SAJIDA Foundation

Evaluation Report of Community Health Program 2015

Table of Contents

Executive Summary

Background

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SAJIDA Foundation is a national NGO setup in 1994 and currently works in districts nationwide: Dhaka, Chittagong, Jamalpur, Gazipur and Narsindhi. It's vision is for *health, happiness & dignity for all*, particularly those the communities with whom they work. The foundation works on four main areas: micro-finance including micro-insurance, health; education; and disaster preparedness. Through its various programs they support over 150,000 families.

In January 2015 SAJIDA Foundation commissioned an internal evaluation of its community health program under its micro-insurance program, *Nirapotta* (safety net), which has been running since 2010 in different manifestations. The current model uses a cadre of health workers called *SAJIDA Bondhus* (SAJIDA Friends) who are are frontline community health workers trained by the organisation to provide basic primary care to the micro-insurance policyholders and their family. Due to the Foundations unique funding structure the community health program (CHP) is directly funded through the micro-insurance premiums and subsidized by the profit from micro-finance. As a result of this the two are closely inter-linked and the micro-insurance program (including the CHP) uses the infrastructure of the micro-finance program to deliver, manage and over see their work.

The SAJIDA Bondhus (SBs) deliver close to community health care through awareness raising; direct care delivery; and conducting referrals to SAJIDA hospitals or other health care facilities. The evaluation was conducted between January-March, with all the of the data collection taking place during February.

Evaluation objectives

The objectives of the evaluation were to:

- Assess and evaluate the role of SAJIDA Bondhu in reference to their current responsibilities.
- Explore unmet needs of the members (service users) and if/how SAJIDA Bondhu's role can accommodate.

To explore the objectives three themes were set and under each theme there were a series of questions and under each question a series of sub-questions. The themes were devised to assess the program from three perspectives: program management and service delivery; service users' needs and assessment of the program and services; and from the SBs' themselves. The themes and main questions were:

1) What is the role of SAJIDA Bondhus in the overall program?
- How do branch/staff evaluate the services of SAJIDA Bondhu?
- Whether the assistance of branch managers and field officers is adequate towards SAJIDA Bondhu

- What is the added value provided by SAJIDA Bondhu to the MF program?
- How necessary are SB's role in claims management?
- What is the complaints and feedback mechanism?
- Is there any value in specialized Bondhus at the cluster level?

2) What and how much of the services provided by SAJIDA Bondhu is essential/useful to members?

- Are members satisfied with the current services provided by SAJIDA Bondhu?
- What other services do the members expect from SAJIDA Bondhu over the existing services?
- Would they be willing to pay a higher premium?
- Perception of helpfulness of SAJIDA Bondhu in developing the health behavior of the members and view of the services
- Evaluation of the need and efficacy of psychosocial counseling support
- Strengthen the role of SAJIDA Bondhu in implementing Nirapotta Program

3) How can the role of the Bondhu be strengthened/modified to better meet overall needs of the program?

- How far the training of SAJIDA Bondhu is adequate
- Explore the relevance and areas of capacity building of SAJIDA Bondhu
- Evaluate the responsibilities on the basis of the capability of SAJIDA Bondhu
- Best practice for recruitment &retention

Methodology and data collection

The study employed a mixed method approach, using a mixture of surveys, focus group discussions (FGDs) and in depth interviews (IDIs) with a range of stakeholders. To ensure fair representation cluster sampling was used with the geographic location of the branch where the SB was based; the knowledge of the SB- determined by their training status- and whether they were conducting psychosocial workshops, serving as different cluster types. Using these parameters 30 sites were selected.

The surveys were conducted at the micro-finance loan collection centre meetings due to the time constraint of the study. The participants of the FGDs and IDIs were a mixture of the SBs, branch managers, field officers and a selection of service users of each branch. To select the service users we randomly selected service users who fell under the following categories: not taken any services in the past three months; taken the following services in the past three months: antenatal/postnatal care; child immunization; those who were referred to other service providers; taken any other services; and where appropriate attended the psychosocial counseling workshops.

Trained, independent data collectors collected all data.

Key findings and recommendations

We found that the SAJIDABondhus, and the program, had a very high acceptability rate across various stakeholders. It was evident to us that the service users who accessed services from the SBs were overwhelming satisfied with it and rely upon it to some

extent. It was also evident that there were a number of unmet service user needs, by making some changes a number of them could be met.

One of the most striking findings was the SBs play a far wider role than just that of a health worker, the service users turn to them for information and advice on personal and private matters. This indicates the high level of acceptance of the SBs and that they are able conduct their work with a degree of competence; it is because they are able to provide information, advice and very basic primary health care that the services user's confidence and relationship with the SBs has grown.

There is however a number of issues in the program that needs to be addressed. The most important issues that we feel need to be addressed immediately are:

o Clear aims and objectives for the program that is then communicated with all stakeholders. As currently there is little clear understanding of what the program is and should be, this leads to unrealistic expectations of the SBs;

o There is a lack of adequate supervision given to the SBs, particularly on technical issues and in the field and to rectify this field level supervisors should be introduced;

o SBs are unhappy with their current financial package as it does not adequately reflect their work and they incur a high level of out of pocket expenses that are not remunerated;

o There are no standardized and agreed core competencies for the SBs and as a result the quality of service may vary greatly from one SB to another. Core competencies linked to the program aims and objectives should be set and the SBs should be regularly assessed on those;

o The currently monitoring system (registers) is far too complicated, leading to SBs making mistakes and making it hard for their current line managers to adequately supervise them. These should be reviewed and a new, simpler system should be introduced;

o To improve the communication and working relationship within the branch regular, structured meetings must be implemented with all staff members to regularly update each other on their work;

o The program in rural areas should be modified to better meet local needs with the introduction of regular health camps and health meetings;

o And finally, to make the work information and advice giving more effective the delivery method must be reviewed with the introduction of audio/visual materials.

Introduction

SAJIDA Foundations' community health program (CHP) was established in 2010 to help meet the health needs of micro-finance borrowers and their family. The program has been running for a number of years and has undergone a number of changes and evolutions since its inception. After running for three years in its current form it was felt an evaluation of the program was required to document, learn and strengthen it as the working area and scope had changed without the model being modified.

The Foundation's CHP is a generalist service that focuses on providing members and their families with the following support: ante-natal and post-natal care; new born and baby care; immunization; information giving on how to control basic illnesses, emergency care and psychosocial workshops. They also provide undertake a number of other activities, such as measuring the weight of the service users, diabetes control, pregnancy testing and assisting the branch managers with micro-insurance claims management. As the CHPs are generalists another important portion of their work is to signpost and refer patients to specialists and accompany them if necessary.

The main objectives of the evaluation was to assess and evaluate the role of the community health workers in reference to their responsibilities and to explore the unmet needs of the members and if/how the community health workers' role can accommodate them. These objectives were broken down into three separate themes,which werefurther broken down into a series of questions, and those in to sub-questions. The three themes were:

o What is the role of the community health worker in the overall program?
o What and how much of the services provided by the community health worker is essential/useful to members?
o How can the role of the community health worker be strengthened/modified to better meet the overall needs of the program?

Through the sub-questions we explored the program's functionality as recommended by the *Community Health Worker Assessment and Improvement Matrix[1]:* capacity building, human resource management, support and links.

The evaluation was undertaken from January-March 2015 across the different sites that the Foundation operates.

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[1]Crigler, L, et al. 2011

Background

Community health program background

The CHP started in 2010 as an addition to its micro-insurance programby expanding upon the health benefits that were already being offered by including direct health care support as a form of preventative care to the policy holder and their family. The first phase of the program relied on a technological intervention that linked service users with doctors through trained intermediaries who sent patient information to qualified doctors. Once the doctors reviewed the information they sent instructions to the intermediaries who then followed up with the patients. After a year of piloting it was decided that the service needed to be more direct and a more conventional CHP was setup.

The CHP program with SBs was piloted for a year in Dhaka in 2011 and has since been scaled to other SF working areas. SBs are based out of SAJIDA Foundation's (SF) micro-finance branches and work exclusively with the members of SF's borrowing groups and their families. As a part of their loan each member also takes out a mandatory micro-insurance policy that covers they and up to five members of their family, with an option to add an additional two members. The insurance covers the them the following five areas:
o   Set health care costs incurred at any health facility
o   Life insurance for the policy holder and guarantor
o   Fire insurance
o   Education scholarships for their children
o   Legal aid

On top of these benefits all members and their families are eligible for 50% discount on their medical and hospital bills when they access services at SAJIDA hospitals, of which there are two. One is a 100 bed hospital in Karaniganj and the other a 60 bed hospital in Narayanganj, bother are in Dhaka.

SAJIDABondhus

The SBs are paid, female community health workers recruited at the local branches by the branch manager, the area co-ordinator and the CHP co-ordinator. Once they are recruited the SBs are given an introduction to the work by the CHP co-ordinator and the chance to shadow an existing SB for a few days to get an insight ofwhat the day-day work entails. If the newly recruited SB wishes to continue to they are then trained at the Institute of Health Science (IHS), a facility developed by SF to train health workers based at the Karaniganj hospital.

As there is one SB per branch they are expected to provide support to all the micro-insurance policyholder and their families for a year- the term of the insurance.On

average each branch has 1,500 micro-credit borrowers who are divided in to different centre, with each centre consisting of upto 30 members. In accordance to their micro-credit loan repayment the members must visit their centres once a week to pay their loan repayment installments. The SBs accompany the field officers (loan officers) on their morning rounds and visit three centres a day to meet with service users.

This is a distinguishing feature of the SBs' work as most community health workers cover between 300-500 families, the SBs work with on average 1,500 families or more in larger branches. Another thing that sets this program apart from most other CHPs is that they are not required to.

Methodology

Method

The study was conducted using mixed methods, both quantitative and qualitative approaches to gather data to answer the overarching objectives. For the quantitative data a service user survey was conducted across the branches and a review of the clinical skills and medical knowledge of the SBs. The quantitative component engaged service users, branch managers, branch staff and co-ordinators through focus group discussions (FGDs) and in-depth interviews (IDIs).

Research questions

In trying to understand the program better the three research themes contained a number of questions that aims to understand the work of the SBs from the management perspective, the service users perspective and the perspective of the SBs themselves. In gathering the information from these perspectives a multi-dimensional understanding of the program was developed to highlight the strengths and areas that need further strengthening.

The breakdown of the three main questions and their sub-questions are the following:

1) What is the role of SAJIDA Bondhus in the overall program?
- How do branch/staff evaluate the services of SAJIDA Bondhu?
- Whether the assistance of branch managers and field officers is adequate towards SAJIDA Bondhu
- What is the added value provided by SAJIDA Bondhu to the MF program?
- How necessary are SB's role in claims management?
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- Are members satisfied with the current services provided by SAJIDA Bondhu?
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- Would they be willing to pay a higher premium?

- Perception of helpfulness of SAJIDA Bondhu in developing the health behavior of the members and view of the services
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3) How can the role of the Bondhu be strengthened/modified to better meet overall needs of the program?
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- Evaluate the responsibilities on the basis of the capability of SAJIDA Bondhu
- Best practice for recruitment &retention

Sampling and site selection

A cluster sampling method was used to group and select the sites. The SB based CHP run out of 78- of SFs branches (at the time of the study) and to ensure that sampling and the site selection was as representative of the population served and the abilities of the SBs the following criteria were set in the creation of the clusters:
- Geographic
  o Urban vs. peri-urban/rural- ensure that there was an equally weighted representation of urban and peri-urban sites that broadly represent the overall branches with SBs
  o City- ensuring that there was equal weighting between the number of branches in Dhaka and Chittagong.
- Knowledge- as there is no formal assessment of the SBs' actual knowledge with regards to their training it was decided that this would be categorised as *new* and *old* SBs; with *old* SBs being more knowledgeable due to them having received more trainings and refresher trainings. Given that all SBs enter with little or no experience of health knowledge and from a similar educational background this was the best method to differentiate. A year and a half was the demarcation between the two, anyone under this term was considered a new SB and these over an old SB.
- Psychosocial training- ensuring that the number of SBs with psychosocial training was weighted and representative in accordance to the overall number of SBs who had received the training.

Once the branches were categorised they were randomly selected.

Special criteria were included in the site selection for branches where the SB position was vacant, and if the SB was newly recruited and were yet to receive their basic training. The reason that these branches were treated separately was because they were to be the comparison group to understand if the training was effective and how members felt if there was no SB to support them. In the cases of untrained SBs we ensured that they had been working for a minimum for 3 months, as it would have allowed them to gain an understanding of their work and spend sufficient time in interacting with other staff members and service users.

In total 30 branches were included in the study to ensure fair representation. Dhaka clusters were taken to be homogenous and the reason for them being split in two was more administrative reasons, one cluster does not vary greatly from the other apart from where in the city they are located. The table below details the breakdown of the clusters:

Cluster name	Dhaka Cluster 1	Dhaka Cluster 2	Chittagong Cluster	Rural Dhaka	No SB	Untrained SB
Number of branches	8 (4 with psycho-social training)	8 (4 with psycho-social training)	4 (0 with psychosocial training)	4 (2 with psychosocial training)	3	3

Table 1: Cluster breakdown

Due to the political situation we were unable to conduct fieldwork at rural sites in Chittagong district.

Sample selection

From these sample sites we used a mixture of purposive and randomised sampling to engage with the target population.

As the SBs have to keep a written record of the members who have taken their service and the nature of the service provided, we requested records of those who had taken services in the last three months to be categorised into six different service headers, with one for those who had not taken any services. The services were: ANC/PNC support; hospital referral; child immunisation; other services (includes blood pressure, blood glucose measurements, being present at centre meetings whilst health information was disseminated, etc); and psychosocial workshops. The reason for the purposive sampling was so that we had feedback from a cross section of service users to get an accurate reflection of the SBs' work and their perceived help/usefulness in different situations.

These records were sent to the research team using only their membership and centre numbers. They were then randomly selected ensuring three people from each category was picked, with the list then sent to the branch for verification- to make sure those picked were still living in the area and still service users and/or lived in the area.

It was through this method that the participants for the service users' FGDs and IDIs were selected. It was also planned that the respondents for the semi-structured surveys would be identified this was but this had to be modified after the pilot as it was not an effective method of data collection. As a result the respondents for the questionnaires were randomly selected from those who attended the micro-finance collection centre meetings on the morning of the data collection visit. To ensure representation data was collected from three different micro-finance collection centre meetings per branch.

The managers, cluster leaders and field officers selected for FGDs and IDIs were selected representationally from each of the branches. We conducted IDIs and FGDs with all the SBs in the selected branches.

Sample size

To determine the sample size we used a standard calculation of a minimum of 370 service users to give us a 95% confidence level and a 5% error margin as our population size was roughly 50,000 service users.

The tables below detail the sample size and representation.

Members: 844	Staff: 124	Total: 968
FGD: 304	SAJIDA Bondhu: 31 (IDIs and FGDs)	
Survey: 495	Branch Managers FGD: 20	
IDIs: 45	Branch Managers IDIs: 14	
	Field Officers FGD: 66	
	Cluster leader FGD: 5	
	Project Co-ordinator: 1	
	Psychosocial Counselling co-ordinator: 1	

Table 2: Sample size

Tools development

All data collection tools were developed first in English and then translated into Bengali which were then field tested a number of times with different groups- those not a part of the study- and modified to ensure that the language use and flow was consistent. In total 8 were created.

1A Borrowers' (service users) Questionnaire
1A Borrowers' (Service users) FGD Guideline
1C Borrowers' (service users) IDI with psychosocial
1D Borrowers' (service users) IDI without psychosocial
2A SBs' Interview IDI
2B SBs' FGD Guideline
3A Branch Managers' IDI
3B Branch Managers' FGD
4A Field Officers' FGD Guideline

For the project co-ordinator, the psychosocial unit co-ordinator and cluster leaders of semi-structured interviews were undertaken.

The tools can be found in their English form in the annex.

Pilot and data collection

The research team comprised of 16 people, 4 core researchers and 12 external research assistants who were hired for the purposes of data collection, with three who analysed the data. The research assistants collected the data from the 1st-24th February. The training for the data collectors took place prior to and during the pilot. The data collectors were paired to ensure that all teams had a female interviewer. This was an important factor when composing the team as the service user FGDs and IDIs were with women who might not have felt as comfortable with male interviewers. This was confirmed during the pilot when the women would whisper particular health issues they have/have had in the presence of male facilitators.

A number of other findings from the pilot were that:

- It was learnt that targeted semi-structured questionnaires were not possible due to the distances between the member's houses (as they had been randomly selected by service taken) as was not possible to conduct the requisite number of questionnaires required in a day. This was due to the physical distances being too great to cover by foot and hiring transportation would have made it too costly. Also, when visiting a member's house some members were not present and waiting for them or going to the next house meant additional time was lost.
- A further problem was that as the member numbers had to be verified at the branches it was felt that the SBs visited some of the service users to coach them. To remove this bias during the data collection the member number were only revealed to the branch staff on the day of the visit so as to reduce this possibility.

All FGDs and IDIs were recorded[2] and the transcripts were written from the recordings. A sample of the transcripts was crossed checked with the recordings to verify them. Due to the anonymous nature of the questionnaires they could not be crosschecked but members of the core team were present at a number of data collection days. This was done for the dual purpose of quality checking FGD and IDI facilitation and making sure there was no data manipulation.

Data processing and analysis

As all data was collected in Bengali half of the recordings were transcribed verbatim first into Bengali and then translated into English, of the remaining half a roughly half were translated directly into English keeping as close to the original as possible and the remaining were loosely translated into English. To ensure that the transcriptions were as authentic to the original as possible all the direct translation from Bengali-English were done by the research assistants who had conducted the interviews or FGDs themselves. The table below outlines how the data was transcribed:

	Number of transcriptions
Bengali transcription-English	40
Audio Bengali-English	25
Loose Translation	16

Table 3: Translation breakdown

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[2] All but two which due to recorder malfunction

The table below illustrates how the transcribed data correlates with each cluster.

	Service user FGD	Service user IDI	Staff IDI	Staff FGD	Total
Dhaka clusters (both)	11	15	10	6	42
Chittagong cluster	3	4			14
Dhaka rural	3	0			
No SB	2	2			
Untrained SB	2	2			
Psychosocial workshop attendees	2				

Table 4: Transcription breakdown

Once the documents were all translated into English they were all manually coded and grouped. As the different clusters represented different standards those from comparable clusters were first cross analysed and then they were then cross analysed with those from the different standards. This meant that as the two Dhaka clusters and Chittagong cluster served service users who were comparable, worked under similar urban/peri-urban conditions they could be analysed as a block together. This information was then analysed with the three other clusters to look for similarities and differences. The information from the psychosocial workshop attendees was analysed separately as it dealt very much with a single issue.

To analyse the data the codes were arranged thematically to create a network under each question using the thematic network analysis method. This method allows for vast quantities of qualitative data to be organised around a central theme by filtering them through different stages, allowing for the exploration and understanding of significant ideas rather than seeking to simply reconcile conflicting ones[3]. This is done by organising the ideas at three levels: the *Global Theme; Organizing Theme; and BasicTheme.*

The *basic themes* are statements derived from the codes that were organised around the sub-questions, serving as our *organizing theme*. The relationships between the *organizing themes* were then explored and summarised around the three main questions, *global themes.*

The quantitative data collected was used primarily to create a profile of the micro-finance members and to compare with the quantitative data to verify if the information is representative for the bigger group.

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[3]Attridge-Stirling, J. 2001

Study limitations

There are a number of limitations to the study that pertain to its scope. Due to time limitations it was not possible to directly observe the SBs delivering their duties. This meant that it was not possible to assess the depth of each SB's knowledge on the issues they spoke and gave information. Given the limited time we tried to gauge the depth of the SBs' knowledge on a number of issues through the skills assessment. To further highlight any gaps and weaknesses that SBs had in discharging their responsibilities there were knowledge probing questions in the IDIs and the sample medical and clinical testing.

Another major limitation of the study is that it only engaged the policyholders and not their family members who too access the services of the SB. Due to time limitations it was not possible to target other members of the family as it would have required repeated house visits. From the perspective of the study we feel we tried to mitigate this issue by designing questions that sought the responder to take into account the entire household. Also, it is worth baring in mind that the policyholders are the first point of contact between the household and the SB, as such they would have knowledge of most of the health information within the household, as well as perceptions of the SB.

The method in which the questionnaires were conducted was less than ideal. As mentioned earlier, the original method was to conduct them at the service user's residence but the pilot highlighted that it was not possible to do so within our timeframe. Conducting the questionnaires at the micro-finance collection centres gave use access to women who from the data we learnt regularly attend the meetings missing those who do not regularly attend. The problems with this being that those who regularly attend have regular exposure to the SB and her work and as therefore more likely to have a positive outlook on her work. Engaging those who do not attend the meetings and are less exposed to the SBs work would have been more representative of the population she serves, especially as anecdotally 50% of services do not regularly attend the meetings. This means that the survey data may not be representative of all service users but of those who regularly attend the meetings.

A final point on the questionnaire data collection is that even though they were done as far away from the SB and field officer as possible, due to the restriction of space at the meetings – a large number of surveys were conducted outside the meeting rooms- and time – the majority of service users usually simply pay their dues and leave and as they were unaware that the data collectors would be coming they had left children unattended and/or cooking on the stove. This means that some of the answers may have been rushed and not as well thought out as possible. This issue was factored in during the creation of the tools and as a result it was deliberately made as short as possible as many closed and non-repetitive questions as possible.

Findings and discussion

In this section we will present our findings along with our discussion and analysis. Each of the following sections will be divided into a number of sub-sections, challenges- if any were identified- and a series of recommendations.

There are five sections in this chapter with the first three representing different perspectives – SAJIDABondhus, management, and the service users- followed by two thematic sections at the end that take in to account issues that are cross-cutting – rural service provision and the value added by the SBs.

4.1 SAJIDA Bondhu

To understand the program it is important to understand the SBs themselves as without them it would not function and would cease to exist in its current form. In this section we will explore how their work, their recruitment, what they perceive to the benefits and challenges of being an SB and conclude with our recommendations.

Background

The program was set up taking into account the national context of high maternal and neo-natal mortalities, something that is reflected in SF's working areas. To combat this the primary role of the SB is to provide at least three antenatal checkups per pregnant service user and one post-natal checkup within seven days of birth. As a part of this work the SBs also try to promote facility births and if that is not possible then for a trained birth assistant to be present at the birth; to traditional home births overseen by traditional birth attendants is a leading problem in the high mortality rates. The SBs are also to follow-up with mothers to remind and record the immunization of their children, they do not provide the immunization themselves as the government runs a free, comprehensive immunization program.

As these two are the highest priority work for the SBs, they are also tasked with taking the patients and their families to the facilities if required- during pregnancy, at the time of birth and after the birth if needed. This is an important aspect of their work due to barriers of access and travel faced by women in some areas of Bangladesh.

Along with these the other priority for SBs is to respond to emergencies that members or their family members may have, this may be by making a home visit, taking them to a health care facility or meeting them at the health care facility. To prepare members for any everyday accidents they gave information on what to do and where to go- such as dog or snake bites, fire burns, cuts, etc.

A large part of the SBs' work relies on them being able to cultivate and build relationships with other service providers, as referring patients to the right places is as important as making sure the patient is attended to. To aid in this the SBs visit a list of the closest free government, NGO and inexpensive health service providers in their area. A particular problem for the service users is that they are not always familiar with the all the service providers in their proximity; as a result they choose to go to the

closest health care provider,one that may be expensive. To help reduce this practice the SBs local knowledge and relationships are very useful.

Along with these health issues the SBs are also given training on how to deliver information on hygiene and sanitation issues, how to overcome common illnesses and diseases, taught how to measure weight, temperature, blood pressure and blood sugar and identify serious issues that need, referral amongst other things.

As generalists the SBs work is to give primary support and care as much as possible and to refer for more complex issues.

Workday

SBs have a set routine that they follow each day- except for when they have office days and trainings. They leave the office with the morning with the micro-finance field officers and visit three micro-finance collection centres, they can be one after the other in different locations or two or three of the centres take place at the same time, at the same place. The aim is to cover all micro-finance centres in a month – on average each branch has 60 centres.

At the centres the SB's main tasks are to give health and wellbeing information on a number of topics – importance of immunization, importance of hygiene, what to do in cases of diarrhea, healthy eating, and what to do in cases on emergencies, amongst other things-; how to make claims on the micro-insurance; conduct weight, blood pressure & blood sugar tests for those who wa it and give advice on follow-up action; and review the general health of the members and their families, including making appointments to make house visits if required.

This usually lasts until midday at which time the SB returns to the office. Before returning to the office the SB may make a few house visits in the area to check on pregnant patients, those with young babies and/or others who require follow-up attention.

After lunch is when the micro-finance program disburses loans and all members must go to their local office to receive the loan. After they have received their loan each member and their accompanying guarantor must meet with the SB to register their information. During this meeting the SB notes the basic information – name, age, gender, health status- of all family members covered by the micro-insurance. After this is completed the SB makes home visit where she verifies the details given during the registration, follows up with whose who had requested home visits from the morning, visits other patients who are on her follow-up list.

The SBs preplan which members they will visit each day to maximize their efficiency as some SBs geographical coverage areas are spread widely and modify them regularly as required. They share their work plan with the branch manager to keep them aware of their movements. In cases of emergencies SBs are expected to forego their work plan and tend to the emergency, be it visiting someone's house, taking them to the hospital, or whatever it may be. In these situations they inform the branch manager of their movements and request any additional help from them if required.

In addition to the health work the SBs are responsible for visiting and verifying the micro-insurance claims made by the policyholders. This is a task that they sometimes share with field officers.

Recruitment and retention

SAJIDABondhus are an all female community health workers recruited from the communities they serve, with the average SB is in her early 30s, having worked in the program for one and a half years, and an SSC graduate. Some SBs come with a science background but the majority does not have much knowledge of health issues prior to joining.

From the profile of the SBs two issues were raised by those who work with them and oversee their workwould it be beneficial to the programis all SBs were HSC graduates, and whether SBs would be better able to meet the needs of the service users and gain better acceptance if they were mothers. The first question was raised primarily due to the belief that an SB with higher education would be more competent, and the second due to socio-cultural norms where mothers have a higher status to none mothers. This was thought to be an issue with elder service users who can be more conservative and may not value the advice on pregnancy and neonatal health issues from someone who has not gone through the experience.

The strongest proponent of the higher educational qualification came from the trainers as they had a distinct impression that those with a higher educational background made better students. This was due to them being able to engage with the material better and grasp the concepts. There were further recommendations from the trainers that if possible the SBs should come from a science background as it would be easier for them to understand the material, though this was not something that they deemed to be obligatory.

The SBs themselves were of mixed opinion regarding a science background, as they did not feel that they did not have any problems with the training or the material due to their non-science background but did agree that it may have helped some of them:

SB: We did not ask any question. Whatever is taught, we tried to understand that. If we had prior knowledge, we could have understood easily or, learnt more. [Three SBs agreed]

– UD 1.1 SB FGD

Some did however note that those who had prior knowledge did not engage with the training as best they could have:

SB 1: If some one has prior knowledge, it causes lack of attention and concentration during the training session. We knew nothing that is why we were interested and attentive to the class.
SB 2: At that time during training I did not give attention, because I already know about it. Another woman disturbed me in the class; she worked as a health worker before. .

– UD 1.1 SB FGD

The project co-ordinator's opinion regarding these recruitment issues were more that ideally all SBs would have an HSC certificate but this was not realistic as the salary was low and the work hard, meaning that not very many women wanted to do it. As a result the recruitment criteria on qualification has had to be flexible, and in her opinion it would not be possible to stick to such a standard. From her experience she stated that although there were other important criteria in the recruitment of SBs that were just as important, if not more: if the person was a good communicators as a large portion of their work is speaking in groups, their interpersonal skills as it is important to build a rapport with the service users as well as their family, if they were empathetic, and if they had any young children at home to look after, as this may result in their inability to stay overnight for residential trainings.

All of these criteria are logical in selecting a community health worker and the issue of the SBs being a mother is not part of the current requirements. Some CHPs mandate that the worker must be married to gain acceptance with the target population, but this is not the case with SF's program. There are many single SBs and only recently the minimum age of the SB was raised to 25 due to feedback that younger SBs were not taken seriously due to their age.

The debate as to whether an SB should be married and/or be a mother was not felt to be decisive as the service-users were all familiar with the organisation and from the years of services they have received there was an acceptance of the SBs. When there are issues of credibility for the SB they are usually due to other dynamics that her marital and fertility status would not be able to overcome. These are most commonly due to: a traditional mother-in-law who is skeptical of medical facilities and husbands who are adamant that their opinion is right and there is no need to listen to the SBs' advice, unless the advice came from someone with a higher qualification, such as a doctor, they are unlikely to budge.

In matters that the SB feels a certain course of action must be taken they request the intervention of their branch managers and if that is not effective then the area co-ordinator and the cluster leader intervene, if needed. With this support the project co-ordinator feels that when such issues arise they can be overcome, and if someone does not want to take the recommended course of action there is nothing more the program can do.

Similar life-experiences and life-histories are an important factor in CHPs[4] not being a mother or married can be seen to be barrier but due to their work experience, ability to cite successful interventions they have made, these interventions becoming common knowledge and attributed to the SB it is possible for them to work and gain the respect of their peers- those they serve. This is reflected when the SBs speak as to why they are in this profession; they see themselves and feel that they are respected members of their community, they are sought afterto give advice- including matters outside health- and treated well by service users. The fact that service users themselves highlightedthe SBs provided them with as an important service reflected this point of view.

Retention of SBs, particularly skilled SBs was a matter of importance for both the project co-ordinator and the trainers as recruitment and training are both a financial

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[4]Crigler, L, et al. 2013

burden as well a programmatic problem; especially as it took a few months between an SB leaving her post and the following SB being trained to provide all services.

The turnover rate of SBs is around 30% a year, a figure that is roughly appropriate given the working area of the program and the model. Other similar global or local programs have a similar or slightly higher turnover rate[5]. When investigating the factors for the SBs left the project we were unable to meet with any previous SBs but from the information collected from current SBs as to why they are dissatisfied a number of issues arose. These were later echoed by the project co-ordinator.

Benefits of being a SAJIDA Bondhu

There were four major benefits of being an SB according to SBs, the most obvious being that as they were paid (even if they weren't satisfied with their pay) the additional income to the household was very valuable. The quote underneath highlights the positive impact being employed as an SB:

"A girl who is SAJIDA Bondhu can get financial support along with respect. In before she may not be familiar by other people or neglected by family member or husband but after being SAJIDA Bondhu, she gets respect, she walks with field officer, she gets greeting first than that officer. Moreover we can learn a lot of thing that is important for our real life. We can make aware our family members, relatives. Before getting training we did not know this kind of information. But now we learned many things. This is very much important in our real life".

-UC1.3_SB_IDI_p2

Apart from income the main benefit of working as an SB is respect. This is something that every SB mentioned and explored in detail: the respect that they received from their families; from their community; and from the service users; and their families. This is a very positive sign that they are accepted by the service users as it is mainly through their interaction with and the respect flowing form that relationship that it permeates to the wider community. The literature on community health workers also highlights how respect and status elevation was an important factor in CHPs retaining the workers, especially if the worker is unpaid or inadequately paid[6].

The respect that the SBs receives from the service users manifests itself in a number of different ways: the relationship between the SB and the service users takes on a more intimate nature where the service user seeks the SB's advice on issues other than health, invites the SB to social gatherings and publically shows respect by calling the SB *apa* (sister) even if they are older than them. These various shows of affection andrespect have a high impact on the SBs' own self worth and esteem.It enables them to access a higher status amongst their peers that may otherwise not have been open to them. This coupled with the higher status within the household due to their ability to support their families and independence are the most important factors in retaining SBs.

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[5] ibid

[6] ibid

A final benefit to the SBs and their families is that through the trainings they increase their health knowledge and directly apply it to their own lives and the lives of their family. This is something all SBs highlighted, how they were better able to take care of themselves

Challenges

Pay was one of the biggest issues as the SBs did not feel that they were adequately remunerated for the work they did, especially as it is at times physically taxing and the hours long. This was compounded by the fact that they knew they were the lowest paid staff member in their office; the office cook's salary is higher than theirs and is particularly offensive to them. The quotes below illustrate why they felt their salary was inadequate and sheds light on their frustrations.

"Our salary is very poor. We have to do work in field and office in whole day. Here we need to spend more than half of salary for transportation and food cost. Sometime I need to pay for transport when I take emergency patient in hospital. If I stay with them, sometime I had to take food from restaurant".

- UC1.3 SB IDI

"SB's Conveyance should be increased. FO gets 1500 taka as conveyance but SB does not get as like as this. Every FO collects money from three centers. SB visits the three centers. But their conveyance is not same. That's why, SB reluctant to her job. Their salary is not good. Her salary should be minimum 8000 taka. Sometimes SB has to carry patient hospital. She needs to visit household. That's why her transport cost should be increased".

-UC1.1 BM FGD

"Sometimes SAJIDA Bondhu has to give transport cost during taking patient to hospital. In this case conveyance should be increased. Then they will be inspired for work".

-UD1 FO FGD

The issue of low pay is something that was echoed by the SBs' colleagues, the field officers, branch managers and the project co-ordinator all felt that their current salary was inadequate and one of the main reasons for SBs leaving their post. They all felt that given the SBs' workload they should bebettercompensated, especially as they incur a high level of out of pocket expense linked to transport.

Another challenge is the perceived lack of respect that some SBs receive from their colleagues, mainly field officers in fact a serious problem that has been known to the branch managers and the project co-ordinator for some time but they have not been able to help the SBs overcome it. The seriousness is not only in that it demoralizes the SBs but that it also has an adverse effect on the SBs ability to conduct their work; especially when the field officers make derogatory comments regarding the SBs abilities in front of the service users. We will explore this issue in greater depth in the following section.

Added to this problem of being disrespected the SBs also take offense to the fact that they are temporary staff and all others in the branch except the cook are permanent staff. This causes a problem for them not because they feel insecure but rather that the organisation does not value them as much as field officers and micro-finance staff.

R 1:*If Khala (cook) does not cook, they will have to starve, they will have nothing to eat, this is why the value of Khala is very high (mocking tone)*
R2: *Everyone in the field loves us.*
R3: *Members say, "Apa, we have not met for a long time."*
R4: *Members respects us, but in office, there is no one.*
R5: *When we check blood pressure at centre, there are some people, who taunts, "Oh!!! You are measuring pressure; it is not such a big deal. If I train, a member can also check it."*

– UD 1.1 SB FGD

The weight of their equipment due to them having to carry thick, hardbound registers, their blood pressure and sugar level checking equipment and a heavy weighing machine causes physical problems for the SBs. It is with this full kit that the they must travel when visiting service users house-house, and even though they have been told that they do not have to always carry the weighing machine, the load is often too much as they complained of back and chest pains. The issue of the heavy load was also expressed by their other colleagues with the project co-ordinator indicating that a common practice being that the SBs would leave some of their registers at the office and make notes on paper that were then copied into the register.

A final grievance the SBs had was the lack of career progression and assessment as there is no scope for an SB to progress and reach a higher level, they are unfortunately stuck at the same level. To help overcome the stagnation that the SBs face the project co-ordinator had planned to create the post of a senior-SB whose role would be to support new and struggling SBs. The idea is something that was shared with the SBs and they are favour of such a move, as it would give them more opportunities. The other option that the SBs identified was to conduct assessments and reviews of the SBs and to pay them according to their ability. Currently all SBs are paid the same depending on the length of their employment.

Though the idea of a senior-SB is persuasive in overcoming the issue of progression, in reality it would only apply to a very small handful of SBs and would not allow for progression for more than 3-4 SBs at a time. From the standpoint of quality, whether this will overcome the problems faced by the program with regards to the service delivery is not very clear owing to the SBs' limited medical and clinical knowledge.

Even if it is not possible to promote SBs as seniors they should be regularly assessed and appraisals should be conducted around a set of core competencies. This will give the SBs a motivation to be identified as a *good* SB as status and recognition are very important to them. From a programmatic perspective it assist with training, service delivery and monitoring of the SBs, leading to the strengthening of the program. A method of doing this would be by benchmarking the competencies of the SBs to measure those who are not meeting the minimum standard and identifying the areas that need strengthening to give them further training. An outcome of this will be all SBs will be operating at a similar standard, ensuring quality service delivery for the service users.

Recommendations

Overall most SBs are content with their work, even if most are unhappy with their pay they continue to and will continue to be engaged with the program because of the elevated status that they enjoy as a part of the program. There is however a number of issues that needs to be reviewed to reduce dropout and to improve the satisfaction of the SBs.

Recruitment
o SBs should be between 25-50 years old when recruited
o If possible married
o If they have children the youngest should be two years old

Human resource
o Raise SBs' salary and increase their travel and mobile phone bills as they incur a lot of out-of-pocket expense in these areas
o Make SBs permanent staff

Programmatic
o Undertake regular assessment and appraisal of SBs
o Reduce the weight of the SBs' bags

4.2 Program Management

In this section we explore program management by looking at how other staff evaluate the work of the SB, the monitoring system in place, the assistance they receive from branch staff and their interpersonal relationship and training. Due to the nature of the SBs' work it is important for them to work closely with other members of staff, particularly in the branch as their work are at times an extension of other programs.

Program Management

The CWP has a two-tier management structure where they report on their day-day activities to the branch managers- as they have daily direct contact with them- and it is their role to ensure that SBs undertake their activities suitably and that they are following up patients. The SBs also report to the CHP co-ordinator on progamme related issues: making sure supplies are sent to SBs, reviews the monthly monitoring data, arranges and co-ordinates training and reviewing the training materials, hiring and other HR related work.

Previously the SBs would directly report to the co-ordinator but as the branch numbers were increased it became difficult for one person to manage all the SBs and to over see their daily work. As a result the change the two-tier management system was set up. The flow of information is supposed go from the co-ordinator to the cluster leader, who then send it to the area co-ordinators and then it reaches the SB through the branch manager.

There were a number of complaints in the current management structure as those tasked with supervising the SB feel that they either do not get given information about the program, including planned activities and updates; and the line of communication was not followed as the SBs continued to communicate directly with the project co-ordinator and vice-versa creating communication gaps as some people were left out of the loop.

The biggest problem this creates is that the supervisors are unable to supervise the SBs adequately as they are sometimes unaware if changes are made to the program. Another problem that surfaces from this is that the branch managers, the primary supervisor of SBs, do not take complete ownership of the SBs as they feel disconnected. This then has a negative affect on their program as they are unable to provide the support the SBs may require.

The current situation stems from an inability to follow protocol due to previous communication and management method and with greater rigor it can be overcome.

Apart from the communication issues the current management structure in fact offers little field level supervision due to the other responsibilities of the branch managers. We also recognize that the branch managers do not come from a health background and do not possess the technical knowledge to offer guidance or support to the SB. Currently the SB phones the project co-ordinator or the trainers when in need of this technical support. This is not to say that the managers do not and cannot support the SB but that they face a limitation in providing them with all the support they need.

For this reason we recommend that their be a new cohort of technical supervisors introduced who will work with 10-15 SBs that are geographically near to them. Their role will be to provide technical and logistical support to the SBs, to facilitate better communication between the CHP and the micro-finance supervision hierarchy. It will not mean that the SB will no longer be accountable to the branch manager, this this continue and in addition to this the new technical supervisor will provide field level oversight that is not possible for the project co-ordinator to provide. They will also help strengthen the knowledge, monitoring and assessment of the program.

Monitoring System

SB: But maintaining registrar is also important because it is the proof of what we are doing practically. If we find any new patient, we will have to record her name. Otherwise she will not get any service.
SB: When we work in the field, there is no one to monitor us. Registrar book is the one and only proof.

<div align="right">

– UD 1.1 SB FGD

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Branch Manager: "Actually I check her daily registrar or follow up registrar once in a week. I observe once in a week. I have one copy of her schedule where it is written that from Sunday to Thursday, where and when she will visit the members. Let, she had to go to the center no. - on the last Sunday. Then I check in the follow up

registrar if there was any sign or if there was any discussion with the members in the daily registrar."

-USB 1.2 BM IDI

SAJIDABondhus' work is evaluated primarily through their registers as the quote suggests as theyhave little field level supervision due to the project co-ordinator and the branch managers being unable to make frequent visit to the field. In addition to the registers the branch managers also rely on feedback from the field officers and service users to keep updated on the SBs' activities.

There are three registers that are used to monitor and keep track of service users, their family members and track who has and has not been followed up: the member register tracks all the members who are covered under the micro-insurance program, including their names, age and pre-existing any health issues; the centre register tracks which centres were visited, note what services were given, which service users were present and the service they required; and the follow-up register that is divided into three sections, the pregnancy follow-up, the immunization follow-up and other issues follow-up.

To help the SB manage their work they also have a work calendar they produce a monthly plan that is shared with the branch manager and the project co-ordinator to ensure that everyone is aware of their movement in case they wanted to visit them in the field. The work calendar tries to prioritize the visitation of centres not visited the previous month by visiting them in the first week of the next month if possible.

The information in the registersare tallied onto a monthly submission sheet that takes into account, amongst other things, the number of new members registered, the number of new pregnant service users, the number of women who gave birth during the month, any infant or maternal mortalities, the number of ANC and PNC visits and number of immunization facilitated. To gather this information the SBs have to consult all of their different registers to cross-check the information as there is no system of cataloguing members as members' name and information is entered chronologically. This makes it very inefficient for those following-up the SBs work to also check the service users' information quickly without assistance.

The challenge that the registers pose are as a result two fold: as they are complicated it is hard for all those who are meant to be able to follow-up to check on the SBs' work to do so properly, and as the monthly submission information requires the tallying of information across the different registers, for a single piece of information sometimes, leading to mistakes being made. Once these mistakes are made a lot of time is spent on finding and correcting the information from the MIS team. Due to the nature of the record keeping this means that both the MIS officer and the SB have to spend large amounts of time reviewing the work once the data has been compiled.

To make the process more effective and efficient for both purposes a review and redesign of the registers with consultation from all the actors involved in its checking and following-up, including the area co-ordinator and cluster leaders, is recommended.

Aside from the monitoring method there are also concerns as the quality of the monitoring and supervision itself as the none of their supervisors have a health background, though the project co-ordinator has learnt a lot through her experience.

This has two big draw backs as it means that when SBs have a problem they contact the trainers who are health care professionals but may not be always at hand, and almost more importantly the quality of care and treatment given by the SB cannot be adequately monitored and evaluated. With the introduction of the new technical supervisors we are confident that this gap can be overcome.

Training

As mentioned in the previous section the SAJIDABondhus do not have a background in health or the sciences when recruited and as a result it is important conduct thoroughly to ensure they are able to serve the members. To this end 10-days of basic training are held at SF's by health professionals when SBs start. Thisisfollowed-up with 2-days refresher training, also located at the HIS in Dhaka.

As there were no trainings during the period of the research we were unable to observe any trainings. To collect information on assessing the adequacy of the trainings we spoke to the trainers, the SBs, reviewed the training material and conducted clinical and medical assessments of the SBs knowledge and skill.

When speaking of the trainings most SBs felt that both the trainings and the trainers were very good and helped them understand issues that they did not know about. This was something that was reflected by all most all SBs who made similar comments to the following:

"Training and trainer both were very nice. Our trainer was Muztafizvi. He taught us by acting. His body language was good. In training we all came from different area. There was no combination of our language. During teaching he used local language. In one sentence we enjoyed a lot in training."

-UD1_SB_FGD_p3

"Trainer was good. He taught us by acting in local language. He asked question to asses us whether we understood or not. If not then he tried his best to make understand us in an easy way. The training was good. Environment was good, sequestered and prettied".

-UC1.3_SB_IDI_p3

When it came to the refresher trainings however the SBs had a number of misgivings. They wanted them to be more frequent and more for longer periods of time:

SB1: *Duration of refresher training should e 4 days, instead of 2 days. Sometimes, we can not ask questions due to shortage of time. If 10 SBs ask 10 questions, it will take time to answer all those.*
SB2: *Time should be increased.*
SB3: *It will help us to learn more.*
SB4: *It will help us to provide better service.*

– UD 1 SB FGD

It will be better if training is arranged for us every three months. If we are trained frequently we will be more enthusiastic about our work. We will also be able to provide some new services to the members.

-UC 1.1 SB IDI

The main reason that the SBs wanted refresher trainings for longer was because, as the second quote above highlights, individual SBs did not receive refresher trainings every month, rather there was one being organized for a the program. The reason that SBs received revolving refresher trainings of maybe one a year is that all refreshers were conducted at the IHS in Dhaka and as they had limited capacity and run other programs they are unable to run more trainings for the CHP. Also, financially running more refresher trainings would not be viable under the current model.

An example of the need for more field level training was highlighted by the SBs who indicated that there are areas of their work that they are still nervous in performing, even those with years of experience. The main areas that the SB identified as feel nervous on unsure of were: measuring blood pressure as the members may get their pressure checked elsewhere and expect the rate to remain constant, even though it can fluctuate many times within a day; and conducting ANC and PNC checkups.

Due to their current lack of field level support and when the SBs require they indicated that most have found the training manual given to them to be useful and study it if they feel as though they have forgotten something.

There are many diseases with low prevalence rate; we rarely get patients with those diseases. There is a probability that we may forget some points. When I read the books, I can recall the information.

-UD 1.2 SB IDI

However the manual is not sufficient in overcoming the problems faced by the SBs as a lot of the time they cannot be remedied without practical supervision and experience:

"I am comfortable to check up blood pressure, diabetes of patient and pregnant women. But sometime it is very difficult to identify the baby's heartbeat, sometime could not hear because of being pregnant mother fatty. That time I scared."

-UD1 SB FGD

"During ANC, I scared to put my hand on belly of pregnant women, if she gets pain".

- UD1 SB FGD

"I am comfortable on physical checkup such as measurement of diabetes, blood pressure, weight. I am good in pulse detection as well. Sometime I face difficulties and fear to detect the uterine height during ANC because the information which is given by me whether it's right or wrong."

-UC1.3 SB IDI

Programmatically it is worrisome that so many SBs are not confident in conducting ANC checkups, as this is one of their primary roles. One of the things that the SBs who feel little confidence in undertaking ANC checkups is that they refer to the nearest professional who is able to undertake the checkup.

Another area of concern is that of claims management as the SBs are not properly trained on how to comply with and undertake this piece of work, and as a result often make mistakes. If claim management is to be a part of the SBs work then they should be

trained on the procedure as otherwise they will continue to make mistakes. This causes obvious programmatic problems in requiring additional man-hours rectifying the situation, and puts a strain on the relationship between the SB and her co-workers as the following section will highlight.

Clinical and medical assessments

To assess the SBs' technical skills and ability we conducted a small medical and clinical assessment with the help of the two SAJIDA hospitals and lab technicians and health care professionals oversaw the assessments. The five areas we tested were:
o Blood sugar measurement
o Blood pressure measurement
o Temperature measurement
o Pregnancy test
o Pulse measurement

Along with the tests we asked the SBs if how they conduct and the information the give and receive when conducting ANC care and whilst undertaking the blood sugar measurement.

	Passed	Failed
Blood pressure measurement	12	-
Pulse measurement	5	7
Temperature measurement[7]	4	8
Pregnancy test	11	1
Blood sugar test	12	-
Undertanding of ANC procedures	6	6
Understanding of diabetes testing procedure	3	9[8]

Table 5: Assessment result

From the assessment it is clear that the SBs require more technical training, monitoring and supervision to help improve the quality of the program but unfortunately they are not periodically tested. This practice should be modified so that the SBs are all periodically assessed and tested on their medical and clinical skills.

Psychosocial Counseling

In addition to the medical and clinical information the SBs give, they also receive psychosocial counseling for the workshops they conduct with service users. For this they receive separate training conducted by SF's Psychosocial Counseling Unit who has developed special group workshops for the service users. Currently the training is conducted over 5 non-sequentially days, after the first three days the SBs conduct

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[7] The thermometer used in the testing is different from the ones used by the SBs and they cited that as a cause for confusion.
[8] Most SBs were unclear as to what the blood glucose range should be for a fasting test.

observed workshops with service users, subsequently they receive feedback and the following two trainings, again non-sequentially.

Apart from the basic training the SBs do not receive any further trainings from the psychosocial unit, but are sometimes supervised by facilitators from the unit when they conduct the psychosocial counseling workshops. Due to the high number of SBs and low number of facilitators it is not possible for the SBs to receive as support as the need, especially as this is an area that is new to all SBs.

"If office manages refresher training on health and psychosocial training for us, then we would give better service to the members".
[All vocal and agree}

–UD1 SB FGD

"[Asked if the psychosocial workshop training is adequate] No, it is not enough. We do not clear on this. We need more training on this"

-UD1 SB FGD

"We need but if there is a written book on psychosocial, it will help us a lot."

-UD1SBFGD

When speaking to the psychosocial supervisors they confirmed that the SBs were not always confident or able to conduct the workshops themselves and in many instances they have to be guided during the sessions, or the facilitators take over the sessions and deliver themselves. This is not a very positive sign for the even if it is deemed to be a success by the service users it does not ensure the quality of the program, especially in branches where the SBs are not satisfactorily able to deliver the workshops.

If possible there should be refresher trainings arranged for the SBs as they currently rely on the basic training and the support of supervisors when they are present. This is particularly important to ensure the quality of the program as in a year the SB conducts the workshops with three cohorts of service users with each cohort taking ten weeks to complete the course. As a result of this there is a three-month gap between each time the SB conducts a particular workshop and without a manual it is put to them to recall the information in each workshop.

Untrained SAJIDABondhus

All those spoken to agreed on the importance of training and when speaking to SBs who had yet to receive the training they felt that they are unable to conduct their duties to the level required and seek help; sometimes from external, unauthorized support:

Since I didn't receive training, I have to know and understand their inside stories/condition so I am able to share properly with them. As I did not receive full training what service can I give. If they face any problems then I can talk to them over the phone and try to solve it. The manager has the phone with him, I call him about the problem and ask him how I might be able to solve it.

– USB SB FGD

We haven't received any training yet. But still I go to doctor apa [paramedic], I go to her every week and learn quite a lot of things from her.

– USB 1.3 SB IDI

"I think that SAJIDABondhu should get skilled training before going to the field. Then she can give service more rapidly.

-RD 1.1 BM IDI

"To increase the competency of SAJIDABondhu, we have to make them trained up. As a nurse serves the patients and gives them primary treatment, we have to train up the bondhu in such a way that they can achieve the quality of a nurse. Actually, there is no alternative to training."

-USB 1.2 BM IDI

As basic training can only be organized once an adequate number of new SBs have joined it is not financial viable to hold them very regularly, and a possible solution to this maybe the frequent localized refresher training acting as a stop gap. Where this has happened in the past it has been successful:

Before I was having trouble in measuring blood pressure. After the 2 day training they showed it to me properly. Now it is fully clear to me. I have learned how to measure blood pressure properly now. [She attended a refresher training in Dhaka for two days]

– USB 1.3 SB IDI

To overcomethis and some of the training related obstacles it maybe possible to change the model to decentralize refresher training whereby the SBs are trained locally to reduce cost. The new technical supervisors could undertake this with for the medical and clinical issues and a trainer from the psychosocial unit for the counseling workshops. The advantage of this would also be that the new supervisor would be able to incorporate observations from their field visits into trainings and follow-up with individual SBs when required. Currently there is a gap in this process as the project co-ordinator informs the trainers as the areas the refresher trainings should be conducted and then follows-up with the SB. As there is no assessment at the end of the current refresher training and the gap between the trainings means that if an SB has a problem area it is hard to overcome.

Staff evaluation and perception of the SAJIDABondhu's work

Branch staff evaluation and perception of SAJIDABondhus and the CHP is complex as there are a number of issues that they factor when making a judgment. On the one hand they identify the program as being helpful to the members and ultimately to themselves as healthier members mean they are productive and capable of repaying their loans, helping them with their work. On the other, there is a clear recognition from the branch staff (including the SBs) as to the clear limits of their work and the support they can give members.

Given the understanding of the limitations of the program the general consensus is that the service users regard them warmly, most are committed to their work and try to work to the best of their abilities:

One of the days I saw that a member come close to the SB & hugs her. I ask her that is she your relative. She said that "No".

-USB FO FGD

There was a SB in our branch. One of our members was in labor pain. It was at 10:00PM. SB immediately went to the member's home & brings her to the hospital.

- USB FO FGD

Our most of the members are female. So they can talk freely with SB. Members belief that SB has information, she can give suggestion about doctor and disease. I think every member share everything with SB.

-UD 1 BM FGD

"We are working with people who cannot go hospital and doctor in higher cost. They praise a lot to SB because of her work. We are giving all kind of services through SB. When she visits the member's household, she discuss about our facilities. This is the good way for giving services."

-UC1.1BM FGD

This howevermay create a contradiction, as it may be that a field officer sees the benefit of the program but may not show sufficient respect to the SB- as we have discussed earlier and will explore in greater depth shortly. One of the reasons maybe the lack of knowledge the field officers may have on the actual aims and objectives of the program. As the primary aim is to basic provide primary care and to refer more complicated issues to higher level health care professionals, it maybe important to orientate wider branch staff as to the aims and objectives of the program..

The following quote illustrates how a branch manager and field officer are not satisfied with the SBs work, even if she is doing what has been mandated to her and by clearly communicating the work and role of the SB their acceptance of their work, the program and its limitations:

...[S]he [SAJIDABondhu] is not able to give all kind of health services. She can measure only the diabetes, blood pressure and weight.

– UD 2.5 BM IDI

[Speaking about the death of a service user a field officer suggests that]   Giving Suggestion is not a work....

-UD 2 FO FGD

As some of the quotations and passages below highlight, some staff members feel that there are ways to improve upon the work undertaken by the SBs through simple changes or re orientating the focus of the program:

SB starts their work after prayer with us…. [b]y visiting center she can't give service properly. She talks with member. But this conversation is not called service because it's not effective. Instead of this if she visit household, it will be effective.

-UD 2 FO FGD

I: What should be the primary responsibilities of SAJIDA Bondhu?
R:*House hold visit of nirapotaa members in emergency.*

-UD 2 FO FGD

Along with changing the focus of the program many felt that the scope of the SBs work should be expanded to make them more specialized to offer better care and support for to service users.

Even though the vast majority of the staff seemed happy with the program few were clear on its aims, objectives and what the core competencies of the SBs are. It is important that in a situation such as this, where a program needs the support of multiple stakeholders to be clear about these issues. To help bridge gaps that currently exist it is important that the role of the SB and the program is reviewed and communicated. At present the SB is a generalist and provides very basic primary care support but as they are held to higher standards by their colleagues the branch staff are not as strong supporters of the program as they could be. This has a number of knock on effects as the following section explores.

Inter-staff relationship

On the whole the program is able to run due to the good relationships between the actors involved, however there is one relationship that can at times be problematic, that between the SB and the field officer. The previous section explored how most staff are generally positive towards the program and the SBs' relationships with the service users. The following continue that theme in showing the amiable relationship between most SBs, branch managers and field officers:

Sometime it is not possible to visit every center in a week. So it is very difficult for me to find out about the pregnant women in every center. In that case field officer would give information about the pregnant women or other patient then it is fine for me to give them service 0.

-UD 2.6 SB IDI

"There are many works between Bondhu and employees, suppose if there is a caesarian operation, we cannot monitor that as a male. But SAJIDABondhu takes her to hospital and we visit after that. Besides, in case of complications or emergency diseases, she wants to know from us about the treatment or information about that disease. And she can know that from our employees."

- RD 1.1 BM IDI

Recently a member had a delivery in hospital; but she did not know that. That means she went to the center but that member did not come. Then I told her that, that member had a delivery in the hospital. Then Bondhu said that, okay, I had reminded her, she had no knowledge about this. It was written before; maybe it was not in her knowledge. It was recorded many times ago. So, after telling this, she visited. After

visiting she informed me all the information. After being informed, I came with the hospital documents, and then I submitted the documents."

<div align="right">**- RD 1 FO FGD**</div>

Referral system

Owing to the time limitation of the program it was not possible to investigate the SBs' referral and partnership network in great depth. Programmatically each SB is given a list of government, NGO or low cost health facilities in their area with a list of the services that can be expected at each. When a new SB joins she is taken to a number of the most local service providers and introduced by the project co-ordinator and they exchange contact details. Through this exercise the SBs learn the location of the service provider and is personally introduced to the most relevant person at the facility and has their contact details, in case they need to communicate with them.

On reviewing the referral list we found that there were a number of facilities missing from the majority of the lists, the list is only made available for to the SB and should be made more public for other branch staff and service users in case they too require the information but the SB is not at hand to provide it.

At present the referral system is an informal system with no records kept as to where service users are being referred and for what purpose. It is important to keep such a record to periodically evaluate which of the referred facilities are better than others, which provide better service and which do not. As the SBs provide little care past very basic primary care it is important that patients are sent to the most reliable health care provider.

The final issue regarding the referral system is that the SBs feel that they are unable to give sufficient time to cultivate meaningful relationships with the health care facilities due to a lack of time, and as their status as field workers. The reason that they feel there needs to be better relationships with the health care providers is because to ensure better treatment of the patients when referred. Those who have been able to nurture such relationships state that they have managed to secure a discount for patients who come through the SBs' referral[9] and waiting times are reduced. Both of these would make a positive difference to the service users and more effort must be put into establish this with the task given to the technical supervisors who would have easier access given their professional background.

Challenges

The conflict, in cases that there are conflict, stem from three particular areas: respect (as mentioned previously), supervision and communication. As we have explored the issues that arise from a lack of clear wider communication programmatic overview we will concentrate on other forms of communication gaps and problems in this section.

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[9] A common practice in Bangladesh is that health care facilities hire touts who work as middlemen to facilitate patients and receive a fee if they register one. As the SBs do not receive this payment the facility can afford to charge the patient less.

The SBs have a litany of complaints against the field officers and the field officers have a number against the SBs. Some SAJIDABondhus feel that field officers do not show them adequate respect in front of the service users and this in term has a negative impact on their ability to conduct their work. As for the SBs their relationships with the service users is very important it is something that they take very personally.

SB 1: When we talk with members at center, FOs feel disturbed and they say, "Keep quite. Check blood pressure. Measure weight. You will talk with them later."
SB 2: If FOs scold us in front of members, then why will members respects us? They will not respect us also.
SB 3: If they scold us individually for my fault, this is one thing. But if they scold us without any valid reason in front of everyone, I feel ashamed.

– UD 1 SB FGD

In some cases the SBs have problems with the branch managers and field officers owing to the previously mentioned issues of supervision. As a lot of the work of the SB is independent they are only monitored when in the office or making a centre visit with the field officer. Outside these two activities they conduct house-house visits, patient follow-ups and referrals and other work that is not seen by the other office staff. This too has a negative impact on the morale of the SB:

I have to work a lot. From 8 am to 2pm I work at field level the I go to the office and work there, and after 3pm I have to work at the field level again. However, after doing all this work the manager and supervisor complain saying, 'The work you do is not significant work. Due to this I lose encouragement to work. They think that we play 'hide-and-seek' at the field level. They cannot distinguish between good and bad [workers}.

– UC 1.1 SB IDI

It is not just the SBs who sometimes have problems with their colleagues,as they too are at times critical of her:

Relationship is good, behavior is good, but after [morning] meeting they [SAJIDA Bondhu] don't share with us what actually happened in meeting. Why they behave like this, we don't know. May be they think, there is no point to say.

– UD 2 FO FGD

"Relationship can be improved by training SAJIDA Bondhu. She should be monitored separately. SB should be assigned based on locality. SAJIDA Bondhu should be directly monitored what actually she doing".

-UC 1.1 FO FGD

As the second quote above shows, some field officers have a distrust of SBs and that they are undertaking and conducting their work adequately. This is a reason that some field officers have taken it upon themselves to monitor and act as the SBs' supervisor. While this is welcome by some branch managers due to their inability to directly supervise the SB others have the opposite complaint. The following passage highlights gets to the heart the problems the field officers' have with the SBs:

R1: There is some relationship gap between SAJIDABondhu and us because of branch. Sometimes SAJIDABondhu acts as a spy. She follows up the work of all employees. She

thinks that she is a monitoring agent of the manager, that's why she never counts us. That time, we try to avoid her. Officers are think all kind of talking is passing out by SB to manager. For this once SAJIDABondhu was familiar as "special battalion". They directly passed information from branch to head office. That time relationship declines. Head office can improve this relationship. If head office follow-up and monitoring the exact responsibilities whatever she supposed to do, then we think relationship will improve.

R2:*Apa [SAJIDABondhu] said that she is passing information to head office directly. How can she do? She can do because of power. I am a witness that if any male employee talks with female and laughing. Then she discuss that something is happening between them. If office or manager encourages doing their own job whatever she is supposed to do. Then I think this problem will be declined.*

R3:*If she has a boss to whom she should be accountable for every work, then problem can be solved.*

<div align="right">

-UD 2 FO FGD

</div>

As one branch highlights there maybe other reasons for the disagreements that are not due to the fault of any individual but a lack of understanding of their task:

"FO shows attitude. SB keeps silence. Nirapotta claims come. SB has to visit that. They impose that responsibility one to another. Furtherthefield officer does not give their comments. In this case, there are lots of problems. Lack of concentration on visit, SB can't work properly with Nirapotta claim."

<div align="right">

- UC1.1 BM FGD

</div>

All office relationships are fraught with complexities and in the case of the relationship between the SBs and their colleagues the solutions are easily identifiable. By working closer together the issues of communication and supervision can be overcome, especially with the addition of a technical supervisor. As the following quote highlights, there is a gap in the field officers' understanding and perception of how the SBs are supervised, and this gap must be bridged to improve the program:

"In office our boss is manager. We have to accountable to him, what actually we did in field, how many installments we collect how many left everything we had to explain to manager. But for SAJIDA Bondhu, she does not need to be accountable anybody in office. May be every month she has to explain to head office. But in field how many household she visits, what she did. Nobody in office to ask her this kind of questions."

<div align="right">

-UD 2 FO FGD

</div>

Recommendations

Programmatic
o Set clear aims and objectives of the CHP and it must be communicated with all stakeholders to ensure that everyone is aware of what the program hopes to achieve
o Core competencies for the SB should be set and communicated with all stakeholders
o Establish better relationship with health care providers to strengthen the referral system

Supervision
o   Hire technical supervisorswith a health background, ideally medical examiners or paramedics
o   Increased and regular field level monitoring, including the assessment of key skills
o   Ensure the communication protocol is followed
o   Review registers to increase usability and effectiveness

Training
o   Training aligned with core competencies and objectives
o   Localised refresher trainings that are conducted every three months that are flexible on the need of the SBs
o   Practical testing in the field within a certain time of basic training – 1-3 months to ensure minimum standards are met
o   Psychosocial counseling refreshers training
o   Identify and support weaker SBs

Interpersonal relationship
o   Conduct structured meeting with all branch staff to clarify program objectives, the role and responsibilities of both SBs and field officers and how it ties into the micro-finance program
o   Conduct regular and structured meeting at the branch level for the all members to update each other on their activities and their upcoming work

4.3 Nirapotta member perception of services

Having explored what those involved in the program from a management and delivery perspective this chapter explores the perception of the service users. As this program is unique amongst CHPs due to its funding model not only are the service users *beneficiaries*, they directly fund the program and as such their need and satisfaction is of the utmost importance.

Currently SF is the only organisation that provides a service such as this and as such it is important to understand how service users feel being a part of this program, what they are satisfied with and the areas that need to be strengthened. It is hoped that this learning will serve not only this program but also others seeking to replicate such a model.

This chapter aims to better ascertain service users' engagement with SF, how much they use and their opinion of the SBs and the service they provide, and if there were any needs that were being unmet that they felt the program should address.

Background

The SAJIDABondhus provide services to the SF'S group micro-finance borrowers take out a compulsary micro-insurance policy as a part of their loan, it covers five members of the policy holder's family as standard and two additional children can be added to the policy at an extra cost.

The loans are primarily taken by women are engaged in small cottage industry or take out the loans on behalf of their husband or sons, who are semi-skilled labourers or own their own small business. Given the areas that SF work there is a fluctuation as to the percentage of women in each group that are employed- in some areas the number is very high due to employment opporutnities in the ready made garments sector.

As mentioned in the methodology section, the surveys were conducted at the micro-finance group collection meetings in the morning with those members who had time. This is reflected in the data collected as the graph1 highlights, the largest majority of those who spoke to us were very regular to centre visits. We know from anecdotal information that only a third of members are regular to the meetings, another third are semi-regular and the final third are very infrequent- largely owing to the fact that they are employed and cannot make the meetings.

How often do members visit the center?

2% 3% 3% 2%

90%

- Less than once a month
- Once a month
- Twice a month
- Three times a month
- Four times a month
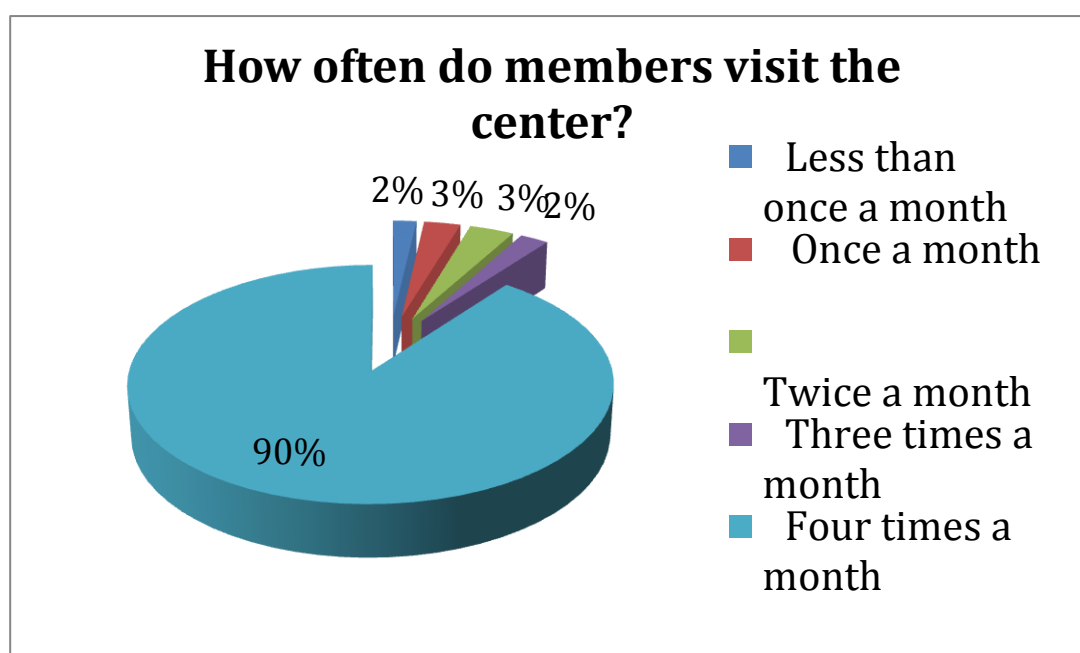
Graph 1: Frequency of visits

The other data that raises questions regarding the representation of the sample size is thatthe majority of respondents have been members for over 3 or more years (graph 2). The reason this is significant is that there is anecdotallyinformationthat an annual member turn over rate is 30%, and to have over 55% means that it might not be representative of all members.

How long have you been a member of SAJIDA Foundation (Nirapotta)?

3 Months+	30	6
6 Months+	44	8.9
1 Year+	82	16.6
2 Year+	65	13.1
3/3+ Years	272	55.1

Table 6: Service user

To reiterate, the surveys are not representative of all service users, but only those who come to the micro-finance collection centre meetings in the morning. The representation in the FGDs was wider as their were selected on having taken a service from the SB – as well as some non-service takers- in the previous three months, and as the majority of the services are non-centre based we are confident the data represents a more diverse group.

Awareness and utilization of services

From the surveys we found that majority of respondents could only name one or two of the seven tasks that the SBs undertake (graph 2). This was a very sobering as there are a number of services that the SBs provide at the centres alone, and as the majority of the members attend the meetings every week and the SB visits the centre on average every five weeks. Further more over 50% of members indicated that they had taken a service from the SB in the past three months (graph 3). This then indicates that people may view the SBs as a single service provider.
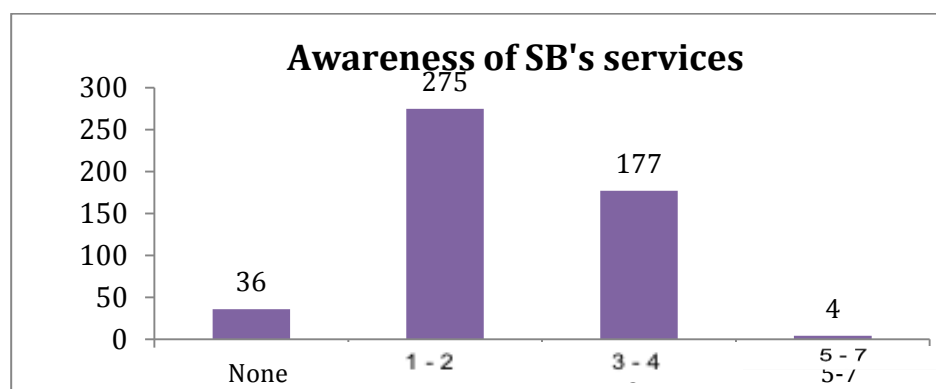
Graph 2: Awareness of SB's services
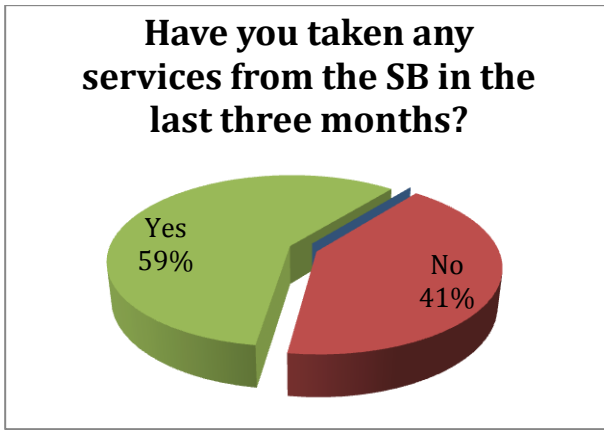
Graph 3: If service were taken in the past three months

The idea that the service users view SBs as single service givers further supported by the graph 4 as it shows the most popular service provided by the SB was getting their blood pressure measured and their weight measured. Receiving health information/advice, something that occurs during the meetings themselves, was the second most accessed service, followed by the buying of medicine, –something being phased out during the research- accessing maternal care services and being referred to other services. The data on graph 4 also shows no dental care was givenany member in the past 3 months.

Given that graph 2 shows that most members can only identify up to two services provided by the SB it is possible to conclude that most service users mostly remember the SB for the services that they take or have taken from her. It then does not matter if the service user has been a member for a long or short period of time, as they continue to use the same service.
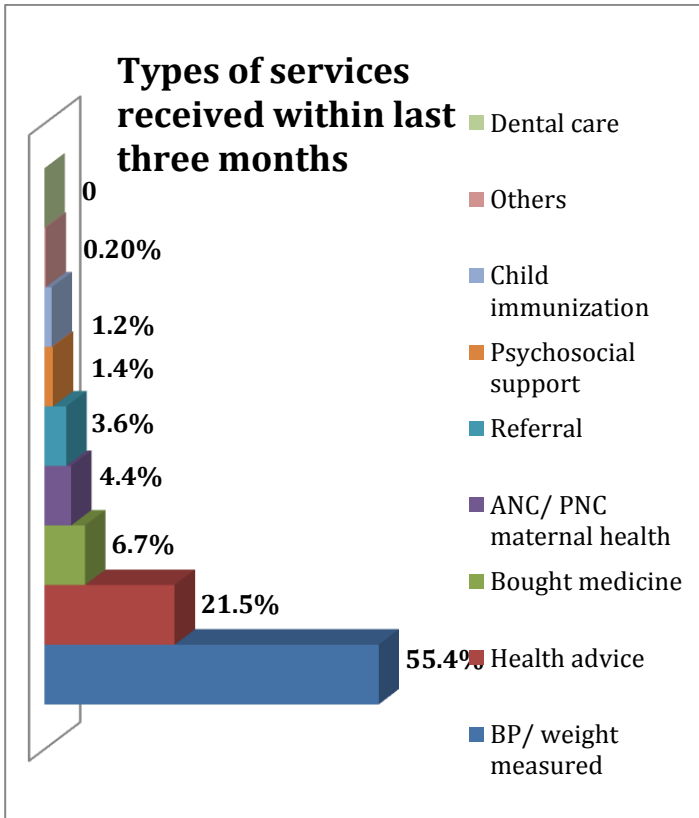
Graph 4: Types of services taken in the past three months

From the FGDs data we can start to understand why it is that members conceptualize the SBs as they do:

R 1:BondhuApa measures my blood pressure regularly. She also inquiries whether I am taking my medicine regularly or not. She also gives advice about health related issues. I am satisfied with her service.
R 2: I have never taken any service from her. She visits all the centers regularly. Sometimes we meet each other. But I have never taken any service from her. Overall, she is good.
R 3: She measured my weight and blood pressure. But I have never gone to any hospital with her. I am happy with her service and advice.
R 4: When I was pregnant, she did checkups. Now my baby is three months old and Apa regularly asks about my baby.

-UD 1.2 Member FGD

In this particular FGD when questions the attendees had taken the following services: 5 had their blood pressure and measured, 3 received maternal health services and 2 were given contact information of doctors.

"There are lot of health complication that can occur. She can't treat us but gives us suggestion. We consider this suggestion as a treatment. Because who will suggest us. Nobody has time to give suggestion."

-UD 2.5 members FGD

"Actually who are higher socioeconomic, they don't accept to SAJIDA Bondhu that much.On the basis of qualification and body fitness of SB, some members are accepting to her properly and some are not accept her. They tell that SB is giving just suggestion but not giving treatment. Because who has money, they have no problem to visit doctor by paying 400 tk or 500 tk".

-UD 1BM FGD

"She is very much important to us. We are ignorant; we don't give her importance that much. I have to busy with household work. If SB give extra time, it would be good."

-UD1.6 Member IDI

"She does not do other job. She gives medicine for common cold".

-UC 1.2 Members FGD

"Checkup pressure, when I was pregnant, that time she came to my home at regular basis. Even after delivery she followed up me. She suggested me to visit good doctor who are assigned in SAJIDA hospital".

-UC 1.2 Members FGD

As supported by the survey information the majority of service users get SBs to weigh them and measure their blood pressure. From the other quotes we see that members are aware of the limitations health workers and if they are able to afford it, they by-pass her services and access health professionals. For those who take her services they too are aware of the limitations of the SB's skills and rely on her for her knowledge of other service providers and her support.

From the data it is clear that the SBs are undertaking the three of their priority roles: conducting basic health checked; providing maternal and neo-natal support; and referral services to specialists. This is a very positive sign for the program as it seems that the SBs are able to undertake their tasks satisfactorily as the service users are accessing them. The only area that service uptake is extremely low, even though it is a priority is the information on child immunization. We did not explore why this was in greater depth but as there is a big national immunization campaign that is successfully run by the government, we feel that even if the SB spoke of the importance and location of the immunization camp the overlap of information with other service providers may have distorted the response.

Another program priority is to give emergency support to the members when they require support but from the survey less than half of the respondents were aware that the SBs provided this service. When probed 110 of the respondents said they had an emergency since they have been a service user, and just under half, 46 called the SB. When asked why the others did not they indicated that it was because 34% did not need the SB, 31% did not know that the SB could be contacted, and19% did not remember to call the SB. Of these responses 50% of those who did not contact the SB did were not able to do to, even though each member is given the SBs contact details and informed to contact the SB. This highlights that that the message needs to be strengthened as just over 25% of those who should have been served were unable to access a service they required.

Of those who accessed emergency services, 45 of the 46 were happy with the service received and the one person who was not was because the emergency was beyond the SBs' capacity and had to seek support elsewhere.

The fact that the members are overwhelmingly satisfied by the support they receive in cases of emergencies is also reflected in our qualitative data as a number of service users have indicated that they were able to access the SB when they needed her most, and she was able to help them overcome their problem:

"In any emergency situation, if we call her, she will be here to help us. She stands by our side in any need, and it is very important that there is someone who is always there with you."

-UD 1.5 Member IDI

"I keep her phone number. In emergency I call her. She gives me suggestion, what I have to do. Once I was sick, I forgot to vaccinate to my baby. I want suggestion from apa, she said to give vaccine to my child. I give two vaccines together to my child.

– UD 2.1 Member FGD

A final indicator for the program's importance to the service users is that when asked if there would be any problems in their lives with regards to their health care if there were no SBs, 65% (graph 5) indicated that there would be. This is 10% more than those who had taken services in the past three months, indicating that it is not only those currently taking services who would be affected. When asked what the problem would be, 44% (graph 6) said that it would reduce their access to health care services and 20% said it would result in them having to spend more time and money accessing services.

This clearly indicates that a large majority of the service users consider the SB as an important health care provider; even if she is a generalist and the scope of her interventions are very limited. Service users then rely on her and the program to help meet their health needs and has formed an important relationship with them:

"Whenever we call to Bondhuapa, immediately she come to our house. Nobody comes, but SAJIDA Bondhucome. We learned a lot of thing related to health from her. Pregnant women can checkup regularly. We can talk with her that is very important and confidential thing. She gives us very good suggestion. During crisis, she stays beside us. She follows up the child immunization. If any member forgets to vaccinate her child, then Bondhu ask to that mother to vaccinate her child".

-UC 1.2 memberrs FGD

R: We get many benefits and help form her; I cannot explain it in words. If she was not here, we will be in trouble. For example, in case of emergency, we can call her and take her advice. This is very important. She comes here every month and provides service. In this case I think her presence is an important part in our life. She is an indispensible part in our life.

UD 1.5 Member IDI
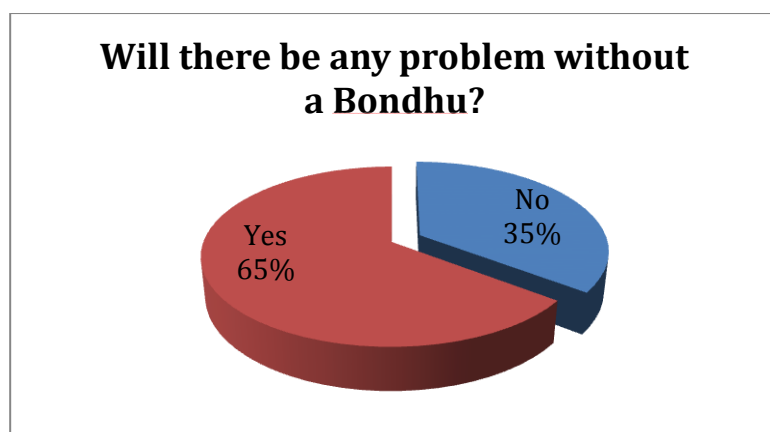
Graph 6: Would members have a problem if the CHP programme ceased?
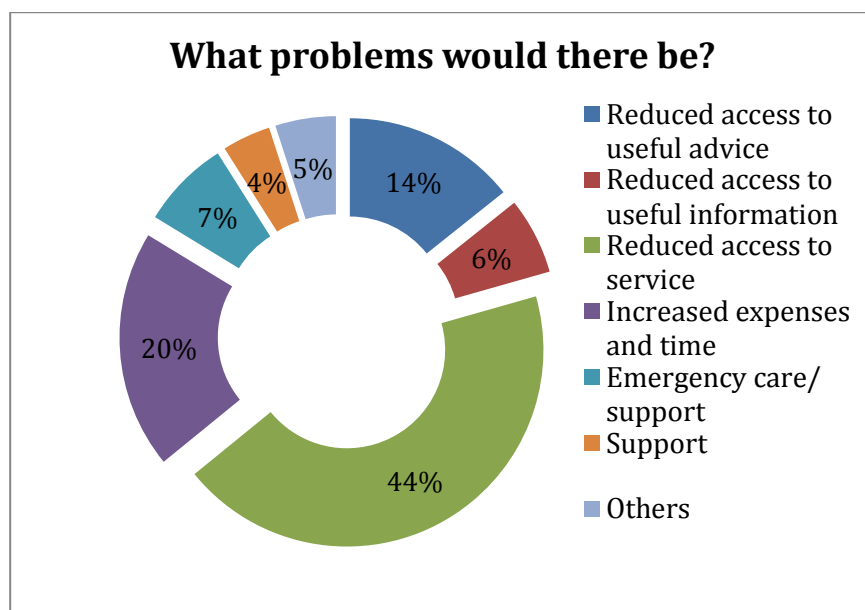
An important factor to recall here is that SBs may not be providing a service to the service users due to their being no need for a service. An important indicator as to how members assess the program is their relationship with the SBs and given the relatively low level of skill that the SBs have due to them being generalists. As a result it is possible that the members utilize the SBs in ways that are different from the manner in which they were conceptualized during the setting of the program. The next section explores this in greater detail.

Perception of SB

In the previous section we explored how members utilize the service and along with that it is important to understand why it is that they do so; in previous sections both service users and staff indicated that it was the relationship between the SBs and service users that is an important factor. In the first section we saw how the SBs saw themselves in the members' eyes: being respected, and being important in the lives of the service users due to the fact they are entrusted and enlisted for help and support for non-health related matters. Sometimes they are personal and very private issues that the members do not share with other people that they share with the SB.

This strong relationship built between the SB and the members is arguably the important achievement of the program, it is a means through which the SBs are able to discharge their work; providing health care to the service user and their family and in doing so bridges the gap into actually becoming their *bondhu*(friend)*.

Issues they will never share with their husbands, they share those issues with us. I hope you can understand. Husband is her own, but still he is a member and son of another family as well. He may taunt her.

– UD 1.1 SB FGD

Everyone in the community knows me. They share their problems with me. Nobody knew me before. Now they all behave nicely with me which was not there before.

- UD 1.2 SB IDI

Some doctors sometimes misbehave with the patient. I like her behavior & the way she talk. My son has a history of operation in the nose in USTC. I was feeling like hell there. If I had SB there at that time, it will very good. I feel like that if I can hear her I will be cure.

- UC 1.3 Member FGD

It is very important sir because we don't get anybody as a friend to whom we can talk frankly. We call to apa. She takes us to hospital. It is very important.

– UD 2.5 Member FGD

As the quotes above highlight this relationship between the SBs and the members is very important and it is this that has helped the program succeed in the ways that it has. By being a *friend* the SBs provide a service that is required and missing in the lives

of the members and through the implementation of the psychosocial counseling program this bond has been strengthened.

Psychosocial counseling workshops

The relationship between the SBs and the service users is an important factor that has led to the uptake of services and arguably the success of the program; the health workers are only partially seen as a health worker, they are also seen as a source of emotional support. This sentiment has been strengthened through the psychosocial workshops that are conducted by the SBs. As discussed earlier there is a need to strengthen the quality of the workshops through refresher trainings, from the service acceptance side however, there are other issues that surface.

In general the majority of those who received the workshops were satisfied, in the survey 72% of the respondents had completed the workshops and indicated that they were helpful to them. When probed as to why this was, the common response was that they were relevant and useful to their lives; some even indicating that these should be extended to other family members as it would be helpful for them too.

R. We did not go for higher studies. There are some issues we do not understand. If SB helps us about that, we can learn from her about these things. Then we can teach other people also.
Q. If you give me an example please?
R. Now a day's TV serials shows so many incidents, about child, about husband. I feel doubt in my mind about that. If I have clear idea about that, then problem will solved.

-UC 1.2 Member IDI

"I call her whenever there is any family problems which I have to manage like what to do, when to do, how to do. For example, my elder daughter reads in class 10. We have already got a proposal for her marriage. The bridegroom is well established, he is going to Saudi. We did agree for this proposal. But Bondhuapa has said me that my daughter has only completed 15 years. She advised me not to get her married so early. I liked her advices."

-RD 1.2 Members FGD

"If they arrange any program for our men, it would be good because one issue is addiction that is done by men. So it is very much essential to teach them directly in a same way they teach us. And this can be arranged in weekend day. Because in working day men are busy with their work."

- UD 2.1 Member IDI

In addition to the service users the trainings and workshops have also helped the SBs, as it has better prepared them for the field, they are not better equipped to answer the questions and give advice on issues apart from health. There is however a slight problem in the acceptance of the program as some field officers are not very supportive of the workshops, partly due to their interactive nature. It would be generally helpful to the program is field officers are better sensitized to the program as it will help raise

aware amongst the service users as to the workshops' acceptance amongst those who are yet to receive the sessions.

Generally it is recommended that the program be expanded, both geographically, to cover all branches, and in content, to include wider issues that may be region or context specific, and if possible other family members should be included.

A further recommendation is that as the SBs deal with the issues themselves, with little support –though there is support on demand from the psychosocial unit it is rarely accessed- cluster based support groups from SBs should be set up for them to refresh what that they learnt, and share possible issues that members have shared with them to help find solutions to them.

Nirapotta in general

One of the sub-questions in this theme was to learn how members felt regarding the Nirapotta (micro-insurance) program, if it was possible to increase the micro-insurance coverage rates, and whether the SBs' involvement in the program should be stopped.

With regard the micro-insurance it is compulsory and at a cost to the micro-finance borrower as they have to pay an additional sum at the time they receive their loan to qualify for their loan. The insurance scheme, the elements and the policy is explained to them at the time they withdraw the loan and afterwards by the SB who regularly inform the service users of the benefits and the five elements of the insurance.

From the surveys it is evident that most members are well informed regarding the program and the areas that they are insured with 44% being aware of 3-4 (graph 8) of the areas that they are covered. More importantly, in terms of issues 87% (graph 9) were aware that health was covered, 64% death but only 45% knew about disaster cover. The low rate of knowledge on disaster coverage is worrisome as this is a unique element of SF's micro-insurance program as is used as a selling point of the program. What this then means is that either disaster coverage is not very important to members, or the others are more important. Those who were aware of this however were very happy with this coverage, especially if they received a payout.
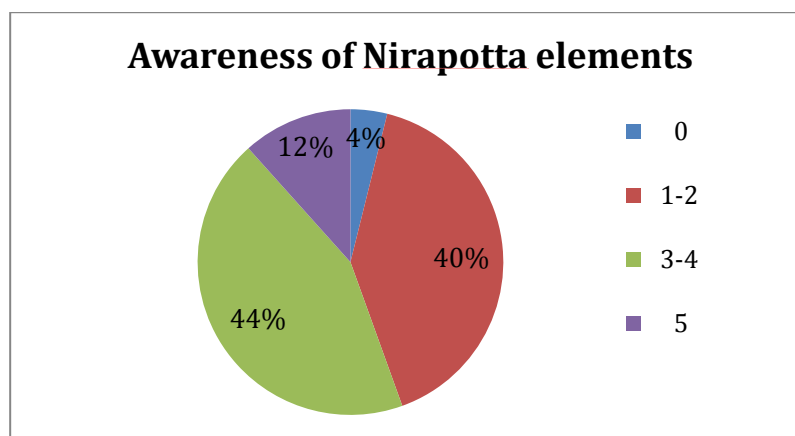
Graph 8: Service users' awareness of Nirapotta elements
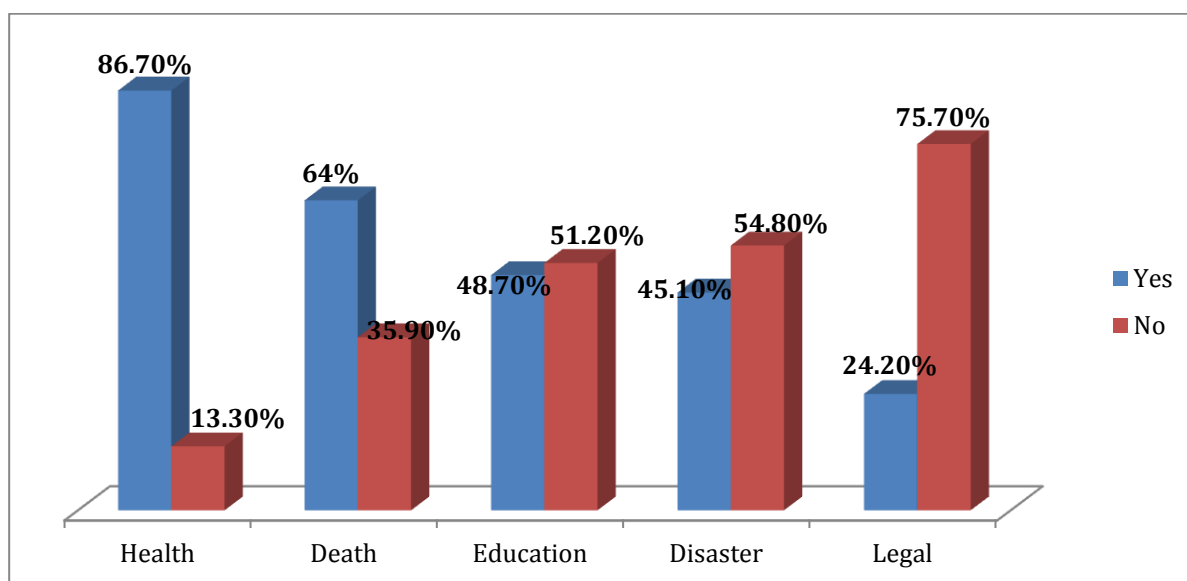
Graph 9: Knowledge of Nirapotta elements

Aside from the move for improvement of service users' knowledge of the different micro-insurance elements there is also some work that needs to be done to help strengthen the program from a delivery perspective. As mentioned in previous sections the SBs are untrained on how to conduct and undertake *claims management*, and as a result they are reluctant to undertake this task and/or make mistakes to the ire of their colleagues.

The question was asked if the SBs should continue or stop this task and there are many reasons for and against it: primarily that this will free them to conduct more health work and allow them to increase their coverage. We however feel that it is important that they continue: it is the only issue where all branch staff work together, which is important in building inter-personal relationships; it increases the SBs' contact with the service users, where they are usually the sympathetic face of the organization who is there to support them and on *their side;* and the SBs are able to undertake direct verification due to their embeddedness in the field, as these quotes highlight:

"SB is adding a great value to the micro finance program. She goes to the centers, house visits also. We can speed up our claims checking and paying because of her. She has been a great help in verifying many sensitive claims C-section, personal diseases of female members etc."

-UD2 FGD BM

"In branch -, one member's home and half of the poultry farm burnt. That time SAJIDA Bondhu was present there. She called me to come there. I immediately reached there with my branch manager and give ready cash after inquiry."

-UD1 FO FGD

For these reasons we recommend that the SB continue to work on claims management, but with training. We also learnt that the claims management system itself suffers from a number of problems. These have ben highlighted to the program's management separately.

Briefly on the issue regarding the micro-insurance is whether members are willing to pay more. The answer to this question for the majority is no or a very modest increase; eventhough some service users recognize that they are better off under the insurance scheme they are not willing to pay more. A small number are willing to pay more if the scope of the services were widened. There was a small minority who however wanted the charge to be lowered,this is because some members do not use the services of the SBs or feel that they receive any benefit from the insurance.

Additional needs

As it has been stated and is very clear to the service users, the SBs are generalists who are trained to give very basic primary care and for more complicated matters they refer to more specialized health professionals. To improve the services of the SBs by better meeting the needs of the service users we asked those surveyed what more they would like if the SBs were given additional training. From the responses the majority of the requests were information based and some additional services at the centres (graph 10), a number of which are achievable as they will not require much additional resources and fits in well with the SBs' remit as generalists.

Providing information on fitness, nutrition and family planning are all very possible, but some of the other requests, understanding of prescriptions and provision of other drugs is highlight improbable in this model. It will require the SB to be trained to a much higher level and may not be possible due to legal restrictions, unless more qualified health workers were employed.
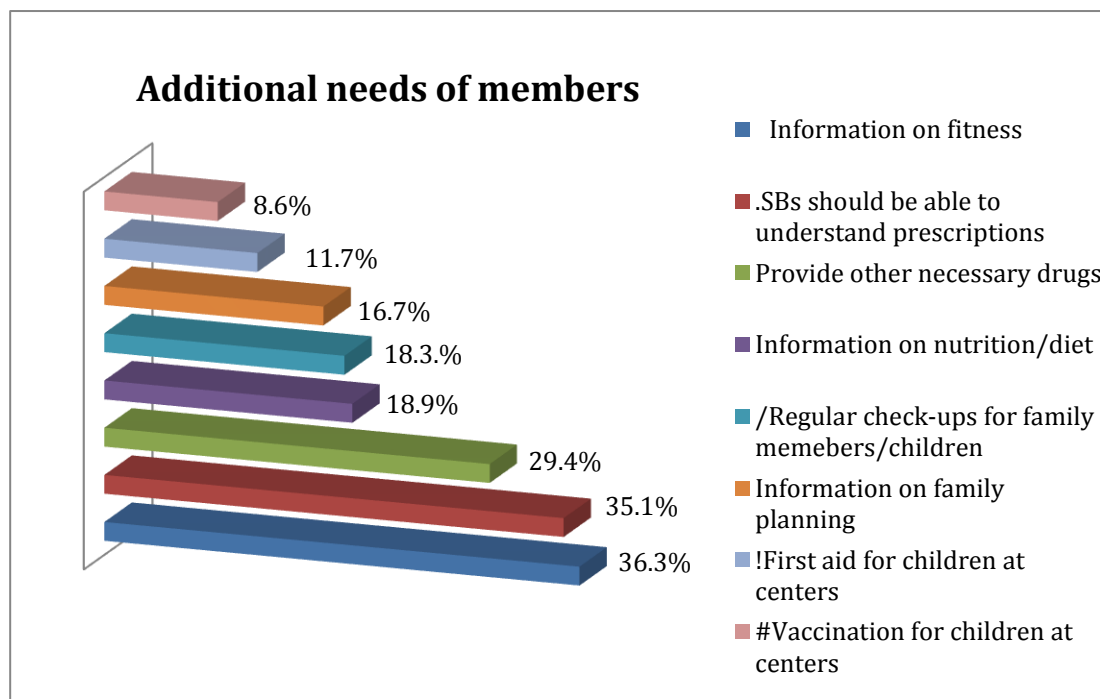
It is recommended those services which are feasible in the current model be included.

Challenges

The biggest challenge with regards to Nirapotta members lay in the fact that the SB is unable to meet with all the policyholders as they do not frequently visit the morning collection meetings as they are employed, and when the SBs make house visits they are not present either. This means that there is a section of the population that is underserved, and as the program takes funds from each policyholder it means that some are not getting a service they are entitled to. From a programmatic perspective there is little that can be done unless the SBs work a number of weekends so as to be able to meet the service users.

To make such a change it needs to be better understood if those who are not currently being reached require the service and to what extent, because it would mean reducing access to those who are currently receiving services. With the SBs' working hours being limited there needs to be a review of whether it is in fact necessary to reach all those who are policy holders or to concentrate on those who need the service. Here need is being defined as being those who require support and are unable to access other health care professionals. The reason for the later part of the definition is because there are service users who are able to afford and prefer to seek health and support from better-trained health care professionals. Since these individuals are able to access such a service the program should seek to engage those left at the margins who are unable to access services until their medical situation worsens, as delayed treatment is a typical health seeking strategy for those who have limited financial resources.

Another challenge is that the program is provides very general support and as a result some stakeholders do not feel it is adequate and want more services. One of the most common requests by service users was that the CHP provides female doctors, particularly gynecologists as there is a lack of female doctors in some areas, or there is a financial barrier in accessing them. Some even suggested that the SBs be trained in gynecological health so as to better help the service users. The other specialist requested was a pediatric doctor as the service users felt that there was also a gap in good, trusted child specialist doctors.

This raises a particular issue that we had been asked to investigate, should be SBs remain generalists or should they be made into specialists, or should a cadre of more specialized health care professional replace them?

From the findings of this report we feel that the SBs should remain generalists as this way they are able to develop their relationships with the service users that go beyond just being a resource for health issues. Given the limitations of the program it will not be possible to provide as many higher-trained health care professionals which will mean the contact between the health worker and the service user will reduce and will be replaced with a more rigid relationship.

What is recommended instead is if female and pediatric doctors are linked to the CHP so as to be able to provide health care that the service users require, this will strengthen the overall program by providing a higher standard of care for and boost the engagement of service users.

Some of the SB related challenges relate to the fact that the delivery mechanism for the health information and advice needs to be strengthened, as members did not recall the

information that is regularly provided. It is due to both delivery mechanism as currently the SB to speaks to a group without any materials, whereas the common practice is the use of BCC materials to visually stimulate the participants; the other reason owing to the fact that mixing the information giving sessions with the micro-finance loan collection means that most attendees are more interested in servicing their loans and do not come to the meetings with the aim of staying for longer than the necessary time to make the payment. As a result of this they do not pay a great deal of attention to what is being said as they are concentrating on the field officer and maybe in a rush to return home.

To overcome these issues it is recommended that standalone information giving workshops be instituted where the members come primarily for health related activities, and if possible these use audio-visual material to make them more effective and attractive. We recognize that the biggest problem with implementing this is that SF works primarily in urban and peri-urban settings were it is harder to find centralized locations to host such meetings without incurring a high cost. There maybe alternative methods of reaching the target population, especially if audio-visual tools are used and it is strongly suggested such an option is investigated, especially if further information giving modules are added to the program.

Recommendations

Programmatic
o The program needs to set a priority of who it aims to engaged, all policy holders equally or target those whom the SB can have a greater impact and require more support

Service delivery
o It is strongly recommended that the SAJIDABondhus remain generalists as their strengthen, and the strength of the program is that they are seen as more than health workers and are used to social and emotional support
o To strengthen and meet the need of the service users there should be an addition of higher-qualified health care workers in areas where there is a lack of service provision
o To strengthen the health information and advice giving sessions BCC materials should be incorporated
o The program should investigate the use of stand alone health sessions that are run around audio-visual tools

Psychosocial workshops
o The program should investigate conducting workshops with family members, particularly if it seeks to change familial behavior
o The scope of the program should be expanded, both geographically to cover all work area and more context specific themes for workshops should be investigated

Additional services
o SBs should be trained to provide information on fitness, nutrition and family planning

4.4 Rural/ Urban

One of the issues that SF wanted to investigate was if there was a big difference between rural and urban/peri-urban sites as currently there is no distinction between the two. From our findings there are a number of issues that distinguish the two different sites that can be categorized broadly as the need of the members and the need of the SBs.

Aside from geographical location, another distinguishing feature of the two is that in general rural branches have fewer numbers of service users and centres. This then means that the SBs may have less people to serve but over a greater distance as the centres and the members' houses are spread out, as opposed to in urban areas were it is not uncommon for the same site to house more than one centre and there to be a congregation of members in one abode.

Needs of rural service users

Owing to the lack of equitable distribution of health care facilities there is a much higher concentration in urban areas making it harder for rural service users access them. As a result the work of the SBs and the SBs are held in higher esteem in rural areas:

"We need to check our pressure, diabetes; we cannot go far away for this. So, SAJIDABondhu helps us this way."

-RD 1.1 Member FGD

"Bondhuapa provides health care service to us. The advantage is, we cannot share our feelings with a male. Our women have many personal problems; so it is an advantage for us that we have Bondhuapa. Suppose once I had uterine problem. When I went to Bondhuapa, she took me to the hospital and did treatment."

-RD 1.3 Member FGD

The quotes above highlight two key roles that the SBs' play, service referral and close-to-community service delivery, and these two services are what the service users rely on the most. This is because of a number of correlating factors, such as: rural areas tend to be more conservative and it is harder for women to travel alone, even fore medical purposes and as their husbands maybe busy they rely on the SBs to take them to health care facilities; the health care facilities are further away meaning that the members are unable or unwilling to go alone; due to the frequent visits the SBs make to the health facilities with service users they have developed good working relationships with them, this then helps facilitate quicker and sometimes cheaper access for service users.

The other major issue between rural and urban areas is again owing to the population being more traditional, as women are less likely to receive and adopt antenatal and maternal care and support. This the SBs, and some members attribute to the attitudes of the pregnant women's families as the quotes highlight:

This is a rural area; here many families prefer home delivery. Mother in laws, sister in laws, older persons and even neighbors believe in superstition, and they say that

pregnant mother should work hard, and it is beneficial for the fetus, when we try to counsel them. These services are important for the well being of both, newborn and mother.

- RD 1.2 SB IDI

When I ask the member to deliver her baby in the hospital, then husband, mother in law and other family members express different opinions, and they support home delivery. Once I was counseling the pregnant mother and suddenly her mother in law came in and said, "The rules were not like this before. There were no restrictions. I have 10 children. When I was pregnant, I did all household chores and nothing happened to me. After two days of delivery, I started working again." Then I tried to make her understand. Next she replied, "You will say many things now. Elder child was delivered at home, so was the next one." And, that baby was delivered at home, not in the hospital. They also do not want to dry clothes, wrappers and bed sheet of the babies in sun. They say it will cause illness and common cold of newborns, all the clothes should be dried inside the room on a rack.

*–**RD 1.2 SB IDI***

In situations where members refuse to consider facility births or the assistance of trained birth attendants the branch manager, area co-ordinator and even the cluster leader are meant to intervene to convince them to reconsider, or at least visit health care facilities. As this issue is a common national program, one that contributes to high levels of maternal and neo-natal mortalities, strengthening the relationship with local trained birth attendants and ensuring they visit the family is the only option available.

Once a family has decided that they will conduct a home birth their decision is not easily over turned, as a result it is important to provide them with the available facilities close at hand. Though this issue is al true for urban areas it is more salient in rural areas due to the large distances and low availability of trained health workers,it is therefore recommended that all pregnant mothers are introduced to their local trained birth attendants. In some cases the families may not allow access to the trained birth attendant but by being at hand if any complications do arise they will be able to respond immediately.

Rural SAJIDABondhus

A major difference between urban and rural SBs is the distances between the houses of service users as are greater and they generally cover a wider geographic area. The pay and travel conveyance of rural and urban SBs are the same though those in rural areas having to spend more in transport and travel and incur greater out of pocket expenses, sometimes twice as much. This is something that can and should be addressed

Owing to the greater geographic spread of service users it is also harder for the SBs to cover visit as many members' houses and conduct follow-up visits and from the discussions we learnt that in rural areas there is a higher preference in receiving services individually and at home; owing to distances to the centres and the greater privacy it affords:

"We have to go to the center every week, but as it is far; so become tough for us. So, if she comes to our houses, it becomes good."

– RD 1.1 Member FGD

"Often it is seen that, members, if fall sick; cannot go to the center. If apa comes, then she does not have to suffer too much."

-RD 1.3 Member FGD

"They think that if she goes to houses, they can share personal things with her."

- RD 1.3 Member FGD

It is also important to recall that the number of service users a rural SB may have to serve is lower but the level of level of service required may be more intensive, as the previous section showed. Another distinguishing feature between the two location types is that it would be much easier to organize and conduct *courtyard* type meetings to discuss with the service users, especially as this is a format they would already be used to. It is therefore recommended that the SB reduce the number of centre visits they make a month an undertake health awareness sessions. By conducting the health awareness workshops the SBs will also free up more time in the mornings to conduct more house visits as the sessions would last up to an hour, giving her an extra hour and a half on the mornings the sessions take place.

Another recommendation for rural sites is that relevant health care professionals conduct health camps; from the information from service users, the branch staff and the health workers, the majority of rural sites where SF is based do not have medical facilities and they lack female doctors. This is a proven method of increasing access to health care in areas where access is a problem, and given the qualifications of the SB they are unable to meet the needs of the service users. The current method of referring and taking patients to health care providers is able to meet some of the needs but is not ideal as this causes delayed treatment. If treatment was provided more locally it would move towards overcoming this problem.

Recommendations

o Strengthen relationship with trained birth attendants in rural areas
o Conduct *courtyard meetings* on health issues
o Increase the number of house visit
o Set up health camps on relevant health issues
o Increase SBs' travel conveyance if they are covering rural areas

4.5 Value added by SAJIDA Bondhu

In the final section we would like to conclude on a few brief remarks regarding the SAJIDABondhus as they are instrumental in the program but their impact is far wider reaching than that, they have become the organisations' ambassador and information source in the community.

As the SBs are from the community in which they are to work they have a better relationship with those who live there and know the individuals better than in the office. This has a very positive impact on the micro-finance and micro-insurance

programs as they are able to verify the information faster and through alternative, more organic sources. As a result of this the organisation is able to provide better service- in case of micro-insurance- and save the organisation from risk by helping in the vetting of prospective new borrowers.

In addition to this service the SB is also a marketing and advertising advantage. The SBs all don an apron with the organisation's name emblazed on it and due to this she is highlight visable within the community; a result of which members of the general public are aware that the organization provides a particular service that other micro-financneorganisations do not, targeted health care for their service users. Given the competitive micro-finance market where the potential clients are well informed regarding the different organisations and with very little that distinguishes one from another, having a visible additional program like this is a benefit.

This distinction that the organisation receives though mostly positive does have a negative aspect; potential borrowers are aware that there is a higher cost of borrowing at SF as they do not understand the distinction between the micro-finance costs and the micro-insurance one. Greater work needs to be done to help people understand the difference and the benefits of micro-insurance, and the SB is ideally located to help do that.

The SB may also have a big benefit in relation to existing members as well as it shows members the organisation cares about their health and wellbeing, and are not like other micro-finance institutions that only care about interested in debt servicing. As explored in great depth earlier the SFs develop a personal relationship with the service users and through this it is important to the service users.

A final point is that the SBs help ensure that the service users and their families are healthy and this then means that they service users are better able to repay their loan. This makes good business sense for an organisation whose sustainability is dependent on their loan portfolio being serviced regularly without a high level of default. One of the main reasons borrowers default on their loan is because the of poor health, either theirs or their family members' which results in missing work, or the additional household expense of health care cost.

Overall, the addition of the SAJIDABondhu has been widely greeted positively by all stakeholders as a unique and distinguishing feature of the Foundation's work.

5. Conclusion and recommendation

From our study we have found that the community health program benefits the service users in a number of ways: it reduces barriers in seeking health care through its close to community delivery model; it provides access to services to people who may otherwise not have access to some of the services, especially the psychosocial workshops; and helps to strengthen the health seeking behaviour of the services users by providing useful information, or taking them to the relevant health care professional. The health worker functions as more than a health worker as they provide emotional and personal support to the service users and their family on a wider range of issues. In addition to the issues mentioned that are a number other positives that are derived from that program as the previous sections detail.

When setting questions for this study, one was set that asked whether the health workers should be retrained as specialists in different health issues and from our findings we feel they should not. The SAJIDA Bondhus should instead be retrained on a number of key issues that they are currently working on, there a number of additions that should be made to their work portfolio but they should remain generalists. The main reason for this, as mentioned above, is that the SBs are performing more than a health service, having developed close and personal relationships with service users they are able to give them support than they would otherwise not be able to do if they were specialized in one particular area. The SBs would not have the time to build these relationships with service users if they became highly trained health care professionals due to a shift in the focus of their work. To improve the quality of care trained, technical supervisors should be introduced, allowing the SBs to continue what they do best.

There is however a number of issues that needs to be addressed to improve and strengthen aspects of the program, the most important we feel is to have clearly defined aims, objectives and core competencies for the SBs. This is something that is currently missing, and as a result there approach to the program is cohesive that it would otherwise be. Different stakeholders have different inclinations of what the program is and should be, this creates conflict and inhibits the SBs from undertaking their work as effectively as they could. Once the aims and objectives are set it will be important to communicate them with all stakeholders to ensure that everyone is aware of the direction of the program.

Other key recommendations are:

Programmatic
o Establish better relationship with health care providers to strengthen the referral system
o Undertake regular assessment and appraisal of SBs
o Set a priority of who the program aims to engage, all policy holders equally or target those whom the SB can have a greater impact and require more support

Supervision
o Hire technical supervisors with a health background, ideally medical examiners or paramedics

- Increased and regular field level monitoring, including the assessment of key skills
- Ensure the communication protocol is followed
- Review registers to increase usability and effectiveness

Human resource
- Raise SBs salary and increase their travel and mobile phone bills as they incur a lot of out-of-pocket expense in these areas
- Make SBs permanent staff

Training
- Training aligned with core competencies and objectives
- Localised refresher trainings that are conducted every three months that are flexible on the need of the SBs
- Practical testing in the field within a certain time of basic training – 1-3 months to ensure minimum standards are met
- Psychosocial counseling refreshers training
- Identify and support weaker SBs

Service delivery
- To strengthen the health information and advice giving sessions BCC materials should be incorporated
- The program should investigate the use of stand alone health sessions that are run around audio-visual tools
- SBs should be trained to provide information on fitness, nutrition and family planning

Interpersonal relationship
- Conduct structured meeting with all branch staff to clarify program objectives, the role and responsibilities of both SBs and field officers and how it ties into the micro-finance program
- Conduct regular and structured meeting at the branch level for the all members to update each other on their activities and their upcoming work

Psychosocial workshops
- The program should investigate conducting workshops with family members, particularly if it seeks to change familial behavior
- The scope of the program should be expanded, both geographically to cover all work area and more context specific themes for workshops should be investigated

Rural working areas
- Conduct *courtyard meetings* on health issues
- Increase the number of house visit
- Set up health camps on relevant health issues
- Increase SBs' travel conveyance if they are covering rural areas

Overall, the addition of the SAJIDA Bondhu has been widely greeted positively by all stakeholders as a unique and distinguishing feature of the Foundation's work.
We are confident that if these changes are implemented properly the gaps and weaknesses of the program can be successfully overcome.

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Annexure 1 : Research Tools

wbivcËv m`m¨ Rwic

1(a) Survey for Nirapotta Members

ZvwiL: M‡elKe„›`:

Date: Researchers:

mvÿvrKvi ïiæi mgq :   mvÿvrKvi mgvwßi mgq:
Start of interview: End of interview:

kvLv †KvW :   Rwic bs:
Branch ID: Survey No:

1) MZ wZb gv‡m Avcwb mv‡R`›v eÜzi KvQ †_‡K †Kvb †mev wb‡q‡Qb wK? nu¨v / bv

<div style="border:1px solid">If **NO** to Q1) skip to Q2)</div>

   1.1) ‡mevi aib:
      K) GGbwm/ wcGbwm/ Mf©Kvjxb d‡jvAvc †mev
      L) wkï¯^v¯’¨ I UxKv msµvšÍ d‡jvAvc
      M) †idv‡ij †mev
      N) g‡bvmvgvwRK mnvqZv
      O) ‡W›Uvj †mev
      P) †PKAvc : †cÖmvi gvcv / IRb gvcv / Wvqv‡ewUm †U÷
      Q) exgv `vwe
      R) Ab¨vb¨ ....

1) Have you taken any service from the SB in the last three months? Yes / No
    1.1) What was the nature of the service?
      a) ANC/PNC/Maternity follow-up
      b) Children's care
      c) Referral services
      d) Psychosocial care
      e) Dental Care
      f) Check up: BP/ weight / Diabetes
      g) Insurance claim
      h) Other
....

   1.2) Avcwb †Kv_vq mv‡R`›v eÜzi KvQ †_‡K †mev wb‡qwQ‡jb?
      K) kvLv
      L) †K›`ª
      M) evmv
      N) nvmcvZvj
      O) Ab¨vb¨ ....
   1.2) Where did you take the service from SB?
      a) Branch
      b) Centre

c) Home
e) Hospital
f) Other..

1.3) mvavibZt Avcbvi mv‡_ mv‡R`v eÜzi KZw`b cici †`Lv nq? (Prompt/ read)
        K) cÖwZ mßv‡n
        L) cÖwZ gv‡m
        M) 2 gv‡m GKevi
        N) 3 gv‡m GKevi
        O) wbwðZ bB

1.3) How often do you see the SB?
        a) Weekly
        b) Monthly
        c) Every two months
        d) Every three months
        e) Not sure

2) †kl K‡e Avcwb mv‡R`v eÜzi KvQ †_‡K †mev wb‡qwQ‡jb?...

2) When was the last time you interacted with the SB? ....

3) GKRb mv‡R`v eÜzi KvQ †_‡K wK wK †mev cvIqvi K_v? (Do not prompt/Do not read the following options)

K) GGbwm/ wcGbwm/ Mf©Kvjxb d‡jvAvc †mev   L)wkï ¯^v¯’¨ I UxKv msµvšÍ d‡jvAvc   M) †idv‡ij †mev   N) g‡bvmvgvwRK mnvqZv   O) ‡W›Uvj †mev   P) †PKAvc : †cÖmvi gvcv / IRb gvcv / Wvqv‡ewUm †U÷   Q) exgv `vwe   R) Ab¨vb¨ :..

3) What services should be provided by the SB:
  a) ANC/PNC/Maternity follow-up   b) Children's care
  c) Referral services   d) Psychosocial care
  e) Dental Care   f) Check up: BP/ weight / Diabetes
  g) Insurance claim   h) Other ....

4) mv‡R`v eÜzi KvQ †_‡K Avcwb Avi wK wK †mev †c‡Z Pvb?
  K)   L)   M)
  N)   O)   P)
  Q)   R)   S)

4) What other services would you like from the SB?
  a)   b)   c)
  d)   e)   f)
  g)   h)   i)

5) Avcbvi cwiev‡ii KZRb m`m¨ mv‡R`v eÜzi KvQ †_‡K †mev †c‡q‡Q?

K) ‡KD bv   L) 1 Rb   M) 2 Rb   N) 3+

5) How many of your family members have used services from the SB?
   a) None   b) 1   c) 2   d) 3+

6) Avcbvi †K‡›`ªi ‡KD wK mv‡R`v eÜzi KvQ †_‡K †mev wb‡q‡Qb? nu¨v / bv/ wbwðZ bB
   6.1) KZRb? ....
   6.2) Zviv wK wK †mev wb‡q _v‡Kb? ....

6) Do you know of anyone from your centre who uses the SB service? Yes / No/ don't know
   6.1) How many?
....
   6.2) What services do they get?
....

7) Riæix cÖ‡qvR‡b / Bgv‡R©Ýx‡Z Avcwb wK KL‡bv mv‡R`v eÜzi mv‡_ †hvMv‡hvM K‡i‡Qb?
nu¨v / bv
   7.1) mv‡R`v eÜz wK Avcbv‡K mvnvh¨ Ki‡Z †c‡iwQj? nu¨v / bv
   7.2) hw` bv nq, Z‡e mv‡R`v eÜz wK Avcbv‡K Ggb †Kv_vI wb‡q †h‡Z †c‡iwQj †hLvb †_‡K
Avcwb mvnvh¨ †c‡q‡Qb? nu¨v / bv
   7.3) ‡m mgq mv‡R`v eÜzi †mev wb‡q wK Avcwb mšy'ó? nu¨v / bv

7) In case of an emergency have you ever contacted the SB? Yes / No
   7.1) Was the SB able to help you? Yes / No
   7.2) If not, was the SB able to take you somewhere you could get the help needed? Yes / No
   7.3) Were you satisfied with the service provided by the SB? Yes / No

8) hLb mv‡R`v eÜz †K‡›`ª Av‡mb ZLb wZwb ¯^v¯’¨welqK †Kvb †Kvb K_v e‡jb? When the SB comes to the centre what health issues, does she speak about?

....
....
....
....
....
....

9) Avcbvi g‡Z mv‡R`v eÜz Avi wK wK Z_¨ w`‡j Avcbvi fvj n‡Zv? In your opinion, what other Information could the SAJIDA Bondhu provide that would be beneficial for you?

....
....
....
....

58

....
....

10) mv‡R`v eÜz Avi wK wK †mev cÖ`vb Ki‡j Avcwb Zv e¨envi/ MÖnb Ki‡eb? Would you use the SB services more if she provided different services? What could they be?

....
....

....
....

....
....

11) Avcbvi g‡Z, mv‡R`v eÜzi me‡P‡q ¸iæZ¡c~Y© KvR wK Riæix/ Bgv‡R©Ýx †mev cÖ`vb Kiv? nu¨v / bv
   11.1)mv‡R`v eÜz Ab¨ wK wK KvR K‡i?

....
....
....
....

11) In your opinion, is the primary role of SAJIDA Bondhus to provide emergency support? Yes/No
   11.1) What other roles do you think they play?

12) mv‡R`v eÜz wK KLbI Avcbv‡K / Avcbvi cwiwPZ KvD‡K mv‡R`v nvmcvZvj ev Ab¨ †Kvb nvmcvZv‡j wb‡q †M‡Qb? nu¨v / bv
   12.1) KZ w`b Av‡M? ....
   12.2) Avcwb wK mv‡R`v eÜz†K nvmcvZv‡j wb‡q hvIqvi Rb¨ Aby‡iva K‡iwQ‡jb? nu¨v / bv

12) Has the SB ever taken you or anyone you know to SAJIDA Hospital, or any other hospital? Yes /No
   12.1) When?..
   12.2) Did you request to be taken by the SB? Yes/ No

<div style="border:1px solid #c0504d; display:inline-block; padding:4px;">If NO to Q12) skip to Q13)</div>

13) Ggb wK KLbI n‡q‡Q †h Avcwb mv‡R`v eÜz†K nvmcvZv‡j wb‡q hvIqvi Rb¨ Aby‡iva K‡iwQ‡jb wKš‘ mv‡R`v eÜz Avcbv‡K wb‡q hvbwb? nu¨v / bv
   13.1) mv‡R`v eÜz wK Zvi bv †h‡Z cvivi Kvib e‡jwQ‡jb? nu¨v / bv
   13.2) KvibwU ejyb
....

   13.3) Avcbvi Kv‡Q wK KvibwU hyw³m½Z g‡b n‡h‡Q? nu¨v / bv

13) Have you ever requested that the SB take you to a hospital but was not able to? Yes/ No
   13.1) Did the SB tell you why she was unable to? Yes/ No

<div style="border:1px solid #c0504d; display:inline-block; padding:4px;">If NO to Q13) skip to Q14)</div>

13.2) If yes, what was the reason? ....

13.2) Do you feel that her reason was valid? Yes/ No

14) Avcwb A_ev Avcbvi cwiwPZ †KD wK KLbI mv‡R`v eÜz m¤ú‡K© Awf‡hvM K‡iwQ‡jb/ Ki‡Z †P‡qwQ‡jb? nu¨v / bv

    14.1) Avcwb A_ev Zviv Kvi Kv‡Q Awf‡hvM K‡iwQ‡jb? ....

    14.2) †Kvb e¨e¯’v †bIqv n‡qwQj wK? nu¨v / bv

    14.3) wK e¨e¯’v †bIqv n‡qwQj? ....

    14.4) M„nxZ e¨e¯’v wb‡q Avcwb wK mš‘ó? nu¨v / bv

    14.5) Avcwb †Kb Awf‡hvM K‡ib wb? ....

14) Have you or anyone you know had to/ wanted to complain about the SB? Yes / No

    14.1) Who did you/they complain to? ....

    14.2) Was any action taken? Yes / No

    14.3)What action was taken?...

    14.4) Were you/they satisfied with the action taken? Yes / No

    14.5) What was the reason you did not file a complaint? ....

> If **NO** to Q14) skip to Q15)

15) Avcwb hw` mv‡R`v eÜzi †Kvb KvR ev †mevi cwieZ©b Ki‡Z Pvb Z‡e Zv wK? If you could change anything about the SB's services or work, what would it be?

....
......

....
......

16) mv‡R`v eÜz bv _vK‡j Avcbvi ‡Kvb mgm¨v / Amyweav n‡e wK? nu¨v / bv. If the SB was not present would it this cause any problem for you? Yes / No

    16.1) mv‡R`v eÜz bv _vK‡j Avcbvi wK ai‡bi mgm¨v n‡e ? What would the problems be?

....
....

....
....

....
....

17) Avcwb Ab¨ †Kv_vq / Kvi KvQ †_‡K (webvg~‡j¨ ev UvKv w`‡q) ¯^v¯’¨ msµvšÍ Z_¨ I †mev †c‡q‡Qb (ms¯’vi bvg wjL‡Z n‡e)? Who/what, are your other sources of health information and services (free or otherwise)?

....
....

………
………

………
………

18) Avcbvi g‡Z wK AviI †ewk wPwKrmv, †ivM wbY©q I Jla msµvšÍ †mev †`Iqv DwPr? nu¨v / bv
18) Would a more clinical/medical intervention be better suited? Yes / No

19) Avcwb wK KLbI mv‡R`v eÜzi KvQ †_‡K g‡bvmvgvwRK mnvqZv †c‡q‡Qb? r

   19.1) g‡bvmvgvwRK mnvqZv m¤ú‡K© Avcbvi gZvgZ wK?

………
………

………
………

………
………

19) Have you ever received any psychosocial support from the SB? Yes / No
   19.1) What did you think about the support?

………
………

………
………

………
………

20) g‡bvmvgvwRK mnvqZv m¤ú‡K© †Kvb d‡jvAvc Kiv n‡q‡Q wK bv ? nu¨v / bv
   20.1) wKfv‡e d‡jvAvc Kiv n‡q‡Q ?

………
………

………
………

20) Has there been any follow-up in this regard? Yes / No
   20.1)
How?……

………
………

………
………

21) g‡bvmvgvwRK mnvqZv ‡_‡K Avcwb wK †Kvb DcKvi †c‡q‡Qb? nu¨v / bv

21.1) wK DcKvi †c‡q‡Qb ?

……
………

……
………

21) Would you say that it has helped you? Yes / No
    21.1)
How?………..

……
………

22) g‡bvmvgvgvwRK mnvqZ †K AviI wKfv‡e DbœZ Kiv hvq? How do you think it could be
improved?

……
………

……
………

23) ÿz`ª exgv Kg©m~wPi AvIZvq cÖ`Ë Avw_©K myweav/ webvg~‡j¨ †mev †Kvb&¸‡jv? Which
    of these are covered by the Nirrapotta insurance program? (Please indicate whether the
    following is True/ False)

a) nuvofv½vi wPwKrmvi †ÿ‡Î Avw_©K myweav (Insurance payout in case of Fractures)
True/ False

b) ‡h †Kvb nvmcvZv‡j webvg~‡j¨ †Pv‡Li Qvwb Acv‡ikb (Free cataract operation everywhere)
True/ False

c) ¯¿x-‡ivM I cÖm~wZ RwbZ Acv‡ik‡bi †ÿ‡Î webvg~‡j¨ mv‡R`v eÜz KZ…©K †mev
    (Obstetrical Gynecological surgery free service by SB)
True/ False

d) mv‡R`v nvmcvZv†j webvg~‡j¨ GgweweGm Wv³v‡ii civgk© (Free advice from a doctor
    SAJIDA Hospital)
True/ False

e) K¨vbmvi wPwKrmvq webvg~‡j¨ †mev (Free service in case of Cancer treatment)
True/ False

f) webvg~‡j¨ Mf©eZx †PKAvc| Free pregnancy checkup
True/ False

g) GKeQ‡i hZ¸‡jv `iKvi ZZ¸‡jv `vex †gUv‡bv nq| Unlimited claims a year
True/ False

h) mv‡R`v nvmcvZv†j webvg~‡j¨ ¯^vfvweK †Wwjfvix| Free normal delivery

True/ False

i) nvmcvZv‡j 2 w`b fwZ© _vK‡j| (Spending 2 days in hospital)
True/ False

j) gv_vq AvNvZ cvIqvi Kvi‡b wbR evmvq wPwKrmv †`Iqv| Home care for head injuries
True/ Fals
Avcbvi †Kvb gZvgZ,cÖkœ ev civgk© _vK‡j ejyb (Do you have any other comments, questions or suggestions?)

2.a: SB In-depth Interview Questions

THEME 3/1

1) Avcbvi KvR My‡jvi g‡a¨ ‡ekx ¸iyZ¡c~Y KvR †Kvb ¸‡jv ejyb| G KvR My‡jv †Kb ‡ekx ¸iyZ¡c~Y ? (How do you prioritize your work)? - ideal & actual situation
   a. ¸iyZ¡ Abyhvqx Kv‡Ri ZvwjKv (Ranking of activities)
   b. `vßwiK KvR /gvV chv©‡q KvR (Clerical vs clinical)

2) Preparedness
   a. Recruitment process/career:
      i. Avcwb †Kb mv‡R`veÜy nIqvi wm×všÍ wb‡qwQ‡jb (Why did you decide to become a Bondhu)?
      ii. Avcbv‡K wb‡qvM ‡`Iqvi mgq †h B›UviwfD n‡q‡Q Zv m¤ú‡©©K ejyb| (How were you recruited? Please describe the process).
      iii. Avcbvi PvKzix Rxe‡bi jÿ¨ wK? 1 eQi ci wb‡R‡K †Kv_vq †`L‡Z Pvb (What are your career aspirations/goals? Where do you see yourself in year or so)?
   b. Training:
      i. ‡Uªwbs mgq †Kvb g¨byqvj/ eB †c‡q‡Qb wK? †c‡q _vK‡j c‡o‡Qb wK? G‡jv Avcbv‡K Kv‡Ri †ÿ‡Î KZUzKz mvnvh¨ K‡i (Have you received and read through any materials/written instructions? Was this useful)?
      ii. ‡Uªwbs mgq †kLv †Kvb welqwU gvV ch©v‡q Avcwb me‡P‡q fvjfv‡e e¨envi Ki‡Z cv‡ib Ges †KvbwU e¨envi Ki‡Z me‡P‡q Amyweav nq? Av‡jvPbv Kiyb (In terms of content, please discuss what you feel most and least confident about). – *give examples if needed*
      iii. ‡UªBbvi Ges ‡Uªwbs wel‡q Avcbvi AwfÁZv e¨³ Kiyb (Please describe your experience of the training provided in terms of the trainer and the content).
      iv. mv‡R`veÜy wn‡m‡e KvR Kivi Av‡M ¯^v¯^¨ welqK Ávb _vKv GB ‡ewmK ‡Uªwbs Rb¨ KZUzKz ¸iæZ¡c~b© (In your opinion, how important is prior knowledge in this regard)?
   c. Support:
      i. ‡Kvb †Kvb ‡ÿ‡Î Avcbvi mnqZv cÖ‡qvRb (Where would like more support? (Eg. medical/clerical/time management etc.) – *give examples if needed*

3) Capacity & challenges

a. mv‡R`v eÜz wn‡m‡e Avcbvi K‡Ri g‡a¨ †Kvb ai‡bi Ae¯'v Avcbv‡K mš'ó / Lykx K‡i?  D`vnib w`b (What gives you job satisfaction/ makes you happy as a SAJIDA Bondhu, give examples)|

i. Kv‡Ri †ÿ†Î wK ai‡bi evavi m¤§yLxb nb (What hinders you from providing services as you would like) – *give examples if needed*

b. Avcwb wKfv‡e m`m¨‡`i AviI fv‡jv †mev w`‡Z cvi‡eb? (How can you better serve the members).

8) Õmv‡R``veÜyÕ wn‡m‡e KvR Kivi evav/ mgm¨v ¸‡jv wPwývZ Kiæb (Please outline challenges in working as a Bondhu)

a. Avcbv‡`v wK AviI cÖwkÿb cÖ‡qvRb (Do you want more training)?

b. Avcwb wK ‡Kvb GKwU ‡ÿ‡Î `ÿ n‡Z AvMÖwn? (Would you like to specialize in a particular area? If so, what)?

4) <u>Community acceptance</u>

a. wbivcËv m`m¨‡`i mv‡_ Avcbvi m¤ú©©K †Kgb Av‡jvPbv Kiæb. Avcwb wKfv‡e wbivcËv m`m¨‡`i KvQ †_‡K wdWe¨vK cvb (How would you describe your rapport/relationship with the community? How do you get feedback from the community)?

b. Õmv‡R``veÜyÕ‡K KZUzKz m¤§vbRbK †ckv wn‡m‡e gvV chv©‡q g~j¨vqb Kiv nq (Is this viewed as a respectable profession)?

c. m`m¨iv wK ai‡bi mgm¨v wb‡q Avcbvi Kv‡Q Av‡m? D`vnib w`b (Do people come to you with problems? If so, what kind? Please give examples).

d. ‡hme wel‡q Avcbvi `ÿZv Kg †m‡ÿ‡Î Avcwb wK K‡ib (How do you solve the problems you are less equipped to deal with)?

THEME 2

5) <u>Community needs</u>

a. gvV chv©‡q Avcbvi ‡mev¸‡jvi Pvwn`v/ cÖ‡qvRb Abyhvwq ZvwjKv ˆZix Kiæb (Ranking existing services provided)
<mark>LIST</mark>

b. gvV chv©‡q Avcbvi Avi wK wK ‡mev ‡`qv DwPr e‡j g‡b K‡ib (What services/activities do you feel are missing, if any)?

THEME 2/3

6) <u>Psychosocial</u>

a. Avcbv‡`i †K †h g‡bvmvgvwRK mnqZvi †Uªwbs †`qv nq Zv m`m¨‡`i wVKg‡Zv g‡bvmvgvwRK mnqZvi †`qvi Rb¨ h‡_ó wK bv (Do you feel that psychosocial training is adequate)?

b. Avcwb wK g‡bvmvgvwRK mgm¨vi mgvavb Ki‡Z cv‡ib, Av‡M wKfv‡e K‡i‡Qb cÖwK¶qvwU ejyb| (Are you able to solve problems? Tell us how you have tackled problems. Please map the process).

c. fv‡jvfv‡e m`m¨‡`i g‡bvmvgvwRK mnqZvi ‡`qvi ‡ÿ‡Î Avcbvi Avi wK wK mvnvh¨ cÖ‡qvRb (What further support do you require in this regard)?

d. RwUj g‡bvmvgvwRK mgm¨vi ‡ÿ‡Î Avcwb wK K‡ib (What do you do for more serious cases)?

Do you have any other comments or suggestions?

3.a : Branch Managers In-depth Interview

THEME 1

1) mv‡R`v eÜzi mv‡_ Avcbvi †hvMv‡hvM/ m¤úK© †Kgb Zv Av‡jvPbv Kiæb|

1) Please describe your interactions with the Bondhu.

2) Avcbvi kvLvi wbivcËv m`m¨‡`i mv‡_ mv‡R`v eÜzi †hvMv‡hvM/ m¤úK© †Kgb Zv Av‡jvPbv Kiæb|

2) What is the relationship between your members and the Bondhu?

 a. How would you describe the level of acceptance of Bondhus?

 K) gvV chv©‡q Avcbvi kvLvi mv‡R`v eÜzi MÖnb‡hvM¨Zv KZUzKz?

 b. How do you ensure informal feedback?

 L) mv‡R`v eÜzi KvR m¤ú©©‡K gvV †_‡K wdWe¨K Avmv wKfv‡e wbwðZ K‡ib?

 c. General perception and challenges.

 M) mvavib gZvgZ I evav mg~n e¨³ Kiæb|

3) How would you describe the relationship between the Bondhu and other branch staff? Do you think the Bondhus have enough support?

3)   mv‡R`v eÜzi mv‡_ Avcbvi kvLvi Kg©x‡`i †hvMv‡hvM/ m¤úK© †Kgb? mv‡R`v eÜz wK Avb¨vb¨ Kg©x‡`i KvQ †_‡K h‡_ó mnvqZv cvq?

4) How do you think the working relationship between Bondhus and branch staff can be improved? Please describe with examples.

4) mv‡R`v eÜzi mv‡_ Avcbvi kvLvi Kg©x‡`i †hvMv‡hvM/ Kg© †ÿ‡Î m¤ú©©K wKfv‡e Dbœqb Kiv hvq, D`vnib mn ejyb|

THEME 2/3

5) Ranking of service in terms of members' importance

 a. In your opinion, what is missing from the current list of activities?

   ==LIST==

6) Are the Bondhus able to meet the needs of the members? How could Bondhus be more effective in this regard?

7) How much time do Bondhus spend working on claims? In your opinion, how does this affect their role as community health workers?

 a. If in future Bondhus do not process claims, how would this impact the workload/program at your branch?

8) What other services could be offered?

9) What, in your opinion, are the qualities of a competent Bondhu?

THEME 1

10) Do you think Bondhus add value to the program?

 a. If they weren't there where would the families access these services?

 b. Do they feel that the Bondus offer adequate services?

 c. Do the members value the Bondus' services?

11) Management:

 a. How are the health services integrated into the wider program?

b. What is the complaints feedback mechanism?

Do you have any other comments or suggestions?

1(a) . m`m¨‡`i GdwRwW (Members FGD)
Icebreaker
1. When was the last time that you, or a family member met with, spoke to, interact with the CHP?
    a. Where did you meet her?
    b. What was the nature of the conversation?
    c. How did you feel at the end?

   1) †kl K‡e Avcwb ev Avcbvi cwiev‡ii †Kvb m`m¨ ‡nj&_ cÖ‡gvU‡ii KvQ †_‡K †mev wb‡qwQ‡jb?
        1. ‡Kv_vq †`Lv n‡qwQj?
        2. wK †mev wb‡qwQ‡jb ?
        3. ‡hvMv‡hv‡Mi ci Avcbvi †Kgb †j‡MwQj?
2) When was the last time you, or a family member met with, spoke to, interact with the PP?
    a. Where did you meet her?
    b. What was the nature of the conversation?
    c. How did you feel at the end?
    2) †kl K‡e Avcwb ev Avcbvi cwiev‡ii †Kvb m`m¨ cjøx c¨iv‡gwW‡Ki KvQ †_‡K †mev wb‡qwQ‡jb?
        1. ‡Kv_vq †`Lv n‡qwQj?
        2. wK †mev wb‡qwQ‡jb ?
        3. ‡hvMv‡hv‡Mi ci Avcbvi †Kgb †j‡MwQj?

3) What are the main differences between the CHP and the PP?
3) cjøx c¨iv‡gwWK I ‡nj&_ cÖ‡gvU†ii g~j cv_©K¨ wK wK?

4) What are the positives and the negatives of these different service delivery methods?
    a. Household visits (CHP);
    b. Group meetings (CHP);
    c. Satellite clinics (PP)
    d. Static Clinic (PP)
   4) ‡mev cÖ`v‡bi †ÿÎ wb‡¤œi KvR (cÖwKªqv) ¸jvi myweav / Amyweav ¸jv ejyb
        1. evwo wfwRU
        2. wgwUs
        3. m¨v‡UjvBU wK¬wbK
        4. ÷¨vwUK wK¬wbK
5) What were your methods of receiving health care before you joined the PRIME project?
    a. Has this made any difference to you?
   5) cÖvBg †cÖv‡R± †XvKvi c~‡e© cjøx c¨iv‡gwWK I ‡nj&_ cÖ‡gvUiiv †h †mev ¸jv ‡q †m¸jv wKfv‡e †c‡Zb?
        1) cÖvBg †cÖv‡R± †XvKvi c‡i GBme †mev MÖn‡bi/ cvIqvi †ÿÎ †Kvb cv_©K¨ ‡c‡q‡Qb wK?

6) What health services do you, your family and/or the community need that is not currently being provided by the program?
   a. Where do you go to seek these services?
   b. Is it sufficient?

6) Avcwb/ Avcbvi cwiev‡ii/ Avcbvi GjvKvq Avi wK wK m¦v¯’¨ †mev cÖ‡qvRb hv eZ©gv‡b cÖvBg †cÖv‡R± †_‡K †`qv n‡”Qbv?
   1) GB †mev ¸‡jv †Kv_vq cvIqv hvq?
   2) GB †ÿ‡Î hv cv‡”Qb Zv h‡_ó wK?

7) If you could change one thing about the programme's health elements what would it?

7) hw` cÖvBg †cÖv‡R†±i m¦v¯’¨ †mevi †h‡Kvb 1wU Ask/ welq cwieZ©b Ki‡Z ejv nq, Avcbvi g‡Z †KvbwU cwieZ©b Kiv DwPr?

8) Is there anything you could like to say, ask or any comments you'd like to make?

8) Avcbvi †h‡Kvb gZvgZ, cÖkœ, gšÍe¨ _vK‡j ejyb|

2(a) PP FGD
Icebreaker
1) What are the most prevalent issues that you have to deal with in your work?
   a. If people did not come to you where else would they seek treatment?
   b. What are the advantages & disadvantages of coming to see you over the alternatives?

1) Kv‡Ri †ÿ‡Î wK wK e¨cvi Avcbvi cÖvqkB ‡gvKv‡ejv Ki‡Z nq?
   1. m`m¨iv hw` Avcbvi Kv‡Q bv AvmZ Zvn‡j Avi Kvi Kv‡Q/ †Kv_vq GB †mev ¸‡jv †c‡Z cviZ?
   2. Ab¨ †Kv_vI bv wM‡q Avcbvi Kv‡Q †mev †bIqvi myweav / Amyweav ¸‡jv ejyb

2) Which in your opinion are more effective, satellite or static clinics? Why?
   a. Have you had any feedback? How do you know which is more effective?
   b. How important are household visits? Why?

2) Avcbvi g‡Z m¨v‡UjvBU wK¬wbK I ÷¨vwUK wK¬wb†Ki g‡a¨ †KvbwU †ekx Kvh©Ki? †Kb?
   1) Avcwb wK †Kvb wdWe¨vK †c‡q‡Qb? Avcwb wKfv‡e eyS‡jb ‡h †KvbwU †ekx Kvh©Ki?
   2) evwo wfwRU KZUzKz ¸iyZ¡c~Y©? †Kb?

3) What type of support do you receive from your colleagues?
   a. CHPs
   b. PP supervisors
   c. Branch managers

3) Avcbvi mnKg©xiv Avcbv‡K wK ai‡bi mn‡hvMxZv K‡i?
   1) ‡nj&_ cÖ‡gvUi
   2) wcwc mycvi fvBRvi
   3) kvLv g¨v‡bRvi

4) What is the role of the CHP?
   a. What do they do with the members?
   b. How do you get feedback on CHP's works from the field?

4) ‡nj&_ cÖ‡gvUi‡i KvR wK wK?
   1) ‡nj&_ cÖ‡gvUiiv m`m¨‡`i mv‡_ wK wK KvR K‡i?

2) gvV ch©vq †_‡K ‡nj&_ cÖ‡gvUi†`i Kv‡Ri wdWe¨vK wKfv‡e cvb?

5) How do they add value to the PRIME project?
   a. What would happen if there were less CHPs per branch?
   b. What would be effect of no CHPs in the program, just paramedics?

5) cÖvBg †cÖv‡R†± ‡nj&_ cÖ‡gvUiiv KZUzKz ¸iyZ¡c~Y©?
   1) kvLvq 3 R‡bi Kg ‡nj&_ cÖ‡gvUi _vK‡j wK wK Amyweav nZ?
   2) cÖvBg †cÖv‡R†± ‡nj&_ cÖ‡gvUiiv bv †_‡K ïay cjøx c¨iv‡gwWK _vK‡j †Kgb nZ?

6) Do think that there is a need for one PP per branch or could one PP cover three or four branches?
   a. What would be the positives and negatives of this approach?
   b. What support would they need if this was done (there needs to be CHPs at each branch?)

6) Avcbv‡`i g‡Z GKRb cjøx c¨iv‡gwWK GKwU kvLvq KvR Kiv DwPr bvwK GKRb cjøx c¨iv‡gwWK 4/ 5 wU kvLvqI KvR Ki‡Z cvi‡e?
   1) GwU Ki‡j wK wK myweav / Amyweav n‡Z cv‡i ejyb
   2) GwU Ki‡j Avcbv‡`i wK wK mvnvh¨/ mn‡hvMxZv cÖ‡qvRb n‡Z cv‡i?(cÖwZ kvLvq ‡nj&_ cÖ‡gvUi _vKvi cÖ‡qvRb ejyb)

7) What would happen if only CHP health services were provided, what would be the impact of this?

7) ïay ‡nj&_ cÖ‡gvUiiv m¦v¯’¨ †mev w`‡j †Kgb nZ, Gi djvdj †Kgb n‡e?

8) Are there any gaps in the current model, do members want or need other services? From your perspective (personal)?
   a. Do they want doctor services?
   b. Do they want more home visits?
   c. A lack of specialist service in an area?

8) eZ©gv‡b †hfv‡e cÖvBg †cÖv‡R†± m¦v¯’¨ Kvh©µg Pj‡Q Zv‡Z wK wK mgm¨/ dvuK Av‡Q ejyb| m`m¨‡`i wK AviI †Kvb
   †mevi cÖ‡qvRb Av‡Q? (Avcbvi gZvgZ w`b)
   1) Zviv wK Wv³vi KZ…K †mev Pvq?
   2) Zviv wK Zv‡`i evwo‡Z AviI †ekx wfwRU Pvq?
   3) GjvKvq we‡klÁ †mevi NvUwZ Av‡Q

9) What is your opinion on Kishori Meeting? Why?
   a. What is most effective? What is least effective?
   b. What are the challenges? (Excluding program)
   c. What can be an alternative?

9) wK‡kvix wgwUs m¤ú©‡K Avcbvi gZvgZ w`b I gZvg‡Zi c‡ÿ hyw³ w`b|
   1) me‡P‡q †ekx Kvh©Ki †Kvb †Kvb welqwU/ me‡P‡q Kg Kvh©Ki †Kvb welqwU
   2) G‡ÿ‡Î P¨v‡jÄ wK wK?
   3) GQvov Avi wK wK Kiv hq?

10) Is there anything you could like to say, ask or any comments you'd like to make?

10) Avcbvi †h‡Kvb gZvgZ, cÖkœ, gšÍe¨ _vK‡j ejyb|

3 (a) BM FGD
Icebreaker
1) What are the services provided by the CHP and PP?

1) cjøx c¨iv‡gwWK I ‡nj&_ cÖ‡gvU†ii m`m¨‡`i wK wK †mev †`Iqvi K_v ?

2) Which of these services do you think is THE most important for members? Why?
   a. Have you had any feedback from the members?
   b. Do you think that the services are provided as best they could be? How could it be improved?

2) GB †mev ¸‡jvi g‡a¨ †KvbwU me‡P‡q ¸iæZ¡c~Y©? †Kb?
   1) †g¤^vi‡`i KvQ †_‡K †Kvb wdWe¨vK †c‡q‡Qb wK?
   2) Avcwb wK g‡b K‡ib †mev ¸jv m‡e©v”P gvb m¤§Zfv‡e w`‡Z cwi‡Qb? GwU wKfv‡e AviI fv‡jv Kiv hvq?

3) Which of these services are hardest to deliver, members least receptive to?
   a. Is it an issue of the delivery?

3) †Kvb †mevwU †`qv me‡P‡q Kómva¨/ †KvbwU m`m¨iv MÖnb Ki‡Z Pvqbv?
   1) †mevwU †h m`m¨iv MÖnb Ki‡Z Pvqbv †mwU wK †cÖvMÖv‡gi mgm¨v?

4) What would happen if there were less CHP per branch?

4) cÖwZ kvLvq AviI Kg ‡nj&_ cÖ‡gvUi _vK‡j ‡Kgb nZ?

5) What would happen if each PP had to cover 4-5branches?

5) 1 Rb ‡nj&_ cÖ‡gvU†ii hw` 4-5 wU kvLvq †mev w`‡Z nZ Zvn‡j †Kgb nZ?

6) If one of these two services had to be stopped which would they choose? Why?

6) cjøx c¨iv‡gwWK I ‡nj&_ cÖ‡gvU†ii g‡a¨ †h‡Kvb &GKwU †mev eÜ Ki‡Z n‡j Avcbvi g‡Z †KvbwU eÜ Kiv &&&DwPr? †Kb?

7) Are there any gaps in the current model, do members want or need other services?
   a. Do they want doctor services?
   b. Do they want more home visits?
   c. A lack of specialist service in an area?

7) eZ©©gv‡b †hfv‡e cÖvBg †cÖv‡R†± m¦v¯’¨¨ Kvh©©µg Pj‡Q Zv‡Z wK wK mgm¨/ dvuK Av‡Q ejyb| m`m¨‡`i wK AviI †Kvb
   †mevi cÖ‡qvRb Av‡Q? (Avcbvi gZvgZ w`b)
   1) Zviv wK Wv³vi KZ…K †mev Pvq?
   2) Zviv wK Zv‡`i evwo‡Z AviI †ekx wfwRU Pvq?
   3) GjvKvq we‡klÁ †mevi NvUwZ Av‡Q

8) How can the health program be strengthened?

8) cÖvBg †cÖv‡R†±i m¦v¯’¨¨ Kvh©©µg wKfv‡e AviI kw³kvjx Kiv hvq?

9) Is there anything you could like to say, ask or any comments you'd like to make?

9)Avcbvi †h‡Kvb gZvgZ, cÖkœ, gšÍe¨ _v‡Z ejyb|

4 (a) . CHP FGD
Icebreaker

1) What are the most prevalent issues that you have to deal with in your work?
   a. If you did not go to see people where else could they seek/receive information?
   b. What are the advantages & disadvantages of seeing you over the alternatives?

1) Kv‡Ri †ÿ‡Î wK wK e¨cvi Avcbvi cÖvqkB ‡gvKv‡ejv Ki‡Z nq

1) m`m¨iv hw` Avcbvi Kv‡Q AvmZ Zvn‡j Avi Kvi Kv‡Q/ †Kv_vq GB †mev ¸‡jv †c‡Z cviZ?

2) Ab¨ †Kv_vI bv wM‡q Avcbvi Kv‡Q †mev †bIqvi myweav / Amyweav ¸‡jv ejyb

2) What are the issues that you give information on and to whom?

    a. Which topics are easiest to explain, convey? Why? Do you see people do what you say they should?

    b. Which topics are hardest to explain, convey? Why? How else could they be done?

2) Avcwb Kv‡`i Ges wK wK wel‡q Z_¨ †`b?

1) †Kvb †Kvb welq ¸‡jv e¨vL¨v Kiv Avcbvi Rb¨ mnR nq? †Kb? Avcwb m`m‡`i ‡hme Z_¨/ civgk© †`b Zv wK Zviv †g‡b P‡j?

2) †Kvb †Kvb welq ¸‡jv e¨vL¨v Kiv Avcbvi Rb¨ KwVb nq? †Kb? Ab¨ wKfv‡e Ki‡j Zv mnR nZ?

3) Which in your opinion is a more effective, house visit or courtyard meetings? Why?

    a. Have you had any feedback? How do you know which is more effective?

    b. How important are household visits?

3) Avcbvi g‡Z evwo wfwRU I DVvb ˆeV‡Ki g‡a¨ †KvbwU †ekx Kvh©Ki? †Kb?
1) Avcwb wK †Kvb wdWe¨vK †c‡q‡Qb? Avcwb wKfv‡e eyS‡jb ‡h †KvbwU †ekx Kvh©Ki?
2) evwo wfwRU KZUzKz ¸iyZ¡c~Y©? †Kb?

4) If there were less CHP per branch what would happen?

    a. Is it important to visit each household? What would happen if all households were not visited as frequently?

4) kvLvq 3 R‡bi Kg ‡nj&_ cÖ‡gvUi _vK‡j wK wK myweav/ Amyweav nZ?
1) cÖwZwU evwo wfwRU Kiv wK Riæix? cÖwZwU evwo hw` wbqwgZ wfwRU Kiv bv nZ Zvn‡j †Kgb nZ?

5) Do you think that the satellite clinic or the static clinic is more effective? Why?

    a. What are the advantages and disadvantages of one over the other?

    b. Why do you think this, can you think of examples from what members have said to you?

5) Avcbvi g‡Z m¨v‡UjvBU wK¬wbK I ÷¨vwUK wK¬wbK wK †ekx Kvh©Ki? †Kb?
1) GB `ywUi Zzjbvg~jK myweav / Amyweav ¸‡jv ejyb|
2) Avcbvi GB avibvi Kvib ejyb, Avcwb m`m¨‡`i ejv †Kvb NUbv / K_v i D`vnib w`‡Z cvi‡eb wK?

6) Do they think that there is a need for one PP per branch or could one PP cover two, or three branches?

    a. What would be the positives and negatives of this approach?

    b. What support would they need if this were done?

6) Avcbv‡`i g‡Z GKRb cjøx c¨iv‡gwWK GKwU kvLvq KvR Kiv DwPr bvwK GKRb cjøx c¨iv‡gwWK 4/ 5 wU kvLvqI KvR Ki‡Z cvi‡e?
1) GwU Ki‡j wK wK myweav / Amyweav n‡Z cv‡i ejyb |
2) GwU Ki‡j Avcbv‡`i wK wK mnvh¨/ mn‡hvMxZv cÖ‡qvRb n‡Z cv‡i? (cÖwZ kvLvq c¨iv‡gwWK _vKvi cÖ‡qvRb ejyb)

7) What do they think will happen if there were only PP services?

    a. What would be the effect on the members?

    b. What would be the positive and negatives of this?

    c. Would the PPs be able to serve the needs of the members?

7) ïay cjøx c¨iv‡gwWKiv m¦v¯’¨ †mev w`‡j †Kgb nZ, Gi djvdj †Kgb n‡e?

     1) GwU Ki‡j m`m¨‡`i Dci wK wK cÖfve co‡e?

     2) GwU Ki‡j wK wK myweav / Amyweav n‡Z cv‡i ejyb|

     3) ïay cjøx c¨iv‡gwWKiv wK m`m¨‡`i Pvwn`v Abyhvqx †mev w`‡Z mÿg?

8) What is your opinion on Kishori Meeting? Why?

    a. What is most effective? What is least effective?

    b. What are the challenges? (Excluding program)

    c. What can be an alternative?

9) wK‡kvix wgwUs m¤ú©‡K Avcbvi gZvgZ w`b

    1) me‡P‡q †ekx Kvh©Ki †Kvb welqwU/ me‡P‡q Kg Kvh©Ki †Kvb welqwU

    2) G‡ÿ‡Î P¨v‡j‡Ä wK wK?

    3) GQvov Avi wK wK Kiv hvq?

9) What do they think will happen if there were only CHP services?

    a.   What would be the effect on the members?

    b.   What would be the positive and negatives of this?

    c. Who would provide the services being provided by the PP, are there other service providers or is it not very necessary?

7) ïay ‡nj&_ cÖ‡gvUiiv m¦v¯’¨ †mev w`‡j †Kgb nZ, Gi djvdj †Kgb n‡e?

     1) GwU Ki‡j m`m¨‡`i Dci wK wK cÖfve co‡e?

     2) GwU Ki‡j wK wK myweav / Amyweav n‡Z cv‡i ejyb|

     3) cjøx c¨iv‡gwWKiv †h me †mev †`q, m`m¨iv ZLb †m †mev ¸jv †Kv_v cv‡e? †mev ¸jvi `iKvi Av‡Q wKbv?

10)Are there any gaps in the current model, do members want or need other services? From your perspective (personal)?

    c. Do they want doctor services?

    d. Do they want more home visits?

    e. A lack of specialist service in an area?

10) eZ©gv‡b †hfv‡e cÖvBg †cÖv‡R†± m¦v¯’¨ Kvh©µg Pj‡Q Zv‡Z wK wK mgm¨/ dvuK Av‡Q ejyb| m`m¨‡`i wK AviI †Kvb

    †mevi cÖ‡qvRb Av‡Q? (Avcbvi gZvgZ w`b)

    1) Zviv wK Wv³vi KZ…K †mev Pvq?

    2) Zviv wK Zv‡`i evwo‡Z AviI †ekx wfwRU Pvq?

    3) GjvKvq we‡klÁ †mevi NvUwZ Av‡Q

11)Is there anything you could like to say, ask or any comments you'd like to make?

11) Avcbvi †h‡Kvb gZvgZ, cÖkœ, gšÍe¨ _vK‡j ejyb|

PP Supervisor IDI (cjøx c¨iv‡gwWK‡`i mycvi fvBRvi`i AvBwWAvB)

    1) How are PPs selected?

     a. What are the criteria for their appointment?

     b. Are they given any further training?

1) cjøx c¨iv‡gwWK‡`i wKfv‡e wb‡qvM †`qv nq?

     1) cjøx c¨iv‡gwWK wn‡m‡e wb‡qvM w`‡Z n‡j cÖv_©xi wK wK †hvM¨Zv _vKv jv‡M?

     2) Zv‡`i wK Av‡M †Kvb cÖwkÿb †`qv nq?

    2) How are CHPs selected?

     a. What are the criteria for their appointment?

     b. What training are they given?

2) ‡nj&_ cÖ‡gvUi‡`i wKfv‡e wb‡qvM †`qv nq?

     1) ‡nj&_ cÖ‡gvUi‡`i wn‡m‡e wb‡qvM w`‡Z n‡j cÖv_©xi wK wK †hvM¨Zv _vKv jv‡M?

      2) ‡nj&_ cÖ‡gvUi‡`i wK wK †UªBwbs †`qv nq?

3) What makes a good PP or CHP?
      a. How are good PPs and CHPs supported?
      b. How do you identify PPs or CHPs needs more support?

3) †Kvb †Kvb ¸b GKRb cjøx c¨iv‡gwWK/ ‡nj&_ cÖ‡gvUi †K fv‡jv wn‡m‡e wPw݇Z K‡i?
      1) fv‡jv cjøx c¨iv‡gwWK/ ‡nj&_ cÖ‡gvUi‡`i wKfv‡e mv‡cvU© ‡`qv nq?
      2) †Kvb cjøx c¨iv‡gwWK/ ‡nj&_ cÖ‡gvU‡ii mn‡hvMxZv cÖ‡qvRb, Zv Avcwb wKfv‡e wPw݇Z   K‡ib?

4) What are the most important features of the project's health intervention?

4) cÖvBg †cÖv‡R†±i m¦v¯’¨ †mev ¸‡jvi g‡a¨ me‡P‡q ¸iæZ¡c~b© wK wK?

5) If you could redesign the health intervention of the project what and how would you do?
      a. Would you keep the same number of staff?
      b. Would you reduce or redistribute staff?
      c. Would you change their focus or their areas of work?

5) Avcbv‡K hw` cÖvBg †cÖv‡R†±i m¦v¯’¨ †mevi © intervention bZzb K‡i wba©vib Ki‡Z ejv nq Avcwb wK wK cwieZ©b Ki‡eb?
      1) Avcwb wK Kgx© msL¨v cwieZ©b Ki‡eb?
      2) Avcwb wK Kgx© msL¨v Kgv‡eb A_ev bZzb K‡i Zv‡`i KvR ¸¨jv fvM K‡i w`‡eb?
      3) Avcwb wK Kgx†`i g~j KvR / Kv‡Ri cwiwa cwieZ©b Ki‡eb?

6) If the program was redesigned with only the opportunity to keep either CHPs or PPs who would you keep?
      a. Why would you keep them?
      b. Who will do the job that those who have been left out?
      c. How will this affect the service?

6) hw` Ggb nq †h cÖvBg †cÖv‡R†± cjøx c¨iv‡gwWK I ‡nj&_ cÖ‡gvU†ii g‡a¨ †h‡Kvb GKRb _vK‡e Avcwb Kv‡K ivL‡eb?

7) Is there anything you could like to say, ask or any comments you'd like to make?

7) Avcbvi †h‡Kvb gZvgZ, cÖkœ, gšĺe¨ _vK‡j ejyb|

Annexure 2: List of Researchers Involved

Research Lead:
Md. Fazlul Haque, Director Capacity Building
Research Coordinators:
Imran Jamal
Prima Alam
Research Managers:
Rownak Jahan Archie
Saira Banu
Research Associates:
Anindya Das
Hawa Mustagfira Esha
Sanjida Binte Alam
Md. Tauhidur Rahman
Research Assistants: (Temporary)
Nilufa Khatun
Shaan Muberra Khan
Promiti rani Saha
Md. Awlad Hussain
Khurshida Khatun
Md. Hasan
Masuda Bhuiyan

Shelly Sultana