ANALYSIS ON HEALTH SERVICES IN NETRAKONA THANA.

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IN NETRAKONA THANA THERE ARE MANY GAPS TO BRIDGE.

THERE ARE GAPS BETWEEN:

PAST AND FUTURE

TRADITION AND MODERNISM

MEN AND WOMEN

RICH AND POOR

THEORY AND PRACTICE

POLICY AND IMPLEMENTATION

GOVERNMENT AND NGOs

HOSPITAL AND THANA HEALTH COMPLEX

HEALTH CENTRE AND COMMUNITY

TABLE OF CONTENTS

INTRODUCTION

1. BRIEF COUNTRY PROFILE
1.2. SHORT DESCRIPTION OF NETRAKONA THANA

2. HEALTH CARE SERVICES PROVIDED BY NGOS IN NETRAKONA THANA/DISTRICT
    2.1. INTRODUCTION
    2.2. SABALAMBY UNNAYAN SAMITY
    2.3. DAMIAN FOUNDATION
    2.4. WORLD VISION
    2.5. RECOMMENDATIONS/OPTIONS

3. HEALTH CARE SERVICES PROVIDED BY THE GOVERNMENT
    3.1. INTRODUCTION
    3.2. SHORT DESCRIPTION OF DISTRICT HEALTH DIRECTORATE
    3.3. NETRAKONA DISTRICT HOSPITAL
    3.4. ATPARA THANA HEALTH COMPLEX
    3.5. NETRAKONA THANA PREVENTIVE HEALTH CENTRE
    3.6. UNION HEALTH CENTRE MADANPUR
    3.7. RECOMMENDATIONS/OPTIONS

4. FAMILY PLANNING SERVICES IN NETRAKONA THANA
    4.1. INTRODUCTION
    4.2. SHORT HISTORY OF FAMILY PLANNING
    4.3. SHORT DESCRIPTION NETRAKONA F.P. DIRECTORATE
    4.4. NETRAKONA MCHC/FP WELFARE CLINIC
    4.5. BALVAKANDA FAMILY PLANNING CENTRE
    4.6. FAMILY PLANNING SERVICES SUS PREMISES
    4.7. RECOMMENDATIONS/OPTIONS

5. TRADITIONAL HEALTH CARE SERVICES
    5.1. INTRODUCTION
    5.2. TRADITIONAL HEALER
    5.3. RURAL LOCAL DOCTOR
    5.4. PRIVATE PRACTITIONERS

6. RECOMMENDATIONS/OPTIONS SUS ORGANISATION

7. PROJECT PROPOSAL FOR SERVICES IN SUS IDEAL HEALTH CENTRE

ANNEXES:

A. SCHEDULE OF VISITS

B. ABBREVIATIONS

C. MAP OF BANGLADESH

Ca. MAP OF NETRAKONA DISTRICT

D. HUMAN DEVELOPMENT INDICATORS

E. SUS ORGANOGRAM

F. GoB HEALTH POLICY

G. GoB HEALTH ORGANOGRAM

H. ORGANOGRAM FAMILY WELFARE DISTRICT DIRECTORATE.

I. UNICEF BASIC INDICATORS

J. ARTICLE

K. HEALTH CENTRE STATISTICS

L. BASELINE SURVEY FORM

M. KEY REFERENCES

N. TERMS OF REFERENCE

INTRODUCTION:

The collaboration between SABALAMBY UNNAYAN SAMITY and the PEOPLE'S MEETING CENTRE for the DEVELOPMENT of PEOPLE and JUSTICE AND PEACE (COV) began with a visit to the Netherlands from Bangladesh by Begum Rokeya in 1995. Links were strengthened in August 1996 when Begum Rokeya revisited the COV to exchange ideas and discuss possible cooperation in the health sector of Sabalamby Unnayan Samity (SUS).

As a result of this visit, COV in the Netherlands was asked to find ways of improving the health services in SUS. A project proposal was forwarded by SUS to the COV requesting personnel assistance. In the COV project committee meeting, this proposal aroused many questions, especially about the structure and function of the SUS health centre, and the standard of health care in the Netrakona area.

I was asked by the COV staff to represent their organisation officially for the 10th anniversary of SUS in Bangladesh (December 29th, 1996). I agreed to carry out a short analysis of the health facilities in Netrakona District. This has turned into a more comprehensive study, completed between December 17th, 1996, and 16th January, 1997.

The present report is based on interviews with SUS staff involved in the health sector, and discussions with representatives from the District Directorates of Curative Health and Family Planning Services. In addition, Thana and Union Health Services, Traditional Healers, Rural Traditional Doctors, Private Doctors and Traditional Birth Attendants were investigated. All these health providers were most cooperative in providing essential information for this report.

Netrakona District is a neglected area, the focus of few NGOs. COV in the Netherlands has always targeted areas where health services are lacking and therefore shares the same goals as SUS in Bangladesh. The two organisations are thus make ideal development partners.

I sincerely hope this report will promote not only dialogue on the future role of SUS in improving health facilities in Netrakona District, but also concrete action towards the proposed developments.

I would like to thank Begum Rokeya and Mr. Ton van Zutphen and all the staff for their logistical support in making this visit possible; their technical input into discussions; their faith in the future, and their hospitality. It was a great pleasure to work with all of you.

Toos van Helvoort
Dhaka 16 January 1997

1.0 BRIEF COUNTRY PROFILE:

1.1. General information

Situated in South Asia, Bangladesh contains almost all of the huge delta system formed by the Ganges, Brahmaputra and Meghna rivers. Up to four months of the year 2/3 of the land is washed by seven major, and more than 200 minor rivers. Bangladesh is a small country, four times the size of the Netherlands, with an estimated population of 130 million. (see annex C)
It has one of the world's densest populations: 800 people per square kilometer. Of those, 80% inhabit rural areas, 60% of whom live below the poverty line.

Administrative set up of the Government of Bangladesh

The Health infrastructure of the Government of Bangladesh (GoB) has not changed since the country's independence from Pakistan in 1971. The resently elected government (June 1996) has promised to prepare a new health policy (see Annex F). The country is divided into six regions, known as divisions. Each contains districts, of which there are 64 in the country. Districts are divided into 489 thanas. Each thana contains eight to twelve unions; there are thus about 21.000 unions in the country. One union comprises 8 to 40 villages. The thana is the basic administration unit. Netrakona thana has 269.540 inhabitants. The total population of Netrakona District is 1.855.465 (EPI 1996)

The National Parliament has more than 300 members. The President is the Head of State and the Prime Minister the Head of Government. The Secretary is the permanent officer in charge of the ministry. There are about 35 ministries. The District Commissioner is the most powerful man in the area politically; all the departments are under his authority.

The population is more than 80% muslim and the Islam is the state religion of Bangladesh.

1.2. SHORT DECRIPTION OF NETRAKONA THANA:

General information.

Netrakona is a low-lying district, many areas of which are submerged during the rainy season. In the six out of ten thanas, 50% to 80% of land is covered with water for about four months. The land is suitable for rice production and fish cultivation.

The town of Netrakona with 150.000 inhabitants, and the smaller thana centres with populations up to 30.000, appear very congested.

Road transport between these centres is often very difficult, especially during the monsoon, when boats are the preferred forms of transport between lower areas where roads are often impassable.
Health indicators show Netrakona to be one of the five most vulnerable of the 25 districts in Dhaka Division(see Annex D).

Health care services provided in Netrakona District

After the Minister and Secretary, there are two directors in the Ministry of Health: the Director for curative services, and the Director for Family Planning and Welfare services. Netrakona district has one hospital with 50 beds.

Each of the district's thanas has a 31-bed health complex. It should function as a small hospital but the services are deplorable. Each than also contains 28 health centres in the most densely populated areas. The high transferral rate on paper belies the real situation. Patients are transferred from the health clinic to the thana health complex unless their condition is critical; in this case, transferral will be to the district hospital. Medicines are distributed from the central medical store to the district pharmacy which delivers them to the thana health complex. From here, the medicines are distributed to the union health clinics.

The few statistics available show that Bangladesh is poorly served by the health services. There are only 890 hospitals with a total of 35,000 beds, 21,000 doctors and 11,000 nurses: all serving a population of around 130 million.
Reasons given for this shortage are; the emigration of doctors and nurses to the Arabic states and Malaysia, which is lucrative for the Government to get income of foreign currency.

3.3 NETRAKONA DISTRICT HOSPITAL (NDH)

HISTORY

The hospital was built in 1992. Its physical state is deplorable and it is hard to believe the hospital is only four years old.

OWNERSHIP OF HE DISTRICT HOSPITAL

It is owned by the Government of Bangladesh. Decentralisation has been discussed and apparently approved by government officials, but all administration, salaries and medicines come through the Ministry of Health and Family Planning in Dhaka. The hospital owner is under obligation to keep up health care standards but the environment is currently in a severe state of decay.

FACILITIES.

There are three types:
The indoor hospital: has an official capacity of 40 beds. Four times that mumber of patients are admitted on avarage. There are two wards; one for female patients and one for male. Each ward is divided into a medical and surgical/orthopedic section.
The outdoor: capacity has 10 beds for observation.
The emergency and outpatients department (OPD) has several consultation rooms; a dentist room; a loboratory; a radiographic room; a dressing room and administrative facilities.

CATCHMENT AREA.

The catchment area for NDH is Netrakona District. Patients are referred here by medical officers from the thana health complexes to the district hospital.
Netrakona does not have a health complex; its patients must therefore use the district hospital as their health complex. It is staggering to learn that 50 beds are available for a population of 1.850.000

MAJOR HEALTH PROBLEMS.

The health problems faced in this hospital are immense. One doctor observed that when you are admitted with one disease you might well leave with two or three others. The most common diseases are: diarrhoea, pneumonia, dysentry (two types), hepatitis, malaria, injuries, malnutrition and all other surgical and medical diseases. Infectious diseases are more seasonal.

2. HEALTH CARE SERVICES PROVIDED BY NON-GOVERNMENTAL ORGANISATIONS

2.1 Introduction: Organisations visited in the Netrakona area

Few NGOs are involved with health services in Netrakona Thana. The two chosen for analysis here are not that large and can be easily compared with SUS later on. Furthermore, there are no other organistions providing health services. These two centres are here compared. All the other NGOs are involved with development, water and sanitation, but offer no integrated health development programme comparable to SUS.

The Damian Foundation (DF) is a local NGO but its work is fragmentary, with a vertical approach. It is most sophisticated in curative treatment of tuberculosis (TB) and leprosy. There are obvious comparisons between SUS and the DF in levels of funding and cooperation with government officials. DF is a Christian organisation, founded in Belgium in the early 1950s. In Bangladesh the organisation works explicitly on TB and leprosy and not towards a comprehensive health programme.

World Vision claimed not to be a Christian organisation. Comparisons with SUS are harder: World Vision works with children and on relief programmes after famines or floods.

Through visiting the health facilities in Netrakona, I have observed a lack of care for sick patients. No nurses are employed in hsopital wards and clinics. Indeed, the nursing profession is generally underdeveloped in Bangladesh, for the following reasons:

- Religious taboos have prevented women's open involvement until recent times, and
- Nurses occupy a low social status in the country.

Sabalamby Unnayan Samity (SUS) is working to establish grass roots democracy and people-centred development. Beneficiaries include landless and marginal farming families; divorced poor women; child dropouts, and adolescent girls (aged ten to eighteen). SUS also aims to support battered, disabled and abandoned women in a sheltered home.

2.2 SABALAMBY UNNAYAN SAMITY: THE ORGANISATION

HISTORY

Sabalamby Unnayan Samity (SUS - 'Self-reliant Development Society') is a private voluntary organisation established in 1996. Registered formally with the Ministry of Social Welfare, SUS was informally organised informally by four women and three men in 1985 under the guidance and charismatic leadership of Mrs. Begum Rokeya who is presently the Executive Director. As in many such organisations, the personal experiences of Begum Rokeya provided the driving force to found SUS. She faced amny challenges and struggles before attaining recognition, independence and respect as a woman in the community. After seven years of marriage and

two children, she was divorced. With her experience and with her strong personality she vo-weed to help other women build confidence and self-esteem in their daily lives.

OWNERSHIP OF SABALAMBY UNNAYAN SAMITY

SUS is located in the heart of the slum area. It owns office premises and operates over 123 villages in Netrakona Thana. The Executive Committee consist of 11 members: three men and eight women who are partly elected and partly selected for two years. All the members are from the community and participate in decision-making and approving requests from SUS staff. The General Secretary is also the Executive Director and exercises great influences over the members of the EC. She is appointed lfelong Executive Director. Another strong woman has now emerged as deputy who will eventually succeed her. The organsiation is structured according to sectors and projects (see Annex E).

FACILITIES

The existing building has been enlarged into a two-storey building. The health centre is very small. Four rooms are assigned to the FPSTC programme. There is one doctor's room with an investigation couch and instruments. Plans for the new Health Centre are complete and building has been approved by the donor organisation in England. It will be a momentous achievement when SUS opens its " Ideal Health Centre" in Netrakona town, which also provides office and project facilities in 1997.

Activities are divided into the following sectors: the Social Development and Credit Programme; the Non-formal Primary Education Programme; Employment Counselling, Health and Family Planning with HCHC; Training, SUS-Trade, and the Administration Block. The Model Farm Project is outside the premises. there are also rooms for sewing, knitting, basket- making and batik work.

CATCHMENT AREA FOR THE SUS PROGRAMME

The catchment area is located in three different thanas. In Netrakona Thana the total population is 265,064. Out of these, SUS is caring for 30.000 people. There are 66 villages with 3.534 households.
In Atpara Thana the population is 139,077. SUS cares for 22.000 people. There are 36 villages with 1,400 households.
The population of Madon Thana is 133,423. SUS cres for 8,000 people in 21 villages and 800 households.
Thus SUS cares, in total, for about 60.000 people: around 13,400 households. From these, the target groups must be isolated. The average number of children per household is 5.29.

HEALTH AND FAMILY PLANNING WITH MCHC PROGRAMME

The family planning service has been affiliated with FPSTC through USAID since 1986. A collaboration between this FP programme and an NGO, which was begun in 1983, had to be stopped in 1985 because of mismanagement within the NGO. In 1986 Begum Rokeya, from SUS, was approached by FPSTC to take over the programme. No building was available, so a house was rented in town. In 1993 the FPSTC rented part of the SUS training and resource centre.

The FPSTC programme has no direct connection with SUS; it merely uses the facilities. No rent has been paid for two years. The programme is little more than a burden to SUS, with no foreseeable end, and a less than dynamic approach (see Family Planning, chapter 4).

In 1996, SUS started its own health programme. Five traditional birth attendants (TBAs) who had worked previously in family planning were employed by Begum Rokeya in the SUS centre. They were trained by a doctor from the local nurse training school; a health educator, and the doctor employed on the SUS health programme. After one week's training, each TBA was assigned an area. They are now linked to six villages where they visit homes and organised women's groups to deliver health education.

Each TBA meets twenty groups per month to discuss pre- and postnatal care; hygiene; education on EPI, and a wide variety of other problems. They activate the satellite centres where government staf come for immunisation. They instruct the government Family Welfare Visitor (FWV) to visit sick women and children in the families. After the training, they receive a maternal kit and carry out deliveries in the home when requested.

MAJOR HEALTH PROBLEMS

In the beginning of 1996 a needs assessment was carried out by SUS to indicate the local health situation. Part of the information collected is described below:

- Total number of surveyed families : 118
- Total number of family members : 732
- % male : 31
- % female : 37
- % children (0-5yrs) : 32

During last one year, 573 members out of 732 have been affected by fever, dysentary, diarrhoea, worm infestations, allergies, pregnancy complications, anaemia, gastric problems, hepatitis, malaria etc. 364 persons visited doctors for treatment.

The survey showed that 63% went to village doctors, 12% went to private doctors and 25% attended government hospitals and health complexes. 209 patients visited neither the doctor nor the hospital because of lack of awareness and money. Four patients died for want of treatment.

STAFF SITUATION IN THE HEALTH DEPARTMENT

1 part-time male doctor, visiting once a week the health centre in Atpara town. A male doctor in Bangladesh is very limited in his activities and investigations. He delivers no babies nor inserts IUDs, vaginal investigations being completely taboo for a man. A health assistant performs administrative duties and helps the doctor during consultations.
5 traditional birth attendants
1 'health educator' (few qualifications) supervises the TBAs (see Annex K).

FINANCE:

The part-time doctor is paid through the organisation ACTIONAID BANGLADESH.
The other 6 people are paid by SUS with savings from a relief programme.

The planned health centre will be paid for by an English organisation.
The patients pay 5 Taka (25cts) for each visit in the health centre and for the medicines received.
For 1996 the income from the health services was Taka 13.491.

HOW DO WOMEN BECOME A MEMBER OF SUS?

The Department of Social Development and the Credit Programme organise meetings in the villages with women. Then a baseline door-to-door survey is carried out by the team. This identifies which families are headed by women. Other underprivileged women's groups include divorcees, widows, abandoned and invalid women and wives of invalid men. These women may become members of SUS, gaining the opportunity to receive help in education, health, job creation etc. the organisation's approach is participatory and integrative (Paulo Freire). The first year of membership, the women learn about household savings: low cost stoves etc. After five years of membership, groups are formed and pursue their work with much greater independence and self-reliance (see Annex L).

In Bangladesh 13% of the population - 15,000 families - are headed by women. These women have traditionally few rights in the Muslim and Hindu cultures. Through SUS they receive credit to start up small trades. Their health awareness is raised and the health of the whole village can thus be raised. Through this integrated participatory approach men are also involved and befome interested in contributing. They may also be helped to start small income generating projects.

2.3. DAMIAN FOUNDATION, NETRAKONA DISTRICT:

HISTORY:

The Damian Foundation (DF) is a Belgian non-governmental organisation and has worked on leprosy in Bangladesh since 1972. An initial pilot project on tuberculosis (TB) has also now been intergrated into a vertical programme. The DF currently has the status of a local non-governmental foundation. Servicies are funded mainly from abroad.
Since there is a restriction for admission of TB/ leprosy patients in government facilities, a new 50-bed hospital has been constructed and opened in 1996.

FACILITIES:

The 50-bed hospital can officially admit 35 TB and 15 leprosy patients. About 95 % of beds are occupied on average. The hospital has all the necessary equipment for the treatment and rehabilitation of TB and Leprosy sufferers.

CATCHMENT AREA:

Netrakona district is 2.810 square kilometers in area with a population of 1.855.564 (1996). The DF is working in eight of the ten thanas in Netrakona district.

GOVERNMENT FACILITIES:

The strenghtening of the National TB/Leprosy Programme in the last few years has increased the opportunities for NGOs. Integration is sought on both sides, although in practice NGOs are entirely responsible for the implementation of the TB/Leprosy Programme in the allocated areas. The Government has only specialized services for TB/Leprosy patients. In Netrakona district, eight out of ten thanas are served by the DF TB/Leprosy Programme. No other NGOs are working here on TB/ Leprosy.

MAJOR PROBLEMS:

* Mistrust is a major problem faced by the DF staff. Another concern is the lack of accountability of DF staff to government officials. The Government provides TB drugs free of charge to the foundation. These medicines should come through the District hospital medical store but, because of mistrust towards the DF, TB medicines are delivered through the head office in Dhaka.
* The admission of TB/ Leprosy patients is done on a very selected scheme. Government doctors prefer not to have TB/Leprosy patients on their premises. Because of this, the DF's TB/Leprosy hospital is often overcrowded.
* There is a lack of personnel, especially qualified nurses.

* Working with Government nurses is difficult; they are often not committed, and may have a bad attitude towards the work and the patients.
* DF personnel have no pension scheme.
* Postgraduate courses in other subjects as TB/Leprosy are not available.

HEALTH SERVICES PROVIDED:

The TB/Leprosy Community Assistants (TLCA) visit and trace defaulters in the villages. In five government health complexes and union health centres a small room is set aside for the DF's supervisor. In Netrakona Thana there are five intermittent TB/Leprosy clinics. In these centres, patients visit the TB/Leprosy control officer. The patients receive their treatment for the next period and obtain information as necesary. There are also five distribution points for medicines in Netrakona Thana. The hospital has a very friendly environment, and are well organised and maintained.

Effective coverage of the whole Netrakona District has been recognised as the first priority. In the past, over-emphasis has been put on hospital-based services, and there has been too little on improving accessability. The DF is medically a very specialised NGO, opting more for centers to detect and treat both diseases than community-based approach.
In Bangladesh there is a high prevalence of TB and Leprosy. The estimated number of leprosy cases is about 136.000 making Bangladesh number threee in the world after India and Brazil. In Netrakona District there were 213 new cases under treatment in 1995.

TB is highly prevalent, with an estimated 5 cases per 1000 people. In total, 906 cases of TB were registered in 1995.

GOOD ELEMENTS IN THE SERVICES (according to DF staff)

* The DF staff are committed and motivated towards the patients and the entire hospital setting.
* Staff training is done by the staff in the hospital
* Salaries are higher than in government services.

STAFF SITUATION:

Hospital and field staff:
1 project coordinator, senior TB & Leprosy coordinator
2 medical officers, 3 TB & leprosy control officers, 19 TB & leprosy control assistants, physiotechnicians, 1 laboratory technician, 4 nurses, technical/ administrative staff, 20 cleaners, cooks, drivers etc.

FINANCE: In Bangladesh, all TB and Leprosy services is free of charge.

2.4. WORLD VISION

World Vision is the third NGO I visited in Netrakona town during my stay with SUS. The organisation works mainly with children in developing countries. It has only one project in Netrakona town. It was observed that work satisfaction among staff in the twenty other projects in rural Netrakona District seemed higher. The absence of other projects in these areas prevents disruption of World Vision projects with their money.

HISTORY

World Vision has been working in Netrakona town since 1993. In the whole district there are twenty projects funded from the World Vision head office in Dhaka.

FACILITIES

The building, rented by the head office in Dhaka, has two classrooms for primary school education; a room functioning as a clinic with a waiting area; two offices, and a large courtyard with a gate. The classrooms are used from 07.00 till 09.00 to teach the children of World Vision (WV) beneficiaries.

HEALTH SERVICES PROVIDED

These are focused mainly on health education for children and adolescent girls. EPI is not offered by the clinic, but the mothers are motivated to go with their children to the government health services. There are five health volunteers employed who give health talks to the beneficiary families.

There is no doctor employed by WV: a registered nurse is in charge of the clinic. She informed us of her work procedures. She screens the patients and, if she cannot treat them, she writes a letter for a consultation with a private practitioner. The patient is referred and the doctor's fee is paid by WV. The same is done when the patient needs a laboratory investigation.

The nurse has qualified fully from a mission hospital and did her state exams in Dhaka where she become registered as a nurse midwife. The health centre was very efficiently organised. Each mother and child receives a health passport in which all visits are written down, as well as the drugs which have been prescribed. Health education is delivered on all kinds of diseases which are common in the vicinity of Netrakona. Some health workers provide education on sanitation. This programme, however, is related to the government programme in Netrakona. WV has produced its own books for health workers in Bengali.

THE DAILY AVERAGE NUMBER OF PATIENTS IN THE CLINIC

This is around 20/25 a day.

STAFF

Only seven staff members are officially employed and paid by WV:
1 project manager
1 registered nurse/midwife

5 school educators
5 health volunteers working in the villages who earn 400 Taka a month.

FINANCE

This January a new system has been implemented for the 1,366 beneficiary families. The mothers pay a 20 Taka annual fee. For each consultation. the child pays 1 Taka and the mother 5 Taka. WV's work in Bangladesh is funded by everal foreign donors.

PERCEPTION OF WV'S WORK BY BENEFICIARIES

- People appreciate paid-for health services more than those which are free of charge.
- The staff impression is that patients appreciate visiting their clinic.

CONSTRAINTS

1. At first WV was heavily scrutinised by religious members of the community who feared they may try to convert beneficiaries to Christianity.
2. WV aims to work for children in Bangladesh, for whom resources are limited.
3. Many NGOs are currently working in Netrakona District. There is some duplication of services, and WV is facing competition in its loan provision to beneficiaries from other NGOs.

OTHER INFORMATION GLEANED

WV is also performing relief work, e.g. distributing clothes and mosquito nets, and giving money to the people. Christian evangelism has been a previous feature of some WV mission hospitals.

2.5 OPTIONS AND RECOMMENDATIONS FOR FURTHER ACTION

Suggested developments for the NGOs working in Netrakona Thana are as follows:

1. Health education has been given to communities and individuals for many years.

Why are easily preventable diseases still among the top ten most common complaints? Is the approach used by health personnel not appropriate for the community: e.g. the incidence of TB increases among youth?

2. Interaction with government officials is often seen by NGOs as difficult and avoidable. However, government officials often regard NGO personnel as imcompetent, insecure etc.

What can be done to overcome these misunderstandings?
Could be the idea of a platform, or forum for discussion, between NGOs and Government help to achieve a better understanding?

3. NGO are often recognised for their ability to reach the grassroots level.

Despite this, poverty alleviation resulting from NGO activities has been limited.

4. In the district, several NGOs are working in the same sector. Smaller organisations are evidently often overruled by larger ones.

At district level more coordination is needed between NGOs themselves to overcome such problems as duplication and unhealthy competition or rivalry.

5. In three organisations I visited, there was no mention of HIV/AIDS. Is this not a concern of the people, or is it not recognised as an eventual problem?

Should organisations come together on this issue and see what can be done to combat the disease instead of keeping silent?

3.1. INTRODUCTION TO GOVERNMENT HEALTH CARE SERVICES

During my stay, I visited several health facilities to familiarise myself with the system in Netrakona District. The aims of these visits were to obtain an overview of the health structure of the district; to identify the good elements, and to understand the daily constraints faced by staff and patients.

My sequence of visits was:
1. To the Directorate of Curative and PHC Services,
2. To Netrakona District Hospital,
3. To Atpara Thana Health Complex,
4. To the thana preventive health centre, and finally
5. To the union health centre.

In the Netherlands, the fundamental questions are:

- Is the government health structure accessible, appropriate and affordable for people now and in the future?
- How is PHC integrated in the health system of Bangladesh?

The umbrella organisation Personal Assistance Overseas (PSO) is often reluctant to approve an application for personnel assistance when there is no clear plan for cooperation with the government health infrastructure.

Every week, one or two hospitals are scrutinized and criticized on their functioning. It became clear to me that reading and observing give very different pictures; the real situation is far worse. As one doctor observed: "You come with one ailment and leave with two more".

Not all frustration and blame can be directed at the Government; communities have lived for years amid these deplorable conditions and widespread corruption. Indeed they are part of it. A clinic may be visited not because a person is sick but because he or she wants medicines from the doctor. Real patients buy the drugs on prescription from the doctor at the market.

How can the Govenment of Bangladesh overcome these immense problems?

3.2HEALTH SERVICES AT DISTRICT LEVEL

Organisational structure of the health service at district level

The chart of health personnel is no longer valid. The post mentioned in the **National Health Policy Bangladesh** does not exist. I was advised not to use this report for my work.

HISTORY

This organisational structure has existed for many years. The name has changed but the function. On paper the system looks very advanced, but in reality the country's infrastructure and management is deteriorating rapidly. Before the 1996 elections many promises were made by all parties. Will these promises also be fulfilled to improve the lives of underprivileged people in the country?

District level health services have changed over the last ten years. Netrakona became a district in 1982, before which time it was a subdistrict of Mymensingh.

The district has two divisions:
1. Health services curative care and primary health care (PHC).
2. Family planning and welfare.

HEALTH SERVICES AT DISTRICT LEVEL

The Civil Surgeon was not present during my visit; I met the Deputy District Medical Officer. The district has ten thanas, each of which has a health complex. That of Netrakona provides no curative care; it is a preventive and family planning/welfare clinic.

One union may have a health centre or a health and family welfare centre. This means one union may come under the Health Department and another under the Family Planning Department. Supervision is done separately by each department.

FACILITIES

The District Health Department facilitates all curative services and organises the supervision of district health facilities. Drugs are distributed to the district pharmacy from the central region. From here, they are sent to thana health complexes and union health centres.
There are laboratory facilities for the district hospital and thana health complexes. Only pathological investigations are possible, such as malaria smears, worms, and blood and urine investigations.

PRIMARY HEALTH CARE PROGRAMME

This was described as the only programme to have a positive impact on health standards in the villages.

Control of Diarrhoeal Diseases (CDD) Programme: The CDD District Coordinator is presonsible for installing an oral dehydration treatment corner (ODTC) in each thana health complex. Initial results from the training programme indicate some success in curbing diarrhoea, although this was not confirmed by other health officials. Next year 1050 workers will receive be trained as trainers to educate villagers in treating diarrhoea.

EPI Programme: The doctors believe that EPI is working. They report that coverage is high, despite occasional outbreaks of polio. Their optimism is not shared by some.

Sanitation and Water: This does not come under the Health Department, but Public Engineering and Municipality.

Deworming and Vitamin A Programme: This started in 1994. Is not done on a regular basis.

Malaria: The hilly Indian border location makes this a problem; malaria is endemic to Netralona district.

MAJOR HEALTH PROBLEMS

I. No anaesthesia is available;
II. There are not enough drugs for patients;
III. There is no bloodbank for transfusions, and
IV There are no consultant doctors or gynaecologists to perform operations and therefore, presumably, no operations.

MAJOR PROBLEMS FOR THE DOCTORS

I. Working conditions are very poor, with some shifts lasting 24 hours;
II. Salaries are very low, a national problem;
III. Patients are often dissatisfied and complain and doctors therefore may feel unsafe;
IV. Doctors are often accused by their superiors of failing to perform their work properly, and
V. There is no vehicle available for the District Primary Health Care Coordinator to visit thana health complexes.

Note on traditional healers

Patients may resort to other means of treatment because of the poor facilites in hospitals.

Netrakona District Hospital is the referral centre for all thana health complexes.

Ownership

The Government of Bangladesh is the legal owner of the hospital.

Problems include:
- No general anaesthetics in the distrct pharmacy,
- Insufficient medicines to cure patients,
- No bloodbank for emergency transfusions,
- Vacancies for consultant doctors and gynaecologists,
- Lack of operations because of the absence of any specialists,
- Not enough beds and bedlinen,
- Not enough proper theatre instruments.

MAJOR PROBLEMS FACED BY DOCTORS.

These include:

I. Long working hours: often 24 hours on duty
II. Very low salaries, a national problem
III Fustrated patients, insecure doctors
IV Doctors may be accused by their bosses of not doing their work properly.
V. The district PHC co-ordinator has no vehicle to supervise thana health complexes,
VI. Not enough staff: nurses or doctors.

HEALTH SERVICES PROVIDED

Indoor treatment.

There is currently:
- 1 specialist for medical diseases,
- 1 specialist for pediatrics,
- 1 specialist for surgery.

Operations can only be done by local anaesthetic; there is nothing for major operations.

Only illiterate people and the poorest of the poor attend this hospital on referral by medical doctors. Those who can afford better health care and treatment avoid this health facility. There are no sheets, blankets or cushions on the beds. The matrasses are torn and very dirty.The floor and walls are filthy with spit from patients. The main current problems are a lack of disinfectants and cleaning materials. Soap was only sometimes available in the hospital. I learned that the hospital stocks medicine for patients who can pay for their treatment.

Outdoor treatment.

A 24 hour service is provided in the 'Outpatients' Department (OPD). All patients may be seen by the doctor: this is a general rule in Bangladesh. There is no system of screening patients by nurses of medical assistants in the OPD. The doctors complained that some times of the year they see 400/500 patients a day. The laboratory has no miscroscope or

any other equipment.

The lab technician and assistant are doing investigations with the most old fashioned apparatus. Requests from doctors for blood and urine examinitions must be brought to the laboratory of the district health directorate administration. During my visit, while the pharmacy prepared some tablets, I observed that the dressing room was very untidy, with used dressings soaked in blood lying on the floor.

EMERGENCY DEPARTMENT.

This has 10 beds. One room is for 24 hour observation of critical patients and the other is for infectious diseases such as diarrhoea and dehydrated cases. After 24 hour's observation the patients are discharged or admitted into the wards.

STAFF SITUATION

There is an immense shortage of staff in the hospital. The Government has frozen all present vacancies, so that the hospital is not allowed to employ more doctors, nurses or other personel.
There is no money to boost care for the community. The staff currently comprise:

- 3 specialists,
- 9 medical officers who rotate very 24 hours around the three departments.
- 3 senior nurse supervisors,
- 15 registered nurses,
- 5 assistant nurses,
- 1 radiopgraphy assistant,
- 1 laboratory assistant,.
- 1 dental technician.

The Civil Surgeon is the head of the District Health Services, functioning also as the medical superintendent of the district hospital. The Civil Surgeon and two medical officers are supposed to supervise all the thana health complexes (see annex J).

NUMBER OF PATIENTS.

1995 statistics could not be forwarded to me in the hospital; they must be obtained from a higher level.

FINANCE

The costs in this system are hard to define, because of the shortage of materials and the many vacancies in the services. The running costs for patients are minimal in comparison to the real costs of the hospital. Each patient seen by the

doctor has to pay 2 Taka. Admission costs 5 Taka and emergency cases 3.30 Taka. Time cost: it was said these patients do not have work and are so poor that time is not an issue for them. The money goes to the treasury of the Ministry of Health. Food is provided by governement.

The Chief Civil Surgeon was asked about building a clinic on the SUS premises. His answer was positive. The clinic will not be competetive or duplicate the government services. It can be a synergetic model for them and SUS. It will serve the poor and distitute in the future.

NOTE ON TRADITIONAL HEALERS.

The deteriorating health services are bringing patients back to the old system of traditional healers.

3.4 ATPARA THANA HEALTH COMPLEX

HISTORY

This thana health complex (THC) opened in 1996 in Netrakona subdistrict, which was under the authority of Netrakona district hospital.

OWNERSHIP

The property belongs to the Government of Bangladesh and is under the executive control of Netrakona District.

FACILITIES

The 32 beds in this THC cater to a population of 139.679,. The complex comprises: two wards, for female and male indoor patients; an operating theatre; a laboratory; a kitchen, and an ablution block for female and male patients. There are also doctor's investigation rooms and a sister's staffroom. The oral rehydration treatment room was closed.

CATCHMENT AREA

Atpara is 26 km. from Netrakona. The catchment area is 47.360 square km.

MAJOR HEALTH PROBLEMS

Respiratory infections (such as pneumonia and bronchitis), anaemia, malnutrition, STD's, skin diseases (e.g. like scabies and ringworm) and water-related diseases, are the main health problems. The commonest complaints are diarrhoea, dysentry, worms and typhoid fever. Eclampsia is common under young pregnant women because of the widespread use of salt and herbs. There is a lack of provision of health education.

HEALTH SERVICES

Like the district hospital, the THC provides a 24 hours services.

1) **Indoor services**: Only 24 patients were present in the two wards during my visit. The reason given was that the largely rural inhabitants of the catchment area are frightened of being admitted. Indoor services are limited; for months the electricity has failed repeatedly. Its repair is the Government's responsibility but nothing has been done.
No major operations are done, emergency cases must be transferred to another district hospital. Minor cases, such as caesarean sections, sterilizations and vasectomies, are done under local anaestetic. Nurses merely supervise and carry out administration work in the wards.

2)Outdoor services-known as the "Outpatients Department".
Under Bangladesh law, all patients must be seen by a doctor. In some months, more than 6000 patients visit the doctor.

Nurses are not trained to screen the patients. The latter often ask for medicine which they promptly sell at the market. Medicines disappear from the hospital and it is impossible for doctors to keep a check on all personnel.

3) 24 hour emergency services
Major cases from other union health centres have been referred to the district hospitals in Netrakona or Mymensingh. There is a clinical laboratory and technicion, but no materials to perform the work.

Preventive services are under the Curative Health Department.

Preventive care: EPI activities. Because the hospital has no electricity, vaccines are stored in fridges in neighbouring NGO premises. Curative care is provided for mothers and children under five. Vitamin A and deworming programmes are listed on paper but delivered rarely.
Awareness programmes are held in seven satellite clinics (outreach points) on sanitation and safe water.

STAFF SITUATION

The establishment list shows posts for:
- 4 medical doctors,
- 4 specialists,
- 1 dentist,
- 1 resident medical officer.

Out of these 10 posts, only 3 medical officers are employed by the Government. The other 7 are vacant. Of 4 approved nurses posts, 1 is vacant. Most doctors, nurses and midwives run private practices to earn money. Salaries for health personel are very low.

FINANCE

Health care services are free of charge in the THC and Family Welfare Clinics.

3.5. NETRAKONA PREVENTIVE HEALTH CARE CENTRE

HISTORY

This health centre was built in British colonial times. About 50 years ago it became the district hospital for Netrakona. After the new district hospital was built, this centre was transformed into a preventive health clinic.

FACILITIES

The building looks very old, but the walls and roofs are still in good condition. The building urgently needs painting.

HEALTH CARE SERVICES

Only health care education and EPI are provided. Vaccinations must be done in the health centre by health assistants. Only for national campaigns (such as that for polio on 8th January) are women mobilised to help vaccinate children under five (see Annex D).

MAJOR PROBLEMS

These were outlined by the doctor and administrative personnel working in the health centre:

- Drug shortage;
- Shortage of staff in rural areas;
- Nurses previously employed in rural health centres are transferred to the district hospital in Netrakona;
- Low salaries for doctors and other health personnel;
- No transport for supervision of the health clinics;
- Bad roads in rural areas, and

There is no specification for an emergency doctor on the establishment list: a must for a district hospital.

STAFF

1 thana field officer
1 medical officer (3 places vacant)
No nurses
1 sanitation inspector
9 health inspectors
45 health assistants and administrative personnel.

FINANCE

There are enough vaccines for the crack-down polio campaign on the 8th of January. UNICEF has provided the cold chain equipment for the district.
I was astonished to see the field vaccine carriers lying in a heap in one corner. The cool boxes did not contain the temperature cards needed for checking the temperature of the vaccines twi ce a day.

3.6. MADANPUR UNION HEALTH and FAMILY PLANNING CENTRE

HISTORY

The centre opened in 1963 as a dispensary. In 1975 it was renamed 'Rural Dispensary' and in 1994 it became a union health and family planning centre. Both services are now provided, although I visited only the health section.

FACILITIES

The building looks old but strong, like a castle. The interior is clean and well maintained. There are many rooms and a large waiting hall with benches for patients.

CATCHMENT AREA

This was not known, though there are eighteen villages in the union.

SERVICES PROVIDED BY THE HEALTH CENTRE

Only a few outdoor services are delivered by the medical assistant. The medical officer (MO) comes once a week to check up on the work. Most MOs earn both a government salary and a separate income from private practices in town. No operations or investigations can be done in the health centre. EPI is provided by the thana preventive health services in Netrakona. Twice a week health education is given in the waiting hall. Home health visits are made by health assistants.

MAJOR HEALTH PROBLEMS

Diarrhoea, dysentery, worm infections, common colds, bronchial asthma, anaemia, malnutrition and STD cases are investigated at the hospital. No AIDS cases have been reported and only a few cases of malaria were cited: it is not endemic to the area. An average of 100 to 150 patients visit daily.

MAJOR STAFF PROBLEMS

- Few drugs are available;
- Instruments for only minor operations are provided;
- Only local anaesthetic is available;
- There is no transport for ill patients, and
- People with no complaints sometimes claim medicines at the health centre. Medical assistants are often afraid to refuse.

STAFF

1 medical officer (not present)
1 medical assistant
4 health assistants

1 pharmacist (if there are no medicines, however, there is no work)
1 subordinate

FINANCE

All services are free of charge in union health centres. If charges were levied, fewer patients should come.

3.7 RECOMMENDATIONS AND OPTIONS FOR THE FUTURE

Health complexes, health centres and all primary health care (PHC) activities are free of charge.

1. Can a country sustain free food and health care for every citizen?

Should the Government of Bangladesh not impose some charge on health care to provide a better services to the people? People are generally willing to pay for their health care; it enables them to demand better services. Patients are prepared to pay for the services of private doctors; traditional healers; local rural doctors, and TBAs.

2. Salaries are low compared to the private sector, resulting in a brain drain of intelligent young people to other countries.

Most of these people clearly have no intention of returning to build a new and prosperous Bangladesh.

3. Many employees of these organisations are simultaneously developiong their own businesses.

The monitoring and supervisory system should be revised for all categories of employee.

4. The health services is fragmented through departments. Primary health care (PHC) comes under curative health services; Family Planning (FP) and maternal and child health care (MCHC) are under the welfare directorate, and water and sanitation are under another department.

One PHC directorate could be established which incorporates FP/MCHC and water and sanitation services. Supervisory visits could be done by the respomsible department.

5. Is it really a sign of poverty when hospital or other health facilities are poor when floors are littered with soiled linen, bandages and plastic syringes and needles? The danger of HIV/AIDS infection is evident.

Could domestic staff be educated to become responsible for cleaning up and telling people not to litter hospital premises?

4. FAMILY PLANNING & WELFARE SERVICES

4.1 INTRODUCTION

Family Planning (FP) is of huge importance to Bangladesh. I believe that FP, in most cases, is imposed on women or families by providers of contraceptive methods. Women are not free to choose their preferred method of birth control.

In many countries, education and health are run by the government. Bangladesh is one of the developing countries where some of these programmes have been taken over by NGOs. With 'sustanaibility' - the fashionable current slogan - we can expect that, after some years of support, donors will withdraw their funds and demand that local NGOs maintain their programmes. The withdrawal of USAID funds in July 1997 will speed up this process. If services stop then, women will resume their previous lifestyles. Without empowerment they will have no say about when to have sex; the decision lies solely with their husbands. Providing health care and family planning alone does not empower women. Participation is crucial to strengthen their voice.

4.2 HISTORY OF FAMILY PLANNING IN BANGLADESH

The first NGO FP programme began in 1953. The goals were to raise awareness, and support and encourage community members to plan their families. In 1965 the Government of Pakistan introduced FP services in their own health facilities. In 1978 the Family Planning Services and Training Centre (FPSTC) was established by the Government of Bangladesh. This cooperating agency has 47 local NGOs which deliver FP under its umbrella. (Other local NGO cooperating agencies support the government FP programme).

The aims of this organisation are:
1. To coordinate local NGOs in the FP field, and
2. to provide technical support to field workers.

FPSTC is funded directly by USAID. The FPSTC office in Dkaka pays the running costs nd salaries of associated local NGOs. The NGOs never receive money diectly from USAID.

Before Bangladeshi independence the contraceptive prevalence rate (CPR) was around 10%. In 1996 it was about 45%. The Government aims to reach a CPR of 55% by the year 2000.
In earlier days, sterilisation was very 'popular'. With the development of other contraceptive methods it has become less common. Alternatives include the intrauterine device (IUD) which can last for eight to ten years.

The average number of children per family in rural areas is around 5.29. Th birth rate in 1996 was 2.1%; the aim is to reduce this to 1.0%. The target growth rate in the year must be 2.0.%

Family Planning Service Training Centre (FPSTC)

This provides only formal training for NGO project staff. Courses on Management and Supervision are held for family planning (FP) programme officers. In June 1997 USAID will withdraw most of their financial support from Bangladesh. Some people attribute the pull-out to a lack of programme success, particularly a failure to reach target groups. The aid may be diverted to other African countries which have CPRs under 20%.

4.3 FAMILY PLANNING DIRECTORATE

I met the Deputy Director of Family Planning, the Clinical Medical Officer and the Thana Family Planning Officer. The main aim of this visit was to elicit more information on the CPR in the district; statistics on the methods used, and the constraints to distribution of the methods in the rural and urban areas.

The CPR for using FP is 56% in Netrakona District. The use of FP methods outside wedlock was not known and not discussed in depth. Asking about the constraints faced in the FP Department seemed to take them aback. They replied initially that all FP problems had been overcome. It emerged, however, that many constraints still exist:

- Many problems have arisen from religion. There has been, in particular, conflict between the FP Department and Muslim leaders. The department convened several meetings with the religious leaders and tensions have now subsided.
- x Illiterate people do not see direct economic benefits from the FP programme. Most in this group are poor and landless, and need the children to work in the fields. Some people are motivated from outside, e.g. small families can send their children for further studies (see Annex H).

4.4. MOTHER AND CHILD HEALTH (MCH) AND FAMILY PLANNING (FP) CENTRE

HISTORY

The maternity hospital was built in 1975 and functions as a district MCH and FP centre.

OWNERSHIP OF THE MCH and FP CENTRE

The Government of Bangladesh owns the premises. The Division of Family Planning and Welfare has executive control over the building. It is poorly maintained.

FACILITIES

The maternity hospital has two storeys. Outdoor facilites are on the ground floor along with a waiting area for mothers; a registration room; an investigation room; an ablution block, and a doctors' room. On the first floor are the delivery room; a small theatre; a ward for inpatients, and the ablution block.

The interior and exterior of the building are not well maintained. It is very dirty; the floors in paticular are filthy. Fortunately, maternity patients do not stay long in the hospital. The risk of catching other diseases appears very real.

CATCHMENT AREA

The hospital functions as a district referral MCH and FP centre. The Deputy Director mentioned that the centre will be upgraded and modernized to an acceptable standard.

MAJOR HEALTH PROBLEMS

These include:

- Insufficient drugs to treat mothers and children for common diseases;
- Diarrhoea in children under five;
- No wherewithal to perform caesarian sections throughout the district;
- No anaesthetics available for major operations, and
- No gynaecologist or obstetrician in the whole of Netrakona District.

HEALTH SERVICES PROVIDED

These are indoor and outdoor.

Indoor: these services are for women who come for normal deliveries. Complicated cases cannot be admitted because there is no obstetrician/gyneacologist in the district hospital.

Outdoor: On paper, family welfare visiters (FWVs) carry out mother and child health care, antenatal and postnatal care, under fives monitoring, growth monitoring, EPI programmes and family planning, in which all types of contraceptive are supplied to clients. Outdoor services are provided FWVs who visit houses and perform deliveries when requested. All family planning and welfare services are free of charge. However, the FWV is paid directly by families for deliveries at home. The present facility is very poorly furnished. No sonar or other medical investigations can be done. Caesarian sections cannot be performed; these patients must be transferred to Mymensingh Medical Hospital. Sterilisations are performed under local anaesthetic.

The small number of staff must also perform field visits. When asked if they monitor the growth of under fives, they produced weighing scales from the cupboard which were still packed in the box. The only procedures we observed were writing in the attendence book and taking blood pressure. No investigations on urine or blood were performed. The health service provided is minimal. The FWVs receive eighteen months' training to do deliveries. An ambulance is available for emergencies.

NUMBER OF PATIENTS

There are only 40-50 deliveries per month at the MCH/FP centre.
Traditional Birth Attendants work very effectively in the field and most deliviries are done at home. Women's attendance at the centre was very low: 20 to 30 per a day.

STAFF SITUATION

In the maternity hospital:
1 doctor,
3 FWVs,
1 family assistant and
1 administrative assistant.
It did not emerge that any cleaners were employed.

FINANCE

All family planning and welfare activities are free of charge in Bangladesh. Because of low salaries, people often also practise privately (see Annex I).

4.5. BALVAKANDA FAMILY WELFARE CENTRE (FWC)

HISTORY

The clinic was built ten years ago as a family welfare centre for one of the unions of Netrakona Thana. There is no health centre for sick people in this area.

CATCHMENT AREA

The centre is 6 km from Netrakona town. The local inhabitants are mainly poor farm labourers. The road is very rough with many potholes. It takes about an hour to reach the centre by rickshaw. There are 40 villages in the union, but the population of the catchment area is not known.

HEALTH SERVICES PROVIDED

The centre has eight satellite clinics which are visited once a month by staff. Family planning clients are referred to the centre. On our arrival, we saw many women waiting on benches. The family planning welfare visitors provide outdoor services in the clinic, such as: intrauterine devices (IUDs) for married women, and depo provera injections to illiterate women and women who have already borne one or two children. Pills and condoms are also available. Sterilisations are decreasing with the rise in number of IUD insertions and DP injections. The FPWV also do deliveries on request at home.

Female circumcision is not practised in Bangladesh. Both Muslim and Hindu men are circumcised. There is an average of 70-90 clients daily.

MAJOR HEALTH PROBLEMS

Clients, mainly women with children, come to the FPWC for treatment, mainly women with children. The most common minor diseases are: both types of dysentery, bronchitis, anaemia, pelvic infections, STDs, side effects from contraceptive methods, such as bleeding and amenorrhoea. A few infections are caused by unhygienic living conditions. The average age of children in the families treated is 5 to 6. Younger couples tend to have only one or two children.

FINANCE

Health care services are free in all health centres. Only condoms cost - 1 Taka per dozen - and are supplied to both men and women.

STAFF

2 family welfare visitors,
6 family welfare assistants,
1 pharmacist,
1 medical assistant.
The centre has no medical officer.

HOW DO PATIENTS PERCEIVE THE HEALTH SERVICES?

The present staff felt that clients and patients are staisfied with the services and staff.

CONSTRAINTS

- The main problem cited was clients' ignorance and lack of commitment towards changing lifestyles, and
- Superstition preventing IUD and depo provera use.

4.6. FAMILY PLANNING PROGRAMME ON SUS PREMISES

The family planning and maternal and child health care (FP/MCHC) programme on the SUS premises is completely separate from the integrated participatory programme of the centre.

The Family Planning Service Training Centre rents four rooms for this purpose. The programme is vertical and described as a burden to SUS: it is not dynamic and therfore unsustainable. Field workers sometimes buy services from the women to reach their target number. If it is not reached, they do not receive their end-of-month bonus. The target is set a the beginning of the year. If it is not met by the end, a field worker may be dismissed.

The Government of Bangladesh (GoB) provides 275 Taka and a sari to women who agree to be sterilised. March and October are described as months of silent crisis for poor people, when food shortages are common. This is when women are most likely to go to hospital to be sterilized to feed their children.

The family planning (FP) area is defined by the GoB. The Deputy Director of Family Planning decides the catchment areas in which the NGOs can provide FP. SUS works in 35 villages and 13 slums - called 'municipality areas' - in town. In total, 48 villages have been allocated to SUS. Women are not allowed to visit FP centres outside their defined area, even if their houses border another FP area.

FP field workers are trained by the FPSTC staff. They visit homes and give health talks and counselling, although the main aim is to provide family planning advice. Field workers carry condoms and pills around on this door-to-door programme. Check-ups are done at the health centre by the midwife.

There is a total of 10,000 couples eligible for family planning in the villages and around 7000 active female clients for FP in the FPSTC programme on the SUS premises. The contraceptive prevalence rate (CPR) is 64.49%, compared to the government CPR of 56%.

The staff comprise:
1 FP programme officer,
1 FP welfare visiter,
12 field workers.
In July all the staff will be retrenched by the head office of FPSTC in Dhaka.

4.7 RECOMMENDATIONS AND OPTIONS FOR THE FUTURE

1. Family planning should be integrated into the SUS comprehensive PHC programme.

2. In future, women should be able to use their preferred method of family planning free of charge.

3. Incentives and bonuses in FP should be abolished in the future, in both government and non-government services.

4. More emphasis should be placed on vasectomies.

5. TRADITIONAL HEALERS, RURAL LOCAL DOCTORS

5.1 INTRODUCTION

One doctor told me that, when the official allopatic medical care does not work, people will return to their traditional healers, the witch doctors.

Medical professionals are often reluctant to discuss the ancient profession of healing. Doctors have not seriously considered the possibilities of working with traditional healers, perhaps providing a room for them in hospitals. In Bangladesh, doctors are trained in western medicine, without any holistic approach. The patient's physical condition and appearance only are considered; his or her spiritual wellbeing is ignored. By contrast, the traditional healer views subjects in a spiritual and social, as well as physical, context.

The ancient practices of homeopathy and acupuncture are now gaining ground in western countries, having long taken a back seat to allopathic medicine. In Bangladesh, I found out that more then 60% of people visit traditional healers. The Government has started training traditional healers and midwives to work in villages. They are on no establishement list but are paid either in money or kind.

During my time in Africa, I was very interested in traditional healing. In Bangladesh, the practices appear to be more open.

5.2 TRADITIONAL HEALERS

Their work is accepted by people for the following reasons:
1. Government services are inefficient, so that sick people resort to traditional healers.
2. Rural people are not used to modern medical facilities. They prefer to visit their own familiar village 'doctors'.

Visit to Mr. Sudhan Takur, traditional healer, in the urban area of Netrakona town

For many years, Mr. Takur has been practising local medicine.
He 'received' the instruction to heal in a dream; before he had no knowledge of traditional medicine.

His practisees from his homestead. Every day around 80 to 100 people come to be healed.
The visits are free of charge; only medicines are sold, to provides his income. The herbs are found in the fields and he prepares them himself. The ingredients used are the leaves, roots and seeds of certain plants and trees. We could not find out if he practises other procedures such as cuts , burns and tattoos.

Ailments to be cured in his practice

Wounds, skin diseases, hepatitis, stomach ulcers, stomach ache, headache, measels, psychiatric disorders, sexually transmitted diseases.

Ailments not to be cured in his practice

Polio, tetanus, malaria, rheumatic pain, snake bites.

He denied facing any problems in the community because of his work, but said he was well trusted. His practice is recognised by the community, if not by medical doctors. He worked between 6.00 am to 10.00 pm. The Government does not deny the existence of traditional healers, but provides no support.

An 'Association for Traditional Healers' exists in Bangladesh, of which, however, this traditional healer was unaware.

Impressions during my visit:
1. This traditional healer looked confident and powerful.
2. People trust his knowledge (80 to 100 patients a day).
3. He is recognised by communities in and out of the area.
4. He needs no further training.

5.3. RURAL LOCAL DOCTORS

HISTORY

The 'Rural Local Doctors' (RLD) Training' is an offical programme, legalized by the Government. RLD are not traditional healers (who treat patients with local medicines) but they receive medicines from the THC.

CATCHMENT AREA

RLD are trained to work in their own rural or urban villages. There are usually one or two RLD per union.

TRAINING FACILITIES

RLD are receive 1.5 years' training in a thana health complex.
The curriculum is on preventive and promotive rather than curative issues. The most common diseases are taught in classroom settings. During my visit to Atpara Thana Health Complex (THC), seven male and one female RLD attended an upgrading session. These are given regularly - usually once a month - by a THC doctor.

WORKING AREA

The RLD are not on the Government's official establishment list. They have their own village practices. Most general drugs are provided by the THC through government channels (when in stock). These RLD aresaid to provide 70% of the health care services in rural/urban areas.

MAJOR HEALTH PROBLEMS

They treat common diseases. Patients with more serious ailments can be referred to the THC. Doctors observed that patients tend to trust the RLD more than hospital staff. Confidence is shifting away from government services towards traditional healing.

5.4. PRIVATE PRACTITIONERS

A visit was made to Dr. Abul Hossain Talukdar, medical assistant. He had trained for four years as a medical assistant and completed a diploma course. His practice was in one of the most congested streets of Netrakona town. He appeared confident and was dressed in European style.

During the discussion he described facing the problem of not being recognised as a doctor. While letters from the Department of Family Planning address him as a community medical doctor, the Health Division acknowledges him as a medical assistant. Another frustration was in prescribing drugs. As a medical assistant he can only prescribe 45 different drugs for his patients. He suggests the designation of Medical Assistant should be abolished. Patients with all ailments excluding gynaecological complaints attend his practice.

My impression was that Dr. Abul Hossain Talukdar is frustrated by his lack of government recognition as a private practitioner. Having visited only one private practitioner in his practice, I feel no need to investigate their work further. Most of these doctors are employed as civil servants under the Ministry of Health and Family Welfare and practise privately during working hours. Wherever I had discussions with doctors, they explained this practice is necessary because they cannot support their families on government salaries.

6. RECOMMENDATIONS AND OPTIONS FOR SUS

Over the last ten years, the SUS organisation (with locally recruited health staff) has played an important role in providing quality health care in the rural and urban areas of Netrakona Thana. Health cannot be promoted separately from nutrition, education, a safe environment, self-government and equity.

1. NGOs are recognised for their ability to reach the grass-roots level. Despite some tremendous achievenets, poverty allevation as a result of NGO activities has been limited.

NGOs such as SUS need support and encouragement at district level from government authorities to facilitate and extend their positive contribution to the community.

2. At present, almost equal numbers of men and women are employed in the organisation. Sabalamby Unnayan Samity has been founded to educate and empower women to become leaders also in their organisational structure.

In future, it is advisable that more women than men are appointed to higher positions in the organisation. The organisations' goal, to care for women and children, should not be jeopardised by the emplyment of too many men.

3. USAID is presently in the process of withdrawing funds from the Bangladesh family planning programme.

To guarantee the future for SUS in the health sector, it is imperative that dialogue begins to involve the district health services in the process of decentarlisation of the FP programme.

It is also strongly recommended that SUS examines the possibility of government cofinancing for the FP programme, while ensuring they retain their own identity and control.

4. In Bangladesh, the HIV/AIDS problem is not yet as visible as in other countries. The Government is reluctant to proclaim the existence of the disease in the country.

SUS could take up the challenge of starting an HIV/AIDS programme in the primary health care context. Awarness of this disease should be raised before it is too late. Training could be provided by organisations which have worked in HIV/AIDS programmes in other countries.

5. Many of the health problems in the district are still related to water, sanitation and education. The imminent Country Health Policy aims to use primary health care as the main long-term

strategy to address health problems. To this end, a reorientation of the SUS health programme is essential.

The process of reorientation and reorganisation of the SUS health system will require the development of a Sabalamby Unnayan Samity health policy, and a detailed plan of action for the health programme in coming years.

6. It is advisable that the new SUS Ideal Health Centre be started in phases. To introduce everything together could overlook the main goal: a COMPREHENSIVE HOLISTIC APPROACH. Short and long term planning could be part of the proposed five year action plan.

7. To reorient the SUS health programme towards COMPREHENSIVE PHC, and ensure cooperation (both technical and administrative) with the Department of Health and Welfare, an experienced PHC coordinator is needed to strengthen the SUS organisation. The sharing of experiences in PHC in other developing countries is advisable. The coordinator should liaise with the Department of Health and Welfare and possibly also with donor agencies. It is proposed that COV be approached to identify and recruit a PHC nurse with the qualifications needed to fulfil the above post.

7. PROJECT PROPOSAL FOR SERVICES IN SUS IDEAL HEALTH CENTRE

JUSTIFICATION OF THE PROJECT

My visit showed the health facilities in Netrakona and Atpara Thanas to be of a poor standard. People who can it will use private services. I asked the cost to people of waiting for hours to see a doctor. The reply was:
" They have no work, so no money is lost."
In Bangladesh, the doctors maintain the status quo in the health services. Their attitude - often a bad work ethos with corruption rife - affect the whole atmosphere. Doctors have the power to improve a dirty environment, simply by instructing domestic workers to clean. The nursing sector is much smaller than that of the doctors. In most countries it is the nurses who care for the patients. Bangladesh seems to miss this category of caretakers.

Could NGOs intervene to bring the condition of government health facilities to the attention of the highest levels? At present, nothing is being done. Must SUS wait for the Government to present its health policy? No! I feel that SUS should start to build its Ideal Health Centre.

The Deputy Civil Surgeon has been asked to justify the building of this centre. His answer was very clear:
" The SUS Health Centre will not duplicate or compete with government services. It will be a synergetic model for them and SUS". He added that "SUS is caring for the poor of this area".

The present SUS Health Centre is too small and not convenient for setting up a comprehensive PHC pilot programme and for curative health purposes. The new building will be completed at the end of this year. Maps are ready and documents signed. Final approval rests with the Director of Curative Services.

The project should start with a pilot programme in the SUS communities, in which the preventive and curative sectors should be linked so that there is interaction between the two.
Coordination between the programmes is essential to achieve the goal of caring for sick and marginalised people.

The head of the initiative should be an excellent PHC mamager able to socialise easily and adjust quickly to life in a remote area. He or she should be able to to train others in in PHC activities.

The project should not start immediately with all activities and training. It should be implemented in short and long term phases.

PRIMARY HEALTH CARE PROGRAMME

This programme should become a model for the Netrakona Thana.

Implementation

1. Expanded Programme of Immunisation:

- Immunizations services
- Cold chain instructions
- Early determination of physical disabilities in newborn babies.

In this programme a ROAD-TO RAOD PASSPORT should be introduced to mothers and children under five years of age.

The COLD CHAIN EQUIPMENT could be procured through goverment channels from UNICEF offices to SUS.

2. Growth Monitoring:

- Children under five
- Weighing and length measuring
- Upper Arm Interference Measuring (UAIM)
- Malnutrition
- Deworming and distribution of Vitamin A

3. Mother and Child Health Care:

- Prenatal, natal and postnatal care
- Care for the newborn baby
- Tetanus vaccinations. The new schedule of 5 vaccinations for women from 15 to 45 years of age should be implemented in the SUS programme.
- Iodised salt
- Family planning, their own choice.

4. TB and Leprosy Control Progamme:

The TB and Leprosy Programme should collaborate with the Damian Foundation. Drugs could be distributed from the SUS health centres.

5. HIV/AIDS Programme:

HIV/AIDS can be placed under TB/Leprosy or another programme such as Education or the Community Based Health Care Programme.

6. Malaria Control Programme:

This programme is especially important during the rainly malarial season. Mosquito nets should be provided to malarial areas.

7. School Health Programme:

In SUS schools, children should be seen by the doctor to determine deformities, sight problems and skin diseases.

The ORT corner could be introduced to schools. Studies have shown that children are the best teachers at home of what they learn at school.

8.Community based health care programme:

The training of community leaders should come under an official health programme. The trained leaders should be called **village health workers,** an official name, used in many other countries. The training must be systematic.

Traditional birth attendants and traditional healers could be also trained under this programme.

ANNEX A. SCHEDULE OF VISIT

17 DECEMBER:

ARRIVAL IN DHAKA

MEETING WITH MR. TON VAN ZUTHPEN.

18 DECEMBER

OFFICE ACTION AID:
- MEETING WITH DR.NAFEESUR RAHMAN
  PROGRAMME OFFICER DISABILITY/ AIDS COORDINATOR
- MEETING WITH MRS. MOUSHUMI E. NASSER PROGRAMME OFFICER UR BAN ADOLESCENT UNIT.
- MEETING WITH MR. TON VAN ZUTPHEN ACTION AID, MR. FEISAL AC TION AID, BEGUM ROKEYA SABALAMBY UNNAYAN SAMITY (SUS) TOOS VAN HELVOORT.

DEPARTURE TO NETRAKONA SUS GUESTHOUSE.

19 DECEMBER
- VISIT TO THE MODEL FARM PROJECT, DIARY, FISH PONT (MFP)
- NON FORMAL EDUCATION PROGRAMME (NFEP) DIFFERENT SECTION VI SITED; BATIK, EMBROIDERY, BAMBOO AND JUTE WORK,KNITTING, TAILORING.
- SOCIAL DEVELOPMENT AND CREDIT PROGRAMME (SDCP)
- HEALTH AND FAMILY PLANNING (MCHC)

20 DECEMBER
- MEETING WITH STAFF OF THE DAMIAN FOUNDATION, HOSPITAL FOR TB AND LEPRA PATIENTS.
- DISCUSSION WITH A LOCAL HEALER, MR.SUDHAN TAKUR
- VISIT TO A PRIVATE PRACTIONER IN NETRAKONA TOWN Dr.ABUL HOSSAIN TALUKDAR.

21 DECEMBER
- VISIT TO THE MATERNITY HOSPITAL NETRAKONA.
  DISCUSSION WITH DR. FERDOWS ARA AUTER
  DR. MD. EMARAT HUSSAIN DISTRICT M.O. FP.(cc)
- VISIT THE THE CHIEF SURGEON OF THE DISTRICT HEALTH DIVISION OF NETRAKONA .
  DISCUSSION WITH DR. M.ABDUL WADUL M.O.
  DR.WAHID RUSCHIE M.O.

06 JANUARY

- TRIP TO THE RURAL AREA TO THE FPW CENTRE AT BALVAKANDA
- VISIT TO UNION HEALTH CENTRE AT MADANPUR

11 JANUARY

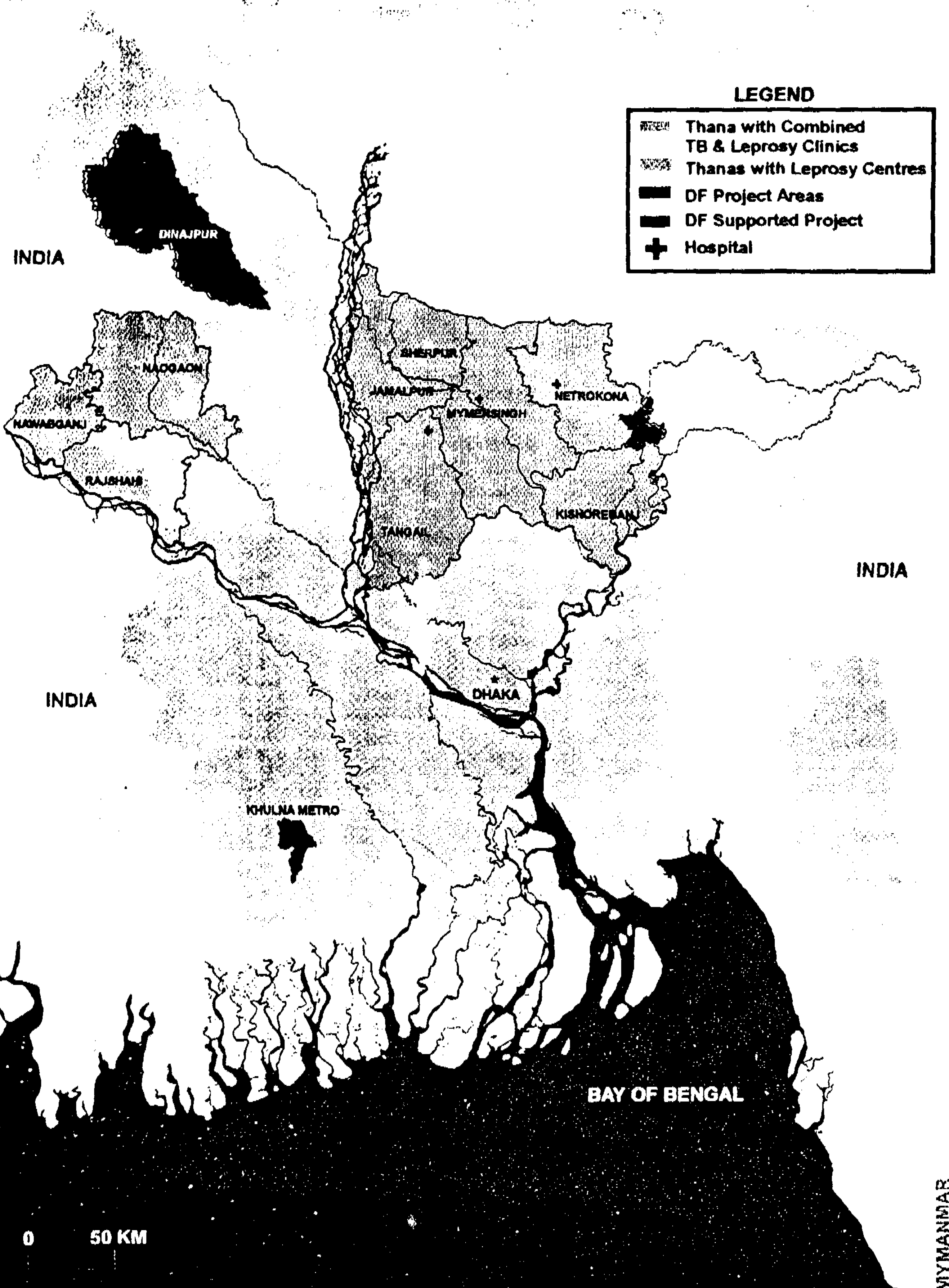
- RETURNING BACK TO DHAKA:

Annex B

LIST OF ABBREVIATIONS

AAB	Action Aid Bangladesh
CPR	Contraceptive Prevalence Rate
DFB	Damian Foundation Bangladesh
EPI	Expanded Programme of Immunization
FP	Family Planning
FWV	Family Welfare Visitor
FWA	Family Welfare Assistant
FPSTC	Family Planning Service Training Centre
GOB	Gross Domestic Product
HC	Health Centre
RLD	Rural Local Doctor
MCHC	Mother Child Health Care
MUAC	Measure Upper Arm Circumference
ORT	Oral Rehydration Treatment
ORS	Oral Rehydration Solution
NGO	Non-Governmental Organisation
OPD	Outpatients' Department
THC	Thana Health Complex
TH	Traditional Healer
TBA	Traditional Birth Assistant
TLCA	Tuberculosis - Leprosy Control Assistant

ANNEX C



ANNEX Ca

NETRAKONA DISTRICT

December 1995

INDIA

KALMAKANDA

DURGAPUR

PUBADHALA

NETRAKONA

BARHATTA

SYLHET

MOHANGANJ

ATPARA

MYMENSINGH

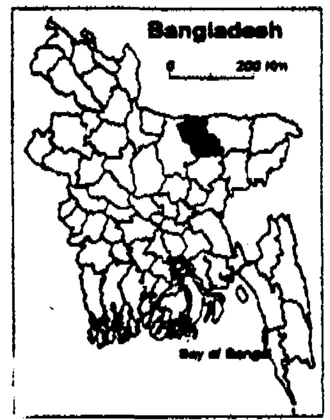
KENDUA

MADAN

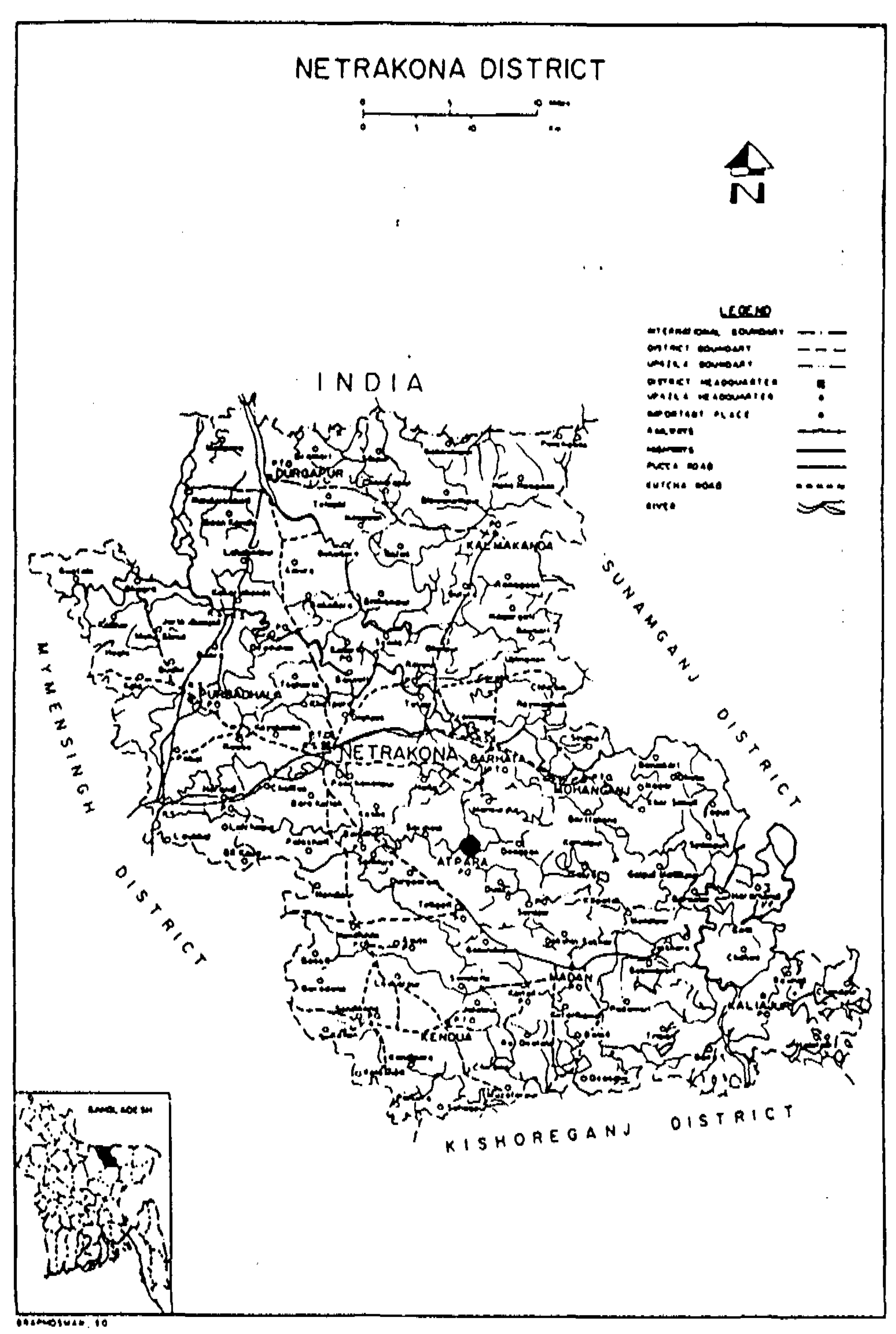
KISHORGANJ

LEGEND

- Thanas with Combined TB & Leprosy Clinics
- Thanas with Leprosy Centres
- DF Area
- Hospital



Annexure A1: Map of Netrakona district



V. NATIONAL HEALTH POLICY

- There is yet no formal document embodying the national health policy. But in the Fourth Five year plan a health policy guideline has been put to reflect the health planning for the year 1990-95.
- A National health policy is to be developed to reorganize / restructure the existing health care system to ensure preventive, promotive and rehabilitative health care to the general masses and to bring about qualitative and quantitative changes in health services. It aims at improvement of the overall standard of health services in the country through bringing about a reformative change over the existing health system. It will ensure the exercise of people's local health programmes so as to ensure effective delivery of health care, better coordination and optimum utilization of health services. The main **features/elements of the National Health Policy**, among others, may be listed as follows:

1. Preparation and attestation of the list of destitute persons and distressed widows of the society to ensure preventive and curative health care and family planning services from the THFWCs THCs and if required, from other hospitals at higher level at free of cost;
2. Making public and private health services easily available with minimum cost to the people at all levels;
3. Creation of special medical facilities for school students, mentally retarded persons, destitutes and disabled;
4. Making treatment facilities of common diseases and injuries easily available to the people of all areas of the country at a minimum cost;
5. Taking special measures for control and treatment of epidemic and endemic diseases including diseases arising out of natural calamities;
6. Increased access to safe drinking water and sanitation for rural and urban population and measures against environment pollution;
7. Advocating breast feeding practices (at the national level) and creation of mass awareness about the merits of breast feeding;
8. Initiating special programmes towards creation of awareness on women health and their health related problems, as in the existing social system, they enjoy a lower health status and their health problems are neglected in the family as well in the society;
9. Undertaking preventive, curative and reformative measures for safeguarding people from the curse of smoking, drug addiction, adulterated food and poor quality medicine;
10. Undertaking special measures towards preventing people particularly children from smoking, drug addiction and drinks, formulation of acts towards awarding heavy punishment to the sellers and suppliers for selling these items of addiction to the boys and girls under 16 years of age;
11. Reflection of national population policy in the programmes of family welfare activities and implementation of population policy through providing different special facilities in education, social and cultural fields;
12. Undertaking efforts for delaying marriage and preventing birth through raising the minimum age at marriage of male and female, if required;
13. Identification of under-privileged and vulnerable families locally and undertaking measures for providing food and nutrition to the children and women of these families;
14. Undertaking immunization activities against "vaccine preventable" communicable diseases and making vaccination compulsory;
15. Treatment of diseases caused by various professions and creation of compulsory medicare facilities by the industrial entrepreneurs of mills and factories for their workers;
16. Undertaking measures for provision of safe water and creation of pollution free environment since health and environment are closely related. *[Source : FFYP (1990-95)]*

VI. HEALTH PLANNING IN BANGLADESH

A. Planning Commission

Bangladesh set up a Planning Commission since her independence. It is to make an assessment of the material, capital and human resources of the country, and to draft developmental plans for the most effective utilization of these resources.

Over the years, the Planning Commission has been formulating First Five Year Plan (1973-78), Two Year Plan (1978-80), Second Five Year Plan (1980-85) Third Five Year Plan(1985-90) and Fourth five year plan (1990-95).

B. National health planning

Based on the broad guidelines and financial ceiling as provided by the planning commission, the Ministry of Health and Family Welfare prepares a draft of health sector Five Year Plan for submission to the planning commission.

After review by the Planning Commission, the Health Sector Plan is incorporated into the Five-Year socio-economic development plan of the country. The Ministry of Health and Family Welfare then prepares detailed plans for all development projects within the financial allocation indicated by the Planning Commission. Once the detailed plan is approved by the National Economic Council, it is ready for implementation by the Ministry of Health and Family Welfare. For the purpose of implementation detailed annual work plan and annual budget estimates for various programmes and projects are prepared by the planning unit of the Directorate General of Health Services.

I. Objectives

The objective of the Health Sector during the Fourth Five Year Plan have been formulated within promoting and supporting development and operation of national health care system so as to attain the national strategy for 'Health

for All by the year 2000'. The Fourth Five Year Plan will have special emphasis on consolidation of existing health facilities and programmes and strengthening of management capabilities to ensure efficient functioning and optimum utilisation of the same.

Major objectives of the Fourth Five Year Plan will be as follows:

i. to improve the health status of population, prticularly of mothers and children;
ii. to consolidate and strengthen the coverage of Primary Health Care and its supporting services for improved quality and quantity of health services;
iii. to deliver improved heqlth and family planning services in a package to the family with a view to increasing its welfare;
iv. to prevent, control and treat major communicable and non-communicable diseases;
v. to improve nutritional status of the population particularly of mothers and children;
vi. to foster appropriate health manpower development and its optimum utilization;
vii. to promote adequate production, supply and distribution of essential drugs, vaccines and other diagnostic and therapeutic agents; and
viii. to strengthen planning and management capabilities of the health system for utilization of existing facilities to the fullest extent and optimisation of health services; and to promote and strengthen health system and bio-medical research.

2. Strategies for the Fourth Five Year Plan

In order to attain the above objectives, the following strategies will be adopted:

i. Primary Health Care Services will be provided through a three tier system for health promotion, disease prevention, treatment and referral. The level of services considered are
   (a) *Community level*—through community health workers, village defence party (VDP), mothers club etc. This would be linked to the overall village development programme with people's participation, as envisaged during the Fourth Five Year Plan.
   (b) *Ward level*—through satellite clinics (health post) with mid-level health manpower, and
   (c) *Union level*—through Uning Health and Family Welfare Centre. The on going programme for establishement of TH-FWC and raising of voluntary community Health workers/health volunteers will be speeded up. All THCs and UHFWCs will be equipped with necessary diagnostic and treatment facilities to provide PHC and act as referral centres.
ii. Health and family planning services will be integrated through unification of the Directorate of Health Services and Directorate of Family Welfare to provide comprehensive services of PHC and MCH including family planning, in a package form;
iii. The immunization and other related programmes such as health laboratory, epidemiological surveillance/health information system and health education will be further expanded and strengthened to control communicable diseases effectively;
iv. Health manpower will be developed through development and implementation of appropriate curriculum and basic in-service training of all categories of health service providers i.e. doctors, para professionals etc. The thrust will be on production of specialised manpower (technical and managerial) and also on production of the mid and grass-root level health manpower. To meet acute shortage of graded specialists, some of the existing medical colleges will be upgraded with necessary facilities for post -graduate level medical training and research;
v. Health infrastructure throughout the country will be built with special emphasis on development of graded services with thana, district and national level, linked with a referral system. Thana Health Complexes will be strengthened in phases to provide first level specialised care; District hospitals will be expanded with increased number of beds for different specialities. Medical College hospitals and specialised hospitals and institutes will be strengthened to provide services at the tertiary level;
vi. Supply of essential drugs, vaccines, sera, chemical and reagents, rehydration fluids, etc. will be augmented by increasing their production in the country. Bottlenecks experienced in the past due to an over centralised system of supply of basic drugs and medicines will be removed by decentralisation of the system through establishment of supply depots and subdepots at district/regional level and streamlining the distribution system;
vii. Intersectoral coordination and interaction between health and other sectors will be fostered, especially in relation to such fields as mother and child care, family planning, nutrition, health education, safe water supply and sanitation, local production of essential drugs;
viii. The entire health system will be restructured for efficient management and improved service delivery;
ix. Development of indigenous and homeopathic systems of medicine will be encouraged under public and private sectors. To this end, manpower development through education, training and research will be pursued so that these systems play complementary role to modern system of medicine;

Table 1 : Major Health Indicators and Targets of the Fourth Five Year Plan (1990-95)

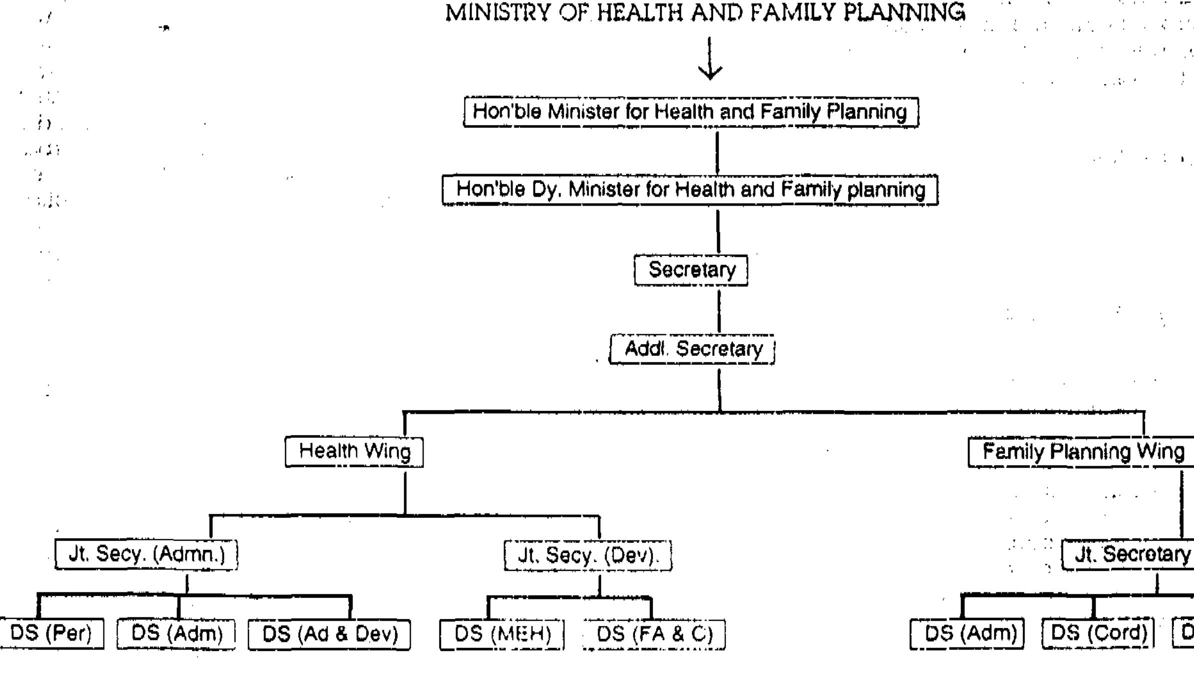
Sl. No.	Health Incator	Unit	1989-90 Bench Mark	1994-95 Target
1	2	3	4	5
1.	Infant Mortality Rate	/1000 live Birth	110	80
2.	Child Mortality Rate	/1000 upto 5 Years	11	9
3.	Maternal Mortality Rate	/1000 live Birth	7	4.5
4.	Crude Birth Rate	/1000 Population	35.2	30
5.	Crude Death Rate	/1000 Population	13.9	12
6.	Population Growth	%Year	2.16	1.8
7.	Life Expectancy at birth	years at birth	53	55
8.	Hospital Beds	Comulative	34488	36488
	a) Health Services	Ditto	24501	26001
	b) Other Ministries & Private	Ditto	9987	10487
9.	Thana Health Complex	One in each Thana	351	397
10.	UHFWC/RD	One in each Union	3375	4325
11.	Immunization (0-1 Years)			
	a) BCG	% coverage	75	85
	b) DPT	Ditto	68	85
	c) Measles	Ditto	50	85
	d) Polio	Ditto	68	85
	e) TT (Pregnancy)	Ditto	45	85
12.	Control of Diarrhea	% of coverage of ORS Distribution	90	90
13.	Control of T. B.	% of cases found (sputum positive)	20	50
14.	Delivery by trained personnel	% of pregnant women	20	50
15.	Antenatal care	% of pregnant women	45	60
16.	Nutritional Status	Av. adult energy intake in kcal	1850	2100
17.	Prevention of Night Blindness	% of children under 6 receiving Vit-A capsule	66	90
13	Control of Goitre	% covered for protection through		
		i) Lipiodol	70	100
		ii) Iodized salt	10	100
19.	Nutrition services	% of 2nd/3rd degree malnutrition treated	50	60
20.	Coverage of population by PHC	% of population	50	80
21.	Essential drugs and vaccines	Availability for public health services (% of total required)	60	70
22.	Health Lab Services			
	a) Simple lab facilities at THCs	% of coverage	100	100
	b) Simple lab facilities at district level	% of coverage	100	100
23.	X-Ray facilities in THCs	Number	143	397
24.	Blood transfusion upto District level (including Medical Colleges)	Number	46	71
25.	Production of essential drugs, ORS, vaccines & I. V. fluids	Value in million taka	4317	4826
	Public		389	408
	Private		3928	4418
26.	Health Manpower :			
	a) MBBS Doctors	Cumulative	20590	25600
	b) Dentist	Ditto	805	1150
	c) Basic Nurse	Ditto	9100	11350
	d) Medical Assistant	Ditto	4348	4700
	e) Lab Technician	Ditto	1702	2050
	f) Radiographer	Ditto	522	850
	g) Pharmacist	Ditto	6283	7000

Source : PDEU, Planning Commission.

B. ORGANIZATION OF HEALTH SERVICES

1. **National level — Ministry of Health and Family Planning**
   - The Ministry of Health and Family Planning is headed by a Minister. He is assisted by a Deputy Minister, a Secretary, an Additional Secretary, Joint Secretaries, Deputy secretaries and Assistant Secretaries (Table 1).
   - The Ministry is responsible for policy and planning formulation and decision making.
2. **Central level — Health Directorates** (Table 2)
   - Under the Ministry, there are two Director General, one for health and the other for family planning.
   - The Director General of Health Services is responsible for implementation of all health programs and projects and for providing technical guidance to the Ministry.
3. **Divisional level**
   - The functional unit at the divisional level is the Divisional Health Authority. It is headed by one Deputy Director who is assisted by 2 Assistant Directors — 1 for administration and the other for communicable disease control (CDC).
   - Divisional Health Authority is responsible for supervision, monitoring and coordination of health activities in all the districts of the division.
4. **District level**
   - At this level, the Civil Surgeon is the team leader and health authority in the District. He is also the Ex-officio Superintendent of the district hospital.
     The Civil Surgeon is assisted by a Deputy Civil Surgeon and medical officers.
   - The Civil Surgeon is responsible for all health activities, domiciliary and institutional (except medical colleges and medical assistant training schools) in his district.

Table 1. Organizational chart of the Ministry of Health and Family Planning



Note : *Per* - Personal
Admn - Administration
Dev-development
Ad - Advancement
MEH - Medical Education & Hsopital
Cord - Coordination

Table 2. Organizational chart of Directorate General, Health Services

Ministry of Health & Family Planning

IPGM&R
IDCH
ICVD
RIHD
NIPSOM
IPH
IRHN
NIO

Director General, Health Services

Asstt. Dir. Coordination

Director General Family Planning

Addl. Director General

Asstt. Dir. Prject Coordination

Director Drug Admin.

Director Nursing

Director Admin.

Director Flinance

Derector Medical Education & Man power Dev.

Director Hospital

Director PHC & CDC

Director Central Medical Stores

Dir ctor Planning, Research & MIS

De--ctor Homeo & indigen. Medicine

Dy. Dir. Service

Dy. Dir. Education

Dy. Dir. Accounts & Budget

Dy. Dir. Audit

Dy. Dir. Hospital (I)

Dy. Dir. Hospital (I)

Dy. Dir. Procur.

Dy. Dir. Distule.

Dy. Dir.

Dy. Dir. Admn.

Dy. Dir. Per. (2)

Dy. Dir. Discipline & legislation

Dy. Dir. Med. Aid

Dy. Dir. Training

Dy. Dir. HMPD

Dy. Dir. MIS&HI

Dy. Dir. Pln. & Research

Dy. Dir. Regist. & Quality Control

Dy. Dir. Inspect. & Licensing

Dy. Dir. Tasting Lab.

Dy. Dir. PHC

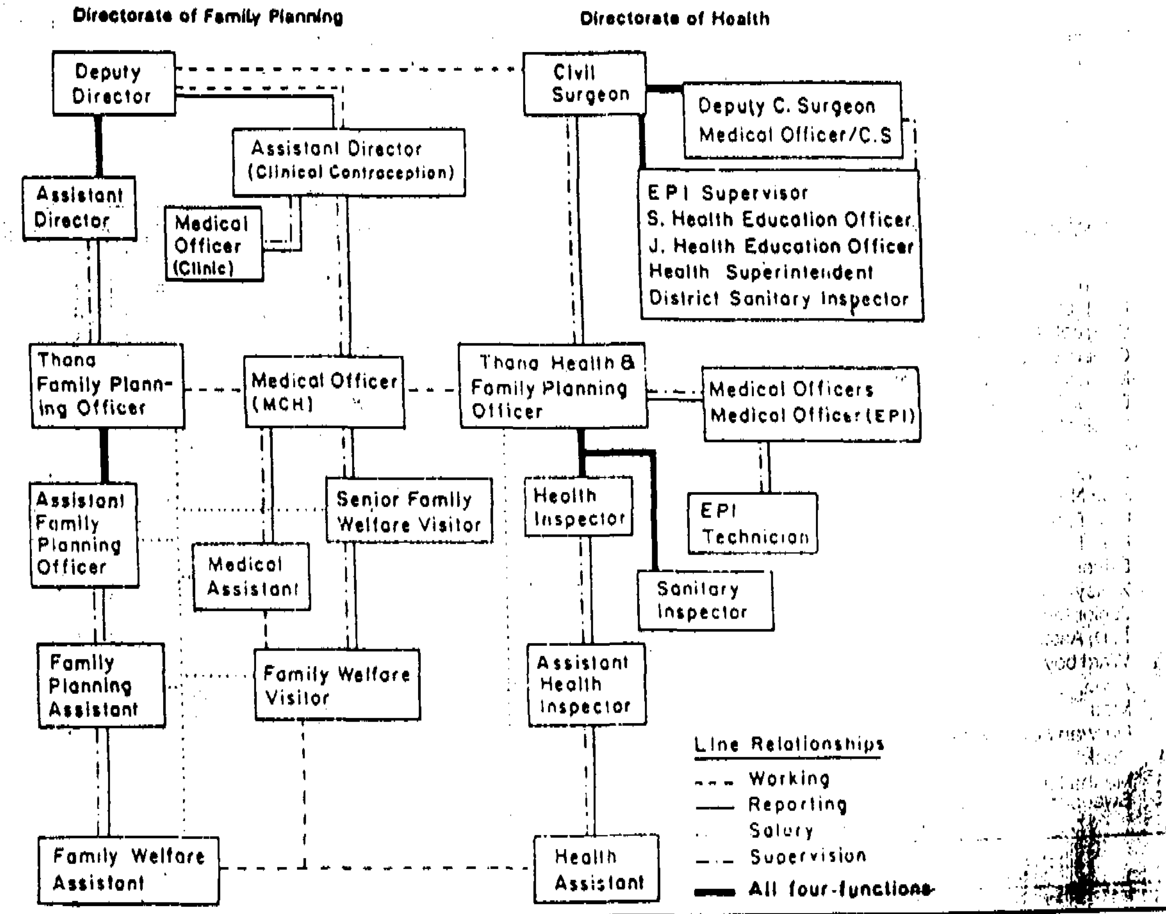
Dy. Dir. EPI

Dy. Dir. Mal & PDC

Dy. Dir. MBDC

Dy. Dir. CDC

Table 3. Organization of Health Administration at District level and Below.



5. **Thana level**
   - The Thana Health and Family Planning Officer (THFPO) is incharge of the health and family planning activities at the thana level. The THFPO is being assisted by other midical and general personnel (Table 4).
   - **Thana Health Complex (THC)**
     It is 31-beded hospital at the thana level. It is called complex because it offers —
     — outdoor and indoor services,
     — administration and technical support;
     — training and supplies;
     — referral treatment for Union Health and Family welfare centers.
     In each THC, there are 8 doctors and 1 dental surgeon.

6. **Union level**
   - At this level, there are Health and Family welfare centers / subcenters. One MBBS medical graduate is incharge of this union level facility.

C. Services available at Thana Health Complex

1. Indoor services with 25 general beds and 6 maternity beds.
2. Out door services :
   i) Diagnosis and treatment facilities.
   ii) Referral of serious and difficult cases to higher institutions.
   iii) Co-ordination of various health activities at thana level.
   iv) Family planning and meternity and child health care.
   v) Prevention and control of diseases—
      (a) Immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis, and tuberculosis.
      (b) Health education.
      (c) Providing diagnosis and advice about health oriented problem to the field workers.
3. Laboratory services.
4. Control and supervision of the work of the sub-centres.

Table 4. Organizational structure of Thana Health complex

Thana Health Complex

Personnel — 7
1 T. H. F. P. O,
1 Head Asstt. cum-Accountant.
1 Statistician.
1 Cleark-cum-Typist.
1 Cashier.
1 Store keeper.
1 Peon.

HEALTH SERVICE ← → FAMILY PLANNING

HEALTH SERVICE: HOSPITAL (INDOOR & OUTDOOR)	HEALTH SERVICE: DOMICILIARY SERVICE	FAMILY PLANNING: MCH	FAMILY PLANNING: FAMILY PLANNING
Personnel—39	Personnel—4	Personnel—4	Personnel—6
1 R. M. O.	1 Health Inspector (for 3 A.H.I.)	1 Medical Officer.	1 T. F. P. O.
1 Surgical Specialist.	1 Sanitary Inspector.	1 Family Welfare Visitor.	1 A. U. F. P. O.
1 Gynaecologist.	1 Peon–cum–med. carrier.	1 Aya.	3 FPA
1 Medical Specialist.	1 Peon–cum–lab. specimen carrier.	1 Miss/ Peon.	1 Miss / Peon
1 Dental Surgeon.			
2 Medical Officer.			
2 Medical Asstt.			
2 Compounder –cum – Dresser.			
5 Staff Nurse.			
2 Lab. Techn.			
1 E. P. I. Techn.			
1 Driver*			
1 X-Ray Techn.			
1 Junior Mechanic			
2 L. D. Asstt.			
3 Ward boy.			
2 Aya.			
1 Mali			
2 Darwan / Chowkider.			
1 Cook			
1 Masha.lchi			
5 Sweeper.			

Note :

1 No. of health Inspectors depends on the number of Asstt. Health Inspectors.
2 One peon–cum–lab. specimen carrier for one Health Inspector.

* Where Transport is available.

ANNEX I

Basic Indicators on Situation of Children and Women in Bangladesh

1. Demography

- Total population — 122.1 million (1995)
  - Urban — 21 %
  - Rural — 79 %
- Population annual growth rate — 1.80 %
- Annual growth rate of urban population — 6 %
- Pre-school (1 to under 5 years) — 16 %
- School (5 to under 16 years) — 44 %
- Crude birth rate — 26.5 per thousand
- Crude death rate — 8.4 per thousand
- Sex-ratio at birth (males per 100 females) — 104 : 100
- Life expectancy at birth:
  - Male — 58.4 years
  - Female — 58.1 years
- Total fertility rate — 3.45

2. Economy

- Annual growth rate of economy — 4.7 %
- Gross National Product (GNP) per capita US$ — 253
- Percentage of population below poverty line — 47 % (1992)
- External debt service as percentage of export of goods and services — 9.8 %
- Official Development Assistance (ODA) as percentage of GNP — 4.5 %
- Annual rate of under employment — 26 %

Extract from Unicef yearly report '96

3. Health

•	Infant mortality rate:	75 per 1000 live births (1995)
•	Under-five mortality rate	137 per 1000 live births (1995)
•	Neonatal mortality rate:	54 per 1000 live births (1995)
•	Maternal mortality rate:	4.47 per 1000 live births (1995)
•	Contraceptive prevalence: All methods: Source: Health Demographic Survey	45 % (1994)
•	*Women receiving* training assistance at delivery (by doctor or qualified midwife/nurse).	14 % (1994)
•	Children under 5 years: ORT usage rate	66 %

4. Immunization

•	a) DPT3/OPV3	69 %
	b) Measles	79 %
	c) Tetanus Toxoid - 2 doses (pregnant women)	86 %
•	Neonatal Tetanus Annual number of cases	735
•	Measles: Annual number for all cases	4995
•	Polio: Annual number of cases	207

5. Nutrition

- Pre-school children malnourished: 69 %
- Population with goitre: 47 %
- Children under 5 years Vitamin A deficiency: Night blindness 0.7 %
- Children under 5 years receiving Vit. A supplement 80 %
- Number of salt crushing unit with iodization capacity 96 %
- Hospitals/maternities certified as baby friendly 130

6. Education

- Children entering school at school entry age (Net enrolment)
  - Boys 82 %
  - Girls 82 %
  - Combined 82 %
- Children enrolled in grade 1 who complete primary education 61 %
- Adult literacy rate (age 15 and over) 44 %

7. Water and Sanitation

- People with access to safe drinking water (1995)
  - Rural 96 %
  - Urban 99 %
  - Combined 97 %
- People with sanitary facility within convenient distance (1995)
  - Rural 44 %
  - Urban 79 %
  - Combined 48 %

Note on Sources: The data sources are a. Progr r Pathey, BBS-UNICEF Multiple Indicator Cluster Survey b. The Bangladesh Data Sheet 199 published by Bureau of Statistics (BBS), c. The 1996 Statistical Yearbook, (BBS,) d. Informa on received directly from different implementing ministries, e. The World Bank.

Patients go back disappointed without treatment

Shortage of doctors, medicines in health complexes

From Our Correspondent

PANCHAGARH, Dec 23:—The shortage of medicines, medical apparatus, doctors, absence of blood bank, oxygen and lack of modern facilities have rendered the Boda Hospital inoperative.

A large number of patients, both males and females coming from farf-lung areas, everyday to the hospital with the hope of proper treatment go back disappointed. They go back without medicines and even prescriptions due to negligence of the doctors as they are busy with private practice.

There is sufficient dental equipments but there is no dental doctors. The patients are required to buy medicines at export price from markets. The worst sufferers complained that even detol was not available in the hospital.

There is no waiting room for the outdoor patients although about 200 patients come for treatment everyday.

Out of 8 posts of the doctors in the hospital 4 posts have been lying vacant for a long time. There is no consultant for medicine in the hospital.

The patients are deprived of surgical treatment for want of doctors and dental specialist in the hospital.

Bed-sheets, pillows, blankets and mattresses remain uncleaned for days together.

Sometimes the patients requiring operation are compelled to go to either Rangpur or Dinajpur as there is not proper arrangement for surgical treatment. In most of the cases critical patients expired without surgical treatment.

Besides, the patients with infectious diseases are accommodated in the general ward. The diets served to the patients are not up to the standard but there is none to check the malpractice.

Netrakona

Our Netrakona Correspondent reports : Thousands of patients are deprived of proper treatment in 10 thana health complexes and medical sub-centres of Netrakona district due to shortage of medicine and doctors.

The civil surgeon office sources said that there is a shortage of 20 doctors in 10 thana health complexes of the district and more than 30 posts of doctors in medical sub-centres are lying vacant for a long time. Though authority concerned have posted doctors to respective vacant posts, they remain absent.

There is a shortage of life-saving drugs in all the health complexes and medical sub-centres causing concern among the poor patients who comes from rural area in order to take *proper medicare*. The patients go back disappointed wih the prescriptions only.

In most cases doctors on duty, specially advised them to consult at his chamber as they prefer practice to office defying government restriction.

Besides, internal conflict among THFPO and doctors or officers and staffs hampers the treatment.

The people of the district especially rural areas urged upon the authority concerned to supply medicines and to fill up vacant doctors in all the thana health complexes of the district immediately to solve the problem.

PANCHAGARH: The dental treatment equipments are lying unused for want of doctor in Boda Hospital. —OBSERVER

The Bangladesh Observer
26-12-1996

KEY REFERENCES:

Annual Report, Damian Foundation Dhaka 1995

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Country Strategy Paper (1994-1998)/AAB Dhaka 1994

Development Area Appraisal Document SUS
AAB/ Dhaka June 1995

The Role of Voluntary Organisations in Development/
Brown L David &. Korten David C/ 1989/ Boston

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World Bank / September/ 1996

Bangladesh Observer/ December 1996

ANNEX N

TERMS OF REFERENCE FOR FEASIBILITY STUDY :

NETRAKONA THANA- SABALAMBY UNNAYAN SAMITY:

The feasibility study will take place from the 18th of December till the 15th of January 1997.

Please fin below some ideas and suggestions concerning this visit.

A: Different expectations by parties involved:

- The SUS organisation considers requesting COV for technical assistance. The intial re quest is not yet specified. It is therefore important to identify the type of expertise required.

- COV is in principal prepared to provide technical assistance provided a feasibility study related to the future health situation will be carried out. In order to collect data, interviews must take place with the health authorities from SUS, Health Directorate of the District, NGOs working in the area and Traditional healers.

B: Descrition on the social/ economic background of the country.

C:- To analyse the strenght and weaknesses of the Preventive/ Curative Health Care Systems in the district.

1. Government Health Facilities, including PHC/FP.
2. NGOs working in health in the area.
3. Private services
4. Traditional Services.

D: The specific role of the organisation SUS.

- short history
- current activities

E: Recommendations

- visulize the future of the Ideal Health Centre.
- what is the goal of the HC

F: Recommend elements of comprehensive H.C. system on PHC and linked to the exis ting Curative Health Stucture.

G: Possible options for improving the situation and with recommendations for further action.

H: Justification of the Ideal Health Centre and proposal for technical assistance in the field of Comprehensive Primary Health Care programme..

Cadier en Keer 10 December 1996