WORLD HEALTH
ORGANIZATION

REGIONAL OFFICE FOR
SOUTH EAST ASIA

28 March 1977

REPORT ON A VISIT TO
BANGLADESH

8-22 March 1977

by

David Drucker
Social Scientist

Distribution: DHS
ADT
ADA
WR Bangladesh
PLN
PMO
ECON
RA HS
IRU
RDOC
CHS
REG.

Purpose of Visit

To assist with the organising of a Data Collecting Group in preparation for the proposed Country Health Programming. Attempting to improve upon previous CHP performances by strengthening attention to be given to :

a) Policy Analysis

b) Health service outside of the government system, and qualitative information which might be usefully added to the more familiar quantative information.

In view of the emphasis on rural health services in Bangladesh and the forthcoming National Regional and International Promotion of PHC, to examine the situation in Bangladesh with CHP in mind.

Introduction

Dr G.E. Cumper, Economist (SEARO) will report on the establishment of the Data Collecting Group, its overall progress and the current situation so that none of this need be repeated here. This report should be read as a supplement to Dr Cumper's. The contents of this report were briefly given to WR, Dr Han before leaving Bangladesh.

Policy Analysis

The sub-group which was to examine the policy analysis aspects of CHP did not really materialise. Dr A.Q. Khan, Director of the Institute of Epidemiology, Disease Control and Research, who chaired the overall Data Collecting Group showed interest, took part in some discussion but had many other duties to perform. Dr Md. Foyezuddin Mian, Civil Surgeon, Dacca, attended an initial meeting but did not show up again and Dr Sathianathan of WHO was necessarily away at the UNICEF, CHP Workshop at Chittagong for the main working week. The ordinary difficulties of getting staff assigned and regularly attending in the early stages of CHP are compounded when the subject area is policy analysis. It can be no mere oversight that this matter of policy analysis has featured very little in previous CHPs. It follows that there is little tried methodology in this area, to guide us from the earlier experiences. The Social Scientist addressed himself to this, prepared "DISCUSSION MATERIAL I"* as the basis for working out an approach, suggested 5 stages to the work, gave some indication of where information related to policy might be located and how some analysis might be prepared for the later CHP group.

*See Appendix - DISCUSSION MATERIAL I POLICY ANALYSIS

By its nature policy is political. The participants at the recent Inter-Regional Workshop held in Delhi stressed emphatically that CHP had to be a national activity and nowhere was this more emphasised than in relation to policy and the CHP activity of examining policy. Thinking regarding the 'correct' WHO role in this activity remains somewhat ambiguous but all recommended extreme caution. In Bangladesh our inability to convene an active policy analysis group which might include an active member of the Planning Commission for this purpose resulted in no operative commitment to the tentative suggestions made in the Discussion Material.

In addition to lack of persons, the time available is a serious constraint in preparing this particular area of work and perhaps we must think through these scheduling problems for future CHPs. Some of the threatening aspects and the risks of controversy of the policy analysis activity are obvious. These were discussed at length with WR, Dr Han, and Dr Sathianathan and at the latters request I hurriedly drafted a confidential note related to these problems in the Bangladesh context. ("A note for Dr Sathianathan".) The outcome is that we can probably expect a collection of statements of policy to be prepared for the CHP exercise but little beyond that unless WHO staff take up the task. It is perhaps wise to go only as far as the nationals can be encouraged to deliver, recognizing that this places some limitations on the potential impact of CHP on the development and effectiveness of health care approaches in Bangladesh, in exchange for reducing the risk of failure to obtain commitment or even outright rejection.

Health Systems outside the Government Service

Discussion Material II* was addressed to this area and suggests that descriptions might be attempted of :

a) the 'private' sector

b) the 'private' sector provided by government servants outside/ inside working hours.

c) the role of pharmacists

d) the indigenous healers of different kinds

e) the voluntary agencies.

As the voluntary agencies are conspicuous in Bangladesh and there is an obvious need for planning in relation to them, Discussion Material III addressed itself to the voluntary agencies. At least 58 of these serve family planning and 129 broader development programmes including health care.

*See Appendix - Discussion Material II, Health Systems outside the Government Service.

Visits were paid to one of the major agencies - Bangladesh Rural Advancement Committee and to the Ministry of Social Welfare. Discussion Material III* provides an illustration of how information from such agencies might be examined and used for CHP purposes.

Primary Health Care

The Social Scientist reviewed a large amount of material which might be relevant to PHC developments in Bangladesh and which needs to be properly related to the important Thana Health Complex Scheme. A start was made in drafting a brief "position paper" in this regard. On completion decisions will need to be made regarding whether or how to use it in regard to CHP and in relation to the up-coming workshops in Bangladesh.

---

*See Appendix Discussion - Material III, Voluntary Agencies.

DISCUSSION MATERIAL

COUNTRY HEALTH PROGRAMMING:

Data Collecting Stage - Material for Policy Analysis

Suggestions for group responsible for this section of the data package.

1. Provide a chronological account of the development of policy in the health field and in the directly related socio-economic fields.

   Here we could begin with the statements and objectives as they appear in the Bangladesh First Five Year Plan - and then trace the elaboration or change in direction of policy positions since then.

   Elaboration and changes in direction can be obgained by :

   a) Collecting the formal statements made by the related Ministries
   b) Identifying and collecting semi-formal statements
   c) Sifting the newspaper reported statements of Ministries etc. (Newspaper clippings exist in the WHO files from May 1975 todate. Is there a clipping service in the Ministry(s)?).

2. Make an attempt to throw into relief the account we have given in the chronology of policy and objectives by :

   Identifying, collecting, examining and presenting;

   a) Commentary on policy to be found in articles, seminar papers etc.
   b) Evaluation of programme which reflects upon policy intentions and objectives to be found in evaluations, surveys, articles etc.
   c) The influences that external AID agencies may be making in determining policy.

Note: I have been examining (as a special interest) the community involvement and primary health care.

Sources which yield the kind of information which might be of value in undertaking this section includes:

The Ministry of Health, Population Control and Family Planning, Ford Foundation, the paper by Oscar Gish.

"The Development of Health Services in Bangladesh, Feb 1976"

Papers delivered to the ESCAP workshop on Integrated Rural Development at Comilla in November, 1976.

"UNICEF Bangladesh Situation report on Health and Family Planning"

E. Preble 4/March/1977

"Establishment of Thana Health Complex Revised 1976".

"Proposal to the 2nd Five Year Plan, MCH and F.P. Service Delivery".

The Planning Commission", "Interim report on Performances of Family Planning Scheme (1975-1978)".

Material from Voluntary Agencies such as:

"Health Care in Bangladesh" Jan.77 by Rahman, Abed, Aldis and McCord".

3. Attempt a review and summarisation of policy as it seems to stand at the present time.

4. Identify 'Issues' which we think are raised by the current situation related to policy.

For example, there are issues raised around:

Community participation in the planning and supervision of a rural health service.

The most effective and preferred kind of community institutions for developing such services, village committees, union parichads, co-operatives, etc.

The possible establishment of village (Volunteers) Health workers
Payment for service.

The most effective role, and mode of collaboration with voluntary agencies etc., etc.

5. Select important items for preparing "position papers" which might be an aid for possibly seeking policy:

Guidance
Clarification
Redefinitions
Restatement
Reformulation
New departures

Note: Primary Health Care is scheduled to be the subject of National, Regional and International deliberation within the next year or two. The nature of community involvement in the Bangladesh context might profitably be one of these position papers to be presented for discussion. (I have begun a draft to illustrate what is in mind here).

D. DRUCKER

DISCUSSION MATERIAL

COUNTRY HEALTH PROGRAMMING

Data Collecting Stage

Health Systems Outside the Government Sector

It has been noted that CHP conducted in the region has often left out of its consideration broader aspects of health provision (which sometimes are larger than Government services themselves).

Descriptions might be attempted of:

i) the 'private' sector

ii) the 'private' sector provided by Government servants outside/ inside working hours.

iii) the role of the pharmacists

iv) the indigenous healers of different kinds

v) the voluntary agencies (for example 58 of these are listed by Ministry of Population Control and it suggests that some planning be undertaken in relation to these).*

Not only quantative but qualitative descriptions might be collected. See few example accounts drawn from Gonoshaystha Kondra (Newspaper 12.2.76).

Also see the account in the Bangladesh Observer, March 16, 1977 of a woman's experience in Morocco when seeking help.

Where can such material be found in Bangladesh, so that we can make some distinction regarding what service is thought to be available, and what actually exists in the eyes of the 'consumers'?

D. DRUCKER

*VOLAG DIRECTORY LISTS 129

DISCUSSION MATERIAL

Country Health Programming

Data Collecting Stage - Voluntary Agencies

Voluntary Agencies are deeply involved in health provision in Bangladesh. The following is an example of what might be extracted from such sources, which can be contributed to a CHP exercise.

Would it be worth examining the work of these agencies in this way for CHP

(Is there a collection of these materials centrally located in Ministry of Social Welfare or elsewhere?)

Introductory Note:

Voluntary organisations characteristically are found providing service where no formal programme is available; where resources are limited and there is access to special funds or personnel; in experimental and controversial programmes. At their best voluntary organisations are pathfinders and demonstrators of what is possible and what can be replicated on a much larger scale. Governments have found it rewarding to work out collaboration with voluntary agencies; often actively support them; sometimes delegate areas of responsibility; and occasionally take over and expand into a national programme services pioneered by such agencies.

It is noted that Population Control/Family Planning talk about 'Social Voluntary Organisations' that are 'supplementing' the Governent MCH/FP Programme and 'it is suggested that a plan be prepared...' for the purpose of collaboration amongst those agencies. Leaving aside the inferences of 'supplementing,' the case is easily made for knowing the full scale, nature, and range of these services when planning the Government programme. Such services although not committed to the kind of coverage required of a Government service might however carry ideas and have gathered information and experience which might suggest innovative and enriching approaches for consideration, when redefining policy, programming, and project formulation take place.

Perhaps the data-finding should contain a digest of the important elements of the voluntary agencies, which would be available for analysis during CHP. As and if required spokesman for an agency could be asked to clarify, expand and contribute specific points during the planning process. One such example of a voluntary agency with potentially something to contribute is Bangladesh Rural Advancement Committee (BRAC).

BRAC - an Analysis

Bangladesh Rural Advancement Committee: runs a community development based programme with a strong primary health care component.

Some feature of BRAC's P.H.C. Programme are:

1) The establishment of village development committees:

with a women group
a youth group
a co-operative group

2) The use of lay persons trained to deal with a simple range of complaints in the villages:

i.e. skin complaints only
diarrohea complaints only etc.

3) A group Health Insurance Scheme - 5 kgs of paddy per head for whole villages.

They calculate 3 consultations per year to para-medicals or the doctor (who serves 40 000 population). The paddy pays for 75% of the costs of medicines and personnel. They point out that retirement and other benefits do not have to be paid as in the case of Government employed PHC workers.

4) External funds support the programme but BRAC claims it is indigenously based.

5) Some have been critical regarding the kind and cost of medicines that the programme uses, which it is said could not be replicated nationally.

6) BRAC repeats the oft heard view that village level organisation does not exist in Bangladesh to carry the planning and implementation of development programmes and that they therefore need to build the structure at the village level, eventually tying it into the union structure where present organization does exist (even though it has its limitations). They look to this organizational structure eventually taking full and independent control of the BRAC initiated programmes.

COMMENT:

1. The strongest argument is made by BRAC for community involvement and the health programme is seen as an extension of village level organization in contrast to Government programme which they say attempts to provide village workers as an extension of the health service organization.

That there needs to be a vital interface between community and health service, both sides would agree. It is the entry point and control in organising village health workers which is in dispute here and this raises very important technical and policy issues.

2. The training aspects are of interest here:

a) with the emphasis on building village organisation comes the need for a community development oriented worker.

b) The different symptoms are divided up between a group of workers : scabies, gastro-enteritis, family planning, etc. are not all in the hands of [illegible] each worker, but one of a group of village workers [illegible] is seen as a kind of specialist. Thus training is highly specific, limited responsibility is placed on each worker and drop outs do not take with them large training inputs.

3. The implications of an 'insurance' approach in nonmonitised contribution are worth considering in regard to a national programme.

A Note for Dr Sathianathan

The broadest statements of policy insist on the concentration of services for the rural masses.* The Thana Health Complex Scheme (THCS) is the main thrust of such a policy in the Health Sector. A major aspect of policy analysis would be related to the Thana Health Complex Schemes. The first CHP examined THCS. A major revision of the Scheme was finalized in 1976. Some facts in relation to the programme reflect both upon the "Quality" of the policy and upon how such policy was arrived at. Anything we can identify in this regard would be invaluable as a guide of what to do or not to do in the next CHP.

For example though the THCS Programme was planned on a five year completio time frame we are told authoritatively (but unofficially) that there is no possibility of the Scheme being implemented (funds, staff etc ...) for fifteen ye Although contingency planning might be expected to take care of even the most unexpected impediments for carrying out such programmes, the magnitude of the 5-15 years factor is such that Policy must be made regarding pace of growth, coverage etc ... (not just programming - but policy regarding criteria for coverage, stages of initiation of services etc. etc.).

It is also opined (again with authority but un-officially) that even were the THCS implemented fully there are serious questions regarding whether it would result in delivery of the health services which the policy intends.

The up-coming promotion of PHC will certainly emphasise if not confirm such doubts and can forseeably raise very important policy questions regarding whether the THCS should be proceeded with either as planned (or as happens) on the present basis, or modified (again) to meet changes in events and thinking. The very raising of such issues in policy analysis and the insistence on clarity and orderly progression that is implicit in the CHP process can be (and more often than not is) a political matter.

It is political in the sense that it pin-points the decision maker and relates him firmly to specific decisions (when it is often safer to have such matters obscure) and questions the basis on which he makes decisions (It is by the very nature of the present climate of political and administrative functionin that insufficiency of information and thought is available, and policy is to a surprising extent voiced, rather than formulated by some identifiably rational process).

We are faced in Dacca with the practical problem of whether national staff - those responsible for programme having had little choice but to accept the political pronouncements; and those who made the pronouncements, - are readil prepared to examine policy in this way and in some depth.

The indications are that the people concerned shy away from such an activity (if only demonstrating that staff are not available because there are other priorities). k How a priority is so defined and where CHP stands is again political). Regarding THCS it is bound to be asked how, if there is so much doubt about it, did it come about? How did it reemerge from the earlier CHP? how did it get revised and agreed to only some months ago?, etc. etc.

---

*Some doubts have been expressed regarding whether even the budget shows a responding reflection of this policy.

These are very uncomfortable questions; they can be diplomatically formulated but must certainly be approached (if at all) with caution.

The question arises, how far and how fast should WHO go?

Should it:

Stick to the dead-line for a data package including this policy analysis type of information?

Change the deadline ?

Change the nature or depth of the policy analysis factor ?

Do much of the marshalling of facts and raising of issues itself ?

Pace itself to the degree to which the nationals are ready to go ?

Back off ?