবার কল্যাণ পরিদর্শিকা ২. সরকারি সিএসবিএ
৩. অন্যান্য, নির্দিষ্ট করে লিখুন যেমন ----------

৭.৪ সপ্তাহে ৭ দিন, দিন-রাত ২৪ ঘন্টা (২৪/৭) স্বাভাবিক প্রসবসেবা প্রদান করা হয় কিনা? ১. হ্যাঁ ২. না

৭.৫ মানোন্নীত কেন্দ্রে রূপান্তরিত করার তারিখ: ____/____/____

৭.৬ গত এক বছরে এই কেন্দ্রে মোট ডেলিভারীর সংখ্যা (এমআইএস ফরম-৩ হতে রেকর্ড করুন)											
জানুয়ারী ২০১৪	ফেব্রুয়ারী ২০১৪	মার্চ ২০১৪	এপ্রিল ২০১৪	মে ২০১৪	জুন ২০১৪	জুলাই ২০১৪	আগষ্ট ২০১৪	সেপ্টেম্বর ২০১৪	অক্টোবর ২০১৪	নভেম্বর ২০১৪	ডিসেম্বর ২০১৪

৭.৭ এই ইউনিয়নে স্বাভাবিক প্রসবসেবা প্রদান করা হয় এমন **নিকটবর্তী/পার্শ্ববর্তী/দূরবর্তী সরকারি এবং বেসরকারি** প্রতিষ্ঠানের তালিকা:

কেন্দ্রের নাম	**কে স্বাভাবিক প্রসবসেবা প্রদান করেন** (ডাক্তার, প্যারামেডিক, সিএইচসিপি, অন্যান্য)	**সংস্থা**	**২৪/৭ স্বাভাবিক প্রসবসেবা প্রদান করা হয় কিনা? (হ্যাঁ/না)**

সেকশান ৮: কেন্দ্রের বর্জ্য ব্যবস্থাপনা:

৮.১ সাধারন/কঠিন বর্জ্য (ব্যবহৃত স্যালাইন ব্যাগ, সুচ, সিরিঞ্জ, গজ, তুলা, ঔষধের প্যাকেট/ষ্ট্রিপ, নষ্ট হ্যান্ড গ্ল্যাভস, ইত্যাদি) ধ্বংস করার জন্য ইনসিনারেটর আছে কিনা? ১. হ্যাঁ ২. না, সাধারন/কঠিন বর্জ্য কিভাবে ধ্বংস করা হয়? (বিস্তারিত লিখুন) _____

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৮.২ তরল বর্জ্য (ডেলিভারীর পর যে সমস্ত তরল পদার্থ বের হয়, গর্ভফুল/গর্ভসংক্রান্ত বর্জ্য, ইত্যাদি) ধ্বংস করার জন্য ডাম্পিং পিট (৫ ফিট ব্যাসার্ধ ও ৬.৫ ফিট গভীর গর্ত যার চারপাশে ইটের দেয়াল, উপরে সিমেন্টের ঢালাই এর ঢাকনা যুক্ত ও ঢাকনার সাথে ৬ ফিট উচু প্লাস্টিকের পাইপ যার ব্যাস ৩ ইঞ্চি) আছে কি না? ১. হ্যাঁ ২. না, তরল বর্জ্য কিভাবে ধ্বংস করা হয়? (বিস্তারিত লিখুন) _____

_____

_____

সেকশান ৯: রেফারাল কেন্দ্র/হাসপাতাল সমূহের তথ্য

□ উপজেলা স্বাস্থ্য কমপ্লেক্স (UHC)

আনুমানিক দূরত্ব (কি.মি.):_____

কিভাবে যেতে হয়: _____

পৌঁছাতে কত সময় লাগে (ঘন্টা):_____

পৌঁছাতে কত খরচ হয় (টাকা):

□ মা ও শিশু কল্যাণ কেন্দ্র (MCWC)

আনুমানিক দূরত্ব (কি.মি.):_____

কিভাবে যেতে হয়: _____

পৌঁছাতে কত সময় লাগে (ঘন্টা):_____

পৌঁছাতে কত খরচ হয় (টাকা):_____

□ জেলা সদর/সাধারণ হাসপাতাল

আনুমানিক দূরত্ব (কি.মি.):_____

কিভাবে যেতে হয়: _____

পৌঁছাতে কত সময় লাগে (ঘন্টা):_____

পৌঁছাতে কত খরচ হয় (টাকা)_____

□ মেডিকেল কলেজ হাসপাতাল

আনুমানিক দূরত্ব (কি.মি.):_____

কিভাবে যেতে হয়: _____

পৌঁছাতে কত সময় লাগে (ঘন্টা):_____

পৌঁছাতে কত খরচ হয় (টাকা):_____

□ অন্যান্য

নাম:_____

আনুমানিক দূরত্ব (কি.মি.):_____

কিভাবে যেতে হয়: _____

পৌঁছাতে কত সময় লাগে (ঘন্টা):_____

পৌঁছাতে কত খরচ হয় (টাকা)_____

সেকশান ১০: ইউনিয়নে কর্মরত সিএসবিএ এর তালিকাঃ

ক্রমিক নং	সিএসবিএর নাম	পদবী	সরকারি/এনজিও/প্রাইভেট, ইত্যাদি উল্লেখ করুন	কর্ম এলাকা		গত ৩ মাসে কয়টি ডেলিভারী সম্পন্ন হয়েছে	জানা নাই
				ওয়ার্ড নম্বর	ইউনিট নম্বর		

Annex B: Distribution of number of union facilities functioning as UH&FWCs by category and by district

Distribution of number of union facilities functioning as UH&FWCs by category and by district

Division	District	Categories			Total
		A	B	C	
Barisal	Barguna	6	21	3	30
	Barisal	10	45	10	65
	Bhola	8	35	4	47
	Jhalokathi	4	18	7	29
	Patuakhali	11	36	10	57
	Pirojpur	2	32	11	45
	Sub-total	41	187	45	273
Chittagong	Bandarban	3	13	5	21
	Brahamanbaria	17	44	17	78
	Chandpur	8	63	9	80
	Chittagong	14	99	36	149
	Comilla	19	82	36	137
	Cox's Bazar	8	41	6	55
	Feni	6	35	1	42
	Khagrachhari	3	18	2	23
	Lakhsmipur	11	27	3	41
	Noakhali	11	46	12	69
	Rangamati	1	14	14	29
	Sub-total	101	482	141	724
Dhaka	Dhaka	7	39	7	53
	Faridpur	7	46	8	61
	Gazipur	9	25	2	36
	Gopalganj	2	37	20	59
	Jamalpur	10	39	6	55
	Kishoregonj	7	44	28	79
	Madaripur	5	34	14	53
	Manikganj	8	35	7	50
	Munshiganj	2	34	19	55
	Mymensingh	7	59	36	102
	Narayanganj	7	22	2	31
	Narsingdi	3	43	13	59
	Netrakona	1	40	19	60
	Rajbari	5	25	2	32
	Shariatpur	5	35	5	45
	Sherpur	2	29	9	40
	Tangail	14	61	12	87
	Sub-total	101	647	209	957

Khulna	Bagerhat	10	32	22	64
	Chuadanga	8	16	0	24
	Jessore	8	59	15	82
	Jhenaidah	4	47	12	63
	Khulna	6	32	13	51
	Kustia	8	34	9	51
	Magura	7	23	0	30
	Meherpur	3	11	3	17
	Narail	4	26	4	34
	Satkhira	5	53	13	71
	Sub-total	63	333	91	487
Rajshahi	Bogra	17	62	11	90
	Chapai Nababganj	8	25	4	37
	Joypurhat	4	19	5	28
	Naogaon	6	54	14	74
	Natore	7	28	4	39
	Pabna	11	46	4	61
	Rajshahi	3	48	8	59
	Sirajganj	5	45	8	58
	Sub-total	61	327	58	446
Rangpur	Dinajpur	25	57	8	90
	Gaibandha	4	53	14	71
	Kurigram	3	39	11	53
	Lalmonirhat	2	31	3	36
	Nilphamari	5	47	9	61
	Panchagarh	10	28	1	39
	Rangpur	8	59	7	74
	Thakurgaon	6	36	1	43
	Sub-total	63	350	54	467
Sylhet	Habiganj	28	29	7	64
	Maulvibazar	15	40	0	55
	Sunamganj	4	30	12	46
	Sylhet	12	55	4	71
	Sub-total	59	154	23	236
Total		**489**	**2,480**	**621**	**3,590**

Annex C: List of persons involved with the assessment

DGFP
Dr. Mohammed Sharif
Dr. Tapash Ranjan Das
Dr. Fahmida Sultana
Dr. ABM Shamsuddin
Dr. Farid Uddin Ahmed
Dr. Shamsul Karim
Dr. Nurun Nahar Rozy

DGHS
Dr. Habib Abdullah Sohel

MaMoni HSS
Mr. Joby George
Dr. Selina Amin
Dr. Jebunessa Rahman
Dr. Muhibbul Abrar
Ms. Marufa Aziz Khan
Dr. Farzana Islam
Mr. Mamun-ur Rashid
Sk. Towhidur Rahaman
Ms. Aleisha Rozario

ICDDR,B
Mr. AKM Tanvir Hossain
Md. Mostofa Kamal

Save the Children
Dr. Ishtiaq Mannan

USAID
Dr. Umme Salma Jahan Meena

End Notes

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[v] National Institute of Population Research and Training (NIPORT) and ICF international. 2016. Bangladesh Demographic and Health Survey 2014: Policy Briefs. Dhaka, Bangladesh and Rockville, Maryland, USA. NIPORT and ICF international.
[vi] National Institute of Population Research and Training (NIPORT), Associate for Community and Population Research (ACPR) and ICF international. 2016. Bangladesh Health facility Survey 2014. Dhaka, Bangladesh: NIPORT, ACPR and ICF International
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