**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AMTSL</td>
<td>Active Management of the Third Stage of Labor</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante-natal Care</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>ASK</td>
<td>Ain-o-Shalish Kendra</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>CS</td>
<td>Caesarean Section</td>
</tr>
<tr>
<td>CM</td>
<td>Clinic Manager</td>
</tr>
<tr>
<td>CoCC</td>
<td>Comilla City Corporation</td>
</tr>
<tr>
<td>CRHCC</td>
<td>Comprehensive Reproductive Health Care Center</td>
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<tr>
<td>DMF</td>
<td>Design and Monitoring Framework</td>
</tr>
<tr>
<td>DNCC</td>
<td>Dhaka North City Corporation</td>
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<tr>
<td>DSCC</td>
<td>Dhaka South City Corporation</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FMIS</td>
<td>Financial Management Information System</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FS</td>
<td>Field Supervisor</td>
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<td>FW</td>
<td>Field Worker</td>
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<tr>
<td>FWA</td>
<td>Family Welfare Assistant</td>
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<tr>
<td>FWV</td>
<td>Family Welfare Visitor</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>GaCC</td>
<td>Gazipur City Corporation</td>
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<tr>
<td>GIS</td>
<td>Geographical Information System</td>
</tr>
<tr>
<td>GM</td>
<td>Gopalganj Municipality</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HLD</td>
<td>High Level Disinfection</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HRM</td>
<td>Human Resource Management</td>
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<tr>
<td>HW</td>
<td>Health Worker</td>
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<tr>
<td>IDI</td>
<td>In-depth Interview</td>
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<tr>
<td>ISI</td>
<td>Integrated Supervisory Instrument</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Contraceptive Device</td>
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<tr>
<td>KCC</td>
<td>Khulna City Corporation</td>
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<tr>
<td>KsM</td>
<td>Kishoreganj Municipality</td>
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<tr>
<td>KstM</td>
<td>Kushtia Municipality</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MR</td>
<td>Menstrual Regulation</td>
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<tr>
<td>NaCC</td>
<td>Narayanganj City Corporation</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NVD</td>
<td>Normal Vaginal Delivery</td>
</tr>
<tr>
<td>PA</td>
<td>Partnership Area</td>
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<tr>
<td>PA NGO</td>
<td>Partnership Area Non-Government Organization</td>
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<tr>
<td>PAA</td>
<td>Partnership Agreement Area</td>
</tr>
<tr>
<td>PAHQ</td>
<td>Partnership Area Head Quarter</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHCC</td>
<td>Primary Health Care Center</td>
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<tr>
<td>PIU</td>
<td>Project Implementation Unit</td>
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<tr>
<td>PM</td>
<td>Project Manager</td>
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<tr>
<td>PMU</td>
<td>Project Management Unit</td>
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<tr>
<td>Acronym</td>
<td>Abbreviation</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
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<tr>
<td>PPM&amp;E</td>
<td>Project Performance Monitoring and Evaluation</td>
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<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PRA</td>
<td>Participatory Rapid Appraisal</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RaCC</td>
<td>Rangpur City Corporation</td>
</tr>
<tr>
<td>RCC</td>
<td>Rajshahi City Corporation</td>
</tr>
<tr>
<td>RHSTEP</td>
<td>Reproductive Health Services Training and Education Program</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SC</td>
<td>Satellite Clinic</td>
</tr>
<tr>
<td>SCC</td>
<td>Sylhet City Corporation</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>SM</td>
<td>Sirajganj Municipality</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package of Social Science</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoids</td>
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<tr>
<td>ULB</td>
<td>Urban Local Body</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<tr>
<td>UPHCP</td>
<td>Urban Primary Health Care Project</td>
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<tr>
<td>UPHCSDP</td>
<td>Urban Primary Health Care Services Delivery Project</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence against Women</td>
</tr>
<tr>
<td>VDRL</td>
<td>Venereal Disease Research Laboratory</td>
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<tr>
<td>VG</td>
<td>Vulnerable Group</td>
</tr>
<tr>
<td>WG</td>
<td>Women's Group</td>
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<tr>
<td>WUHCC</td>
<td>Ward Urban Health Coordination Committee</td>
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Executive Summary

1. The Urban Primary Health Care Services Delivery Project (UPHCSDP) has been providing health care services to the urban people with special emphasis on maternal and child health since 2012 in fourteen towns¹ (ten city corporations and four municipalities). It is the continuation of earlier two phases beginning in 1998. The present qualitative survey is one of the important deliverables of the Project Performance Monitoring and Evaluation (PPM&E) Firm. The main objectives of the survey is to assess quality of services delivered by the 25 Partnership Areas under the project and seek stakeholder’s perception on service delivery with a view to gain deeper insight into various aspects of primary health care services, service provisions, community awareness, client choices and satisfactions.

2. Participatory Rapid Appraisal (PRA) method was followed in the study and qualitative feedback was captured using tools and techniques like Focus Group Discussion (FGD), In-Depth Interview (IDI), Transect Walk, Social Mapping, Problem Ranking and Venn diagram. The participatory respondents were drawn from among the service recipients, service providers and the community at large.

3. The participants of FGD sessions included Members of Women’s Group, Men’s Group, Vulnerable Group, Users’ Forum, Adolescent Group, Community Leaders and Health Workers. The respondents of IDI were Male Ward Councilors, Female Ward Councilors, Poor Women, Members of Ward Urban Health Coordination Committee (WUHCC), Women Victims of Violence, Members of Users’ Forum (UF), Chairpersons/Secretaries of UF, and Doctors/Quacks/Kabiraj/ Homeopath/ Traditional Healers, Clinic Manager cum-Medical Officers, Paramedics/Counselors of CRHCC/ PHCC of UPHCSDP. The participants of transect walk, social mapping, problem ranking and Venn diagram were project beneficiaries and community people.

4. The survey identified diseases that beneficiaries generally suffer in the catchment areas. The diseases are categorized as: (i) adults: cold, fever, cough, diarrhea, tuberculosis (TB), diabetes; (ii) women: ante natal care (ANC), post natal care (PNC), post abortion care (PAC), diabetes, menstrual regulation (MR); (iii) children: cold, fever, cough, malnutrition etc.; (iv) adolescent: MR, sexually transmitted diseases (STD), malnutrition, and; (v) elderly people: cold, fever, cough, asthma, diarrhea, TB, diabetes and, old age diseases.

5. UPHCSDP is providing primary health care services through PA NGOs under partnership agreement in 25 Partnership Agreement Areas (PAAs). Services are provided from three levels of facilities such as Comprehensive Reproductive Health Care Centre (CRHCC), Primary Health Care Centre (PHCC), and Satellite Clinic.

6. Health care services available in a CRHCC includes general health care services plus ANC, PNC, MR, Dilatation and Curettage (DNC), PAC, child health care, Normal Vaginal Delivery (NVD), and delivery by Caesarean Section(C/S), Reproductive Tract Infection (RTI), Sexually Transmitted Infection (STI) and Family Planning (FP). In PHCC, the services are general health services, ANC, PNC, MR, diarrhea and FP. In satellite clinics the available services are child immunization, FP. The CRHCCs and PHCCs also provide medical treatments to the victims of Violence against Women (VAW).

7. The survey reflects the major role played by CRHCC and PHCC in providing primary health care services in the catchments area in comparison to other public and private health facilities. The survey also found that PHCC is reaching the majority of the people in the catchments area with health care services. The beneficiaries requested to establish more PHCCs and satellite centers particularly in the newly included city corporations to cover more population in general and the poor in particular.

¹ Dhaka South City Corporation, Dhaka North City Corporation, Rajshahi City Corporation, Khulna City Corporation, Barisal City Corporation, Sylhet City Corporation, Rangpur City Corporation, Narayanganj City Corporation, Gazipur City Corporation, Comilla City Corporation, Sirajgong Municipality, Kushitia Municipality, Gopalgonj Municipality, Kishoreganj Municipality.
This explains increasing demand and also the popularity of the urban primary health care services of the Local Government Division.

8. Red card was provided to more than targeted 30% poor beneficiaries in the PA-NGO catchments area to avail all type of health services free of cost. The participants suggested to increase the number of red cards and to improve the management of Red Card distribution system in vogue.

9. Cost of health care services is notified item-wise at the entry point of all the service centers of the project. The beneficiaries mentioned that the cost of medicines as well as the services is lower in the project compared to any other health service facilities. None reported any extra or unwanted payments. The beneficiaries mentioned that the costs of services are generally low. However, in some cases, the cost to beneficiaries located far away from the centers is little higher due to payment of additional travel cost.

10. In general, the participants are satisfied with the availability and quality of services. However, some beneficiaries suggested improvements of existing services. Their suggestions included: increasing service hours of PHCC, service delivery for 24 hours of 365 days a year, creating spacious waiting room, maintaining cleanliness of the centers, ensuring availability of physician and health worker and volunteer, increasing numbers of PHCC and satellite clinics and red card, supply of medicines. The service providers suggested for more training, effective role playing by WUHC and user’s forum, and effective actions on VAW.

11. Gender issue is addressed in the UPHCSDP. At all three levels of service delivery, women service providers over number the men. Likewise, among the service recipients, majority are women. However, among the project managers, men are majority.

12. WUHCC has been formed in all the 25 PA NGOs to address component I of the UPHCSDP for sustainability of the project. WUHCC is helping project implementation through creating awareness among the people. User’s forum has been formed with mostly beneficiaries as members. The UF is also helping project implement through creating awareness. The survey also found that WUHCC and UF are helping victims of VAW. The respondents suggested effective role playing and functioning of both WUHCC and UF.

13. UPHCSDP stands by the VAW when needed. It is to be noted that VAW includes mostly physical, mental and sexual harassments. The survey also found that the violence against women are primarily due to poverty, child marriage, drug addiction, dowry, polygamy, illiteracy, promiscuity, inability to give birth or giving birth to only girl child, living in slum, unemployment of the husband etc. The victims get medical treatment at CRHCC and PHCC. The health workers and family welfare assistants help VAW victims through counseling. The WUHCC and UF also provide them with legal aid and mitigation of their grievances.

14. The health workers, family welfare visitorsassistants make people aware of the project through courtyard meeting (Uthan Baithak), distributing leaflet, announcing through miking, using banners and logos of the project and person to person contact. However, almost all the participants suggested regular meetings of user’s forum and WUHCC, rally in the slum areas, advertisement in TV channel, use of mike, signboard, banner, leaflet etc for creating effective awareness in the community and publicizing the health care services delivery program.

15. The participants listed some strengths of the project such as: effective counseling by the health care service providers, health services through red card, services to mother and child, services to pregnant mothers with high priority, caesarian done with due care, services at low cost or free of cost, services at door step, good infrastructure facility, ambulance services, etc.

16. The participants listed some weaknesses as well such as: inadequate waiting area, inadequate manpower, location of fewer CRHCC and PHCC far away from some beneficiaries, inadequate medicine, frequent disruption of electricity, inadequate budget, lack of pediatrician, lack of
17. publicity, insufficient ultra sonogram facility, insufficient ambulance service, lack of permanent anesthetist, etc.

18. Almost all participants suggested for improved health services through increasing manpower, facilities, availability of ambulance services, salary of staff, and level of awareness and responsibility. The survey observed that some participants are too ambitious and expect unrealistic expectations for providing services X-Ray, ultra sonogram, all medical tests, and ambulatory facility from PHCC.

19. The recommendations and suggestions from the participants are summarized as follows:

- Simplification of eligibility criteria of red card and increasing the number of red card. Red card should bear photograph of all members of the household and signature of respective Project Manager. There should be a master register for red card;
- Less performing PHCC should be more frequently monitored;
- Role and function of WUHCC and UF should be efficiently monitored by PMU and PIU as per guideline;
- Victims of VAW should get effective support and legal aid for mitigation of grievances and redress of their harassment with security;
- The program for adolescent corner should be activated and monitored regularly;
- Behavior Change Communication (BCC) and awareness creation program should be more effective through print and electronic media and traditional means;
- Urban primary health care services may include diabetes patients; and
- All CRHCCs and PHCCs should be established progressively in own buildings of respective city corporations and municipalities on a permanent basis.
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Section I
Project Background, Performance Monitoring and Evaluation

A. Project Background

1. The Urban Primary Health Care Services Delivery Project (UPHCSDP) has been proceeding through a long journey starting with the First Urban Primary Health Care Project in 1998 implemented in only four city corporations with the assistance of Government of Bangladesh (GoB) and Asian Development Bank (ADB). On successful completion of the first UPHCP in 2005, the second phase of UPHCP was designed and implemented successfully during 2005-2012. Supportive government policy and ADB, UNFPA and SIDA’s continued supports combined together with the rising demands created among the beneficiaries the present UPHCSDP was taken up from July 2012 that will close in June 2017. The project is of special type for various reasons particularly being public private partnership for delivery of primary health care services targeting improvement of health condition of the poor through sustainable quality services. This has emerged as a model for delivery of urban PHC services.

2. The Urban Primary Health Care Services Delivery Project (UPHCSDP) has been providing health care services to the urban people with special emphasis on mother and child health in all city corporations (except Chittagong) and four municipalities of Gopalganj, Kishoreganj, Sirajganj and Kushtia. The city corporations and municipalities covered by UPHCSDP is shown in the Bangladesh map below:
B. **Aim, Outcome, and Outputs/Components of the Project**

3. The aim of the UPHCSDP is to improve health of the urban population in Bangladesh, particularly the poor, women and children. The outcome of the project is sustainable good quality urban PHC services provided in areas that target the poor and the needs of women and children. The project outcome is being supported through three major outputs/components (i) strengthened institutional governance and local government capacity to sustainably deliver urban PHC services; (ii) improved accessibility, quality, and utilization of urban PHC services delivery system, with focus on the poor, women, and children, through PPP; and (iii) effective support for decentralized project management.

C. **Project Performance Monitoring and Evaluation (PPM&E)**

4. The purpose of project performance monitoring and evaluation is to assist and work with the PMU and track progress of PA NGOs in achievement of results (quantity, quality, and management aspects), provide a regular independent assessment of performance (on selected topics/areas/issues), conduct mapping activities and provide support to routine monitoring conducted by the project.

5. The scope of PPM&E are to (i) measure project outputs and impacts through surveys (quality survey, household survey, health facility surveys, and a mapping survey); (ii) regularly assess performance through implementation of Integrated Supervisory Instrument (ISI) at all health care facilities and NGO management on a semi-annual basis; (iii) conduct an assessment on impact of the project’s training program; (iv) verify and update households annually and support PA NGOs for effective management of the red card system; (v) develop GIS database linking HMIS and M&E outputs and prepare GIS maps; and (vi) contribute to refinement and improvement of project M&E and QA tools when appropriate in close collaboration with PMU.

D. **Major Monitoring and Evaluation Output Deliverables**

6. The PPM&E firm will deliver the following output deliverables to complete its assignments as per agreed time schedule up to June 2017. In addition, the PPM&E firm will prepare periodic and routine process monitoring reports.

- Qualitative survey report;
- Health facility survey report;
- Training program assessment report;
- GIS database and mapping;
- Half-yearly performance monitoring reports;
- Annual poverty updating and red card verification report; and
- Project end line survey and impact evaluation report.
Section II
Methodology of the Qualitative Survey

A. Approaches for Project Performance Monitoring and Evaluation

7. Project Performance Monitoring and Evaluation (PPM&E) will follow approaches and methodologies including the following:

- Monitor achievements of all three outputs/components in terms of quantity, quality, and management (if possible in time dimension to assess efficacy);
- Report feedback through HMIS, QPR, and time bound seven deliverables as appropriate in consultation with the PMU;
- Participatory and transparent monitoring and evaluation would be the principle and sharing of monitoring and evaluation feedback be adopted as the practice;
- Recognize and respect the observations and opinions of others on principle but undertake monitoring and evaluation independently and professionally without bias;
- Evaluate and compare achievements of specific output indicators in one side with baseline data (end line data of UPHCP II), DMF target indicator data;
- Heightened importance to data validation through verification, triangulation, and other means as appropriate.

B. Methodologies and Tools

8. PPM&E firm has undertaken number of activities while doing monitoring and evaluation. The methodologies and tools are different. More than one methodology has been adopted in accomplishing major outputs. The methodologies followed are being summarized for each of the major activity.

C. Qualitative Survey

9. The present survey is the qualitative assignment by the Project Performance Monitoring and Evaluation (PPM&E) Firm. The main objective of the survey is to assess quality of the primary health care services delivered by the PANGOs of the project, on various aspects of health service management, service provisions, community awareness and client perceptions. Purpose of the qualitative survey is to provide information helpful to the design and inclusion of topics in the questionnaire of household survey to gather in-depth information on specific issues of health service management and other provisions.

10. The qualitative survey is designed to gain deeper insights on various aspects of health service management, service provision, community awareness, client perceptions and others. It has investigated status of Ward Urban Health Coordination Committee(WUHCC), status of users' forum, community and service provider's perceptions on the distribution and utilization of red cards, community awareness of health care services and providers, health care seeking behavior of urban poor, sources of information about health care services, responsiveness of service providers, awareness and service responsiveness to gender equality and violence against women, and linkages with legal aid services.

D. Objectives and Scope of the Qualitative Survey

11. The specific objectives of the qualitative survey are to: (i) identify the status of Ward Urban Health Coordination Committees; (ii) identify poor households with red cards; (iii) determine community awareness of health care providers and knowledge of available services; (iv) identify health care seeking behavior of the urban poor and the criteria used by them in selecting health care providers and assessing quality; (v) understand information network and sources of information about health care issues and service providers among the urban poor; (vi) identify and assess gender-based equity situation in the health care service; (vii) identify and assess violence against women in the
project area; (viii) identify the status of Users’ Forums; and (ix) assess the responsiveness of UPHCSDP, PA-NGOs partners and other organizations.

E.   Methodology and Techniques and Tools used for the Qualitative Survey

12. In order to achieve the objectives of the qualitative survey, the survey used Participatory Rapid Appraisal (PRA) method for collecting data from 25 PA-NGO areas. All the 25 CRHCCs and 25 PHCCs (randomly selected by taking distance as a focal point) one from each partnership area were covered.

13 The approach of Participatory Rapid Appraisal (PRA) owes more to gain an understanding of the complexities of a topic rather than to gather highly accurate statistics on a list of variables. Moreover, in PRA understanding qualitative nuances within a topic is just as important as finding general averages. PRA is used to obtain a differentiated understanding of the population’s attitudes, beliefs, and behaviors towards disease and health care. PRA is applied most effectively in relatively homogeneous communities which share common knowledge, values and beliefs, although it has also been used in more complex urban environments also. Its short duration and low cost also make it possible to carry out a series of PRAs rather than having to rely on the results of one large survey. The PRA tools used for conducting the survey are Focus Group Discussion (FGD). In addition, in-depth Interview (IDI), transect walk, social mapping, problem ranking and Venn diagram were used for the survey. The survey and data collection tools are at Appendices.

F.   Focus Group Discussion (FGD)

14. A total of 50 Focus Group Discussions (FGDs) were conducted (25 in CRHCCs & 25 in PHCCs) with Community Leaders, Women Group, Men Group (MG), Members of Users Forum, Health Workers (HW), Vulnerable Groups (VG) and Adolescent Groups (AG). The category of participants and their number are as follows:

<table>
<thead>
<tr>
<th>Participant Category(s)</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>Women’s Group</td>
<td>18</td>
</tr>
<tr>
<td>Men’s, Group</td>
<td>5</td>
</tr>
<tr>
<td>Community leader</td>
<td>6</td>
</tr>
<tr>
<td>Vulnerable Group</td>
<td>6</td>
</tr>
<tr>
<td>Users Forum</td>
<td>2</td>
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<tr>
<td>Adolescent group</td>
<td>6</td>
</tr>
<tr>
<td>Health worker</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
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</table>
G. **In-depth Interview (IDI)**

15. In-depth interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation.

16. In-depth interviews (IDI) were conducted with the Ward Councilors, Female ward Councilors, Poor women members of WUHCC, Victims of violence/family members of victims, Members of user forums, Chairpersons/secretaries of user forum, MBBS doctors/quacks/kabiraj/homeopaths/traditional healers, Clinic manager cum-medical officers, Paramedics/counselors of CRHCC/PHCC. The number of respondents in each category was 50.

**Table 1: Number of IDI participants**

<table>
<thead>
<tr>
<th>Categories of Respondents</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Councilors</td>
<td>50</td>
</tr>
<tr>
<td>Female ward Councilors</td>
<td>50</td>
</tr>
<tr>
<td>Poor women members of WUHCC</td>
<td>50</td>
</tr>
<tr>
<td>Victims of violence/family members of victims</td>
<td>50</td>
</tr>
<tr>
<td>Members of user forums</td>
<td>50</td>
</tr>
<tr>
<td>Chairpersons/secretaries of users forum</td>
<td>50</td>
</tr>
<tr>
<td>MBBS doctors/quacks/kabiraj/homeopaths/traditional healers</td>
<td>50</td>
</tr>
<tr>
<td>Clinic manager cum-medical officers of CRHCC/PHCC</td>
<td>50</td>
</tr>
<tr>
<td>Paramedics/counselors of CRHCC/PHCC</td>
<td>50</td>
</tr>
<tr>
<td>Counselors of CRHCC/PHCC</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
</tr>
</tbody>
</table>
H. Transect Walk

17. A transect walk is a systematic walk along a defined path (transect) across the community/project area together with the local people by observing, asking, listening, looking and producing a transect diagram.

18. It compares the main features, resources, uses, and problems of different zones presented by participating community members who are knowledgeable and willing to participate in a walk through their surrounding areas. The numbers of Transect walk, Social mapping, Problem ranking and Venn diagram are as follows.

<table>
<thead>
<tr>
<th>Exercise(s) Performed</th>
<th>Number of Participant(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transect walk</td>
<td>50</td>
</tr>
<tr>
<td>Social mapping</td>
<td>50</td>
</tr>
<tr>
<td>Problem ranking</td>
<td>50</td>
</tr>
<tr>
<td>Venn diagram</td>
<td>50</td>
</tr>
</tbody>
</table>

19. To achieve the goal of qualitative survey PRA techniques were applied to collect data from the field. The survey team members with the help of beneficiaries, clients of UPHCSDP of the locality, members of User Forum, Members of WUHCC and outreach workers of PA NGOs visited the catchment area of respective PAs from one end to other. They talked with the people of the locality, asked about health care services status, health service providers availability in the vicinity, extent of availability of health services towards poor and ultra poor, They listed prominent objects, buildings, educational institutions, connecting roads, important structures, hospitals, clinics, diagnostic centers, parks, mosques, temples, shopping malls, apartments, markets, police stations, post office, slums playground and all other noticeable infrastructures of the area. Independent lists of 25 PAs were prepared for every CRHCC separately. Another set of 25 transect walk list for 25 PHCC having one
from each PA was also prepared. Surveyors plotted all the noted objects on a large sheet of paper for every CRHCC and PHCC. Diagram of a transect walk at CRHCC is presented below:
I. Social Mapping

20. Social mapping is a visual method of showing the relative location of households and the distribution of different people (such as male, female, adult, child, land lord, landless, literate, and illiterate) together with the social structure, groups and organizations of an area.

21. Social Mapping presents different house-holds, land record, land, and other assets, holdings, social groups/categories, relative locations of homesteads, different street/paras, location of schools, hospitals, markets, shops, ponds, dikes, mosques are also useful in discussing social problems, coping strategies and solutions. Participants prepared the map indicating the relative locations on the ground and validated by the group by consensus.

22. During transect walk, the main objectives of the survey team were to prepare a list of objects like buildings, educational institutions, connecting roads, important structures, hospitals, clinics, diagnostic centers, parks, mosques, temples, shopping malls, apartments, markets, police stations, post office, slums, playground and all other noticeable infrastructures etc of the area one after another.

23. Surveyors prepared 50 social maps for all 25 CRHCCs and 25 selected PHCCs covering all PA areas. Social maps show the location of PA Head Quarters', CRHCC, PHCCs, Satellite Clinics. Social mapping presents different street/paras, location of schools, madrasah, hospitals, markets, shops, mosques, graveyard, temple, church, government and corporate organizations and establishment, police station.

24. Connecting roads moving toward CRHCC and PHCC were prominently shown. These maps provide the easier way to identify the destination like CRHCC and PHCC by holding numbers showing roads, lane, by lane and route also. Social Map of a CRHCC is presented below:
J. Problem Ranking

25. Problem Ranking is a participatory technique that allows analyzing and identifying the problems participants shared in order to implement adequate improvements and solutions in their community and area. The participants discussed which the most important problems they faced on health services in their community in all 25 CRHCCs and 25 selected PHCCs catchment areas. Afterwards, the participants ranked these problems in regards to their importance. The results of this method provided base for discussions on possible solutions to the priority problems. The trend of problem ranking goes like: distance of CRHCC & PHCC, insufficient ambulance service, lack of experienced physician, insufficient medicine, insufficient red card, less number of field workers, less awareness program etc.

K. Venn Diagram

26. A Venn diagram is an illustration of the relationships between and among sets, groups of objects that share something in common. Usually, Venn diagrams are used to depict set intersections. A Venn diagram shows the key institutions and individuals in a community and their relationships and importance for decision-making. In all 25 CRHCCs and 25 selected PHCCs, Venn Diagrams were drawn identifying the importance and linkage of local groups and institutions; participation of different institutions, involvement of the agencies in the delivery of services, administration by making circles of different size on the ground by the participants. Venn diagram representing the availability of health services from CRHCC catchments area is shown below:
L. Field Works and Data Collection

27. A team of 12 field research assistants was engaged and they were provided intensive training on PRA methods. They collected data and information from the stakeholders administering the techniques of FGD, Transect Walk, Social Mapping, Problem Ranking and Venn diagram following guidelines during 2-27 November 2015. The survey was monitored by the team of consultants and experts from the PPM&E firm. The information and data collected through PRA techniques were transcribed and processed as per objectives of the survey.

Following tools were used for collecting data and information from the field:

- Guidelines for health worker
- Guidelines for women’s group
- Guidelines for community leader
- Guidelines for vulnerable group
- IDI of ward councilor/female ward councilor
- Guidelines on in-depth interview with MBBS doctor/Quack/Kabiraj/Homeopath/Traditional healer
- Guidelines on in-depth interview with women members of WUHCC representative from poor households
- Guidelines on in-depth interview with clinic manger cum Medical officer/Paramedic/Counselor of PHCC
- Guidelines on in-depth interview with Victim/Family Members of Victim/Law enforcing agency
- Transect walk
- Social mapping
- Problem ranking
- Venn diagram
Section III

Major Findings of the Qualitative Survey

A. Introduction

28. Major findings of the qualitative survey collected through PRA techniques of FGD, IDI, Social Mapping, Problem ranking, transect walk and Venn diagram are presented as per the objectives of the survey. The findings reflect the perception of the service providers, services receivers (beneficiaries) and the members of the community served by the concerned PA NGOs. The issues discussed were, prevailing diseases, primary health care services, service providers, service receivers, red card, service cost, awareness building on health and related problems particularly women and children, vulnerable groups, gender, violence on women and legal aids and role and functions of ward urban health coordination committee and users’ forum.

B. Prevailing Diseases

29. The survey identified diseases beneficiaries generally suffer from in the catchment area. The diseases are categorized as (a) for adults: general health care services, cold, fever, cough, diarrhea, tuberculosis (TB), diabetes, (b) for women: general health care services, Ante Natal Care (ANC), Post Natal Care (PNC), diabetes, Menstrual Regulation (MR), Post Abortion Care (PAC), Family Planning (FP), and Violence Against Women (VAW) (c) for children: general health care services, cold, fever, cough, malnutrition etc. (d) for adolescent: general health care services, MR, Sexually Transmitted Diseases (STD), malnutrition, (e) for elderly people: general health care services, cold, fever, cough, asthma, diarrhea, tuberculosis (TB), diabetes and old age diseases. The Health Care Service Providers (MBBS Doctors of CRHCC, Clinic manager cum Medical Officer of PHCC/ Health Workers, Quack/Kabiraj/Homoeopath) also mentioned the same types of diseases prevailing in the area and they provide services.

30. There is variation due to seasons. The participants of beneficiary groups, service provider groups, community members and leader groups showed a common consensus with respect to diseases prevailing in the respective areas.

C. Available Treatments for Diseases

31. UPHCSDP is providing primary health care service through NGOs under partnership agreement. The project coverage is all city corporations (except Chittagong) and Gopalganj, Kishoreganj, Sirajgonj and Kushtia municipalities. The project area is divided into 25 Partnership Areas (PAs). Health care services are provided from three levels of facilities which are Comprehensive Reproductive Health Care Centre (CRHCC), Primary Health Care Centre (PHCC) and Satellite Clinics (SC).

32. Health care services available in a CRHCC are general health services plus ANC, PNC, MR, DNC, PAC, FP, child health care, NVD, C/S, RTI, STI.
PHCC: general health services plus ANC, PNC, MR, PAC, FP, Diarrhea and Satellite: EPI, FP, ANC, PNC. The CRHCCs and PHCCs also provide medical treatments to the victims of VAW.

33. All the participants identified UPHCSDP-CRHCC, PHCC, satellite clinic; NGO, private practitioners, kabiraj and homeopath as health care service providers in the community. Two male groups in RCC-PA2, Ward-26 in Meher Chandi area added that traditional healers and religious leaders also provide health services to the beneficiaries.

34. Most of the participants expressed their satisfaction over availability of the services. There are, however, some observations to improve the prevailing services for attaining sustainability in the future. These are presented as per issues and PAAs. The participants showed expectations to increase logistic facilities in CRHCCs & PHCCs, service providing hours, service scope on holidays, waiting room, cleanliness at centers, availability of physician, health worker and volunteer, red card,
supply of medicine, number of PHCC and satellite. Other issues read as training, and counseling, role and functioning of WUHCC, User’s Forum and violence against women (VAW). The beneficiaries also requested for more PHCCs and Satellite Clinics particularly at the newly included city corporations like Gazipur to cover population.

35. All the health care service providers expressed their satisfaction about the services they provided at CRHCC, PHCC and SC. They found most of the clients return to take services from the centers repeatedly, showing a sign of satisfaction. Other indications of clients’ satisfaction the service providers identified as, the beneficiaries bring their family members, relatives, neighbors to the CRHCC & PHCC for availing health services. However, due to lack of Ultra sonogram, X-ray and ECG machines all type of services cannot be provided. Besides, number of staff was also mentioned not adequate. They suggested to increase the number of physicians and supporting staff and to supply necessary instruments for investigations.

36. The respondents stated the types of services beneficiaries need from the CRHCC are: sufficient medicines, availability of physicians round the clock, facility of all type of general treatments. The workers suggested that in order to making the service more effective, Ultra Sonogram machine should be provided in all the CRHCCs\PHCCs and number of health workers has to be increased.

37. Almost all respondents indicated that they consider the following factors for choosing health centers for seeking health care services.

- Cost within reach
- Good behavior of service providers
- Availability of services
- Close to residents
- Good quality of service
- Specialized physician for diseases
- Free medicine
- Effectiveness of the services
- Less waiting time
- Counseling service
- Privacy of the service

38. Women participants emphasized on special needs for privacy during the treatment. Community leaders added easy communication as one of the criteria for availing the health services from the service providers.

D. Red Card

39. Red card is a family card distributed to the poor household which assures that each member of the card holder family will get all services free of cost from the project clinics. The partner NGO of the partnership area is responsible to identity the poor and distribute red card followed by some specific indicators developed by the project. Red Card is a tool to ensure that no person living in the UPHCSDP area will be deprived of getting primary health care services due to poverty. A target of at least 30% poor and ultra-poor is to be put within umbrella of UPHCSDP.

40. Almost all the participants mentioned that they knew about red card, its criteria and implications to the holders. Most of them, however, could not mention exact numbers of red card distributed in their area. There are, of course variations amongst them. Women group participants of DNCC-PA4 (KMS) PHCC ward no. 8, Block F, Road 6, Mirpur, Dhaka stated that they had no idea about red card. Forty percent women participants of Rajshahi PA-1, PHCC-2 (RIC) ward no 2 Tautly Para ward did not know about free medicine. The women’s group in Rajshahi PA-1, PHCC-5, Choto Bonagram told that they did not get red card.

41. The participants mentioned that they knew about the red card through health workers. Health workers hold discussion with them during visits. They hold Courtyard meeting (Uthan Boithak).
Participants of men’s group expressed the view that red card should be distributed to poor households who did not get red card through survey. Some participants proposed resurvey should be announced through loudspeaker to aware the people. Women participants proposed to increase medicine, red card, and child specialist. Participants in vulnerable women group of PHCC-2, Chawk Kobdas para on the Jamuna embankment, Sirajganj expressed the view that they were eligible for red card but they did not get it. The Project Manager Sirajganj, however, explained the situation as these people were the seasonal migrants due to erosion from the Jamuna during the rain. The participants of other groups more or less expressed their satisfaction on the distribution of red card but recommended more to do in extending numbers and services. The participants of GM PA- I CRHCC mentioned inadequate red card supply and insufficient medicine for red card holders.

42. Participants residing in slums/ temporary sheds somewhere particularly garment workers of PHCC-1-GaCC-PA-1 & PHCC-1, GaCC- PA 2 reported that they could not avail health services from the clinics because during day time they worked outside their area.

43. The participants of CRHCC in BCC-PA- 1, GaCC -PA 1 & PA 2, GM- PA-1, KCC-PA-1 GaCC-PA-1&PA-2, GM- PA-1 & RaCC PA-1 and in PHCC-2 of RCC- PA-1 &PA-2, PHCC-3 of KCC-PA-1, GaCC-PA-1 PHCC-1 &PA-2 –PHCC-1 reported inadequate supply of red cards. Inadequate supply of red cards, medicine and irregularities in distribution of red card were reported in KstM PA-1-PHCC also.

44. All community leaders told that the poor households knew who received red card. All community leaders knew about distribution of red cards but some of them did not know the number. They stated that health workers distributed red card by survey. All groups expressed that health workers discussed about red card. All community leaders told that health workers informed about red card. Some told PHCC offices arranged court yard (Uthan Boithak) session, WUHCC and UF hold meetings to know about the poor households. Almost all community leaders proposed that red card could be distributed to the poor households who were eligible for red card through resurvey.

45. All the member of Users Forum of CRHCC and PHCC mentioned that all poor knew about Red Card, free medicine, free treatment etc. They also mentioned that they knew about Red Card from their neighbors.

46. Poor people were also aware that they were entitled to get red cards and consequently free services with medicine. They knew and made people aware of red cards in their neighborhood. Outreach workers during visits discuss the red card issue but could not tell the number of card holders in their neighborhoods. They know about the distribution of red cards in their locality/neighborhood during court yard meeting (Uthan Boithok), contacting red card users and visit of supervisor and through meeting. They suggested increasing the number of red cards and to do more survey to find out real poor and ultra poor.

47. Health Care Service Providers (MBBS Doctors of CRHCC, Clinic Manager cum Medical Officer of PHCC/ Health Workers, Quaak/Kabiraj/Homoeopath) also informed that the poor people were aware of entitlement to get red cards and free medicines and other services. Health workers discuss on red card with the beneficiaries during their field visit and survey. Field workers of the PA NGO visited to collect information regarding the poor in the respective locality/neighborhood of the beneficiaries. Field staffs identify the poor people who did not receive red card through household survey. The project is providing health care services for the poor at free of cost in their respective localities. They are more or less satisfied with the services they are providing to the red card beneficiaries.

48. The foregoing discussion on red card reflects a positive coordination among the beneficiaries, local people, community and urban local leaders and service providers including all stakeholders. This may lead to extend the health services to the poor through red card successfully.

E. Adolescent

49. Almost all types of participants of adolescent groups reported to have acquired knowledge and awareness on the issues by participating the adolescent sessions of CRHCC of the Urban Primary Health Care Services Delivery Project.
Health Care Services Delivery Project. The participants reported to have learned the benefits of balance diet from them. They have learned about the importance of keeping themselves clean for better health and hygiene during the adolescent period. They got aware of malnutrition and causes of anemia. They got aware of marriage and pregnancy at adolescent age. They got aware of gender issues. They are aware of TT vaccination and took vaccination. They learned negative impact of early marriage on health and hygiene and the causes of maternal death. They learned physical changes during adolescent period as change in voice. The participants were aware of RTI/STI. They were supplied with iron tablet from the project.

50. Participants mentioned that the adolescent groups are mostly girls consisted of students and unemployed female. Boys and girls together are found only in DSCC – PA-4 of PSTC. Most of the participants reported to have sessions by weeks and months. The issues discussed in the sessions are as follows:

- Awareness creation for sexuality and safe sex
- Nutritious food and its impact on the child and adolescent
- T.T. vaccination
- Child marriage, impact of pregnancy at adolescent age
- Gender issues
- Causes of anemia and its prevention
- Symptoms of RTI/STI for girls and boys

51. Almost all the participants mentioned that the adolescent’s problems are not fully addressed in the primary health care services. The participants (of CHRCC- RCC-PA-1& PA-2, RCC-PA-1- PHCC-2) mentioned that there were no facilities for the patients. Participants suggested the sessions should be held twice a week regularly.

F. Ambulance Services

52. Almost all groups stated that they used ambulance service. Performance was satisfactory. They got free of cost services. Behavior was also good. Health workers expressed that vulnerable group members availed the ambulance service and were satisfied with the service. Red card holders normally avail the ambulance service and were satisfied with the service. In some places they were not aware of the service.

53. Participants indentified the following barriers to reach the ambulance services. Participants of CRHCC— DSCC-PA-1, PA-2, PA-4, & PA-5 reported insufficient ambulance services. Participants of CRHCC-SSC-PA-mentioned shortage of ambulance. Participants of CRHCC–NaCC, reported no ambulance service. The project has no provisions for ambulance services for PHCC in spite of that some participants demanded ambulance for PHCCs (DSCC-PA-1 PHCC-2, DSCC-PA-4-PHCC-1, RCC-PA-1-PHCC-2,KCC-PA-1-PHCC, GaCC_PA-1,& KsM-PA-1-PHCC-1).

G. Services Coverage by the Health Services

54. Most of the participants stated that they availed health services from UPHCSDP. About 80% female participants and 20% male participants are receiving health services from the facilities. Health care services available in the CRHCC, PHCC and Satellite Clinics have been highlighted in the subsection C (Available Treatments for Diseases, p.11).

55. The health care service providers also mentioned the same service coverage. There is some exception also. The men’s group of Rajshahi PA-1, PHCC-5 Bonogram, Barorastar Morer slum on Mosques’ Waqf Estate said that they were not included in the health services of the project in spite of their request.
H. Gender Equality

56. The UPHCSDP addresses the gender equality in their program. Majority of the service providers are female. Most of the health workers, counselors, FWAs are female. Only in the Project Manager’s (PM) category number of male is higher. The beneficiaries are also overwhelmingly female. The proportion of female members in WUHCC and UF are fully maintained.

57. The survey reveals that UPHCSDP addressed the gender issues as per project guidelines. The majority of services providers and service recipients were found female. The proportion was high for male only at project manager level.

I. Creating Awareness and Publicity among the Project Participants

58. The UPHCSDP has launched awareness and publicity program to let the beneficiaries know the functions of primary health services to the community by UPHCSDP.

59. Almost all the beneficiary groups and the service providers mentioned different types of activities for creating awareness among the beneficiaries. These include WUHCC meeting, UF meeting, group meeting, court yard session, miking, signboard, banner, leaflet etc.

60. Almost all the groups mentioned that they took part at the national day observance program. They participated also in awareness building program arranged by NGOs. The health worker groups also mentioned that when national day observance program came they took part.

61. The beneficiaries are informed by groups through the informers and awareness program of UPHCSDP;
   - Men: through outreach workers, offices arrange court yard session, WUHCC and UF meetings, person to person contact, family, relatives, neighbors, beneficiaries, miking, signboard, logos of the project & centers, banner, leaflet etc. of PHCC, CRHCC and Satellite.
   - Women: through outreach workers, offices arrange court yard session, WUHCC and UF meetings, person to person contact, family, relatives, neighbors, beneficiaries, miking, logos of the project & centers signboard, banner, leaflet etc. of PHCC, CRHCC and Satellite.
   - Children: through parents and school, person to person contact, family, relatives, neighbors, beneficiaries.
   - Adolescents: through outreach workers, offices arrange court yard session, WUHCC and UF meetings, person to person contact, family, relatives, neighbors, beneficiaries, miking, signboard, banner, leaflet etc. of PHCC, CRHCC and Satellite.
   - Elderly people: through outreach workers, offices arrange court yard session, person to person contact, family, relatives, neighbors, beneficiaries, WUHCC and UF meetings, miking, signboard, logos of the project & centers, banner, leaflet etc. of PHCC, CRHCC and Satellite.

J. Informers’ Role on Creating Awareness and Publicity

65. The project field level service providers and workers and the members of local bodies play vital role in creating awareness among beneficiaries and publicizing the purpose and services of UPHCSDP. All the groups highlighted the role of key informers. The key informers were identified as:

- Field Supervisor
- Family Welfare Visitor
- Family Welfare Assistant
- Ward Urban Health Coordination Committee (WUHCC)
- User Forum
66. Almost all the participants proposed regular meetings of user forum and WUHCC, rally in the slum areas, advertisement in local TV channel, uses of loud speaker, signboard, banner, leaflet etc for creating awareness in the community and publicizing the services of the project more effectively.

67. Almost all service providers mentioned their respective needs to become more responsive. Their vision for more responsiveness are presented as, to increase number of expert medical staff, logistic supply, medicine supply, frequency of training, salary level, provide over time, ambulance, create more space in the centers, modern medical supplies and blood bank services.

68. Almost all the respondents mentioned that they had good net working with other health service providers, both govt. and non govt. organizations. Sometimes they refer patients communicating through that net work.

K. Cost of the Services to the Patients

69. Almost all the participants stated that there was a chart of different cost at the entry of the clinics of UPHCSDP. Clients pay according to that. Red card holders do not pay any cost except transport cost. They cited some cost as below:

- Doctor’s fees- Tk.35.00
- Laboratory tests –Tk. 50.00-150.00
- Medicine- 10% less

70. It is to be noted that none reported payment of bribe or extra amount for the treatment at the CRHCC and PHCC. Almost all the participants stated that the cost of services in UPHCSDP is much less than other organizations in the locality. Besides, if any client is found unable to pay as required UPHCSDP allow sufficient subsidy.

71. Those that have Red Cards do not have to pay, but others have to pay fee of Doctor’s, laboratory test, medicine and transport cost. All most all the participants expressed that the cost is within their reach but they could not bear the expenses for test and medicine to be collected from outside the CRHCC or PHCC. The participants of course mentioned the cost increased due to the distance of the centers.

L. Evaluation of the Services by the Participants

72. During the field visits for data collection, different types of stakeholders participated in transect walk, social mapping, problem ranking and drawing Venn diagram reflecting the availability of UPHCSDP services in the catchment area. Their evaluation is presented as per health service centers in the catchment area.

73. The presentation shows that, the participants mentioned that they availed health services from different sources. Majority of the participants told that they availed health services from CRHCC & PHCC of the UPHCSDP followed by government hospitals and NGOs, pharmacy, homeopath and others. It reflects the major role of CRHCC and PHCC in the community compared to other organizations. Data in the following table shows the participant’s evaluation on the health services provided by different organizations in details.
Table 2: Participants’ Evaluation of the Health Services Provided from UPHCSDP

<table>
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<th>.</th>
<th>PA Areas</th>
<th>CRHCC %</th>
<th>PHCC %</th>
<th>BRAC/NGO clinic %</th>
<th>Pharmacy %</th>
<th>Public. hospitals %</th>
<th>Homoeopathy %</th>
<th>Others %</th>
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74. It is significant to note that a substantial number of participants availed health services from medicine seller at pharmacy. The UPHCSDP may include this segment of participants in their service network by extending its area coverage in future.

M. Participants’ Satisfaction on the Health Services

75. The UPHCSDP is providing primary health services to the population in their respective localities. The participants were more or less satisfied with the services they availed. Almost all the participants considered the following reasons for satisfaction:

- Good counseling
- Free medicine
- Low cost
- Good behavior
- Good treatment
- Short distance
- Can speak to doctors freely
- Doctors pay attention and give sufficient time to listen to the patients.

76. The health service providers mentioned that beneficiaries were satisfied with the services of the health service providers. The causes mentioned were free treatment, medicine at reduced price, and quality services. The health workers mentioned the following expressions as signs of satisfaction by beneficiaries:

- Appearance of the clients expresses their satisfaction level.
- Sometimes they express their happiness.
- During discussion clients express satisfaction.
- Same client visiting facility for many times.
- One client coming with some other client as they are satisfied.

77. The survey reveals that the participants availing the health services provided by UPHCSDP are more or less satisfied with the services. They, however, expressed their perceptions and expectations on the services to improve the prevailing services to be sustainable to the community. These are presented as per issues by PAAs. The issues and services identified were on the facilities in terms of physical location of CRHCCs & PHCCs, service providing hours, service scope on holidays, waiting room, and availability of bed for the inpatient, availability of physician, health worker and volunteer, red card, supply of medicine, number of PHCC and satellite. Other issues read as monitoring, coordination, training and counseling, WUHCC, UF and VAW.

N. Logistics

78. The participants of DNCC-PA-1-CRHCC mentioned that front road of CRHCC is narrow & spaces insufficient.

DNCC-PA 2-PHCC-2 clinic space is insufficient, water logging in front of clinic.
DNCC-PA-3-PHCC-1 reported insufficient space.

The participants of DSCC-PA-1 mentioned CRHCC is outside the catchment area.

The participants of DSCC-PA-4 CRHCC mentioned poor wash room facilities and PHCC-1 and PHCC-2 mentioned waiting room problem and space shortage

The participants of DSCC-PA-5-CRHCC mentioned insufficient medical testing instrument, shortage of staff, PHCC-2 waiting room problem and water supply problem.

The participants of GaCC-PA-1-CRHCC mentioned that PHCC is located at long distance.
Number of PHCC is less than requirement and supply of red card is less.

The participants of GaCC-PA-2-CRHCC also mentioned that PHCC is located at long distance and number of PHCC is less than requirement particularly in slum area.

The participants of NaCC-PA-1-PHCC-1 mentioned insufficient number of PHCC to address aspirant beneficiaries.

The participants of RCC-PA-1- CRHCC is located at the distant western end of catchment area creating problems for the patients resulting less attendance and the participants of PHCC-2 mentioned shortage of doctors and insufficient red card.

The participants of RCC PA-2 mentioned CRHCC is outside the catchment area creating problem for pregnant women and new born and no pediatrician at PHCC-2.

The participants of KCC-PA-2-CRHCC mentioned that CRHCC is outside the catchment area due to which patient is less, irregular supply of logistics, needs doctors and nurse on holidays. The participants of PHCC-3 told that First aid treatment is not always ensured.

The participants of BCC-PA-1-PHCC-3 mentioned shortage of skilled doctor, limited supply of medicine.

The participants of RaCC-PA-1-CRHCC mentioned that CRHCC is not in centre of the city creating problems for pregnant women and new born and insufficient necessary medicine supply. The participants of RaCC-PA-1, PHCC-3 mentioned shortage of doctors, insufficient red card.
The participants of SCC-PA-1-PHCC-5 mentioned insufficient medicine supply, shortage of doctor, nurse and health worker.

The participants of KstM-PA-1-CRHCC: mentioned that BCC materials are insufficient. The participants of PHCC 1 mentioned irregularities in red card distribution.

The participants of KsM-PA-1-CRHCC: PHCC-1 mentioned shortage of doctors, nurse and health workers, shortage of cabin, insufficient medicine.

The participants of GM-PA-1-CRHCC mentioned that program is being run by the Municipality and less medicine supply to red card holders. The participants of PHCC-1 mentioned post of physician is vacant and no gynecologist is there.

However, the participants put some common perceptions on logistic and related issues beyond the provisions of UPHCSDP on the availability of logistic support. These read as availability of x-ray machine at CRHCC, ultra sonogram machine at PHCC, ambulance at PHCC admission of patients at PHCC, inclusion of diabetes as a prevailing common disease etc.

O. Monitoring and Coordination

79. The participants (Service providers) of DSCC-PA-5-CRHCC, DSCC PA-1-PHCC-2, and DSCC PA-3-PHCC-1 DSCC PA-4-PHCC-1 mentioned that monitoring is less. The participants of KCC-PA-2, PHCC3 mentioned inadequate coordination with other organizations. The participants of GM-PA-1-CRHCC mentioned less coordination between PM, PIU and staffs.

Training:
The participants of BCC-PA-1-CRHCC mentioned less training facilities.
The participants of GaCC-PA-2-CRHCC mentioned inadequate training opportunity for medical and health workers.
The participants of DSCC-PA-2, CRHCC mentioned staffs were not well trained.
The participants of RaCC-PA-1, PHCC-2 mentioned less training facility for lab technician.
The participants of Gacc-PA-1-PHCC-1 mentioned insufficient training facility.
The participants of KCC-PA-1-PHCC-3 mentioned inadequate training for staffs.
The participants of KCC-PA-2, PHCC3 mentioned inadequate training facility.
The participants of SM-PA-A-CRHCC mentioned Family Welfare Assistant (FWA) and paramedics are not well trained.

Skilled Doctor, Nurse, and Health Worker: FWV, FWA and Paramedics

The participants of SCC-PA-1- CRHCC: mentioned shortage of skilled doctor, nurse and health worker.
The participants of DSCC-PA-3-PHCC-1-PA-5, PHCC-2 mentioned shortage of skilled doctor.
The participants of CoCC-PA-1 CRHCC: mentioned shortage of skilled doctor, nurse and health worker.
The participants of KSM-PA-1, CRHCC: mentioned shortage of doctor, nurse and health worker.

Part time doctors

The participants of GM-PA-1-CRHCC: mentioned that doctors are working as part time physician.

Gynaecology

The participants of DSCC-PA-3-CRHCC: mentioned shortage of experienced gynaecology/obstetrics doctor.
The participants of GM-PA-1-CRHCC: mentioned lack of gynaecology/obstetrics doctor.

Outreach Worker/Health Worker

The participants of BCC-PA-1-CRHCC mentioned shortage of field worker
Support for Victims of VAW: Role of WUHCC & UF

80. The participants of DSSC-PA-2 CRHCC mentioned less arrangement for legal support to victims of VAW. The participants of KCC-PA-1-CRHCC mentioned victims of VAW did not get sufficient legal help from WUHCC. The participants of GM-PA-1-CRHCC mentioned WUHCC and UF were in register only; victims of VAW were not getting legal help from WUHCC. The participants of RCC-PA-1-CRHCC: mentioned VAW did not get expected support. The participants of KCC-PA-1-PHCC-3 mentioned victims were not getting support from WUHCC. The participants of KstM-PA-1, PHCC-1 mentioned VAW help was irregular.

81. The participants of CRHCC-KCC-PA-2 suggested to provide one doctor and one nurse on holidays to attend VAW cases. The participants of CRHCC-RaCC-PA-1 and the participants of CRHCC-SM-PA-1 suggested that there is insufficient counseling. The participants of UF of CRHCC- RCC-PA-1 and CRHCC-SM-PA-1 suggested that UF members are less acquainted with the public representatives.

82. The participants of KstM-PA-1-PHCC-1, mentioned that UF was not aware of their role and functions. The participants, however, put some expectations on the availability of some issues beyond the provisions of UPHCSDP such as provision of child bed, cabin, orthopedic doctor, etc.

83. Some participants of women group of CHRHC-PA-5, Ward-1, mentioned that, Tilpapara Khilgaon, Dhaka did not give any importance to diseases, showed shyness and maintain secrecy about the female diseases within the family. Some participants of women group of PHCC PA-3, Ward-23, Azimpur, Dhaka (Near graveyard) do not attend the health centers. The reasons mentioned were, superstitions, shyness, negative attitude of guardian, and afraid of disclosure of diseases in the society.

P. Ward Urban Health Coordination Committee

84. Of the three components, number one component of the Urban Primary Health Care Services Delivery Project (UPHCSDP) reads as: “Strengthening institutional governance and government capacity to Sustainably Deliver Urban Primary Health Care Services”. In view of this component the project made provision for constituting local committee headed by the elected representatives of City Corporations and Municipality as per the following guidelines.

85. Each PAA was supposed to use the NGO pro-forma for formation of WUHCC circulated by the City Corporation in 2008. The pro-forma states the following: “Each city corporation and each municipality shall constitute a coordination committee, chaired by the respective local ward Councilor and co-chaired by the female ward Councilor and Zonal Health Officer/ Medical Officer. The WUHCC will consist of zonal health officer/Medical Officer, representative of PA NGO, in-charge of CRHCC, representatives of private health providers in the ward, ‘representatives of other NGOs providing urban PHC’, community based organizations, and at least 3 women living in slums or from poor households.

86. The functions of the WUHCC are (i) to ensure knowledge and access to free health facilities by the poor, especially women and girls; (ii) coordinate UPHCSDP-with other urban health providers/Public Health initiatives in the ward, (iii,) provide ‘user forum’ for public disclosure of services provided by the health facilities, and (iv) ensure grievance and complaint redressed relating to service provision and any resettlement issues. This committee should meet minimum once in 3 months. Committee can co-opt a person as a member who will be necessary for this committee.

87. The survey reveals that WUHCC is formed in all the CRHCCs and PHCCs. The WUHCC was constituted in each city corporation/ municipality areas. The WUHCC was set up as per guidelines mentioned in project proforma. The WUHCC included counselor, CRHCC clinic manager, representative of project manager’s office, 3 poor women, members of NGO Forum, women group, men group. Number ranges from 11 to 14. Majority of the participants showed their satisfaction with the role of WUHCC.
88. The committee met at 3 months interval. Meeting minutes are distributed among the members. It ensures/promotes access of the poor, especially women and girls to increase knowledge and get health services from partner NGOs under UPHCSDP. The committee distributes leaflets, organizes group meeting, aware adolescent about health care facility, court yard meeting, education to adolescent about health care and CRHCC,PHCC, free health facilities for poor, TT vaccine to adolescent, increase knowledge and aware them by counseling. All the committee members are involved in decision making at WUHCC.

89. The committee coordinates with all stakeholders of primary health care services. Majority stated that, the committee referred different types of patients to health centers.

- Deliver care for pregnant women and adolescent health problems, mother and child health, cough, cold, quality of care.
- Coordinate with other health centre based on community.
- Special care to patient referred by BRAC health care centre.
- Coordinate with BRAC, other centre for better treatment.
- Share each other (organization) in the special health events.

90. The WUHCCC Committee organizes forum for public disclosure of services provided by the health facilities under UPHCSDP. The committee have received some complains from the community. They solved the problem by the ward councilor. They have idea about how many poor households received red cards in their locality/neighborhood. Outreach workers during visit discuss with the beneficiaries. The committee put the following suggestions:

- Increase the number of red cards for distribution
- More survey to find out real poor and extreme poor.
- Those who did not get red card needed more inquiry for the poor.
- Prepare a list of poor, then distribute card.
- Got Red Cards but number is not enough.

91. The participants however put observations on the WUHCC. The participants of DSCC PA-2 CRHCC mentioned that WUHCC had no arrangement for legal support for victims of VAW. The participants of KCC PA-1 CRHCC told of less Coordination with the WUHCC and the members of WUHCC do not know the name of the committee (KCC PA-1, PHCC-3). The participants of SM-PA-CRHCC told public representatives are less related to WUHCC & UF also. The participants of GM PA-1 CRHCC told WUHCC & UF are in register only.

Q. **Users Forum (UF)**

92. The survey reveals that in most cases the beneficiaries formed Users Forum at PHCC level. The participants found satisfied with the users forum members with reservation.

93. Each PAA was supposed to form Users Forum for CRHCC and each PHCC. In December 2009, a progress review meeting was held, in which the following decision was taken: "Urban Health User Forum should be formed only by the clients both from red card holders and non card holders. Members of the forum will be limited to 7-10 persons. Gender equality must be ensured.

94. There will be one UF for each CRHCC/PHCC. All project managers of PA NGOs are responsible for the formation of urban health user forum.

95. Participants stated that UF has been formed in each PA area. They mentioned the period of formation from 2013 to October’15. According to guide line provision of members is 7 to 10.

96. Average of total number of members in a forum ranges from 25 to 7, female member’s ranges from 15 to 3 and male member ranges from 10 to 1. Most of the members do not know the provision. Out of 25 CRHCC’s 23 told that UF has been formed as per guide line. DNCC PA-2 and GaCC PA-1 told they have no guide line.
97. The participants know the rules and act accordingly. Rest two, KCC PA-1 and GM PA-1 members did not know roles and responsibilities. All have work plan except of 3 PAs. RaCC PA-1, GaCC PA-1 and GM PA-1 told that they have no work plan. As per guide line quarterly meeting is held.

98. Almost all told they publicized and circulated all the activities of UPHCSDP door to door, inform the patients, informed about the activities of CRHCC of UPHCSDP. Only two, GaCC PA-1 and GM PA-1 told that UF were not active.

99. Almost all told that they worked with publicity and circulation, inform the patients, inform about free treatment, red card system and all other facilities available in UPHCSDP house to house and tells about all activities of UPHCSDP. Only 2 participants of KCC PA-1 and another of GM PA-1, UF are not active in this respect.

100. Almost all the participants told that committee members were involved in decision making. Rest three of KCC PA-1, GaCC PA-1 and GM PA-1 told that committee members were not involved in decision making. Most UF mentioned that they knew the decisions. Decisions were for more publicity against drug, more red cards introduction and to circulate about activities. Only five, DSCC PA-4, DNCC PA-2, DNCC PA-4, GaCC P-1 and GM PA-1 stated that they did not know about this.

101. Almost all the participants told that they did not receive any complain. Only two of DNCC-PA-3 and GM-PA-1 informed, as the committee was not active there was no scope for complain. All members mentioned that all poor knew about red card, free medicine, free treatment etc. All members mentioned that they knew about receiving of red cards from their neighborhood.

102. All members mentioned that they knew through courtyard session, outreach workers of UPHCSDP, health worker, door to door survey during red card issue and they were involved in red card distribution. Almost everyone suggested door to door survey before issuing red card in close coordination with UF and UPHCSDP.

103. All Members mentioned that physical, mental and sexual violence against women took place. In summary the reasons are dowry, drug addiction of husband, financial insolvency, early marriage, illiteracy, polygamy, unemployment, poverty etc.

R. Violence Against Women (VAW) and Legal Aid

104. The UPHCSDP has the provisions to address the victims of VAW. The types of violence are identified as physical, mental and sexual. The reasons identified as poverty, dowry, child marriage, polygamy, promiscuity, and illiteracy, living in slum, always gives birth to girl child, drug addiction, gambling, and illicit relation.

105. They sometimes mentioned about the fate. Almost all the participants mentioned that when national program came on women violence, they took part, they also attended awareness program arranged by NGOs.

106. The violence against women are physical and mental torture and sexual harassment. The causes of violence include slum life, illiteracy, poverty, early marriage, dowry, drug addiction of husband, financial insolvency, polygamy, unemployment, promiscuity, giving birth to only girl child.

107. Maximum groups stated violence against women as: Physical violence occurs about 70%, mental violence about 10% and sexual violence occurs about 20%. Most of them have heard and most of them have not seen.

108. Most of the victims of violence against women first go to CRHCC for treatment. They prefer to go to health worker. After treatment they go to Ward Councilors, Counselors of CRHCC/PHCC, WUHCC, local elites, human rights commission and police. Few victims mentioned that they filed case but produced no output as husbands were influential. They were bound to withdraw the case.
Sometimes they do not go for judgment to maintain family ties. If they try to go for judgment, violence aggravates. Certain respondents of GaCC PA-2 stated that children were in the family so could not go for disclosure.

109. The participants form KCC PA-1 CRHCC and GM PA-1 CRHCC told victims of VAW did not get any legal help from WUHCC of KCC PA-1 PHCC-1. The participants of KsM PA-1 PHCC- told that VAW are not taken in to consideration regularly.

110. Out of 25 victims of VAW 22 stated that there is mitigating facility for violence against women. There is legal aid facility and counseling facility in 23 PA areas except two BCC PA-1 CRHCC and SM PA-1 CRHCC. Three victims mentioned that there is no program of community awareness building (DNCC -PA-1 CRHCC, DNCC -PA-3 CRHCC, SM -PA-1 CRHCC). Four WUHCCs (DNCC PA 2 PHCC-2, KCC PA 1 PHCC 3, KstM PA1 PHCC 1 and GM PA 1 PHCC 1) provided no service towards victim. DSCC-PA-2-CRHCC had no local help to VAW. Almost all the women victims stated that they receive psychological support from the service providers.

111. Case Survey of Victims of Violence Against Women (VAW). Batashi Begum is a beneficiary of KCC-PA-2. She is 30 and her husband Mahin is 40. She is house maid and her husband Mahin is a van driver. They reside at Pura slum. They have two daughters and a son who are still minor and do not go to school. Batashi works in number of houses every day. On the contrary, Mahin is lazy and irregular in work. He takes little care for the family and spends whatever he earns as he wishes. In addition, he demands money from his wife. This leads to quarrels frequently and Batashi sustained injuries. She approached the project for help with medical treatment. The WUHCC mitigated the troubles many times. But the situation aggravated gradually and with the advice of the councilor she filed a case in the court. She could not follow the case due to financial crisis, insecurity of the children, threats, and for fear of disclosure and damage to family image. She has no alternative but to continue with the oppression from the husband.

112. Almost all the victims of VAW stated that the UPHCSDP plays an active role towards women victims and against the offenders. All the victims of VAW stated that they do not face any problem in getting services from the UPHCSDP. But they face following problems when getting legal support:

- Financial incapability
- Threat from influential
- Social stigma
- Afraid of name and fame
- Family barrier.
- Afraid of disclosure
- Insecurity of children
- Door to door visits needed in legal aid.

113. Almost all the participants could mention names of different legal aid groups and service providers (both GOs and NGOs) as Ain O Shalis Kendra(ASK), PHCC, ward commissioner, police, social welfare department, local elites, local public representative, BRAC, human rights commission, directorate of women affairs and court.

114. All kinds of violence against women, physical, mental and sexual were mentioned by the Health Service Providers. The causes behind the violence were described as, dowry, drug addiction of husband, gambling, polygamy, lack of education, husband unemployed, poverty, illicit relationship etc.

115. Most of the respondents (service providers) expressed that, the victims initially approach the local Ward Commissioners for seeking justice and if they advice any legal aid group they approach accordingly with their cooperation. They also mentioned that the local ward commissioners being the Chairperson of WUHCC play active role towards women victims and against offenders by calling both the parties for hearing.

116. As regards types of services available for victims of VAW in UPHCSDP/Partner NGO’s centres, most of the respondents stated that there were services like primary physical treatment, counseling,
and advices for legal actions. Most of the respondents told that there was trained heath service provider for victim of VAW in UPHCSDP. Almost all the respondents stated that they got psychological support through counselling. Sometimes they do not go for seeking justice to maintain family ties, as violence aggravates. In maximum cases the victim cannot make any choice.

S. Problems, Strengths & Weaknesses Identified by the Beneficiaries & Service Providers

116. The participants identified the following problems in availing the health care services from the project health care facilities.

- Less red card.
- Some diseases which cannot be treated here.
- Insufficient number of doctors.
- Insufficient facilities at CRHCC and PHCC.
- Inadequate Ambulance service.
- Child specialist sometimes not available.
- Some medicines are not available.
- Sometimes ultra sonogram needs to be done from outside.
- Guardians do not like to send their daughters to hospitals for fear of disclosure in the community.
- Superstitions, Shyness, threat from guardians.
- Less awareness program.

117. The service providers pointed out some problems they face in providing health services to the beneficiaries that read as political influence, misbehave with doctors and nurses, more patient at a time, patients take this as Govt. hospital and everything is free, do not take medicine as advised, superstition, shortage of manpower, shortage of space, non-availability of place for satellite, limited supply of medicine, unavailability of anesthetist, increased number poor patients for delivery, partial payment of medicine, non poor want to get free treatment, poor logistics.

118. The participants stated some strengths of the project in providing health services as, good counseling was given by the health service providers, health services through red card, services to mother and child, services to pregnant mothers with high priority, caesarean is done with high responsibility, less cost or free of cost health care services, poor people are getting health services at their door step, good building/physical facility, ambulance facility available, better services at low cost, provision of free medicine etc.

119. The participants stated some weaknesses of the project also in providing health services as, inadequate sitting space compared to the number of patients, less number of manpower, CRHCC/PHCC located at distant places, all types of medicines not available, electricity disruption, inadequate budget, lack of pediatrician, insufficient publicity, insufficient ultra sonogram, insufficient ambulance service, lack of permanent anesthetist, etc.

120. Strength and Weakness of UPHCSDP/Partner NGOs (service providers) for taking a responsive role in the community. All Service providers pointed out the strengths and weaknesses of their CRHCCs in their own way. The strengths included: provision of child care, ANC and PNC, labor room facility, Red card for free medicine facility, CRHCC is 24 hours open, treatment is less costly, poor are the target group, discount in medicine price, counseling facility etc. On the other side of the scale the weaknesses included: Lack of eye care facility, inadequate medicine supply, no ultra sonogram machine, no blood bank, less field worker, inadequate lab equipment, no post of anesthetist, less staff, insufficient skilled worker etc.

T. Suggestions

121. Respondents suggested in general for increasing the number of manpower, increasing service facilities like equipments and medicines, increasing salary of service providers, keeping facilities for all type of medical tests and keeping all facilities open round the clock.
Section IV

Summary, Recommendations and Conclusions

A. Summary

122. The Urban Primary Health Care Services Delivery Project (UPHCSDP) has been providing primary health care services to the urban people with special emphasis on maternal and child health since 2012 in all city corporations (except Chittagong) and four municipalities of Gopalganj, Kishoreganj, Sirajganj and Kushtia. It is the continuation of earlier two phases beginning in 1998. The present survey is the qualitative assignment by the Project Performance Monitoring and Evaluation Firm. The main objective of the survey is to assess quality of the services delivered by the project and stakeholder’s perception on service delivery with a view to gain deeper insight into the various aspects of health care services, service provisions, community awareness and client perceptions expectations.

123. The survey followed Participatory Rapid Appraisal (PRA) method administering Focus Group Discussion (FGD), In-Depth Interview (IDI), transect walk, social mapping, problem ranking and Venn diagram techniques. The participatory respondents were service receivers, service providers and the community people.

124. The survey reveals the prevailing diseases beneficiary generally suffer from in the catchment area of the project. The diseases are categorized as (a) for adults: general health care services, cold, fever, cough, diarrhea, tuberculosis (TB), diabetes, (b) for women: general health care services, Ante Natal Care (ANC), Post Natal Care (PNC), diabetes, Menstrual Regulation (MR), Post Abortion Care (PAC), Family Planning (FP), and Violence Against Women (VAW) (c) for children: general health care services, cold, fever, cough, malnutrition etc. (d) for adolescent: general health care services, MR, Sexually Transmitted Diseases (STD), malnutrition, Family Planning (FP), (e) for elderly people: general health care services, cold, fever, cough, asthma, diarrhea, tuberculosis (TB), diabetes and old age diseases.

125. UPHCSDP is providing primary health care services through NGOs under partnership agreement. The project coverage is 10 city corporations and four municipalities. The project has been divided into 25 Partnership Agreement Areas (PA Areas). Primary health care services are provided from three levels of facilities, which are at Comprehensive Reproductive Health Care Centre (CRHCC), Primary Health Care Centre (PHCC) and Satellite Clinic.

126. Health care services available in a CRHCC are general health services plus ANC, PNC, MR, DNC, PAC, FP, child health care, NVD, C/S, RTI, STI; PHCC: general health services plus ANC, PNC, MR, PAC, FP, Diarrhea and Satellite Clinic: EPI, FP, ANC, PNC. Most of the participants expressed their satisfaction over the availability of the health care services. There are, however, some observations over the services. The participants showed expectations to increase logistics in terms of physical facilities, supply of medicine, availability of doctors, specialized physician and skilled health workers at the centers and field levels to improve the services.

127. The survey reflects the major role played by CRHCC and PHCC in providing primary health care services in the catchment area in comparison to other organizations of government and non-government. The survey also reveals that PHCC is reaching to the majority of the beneficiaries with services. The beneficiaries requested to establish more PHCCs and Satellite Clinics particularly in the newly included city corporations to cover more population in general and poor in particular. This may explain the importance and appropriateness of primary health care services in the community.

128. The cost of the services by items is projected at entry point of all health service centers. There is no report of extra or unwanted payment paid for. The beneficiaries expressed that the cost is increased due to the location of the centers and tests from outside that goes out beyond their reach.
129. Gender issue is prominently addressed in the UPHCSDP. Majority of the service providers are women at all levels from CRHCC down to the field level. Somewhere, it is overwhelmed by women. Majority of health service beneficiaries are also woman. However, the only exception is at project manager level where the proportion of women is less.

130. The participants availing the health services provided by UPHCSDP are more or less satisfied with the services. They, however, expressed their perceptions and expectations on the services to improve the prevailing services to be sustainable to the community. The issues and services identified are on the facilities in terms of physical location of CRHCCs & PHCCs, service providing hours, service scope on holidays, waiting room, availability of bed & seat for the admissible patient, availability of physician, health worker and volunteer, red card, supply of medicine, drug addiction, number of PHCC and satellite, monitoring, coordination, training, counseling, WUHC, UF and VAW.

131. WUHCC was formed in all the 25 PAAs to address the component I of the UPHCSDP for sustainability of the project. The WUHCC is helping in creating awareness among the people and helping the implementation of project objectives. Users Forum (UF) is formed with beneficiaries. The UF is helping to implement the project activities and creating awareness. The survey also reveals that WUHCC and UF are helping victims of Violence against Women (VAW). UPHCSDP stands by the victims of violence against women (VAW). The types of tortures mentioned are mostly physical, mental and sexual. Reasons mentioned are poverty, child marriage, drug addiction, dowry, polygamy, illiteracy, promiscuity, not to give birth to male child, living in slum, unemployment of the husband etc. The health workers and family welfare assistants help mentally by counseling. The WUHCC and UF members help them to mitigate and help them to get legal aid. The survey, however, reveals that in most cases the victims can not avail other help except mitigation with the oppressors. The reasons mentioned are poverty, social stigma, threat from the in-laws and husband, affection for children, time consuming procedure of judiciary system and undisclosed issues.

132. Participants are made aware of the project by the health worker, family welfare Visitors through court yard meeting (Uthan Boithak), distributing leaflet, announcing by mining, using banners and logos of the projects and person to person contact. They are made aware by WUHCC & UF, friends, relatives and neighbors also. Almost all the participants proposed regular meetings of users forum (UF) and WUHCC, rally in the slum areas, advertisement in local TV channel, uses of loud speaker, signboard, banner, leaflet etc for creating awareness in the community and publicizing the services of the project more effectively.

133. The participants identified their problems to avail the health services. These are: fewer red card, all diseases are not treated, insufficient doctors, facilities at CRHCC and PHCC inadequate, ambulance services not sufficient, child specialist are not available always, some medicines are not always available, sometimes ultra sonogram needs to be done from outside, guardians do not like to send their daughters to health facilities for fear of disclosure in personal matters, superstitions and shyness and threat from guardians, and inadequate awareness about the program.

134. The health service providers identified some problems such as political influence, misbehavior with doctors and nurses, more patient at a time, patients take this as public hospitals and everything is free, do not take medicine as advised, religious superstition, shortage of manpower, shortage of space, non-availability of place for satellite, limited supply of medicine, unavailability of anesthetist, more poor delivery patients, partial payment of medicine, non poor want to get free treatment, poor logistics.

135. The participants identified some strengths of the project such as good counseling, provision of red card for the poor, services to mother and child, services to pregnant mothers with priority, caesarian is done with high care, low cost or free of cost, door to door services, good infrastructure facility, ambulance facility and free medicine.

136. The participants identified some weaknesses of the project such as: some services are inadequate, inadequate waiting space, inadequate manpower, CRHCC/PHCC are located in areas far from beneficiary clusters, all medicine are not available, frequent electricity failure, inadequate
budget, lack of pediatrician, insufficient publicity, insufficient ultra sonogram, insufficient ambulance service, and lack of permanent anesthetist.

137. The participants put the following suggestions to improve the services of the project. Almost all the participants put the following suggestions for the improvement of the health services: deployment of more manpower, increase of facilities, use of machine and ambulance service to be made available, more test facilities to be created, X-Ray machine to be provided. Increase of awareness Development, increase of salary level of manpower, PHCC to be kept open for 24 hours, all medicines to be made available.

138. It is to be noted that some perceptions and suggestions put by the participants are beyond the set provision of UPHCSDP like providing X-Ray machine for CHRCC, ultra sonogram and ambulance for PHCC, provisions for all laboratory tests at CRHCC/PHCC and more.

B. Recommendations

139. The survey team based on the findings, made several important recommendations here under for consideration in improving the health services of the project.

- Criteria for eligibility and selection of beneficiaries for red card may be reviewed.
- Red card should bear photographs of all members of household, with signature of Project Manager.
- Red card should have separate Master Register.
- Low performing primary health care centers (PHCC) should be kept under special monitoring.
- Role and function of Ward Urban Health Coordinate Committee (WUHCC) and User Forum (UF) should be efficiently monitored as per PMU guidelines.
- Victims of violence against women (VAW) should get more support and legal help for prevention and security.
- Adolescent corner should be activated and monitored regularly.
- Behavior changes communication (BCC) and awareness creating program need to be more activated through print and electronic media and traditional means.
- Urban primary health care services may include diabetic patients.
- Establishing all CRHCCs and PHCCs in own buildings.

C. Conclusions

140. The survey reveals that the project is providing primary health care services to urban population maintaining all provisions set for. The participatory beneficiaries recognize the health services they avail. The major issues stand as types of diseases and treatment, red card, physical infra-structure, cost, awareness & publicity, gender issue, violence against women (VAW) & legal aid, role and functions of WUHCC and UF. The presentation presents deep insight into the project performance for monitoring and evaluation.

141. The survey reflects major role played by CRHCC and PHCC in providing its health services in the catchment area in comparison to other govt. non-govt. organizations. It also represents that majority take services from PHCC. The beneficiaries requested for more PHCCs and satellite clinics particularly at the newly included city corporations, like Gazipur to serve the growing industrial working population. This may explain the importance and appropriateness of primary health care services in the community. It is to be noted that a substantial number of participants availed health services from medicine seller at pharmacy. The UPHCSDP may include this segment of participants in their service net work by extending its area coverage in future.

142. The red card is helping the poor to receive health services who were neglected. Red card needs monitoring and verification in terms of beneficiary selection & distribution. The participants are availing health services from CRHCC, PHCC and Satellite Clinics.
143. The service cost is low. However, the beneficiaries cannot manage the cost if they go outside for tests. This may be addressed by increasing the facility.

144. Majority of the service providers are women at all levels from CRHCC down to the field level. Somewhere, it is over whelmed by women. Majority of health service beneficiary is also women. However, the only exception is at project manager (PM) level where the proportion of women is less.

145. The perceptions and expectations of the beneficiaries need attention in terms of location, physical structure, logistics, distance and number of centers at their reach. The quality and quantity of service providers at centers and field level need attention. The project personnel are engaged for counseling and creating awareness and helping the victims of VAW. More manpower demands in this area.

146. The WUHCC and UF are playing their role in helping the project to make health services available to the beneficiaries. Their roles need to be monitored. Almost all the participants proposed regular meetings of users forum (UF) and WUHCC, rally in the slum areas, advertisement in local TV channel, use of loud speaker, signboard, banner, leaflet etc for creating awareness in the community and publicizing the services of the project more effectively.
APPENDIXES
### Appendix I

**Checklist for FGD with Health Worker**  
**Urban Primary Health Care Services Delivery Project**

<table>
<thead>
<tr>
<th>Schedule No.</th>
<th>Mobile No.</th>
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1. Name of PA: .................................................................

2. PA number: ........................................................................

3. Name and Address of the clinic: ......................................  Ward No: ............

4. Date of interview: .................................................................

5. Total time of discussion:  
   Start: ........................................................................  End: ...............

6. Name of facilitator: .................................................................

7. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicines. [Yes=1, No=2]  
   দরিদ্র জনগণ কি জানেন তাদের লাল কার্ড পাওয়ার কথা এবং একই সাথে বিনা মূল্যে ওষধ পাওয়ার কথা?

8. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards. [Yes=1, No=2]  
   তারা কি জানেন তাদের এলাকায় অথবা পার্শ্ববর্তী এলাকায় কারা লাল কার্ড পেয়েছেন?

9. Did they have any idea about how many poor households received red cards in their locality/neighbourhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue?  
   তাদের কি কোন ধারণা আছে তাদের পাড়ায়/প্রতিবেশীর মধ্যে কতগুলো বাড়ি লাল কার্ড পেয়েছে? যদি তারা জেনে না থাকেন তার সন্দেহে কারণগুলো কি? আউটবার্ড কমিউনিটি বাড়ি পরিদর্শনের সময় এই বিষয়টি নিয়ে কি আলোচনা করেছিলেন?

10. How they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor.  
   তারা কেমন করে জানেন পাড়ায়/প্রতিবেশী এলাকায় কাদেরকে লাল কার্ড বিতরণ করার কথা? দরিদ্রদের সামর্থ্য জন্য তাদের কাছে কি কেউ এসেছিলেন?

11. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?  
   যদি আপনাদের পাড়ায় গরিবরা কোন লাল কার্ড না পেয়ে থাকেন, তাহলে আপনাদের মতে কিভাবে দরিদ্রদের মধ্যে লাল কার্ড বিতরণ করা উচিত?
12. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP/Partner NGO? Do you have any suggestions on how health care services of the poor can be effectively done?

13. Which health care service providers UPHCSDP, GO, NGO, private, kabiraj, homeopath, traditional healers, religious leaders) are available in this community? (Please make a list of service providers)

14. What types of services do these health care service providers generally provide to men, women, children, adolescent boys and girls and elderly people? (Types of services list of services to be provided)

15. What types of community awareness programmes regarding the health services and centres provided by UPHCSDP (PHCC/static clinic, CRHCC, Satellite clinic, mini clinic [outreach centre]) and others exist for men, women, children, adolescents and elderly people? (Name of services)
16. What types of community awareness programmes exist for providing special emphasis on urban poor by UPHCSDP/Partner NGO and other organizations? (Name of programs) अर्थात् प्राइमरी हेल्थ केयार प्रोजेक्ट/पार्टनर एनएजी एवं अन्य व्यवस्था सह संस्था के द्वारा गरीबदेश के मेजबान को बिश्वेष सेवा प्रदान कर कही के संपक्षे कामनान्तित के कि धरणे संहंतनता प्राप्तिल का आच्छ? 

17. What kinds of diseases exist in the community for different age groups? (Please list the disease pattern separately as per category- men, women, children, adolescents and elderly people, as per age group) Use the list of primary health care services to get correct information. (List of diseases to be provided) ऐसे कामनान्तित के विभिन्न बरसे छोले-मेये, पुरुष ओ माहिलाए। कि धरणे के अच्छ के बिसुख कही कहा? (पुरुष, माहिला, शिशु, किशोर-किशोरी एवं बयाझन के जन्म आलादा तालिका तैयर कर कीन एवं तालिका तैयर के लला प्राइमरी हेल्थ केयार सर्च्यू लिस्ट तथा आर्थर याते सब धरणे का तथा संघीकाभाब का आच्छ।)

i. Men
ii. Women
iii. Children
iv. Adolescent
v. Elderly People

18. Where do urban people (men, women, children, adolescent boys and girls, and elderly people—men and women) usually go to obtain health care services? Please specify the types of the service providers and the facilities (organizations). यात्रा सेवा पाओँर जगा शहरेर का जनने सादरणत दिन कोहा याता? (भेअलं: पुरुष, माहिला, शिशु, किशोर-किशोरी एवं बयाझन)? बिसुख धरणे यात्रा सेवा प्रदानकारी एवं संहुषर नाम उल्लेख कर कीन।

i. Men
ii. Women
iii. Children
iv. Adolescent boys and girls
v. Elderly People

19. Why do they go there? What are the reasons for using the specific health services from the specified service providers and from their facilities (organizations)? केवन तारा सेवा सादर का? कि कारण सादर बिश्वेष सेवा प्रदानकारी एवं बिश्वेष संहुषर काछे याता?
20. **What important criteria do the urban poor consider when selecting health care service providers and their facilities? Why? What criteria do they have in mind when assessing the quality of their health services (cost, behaviour of service providers, availability of services, distance, technical quality of services, free medicines, effectiveness of the services, waiting time, counselling, privacy etc.?)**

- i. Cost
- ii. Behavior of service providers
- iii. Availability of services
- iv. Distance
- v. Technical quality of services
- vi. Free medicines
- vii. Effectiveness of the services
- viii. Waiting time
- ix. Counselling
- x. Privacy

21. **Are the health service users happy with the services of health service providers? If yes, why? If not, why not?**

   - [Yes=1, No=2]

22. **How much do they spend on services (doctor’s fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc.)?**

   - তারা সেবা পাওয়ার জন্য কি খরচের খরচ করে থাকেন? (যেমন: ডাক্তারের ফিস, ল্যাবরেটরি টেস্ট এর খরচ, উষ্ণ, যাতায়াত, সেবা প্রদানকারী নাম অথবা সেবা পাওয়ার জন্য তাদেরকে যুক্ত দেয়া ইত্যাদি)।

23. **Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/Partner NGO and other organisations in their area? Do they get the same type of support from all these organizations?**

   - [Yes=1, No=2]
24. What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

25. What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

26. How can the problems be solved? What are their suggestions based on experience?

How can the problems be solved? What are their suggestions based on experience?

27. What types of health services would urban people generally seek from PHCC/CRHCC?

What types of health services would urban people generally seek from PHCC/CRHCC?

28. How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

i. Men

ii. Women

iii. Adolescents

iv. Elderly people and vulnerable groups

29. What are the most important sources of information for them?

What are the most important sources of information for them?

29. What are the most important sources of information for them?

What are the most important sources of information for them?

30. Who are the key informers?

Who are the key informers?

Who are the key informers?
31. As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

Yes = 1, No = 2

32. How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.

33. Are urban volunteers coming from the poor community? How many of them are male and female?

34. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

Physical = 1, Mental and sexual = 2

35. Have the respondents heard about or seen violence against women or were victims in urban poor community? [Yes = 1, No = 2]

36. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)? [Yes = 1, No = 2]

37. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?
38. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

39. Did the community receive any awareness programmes regarding violence against women?

[Yes=1, No=2] Did the community receive any awareness programmes regarding violence against women?
Appendix II

Checklist for FGD with Community Leaders

1. Name of Partner NGO: .................................................................

2. PA number: ..............................................................................

3. Address of the clinic: .............................................................. Ward No: ................................

4. Date of interview or FGD: ..........................................................

5. Total time of discussion: Start: ................................................. End: ..................................

6. Name of Respondent: ........................................................................................................

7. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicines. [Yes=1, No=2]

8. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards? [Yes=1, No=2]

9. Did they have any idea about how many poor households received red cards in their locality/neighbourhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue? [Yes=1, No=2]

10. How/do they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor. [Yes=1, No=2]

11. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?

Eusuf and Associates  Page 36
12. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP/NGO Partners? Do you have any suggestions on how health care services of the poor can be effectively done?

[Yes=1, No=2]

13. Which health care service providers (UPHCSDP, GOs, NGO, private, kabiraj, homeopath, traditional healers, religious leaders) are available in this community? (Please make a list of service providers)

- UPHCSDP
- NGO
- Private
- Kabiraj
- Homeopath
- Traditional healers
- Religious leaders

14. What types of services do these health care service providers generally provide to men, women, children, adolescent boys and girls and elderly people?

- Men
- Women
- Children
- Adolescents
- Elderly people

15. What types of community awareness programmes regarding the health services and centres provided by UPHCSDP- (PHCC/Static Clinic, CRHCC, Satellite Clinic, mini clinic [outreach centre]) and others) exist for men, women, children, adolescents and elderly people?

- PHCC
- CRHCC
- Satellite clinic
- Mini clinic
- Others
16. What types of community awareness programmes exist for providing special emphasis on urban poor by UPHCSDP / NGOs Partners and other organizations? Is there any user’s Forum Organised by PA NGOs in this Community? If yes, how it is functioning? [Yes=1, No=2] 

17. What kinds of diseases exist in the community for different age groups? (Please list the disease pattern separately as per category - men, women, children, adolescents and elderly people, as per age group) Use the list of primary health care services to get correct information.

18. Where do urban people (men, women, children, adolescent boys and girls, and elderly people – men and women) usually go to obtain health care services? Please specify the types of the service providers and the facilities (organizations).

19. Why do they go there? What are the reasons for using the specific health services from the specified service providers and from their facilities (organizations)?
20. What important criteria do the urban poor consider when selecting health care service providers and their facilities? Why? What criteria do they have in mind when assessing the quality of their health services (cost, behaviour of service providers, availability of services, distance, technical quality of services, free medicines, effectiveness of the services, waiting time, counselling, privacy etc.)?

Shahar's dairy plan shows that the urban poor consider the following criteria when selecting health care service providers:

- **Cost**
- **Behavior of service providers**
- **Availability of services**
- **Distance**
- **Technical quality of services**
- **Free medicines**
- **Effectiveness of the services**
- **Waiting time**
- **Counselling**
- **Privacy**

21. Are the health service users happy with the services of health service providers? If yes, why? If not, why not?

Users are satisfied with the services provided, as they are happy with the availability, quality, and cost of the services. They appreciate the efforts made by the providers to ensure timely service delivery.

22. How much do they spend on services (doctor’s fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc...)?

Users spend a significant amount on health services. They have to consider factors such as doctor’s fees, laboratory tests, medicines, transport cost, and any additional fees for non-service providers.

i. Doctor’s fees
ii. Laboratory tests
iii. Medicines
iv. Transport cost
v. Bribe for non-service providers

23. Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/NGO partners and other organisations in their area? Do they get the same type of support from all these organizations?

Users struggle to afford the high costs of health services. They have to make tough choices, such as skipping meals or selling household items to meet these expenses. Support from NGOs and other organizations is crucial, but the type and amount of support vary significantly depending on the organization.

Eusuf and Associates
24. What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

25. What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

26. How can the problems be solved? What are their suggestions based on experience?

27. What types of health services would urban people generally seek from PHCC/CRHCC/Maternity Centre/Satellite Clinic?

28. How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?
29. What are the most important sources of information for them?

তাদের জন্য সবথেকে গুরুত্বপূর্ণ তথ্য কি কি?

30. Who are the key informers?

সব থেকে গুরুত্বপূর্ণ তথ্য প্রদানকারী কে বা কারার?

31. As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

[Yes=1, No=2]

তাদের উপর ভিত্তি করে সেবা প্রদানকারীরা কি সেবা গ্রহণের জন্য সেবা প্রদানকারী সংযোগে গিয়েছিলেন এবং ইএসডি পাকেজ থেকে এক্সচার্জে সেবা গ্রহণ করেছিলেন? তারা কি প্রত্যেক সেবায় সমষ্টি ছিলেন? যদি উত্তর হ’ল হয়, তাহলে কেন? যদি উত্তর না হয়, কেন নয়? তারা কি সেবা প্রদানকারীদের কাছ থেকে এক্সচার্জে সেবা সম্পর্কে অনুভূতি করেছিলেন? যদি উত্তর হ’ল হয়, তারা কেন এক্সচার্জে ব্যবহার করেছিলেন?

32. How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.

যাঁরা সেবা ও সেবা প্রদানকারী সংযোগের ব্যাপারে এলাকার জনগণের মধ্যে যে তথ্যের উত্তর বা মাধ্যম গ্রহণ করেছেন তারা নিজেদের উপর ভিত্তি করে সেবা সম্পর্কে কিছু ভিত্তি করে সেবা গ্রহণ করেন।

33. Whether women community leaders and female ward commissioners are participating in planning for community-based solid waste management.

এলাকার শহর অবজনলা পরিষেবার ব্যবস্থাপনায় মহিলা নেতৃন্দ্র ও মহিলা ওয়ার্ড কমিশনারণ পরিকল্পনায় কি অংশগ্রহণ করেন?

34. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

শহরের দরিদ্র এলাকায় কি ধরনের নারী নির্বাহন (শারীরিক, মানসিক এবং মৌলন নির্বাহন) দেখতে পাওয়া যায়? এর কারণগুলি কি কি?

35. Have the respondents heard about or seen violence against women in urban poor community?

উত্তরদাতা শহরের দরিদ্র এলাকায় নারী নির্বাহন দেখেছেন বা জেনেছেন কি?

36. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

উত্তরদাতারা কি জানেন কাদের কাছ থেকে আইনি সহায়োগিতা এবং সেবা পাওয়া যায় (উভয় সরকারি এবং কেন্দ্রসরকারি সংস্থাও)?
37. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

নির্নির্ণিত মহিলা কি ব্যবস্থা নিয়ে থাকেন? বিচারের জন্য তারা কোথায় যায়? আইনি সহযোগিতা এবং সেবা পাওয়ার জন্য তাদের নিজের কোন পছন্দ বা সিদ্ধান্ত নেয়ার সুযোগ আছে কি?

38. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

নির্নির্ণিত মহিলা এবং নির্নিয়ন্ত্রকদের বিরুদ্ধে WUHCC কি সতর্কতা ভূমিকা পালন করেছিল? যদি করে তাহলে কি ধরনের সাহায্য সহযোগিতা করেছিল?

39. Did the community receive any awareness programmes regarding violence against women?

[Yes=1, No=2]

নারী নির্যাতনের বিরুদ্ধে এলাকার জনগণ কোন সচেতনতামূলক কার্যক্রমের অঙ্গুলি ছিলেন কি?
### Checklist for FGD with Women’s Group/Men’s Group/Members of Users’ Forum

<table>
<thead>
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<th>Schedule No.</th>
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1. Name of PA:..........................................................................................................................

2. PA number:............................................................................................................................

3. Address of the clinic:.............................................................................................................

4. Date of FGD:...........................................................................................................................

5. Total time of discussion: Start:..........................................................End:..........................

6. Name of facilitator: ..................................................................................................................

7. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicines.
   দরিদ্র জনগণ কি জানেন তাদের লাল কার্ড পাওয়ার কথা এবং একই সাথে বিনা মূল্যে ঔষধ পাওয়ার কথা?

8. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards?
   তারা কি জানেন তাদের এলাকায় অথবা পার্বত্য এলাকায় কারা লাল কার্ড পেয়েছেন?

9. Did they have any idea about how many poor households received red cards in their locality/neighbourhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue?
   তাদের কি কেন ধরেন আর তাদের পার্বত্য/পার্বত্যী এলাকায় কী পার্বত্যী বা লাল কার্ড পেয়েছে? যদি তারা জেনে না থাকেন তার কজবা কারণও কি? আউটবাক করতেন বা মহিলা পরিদর্শনের সময় এই বিষয়টি নিয়ে কি আলোচনা করেছিলেন?

10. How they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor.
    তারা কেমন করে জেনে পাড়েন পার্বত্যের ইস্লামী এলাকায় কারার কারণ কি? দরিদ্রদের সম্পর্কে জানার জন্য তাদের কাছে কি কেউ এসেছিল?

11. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?
    যদি আপনাদের পার্বত্য প্রায়োজনীয়তার কারণ লাল কার্ড না পেয়ে থাকেন, তাহলে আপনাদের মতে কিভাবে দরিদ্রদের মধ্যে লাল কার্ড বিতরণ করা উচিত?
12. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP/NGO Partners? Do you have any suggestions on how health care services of the poor can be effectively done?

13. Which health care service providers (UPHCSDP, GOs, NGO, private, kabiraj, homeopath, traditional healers, religious leaders) are available in this community? (Please make a list of service providers)

14. What types of services do these health care service providers generally provide to men, women, children, adolescent boys and girls and elderly people?

15. What types of community awareness programmes regarding the health services and centres provided by UPHCSDP (PHCC/static clinic, CRHCC, Satellite clinic, mini clinic [outreach centre]) and others exist for men, women, children, adolescents and elderly people?
16. What types of community awareness programmes exist for providing special emphasis on urban poor by UPHCSDP/NGOs Partners and other organizations?

17. What kinds of diseases exist in the community for different age groups? (Please list the disease pattern separately as per category- men, women, children, adolescents and elderly people, as per age group) Use the list of primary health care services to get correct information.

i. Men
ii. Women
iii. Children
iv. Adolescents
v. Elderly people

18. Where do urban people (men, women, children, adolescent boys and girls, and elderly people — men and women) usually go to obtain health care services? Please specify the types of the service providers and the facilities (organizations).

i. Men
ii. Women
iii. Children
iv. Adolescents boys and girls
v. Elderly people

19. Why do they go there? What are the reasons for using the specific health services from the specified service providers and from their facilities (organizations)?

Eusuf and Associates
20. What important criteria do the urban poor consider when selecting health care service providers and their facilities? Why? What criteria do they have in mind when assessing the quality of their health services (cost, behaviour of service providers, availability of services, distance, technical quality of services, free medicines, effectiveness of the services, waiting time, counselling, privacy etc.)?

- Cost
- Behavior of service providers
- Availability of services
- Distance
- Technical quality of services
- Free medicines
- Effectiveness of the services
- Waiting time
- Counselling
- Privacy

21. Are the health service users happy with the services of health service providers? If yes, why? If not, why not?
- Are the health service users happy with the services of health service providers? If yes, why? If not, why not?
- Are the health service users happy with the services of health service providers? If yes, why? If not, why not?

22. How much do they spend on services (doctor’s fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc...)?

- How much do they spend on services (doctor's fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc...)?

23. Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/NGO partners and other organisations in their area? Do they get the same type of support from all these organizations?

- Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/NGO partners and other organizations in their area? Do they get the same type of support from all these organizations?
24. What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

তারা সেবা পেয়ে কতটক্ষণ সুখ্ত তা কিভাবে বোঝা যায়? বিভিন্ন সংস্থার সেবা প্রদানের ব্যাপারে তাদের সন্তুষ্টির ব্যাপারটি বুঝিয়ে বলুন।

25. What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

শহরের দরিদ্র জনগণ তাদের যাত্রা সেবা পাওয়ার সময় কি হ্রাসের অসুবিধার সন্তুষ্টি হয়ে থাকেন? সমস্যার অন্তর্ভুক্তিকায়ী প্রতিক করুন।

26. How can the problems be solved? What are their suggestions based on experience?

এই সমস্যাগুলোর সমাধান কিভাবে করা যায়? তাদের অভিজ্ঞতার ভিত্তিতে এ বিষয়ে তাদের প্রস্তাব কি হবে?

27. What types of health services would urban people generally seek from PHCC/CRHCC/ Maternity Centre/Satellite Clinic?

শহরের জনগণ সাধারণতঃ পিএইচসিসি/সিআরএইচসিসি/ম্যাটেরিনারি সেন্টার/স্যাটেলাইট ক্লিনিক থেকে কি হ্রাসের যাত্রা সেবা পেতে চান?

i. PHCC  
ii. CRHCC  
iii. Maternity Centre  
iv. Satellite Clinic

28. How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

যাত্রা সেবা ও সংস্থা সম্পর্কিত তথ্য উপরের গণ্যতারা (পুরুষ, মহিলা, শিশু, কিশোর-কিশোরী, বয়স্ক এবং ভালবাসারক গ্রুপ) কিভাবে পেয়ে থাকেন?

i. Men  
ii. Women  
iii. Children  
iv. Adolescents boys and girls  
v. Elderly people
29. What are the most important sources of information for them?

30. Who are the key informers?

31. As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

32. How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.

33. Among those receiving health care services in relation to their need (equity of coverage, access and use) what is the number of male and female?

34. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

35. Have the respondents heard about or seen violence against women in urban poor community?
36. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

37. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

38. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

39. Did the community receive any awareness programmes regarding violence against women?
Appendix IV

Urban Primary Health Care Services Delivery Project
Checklist for FGD with Adolescent Group

1. Name of Partner NGO: ..........................................................................................................................

2. PA number: ...........................................................................................................................................

3. Address of the PHCC/CRHCC: .......................................................... Ward No: ..................

4. Date of FGD: ...........................................................................................................................................

5. Total time of discussion: Start:................................. End:..........................................

6. Is there any space for adolescent health care services in PHCC/CRHCC? For how many days adolescent health care services is provided in week? What are the major issues discussed with adolescent.

7. Is there any awareness creation session for sexuality and safe sex in the PHCC/CRHCC? If yes how many days in a week this session is conducted.

8. Do you know that special nutrition for adolescent is needed? If yes what are these special nutrition. How malnutrition can be prevented. What are the impact of malnutrition to the child?

9. Do you have knowledge about menstruation hygiene? What steps are taken for proper management of menstruation?

10. Do you know that TT vaccination is needed for adolescent girls? What are the negative impact of not taking of TT at the age of adolescent?

11. Is there any provision for counseling for reducing early marriage? If so which are the topics discussed in the session.

12. What are the negative impact of pregnancy at adolescent age? What are the risk involved for adolescent pregnancy?
13. Whether gender issues are discussed in the counseling meeting?

14. What are the main causes of anemia? How this can be prevented and what are the treatments for anemia for girls and boys?

15. What are the symptoms of RTI/STI for girls and boys?

16. How are you benefited from the project?

17. Are you satisfied with the services of the project?

18. What are your suggestions for improvement of the adolescent health care services?
Appendix V

Checklist for FGD with Vulnerable Group

1. Name of Partner NGO:............................................................................................................................

2. PA number:..............................................................................................................................................

3. Address of the clinic:............................................................... Ward No:.............................................

4. Date of interview or FGD:........................................................................................................................

5. Total time of discussion: Start:........................................ End:..............................................................

6. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicines. [Yes=1, No=2]

7. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards [Yes=1, No=2]

8. Did they have any idea about how many poor households received red cards in their locality/neighbourhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue? 

9. How they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor? [Yes=1, No=2]

10. If in your area poor people did not receive any red card then could you suggest how these cards can be distributed among the poor?
11. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP/NGO Partners? Do you have any suggestions on how health care services of the poor can be effectively done?

12. Which health care service providers (UPHCSDP, GOVT., NGO, private, kabiraj, homeopath, traditional healers, religious leaders) are available in this community? (Please make a list of service providers)

13. What types of services do these health care service providers generally provide to men, women, children, adolescent boys and girls and elderly people?

14. What types of community awareness programmes regarding the health services and centres provided by UPHCSDP- (PHCC/static clinic, CRHCC, Satellite Clinic, Mini Clinic [outreach centre]) and others exist for Men, Women, Children, Adolescents and Elderly People?

15. What types of community awareness programmes exist for providing special emphasis on urban poor by UPHCSDP/NGOs Partners and other organizations?
16. What kinds of diseases exist in the community for different age groups? (Please list the disease pattern separately as per category - men, women, children, adolescents and elderly people, as per age group) Use the list of primary health care services to get correct information.

17. Where do urban people (men, women, children, adolescent boys and girls, and elderly people - men and women) usually go to obtain health care services? Please specify the types of the service providers and the facilities (organizations).

18. Why do they go there? What are the reasons for using the specific health services from the specified service providers and from their facilities (organizations)?

19. What important criteria do the urban poor consider when selecting health care service providers and their facilities? Why? What criteria do they have in mind when assessing the quality of their health services (behaviour of service providers, availability of services, distance, technical quality of services, free medicines, effectiveness of the services, waiting time, counselling, privacy etc.)? List:

20. Are the health service users happy with the services of health service providers? If yes, why? If not, why not? [Yes=1, No=2]
21. How much do they spend on services (doctor’s fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc...)?

- Doctor’s fees
- Laboratory tests
- Medicines
- Transport cost
- Bribe for non-service providers

22. Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/NGO partners and other organisations in their area? Do they get the same type of support from all these organizations?

23. What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

24. What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

25. How can the problems be solved? What are their suggestions based on experience?
26. What types of health services would urban people generally seek from PHCC/CRHCC/Satellite Clinic?

What types of health services would urban people generally seek from PHCC/CRHCC/Satellite Clinic?

i. PHCC
ii. CRHCC
iii. Satellite clinic
iv. Mini clinic

27. How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

i. Men
ii. Women
iii. Adolescents
iv. Elderly people and vulnerable groups

28. What are the most important sources of information for them?

What are the most important sources of information for them?

29. Who are the key informers?

Who are the key informers?

30. As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

31. How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.

How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.
32. Among those receiving health care services in relation to their need (equity of coverage, access and use) what is the number of male and female?

33. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

34. Have the respondents heard about or seen violence against women in urban poor community?

35. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

36. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

37. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

38. Did the community receive any awareness programmes regarding violence against women?
Appendix VI

IDI for Ward Commissioner/Female Ward Commissioner

<table>
<thead>
<tr>
<th>Schedule No.</th>
<th>Mobile No.</th>
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1. Name of Partner NGO: .................................................................

2. PA number: ........................................................................................................

3. Name and Address of the clinic: .............................................................. Ward No:...........

4. Date of interview: .....................................................................................

5. Total time of discussion: Start:.................................................. End:...........................

6. Name of Respondent: ..........................................................................................

7. Occupation: ............................................................ Designation: ..............................................

8. Education: .......................................................................................................

9. Monthly Income: Taka .......................................................................................

10. Whether the WUHCC was constituted in each city corporation/ municipality in each PA area? If yes, when? How was this committee set up? Who are involved in this committee? How many members are there? How many of them were men and women? [Yes=1, No=2]

11. Whether the WUHCC was set up as per guidelines mentioned in the PA NGO’s project proforma. If yes, mention about those? Can you show the guideline? Do they have any workplan? Can you show the workplan? [Yes=1, No=2]

12. At what interval did the committee meet? When did they have the last meeting? Was the meeting minutes distributed? Did you receive the meeting minutes? Is the WUHCC functioning? If yes, what type of activities they are doing?

13. Among the committee members how many were poor men and women from poor communities? [Poor=1, Women=2]

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14. How the committee ensure/promote access of the poor, especially women, men and girls to increase knowledge and get free health services from partner NGOs under UPHCSDP?

15. In the committee, did they have any health users - men and women from the slums/urban poor community from this ward? Whether the health users from urban slums know about their roles and responsibility.

16. Are the committee members involved in decision making at WUHCC?

17. Did they tell you what types of decisions were taken by the committee recently? If yes, why did they take such decisions? Who were involved in decision-making? How were the decisions implemented?

18. Were the health service users involved in decision-making? How did they participate in decision-making?

19. In last six months did WUHCC coordinate with other urban health care providers/initiatives from the same ward? If yes, please explain their coordination in details.

20. When did the committee in the last six months organise a forum for public disclosure of services provided by the health facilities under UPHCSDP? If not, what was the reason for not organising the forum? If, yes what activities were under taken? Please explain in details.
21. During last six months did the committee receive any complaint from the community? How the committee re-addressed it?

거의 여섯 개월 동안 보수 구역에서 부서는 누구의 불만을 접수했나요? 그리고 이 문제는 어떻게 해결되었나요?

22. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicines.

Yes=1, No=2

대부분의 가난한 사람들은 빨간 카드를 받을 수 있음을 알고 있었나요? 그리고 그들은 이러한 카드를 통해 의료 서비스를 받을 수 있었나요?

23. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards.

아무 사람이 그들의 공동체나 주변에 포함된 범위에 있는 빨간 카드를 가졌는지 알았나요?

24. Did they have any idea about how many poor households received red cards in their locality/neighborhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue?

아무리 가난한 가족이 몇 가구에 빨간 카드를 받았는지 알았나요? 그들이 이것을 모르면 가능한 이유는 무엇일까요? 보수 구역 방문 동안 집을 방문하는 밀접한 대응 직원들은 이 문제에 대해 이야기했나요?

25. How they know about the distribution of red cards in their locality/neighborhood? Whether anybody visited them to take information regarding the poor.

그들은 가난한 사람들의 정보를 얻기 위해 방문한 적이 있나요?

26. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?

만약 그들의 지역에서 가난한 사람들이 빨간 카드를 받지 못했다면 이 카드가 가난한 사람들에게 어떻게 분배될 수 있을지 제안해 주시겠어요?
27. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP/NGO Partners? Do you have any suggestions on how health care services of the poor can be effectively done?

28. Which health care service providers (UPHCSDP, GOs, NGO, private, kabiraj, homeopath, traditional healers, religious leaders) are available in this community? (Please make a list of service providers)

29. What types of services do these health care service providers generally provide to men, women, children, adolescent boys and girls and elderly people?

30. What types of community awareness programmes regarding the health services and centres provided by UPHCSDP (PHCC/static clinic, CRHCC, Satellite clinic, mini clinic [outreach centre]) and others exist for men, women, children, adolescents and elderly people?
31. What types of community awareness programmes exist for providing special emphasis on urban poor by UPHCSDP/NGO Partners and other organizations? Is there any users forum organised by PA NGOs in this community? If yes, how it is functioning?

32. What kinds of diseases exist in the community for different age groups? (Please list the disease pattern separately as per category - men, women, children, adolescents and elderly people, as per age group) Use the list of primary health care services to get correct information.

33. Where do urban people (men, women, children, adolescent boys and girls, and elderly people – men and women) usually go to obtain health care services? Please specify the types of the service providers and the facilities (organizations).

34. Why do they go there? What are the reasons for using the specific health services from the specified service providers and from their facilities (organizations)?
35. What important criteria do the urban poor consider when selecting health care service providers and their facilities? Why? What criteria do they have in mind when assessing the quality of their health services (cost, behaviour of service providers, availability of services, distance, technical quality of services, free medicines, effectiveness of the services, waiting time, counselling, privacy etc.)?

36. Are the health service users happy with the services of health service providers? If yes, why? If not, why not?

37. How much do they spend on services (doctor’s fees, laboratory tests, medicines, transport cost, bribe for non-service providers etc...)?

38. Can they afford the cost of these services? If not, what do they do? What type of support do they receive for different services from UPHCSDP/NGO partners and other organisations in their area? Do they get the same type of support from all these organizations?
39. What is their level of satisfaction? Please explain the variation of satisfaction level of different organisations.

তারা সেবা পেয়ে কতটুকু সন্তুষ্ট তা কিভাবে বোঝা যায়। বিভিন্ন সংস্থার সেবা প্রদানের ব্যাপারে তাদের সন্তুষ্টির ব্যাপারটি বুঝিয়ে বলুন।

40. What kinds of problems do the urban poor face when getting health services? Please mention and prioritise the problems.

শহরের দরিদ্র জনগণ তাদের যাত্রা সেবা পাওয়ার সময় কি ধরনের অসুবিধার সম্ভূবিয়ন হয়ে থাকেন? সমস্যার অপরাশিততাবৃদ্ধি লেগে থাকেন। ৩টি সমস্যা উল্লেখ করতে হবে।

41. How can the problems be solved? What are their suggestions based on experience?

এই সমস্যাগুলোর সমাধান কিভাবে করা সম্ভব যাতে তাদের অভিজ্ঞতার ভিত্তিতে এ বিষয়ে তাদের প্রস্তাব কি হবে?

42. What types of health services would urban people generally seek from PHCC/CRHCC/Satellite Clinic?

শহরের জনপ্রি সাধারণতঃ পিএইচসিসি/সিরিয়ারএইচসিসি/ম্যাটারিনিটি সেন্টার/স্যাটেলাইট ক্লিনিক থেকে কি ধরনের যাত্রা সেবা পেতে চান?

43. How do the respondents (men, women, adolescents, elderly people and vulnerable groups) get information on health services and health facilities?

যাত্রা সেবা ও সুবিধা সম্পর্কিত তথ্য উন্নয়নকারী (পুরুষ, মহিলা, শিশু, কিশোর-কিশোরী, বয়স্ক এবং ভালবান ব্যক্তিগত গোষ্ঠী) কিভাবে পেয়ে থাকেন?

i. Men
ii. Women
iii. Children
iv. Adolescents
v. Elderly people

44. What are the most important sources of information for them?

তাদের জন্য সব থেকে জরুরী তথ্য প্রদানকারী কে কিছু?

45. Who are the key informers?

সব থেকে জরুরী তথ্য প্রদানকারী কে বা কারা?
46. As per information did service users visit the facilities and receive ESD package ambulance services? Were they satisfied with the services? If yes, why? If not, why not? Did they hear about ambulance services from the facility? If yes, Did they use the ambulance services?

47. How can the existing sources of information about health care facilities and services for the urban poor be improved? Please note their suggestions.

48. How do service providers of UPHCSDP/NGO partners behave towards the urban poor? What is their attitude? Are the urban poor happy with the behaviour and attitude of service providers? If yes, why? If not, why not? Please give some example.

49. Are the urban poor happy with the service? If yes, why? If not, why not?
   [Yes=1, No=2]

50. Do the service providers of UPHCSDP/NGO partner providers have coordination or networking with other health service providing organizations (GOB, NGO and private organizations)?
    [GOB =1, NGO and private organizations =2]

51. What is the difference between the nature of services provided by the UPHCSDP/NGO partners and the others service providing organizations. If yes, why? If not, why not?
    [Yes=1, No=2]
52. How is the behaviour and attitude of other service providers of different organizations towards the urban poor?

শহরের দরিদ্র জনগনের প্রতি অন্যান্য সংস্থার সেবা প্রদানকারীদের ব্যবহার এবং আচরণ কেমন?

53. Are the urban poor happy with the service received from other service providers? If yes, why? If not, why not?

শহরের দরিদ্র জনগন কি অন্যান্য সেবা প্রদানকারির সেবায় সাফল্য? যদি সফল হয়ে থাকেন, তাহলে কেন? এবং না হয়ে থাকলে, কেন নয়?

54. Do service providers of UPHCSDP/NGO partners refer cases to other service providers?

[Yes=1, No=2]

আরবান গ্রাহিমার হেল্থ কেয়ার প্রজেক্ট/এনজিও পার্টনারের সেবা প্রদানকারীরা রোগীদের চিকিৎসার জন্য অন্য সংস্থায় রেফার করেন কি? যদি করে থাকেন, তাহলে কেন?

55. What are the strengths and weaknesses of service providers of UPHCSDP/NGO partners for taking a responsive role in the community?

কমিউনিটিতে আরবান গ্রাহিমার হেল্থ কেয়ার প্রজেক্ট/এনজিও পার্টনারের সেবা প্রদানকারীদের মধ্যে দায়িত্বশালীর সাথে কাজ করার জন্য সক্রিয় এবং দুর্বল দিকগুলি কি কি? (তিনটি সক্রিয় ও তিনটি দুর্বল দিক)

i. Strength

ii. Weakness

56. What do the respondents (Ward commissioners male and female) suggest for improving the responsiveness of other service providers in the community of the urban poor?

শহরের পরিবার কমিউনিটিতে অন্যান্য সেবা প্রদানকারীর মধ্যে দায়িত্বশালীর কাজ উন্নত করার জন্য উপরাত্মা কি কি প্রস্তাব রাখেন? (তিনটি প্রস্তাব)

57. Among health care service management personnel what is the number of male and female?

[Male=1, Female=2]
58. Whether women community leaders and female ward commissioners are participating in planning for community-based solid waste management.
[Yes=1, No=2]

59. How many members of ward primary health care committee are women?

60. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?
[Physical =1, Mental and sexual =2]

61. Have the respondents heard about or seen or victim violence against women in urban poor community?
[Yes=1, No=2]

62. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

63. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

64. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?
[Yes=1, No=2]

65. Did the community receive any awareness programmes regarding violence against women?
[Yes=1, No=2]
Appendix VII

Checklist for In-depth interview with Clinic manager cum Medical officer/Paramedic/Counsellor of PHCC
Urban Primary Health Care Services Delivery Project

Respondent Code: [Medical Officer=1, Paramedic=2, Counsellor=3]

Schedule No.  Mobile No.  

1. Name of Partner NGO: .................................................................

2. PA number: .....................................................................................

3. Name and Address of the clinic: ...................................................  Ward No:.............

4. Date of interview:..............................................................................

5. Total time of discussion: Start:.............................. End:............................

6. Name of Respondent:......................................................................

7. Occupation:....................................................................................  Designation: .............................................................

8. Education: ........................................................................................

9. Monthly Income (family): Taka ....................................................

10. How do service providers of UPHCSDP/ Partner NGO behave towards the urban poor? What is their attitude? Are the urban poor happy with the behaviour and attitude of service providers? If yes, why? If not, why not? [Yes=1, No=2]

11. Do the service providers of UPHCSDP/ Partner NGO counsel properly? Do they give sufficient time to patients? Do they take immediate actions on what patients required? 

12. Are the urban poor happy with the service? If yes, why? If not, why not? [Yes=1, No=2]

Eusuf and Associates
13. What types of problems do the service providers of UPHCSDP/Partner NGO face in providing the health services to the urban poor? How do they manage the problems?

14. At what level can the service providers of UPHCSDP/Partner NGO take part in the decision making process?

15. What would service providers UPHCSDP/Partner NGO and others) suggest if they want to become more responsive?

16. Do the service providers of UPHCSDP/Partner NGO providers have coordination or networking with other health service providing organizations (GOVT., NGO and private organizations)?

17. Do service providers of UPHCSDP/Partner NGO refer cases to other service providers?
18. What are the strengths and weaknesses of service providers of UPHCSDP/Partner NGO for taking a responsive role in the community?

i. Strength

ii. Weakness

19. What do the respondents (other service providers) suggest for improving the responsiveness of other service providers in the community of the urban poor?

20. Among health care service management personnel what is the number of male and female? [Yes=1, No=2]

21. Among health care service providers what is the number of male and female?

22. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

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23. Have the respondents heard about or seen violence against women in urban poor community?

[Yes=1, No=2]

Have the respondents heard about or seen violence against women in urban poor community?

24. Do the respondents know about legal aid groups and service providers (both GOVT., and NGOs)?

[Yes=1, No=2]

Do the respondents know about legal aid groups and service providers (both GOVT., and NGOs)?

25. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option according to legal aid and services?

What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option according to legal aid and services?

26. From which types of service provider groups (legal aid and treatment) do the female victims feel comfortable to receive services?

From which types of service provider groups (legal aid and treatment) do the female victims feel comfortable to receive services?

27. What types of services for victims of VAW are available in the urban poor community, especially in UPHCSDP/Partner NGO’s centre? Are there adequate trained health service providers to deal with women victims? (physical, sexual and mental violence).

What types of services for victims of VAW are available in the urban poor community, especially in UPHCSDP/Partner NGO’s centre? Are there adequate trained health service providers to deal with women victims? (physical, sexual and mental violence).
28. Do the UPHCSDP/Partner NGOs have a mitigating/eliminating facility (service) for violence against women? Do they have special providers with legal aid and counselling services/community awareness programme?

[Yes=1, No=2]

29. Do women victims receive psychological support from the service providers and law enforcing agency in the community?

[Yes=1, No=2]

30. What types of problems do women victims and family members face when getting health and legal support?

31. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what types of services were provided by them?

32. Did the service providers take responsive role towards women victims and against the offenders?

[Yes=1, No=2]

33. Did the community receive any awareness programs regarding violence against women?

[Yes=1, No=2]
**Appendix VIII**

**Checklist for In-depth interview with MBBS doctor/ Quack/ Kabiraj/ Homeopath/Traditional healer**

<table>
<thead>
<tr>
<th>Schedule No.</th>
<th>Mobile No.</th>
</tr>
</thead>
</table>

1. Name of Partner NGO: .................................................................
2. PA number: ........................................................................................................
3. Name and Address of the clinic: ................................................................. Ward No:............
4. Date of interview: ........................................................................................
5. Total time of discussion: Start:......................... End:...................................
6. Name of Respondent: ......................................................................................
7. Occupation: ...................................................... Designation: ........................................
8. Education: ........................................................................................................
9. Monthly Income: Taka ..................................................................................
10. Do the service providers of UPHCSDP/Partner NGO providers have coordination or networking with other health service providing organizations (GOVT., NGO and private organizations)?

11. Is there any difference between the nature of services provided by the UPHCSDP/Partner NGO and the others service providing organizations. If yes, why? Please explain elaborately.

   [Yes=1, No=2]

12. Do other service providers counsel properly? Do they give sufficient time to patients? Do they take immediate actions on what the patients require?

   [Yes=1, No=2]

13. How is the behaviour and attitude of other service providers of different organizations towards the urban poor?

   शहरी दरिद्र जनगणी के लिए अन्य सेवाप्रदायिकों का उच्च अदेश एवं आदरण केमन?
14. Are the urban poor happy with the service received from other service providers? If yes, why? If not, why not? [Yes=1, No=2]

15. Do service providers of UPHCSDP/Partner NGO refer cases to other service providers? [Yes=1, No=2]

16. What are the strengths and weaknesses of service providers of UPHCSDP/Partner NGO for taking a responsive role in the community?

i. Strength

ii. Weakness

18. What do the respondents (other service providers) suggest for improving the responsiveness of other service providers in the community of the urban poor?
Appendix IX

Urban Primary Health Care Services Delivery Project
IDI for Chairperson/Secretary/Member of User’s Forum

Respondent Code: [Chairperson =1, Secretary =2, Member =3]

Schedule No. __________ Mobile No. __________

1. Name of Partner NGO:
   Partner NGO’s name:

2. PA number
   পিএ নাম্বার:

3. Address of the clinic:  Ward No:
   ক্লিনিকের ঠিকানা:  ওয়ার্ড নং:

4. Date of interview:
   ইন্টারভিউ বা এফজিই করার তারিখ:

5. Total time of discussion:
   আলোচনার সময়:

6. Name of Respondent:
   উপরসাধারণ নাম:

   Occupation:
   পেশা:

   Designation:
   পদবী:

   Education:
   শিক্ষা:

   Monthly Income:
   মাসিক আয়:

7. Whether the User’s Forum is constituted in each city corporation/municipality in each PA area? If yes, when?
   User Form গঠিত হয়েছে কি? যদি গঠিত হয়ে থাকে কখন?

8. How was this forum set up? Who are involved in this forum? How many members are there? How many of them are men and women?
   কমিটি কিভাবে গঠন করা হয়েছিল? কমিটির সাথে করা জড়িত? কমিটিতে কতজন মেয়ের আছেন?
   তাদের মধ্যে কতজন পুরুষ এবং কতজন মহিলা?
9. Among the committee members how many are poor men and women from poor communities?

কমিটির সদস্যদের মধ্যে কতজন পরিদৃশ্য মহিলা ও পুরুষ পরিদৃশ্য এলাকার?

10. Whether the forum is set up as per guidelines mentioned in the PA NGO’s project proforma. (PI. Check with PA-NGO)

NGO-র এর জেষ্ঠ প্রফেসর গাইডলাইন অনুযায়ী কি Forum তৈরি করা হয়েছিলো? (PA-NGO র গাইড লাইন দেখুন?)

11. Whether the Chairperson/Secretary/ Members of Health User’s Forum know about their roles and responsibilities.

এই কমিটির সদস্যরা তাদের দায়িত্ব ও কর্তব্য সম্পর্কে কি জানেন?

12. Do you have any workplan?

এই কমিটির কোন Workplan আছে কি?

13. At what interval do the committee meet? When did they have the last meeting? Was the meeting minutes distributed? Did you receive the meeting minutes?

কতদিন পর কমিটির মিটিং হয়ে থাকে? শেষ মিটিং করে হয়েছিল? মিটিং মিলিটিং কি বিতরণ করা হয়েছিল? আপনি কি মিটিং মিলিটিং পেয়েছিলেন?


User’s Forum কাজ করছে কিনা? যদি কাজ করে থাকে, তাহলে কি ধরনের কর্ত্তব্য করে থাকে? বিস্তারিত বিবরণ দিন।
15. How the forum ensure/promote access of the poor, especially women, men and girls to increase knowledge and get free health services from partner NGOs under UPHCSDP?

16. Are the committee members involved in decision making at the forum?

17. Are you able to tell what types of decisions were taken by the forum recently? How were the decisions implemented?

18. During last six months did the forum receive any complaint from the community? How the forum addressed it?

19. Whether poor people are aware that they are entitled to get red cards and consequently free services with medicines.

20. Whether they know or are aware of anybody in their community or in their neighbourhood having red cards.
21. How they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor.

তারা কেমন করে জানেন পাড়ায়/প্রতিবেশী এলাকায় কাদেরকে লাল কার্ড বিতরণ করার কথা ? দরিদ্রদের সম্পর্কে জানার জন্য তাদের কাছে কি কেউ এসেছিলেন ?

22. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?

যদি আপনাদের পাড়ায় পরিবারে কোন লাল কার্ড না পেয়ে থাকেন, তাহলে আপনাদের মতে কিভাবে দরিদ্রদের মধ্যে লাল কার্ড বিতরণ করা উচিত ?

23. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

শহরের দরিদ্র এলাকায় কি ধরণের নারী নির্বাচন (শারীরিক, মানসিক এবং যৌন নির্বাচন) দেখতে পাওয়া যায় ? এর কারণগুলি কি কি?

24. Have the respondents heard about or seen or victim violence against women in urban poor community?

উত্তরদাতা শহরের দরিদ্র এলাকায় নারী নির্বাচন দেখেছেন বা জেনেছেন অথবা নিজেই নির্বাচিত হয়েছেন কি ?

25. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

উত্তরদাতা কি জানেন কাদের কাছ থেকে আইনি সহযোগিতা এবং সেবা পাওয়া যাবে (সরকারি এবং বেসরকারি সংস্থা)?
26. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

নির্ধারিত মহিলারা কি বাবস্থা নিয়ে থাকেন? বিচারের জন্য তারা কোথায় যান? আইনি সহযোগিতা এবং সেবা পাওয়ার জন্য তাদের নিজস্ব কোন পছন্দ বা সিদ্ধান্ত নেয়ার সুযোগ আছে কি?

27. Did the User's Forum play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?

নির্ধারিত মহিলা এবং নির্ধারিতকারীদের বিরুদ্ধে User Forum কি সত্ত্বা ভূমিকা পালন করেছিল? যদি করে থাকে তাহলে কি ধরনের সাহায্য সহযোগিতা করেছিল?
### Appendix X

**Checklist**

**In-depth interview with Victim/Family Members of Victim/Law enforcing Agency**

<table>
<thead>
<tr>
<th>Schedule No.</th>
<th>Mobile No.</th>
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</table>

1. Name of Partner NGO: .................................................................

2. PA number: ..................................................................................

3. Name and Address of the clinic: .................................................. Ward No:...........

4. Date of interview: ...........................................................................

5. Total time of discussion: Start:.................................................... End:..........................

6. Name of Respondent: ......................................................................

7. Occupation: ..................................................................................

8. Education: ....................................................................................

9. Monthly Income: Taka .................................................................

10. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?

11. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)?

   [Yes=1, No=2]

   উওেদারাকি জানেন কাদের কাছ থেকে আইনি সহযোগিতা এবং সেবা পাওয়া যাবে (উওয়া সরকারি এবং বেসরকারি সংস্থা)?

12. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

   [Yes=1, No=2]

   নির্ধারিত মহিলারা কি ব্যবস্থা নিয়ে থাকেন? বিচারের জন্য তারা কোথা যায়? আইনি সহযোগিতা এবং সেবা পাওয়ার জন্য তাদের নিজের কোন পছন্দ বা সিদ্ধান্ত নেয়ার সুযোগ আছে কি?

13. From which types of service provider groups (legal aid and treatment) do the female victims feel comfortable to receive services?

   নির্ধারিত মহিলারা কোন ধরনের সেবা প্রদানকারীর (আইনি সহযোগিতা এবং চিকিৎসা) কাছ থেকে সেবা পেতে পছন্দ করেন?
14. What types of services for victims of VAW are available in the urban poor community, especially in UPHCSDP/Partner NGO’s centre? Are there adequate trained health service providers to deal with women victims? (physical, sexual and mental violence).

[Physical =1, Sexual and mental violence=2]  
শহরের দরিদ্র এলাকায় নির্বাচিত মহিলাদের জন্য কি ধরনের সেবা বিদ্যমান আছে? বিশেষ করে আরবান প্রাইমারি হেলথ কেয়ার প্রজেক্ট/এনজিও পার্টনারের সেক্টরে সেবা প্রদানকারীরা কি শারীরিক, মানসিক বা যৌন নির্বাচনের শিকার এমন মহিলাদের সেবা প্রদানের জন্য যথেষ্ট প্রশিক্ষিত?

15. Do the UPHCSDP/Partner NGOs have a mitigating/eliminating facility (service) for violence against women? Do they have special providers with legal aid and counselling services/community awareness programme?  
[Yes=1, No=2]  
আরবান প্রাইমারি হেলথ কেয়ার প্রজেক্ট/এনজিও-র পার্টনারের কার্যক্রমে নারী নির্বাচনের ক্ষেত্রে সেবা দেওয়ার ব্যবস্থা কি আছে? নারী নির্বাচনের ক্ষেত্রে আইনি ও কাউন্সেলিং সেবা/সচেতনতামূলক প্রযোজনা চালানোর জন্য এই সমস্ত সংস্থায় বিশেষ সেবা প্রদানকারী কি আছেন?

16. What types of services do the families of women victims look for?  
নির্বাচিত নারীর পরিবার কি ধরনের সেবা পেতে চান?

17. Are women victims immediately referred for legal assistance, counselling and treatment?  
[Yes=1, No=2]  
নির্বাচিত মহিলাদেরকে কি আইনি সহযোগিতা (লিগ্যাল এইড), কাউন্সেলিং এবং চিকিৎসার জন্য তাত্ত্বিকভাবে রেফার করা হয়?

18. Do women victims receive psychological support from the service providers and law enforcing agency in the community?  
কমিউনিটিতে নির্বাচিত মহিলারা কি সেবা প্রদানকারীর কাছ থেকে মানসিক এবং পুলিশের কাছ থেকে আইনি সহযোগিতা পেয়ে থাকেন?
19. What types of problems do women victims and family members face when getting health and legal support?
নির্ধারিত মহিলা ও তাদের পরিবারের সদস্যরা আইনি সহযোগিতা ও যাবার সময় কি কি ধরণের সমস্যার সন্ধান হয়ে থাকেন?

20. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?
নির্ধারিত মহিলা এবং নির্ধারিতকারীদের বিরুদ্ধে WUHCC কি সহযোগিতা পালন করেছিল? যদি করে থাকে তাহলে কি ধরনের সহযোগিতা করেছিল?

21. Did the service providers take responsive role towards women victims and against the offenders?
নির্ধারিত মহিলা এবং নির্ধারিতকারীদের বিরুদ্ধে সেবা প্রদানকারীরা দায়িত্বশীল ভূমিকা পালন করেছিলেন কি?

22. Did the community receive any awareness programmes regarding violence against women?
[Yes=1, No=2]
নারী নির্ধারনের বিরুদ্ধে এলাকার জনগণ কোন সচেতনতামূলক কার্যক্রমের অংশগ্রহণ ছিলেন কি?
## Checklist

**In-depth interview with women members of WUHCC representatives from poor households**

<table>
<thead>
<tr>
<th>Schedule No.</th>
<th>Mobile No.</th>
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</table>

1. **Name of Partner NGO:**

2. **PA number:**

3. **Name and Address of the clinic:**

4. **Date of interview:**

5. **Total time of discussion:**

6. **Name of Respondent:**

7. **Occupation:**

8. **Education:**

9. **Monthly Income (family):** Taka

10. **Whether the WUHCC was constituted in each city corporation/ municipality area? If yes, when? How was this committee set up? Who are involved in this committee? How many members are there?**

11. **Whether the WUHCC was set up as per guidelines mentioned in project proforma. If yes, what are they?**

12. **At what interval did the committee meet? When did they have the last meeting? Did meeting minutes distributed? Did you receive the meeting minutes?**
13. Among the committee members how many were men and women? How many of them were from poor communities?
[Men=1, Women=2]

14. How the committee ensure/promote access of the poor, especially women and girls to increase knowledge and get free health services from partner NGOs under UPHCSDP?

15. In the committee, did they have any health users from the slums/urban poor community from this ward? Whether the health users from urban slums know about their roles and responsibility.
[Yes=1, No=2]

16. Are the committee members involved in decision making at WUHCC?
[Yes=1, No=2]

17. Did they tell you what types of decisions were taken by the committee recently? If yes, why did they take such decisions? Who were involved in decision-making? How were the decisions implemented?
[Yes=1, No=2]

18. Were the health service users involved in decision making? Who participated in decision-making?
[Yes=1, No=2]
19. Did WUHCC coordinate with other urban health care providers/initiatives from the same ward? If yes, please explain their coordination in details.

[WUHCC কি একই শাখার অন্যদের সাথে সম্পর্ক রাখেন? যদি হয়, তাহলে সম্পর্ক রক্ষার জায়গায় বিস্তৃতি হয়েছিল।]

20. Did the committee organise a forum for public disclosure of services provided by the health facilities under UPHCSDP? If not, what was the reason for not organising the forum? If, yes what activities were under taken? Please explain in details.

[Yes=1, No=2]

[Did the committee have received any complain from the community? How the committee readdressed it?]

[Yes=1, No=2]

21. Did the committee have received any complain from the community? How the committee readdressed it?

22. Whether poor people were aware that they were entitled to get red cards and consequently free services with medicine.

[Yes=1, No=2]

23. Whether they knew or were aware of anybody in their community or in their neighbourhood having red cards?

[Yes=1, No=2]
24. Did they have any idea about how many poor households received red cards in their locality/neighbourhood? If they did not know what would be the possible reasons for this? Did the outreach workers during their visits to households discuss about this issue?  
[Yes=1, No=2]  
তাদের কি কোন ধারণা আছে তাদের পাড়ায়/গ্রাম/স্থানীয় মধ্যে কতগুলি বাড়ি লাল কার্ড পেয়েছে? যদি তারা জেনে না থাকেন, তার কারণ কি কি আউটারচার কর্মীরা বাড়ি পরিমাপনের সময় এই বিষয়টি নিয়ে কি আলোচনা করেছিলেন?

25. How they know about the distribution of red cards in their locality/neighbourhood? Whether anybody visited them to take information regarding the poor.  
তারা কেমন করে জানেন পাড়ায়/গ্রাম/স্থানীয় এলাকায় কার্ড কে লাল কার্ড বিতরণ করার কথা? সক্রিয়তার সম্পর্কে জানার জন্য তাদের কাছে কে কেউ এসেছিলেন?

26. If in your area poor people did not receive any red cards then could you suggest how these cards can be distributed among the poor?  
যদি আপনাদের পাড়ায় প্রিন্টেরা কোন লাল কার্ড না পেয়ে থাকেন, তাহলে আপনাদের মতে কিভাবে দরিদ্রদের মধ্যে লাল কার্ড বিতরণ করা উচিত?

27. What is your opinion about health services for the poor in your locality/neighbourhood from UPHCSDP /NGO Partners? Do you have any suggestions on how health care services of the poor can be effectively done?  
আপনাদের পাড়ায়/পার্ষদীক এলাকায় আরামবান প্রাইমারি হেলথ কেয়ার প্রজেক্ট্স/এনজিও প্যার্টনারস দরিদ্রদের জন্য সেবা সম্পর্কে আপনার কি মতামত? এ ব্যাপারে আপনাদের কি কোন প্রস্তাব আছে? কিভাবে দরিদ্রদের জন্য সেবা আরো আরো পরিকল্পনা করা সম্ভব?

28. What kinds of violence against women (physical, mental and sexual) take place in the urban poor community? What are the reasons behind this?  
শহরের দরিদ্র এলাকায় কি ধরণের নারী নির্বাচন (শারীরিক, মানসিক এবং মূল নির্বাচন) দেখতে পাওয়া যায়? এর কারণগুলি কি কি?
29. Have the respondents heard about or seen violence against women in urban poor community? [Yes=1, No=2]

30. Do the respondents know about legal aid groups and service providers (both GOs and NGOs)? [Yes=1, No=2]

31. What do the women victims of violence do? Where do they go for justice? Do they have any scope to select their preferred option regarding legal aid and services?

32. Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them? [Yes=1, No=2]

নির্ধারিত মহিলারা কি ব্যবস্থা নিয়ে থাকেন? বিচারের জন্য তারা কোথায় যান? আইনি সহযোগিতা এবং সেবা পাওয়ার জন্য তাদের নিজের কোন পছন্দ বা সিদ্ধান্ত নেয়ার সুযোগ আছে কি?

Did the WUHCC play an active role towards women victims and against the offenders? If yes, what type of services were provided by them?