Final Report:

FUNCTIONALITY AND SUSTAINABILITY ASSESSMENT OF CSPs

USAID's Advancing Universal Health Coverage (AUHC) Project

Conducted by:

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Contents

CSP Study Tools version English is provided in a separate zipped folder.

List of Abbreviation and Acronyms

ANC	Antenatal Care
AUHC	Advancing Universal Health Coverage
BDT	Bangladesh Taka
BRAC	Bangladesh Rehabilitation Assistance Committee
CBSG	Capacity Building Service Group
CC	Community Clinic
CHCP	Community Health Care Provider
CSA	Community Sales Agent
CSG	Community Support Group
CSP	Community Service Provider
EmOC-B	Basic Emergency Obstetric Care
EmOC-C	Comprehensive Emergency Obstetric Care
EPI	Expanded Program on Immunization
ESP	Essential Services Package
FCC	Family Care Card
FGD	Focus Group Discussion
FP	Family Planning
FWV	Family Welfare Visitor
GMP	Growth Monitoring Promotion
GoB	Government of Bangladesh
HSC	Higher Secondary School Certificate
IDI	In-depth Interview
LG/CC	Limited General/Curative Care
M&E	Monitoring and Evaluation
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCH	Mother & Child Health
MERL	Monitoring Evaluation Research and Learning
NGO	Non-Governmental Organization
NHSDP	NGO Health Service Delivery Project
NSDP	NGO Service Delivery Project
PHNE	Population Health Nutrition and Education
PNC	Postnatal Care
PoP	Poorest of the poor
RCT	Randomized Control Trial
RFP	Request For Proposal
SACMO	Sub-Assistant Community Medical Officer
SDG	Sustainable Development Goals
SHN	Surjer Hashi Network
SK	Sastho Kormi
SMC	Social Marketing Company
SP	Service Promoter
SS	Sastho Sebika
SSC	Secondary School Certificate
SSI	Semi Structured Interview
SSN	Smiling Sun Network
TT	Tetanus Toxoid
USAID	United States Agency for International Development
WB	World Bank

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Executive summary

Background

The USAID's Advancing Universal Health Coverage (AUHC) project in Bangladesh is a Research and Development contract aimed at a paradigm shift of the mode of service delivery and management structure. Instead of providing family planning, maternal and child health focus services through different NGOs, broad range services will be offered for a family. Surjer Hashi Network (SHN)-a pro-poor private social enterprise has been formed to manage the network of clinics in a sustainable manner. CSP and satellite are key health service channels for SHN outreach activities. Several past research studies are showing that the network is being dispirited by losing market share primely to flourishing private providers. Despite having uniform project guideline, different NGOs management practice alienated outreach strategies in terms of both services and products.

SHN's overall objective is to offer high quality affordable care to clients disregarding their financial base and operationalization of an effective cross subsidization mechanism. Improving network efficiency and financial sustainability will remain profoundly important for SHN to contribute to the Bangladesh Governments health sector program and universal health coverage agenda as well as its' own sustainability. . Thus streamlining services and staying pertinent to current market demand has become imperative for SHN.

Objectives

One of the prime objectives of the assessment was to understand current status of the CSP cadre across the network by region and geography not to debunk. After that, overall activities of CSPs were juxtaposed with four other community health workers – BRAC, Marie Stopes, SMC, and JITA.

Methodology

Mixed method design was adopted for this assessment. Through this assessment along with CSPs, clinic managers, service promoters, CHWs and managers of other organizations, , SHN clients and non-clients from clinic catchment areas were interviewed applying both qualitative and quantitative (where applicable) techniques. Data were collected simultaneously and triangulated to draw opinion. The assessment followed a mixture of simple random sampling and multistage sampling to draw ultimate sampling unit. Quantitative data were collected using online data collection platform – SurveyCTO and qualitative data were recorded and transcribed for further analysis.

Findings

The survey results revealed that there are two types of CSPs working under SHN – CSP and CSP-nutrition. Most of them are CSPs and very few are CSP-nutrition, who work only in the USAID's Feed the Future zone. On an average around 52 percent CSPs educational status falls class VIII-X category, while surprisingly 17 percent CSPs neither passed class VIII nor had any formal education at all. Only 31 CSPs found who passed SSC or above while all CSP-nutrition are HSC passed. Moreover, rural CSPs are little bit more experienced than urban. Average monthly honorarium for CSPs and CSP-nutrition were respectively BDT 929 and BDT 2200. CSPs get profit share by referring patient to static clinic and selling products, whereas CSP-nutrition cadre are not engaged in such activity. Service Providers directly supervise CSPs. Clinic manager or SPs meet CSPs basically on satellite day, otherwise, they communicate over phone for any programmatic discussion. CSPs usually attend in the monthly meeting at static clinic for reporting and other issues. There was no structured supervision approach found for CSPs.

Analyzing job description of CSPs, it was identified that they have been entrusted to do about twenty activities which are mostly promotional. None of the CSPs were able to mention name of all the activities.

CSPs are aware about other CHWs working in their area. Besides, CHWs of four other organizations – BRAC, SMC, Marie Stopes, and JITA, name of eight other organizations are: a) Caritas b) Simantik c) Ad-din d) Sajeda foundation e) Palli Unnayan Sangstha f) Jibito Bangladesh, g) FPAB, and i) PKSF. Functional model of the CHWs, CSPs and Government FWA is not uniform and cannot be superimposed. Fundamental difference of CSPs with CHWs was that products and services list across CSPs found heterogeneous, while for the other CHWs the product and service basket remained almost uniform. Community valued the service and products taken to their doorsteps by CHWs including our CSPs.

Capacity of CSPs was evaluated under a composite index which shows that on an average around 24% low capacity CSPs in the network, and remaining CSPs are either medium or high capacity. A robust estimate finds that SHN is spending BDT 15,97,880 per year on low capacity CSPs. Again, when CSPs were categorized according to their referral earning – 40 to50 percent of them earned up to BDT 500. Furthermore, regression analysis suggests that experience of CSPs is positively associated with referral income. Furthermore, training remains an integral part of capacity, the assessment reveals that 17 percent did not receive the fundamental orientation training that the CSPs should have while they start working.

CSPs are working at the community for quite a long time. People know them and they demanded some more products and services from CSPs besides they currently provide; top five of them were – blood pressure checkup, diabetic screening, growth monitoring, pregnancy test, and nebulizer. Likewise, when clients were asked to rank or value the product and information they get from CSPs, oral pill and comparative advantage of various FP methods came out top ranked product and information respectively, followed by condom and EPI information.

CSPs basically have three sources of income - fixed honorarium, referral commission and commission from selling products, none but Marie Stopes CHWs receive fixed honorarium. In terms of overall income, Marie Stopes CHW has highest earrings (BDT 4,500) followed by SHN urban – CSPs (BDT 2,323).

Furthermore, average cost per CSPs found BDT 1,937 (urban- BDT 2,917 and rural - BDT 1489) and revenue contribution per CSP was BDT 1,028 (urban - BDT1547 and rural – BDT 786). It implies that cost recovery for CSPs is 53 percent. Finally, the assessment came up with some recommendations these are –

Training: AUHC/SHN has to train CSPs according to their capacity to get them properly functional. What training other organization are providing could provide an idea for prioritization of training needs.

Redefining service and product basket: To generate more income of CSPs and engage them in SHN clinics, redefining service and product basket has become an imperative. Considering capacity, CSPs can be trained and provided diagnostic equipment like BP and blood sugar screening machine. Moreover, few other OTC drugs can also be made available to CSPs as per demand of clients.

Retention of CSPs: Analysis shows that experienced CSPs have more referral income which implies that they have indulgence with the clinic. Thus, SHN might have strategy to retain experienced CSPs.

Revitalization of mobilization and sensitization: To stay relevant and improve market penetration, revitalization of advertisement, marketing strategy for community mobilization and product promotion is a must.

Rationalize number of CSPs: SHN may consider downsizing number of CSPs. Basis for this cut is a management decision, but the assessment provides few ideas like percentage of low performing CSPs, percentage of CSPs who has no referral income.

Section A: Background and Methodology

1.1 Introduction

The USAID's Advancing Universal Health Coverage (AUHC) project is a care delivery program providing essential health services since 1980s in different names. This project is primarily serving people who remained uncovered under health service delivery network of Government of Bangladesh (GoB). This project currently covering almost 16 percent of entire population in Bangladesh. This project deployed CSPs where Government family welfare assistant (FWA) is absent. This is one of the approaches of the project to complement and supplement government health service agenda of ensuring services for hard to reach and underserved people, thereby contributing to the universal health coverage.

Prime focus of AUHC project is to safeguard sustainability of the network and keep working with the Government agenda of securing universal health coverage by 2030. As part of the process, instead of providing services through NGOs, a single entity has been formed namely - Surjer Hashi Network (SHN). Aim of SHN is to transition all NGO operated clinics into this single management structure and provide quality health services taking into account double bottom line of revenue and health impact.

SHN currently has as many as 7,350 CSPs, who are contributing to about 60 percent of its total service contacts. CSPs, in fact belong to generic category of community health workers (CHWs) and are members of the community, mostly women trained to carry out limited family planning and health services.

This functionality and sustainability assessment of CSP is commissioned by the USAID's AUHC project. The assessment was conceptualized in May 2018, while the data collection was collected in December 2018.

1.2 Background and Assessment Context

According to NHSDP annual report 2017, Surjer Hashi clinics recorded 46.6 million service contacts among its catchment area population in 2016-2017. Approximately 60 percent of these service contacts have been generated by 7350 CSPs. SHN CSPs, are volunteer and ambassador of Surjer Hashi clinic to the community. They have got limited training or orientation basically on maternal and child health issues, and work as first point of contact for some people in the community. They distribute family planning (FP) commodity and few other products and commodities related to health. In addition to delivery of FP and health services, they play a major role in referring clients to static clinics, help organize satellite spots by coordinating logistics and outreach to communities.

Over the decades, the clinics were operated by NGOs and in NHSDP period number of NGOs were 25. Despite having a project guideline, different management practice and service delivery approach emerged due to separate organizational arrangements of the NGOs. Therefore, it became an imperative for AUHC/SHN to know current status of CSPs basically in terms of services and products they offer in the community. As the network is going through transition, SHN needs to stay relevant to community demand and also needs to be self-sustainable.

SHN envisions to augment its essential service package and make the most of their outreach activity - a comprehensive approach to offer services to all strata men, women and children.

SHN, in this new reality, is faced with the need for reviewing and updating its business model, asking itself all kinds of questions: for example, what are the value propositions of the network in the competitive landscape of other private and public provision of health

services, how best to serve the poorest of the poor to achieve the universal health coverage without compromising on sustainability of the network, what measures should SHN adopt to improve operations efficiency and cost recovery, what will be its community outreach and last-mile service provision strategy?

The purpose of this assessment is to gain information and insights on the current state to be able to inform SHN's community outreach and last-mile service provision strategy. This assessment is being conducted simultaneously with another activity that will assess cost-benefit and functionality of the satellite spots. These are all part of the last mile solutions to the health system's inadequacy to reach the poorest of the poor, at times the hard-to-reach communities. This assessment will look at the entire landscape of CSPs within and outside of Surjer Hashi network, discern different models and characteristics, and specificities to regions and demographics. It will explore insights into communities to update AUHC project's understanding of communities' needs and demands for services and healthcare products at their doorsteps (or closer to their households). By this exercise, AUHC/SHN will have acquired the information and insights to help SHN define its strategies for community outreach and provision of services. It is expected that this assessment will provide different scenarios to look at the functionality and relevance of CSPs, while offer corresponding (to the scenarios) review and assessment of capacities (education, knowledge, skills, and attitude) of SHN's community workforce.

1.3 Objectives

The objective of this assessment is to evaluate the functionality and pertinence of CSPs in the future of health service delivery under SHN, to provide scenarios and options based on which SHN will be able to determine the need for community workforce and last mile provision of services.

Specific objectives

- To explore services provided by CSPs based on geographic locations, community settings and under the urban and rural context;
- To evaluate skills, capacity, attitude and management practices of CSPs;
- To understand communities' perception of the need for and role of CSPs ;
- To evaluate the capacity requirements for potential roles of CSPs;
- To assess the services, products and revenue model of CHWs of the other healthcare service providers (BRAC, SMC, Marie Stopes, and JITA).

1.4 Methodology and Extent of the Assessment

1.4.1 Methodology

Study design: In this assessment we employed mixed method, convergent parallel design, approach.

Data collection: Separate data collection team was assigned for each administrative division (Mymensingh was included in Dhaka division). Each team was comprised of three enumerators and a supervisor. Moreover, two coordinators from head office maintained liaison with field and AUHC. In collecting all data, consent was taken from the respondents and recorded.

Sampling technique: Mixture of multistage and simple random sampling.

Sample size: Distribution of sample size by category is delineated in the table below:

Data triangulation: Several qualitative and quantitative interrelated methods were adopted to derive information and data required for the assessment. These methods complemented and supplemented the rigor and authenticity of the assessment results. Results of client survey, FGD, IDI, semi-structured interview and other data sources have been used for comparative analysis and triangulated these data sources to draw assessment conclusions.

Table-A1: Respondent and sample size

	Total	Urban	Rural	Remarks
Clinics covered	28	14	14	Vital=14; B-EmOC=7; C-EmOC=7
CSP-SSI	108	42	66	
Clinic managers	28	14	14	
Service promoters	33	16	17	
Other CHWs	58	14	44	BRAC-29, SMC-20, JITA-5, MSI-4
In-dept interview	9	3	6	MSI-2, SMC=2, JITA=2, BRAC-3
Focus group discussion	14	6	8	CSP=7, Client=7

1.5 Implementation and Data Quality Control

1.5.1 Implementation

CBSG signed the subcontract agreement with Chemonics International Inc. for undertaking this functionality and sustainability assessment on October 21, 2018. However, scope work and contract were modified after the inception phase, due to some inevitable changes made in the assessment objectives.

Following the modification, a detailed methodology and assessment was submitted on November 28, 2018. After training of the field enumerators, data collected was started on 8th December and ended on December 24, 2018.

Overall implementation was conducted in three major phases as follows:

- Inception and Methodology Finalization Phase: October 21 to November 14, 2018
- Field Preparation and Data Collection Phase: November 15 to December 26, 2018
- Analysis, Reporting and Dissemination Phase: December 27, 2018 to February 26, 2019

After field data collection, consistency check, data cleaning and processing were done in SPSS for quantitative and in NVivo for qualitative data.

1.5.2 Quality control

As a part of seamless data collection and systematic monitoring process, CBSG used online tab-based data collection platform – SurveyCTO. This enabled us real time data monitoring that includes – data ranging, imposition of validation rules, popped-up on screen messaged for illogical data entry. CBSG provided SurveyCTO administrative access to AUHC as part of its transparency. Furthermore, a supervisor was assigned for each team who ensured feedback meeting on every evening. Study team lead and chairman of CBSG also visited two division during the data collection. AUHC Research Specialist attended training sessions of data collectors and visited Mymensingh as a part of overseeing data collection process physically.

We had particular effort on sample descriptions and identification of sample locations, strategies to handle non-response and systematic errors, and daily review of the quantitative and qualitative surveys including around 20% back checks.

1.6 Limitation

The assessment data collection phase took place prior to eleventh national election, it is undeniable that the election mounted tension. Moreover, AUHC management had decided to modify the assessment objectives than it was originally delineated in the proposal. Therefore, fundamental limitation of this assessment was limited time period. Furthermore, in this assessment we did not do any estimation of CSPs contribution on how CSPs are saving community – gain to the community.

1.7 Structure of the Report

The report has three major sections with an executive summary in the upfront.

Section-A presents the background and methodology including the implementation stages of this assessment.

Section-B presents the analysis and findings of the assessment. It describes functionality of CSP blended their roles and capacity, while attempts were made to compare their function with other contemporary CHWs.

Section-C provides an overall assessment followed by conclusion, recommendations.

In addition to these sections, a number of reference documents and analysis tables have been presented in the annex.

Section-B: Analysis and Findings

This section presents the findings and analysis the assessment following the chronology of the objectives as the findings under each objective are complementary and supplementary to each other.

2.1 Profile of CSPs

Most of the CSPs working under SHN are married (84 percent) with no significant difference in urban and rural area. For the samples selected, average job tenure remained at 7 years. As per SHN clinic operation guideline, educational requirement for a CSP is at least class VIII pass. But, 17 percent CSPs found who neither had formal education nor passed class VIII. Educational status of the sample respondent varied from illiterate to graduate. There are few special type of CSP – namely CSP-nutrition are also working under SHN. These cadre has been deployed in USAID's Feed the Future zone, basically to work as a community nutrition counselor. Their average remuneration (BDT 2,200) is higher than the CSPs, and they don't sell or distribute any health product, commodity or OTC drug. All of them are found to be passed HSC level and had basic training on nutrition.

Table-B1: Basic socio economic profile of CSPs

Attribute	Total	Urban	Rural
Average age (years)	37	35	39
Job tenure (years)	7	6	8
Marital status	84%	81%	86%
Education:			
▪ No formal education	4%	0%	7%
▪ Below class VIII	13%	17%	11%
▪ Class VIII-X	53%	45%	58%
▪ SSC or Above	30%	38%	24%

Table-B2: Profile of CSP-Nutrition

Particular	Remarks	
Work station	Urban area, and in USAID's Feed the Future zone	
Age (average)	38 years	Range: 25-56 years
Education	HSC	Higher than CSPs
Job tenure (average)	5 years	Range: 2-10 years
Training	One day-long training/orientation on nutrition	
Remuneration	BDT: 2,200 + TA:800	Not entitled to any commission/ referral fees
Catchment area	They work all over the static clinic catchment areas and are not necessarily be the resident of the community.	
Additional role beyond CSPs	Nutrition counseling to Pregnant women and mother of new born babies. They work in static clinics too. They use nutrition chart and also follow-up clients.	
Product distribution/sell	Do not distribute / sell any product.	
Supervision and reporting	Directly to service promoter.	

2.2 Functionalities, Supervision and Monitoring of CSPs

2.2.1 Functional job description and roles of CSPs

Before finalization of the survey questionnaire, job description of CSPs was analyzed. We identified around 20 activities are to be performed by a CSP, and most of the activities are awareness building and promotional. CSPs were asked about their daily job description, and coded their self-reported data. This information were further validated through clinic manager and SP. It revealed that none of the CSPs were able tell all the activities they are supposed to perform, and interestingly there are four activities remained complete non-

response. SHN clinics are characterized as maternal and child healthcare center in the community, thus hundred percent of the community workforce should be able to say that they provide or promote maternal or child healthcare. But the assessment findings didn't portray the perception in the community duly. The table B3 provides better picture of the findings.

One of their prime responsibilities and earning source is to refer client in static clinics. When CSPs were asked whether they refer clients to other non-SHN clinics around 40% (in multiple response) told that they refer clients to other facilities. Two main reasons for non-SHN referral were: not availability of services at SHN clinic and better benefit offer of other clinics.

Table-B3: Activity and job description of CSPs

Sl	Name of the activity	Percentage
1	Ensuring ANC checkup	90.7
2	Inform community and organize satellite	88.9
3	Identify children for EPI	80.6
4	Refer client – SHN clinic	80.6
5	Refer client – non SHN clinic	39.8
6	Keep FP and non-FP commodities and medicine	77.8
7	Identify and register pregnant women	75.9
8	Identify newly married couple and provide contraceptive	75.0
9	Ensure TT (pregnant and non-pregnant)	74.1
10	Provide remainder to injectable	74.1
11	Ensure reproductive health services to adolescents	74.1
12	Identify potential FP clients	73.1
13	Counsel pregnant women for nutrition	67.6
14	Ensure PNC care	48.1
15	Keep family register for all household in catchment area	42.6
16	Distribute IEC materials	39.8
17	Awareness building on ESP	-
18	Identify dropout FP clients	-
19	Identify women who can't come out of home due social stigma and supply FP commodity to them	-
20	Update consumers' knowledge on new services	-

2.2.2 Monitoring and supervision of CSPs

CSPs are directly reportable to service promoters (SPs) with a dotted line to clinic manager. During satellite day usually SP communicate with respective CSP, but don't collect data from them on that day. CSPs work in their catchment area across the month and come to static clinic once in a month to submit their data collection record sheet. Usually on that day SP receives client record sheets from CSPs. Clinic manager and SP has plan to random visit to CSPs to oversee their activity, but no follow up plan or after visit report was generated.

Table-B3: Monitoring practices			
Particulars	**Urban**	**Rural**	**Notes**
SP:CSP	1:5	1:16	
Supervisor	Directly SP, indirectly – CM and paramedic on satellite day		
Interaction with SP	usually weekly	Usually twice in a month (meeting and satellite day)	▪ Sometimes with referral client ▪ CSP invites SP over phone in critical need /day observation ▪ Regularly monitors product sell status and registers ▪ SP provides technical support – maintaining registers – hands on support in routine activities
Role of clinic manager	Random visit	Random visit	▪ Convene monthly meeting ▪ Occasionally monitors product sell status ▪ On emergency need visits
Challenges	For SP and CM - no written monitoring guideline to supervise CSPs Lack of control – as CSPs are volunteers, they often threaten to quit job.		

2.3 Relationship and Comparison of Activities of CSPs and Other CHWs

This assessment profiled activities of four other community health workers – BRAC (sastho sebika), SMC (community sales agent), Marie Stopes (community based mobilizer), and JITA (oporajita). Activities of other CHWs are juxtaposed with SHN CSPs. Before comparing other CHWs with CSPs by specific products, Table B4 provides a general overview about the activities of CSPs and other CHWs. CHWs of other organization are comparatively a bit more educated and their product basket is broad. Some of the organizations are providing more income generating product, equipment, and training. Their CHWs are capable of performing some basic screening like measuring blood pressure, random blood sugar level testing and temperature, whereas satellite spots of SHN are performing such kinds of basic diagnosis in the community. In a nutshell, CHWs of some other organizations are in a better position in terms of both service and products.

Table-B4: General comparison of SHN CSPs with other CHWs	
SHN CSPs	**Other CHWs**
Usually a community member	Not necessarily member of the community
Provides consultation, information and sells limited products to the community	In general service and product basket is broad
Age: On an average late thirties	Mid-twenties or early thirties
Academic background – Mostly below SSC	Usually SSC passed
Gets honorarium	Usually they don't (exception: Marie Stopes)
No formal process of skill development	Trained and provision of skill development
Carries no equipment	Carry equipment – BP, Thermometer and Glucometer
Satellite is backing their presence in the community	No regular/periodic process like satellite clinics
Weak reporting system	More formal reporting process
Provides referral service	Provides referral service

Furthermore, CPSs maintain a mutually beneficial relationship with government and other non-government CHWs in the workplace. They exchange informational and sometime commodities. SHN static clinic allows to get referral commission for any other CHWs by referring clients, and other CHWs are referring clients to SHN static basically for the sake of financial benefit. The following table provides glimpse of mutual support areas for CSPs with other CWHs working in the field.

Table-B5: Collaboration CSPs with other CHWs

Organization/ Cadre	Support areas
FWA/FWV	▪ Take emergency FP contraceptive (informally) ▪ EPI – complementary to each other ▪ Technical support (give intramuscular injection) ▪ Share technical knowledge
Community health care provider (CHCP)	▪ Competition – CC provides everything free
BRAC	▪ They informally refer client for delivery to static clinic for commission ▪ Refer for TT vaccine and Immunization Sastho Sebika (SS) and Sastho Kormi (SK) of visit community before satellite session date which reduce demand for services in the community.
SMC	▪ Send ANC/PNC client to satellite and static
MS	▪ CSP provides commodities (informally) ▪ Exchanges technical and professional information
JITA	▪ No relation established yet
Other NGO	▪ Other NGOs seek support from CSP to understand about the community prior to any new program intervention

2.3.1 Comparison by products

SHN CSPs and BRAC CHWs have a long presence in the community. Number of BRAC CHWs are almost ten times than SHN CSPs, and they have multiple engagement with different BRAC projects. Other organization have scaled up presence of their CHWs in recent past. Among all the five comparison groups product and service type of JITA is distinct. SMC provides more products and profit share to their CSAs. Products offered by SHN CPSs are not uniform rather it varied from past managed NGO to NGO and clinic to clinic. In broad stroke, these five CHWs working for different organizations offer twelve broad product types in the community, and BRAC CHWs are selling highest variety of commodities followed by SMC and SHN CSPs. Type of products are not uniform across CSPs, but it remained almost consistent for other CHWs. For instance, all CSA of SMC has same list of product, whereas CSPs offer few products from the mentioned Table B6. Grocery items of JITA includes edible oil, flour, semolina (suji), noodles and tea. Likewise, cosmetics and hygiene basket of JITA is also diversified, it includes - soap, liquid handwash and soap, tooth powder, tooth paste, lip gel, baby lotion, and toilet cleaner. This table only shows the type of products that are available, but does not reflect how much they earn selling these products. Though there is no written instruction, usually clinics don't give products to CSPs which worth more than her monthly honorarium. How much product CSPs are selling and how much they are getting as profit share can be found in the annex–5 (Table-CSP 05 and Table-CSP 06).

Table-B6: Product range of CSPs and CHWs						
Sl	**Products**	**CSP (%)**	**SMC**	**BRAC**	**MS**	**JITA**
1	FP products	87	√	√	-	-
2	ORS	66	√	√	-	√
3	Sanitary napkins	68	√	√	-	√
4	Iron, Calcium, Zinc	48	√	√	-	-
5	Baby nutrients	48	√	√	-	-
6	Pregnancy test kit	11	√	-	-	-
7	OTC medicine (Paracetamol, Antacid)	20	-	√	-	-
8	Delivery kit	9	√	√	-	-
9	Cosmetic item for women	-	-	-	-	√
10	Reading glass	-	√	√	-	-
11	Grocery item	-	-	-	-	√
12	Iodized salt	-	-	√	-	-

The relationship of CSPs with other CHWs found to be some extent supplementary, but mainly it is competitive. CSPs think that other CHWs have more product and services which attracts more clients.

2.4 Some other CHWs

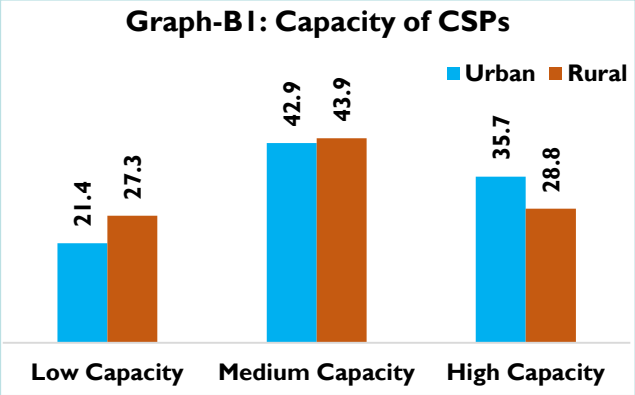
During FGD with CSPs it came out that there are other eight other CHWs working in the sampled assessment area. CSPs also mentioned active presence of village doctors in the community. Penetration of service and products through CHWs is making the market competitive day by day. Though all types of CHWs are not working in the same catchment area, still overlapping exits which is putting CSPs in more competitive state. Some NGOs emerging with new services - for instance Jibito Bangladesh trained their CHWs who can attend home delivery, which reduces scope for both SHN static clinic and CSPs.

Table-B7: Major activities of other CHWs		
Sl	**Organization that have CHWs**	**Major activities**
1	Simantik	✓ Sells moni-mix and zinc tablet ✓ Sells FP products like pill, condom ✓ Sells ORS, napkin, delivery kit ✓ Checks diabetic, weight, temperature, pregnancy using PT strip ✓ Counselling for TT, nutrition, and FP methods
2	Palli Unnayon Songstha	✓ Visits community to know menstruation dates of the women in households and provide services ✓ Sells general medicine like antacid, syrup, iron tablet, vitamin ✓ Sells commodities like napkin, FP products ✓ BP check, Push injection, Diabetic check ✓ Counselling for TT and FP methods
3	Jibito Bangladesh	✓ Jibito Bangladesh health workers conduct home delivery and ✓ Also provides free iron and calcium tablets
5	FPAB	✓ Test the diabetics, check pregnancy, blood pressure screening ✓ Provide calcium and iron tablets ✓ Counselling for nutrition
6	Caritas	✓ Provides nutrition counseling

Table-B7: Major activities of other CHWs		
Sl	**Organization that have CHWs**	**Major activities**
		✓ Counselling for ANC and PNC care ✓ Counselling for breastfeeding
7	Sajeda foundation	✓ Provides nutrition counseling
8	PKSF	✓ Sells pill, condom, moni-mix, iron and calcium tablet ✓ Checks BP, weight, diabetic, baby growth

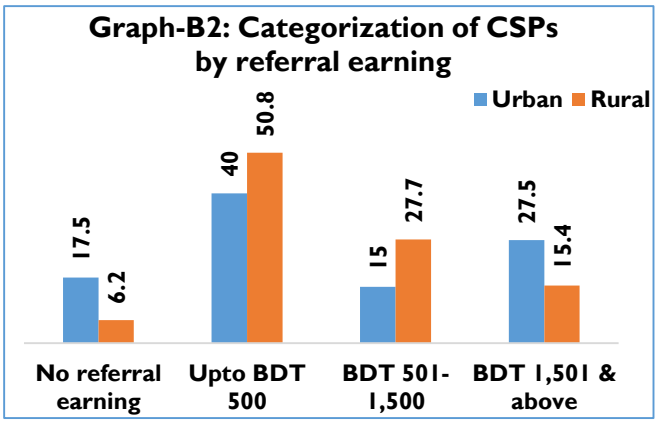
2.5 Capacity and Skill of CSPs

While evaluating capacity and skill of CSPs, several components were taken into considerations. In this assessment, we put forward a composite index to get an overarching idea about CSPs. In categorizing CSPs the variables (with respective weight) we took into account were – education (30%), referral earning (25%), job tenure (15%), responsiveness (10%), behavior (10%), and number of training received (10%). According to the index, we get around 24% low (average urban and rural) capacity CSPs and 32% (average urban and rural) high capacity CSPs working CSPs in the network. Average salary for CSPs (both in urban and rural) is BDT 929, it implies that SHN is spending on an average BDT 15,97,880 for low capacity CSPs in a year (taking total number of CSPs – 7165).



Medium ranges around 10% on mean.

Additionally, CSPs were classified by their status of referral income. The analysis conveys that in general around 12% CSPs do not have any referral earing, and both in urban and rural area most of the CSPs' referral income is around 500 Tk. In the middle range rural CSPs have more referral income, but in upper income range urban CSPs are comparatively better performing – 27.5% urban CPSs have referral earning more than 1500 Tk whereas around 15% rural CSPs earn that amount.



2.6 Influencing Factors to CSP's Referral Earnings

To understand the influencing factors of CSP,s performance, we analyzed job tenure and monthly home visit coverage of CSPs with their respective referral earning. We found that job tenure of CSP has positive association with referral earnings. CPSs with job tenure more than three years had more referral earnings than those with job tenure of less than three years. SHN should give special attention to retain the experienced CSPs. Longer job tenure might have increased network strength of CSPs and boosted the trust of community that have resulted higher referral earnings. Likewise monthly home visits coverage of CSPs has

Table-B8: Influencing factors to referral earnings			
Attributes	**Urban**	**Rural**	**Total**
Job tenure			
▪ Less than 3 yrs	721	471	600
▪ 3 yrs & above	1,476	823	1,044
Monthly HH visit			
▪ Less than 100	1,330	288	448
▪ 100 & above	1,182	834	980
Total	**1,189**	**743**	**916**

positive influence on referral earnings. Referral earnings was found higher for those CSPs whose monthly home visits coverage was above100 households than who visited less than100 households.

Furthermore, in gleaning skill of CSPs we mapped out types of training they attended and compared with other CHWs. All of the training are not directly administered from the central project management level, rather sometimes NGOs had their own initiative or they tagged other government or non-government initiatives. By provision all CSPs must have day long orientation training about their roles and functionality in the community, but surprisingly only 17 percent CSPs admitted that they had this fundamental training. Rigor of the mentioned training was beyond the scope of the assessment. Types of training received by SHN CPSs are unevenly distributed, thus it was difficult to understand the strategy of previous NGOs to utilize CSPs for product and service promotion. From the table below, we relate that other organization trained their CHWs stressing more structured objectives.

Table-B9: Training as a capacity status of CSPs					
Name of the training	**Trained (in %)**				
	SHN	SMC	BRAC	MS	JITA
Training on nutrition	20	√	√	-	-
Orientation training of CSP	17	-	-	-	-
IMCI – training	11	-	√	-	-
Motivation and social mobilization	9	√	√	√	-
Reproductive health	2	√	√	√	-
Basic ANC/PNC care	5		√	-	-
Use of Equipment (BP machine, Glucometer)	-	√	√	-	-
FP method and service	4	-		√	-
Motivating customer	2	√	√	-	√
Product marketing	13	-	-	-	√

2.7 Community Demand for CSPs

CSPs has long presence in the community and they have been able to create a blueprint of Surjer Hashi brand in the community. Due to long standing relationship, people want CSPs to provide more services and products. Different organizations have started customer acquisition approach as a part of their broad social business model. While new players are entering in the landscape, SHN remained almost stagnant with their last mile cadre of service promotion strategy. Community want CSPs to provide few LCCs for instance - blood pressure and diabetic screening, making available of few OTC drugs like paracetamol and antacid. However, clients of CSSs mentioned pharmacies as their obvious alternative source both in urban and rural area.

Table-B10: Community demand for CSPs and comparison with other CHWs						
Services	**CSPs**		**What other CHWs are providing**			
	Urban (%)	Rural (%)	SMC	BRAC	MS	JITA
BP check-up	30	31	√	√	-	-
Diabetic screening	30	11	√	√	-	-
Growth monitoring	14	11	√	√	-	-
Pregnancy test	2	5	√	√	-	-
Nebulizer machine	2	3	-	-	-	-
OTC drug	2	4	√	√	-	-
FP commodities at lower cost	2	1	-	-	-	-
Calcium/ Iron tablet/Zinc	1	2	√	√	-	-
Assistance in safe delivery	2	5	√	√	-	-

Interestingly, clients of CSPs did not consider government facility as their first choice, despite being it free of cost. Detail reasons were not examined in this assessment, but few qualitative information came out where people talked about proximity as the prime factor to choose pharmacy.

Table-B11: Sources of services and products that are not provided by CSPs				
	Pharmacy	**SHN static**	**GoB facility**	**Private**
Urban	78%	26%	7%	4%
Rural	86%	53%	3%	1%

Through this assessment, we asked community to rank or value the services and information they get through CSPs – where the question remained open ended. Later on we categorized broad head services into product and information.

Table-B12: Rank of CSPs' services and information by community		
Rank	**Product**	**Information**
1	Oral pill	Comparative advantages of various FP methods
2	Condom	EPI dates
3	Sanitary napkin	Timing of satellite – ANC/PNC
4	ORS	Date of TT and FP injections
5	Pregnancy test kit	Nutritional foods
6	Baby nutrients (moni-mix), iron tablets, calcium	How to take care of neo-born babies

Clients clearly top ranked FP commodity (condom and pill) as the highest ranked product CSPs offer to them, whereas information on comparative advantage of different FP method information was best value information to them followed by reminding them EPI dates. Except ORS, all the products and information were related to maternal and child health.

2.8 Sustainability of CSPs

The network is currently going through a paradigm shift of management and approach. By that it is meant that, SHN – a centralized management has to meet double bottom line of financial viability and pro-poor service mandate. In this section we will elucidate how much CSPs are taking as different form of compensation and how much they are contributing to revenue. We will also juxtapose income of CSPs with other CHWs by difference sources. At the end of this section we will propose two product and service basket taking into account few assumptions. In this assessment, we did not calculate monetary value of CSPs' activity from community perspective that is how much the community save due the presence of CSPs in the community.

This table (table B-13) ascertains overall income of CSPs and other CHWs by sources. Comparatively new in social business, JITA is providing more fringe benefits for their CHWs to attract and retain for example they provide insurance coverage, festival gift, sometimes unannounced incentives. SMC as producer of products shares more profit margins with their CSAs.

Table-B13: Income (BDT) by sources						
Source of income	CSP-Urban	CSP- Rural	SMC	BRAC	MS	JITA
Referrals	1,189	743	811	668	1,500	-
Device use (tests)	-	-	252	122	-	-
Medicine	40	35	937	320	-	-
Product					-	2,197
Honorarium	1,114	744	-	-	4,500	-
Total Income	2,343	1,540	2,000	1,110	6,000	2,197

2.9 Cost and Revenue of CSPs

Job of CSP is voluntary by nature, but they are contributing towards revenue of the network. The assessment attempted to estimate CSP's cost from SHN's perspective. In doing so, we took into consider: average number of CSPs, monthly honorarium of CSP, monthly salary of CM and SP (annualized proportion), average per month number CSPs monitored by CM and SP, average number of visits by CM and SP to CSP's area, proportion (percent) of CM's and SP's time spent for CSP, and average travel cost of visit per CM and SP. Again, in revenue calculation average sale per month per CSP and average monthly revenue earning from referrals per CSP were taken into account. From table B13, we find that cost recovery for CSP is – is 53%. In terms of absolute numbers urban CSPs are expensive, but their revenue contribution offset it. Detail picture is shown in table-B14.

Table-B14: Cost and revenue of CSP			
	Urban	**Rural**	**Total**
Cost per CSP (BDT)	2,917	1,489	1,937
Revenue contribution per CSP (BDT)	1,547	786	1,028
Cost recovery (%)	53	53	53

The cost and revenue calculation methodologies are presented in annex-4.

Section C: Overall Assessment and Recommendation

Objectives of the assessment was interrelated, and it was fully realized during our data analysis. The overall report has been presented like a story of CHWs working in Bangladesh, and what is the state of SHN CSPs. By understanding state of CPSs we first tried to glean current functionalities of CSPs and then compare with the landscape of other CHWs working for other organizations.

More than seven thousand CSPs are currently working under SHN and the assessment opened up the fact that around seventeen percent of them are did not pass class VIII – in Bangladesh it is assumed that is cohort cannot read and write, which does not match with the entry educational requirement of CSPs. To provide a generalized idea about the capacity of CSPs we developed a composite index considering education, referral income, experience, behavior, responsiveness, and training. The index shows that in SHN there are around sixty six percent CSPs who has some capacity and can be equipped to provide services. In general CSPs not only incur cost for SHN, they also reimburse fifty three percent. If we would estimate savings of the community due to existence of CSPs, actual contribution of CSPs could be more visualized.

Other organizations like SMC and JITA are equipping their CHWs with diversified products and capacity. Due to long existence of Surjer Hashi brand, people have some trust on SHN. But it past research shows that it is depleting. Our assessment found that product and services offered by CSPs are not uniform across the network, other CHWs do have. To be compatible with social business model SHN needs make some structured model for CSPs. Considering the information and insights we got from the study, the team came up with the following set of recommendations:

Training: To keep CSP service relevant AUHC/SHN needs to train them. All the CSPs must know clearly about what their supposed to do, why they are doing it? Basic training could be provided in whole sale approach and region wise by batch. Besides, in a retail approach, AUHC/SHN can provide specific technical – for instance blood pressure and diabetic screening, training to few high capacity CSPs as pilot.

Redefine service and product basket: SHN CSPs need to be compatible with other CHWs in terms of availability of service and products. High capacity CSPs could be provided with BP and diabetic screening machine. Besides, few OTC drug like paracetamol antacid, omeprazole can be include (if allowed by GoB).

Revise role description: Based on CSPs capacity, and service and product basket, revise job description to make them market demand driven. It is also important to review the existing monitoring and supervision system for CSPs, to make them focused and accountable to the community.

Value experienced CSP: Strategy to retain experienced CSPs is required as analysis shows they contribute more towards revenue and referral.

Promotion: SHN and AUHC needs to re-define strategy for community mobilization and product promotion. The name "Surjer Hashi" still is well known among people of all strata, where revitalization is a must.

Downsizing CSPs: SHN may consider rationalize number of CSPs. Those who are not unable to perform, will be burden on SHN. Though it is a management decision about the basis of down sizing number of CSPs-the assessment provided some ideas like low capacity CSP and CSPs who have no referral earning. Around 17 percent CSPs are found low capacitated.

Annexes

Annex-1: Objective Specific Assessment Questions

Sl.	Objective	Key Questions
1	To explore services provided by CSPs based on geographic locations, community settings and under the urban and rural context	a) What services CSPs are providing now? b) What products/ commodities they are providing? c) What costs are incurred to provide these services/ products? d) How much revenue they take in when providing these services and products? e) Are there other services and products that the community wants that CSPs could provide? f) What is the relationship with other private/NGO clinics/other community health workforce?
2	To evaluate skills, capacity, attitude and management practices of CSPs	a) What skills and capacity do CSPs currently have? b) How are CSPs supervised? By whom, how often? Supervisory practices? c) What is the community perception of CSPs? What is the perception of CSPs in comparison to other community health workers? What kind of trainings have CSPs received? d) How can SHN make the best use of a community workforce going forward? What should they do? Who should do it?
3	To understand communities' perception of the need for and role of community service providers.	a) Do the people in the community feel that they benefit from the presence of CSPs? b) How do they benefit from the presence of CSPs? c) What services (including information, and products) of the CSPs do they value the most (try to get a list and rank them) d) If information is valued, what kind of information do the community want from the CSPs e) What additional products or services would they want CSPs to offer? What are the existing sources of these products and services? Why would they prefer CSPs to the existing sources?
4	To evaluate the capacity requirements for potential roles of CSPs;	a) What skills/knowledge the community health workforce requires to deliver on the expectations from their communities? b) What kind of support structure (investment, information, knowledge, skills and other resources) is required to utilize them in future roles?

Sl.	Objective	Key Questions
5	To assess the services, products and revenue model of CSPs of the other healthcare service provider (BRAC, SMC, Marie Stopes). BRAC Shasthya Shebika, SMC-Community Sales Agent, Marie Stopes-community health worker, JITA- Aparajita)?	a) What are the services, products? at what price points? b) Who are your clients? c) Which of these products and services earn revenue, and what do you offer for free? d) Who pays for the cost of your operations? e) What activities do you do on daily basis? f) What are your sources of information, knowledge and other resources? g) Did you receive any training? What are they? h) Do you earn enough revenue to cover the cost of operations? If not, how is your operations financed?
	Comparative mapping to understand market niche (service/products, information, cost, revenue, profit, support system, supervisory perspective)?	a) Do you think your CHWs earn enough revenue to cover the cost of operations? If not, how is your operations financed? b) Do you want to change any part of your operations in the future? Drop any product or service? Or add any new product or service? c) How your product/service basket has been decided? d) How do you promote your products and services?

Annex-2: List of Sample Clinics

Division	District	Thana/ Upazilla	Clinic Address	Clinic Type	Clinic Site	# of SP	# of CSP	Name of Clinic Manager	Cell/ Phone Number
Barishal	Bhola	Charfession	1 No. Word Charfassion Powrosava, Bhola	EMOC-B	Rural	6	72	Md. Shajhan	01716-490089
	Bhola	Monpura	Bhadherhat (Faize Uddin), Post: Hazirhat, Monpura, Bhola	Vital	Urban	2	26	Md. Jafar Ullah	01715-648050
	Barishal	Bakerganj	Vill: Charamoddi, Upazilla: Bakerganj, District: Barishal	Vital	Rural	2	20	Md. Sirajur Rahman	01711-020227
	Barishal	Wazirpur	Vill: Slok, PO: Damura Bandhor, Upazilla: Wazirpur, Barishal	Vital	Rural	2	20	Md. Mizanur Rahman	01717-488172
Sub- Toral	**2 District**	**4 Upazila**		**Vital: 3 EMOC- B: 1**	**Rural: 03 Urban: 01**	**12**	**138**		
Chattogram	Chattogram	Banshkhlai	Chechuria, Banskhali, District: Chattogram	EMOC-B	Rural	2	38	Md. Towhidur Raham	01812-425708, 01714-371414
	Cox's Bazar	Cox's Bazar	Main Road, Rumalirchara, Cox's Bazar	EMOC-C	Urban	2	28	Mohammad Isa	01818-604311, 0341-52128
	Chattogram	Patiya	Haji Jabbar Sawdagar Building, Bus Station, Boiltali Road, Patiya, Chattogram	EMOC-B	Urban	2	20	Rupash Kumar Mutsuddi	01913-848469, 01819-915595
	Cox's Bazar	Ramu	Al-Mazidia Shopping Complex (1st floor), Ramu Bi-pass, Ramu Sadar, Cox's Bazar	EMOC-C	Rural	3	60	Khandaker Delwar Hossain	01813-256611, 01713-601987, 0342-556310
Sub- Total	**2 District**	**4 Upazila**		**EMOC- B: 2 EMOC- C: 2**	**Rural: 02 Urban: 02**	**9**	**146**		
Dhaka	Tangail	Kalihati	Tangail Road (Near Petrol Pump), P. O: & Thana: Kalihati, Tangail	Vital	Rural	3	42	Md. Mokhlesur Rahman	01716-104887
	Dhaka	Shewrapara	674/1 West Shewrapara, Mirpur, Dhaka	Vital	Urban	4	5	Ms. Shahadat Hossain	01727-242620
	Dhaka	Nawabgonj	Sadapur, Nawabgonj	Vital	Rural	1	26	Md. Mizanur Rahman	01729-902686
	Dhaka	Mirpur	City Corporation Building, Golartak (Near Shahid Budhijibi Kabarsthan), Mirpur-1, Dhaka	Vital	Urban	2	6	Tareq Sarwar	01819-838988
Sub Total	**2 District**	**4 Upazila**		**Vital: 04**	**Rural: 2 Urban: 2**	**10**	**79**		
Khulna	Bagerhat	Chitalmari	Borobaria, Chitalmari, Bagerhat	Vital	Rural	3	39	Md. Zahidul Hoque	01748-980377
	Bagerhat	Bagerhat	186 Main Road, Bagerhat	EMOC-C	Urban	4	8	Afsana Khatun	01712-212772
	Khulna	Khulna Sadar	47 South Central Road, Khulna	EMOC-C	Urban	3	4	Md. Anis Uddin	01711-065757, 041-730024
	Khulna	Botiaghata	Sachibuniya	Vital	Rural	2	22	Kumaresh Mondal	01769-935356

Division	District	Thana/ Upazilla	Clinic Address	Clinic Type	Clinic Site	# of SP	# of CSP	Name of Clinic Manager	Cell/ Phone Number
Sub Total	**2 District**	**4 Upazila**		**Vital: 02 EMOC C: 02**	**Rural: 2 Urban: 2**	**12**	**73**		
Rajshahi	Sirajgonj	Shahjadpur	Jhikira (West of Science Collage), Ullapara, Sirajgonj	Vital	Urban	2	6	Salam	01714-865889
	Rajshahi	Poba	Vill: Bayabhola Bari, P.O: Nawhata, Upazilla: Poba, Rajshahi	Vital	Rural	3	36	Md. Salah Uddin	01712-850543
	Sirajgonj	Ullapara	Jhikira (West of Science Collage), Ullapara, Sirajgonj	Vital	Urban	2	4	Shafiqul	01745762248
	Rajshahi	Naodapara	North Naodapara, Bypass More, Naodapara, Rajshahi	EMOC-C	Urban	2	9	Md. Ashikul Huda	01722-403306
Sub Total	**2 District**	**3 Upazila**		**Vital: 03 EMOC C: 01**	**Rural: 1 Urban: 3**	**09**	**55**		
Rangpur	Gaibandha	Sundargonj	Monmoth, Bamundanga, Sundargonj	EMOC-B	Rural	2	48	Poritosh Chandra Barman	01723-208009
	Rangpur	Pirgacha	Vill: West Debu (Matherpar), Union: Tambulpur, Post & Upazila: Pirgacha, Rangpur	EMOC-B	Rural	2	40	Md. Hossain Mondal	01714-600661
	Rangpur	Kaunia	Haquebazar, Haragach, Kaunia, Rangpur	EMOC-B	Urban	2	11	Rebeka Sultana	01796-004875-
	Rangpur	Rangpur Sadar	Mulatole Bazar, Ranngpur	EMOC-C	Urban	3	24	Md. Abdus Salam	01914-145729
Sub Total	**2 District**	**4 Upazila**		**EMOC B: 03 EMOC C: 01**	**Rural: 2 Urban: 2**	**09**	**123**		
Sylhet	Sylhet	Balagonj	Kodomtala, Tajpur, Balagonj, Sylhet	EMOC-B	Rural	3	57	Md. Fozlu Miah	01712-683946
	Habigonj	Habiganj	Zakir Vila, Ramkrishna Mission Road, Habiganj	Vital	Urban	1	5	Motilal Das	01819-572304
	Sylhet	Sadar	46 Shopnil, Ramerdigirpar, Mirjajangal, Sylhet	EMOC-C	Urban	1	4	Sumon Sheikh	01710-707488
	Habigonj	Chunarughat	Ubahata, Chunarughat, Habigonj	Vital	Rural	1	5	Md. Amir Hossen	01718-837327
Sub Total	**2 District**	**4 Upazila**		**Vital: 02 EMOC B: 01 EMOC C: 01**	**Rural: 2 Urban: 2**	**06**	**71**		
Total	**14 District**	**27 Upazila**		**Vital: 14 EMOC- B: 07 EMOC- C: 07**	**Rural- 14 Urban- 14**	**67**	**685**		

Annex-3: Composite Index for categorization of CSPs

SL	Indicators	Mark	Status		
			High	Medium	Low
1	Education:	No formal education =0 Below SSC =1 SSC/equivalent=2 HSC/equivalent and above=3	3	2	1
2	Job tenure	Less than 1 yr=1 1-5 yrs=2 6-10 yrs=3 11 yrs & above=4	4	3-2	1
3	Number of training received by CSP	No. of training…. 0=0 1-2=2 3 & above=4	3	2	1
4	Responsiveness	CM's observation on the assessment of CSP [value 0-4, where Poor=1 Moderate=2 Good=3 Excellent=4]	4	3-2	1
5	Behavior with community		4	3-2	1
6	Earning from referral service	0= less than 100 BDT earning per month ; 1= 100 to BDT 500 earning per month; 2= Above BDT 500 earning per month	3	2	1
		Total Mark	**21**	**12 - 15**	**6**

Reference tool: Clinic Managers' (CM) assessment on CSP's Skill and Capacity

Variable considered and Weightage given:

- Education (30%),
- Revenue earning (25%)
- Number of training received (10%)
- Job tenure (15%)
- Responsiveness (10%), and
- Behavior (10%)

Categorization: Medium ranges around 10% on mean

Annex-4: CSP's Cost and Revenue Calculation Process

Basis of CSP's Cost calculation from SHN's perspective

Now say,

- Average number of CSP=A
- Monthly Honorarium of CSP=B
- Monthly salary of SP (annualized proportion)=C
- Monthly salary of CM (annualized proportion)=D
- Average per month number CSPs, monitored by SP=E
- Average per month number CSPs, monitored by CM=F
- Average number of visits by SP to CSP's area=G
- Average number of visits by CM to CSP's area=H
- Proportion (percent) of SP's time spent for CSP=I
- Proportion (percent) of CM's time spent for CSP=J
- Average travel cost of visit per SP=K
- Average travel cost of visit per CM=L

Calculation process

- Time cost of SP per CSP = (C*I)/E=TS
- Time cost of CM per CSP = (D*J)/F=TM
- Travel cost of SP per CSP = K*(G/A)=VS
- Travel cost of CM per CSP = L*(H/A)=VM

Now average per month COST for CSP = B+TS+TM+VS+VM

Basis for CSP's revenue calculation

Now say,

- Average sale per month per CSP=S
- Average monthly revenue earning from referrals per CSP =R

Calculation process

- Clinic revenue from sales (25% markup-assumption) = S*25%=RS
- Clinic revenue from referrals (40% markup-assumption) = S*40%=RR

Assuming (100-40) = 60% cost includes, Cost of capital items, related staff cost including CSP's remuneration.

Now average per month REVENUE earning per CSP = RS+RR

Annex-5: Reference Output Tables

Table-CSP 01: Basic profile of SHN CSPs

Attributes		Urban		Rural		Overall	
		Mean	Col %	Mean	Col %	Mean	Col %
Avg. age (in yrs)		35		39		37	
Avg. job tenure (in yrs)		7		10		9	
Marital status	Married		81.0		86.4		84.3
	Unmarried		9.5		1.5		4.6
	Divorced/ separated		4.8		3.0		3.7
	Widow		4.8		9.1		7.4
	Total		100.0		100.0		100.0
Education qualification	Informal Education		0.0		7.6		4.6
	Primary level		16.7		10.6		13.0
	Eight passed		45.2		57.6		52.8
	SSC/equivalent passed		19.0		13.6		15.7
	HSC/equivalent passed		11.9		10.6		11.1
	Graduate/equivalent and above		7.1		0.0		2.8
	Total		100.0		100.0		100.0

Table-CSP 02: Basic profile of SHN CSP-Nutrition

Attributes		Urban		Rural		Total	
		Mean	Col %	Mean	Col %	Mean	Col %
Average age (in years)		46		25		39	
Average job tenure (in years)		15		2		11	
Marital status	Unmarried		50.0		100.0		66.7
	Divorced/ separated		50.0		0.0		33.3
	Widow		0.0		0.0		0.0
	Total		100.0		100.0		100.0
Education qualification	SSC/equivalent passed		50.0		0.0		33.3
	HSC/equivalent passed		50.0		100.0		66.7
	Total		100.0		100.0		100.0

Table-CSP 03: Role of CSP in the Community

Sl	Name of the activity	Percentage
1	Ensuring ANC checkup	90.7
2	Inform community and organize satellite	88.9
3	Identify children for EPI	80.6
4	Refer client – SHN clinic	80.6
5	Refer client – non SHN clinic	39.8
6	Keep FP and non-FP commodities and medicine	77.8
7	Identify and register pregnant women	75.9
8	Identify newly married couple and provide contraceptive	75.0
9	Ensure TT (pregnant and non-pregnant)	74.1
10	Provide remainder to injectable	74.1
11	Ensure reproductive health services to adolescents	74.1

Sl	Name of the activity	Percentage
12	Identify potential FP clients	73.1
13	Counsel pregnant women for nutrition	67.6
14	Ensure PNC care	48.1
15	Keep family register for all household in catchment area	42.6
16	Distribute IEC materials	39.8
17	Awareness building on ESP	-
18	Identify dropout FP clients	-
19	Identify women who can't come out of home due social stigma and supply FP commodity to them	-
20	Update consumers' knowledge on new services	-

Multiple responses

Table-CSP 04: Products/commodities (that earn revenue) provided by CSP in the community

	Urban		Rural		Total	
	Col %	Row %	Col %	Row %	Col %	Row %
FP products	81.1	34.1	90.6	65.9	87.1	100.0
Iron, Calcium, Zinc	54.1	41.7	43.8	58.3	47.5	100.0
ORS	64.9	35.8	67.2	64.2	66.3	100.0
OTC medicine (Paracetamol, Antacid)	24.3	45.0	17.2	55.0	19.8	100.0
Sanitary napkins	70.3	37.7	67.2	62.3	68.3	100.0
Soap (Lux & Rin)	2.7	50.0	1.6	50.0	2.0	100.0
Zinc Syrup	27.0	52.6	14.1	47.4	18.8	100.0
Delivery kit	13.5	55.6	6.3	44.4	8.9	100.0
Pregnancy test kit	8.1	27.3	12.5	72.7	10.9	100.0
Mayer bank	2.7	20.0	6.3	80.0	5.0	100.0
Total	100.0	36.6	100.0	63.4	100.0	100.0

Table-CSP 05: Average per month products and commodities sell proceeds by CSP in BDT

Products and commodities	Urban	Rural	Total
Pill (Sukhi)	260	219	232
Condom	120	118	118
Moni mix	134	187	159
ORS	182	156	164
Napkin/ Joya	242	224	232
Iron	140	51	81
Napa/ Paracetamol/ fever & cold	156	56	69
Implant	487		487
Femicon	187	195	192
Mayer Bank	70	93	88
Femi pill	103	76	84
Lux soap	14	196	159
Rin Detergent	250	344	313
Matril		80	80
Antacid/ Seclo/ Renidin	360	219	239
Calcium		88	88

Products and commodities	Urban	Rural	Total
Test me		150	150
Zinc	115	62	92
Delivery Kit	164	95	147
Test me (Mango)	65		65
Alcet	100		100
Nordet 28	50	58	55
Minicon	102	100	101
C-vit	36	36	36
Pampers	100		100
PT strip	300	131	146
Apon pill	78	20	55
Vitamin Syrup		165	165
Cotrim		15	15
Ovested	140	233	210
Marvelon	105	175	158
Lynes	130	173	163
Total	**175**	**154**	**162**

Table-CSP 06: Average monthly profit earned by CSP by selling products and commodities

Products and commodities	Urban	Rural	Total
Pill (Sukhi)	130	91	104
Condom	49	38	42
Moni mix	29	19	24
ORS	19	19	19
Napkin/ Joya	30	29	29
Iron	27	22	24
Napa/ Paracetamol/ fever & cold	31	15	17
Implant	43	.	43
Femicon	22	20	21
Mayer Bank	14	16	15
Femi pill	14	10	11
Lux soap	3	58	47
Rin Detergent	27	65	52
Matril	.	20	20
Antacid/ Seclo/ Renidin	30	64	59
Calcium	.	12	12
Test me	.	23	23
Zinc	22	17	20
Delivery Kit	20	15	19
Test me (Mango)	7	.	7
Alcet	5	.	5
Nordet 28	4	5	4
Minicon	11	10	11
C-vit	6	2	3
Pampers	15	.	15
PT strip	120	39	46
Apon pill	16	4	11
Vitamin Syrup	.	7	7

Products and commodities	Urban	Rural	Total
Cotrim	.	2	2
Ovested	16	25	23
Marvelon	11	17	16
Lynes	14	15	15
Total	**40**	**35**	**37**

Table-SCA 07: Capacity and Skill of CSPs (based on the composite indicators)

	Urban	Rural	Total
Low Capacity	21.4	27.3	25.0
Medium Capacity	42.9	43.9	43.5
High Capacity	35.7	28.8	31.5
Total	100.0	100.0	100.0

Table-CSP 08: Categorization of CSPs by referral earning

	Urban	Rural	Total
No referral earning	17.5	6.2	10.5
Upto BDT 500	40.0	50.8	46.7
BDT 501-1,500	15.0	27.7	22.9
BDT 1,501 & above	27.5	15.4	20.0
Total	100.0	100.0	100.0

Table-CSP 09: Average referral earning per month per CSP

	Urban	Rural	Total
Referral earning per month	1189	743	916

Table-CSP 10: Average monthly honorarium/salary

	Urban	Rural	Total
CSP	1114	744	929
SP	14053	13747	13900
CM	24048	23522	23794

Table-SP 11: Suggestions to make CSPs competent in the changing market scenario of SHN (in terms of investment, information, knowledge, skills and other resources)

	Urban	Rural	Total
Provide subject wise training	100.0	94.1	97.0
Raise Salary of CSPs	62.5	64.7	63.6
Recruit educated CSPs	31.3	35.3	33.3
Provide CSPs with sufficient medicine, goods and products	31.3	23.5	27.3
Provide training and instruments like BP, diabetic testing machine, thermometer, weight machine	6.3	35.3	21.2
Arrange refresher training	25.0	5.9	15.2
Provide knowledge about new services	18.8	5.9	12.1
Provide proper orientation on ESP service	25.0	0.0	12.1
Increase monitoring on the CSPs	18.8	5.9	12.1

Provide CSPs with umbrella, bag, pen, mobile talk-time	12.5	0.0	6.1
Allocate fund to CSPs for publicity	0.0	5.9	3.0
Provide training on safe delivery	0.0	5.9	3.0
Make CSPs as regular staff	6.3	0.0	3.0
Provide books to CSPs on information of health care services	0.0	5.9	3.0
Provide salary to CSPs instead of honorarium	0.0	5.9	3.0
Arrange training on marketing	0.0	5.9	3.0
Give mobile bill to CSPs so that they may contact with SP or office for any information or problem	0.0	5.9	3.0

Multiple responses

Table-SP 12: Gaps and limitation of CSPs to perform effectively at the community level

	Urban	Rural	Total
Low work interest for poor honorarium	62.5	82.4	72.7
CSPs are not enough educated	56.3	82.4	69.7
Lack of training	50.0	58.8	54.5
Lack of necessary instruments	37.5	29.4	33.3
No provision of conveyance allowance to visit all households in the community	12.5	29.4	21.2
Local prejudice and religious restrictions	6.3	5.9	6.1
Lack of knowledge bout BCC materials	0.0	5.9	3.0
No provision of free medicine	6.3	0.0	3.0
No uniform with logo, bag, umbrella	6.3	0.0	3.0
No entertainment allowance	6.3	0.0	3.0

Multiple responses

Table-SP 13: Suggestions to minimize these gaps/ limitations

Particulars	Urban	Rural	Total
Provide training to increase efficiency	68.8	76.5	72.7
Increase honorarium of CSPs	50.0	70.6	60.6
Recruit educated CSPs (at least SSC passed)	25.0	64.7	45.5
Increase supply of necessary martials/products	62.5	29.4	45.5
Pay conveyance allowance to CSPs	18.8	17.6	18.2
Not honorarium but pay salary	6.3	17.6	12.1
Arrange refreshers training regularly	12.5	5.9	9.1
Supply adequate BCC materials	0.0	11.8	6.1
CSPs to make trained on diabetics test, blood grouping etc.	6.3	0.0	3.0
CP to provide iron, folic acid tablets at free of cost to ANC clients	6.3	0.0	3.0
Retrench those who are not capable to work	0.0	5.9	3.0
Recruit educated CSPs with high salary	0.0	5.9	3.0
Provide necessary guidelines to CSPs	6.3	0.0	3.0

Multiple responses

Table-SP 14: Potential roles of community workforce to increase SHN health coverage

Particular	Urban	Rural	Total
Provide service and information by regular home visit	56.3	76.5	66.7
Increase publicity of service through leaflet and posters	62.5	70.6	66.7
Arrange regular meetings to inform community people	31.3	35.3	33.3
Build good relation in the community	31.3	23.5	27.3
Make CSPs capable to check BP, diabetic and ANC	12.5	11.8	12.1
Miking to inform community about satellite day/date through mosque	12.5	5.9	9.1
Conduct meetings with local elites in the community	6.3	5.9	6.1

Create provision of services for male	12.5	0.0	6.1
Inform community about new services	6.3	5.9	6.1
Provide CSPs mobile numbers to the clients so that they can contact when necessary	6.3	0.0	3.0

Multiple responses

Table-Client 15: Community demand from CSPs

	Urban	Rural	Total
Blood Pressure Check-up and Medicine	29.6	30.6	30.2
Diabetics machine	29.6	11.1	19.0
Weight machine	7.4	11.1	9.5
Thermometer machine	14.8	11.1	12.7
Normal delivery	3.7	2.8	3.2
Medicine of cold and fever	.0	8.3	4.8
Iron tablets	.0	2.8	1.6
Delivery kits and open stich	11.1	8.3	9.5
Medicine for diabetics	.0	5.6	3.2
Saline	.0	2.8	1.6
Medicine for tuberculosis TB	3.7	.0	1.6
Medicine for diarrhea	.0	2.8	1.6
Pustikona and medicine for child	.0	2.8	1.6

Table-Client 16: Sources of services and products that are not currently provided by CSPs

	Urban	Rural	Total
Pharmacy	77.8	86.1	82.5
SHN	25.9	52.8	41.3
GoB Facility	7.4	2.8	4.8
Private Clinic	3.7	1.0	1.6
Total	100.0	100.0	100.0

Multiple responses

Table-CHW 17: Types of clients served by other CHWs

Client	SMC			BRAC			Marie Stopes		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Adolescent	0.0	29.0	29.0	18.0	20.7	19.7	23.5	0.0	23.5
Children	0.0	29.0	29.0	22.0	22.0	22.0	23.5	0.0	23.5
Woman	0.0	21.7	21.7	8.0	8.5	8.3	17.6	0.0	17.6
Pregnant	0.0	5.8	5.8	16.0	14.6	15.2	5.9	0.0	5.9
Adult//Old	0.0	4.3	4.3	12.0	7.3	9.1	5.9	0.0	5.9
Eligible Couple	0.0	7.2	7.2	6.0	8.5	7.6	5.9	0.0	5.9
Man	0.0	1.4	1.4	6.0	7.3	6.8	17.6	0.0	17.6
Maternal Mother	0.0	1.4	1.4	2.0	2.4	2.3	0.0	0.0	0.0
Every Person	0.0	0.0	0.0	4.0	3.7	3.8	0.0	0.0	0.0
New Couple	0.0	0.0	0.0	0.0	4.9	3.0	0.0	0.0	0.0
Adult age	0.0	0.0	0.0	6.0	0.0	2.3	0.0	0.0	0.0
Children up to 0 to 12 month	0.0	0.0	0.0	0.0	2.4	1.5	0.0	0.0	0.0
Total	0.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	100.0

Table-CHW 18: Activities of other CHWs

Activities	SMC			BRAC			Marie Stopes		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Advice and selling Sanitary Napkin – (Joya, Sanora)	0.0	27.5	27.5	12.0	14.6	13.6	0.0	0.0	0.0
Selling and advice to use Family Planning Method (Pill and Condom)	0.0	26.1	26.1	6.0	12.2	9.8	0.0	0.0	0.0
Selling and counselling for Nutrition Die	0.0	26.1	26.1	8.0	14.6	12.1	0.0	0.0	0.0
Counselling to women for T Injection	0.0	18.8	18.8	10.0	7.3	8.3	29.4	0.0	29.4
Advice ANC check-up	0.0	14.5	14.5	16.0	6.1	9.8	17.6	0.0	17.6
Sell Iron and Calcium Tablet	0.0	4.3	4.3	18.0	17.1	17.4	0.0	0.0	0.0
Counselling for Immunization	0.0	10.1	10.1	4.0	7.3	6.1	29.4	0.0	29.4
Refer to appropriate clinics for longer-term Family Planning Method	0.0	8.7	8.7	10.0	4.9	6.8	29.4	0.0	29.4
Promote Moni-mix – food and nutrition supplementation for Children	0.0	7.2	7.2	10.0	3.7	6.1	0.0	0.0	0.0
Refer patient to Static Clinic, Hospital, Private Doctor	0.0	7.2	7.2	6.0	6.1	6.1	5.9	0.0	5.9
Sell Oral Saline /ORS	0.0	15.9	15.9	2.0	3.7	3.0	0.0	0.0	0.0
Distribute Iron and Calcium tablets at free of cost	0.0	0.0	0.0	2.0	3.7	3.0	0.0	0.0	0.0
Refer to Pregnant woman for ANC cheek up	0.0	2.9	2.9	10.0	1.2	4.5	0.0	0.0	0.0
Diabetic check-up	0.0	1.4	1.4	8.0	4.9	6.1	0.0	0.0	0.0
Refer for safe Delivery	0.0	8.7	8.7	0.0	0.0	0.0	0.0	0.0	0.0
Bring Patient to Satellite Clinic	0.0	1.4	1.4	2.0	2.4	2.3	0.0	0.0	0.0
List Pregnant Woman	0.0	2.9	2.9	6.0	3.7	4.5	0.0	0.0	0.0
Sell Eye Glass	0.0	0.0	0.0	8.0	2.4	4.5	0.0	0.0	0.0
BP and Diabetic cheek up	0.0	2.9	2.9	6.0	0.0	2.3	0.0	0.0	0.0
Growth monitoring of children	0.0	2.9	2.9	0.0	1.2	.8	0.0	0.0	0.0
Advice on safe Delivery and sell Delivery kit	0.0	4.3	4.3	0.0	0.0	0.0	0.0	0.0	0.0
Blood Grouping	0.0	0.0	0.0	2.0	3.7	3.0	0.0	0.0	0.0
Sell Pregnancy test kit	0.0	0.0	0.0	2.0	1.2	1.5	0.0	0.0	0.0
Organize court-yard meeting	0.0	0.0	0.0	0.0	2.4	1.5	0.0	0.0	0.0
Identify TB Patient and refer for treatment	0.0	0.0	0.0	2.0	1.2	1.5	0.0	0.0	0.0
Advice married women on child spacing	0.0	2.9	2.9	0.0	0.0	0.0	0.0	0.0	0.0
Refer and Advice for MR, DNC to proper place	0.0	0.0	0.0	0.0	0.0	0.0	5.9	0.0	5.9
Refer for IUD and Implant	0.0	0.0	0.0	0.0	1.2	.8	0.0	0.0	0.0
Identify the Eligible Couple for FP methods	0.0	0.0	0.0	2.0	0.0	.8	0.0	0.0	0.0

Activities	SMC			BRAC			Marie Stopes		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Create awareness in the family about care of pregnant women	0.0	0.0	0.0	2.0	0.0	.8	0.0	0.0	0.0

Multiple responses

Table-CHW 19: Products/commodities CHWs offered for free to the community

	SMC			BRAC			Marie Stopes		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Provide Iron Tablet	0.0	33.3	33.3	80.0	55.6	64.3	0.0	0.0	0.0
Pill (Shukhi,)	0.0	66.7	66.7	20.0	66.7	50.0	100.0	0.0	100.0
BP check-up	0.0	33.3	33.3	20.0	0.0	7.1	0.0	0.0	0.0
TB Medicine	0.0	0.0	0.0	40.0	33.3	35.7	0.0	0.0	0.0
Injectable (Birth Control)	0.0	66.7	66.7	0.0	0.0	0.0	0.0	0.0	0.0
Measure fever	0.0	33.3	33.3	0.0	0.0	0.0	0.0	0.0	0.0
Nutritional product	0.0	33.3	33.3	0.0	0.0	0.0	0.0	0.0	0.0
Weight measuring	0.0	0.0	0.0	0.0	11.1	7.1	0.0	0.0	0.0
Hexachord	0.0	33.3	33.3	0.0	0.0	0.0	0.0	0.0	0.0
Condom	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	100.0

Multiple responses

Table-CHW 20: Products/commodities that earned revenue (offered by CHWs to the community)

	SMC			BRAC		
	Urban	Rural	Total	Urban	Rural	Total
Sanitary Napkin – (Joya, Sanora)	0.0	90.0	90.0	80.0	55.6	64.3
Pill (Femicon, Famipil, Norat, Shukhi, Ovested, Norted, MyPill, Ovacon Gold)	0.0	90.0	90.0	60.0	50.0	53.6
Nutrition / Monimix	0.0	90.0	90.0	60.0	55.6	57.1
ORS/ Saline	0.0	90.0	90.0	60.0	50.0	53.6
Condom	0.0	85.0	85.0	40.0	50.0	46.4
Provide Iron Tablet	0.0	5.0	5.0	100.0	61.1	75.0
Calcium	0.0	5.0	5.0	90.0	66.7	75.0
Zinc tablet	0.0	90.0	90.0	0.0	5.6	3.6
Delivery kit	0.0	45.0	45.0	20.0	22.2	21.4
Test me	0.0	70.0	70.0	0.0	0.0	0.0
Paracetamol/ Napa Tablet	0.0	0.0	0.0	30.0	50.0	42.9
Pregnancy test kit	0.0	55.0	55.0	0.0	0.0	0.0
Diaper / Smile Diaper	0.0	40.0	40.0	0.0	0.0	0.0
Ranitidine/ Gastric medicine	0.0	0.0	0.0	40.0	16.7	25.0
Vitamin Tablet	0.0	0.0	0.0	30.0	16.7	21.4
Glucose	0.0	15.0	15.0	0.0	0.0	0.0
Eye Glass	0.0	5.0	5.0	20.0	0.0	7.1
Medicine for Mouth infection	0.0	0.0	0.0	10.0	5.6	7.1
Medicine for Skin Disease	0.0	0.0	0.0	10.0	5.6	7.1
De-warming medicine	0.0	0.0	0.0	20.0	0.0	7.1
Salt	0.0	0.0	0.0	20.0	0.0	7.1
Safety Box/	0.0	5.0	5.0	0.0	0.0	0.0
Vitamin Syrup	0.0	0.0	0.0	0.0	11.1	7.1
Metronidazole	0.0	0.0	0.0	0.0	11.1	7.1
Glucometer (Diabetics)	0.0	0.0	0.0	0.0	0.0	0.0
Medicine for 10 General Deices	0.0	0.0	0.0	10.0	0.0	3.6

Injectable (Birth Control)	0.0	0.0	0.0	0.0	11.1	7.1
Powder Milk	0.0	0.0	0.0	0.0	5.6	3.6

Multiple responses

Table-CHW 21: Trainings the CHWs received

	SMC			BRAC			Marie Stopes			Jita		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Training on Skill Development	0.0	46.9	46.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Training on TB treatment	0.0	6.3	6.3	15.4	21.4	19.1	0.0	0.0	0.0	0.0	0.0	0.0
Training on Reproductive Health and Reproductive mechanism	0.0	25.0	25.0	11.5	4.8	7.4	20.0	0.0	20.0	0.0	0.0	0.0
Training on Nutrition	0.0	0.0	0.0	11.5	16.7	14.7	0.0	0.0	0.0	0.0	0.0	0.0
Training on 10 General diseases	0.0	3.1	3.1	11.5	16.7	14.7	0.0	0.0	0.0	0.0	0.0	0.0
Training on Mother and Child Health	0.0	9.4	9.4	11.5	4.8	7.4	0.0	0.0	0.0	0.0	0.0	0.0
Training on ANC/PNC service	0.0	3.1	3.1	11.5	7.1	8.8	0.0	0.0	0.0	0.0	0.0	0.0
Training on how to motivate customer	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	50.0	40.0	42.9
Training on Family Planning methods and services	0.0	0.0	0.0	3.8	0.0	1.5	20.0	0.0	20.0	0.0	0.0	0.0
Training on identify potential customer	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	50.0	20.0	28.6
Training on product selling and marketing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0	28.6
Motivation / Social Mobilization	0.0	0.0	0.0	0.0	0.0	0.0	40.0	0.0	40.0	0.0	0.0	0.0
Training on supplementary child feeding	0.0	0.0	0.0	3.8	2.4	2.9	0.0	0.0	0.0	0.0	0.0	0.0
Training on Pneumonia	0.0	0.0	0.0	3.8	2.4	2.9	0.0	0.0	0.0	0.0	0.0	0.0
Training on breast feeding	0.0	0.0	0.0	0.0	2.4	1.5	0.0	0.0	0.0	0.0	0.0	0.0
Training on MR,DNC,IUD	0.0	0.0	0.0	0.0	0.0	0.0	20.0	0.0	20.0	0.0	0.0	0.0
Newborn Nursing	0.0	0.0	0.0	3.8	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0
Training on device use – BP, Glucometer etc.	0.0	0.0	0.0	0.0	2.4	1.5	0.0	0.0	0.0	0.0	0.0	0.0

Multiple responses

Table-CHW 22: Procedure of selecting CHWs' service/product list

	SMC			BRAC			Marie Stops		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Based on public demand	0.0	86.7	86.7	0.0	0.0	0.0	0.0	0.0	0.0
As supplied by central office as per client need	0.0	13.3	13.3	100.0	66.7	75.0	0.0	0.0	0.0
Listing demand visiting door to door	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	100.0
As per demand Tally sheet	0.0	0.0	0.0	0.0	16.7	12.5	0.0	0.0	0.0

Based on last month sale trend	0.0	0.0	0.0	0.0	16.7	12.5	0.0	0.0	0.0
Total	0.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	100.0

Table-CHW 23: Promotional activities of other CHWs for marketing their services/products

	SMC			BRAC			Marie Stopes			Jita		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Door to door Advertise	0.0	57.1	57.1	40.0	38.9	39.3	50.0	0.0	50.0	0.0	25.0	20.0
Discuses through Courtyard Meeting	0.0	57.1	57.1	10.0	38.9	28.6	25.0	0.0	25.0	0.0	0.0	0.0
Go to door to door to Sell Items	0.0	33.3	33.3	10.0	27.8	21.4	0.0	0.0	0.0	0.0	75.0	60.0
Home visit	0.0	0.0	0.0	10.0	33.3	25.0	25.0	0.0	25.0	0.0	0.0	0.0
Distribute Leaflet	0.0	4.8	4.8	10.0	11.1	10.7	50.0	0.0	50.0	0.0	0.0	0.0
Campaign saying usefulness	0.0	4.8	4.8	10.0	5.6	7.1	0.0	0.0	0.0	0.0	50.0	40.0
Promote saying low cost medicine	0.0	4.8	4.8	10.0	5.6	7.1	0.0	0.0	0.0	0.0	0.0	0.0
Attract with branding logo	0.0	4.8	4.8	10.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0
Provide sticker to each home	0.0	14.3	14.3	10.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0
Advertise organizing Health Camp	0.0	4.8	4.8	10.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0
Communicate using mobile phone	0.0	9.5	9.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Poster/leaflets	0.0	0.0	0.0	20.0	0.0	7.1	0.0	0.0	0.0	0.0	0.0	0.0
Free medicine for the poor people.	0.0	4.8	4.8	0.0	5.6	3.6	0.0	0.0	0.0	0.0	0.0	0.0
Discuses in the School meeting with adolescent	0.0	4.8	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Advertise in Tea shop and market place	0.0	0.0	0.0	0.0	0.0	0.0	25.0	0.0	25.0	0.0	0.0	0.0

Multiple responses

Table-CSP 24: Average monthly household coverage per CSP

	Urban	Rural	Total
Monthly HH coverage	262.00	190.35	218.21

Table-SCA 25: Customer and service contact per session per CSP

	Urban	Rural	Total
Customer contact	26	29	28
Service contact	47.9	49.4	47.5

Table-SCA 26: Average monthly referral of CSP according to their capacity

	Urban	Rural	Total
Low Capacity	42	19	29
Medium Capacity	48	37	40
High Capacity	28	35	31
Total	39	32	35

Table-SCA 27: Average monthly referral earnings of SHN clinic from CSP

	Urban	Rural	Total
Low Capacity	7625	601	3674
Medium Capacity	1788	2710	2427
High Capacity	9313	1825	5153
Total	6182	1958	3577

Table-SCA 28: Average per month earning of CSP from referral according to their capacity

	Urban	Rural	Total
Low Capacity	1504	315	835
Medium Capacity	562	730	678
High Capacity	2041	422	1142
Total	1363	546	859

Table-CSP 29: Distribution of CSPs by referral earning per month

	Urban	Rural	Total
No referral earning	17.5	6.2	10.5
Upto BDT 500	40.0	50.8	46.7
BDT 501-1,500	15.0	27.7	22.9
BDT 1,501 & above	27.5	15.4	20.0
Total	100.0	100.0	100.0

Table-CSP 30: Average monthly referral earning and service contact of CSP

	Average service contact per session		
	Urban	Rural	Total
No referral earning	32	33	32
Upto BDT 500	55	54	54
BDT 501-1,500	59	48	51
BDT 1,501 & above	42	53	47

Table-CPR 31: Cost of SHN per CSP

Per month cost for each CSP	Urban	Rural	Total
Honorarium of CSP	1,114.28	743.57	928.93
Time cost of SP	1,538.11	523.04	783.78
Time cost of CM	120.33	43.28	66.49
Travel cost of SP	116.16	160.48	137.32
Travel cost of CM	28.68	19.32	20.73
Total Cost	**2,917.55**	**1,489.69**	**1,937.25**

Table-CPR 32: Time value (part of salary) of SP and CM for each CSP

Salary spent for CSP per month	Urban	Rural	Total
% of Salary of SP	10.85	3.77	5.61
% of Salary of CM	6.26	2.20	3.18

Table-SCA 33: Revenue of SHN clinic earned from CSP

Revenue	Urban	Rural	Total
Sales per month per CSP	1,130.72	787.91	905.86
25% of sales (Clinic revenue)	282.68	196.98	226.47
Revenue earning by clinic per month	3,161.81	1,474.58	2,004.85
40% of revenue	1,264.72	589.83	801.94
Revenue of clinic per CSP	**1,547.40**	**786.81**	**1,028.41**

Table-SCA 34: Average monthly income of CSP

Source of income	CSP-Urban	CSP- Rural	SMC	BRAC	MS	JITA
Referrals	1,189	743	811	668	1,500	-
Device use (tests)	-	-	252	122	-	-
Medicine	40	35	937	320	-	-
Product					-	2,197
Honorarium	1,114	744	-	-	4,500	-
Total Income	2,343	1,540	2,000	1,110	6,000	2,197