78th Senior Staff Course

Review of Health Policy 2011: Opportunities and Challenges of Primary Health Care for all

(Module-02)

Module Director: Dr. Rizwan Khair

Submitted

By

Md. Anwar Hossain
Roll- 05

Bangladesh Public Administration Training Centre
Savar, Dhaka 1343
30 October 2016

ACKNOWLEDGEMENT

I Would like to express my deepest gratitude appreciation and highest respect to mentor Mr. Banik Gaur Sunder MDS, Bangladesh public Administration Training Center (BPATC), Course Director, Md. Zaidul Haque Molla NDC MDS, Module Director, Dr. Rizwan Khair, BPATC for his highest corporation Constant supervision and sparing immensely valuable time to guide me throughout this study. I admit that without his active support it would not have to bring it in this form. I wishes to express his gratitude and heartiest thanks to Mr. A.L.M. Abdur Rahman, ndc, respected Rector, BPATC and Course Advisor 78 th Senior Staff Course.

I express my gratitude and regards to Course Coordinators, Director Shoel Iman khan, and Mr. Abdul Kader BPATC for their generous help, logistic support and valuable remarks on the issues of the study that contributed immensely to improve the quality of the study. Cordial thanks are due to the officers and staffs of BPATC, for their valuable assistance not only for the study period but also throughout the SSC at BPATC.

Sincere appreciation and gratitude is also extended to Mrs. Rashida Ferdous. Deputy Commissioner, Manikgonj District, Dr. Md. Imran Ali,Civil surgon and Dr. Ranjit kumar mondol DDFP, Manikgong, for their generous help and kind support during data collection period of the study.

Special gratitude is due to the very large number of individuals the researcher met and interviewed during data collection at Singair. However it would be unfair on author's part if he does not specially mention some names who contributed a lots for conducting the study in Singair. Iwishes to thank the following individuals: Mr. Imran Hossain, Community Health Care Provider, Fortnagar Community Clinic, Mr. Mostafa Mia, President, Fortnagar Community Clinic Management Committee, Dallah Union, Mrs. Chaina Akter, Community Health Care Provider, Khan Taniara Community Clinic, Joy Mantop Union.

Mrs Kanij Shepali, Health Assistant, Mrs. Aleya Akter, Family Welfare Assistant, Khan Baniara Community Clinic, Joy Mantop Union, and Mrs. Hasina Akter, Family Welfare Visitor, Joy Mantop HFWC for their generous help and kind support during data collection period of the study.

Finally, the author gives all credit from his art to the almighty ALLAH whose compassion was the most vital to complete this effort.

Executive Summary

Introduction

Background

The provision of basic health services in Bangladesh is a constitutional obligation of the Government. Article 15 of the Constitution stipulates that it shall be a fundamental responsibility of the State to secure for its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. In addition, Article 18 of the Constitution asserts that the State shall raise the level of nutrition of its population and improve public health as some of its primary duties. In principle, public health facilities are accessible to all citizens of the country irrespective of their social position, race or religion.

In line with this broad legal framework, and considering the important declaration of the Alma Ata Declaration (1978), The World Summit for Children (1990), International Conference on population and Development (1994), Beijing Women's Conference (1995) and the Government Bangladesh has developed the Health policy 2011.

The Health Policy has 3 broad specific objectives, 19 goals, 16 main principles, 18 challenges and 39 strategies. The stated main objectives in the National Health Policy of 2011 are: (i) strengthening primary health and emergency care for all, (ii) expanding the availability of client-centered, equity-focused and high quality health care services, and (iii) motivating people to seek care based on rights for health.

A key aim of the health policy of the Government of Bangladesh (GoB) Has been to provide quality health services to all its citizens. In line with the policy objective, the GoB) has adopted the primary health care (PHC) approach as a health development strategy. Inspired by the Alma Ata Declaration on PHC, the GoB health policy and programmers aim at ensuring "health for all" with special focus on rural population and the poor.

The Government of Bangladesh is committed to ensuring effective access to health services by the people, particularly the poor. The Humble Prime Minister Sheikh Hasina in her inaugural

address at the 64 world Health Assembly in may 2011 declared her commitment to universal health coverage for all of its of its citizens. As part of its commitment to achieving universal health Coverage (UHC) by 2032-announced y Hobble prime Minister Sheikh Hasina at the 64th world Health Assembly in May 2011-the government of Bangladesh is exploring policy options to mobilize additional financial resources for health and to expand coverage while improving service quality and availability.

Statement of the Issue

The main objective of the National Health policy of 2011 is strengthening primary health and emergency care for all. This objective of the policy encompasses constitutional obligations and international conventions of ensuring health for all. Consequently achieve the target of universal health coverage for all including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

General Objective of the Study

To review the ground reality of Health Policy's 2011 Mandate of primary health care for all.

Specific objectives of the study

- To understand overall health system in Bangladesh;
- To review the current process of primary health care at the grass root level;
- To study the existing management of primary health care services;
- To indentify the types of health services available at the village level;
- To find out the knowledge of primary Health Care provider;
- To review the existing logistic and infrastructure facilities;
- Identify the types of patients and frequency of visits;
- To measure the health system performance of existing PHC delivery centers;
- To find out the weaknesses in existing PHC delivery system;
- To evaluate the satisfaction of clients regarding the primary health care services;

❖Finally to develop a policy model of sustainable Universal Health Coverage.

Key Findings of the Study

In depth analysis of secondary data and primary data suggest the following key findings regarding the primary health care for all in Bangladesh.

Key findings from the Secondary Data

- The complexity of the mixed health systems and poor governance;
- Inadequacy of health resources and impact on quality of care;
- Shortage of qualified health-care providers;
- Inadequate and disproportionate health service coverage;
- Health-care financing through catastrophic OOPP by households;
- Urban and gender Biases health system;
- Weak Regulatory and Enforcement Capacity, Contributing to High Rates of absenteeism and Many Unqualified Health Workers;
- Bangladesh is committed to achieve universal health converge by 2032;
- Health-care Financing Strategy (2012-20322) has been developed to provide direction in achieving universal health coverage;
- Inappropriate HRH in rural areas in comparison with urban areas.

Key findings from the primary Data

- Educational Qualification of Service providers is not quite compatible with the intensive primary health care service;
- Community Clinics at the rural level are trying to address the primary health care with limited capacity;
- CHCPs try to address the almost all minor ailments of the patient;
- CHCPs are heavily burden with the writing of register;
- Female stands first position followed by children, man and adolescent to visit CC regularly;
- Survey reveals that very poor and poor people of the society visit frequently to the CC for their treatment;
- Supply of medicine is not sufficient to address the patients properly;

- Blood sugar, urine and stool test facilities are not available but they can perform the pregnancy test;
- In case of emergency or in a complex ailment of patients, CHCP always refer to upazila Health Complex;
- 85% respondents choose CC while 15% respondent chooses private doctor for their minor treatments.
- About 57% respondent visits CC when needed while 23% waist once in a month and 16.67 % twice in month;
- It reveals that majority of the respondents visit community clinic for their common ailments;
- About 90% pregnant mother visit UHFWC of CC for their check up;
- Data on safe delivery by CSBA is not satisfactory. Home delivery by own relatives still on the side of higher magnitude; about 85%;
- It reveals that vaccination of children through CC is remarkably satisfactory;
- Satisfaction level of the respondent evident that the supply of essential medicine is not adequate to address the need of the clients;
- Majority of the respondent (75%) are satisfied with the service of CC. None of the respondents are dissatisfied with the service of the community clinic;
- 80% of the respondents found staff attitude was positive during consultation with them while 20% respondent replied that they cannot realize it;
- Meeting of the Management Group does not occur regularly;
- Government funding is the lone source;
- Management group has no initiative to mobilize the local fund in addition to government fund;
- Community Clinic staffs are in anxiety bath the continuation of their services.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

APPS:	Alternative private providers
ARI:	Acute respiratory infection
BBS:	Bangladesh Bureau of Statistics
BCC:	Behavioral change communication
BCDS:	Bangladesh Chemist and Druggist Sanity
BDHS:	Bangladesh Demographic and Health Survey
BDS:	Bachelor of Dental Surgery
BHE:	Bureau of Health Education
BHW:	Bangladesh Health watch
BMA:	Bangladesh Medical Association
BNC:	Bangladesh National Health Accounts
BPMPA:	Bangladesh private Medical Practitioners Association
CBHC:	Community based health care
CC:	Community Clinic
CD:	Communicable disease
CHCP:	Community health care providers
CHWs:	Community health workers
CRHCCS:	Comprehensive reproductive health care centers
CSBA:	Community based skilled birth attendants
CSR:	Corporate social responsibility
DCM:	Diploma in community medicine
DGFP:	Directorate General of Family Planning
DG:	Director General
DGDA:	Directorate General of Health services
DH:	Directorate of Nursing Services
DPH:	Diploma in public health
DPHE:	Department of public health engineering
EDL:	Essential Drugs list

EmOC:	Emergency obstetrical care
EPI:	Expanded programmed on immunization
FP:	Family planning
FSNSP:	Food Security Nutritional Surveillance Programmed
FWA:	Family Welfare Assistants
FWV:	Family Welfare Visitors
GAVI:	Global Alliance for Vaccines and Immunization
HA:	Health assistants
HDI:	Human Development index
HIES:	Household income and Expenditure Survey
HIS:	Health Information System
HPN:	Health population and Nutrition
HPNSDP:	Health Population and Nutrition sector development Programmed
HPSS:	Health and population sector strategy
HRH:	Human Resources for Health
IMCI:	Integrated Management of Childhood illness
IMR:	Infant mortality rate
MCH:	Maternal and child health
MCWC:	Millennium Development Goals
MMR:	Maternal Mortality ratio
MOHFW:	Ministry of Health and Family Welfare
NCD:	No communicable diseases
NGO:	Nongovernmental Organization
NHA:	National Health Accents
NHP:	National institute of population Research and training
NNMR:	Neonatal Mortality rate
NNP:	Out –f pocket payment
PHC:	Primary health care
PHCCS:	Primary Health-care Centers
SDGs:	Sustainable Development Goals

TFR:	Total fertility rate
THE:	Total hearth expenditure
TTBA:	Trained traditional birth attendants
U5MR:	Under-five mortality rate
UHC:	Upazila Health Complex
UHFWC:	Union Health and family Welfare Centers
UNDP:	United Nations Development Programmed
UPHCPLL:	2nd Urban Primary Health care programmed
UPHCSDP:	Urban Primary health care Services Delivery project
USAID:	United States Agency for international Development
WHO:	Word Health Organization

1. Introduction

1.1 Background

The Provision of basic health series in Bangladesh is a constitutional obligating of the Government. Article 15 of the Constitution stipulates that it shall be a fundamental responsibility of the state to secure for its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. In addition Article 18 of the constitution asserts that state shall raise the level of nutrition of its population and improve public health as some of its ~~remarry~~ primary duties. In principle, Public health facilities are accessible to at citizens of the country irrespective of their social position race of religion.

In line with this broad legal framework, and considering the important declaration of The Alma Ata Declaration (1978), The world Summit for children (1990), International conference on population and development (1994) and Beijing Women's Conference (1995) the Government Bangladesh has developed the health policy 2011.

The Health Policy has 3 broad specific objectives, 19 goals, 16 main principles, 18 challenges and 39 strategies. The stated main objectives in the National Health policy of 2011 are: (i) strengthening primary health and emergency care for all, (ii) expanding the availability of client-centered, equity-focused and high quality health care services, and (iii) motivation people to seek care based on rights for health.

A key aim of the health policy of the government of Bangladesh (GoB) has been to provide quality healthy services to all its citizens. In line with the policy objective, the GoB has adopted the primary health care (PHC) approach as a health development strategy. Inspired by the Alma Ata Declaration on PHC, the GoB Health policy and programmers aim at ensuring "health for all" With special focus on rural population and the poor.

The government of Bangladesh is committed to ensuring effective access to health services by the people, particularly the poor. The honorable Prime Minister Sheikh Hasina in her inaugural address at the 64 World Health Assembly in May 2011 declared her commitment to universal health coverage for all of its citizens. As part of its commitment to achieving universal health coverage (UHC) by 2032 announced by Humble prime Minister Sheikh Hasina at the 64th

World Health Assembly in May 2011 the government of Bangladesh is exploring policy options to mobilize additional financial resources for health and to expand coverage while improving service quality and availability.

The Ministry of Health and Family Welfare regulates both public and private sector health services. As per schedule I of the Rules of Business, the Ministry has been empowered the act as the central body for policy formulation and planning, regulation the medical profession and standards, managing and controlling drug supply, administering medical institutions, providing health services and much more. The ministry with its two wings of health and family planning, manages public sector health services ranging from primary to tertiary care (excluding urban primary care), stretching from the central level to the grassroots and covering both rural and urban areas. It is worth noting that although the Ministry is the leading agency for institution based health care delivery at the national level and in rural apneas, primary health care in urban areas is the responsibility of respective local government institutions (municipalities and city coronations) which are under the Ministry of Local Government Rural Development and cooperatives. Private sector infrastructure on the other hand, is limited to medical colleges, hospitals, clinics of various natures and qualities pharmacies, and untrained healers.

1.2Statement of the Issue

The main objective of the National Health policy of 2011 is strengthening primary health and emergency care for all. This objective of the policy encompasses constitutional obligations and international conventions of ensuring "health for all" Consequently achieve the target of universal health coverage for all, including financial risk pretention, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

1.3 General Objective of the study

To review the ground reality of Health policy's 2011 mandate of primary health care for all.

1.4 Specific objectives of the study

- ❖ To understand overall health system in Bangladesh;
- ❖ To review the current process of primary health care at the grass root leel;
- ❖ To study the existing management of primary health care services;
- ❖ To indentify the types of health services available at the village level;
- ❖ To find out the knowledge of primary Health care provider;
- ❖ To review the existing logistic and infrastructure facilities;
- ❖ To identify the types of patients and frequency of visits;
- ❖ To measure the health system performance of existing PHC delivery centers;
- ❖ To find out the weaknesses in existing PHC delivery system;
- ❖ To evaluate the satisfaction of clients regarding the primary health care services;
- ❖ Finally to develop a policy model of sustainable Universal Health Coverage.

2. Review of Literature

Review of relevant literature provides in depth knowledge and information about the issue of the study. It helps to achieve the expected results of the study.

1.1 Primary Health Care

According to the declaration of Alma-Ata essential primary health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families on the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (World Health Organization, 1978)

The Declaration of Alma-Ata was adopted at the international conference on primary health care (PHC), Almay (formerly Alma-Ata), Kazakhstan (formerly Kazakh soviet socialist Republic), 6-12 September 1978. It expressed the need for urgent action by all government, all health and development workers, and the world community to protect ant promote the health of all people. It easy the first international declaration underlining the importance of primary health care. The primary health care approach has since the been accepted b y member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health for all" But only in developing countries at first. This applied to al other countries five years later.

2.1 A Commonly used definition of PHC:

Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitable trained workforce level care provided by health services and systems with a suitably trained workforce Compared of mothers primary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximizes community partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation (APHCRL, 2009)

2.2 Universal Health Coverage

Universal health coverage (UHC) Means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential; quality health services should by covered including health promotion, prevention and treatment, rehabilitation and palliative care.

UHC requires coverage with key interventions the address the most important causes of disease and mortality. A main objective of UHC is for the quality of health services to be good enough to improve the health of those receiving services.

Universal health coverage has a direct inspect on a population's health .Access to health services enables people to be more productive and active contributors to their families and communities. It also ensures that children can go to school and learn. At the same time financial risk protection prevents people from being pushed into poverty when they have to pay for health services out of their own pockets. Universal health coverage is thus a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. Universal coverage is the hallmark of a government's commitment to improve the wellbeing of all its citizens;

Universal coverage is firmly based on the WHO Constitution of 1948 declaring health a fundamental human right and on the health for all agenda set by the Alma-Ata declaration in 1978 Equity is paramount. this means theta countries need to track progress not just across the national population but within different group (e.g) by income level, sex, age, place of residence, migrant status and ethnic origin).

This definition of UC embodies three related objectives:

equity in access to health services those who need tee services should get them, not only those who can pay for them;

that the quality of health services is good enough to improve the health of those receiving services; and

financial risk protection-ensuring that the cost of using ace does not put people at risk of financial hardship.

WHO Director General Dr Margaret Chan, states that universal health coverage as the single most powerful concept that public health has to offer: it is inclusive. it unifies services and delivers them in a comprehensive and integrated way, based on primary health care.

2.3 Health issue in SDG

The 7 goals of the new development agenda (SDG) integrate all three dimensions of sustainable development (Economic, Social and environmental) around the themes of people, planet, prosperity, peace and partnership. The SDGs sack to continue to prioritize the fight against poverty and hunger, while also focusing on human rights for all, and the empowerment of women and girls as part of the push to achieve gender equality. They also build upon and extend, the MDGs in order to tackle the unfinished business of the MDG etc. The SDGs recognize that eradicating poverty and inequality, erecting inclusive economic growth and preserving the planet are inextricably linked, not only to each other, but also to population health; and the relationships between each of these elements are dynamic and reciprocal. For example, with regard to health, a fundamental assumption of the SDGs is that health is a major contributor and beneficiary of sustainable development policies.

2:4.1 The Health Goal of SDG

Paragraph 26 of the 2030 agenda for sustainable development addresses health as follows: To promote physical and mental health and wellbeing, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health care services including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, Hepatitis, Ebola and other communicable diseases

and epidemics, including by addressing growing antimicrobial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioral, developmental and neurological disorders, which constitute a major challenge for sustainable development.

One of the 17 goals has been devoted specifically to health, and is framed in deliberately broad terms that are relevant to all countries and all populations: Ensure healthy lives and promote well-being for all at all ages the health goal is associated with 13 targets including four means of implementation targets labeled 3. ati 3d overall, the SDGs have 169 targets. Even though the 2030 agenda refers several times to the term human right (s) rights to development, self determination, an adequate standers of living, food, water and sanitation, good governance, and the rule of law, it does not specifically mention that health is a human right.

Health targets in SDG 3

3.1 By 2030, reduce the global maternal mortality ration to less than 70 per 100 000
3.2 By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases
3.4 By 2030, reduce by one third premature mortality from non communicable diseases through prevention and treatment and promote mental health and well-being
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents
3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of Re productive health into national strategies and programmers
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous

Chemicals and all, water and soil pollution and communication.
3.a Strengthen the implementation of the World Health Organization Framework convention on Tobacco control in all countries, as appropriate.
3.b Support the research and development of vaccines and medicines for the communicable and no communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade0Related Aspects of intellectual property Rights regarding flexibilities to protect public health, and in particular, provide access to medicines for all.
3.c Substantially increase health financing and the recruitment development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

2.4.2Monitoring and equity in SDG

Equity is at the heart of the SDGs, which are founded in the concept of leaving no one behind. The overall health SDG calls for healthy lives for all at all ages, positioning equity as a core, cross-cutting theme, while SDG 10 calls for the reduction of inequality within and among countries, and Target 3.8 calls for the establishment of UHC, founded on the principle of equal access to health without risk of financial hardship. A movement towards equity in health depends, at least in part, on strong health and health financing information systems that collect disaggregated data about all health areas and health expenditures. This fact is recognized in Target 17.8, which calls for efforts to build capacity to enable data disaggregation by a number of stratifying factors, including income, gender, age, race, ethnicity, etc. Disaggregated data enable policy-makers to identify vulnerable populations and direct resources accordingly. MDGs were focused on national progress and on specific populations, notably mothers and children and people affected by HIV, TB and malaria. In contrast, the health SDGs address health and well-being at all ages, including in newborns and children, adolescents, adult women and men, and older persons. Not only is the goal to be monitored much broader, but it is also extended over time, and will thus require a

comprehensive, life course approach. Needless to say, such an approach will also be relevant in monitoring progress towards UHC.

2.5 An over view of the Health system of Bangladesh.

Over 45 years after independence in 1971 the health system of Bangladesh has gone through a number of reforms and established an extensive health infrastructure in the public and private sectors. Bangladesh has achieved impressive improvements in population health status by achieving MDG 4 by reducing child death before the 2015 target, and rapidly improving on other key indicators including maternal death, immunization coverage, and survival from some infectious diseases including malaria, tuberculosis, and diarrhea. However, some challenges for the health system remain critical. First, Lack of coordination across two different ministries for implementing primary health care service delivery in rural and urban areas; second critical shortage of trained health providers with appropriate skill mix in the public sector and widespread increase in unregulated informal providers for an alternative source of care; third low annual allocation to health in the government budget and high out of pocket payments by households; and finally, inequitable access to health services between urban and rural areas including variable health financing mechanisms, which have slowed achieving universal health coverage. Mobilizing the private sector to increase the mainstream health system may facilitate reducing the gap in human resources in a relatively shorter time period. There is an urgent need for more investment of public funds and stronger local accountability to improve th quality of public services, and monitoring the quality of care provided by the private and informal sector (Bangladesh Health System Review, 2015)

The Ministry of Health and Family Welfare regulates both public and private sector health services. As per Schedule I of the Rules of Business, the Ministry has been empowered to act as the central body for policy formulation and planning, regulating the medical profession and standards, managing and controlling drug supply, administering medical institutions, providing health services and much more. The Ministry, with its two wings of Health and Family planning, manages public sector health services ranging from primary to tertiary care (excluding urban primary care), stretching from the central level to the grassroots and covering both rural and urban areas. It is worth noting that although the Ministry is the leading agency for institution based health care delivery at the national level and in rural areas, remarry health care in urban areas is the responsibility of respective local government institutions (municipalities and city corporations) which are under the Ministry of local

Government, Rural development and cooperation's . Private sector infrastructure, on the other hand, is limited to medical colleges, hospitals, clinics of various natures and qualities, pharmacies, and untrained healers. Service coverage by the private sector is wider than the public sector.

The Bangladesh Health system review envisages that the health system of Bangladesh is a pluralistic system with four key actors that define the structure and function of the system; government, private sector, nongovernmental organizations (NGOs) and donor agencies. The Government or public sector is the first key actor which by comprehensive health services, including financing and employment of health staff. The Ministry of Health and Family Welfare, through the two Directorates General of Health Services (DGHS) and Family Planning (DGFP), manages a dual system of general health and family planning services through district hospitals, Upazila Health complexes (with 10 to 50 beds) at sub-district level, Union Health and Family Welfare centers at union level, and community clinics at ward level. In addition, the Ministry of Local Government, Rural Development and Cooperatives manage the provision of urban primary care services. Quality of services at these facilities, however, is quite low due to insufficient allocation of resources, institutional limitations and absenteeism or negligence of providers.

The Bangladesh public health system remains highly centralized, with planning undertaken by the ministry of Health and Family Welfare and little authority delegated to local levels. The Health Information system suffers from the bifurcation of the Ministry into DGHS and DGFP, with separate and distinct reporting systems for each Directorate General. While there exist a number of acts and ordinances to regulate the health system, including regulation of different types of providers, practice facilities and NGOs, many of these legal instruments date from several decades ago.]Separate councils for the registration and licensing of medical practitioners, dentists and nurses have been established, but their authority to investigate of discipline providers is weak. A number of initiatives have been undertaken through the joint Government-donor pooled programmers to encourage and support community empowerment and accountability, with limited success. However a number of NGOS remain active in public reporting on government handling of the heath sector.

2.5.1 Health System Organization in Bangladesh

Administrative Structure of the Statutory Health System

The Ministry of Health and Family Welfare implements its programmes and provides services through different executing and regulatory authorities. The executing authorities

include five Directorates of the Ministry and some other Organizations. The Directorates are; the Directorate general of Health Services (DGHS); Directorate General of Family planning (DGFP); Directorate General of Drug Administration (DGDA); Directorate of Nursing Services (DNSP; and the Health Engineering Department (Formerly) known as the construction Management and Maintenance Unit). The DNS and the DGDA are attached to the health wing of the Ministry of Health and Family Welfare. The DNS is responsible for nursing education and nursing services, while the DGDA implements drug regulations. Other executive organizations accomplishing significant tasks of the Ministry include the Transport and Equipment Maintenance organization, National Electro-medical and Engineering workshop, and the essential drugs company limited. The regulatory bodies of the health sector are the Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC), State Medical Faculty (SMF), the Ayurvedic, Homeopathy and Unani Board, and the Bangladesh pharmacy council. To facilitate research and training in medical science, different public sector institutions under the control of the ministry of Health and Family Welfare operate at the National level. There are 21 Government medical colleges, six postgraduate institutes ,three specialized institutes, two institutes of health technology and five medical assistant training schools in Bangladesh (DGHS, 2013). For research there are two institutions, the Bangladesh Medical Research council (BMRC) and the National Institute of Population Research and Training (NIPORT). In addition there are a few public health research and training institutions, including the institute of Epidemiology, Disease control and Research (IEDCR), institute of Public Health (IPH), Institute of Public Health and Nutrition (IPHN) and National Institute of preventive and social medicine (NIPSOM).

Additionally the Government of Bangladesh delivers health are services in partnership with NGOs. The urban primary Health-care services Delivery project (UPHCSDP) covers all seven city corporations and five municipalities (Bogra, Comilla, Madhabdi, Savar and Sirajgonj) in Bangladesh IUPHCSDP, 2014). The Ministry of Local Government, Rural Development and cooperatives is responsible ofr managing the project though a project Management unit established in the six city corporations and the five selected municipalities. Bangladesh has an extensive PHC infrastructure in the public sector but faculties are not adequately provided with human and other resources such as drugs, instruments and supplies. During 2007-2013, the number of both hospitals and total number of beds in the public sector has steadily increased. the number of beds in PHC facilities at upazila level and below reached 18 880across 472 facilities in 2013, and 27 053 in 126 facilities at secondary and tertiary level. In the private sector, there were 2983 registered hospital and clinics, which is

2.5.2 Physical and Human Resources

Infrastructure

Bangladesh has an extensive public sector health infrastructure spanning the county and consisting of primary secondary and tertiary health care facilities. PHC facilities are the first level of care at the community level while the secondary and tertiary facilities are those where more advanced and specialty care is provided.

2.5.2.1 PHC Level Health Facilities

The core of the PHC facilities is the community clinics, a flagship programmed of the current government. With one for every 6000 people, a community clinic brings family planning, preventive, and limited curative services closer to the population usually within 30 minutes walking distance. They are staffed by one health assistant (DGHS) one family welfare assistant (DGFP) and one community health care provider (CHCP) from the project. all provide similar services. when one is preoccupied with domiciliary services, the other staff take responsibility for providing services at the facility, which include health, family planning and nutrition services.

Besides community clinics, the primary infrastructure includes 467 hospitals at upazila-level and below with a bed capacity of 18 880 (MOHFW 2013). There are also 125 union sub centers and 87 union Health and Family welfare Centers (UHFWC) which provide outpatient services only. Besides these, these, there are live 10bed (in Number) and 18 20-bed hospital at he union level number the DGHS. DGFP runs 3827 Union Health and Family Welfare Centers, of which 1500 have been upgrades to provide primary and outdoor care (Bangladesh Health sector profile 2010) at the union level, 24 mother and child welfare centers (MCWC) mainly offer outdoor services, with a few providing emergency obstetrical care (EmOC) services (MOHFW 2012).

Table 2.1 Distribution of beds in the public sector at upazila (sub-district) level and below

Types of Facility	2007		2010		2013	
Upazila Health Complex	413	15741	424	15877	436	18290
50 bed hospital	153	7650	156	7800	268	13400
30/31 bed hospital			11	110	11	110
Union Hospital	17	340	27	410	31	490
20 bed hospital	35	700	14	280	18	360
10 bed hospital			13	130	13	130
Total	430	16781	451	17287	467	18780
Trauma Center (20 bed)			5	100	5	100

Source: Bangladesh Health Bulletins 2007, 2010,2013.

2.5.2.2 Secondary and Tertiary level Facilities

This category of hospitals comprises general hospitals, district hospitals, medical college hospitals, specialty hospitals, and other hospital. At the district level, DGHS operates 53 district hospitals, nine general hospitals, three leprosy hospitals, there communicable disease hospitals, 13 chest disease/TB hospitals, 43 chest/TB clinics and 23 school health clinics (MOHFW, 2012) The district and inpatient services) and emergencies. Leprosy, communicable diseases and chest disease/Tb hospitals provide specialized services thrush outdoors and indoors. services (MOHFW, 2012)

At the national level, DGHS has 17 medical college hospitals under its jurisdiction; these hospitals also offer dental Covering chest diseases, rheumatology, CVDs, ophthalmology, cancer, kidney/urology, aeromedicine and mental health. All of these facilities are located in Dhaka, with the exception of the mental The Bangabandhu sheikh Mujib Medical University (BSMMU) has been the leading postgraduate medical institution in Bangladesh since 1998; and National institute for Kidney Diseases and Urology (NIKD) also received autonomy.

The distribution f beds in the perspective secondary and tertiary level hospitals by year is shown in Table 4.2 As can be trauma centers at the upazila legal and socialized centers for COPD/bronchial asthma and burn the secondary/ tertiary level.

Table 2.2 Distribution of beds in the secondary and Tertiary Hospitals by year

Types of Facility	2007		2010		2013	
	Hos	Bed	Hos	Bed	Hos	Bed
District hospital	49	4950	53	7650	53	7850
General Hospital	13	2950	9	1250	11	1350
Infectious disease hospital	5	180	5	180	5	180
Medical/dental/alternative	16	8280	17	10005	22	11960
Specialized hospital affiliated with post graduate institutes	7	1914	7	2114	7	2300
Specialized hospital (Other)	1	500	20	500	2	750
Chest disease/ TB hospital	11	550	13	546	13	816
Leprosy hospital	3	130	3	130	3	130
Specialized centers			3	150	3	200
Other hospital	3	525	6	305	6	305
BSMMU (medical U)					1	1212
Total	108	19 979	117	22830	126	27 053

Source: Bangladesh Health Bulletins 2007, 2010,2013.

2.5.2.3 Private sector hospitals and Beds

There has been rapid increase in for profit private sector health care facilities in the country commensurate with successive government open door economic policy sinker the 1990s. There are also hospitals and clinics and diagnostic which are of modest standard and costly. currently there are 2983 registered private hospitals and clinics in the country providing abound 45 485 beds (MOHFW, 2013) Only a few among these have free beds for the poor and disadvantaged. Besides the register once,

Insufficient and unsatisfactory services in the public sector, private initiatives have been taken since the 1980s. The cost of services in private health facilities is unaffordable to many poor people. Bangladesh, therefore, still needs to travel a long way to reach universal health coverage. The first ever health-care financing strategy has addressed how to generate new resource for health, how to ensure efficient and equitable utilization of resources, and how to utilize financial risk protection to achieve universal health coverage (MOHFW, 2012). In its 20-year implementation period (2012-2032), the strategy aims at a reduction of OOPP from 64% to 32% of total health expenditure, an increase in government expenditure from 26% to 30%, an increase in social protection social protection from less than 1% to 32%, and reduced dependence on external funds from 8% to 5%.

2.8 Community Clinic (Community Based Health Care)

The core of the PHC facilities is the community clinics, a flagship programme of the current government. With one for every 6000 people, a community clinic brings family planning, preventive, and limited curative services closer to the population, usually within 30 minutes' walking distance. Each clinic consists of two rooms with drinking water and lavatory facilities, and a covered waiting area. Funds for building the clinics were provided centrally, but communities were required to donate land so that there was a sense of ownership, To boost this sense, each community was required to set up a group to support and assist with their management, although the staff and supplies are provided by the Government. As of 2012, there were 12527 functional community clinics in the country (Ministry of Health and Family Welfare, 2013). They are staffed by one Health Assistant (DGHS), in family welfare Assistant (DGFP) and one Community Health-care Provider (CHCP) from the project. All provide similar services. When one is preoccupied with domiciliary services, the other staff take responsibility for providing services at the facility, which include health, family planning and nutrition services.

2.8.1 General Objective of the CC

To improve the general health status of the rural community by providing health, family planning and national services with special emphasis to the poor.

2.8.1.1 Specific Objectives:

- To provide quality primary Health care services to the community people particularly to the poor, marginalized and vulnerable group.
- To institutionalize All community clinics under and integrated Upazila Health System (UHS) and District Health System (DHS) and channelizing effective referral linkage from Community Clinic to Union and Upazila facility for proper management of the cases.
- To improve Maternal, newborn and child care.
- To provide health care services to the senior citizens adolescents, disabled and the under privileged people of the community.
- To establish and maintain effective functional cooperation and coordination among all health, family planning and nutrition service providers.
- To contribute in improving the FP acceptance rate.
- To provide nutritional services to the community.
- To establish community clinic as a focal service delivery point of HPN.
- To strengthen BCC activities through Community Clinic.
- To introduce e-health in community clinics and introduce structured, effective and functional MIS and establish linkage with central MIS.
- To establish functional linkage among the public facilities at union and Upazila level for improving health, family planning and nutrition services through community participation.

2.8.1.2 Services provided from Community Clinic

It is a one stop centre for PHC services at the rural area & the major ones are as follows:

- Maternal and neonatal health care services;
- Integrated Management of Childhood illness
- Reproductive Health and Family Planning Services
- EPI, ARI, CDD
- Registration of newly married couple, pregnant women, birth & death, preservation of EDD
- Health and Family Planning Education & counseling

- Identifications of other severe illnesses like TB, Mataria, Pneumonia, Life threatening influenza obstetric emergencies and prefer to higher facilities
- Identification of emerging & reemerging diseases & refer to higher facilities.
- Other services as identified by GOB under HPNSDP to be provided
- Treatment of minor ailments
- Establishing effective referral linkage with higher facilities

2.8.1.3 Structure of Community Group.

Management of Community Clinic is the responsibility of Community Group. The structure of the community Group is a follows:

President: Concerned elected people's representative (member of Union Parishad) will be elected/nominated as president of community group by holding his/her designation. If more than one people's representatives remain in the area under community clinic, in this case president should be elected based on discussion between Chairman of Union Parishad and Other members of community group.

Vice-President: Two members from community group should be nominated/ elected as Vice-president. Land donor him/herself or his/her representative and other from group members will be nominated/elected based on discussion among group members. At least one female among President and Vice-presidents should be there.

Treasurer: In member should be elected/nominated as Treasure except President and vice presidents.

Member Secretary: Community Health Care Provider carry out this responsibilities of member secretary. Member secretary will provide official assistance to community group in all aspects but he/she will have no voting rights. Mentionable here that except member secretary other service providing staffs will be included as observation members without voting rights.

Community group members: Proposed community group will be formed with 9-13 members as described hereunder (among them at least 4 female members are necessary). It is required to bear in mind during nomination of member the members are not from a special area rather they may in fact represent the whole area. The issue of including representation of female, poor, landless and low earning people of the area in this committee should be treated as special consideration.

- Ward members (elected members of present Parishad/council) of related Union Parishad under community clinic area will be included as member of community group by holding their positions. Generally a member of Union Parishad will be the member of a community group, but one Union Parishad member may hold membership of maximum 2 number of community groups.
- Land donor or his nominee will be included as representative member.
- A freedom fighter will be included in community group as a member.
- Two of teachers (A teacher of educational institution of the area, experienced and interested in social services) or local social and cultural or religious representatives should be included as members of community group. One of them should be a female.
- Two persons as representatives of poor/landless or of low earning group should be included as community group members. Among then one should be a female/adolescent/disabled.
- Community Health Care Provider (subject to employment), Health Assistant and Family Welfare Assistant (working under community clinic area) will be included as member excluding voter rights.
- At least four women dwelling in the area will be included in this group as members. The female member of Union parishad if the resident under related community clinic obviously will be included as member of this group by her designation. In case of inclusion as a member the women should get priority those are voluntarily, directly or indirectly engaged with the improvement of health care in the area.

Life-time member

Only land donor or his/her representative will be treated as life-time member of community group.

3. Study Design and Survey Methodology

Methodology of the Study designed with a view to understand the real situation of primary health care services. To achieve the objectives set for the study, data/information on following issues were collected:

- Overall health system in Bangladesh
- Process of primary health care at the grass rot level;
- existing management of primary health care services;
- types of health services available at the village level;
- knowledge of primary Health Care Provider;
- existing logistic and infrastructure facilities:
- types of patients and frequency of visits;
- health system performance of existing PHC delivery centers;
- weaknesses in existing PHC delivery system;
- satisfaction of clients regarding the primary health care services;

3.1 Types, Sources and Methods of Date Collection

The information and data require for this study collected from various sources as describe below.

3.1.1 Primary Sources of Data Collection

Following methods was adopted for primary data collection

- Observations
- Questionnaire survey
- Discussion

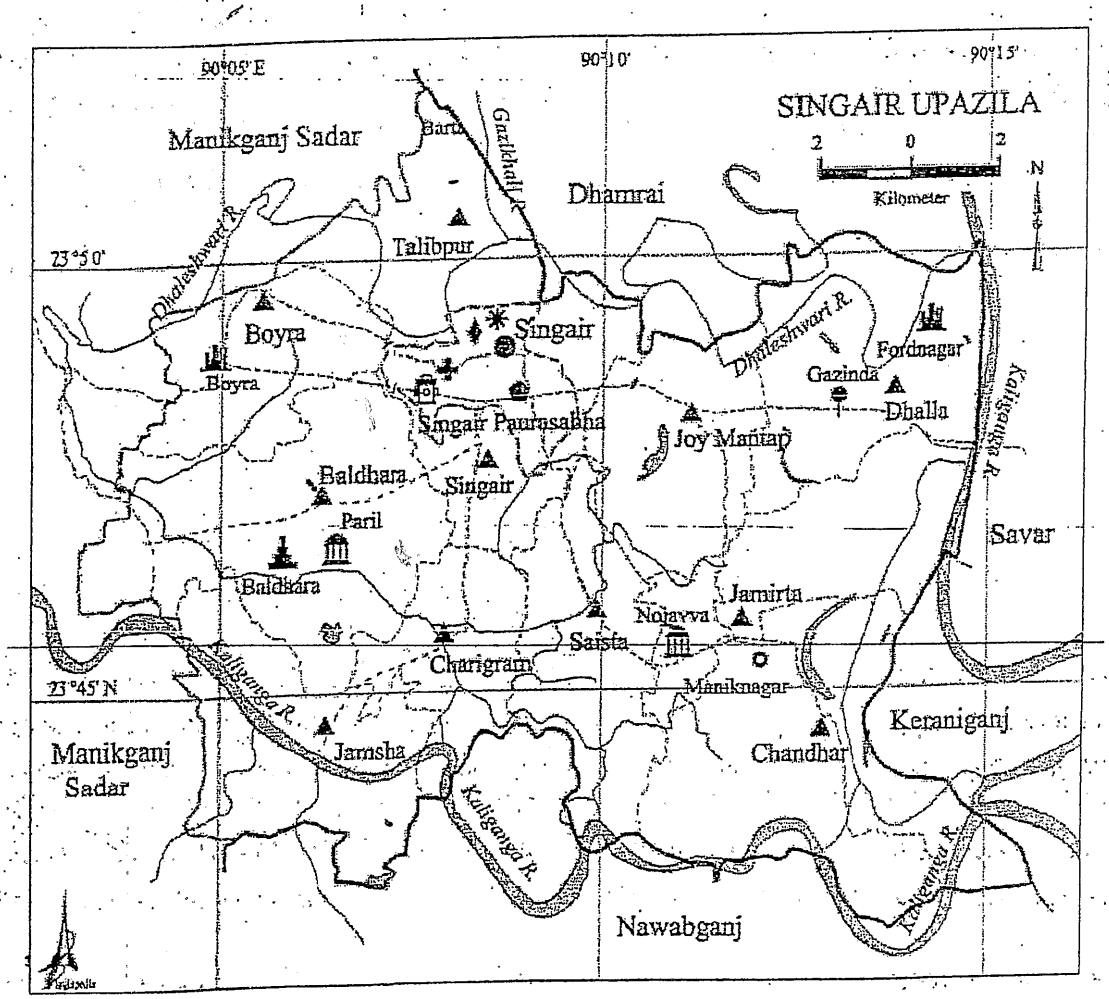
3.1.2 Secondary Sources of Data Collection

Secondary data involves official statistics and surveys carried out by the governments and different research institutes. Secondary information collected from relevant books, journals, reports and family Welfare, Directorate of Health Services, Directorate of Family Planning, web site of World Bank, and Asian Development Bank, United Nations Development Program (UNDP) and USAID.

3.2 Selection of the study Area

The Upazilla selected for this study was Singair under Manikgong distrist

Figure. 2 Map of Singair Upazila



Singair Upazila is bounded by Dhamrai and Manikganj Sadar Upazilas on the north, Nawabganj (Dhaka) upazila on the south, Savar and Keraniganj Upazila on the east Manikganj Sadar Upazila on the west . The area of this upazila is 217.56sq.k having population 287451; male 140834 and female 146617.

Singair has 1 Municipality, 11 Unions, 138 Mauzas, and 245 village. There aro 3 colleges in Singair: Singair University College, Baira College and Golaidanga Muktijoddha College. Number of hig School 23, Government Primary School 69 and 6 Madrashs.

Health facilities of Singair Upazila comprise of UHC, one mother and Child Welfare Centre, 30 Community Clinic, 7 Union Health and Family Welfare Center.

3.2.1 Selection Criteria of Community Clinic (CC) and Union Health and Family Welfare Center (UHFWC)

We did not select earlier any Community Clinic and Union Health and Family welfare Centre (UHFWC) with a view to observe the real situation of health services of CC and UHFWC. Without prior information we visited and collected desire data from Fortnagar CC of Dhallah Union, and Khanbaniara CC of Joy Mantap Union and also visited Joy Mantap Union Health and Family welfare Centre.

Fortnagr Community Clinic: Fortnagar Community clinic is under the Union of Dhallah. It is situated about 1km away from the Dhallah bazaar and Singair, Manikgonj, Dhaka main road. Fortnagar Primary School also very near to the Community clinic. It provides the primary health services of around 6000 people. It has a 9 members management committee. Manpower consists of one Community Clinic service provider (CCSP), one Health Assistant and one Family Welfare Assistant from Department of Family Planning.

We reached there on 10 AM. Mr. Emran Hossain, Community Health Care Service Provider was present but Health Assistant and Family Welfare Assistant was on leave as informed.

Khanbaniara community Clinic: Khanbaniara community Clinic is under Joy Mantop Union of Singair Upazila. It is situated about 2km away from the Joy Mantaap bazaar and Singair, Manikgonj, Dhaka main road. It provides the primary health care services of around

9000 people. It has also management committee. Manpower consists of one Community Clinic service provider (CHCP), one Health Assistant and one Family Welfare Assistant from Department of Family Planning. We reached there on an around 12.30 pm.

Jay Mantap Union HFWC: It is situated about 1.5 km away from the Joy Mantaap bazaar and Singair, Manikgonj, Dhaka main road. It provides the primary health care services of around 27000 people.

Table 3.1 Methods Used with Number of Respondents

Method	Number
Questionnaire Survey with the service recipients/clients	15
Discussions and Questionnaire Survey with the CHCP	2
Observation and in-depth interview with the member of management committee of CC	2
Discussion with FWV	1

On the basis of structured questionnaire, necessary data was collected from the service provider and service recipients. Discussion and face to face method was also applied to understand the management situation, perception and attitude of the people regarding the service of the Community Clinic.

3.3 Scope and Limitations of the Study

- The study has provided the scope of analyzing existing health services of Bangladesh;
- This study has provided the opportunity to know the overall management system of primary health care services;
- Respondents were less interested to provide time for interview;
- For the limitation of time small sample size of questionnaire survey may not be epresentative;
- Limited time also created serious problems for data compilation, analysis and proper report writing.

3.4 Analysis of Primary Data

3.4.1 Educational Qualification of Service Provider

Mr. Imran Hossain, CHCP of Fortnagar Community Clinic is HSC pass having a short training on primary health care. Mrs China Akter, CHCP of Khanbaniara is also HSC pass having a training on CSBA.

3.4.2 Identification of health care services provided by the CHCP

Table 3.2 Identification of health care services provided by the CHCP

Name of the CC	Treatment of minor ailments	Safe delivery	Childhood illness	EPI	Referring
Fortnagar	100 (1)	100 (1	100 (1)	100 (1)	100 (1)
Khanbaniara	100 (1)	-	100 (1)	100 (1)	100 (1)
Total	100 (2)	50 (2)	100 (1)	100 (1)	100 (1)

Source: Field Visit 2016

CHCP of Fortnagar and Khanbaniara correctly identified the services that are resembles with the services of primary health care.

3.4.3. Identifications of types ailments CHCP treat regularly

Table 3.3 Identifications of types ailments CHCP treat regularly

Name of the CC	Fever	Dysentery	Cough	Asthma	Dirrhoea	Allergy	Pain	Skin	Eye
Fortnagar	100 (1)	100 (1	100 (1)	100 (1)	100 (1)	100 (1)	100 (1	100 (1)	100 (1)
Khanbaniara	100 (1)	100 (1	100 (1)	100 (1)	100 (1)	100 (1)	100 (1	100 (1)	100 (1)
Total	100 (2)	100 (2)	100 (2)	100 (2)	100 (2)	100 (2)	100 (2)	100 (2)	100 (2)

Source: Field visit 2016

Note: Figures in the parenthesis indicate numbers

CHCP of Fortnagar and Khanbaniara address almost all minor ailments of the patient.

3.4.4 Ranking the kind of person visit CC regularly

Table 3.4 Ranking of persons identity visit CC regularly

Name of the CC	Female	Children	Man	Adolescent
Fortnagar	1	2	3	4
Khanbaniara	1	2	3	4

Source: Field visit 2016

Survey depicts that female stands first position followed by children, man and adolescent to visit CC regularly.

3.4.5 Ranking the frequency of visit of patience according to social status

Table 3.5 Ranking of the frequency of visit of patience according to social status

Name of the CC	Very poor	Poor	Middle class	Rich	Others
Fortnagar	1	2	3	-	-
Khanbaniara	1	2	3	-	-

Source: Field visit 2016

Survey reveals that very poor and poor people of the society visit frequently to the CC for their treatment.

3. 4. 6 Information on Supply of medicine

Table 3.6 Information on Supply of medicine

Name of the CC	Sufficient	Insufficient
Fortnagar	-	1
Khanbaniara	-	1

Source: Field visit 2016

CHCP of Fortnagar and Khanbaniara replied that the supply of medicine is not sufficient to address the patients properly.

3.4.7 Information on test facility of CC

Table3.7 Information on test facility of CC

Name of CC	Blood Pressure	Lung test	Blood Sugar	Urine	Stool	Pregnancy
Fortnagar	1	1	-	-	-	1
Khanbaniara	1	1	-	-	-	1

Source: Field Visit 2016

Blood sugar, urine and stool test facilities are not available but they can perform the pregnancy test.

3.4.8 Action of CHCP in case of emergency or difficulties to detect the ailment

Table 3.8 Action of CHCP in case of emergency or difficulties to detect the ailment

Name of the CC	Refer to UHC	Refer to Specialist
Fortnagar	1	-
Khanbaniara	1	-

Source: Field visit 2016

In case of emergency or in a complex of patients, CHCP always refer to Upazila Health Complex.

3.4.9 Respondent choice of place or person for minor ailments

Name of the CC	Upazila Health Complex	UHFWC	CC	Private	Others
Fortnagar	-	-	90 (9)	10 (1)	-
Khanbaniara	-	-	80 (4)	20 (1)	-
Total					

Source: Field Visit 2016

The visit of respondent to CC during their ailments is quite satisfactory. 85% respondent choose CC while 15% respondent chooses private doctor for their minor treatments.

3.4.10 Frequently of Visit of Community Clinic by respondents

Name of the CC	Once in a month	Twice a month	More than twice a month	As and when needed
Fortnagar	26.67 (4)	13.33 (2)	6.67 (1)	53.33 (8)
Khanbaniara	20 (1)	20 (1)	-	60.00 (3)
Total	23.33 (5)	16.67 (3)	3.33 (1)	56.67 (11)

Source: Field visit 2016

Note: Figures in the parenthesis indicate numbers

About 57% respondent visits CC when needed while 23% visit once in a month and 16.67% twice in month.

3.4.11 Causes of Visit of Community Clinic by respondents

Table 3.11 Causes of Visit of Community Clinic by respondents

Name of the CC	Fever	Dysentery	Cough	Asthma	Diarrhea	Allergy	pain	Skin	Others
Fortnagar	100 (10)	100 (10)	80 (8)	100 (10)	60 (6)	60 (6)	60 (6)	60 (4)	40 (4)
Khandaniara	100 (5)	100 (5)	80 (4)	60 (3)	100 (5)	80 (4)	60 (3)	80 (4)	40 (2)

Source: Field visit 2016

It reveals that majority of the respondents visit Community Clinic for their common ailments.

3.4.12 Place of Checkup of Pregnant mothers

Table 3.12 Place of Checkup of pregnant mothers

Name of the CC	UHC	UHFWC	CC	Clinic	No Check up
Fortnagar	-	40 (4)	40 (4)	10 (1)	10 (1)
Khanbaniara	-	40 (2)	60 (3)	-	-

Source: Field visited 2016

Respondents answer regarding the checkup of pregnant mother is quite encouraging, about 90% mother visit UHFWC or CC for their checkup.

3.4.13 Respondent reply about the place of delivery

Name of the CC	UHC	UHFWC	CC	Clinic	Home
Fortnagar	-	40 (4)	40 (4)	10 (1)	90 (9)
Khanbaniara	-	-	20 (1)	-	80 (4)

Source : Field visit 2016

Data on safe delivery by CSBA is not satisfactory. Home delivery by own relatives still on the side of higher magnitude' about 85%

3.4.14 Respondent response about the place of vaccination of children

Table: 3.14 Respondent response about the place of vaccination of children

Name of the CC	UHC	UHFWC	CC	Clinic	Home
Fortnagar	-	-	100(10)	-	-
Khanbaniara	-	-	100 (5)	-	-

Source: Filed visit 2016

It reveals that vaccination of children through CC is remarkably satisfactory.

3.4.14.1 EPI SCHEDULE IN BANGLADESH:

- At the 6th week of age: BCG, Penta 1, OPV 1, PCV 1:
- At the 10th week of age: Penta 2, OPV 2, PCV 2;
- At the 14th week of age: Penta 3, OPV 3, IPV;
- At the 18th week of age: PCV 3;
- At 9th competed month: MMR (Measles, Mumps and Rubella);
- At 15th completed month: MMR (Measles, Mumps and Rubella)

3.4.15 Respondent reply about the supply of medicine

Table: 3.15 Respondent reply about the supply of medicine

Supply	Satisfied	Neither Satisfied nor dissatisfied No	Dissatisfied	Can't say
Fortnagar	-	40 (4)	60 (6)	-
Khanbaniara	-	20 (1)	80 (4)	-
Total	-	30 (5)	70 (10)	-

Source: Field visit 2016

Satisfaction level of the respondent evident that the supply of essential medicine is not adequate to address the need of the clients.

3.4.16 Level of Satisfaction with Service of CC

Table 3.16 Level of Satisfaction with Service of CC

Supply	Satisfied	Neither satisfied nor dissatisfied No	Dissatisfied	Can't say
Fortnagar	70 (7)	30 (4)	-	-
Khanbaniara	80 (4)	20 (1)	-	-
Total	75 (1)	25 (5)	-	-

Source: Field visit 2016

Majority of the respondents (75%) are satisfied with of CC. None of the respondents are dissatisfied with the service of the community clinic.

3.4.17 Level of Satisfaction with the behavior of the CHCP

Table 3.17 Level of Satisfaction With the behavior of the CHCP

Community Clinic	Positive	Negative	Cant's say
Fortnagar	80 (8)	-	20 (2)
Khanbaniara	80 (4)	-	20 (1)
Total	80 (12)	-	20 (2)

Source: Field visit 2016

80% per cent of the respondents found staff attitude was positive while consulting with them while 20% respondent replied that they cannot realize it.

3.5 Discussion with the Chair Person of Management committee

Meeting of the Management Committee does not occur regularly. There is no local fund to operate the Community Clinic. Government funding is the lone source. They are not trying to mobilize the local fund in addition to government fund.

3.6 Discussion with the FWV

UHFWC has data of pregnant mothers and provides the necessary advice along with the regular checkup Arrangement of safe delivery at the center is not good enough. Usually male patients do not come to this center.

Findings Conclusion and Recommendations

4.1 Key Findings of the Study

In depth analysis of secondary data and primary data suggest the following key findings regarding the primary health care for all in Bangladesh.

4.1.1 Key findings from the Secondary Data

- The complexity of the mixed health systems and poor governance;
- Inadequacy of health resources and impact on quality of care; 3
- Shortage of qualified health care providers;
- Inadequate and disproportionate health service coverage;
- Health-care financing through catastrophic OOPP by households;
- Inequitable access to health services hindering universal health coverage.
- Skill-Mix Imbalances;
- Urban and Gender Biases health system;
- Weak Regulatory and Enforcement Capacity, Contributing to High Rates of absenteeism and Many Unqualified Health Works;
- Bangladesh is committed to achieve universal health converge by 2032;
- Health-care Financing Strategy (2012-2032) has been developed to provide direction in achieving universal health coverage;
- Inappropriate HRH in rural areas in comparison with urban areas.

4.1.2 Key findings from the primary Data

- Educational qualification of Service Providers is not compatible with the intensive primary health care service;
- Community Clinics at the rural level are trying to address the primary health care with limited capacity;
- CHCPs try to address the almost all minor ailments of the patient;
- CHCPs are heavily burden with the writing of register;
- Female stands first position followed by children, man and adolescent to visit CC regularly;
- Survey reveals that very poor and poor people of the society visit frequently to the CC for their treatment;
- Supply of medicine is not sufficient to address the patients properly;
- Blood sugar, urine and stool test facilities are not available but they can perform the pregnancy test.
- In case of emergency or in a complex ailment of patients, CHCP always refer to Upazila Health Complex.
- 85% respondents choose CC while 156% respondent chooses private doctor for their minor treatments. About 57% respondent visit once in a month and 16.67% twice in month;
- It reveals that majority of the respondents visit Community Clinic for their common ailments;
- About 90% pregnant mother visit UHFWC or CC for their check up:
- Date on safe delivery by CSBA is not satisfactory. Home delivery by own relatives still on the side of higher magnitude; about 85%;

- It reveals that vaccination of children through CC is remarkably satisfactory
- Satisfaction Level of the respondent --- that she supply of essential medicine is not adequate to address the need of the clients;
- Majority of the respondents (75%) are satisfied with the behavior and dealing of the service provider. None of the respondents are dissatisfied with the service of the community clinic;
- 80 per cent of the respondents found staff attitude was positive while consulting with them while 20% respondent replied that they cannot realize it;
- Meeting of the Management Group does not occur regularly;
- Government funding is the lone source;
- Management Group has no initiative to mobilize the local fund in addition to government fund;
- Community Clinic staffs are in anxiety with the continuation of their services;

4.2 Conclusion

The health system has been facing enormous challenges in catering to the health needs of more than 150 million people and this challenge will be even greater in future, with the country on the verge of rapid population growth, particularly due to faster growth in urban areas and slow progress in implementing current strategies for achieving universal health coverage.

Findings of the study suggests that for achieving the target of universal health coverage greater policy intervention in the area of HRH, pragmatic financial mechanism, engagement of local people, reducing the rural-urban gap, regulatory and enforcement and public private partnership are crucial.

Rapid capacity building to promote prevention, particularly to halt the epidemic of NCDs will be essential. Deployment of the large health cadre following regulation and improving the quality of care, may help reduce the gap of trained community based health work force, such as Community Health care providers who have been assigned to community clinics. However it will require the Ministry of Health and Family Welfare to bring informal sector providers under the mainstream health systems and monitor their services under a national policy, which will need strong political will and support from the recognized health-care authorities in the country. Bangladesh need a realistic plan for an affordable payment mechanism from health in order to reduce catastrophic out-of-pocket payments for health and to develop parallel strategies for investing more in health.

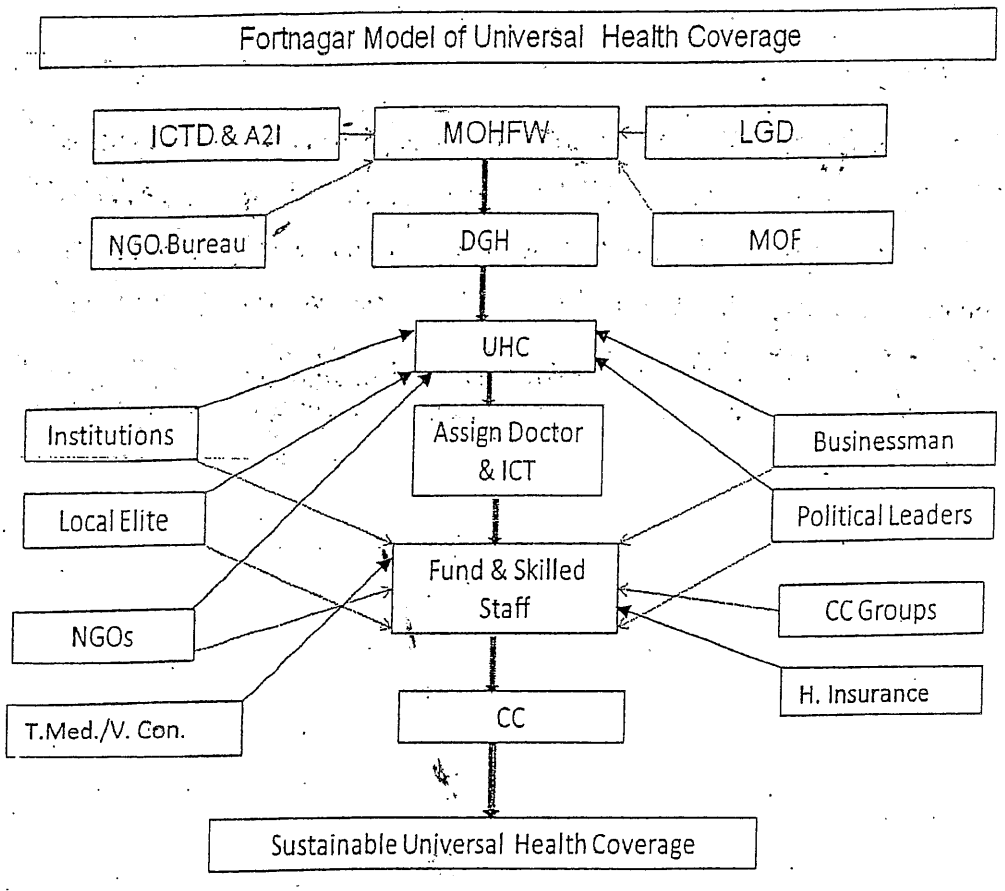
4.3 Recommendations of the Study

The analysis of survey data and secondary information suggest that primary health care for along with the universal health care demand an integrated and coordinated approach by the related ministries/departments and public private partnership. The policy guidelines/recommendations are formulated on the basis of findings and conclusions of this study are outlined below.

- Urgent action is needed to remove the dichotomy and strict jurisdiction assignment of health services at the primary level;
- Strong and effective coordination with the Local Government division is necessary for providing primary health care services in the urban areas;
- Effective and efficient regulatory mechanism and public private coordination is the demand for facilitating private sector health services in rural and urban for sustainable primary health care.
- Recruitment of trained and skilled manpower along with mobilizing of the private sector to produce more health works and bring informal health care providers within the mainstream health systems may facilitate reducing the gap in human resources more quickly.
- There is an urgent need for more investment of public funds and stronger local accountability to improve the quality of public services, as well as improved regulation and monitoring of services provided by the private sector.
- Mobilizing the huge informal health cadres outside the official allopathic system would be a useful strategy for strengthening human resources in health, especially in the remote and hard-to-reach areas of the country, and achieving universal health coverage.
- Reducing the urban rural HRM gap by involving traditional health workers of rural areas through training Programmed;
- Creation of training institutions in rural areas and use careful examination requirements for rural trainees to maximize the likelihood of their staying in these areas once they complete training;

- Making health service in the rural areas more attractive by providing incentives;
- Accelerating the recruitment of nurses and community health workers (CHWs) and introduction of comprehensive HRH master plan to guide the recruitment if new HCPs;
- Introduction of health insurance in primary and secondary level of health services;
- The MOHFW needs to take steps to regulate and enforce dual practice norms;
- Ensuring the participation of the adult wage earners, particularly wealthy, into the UHC programme by providing recognition like HCIP;
- Strengthening and expansion of e-health to the Community Clinic and assigning of specific doctors for of UHC for certain Community clinics for providing necessary medical advice to the CHCP in case of emergency and for critical patients;
- Expansion of telemedicine service through high-quality video-conferencing devices to several thousands of community clinics for providing medical consultation to rural areas where there is no access to specialist doctors;
- Building a unified electronic information system to register all vital statistics and improve coverage of priority maternal and child health services;
- To achieve UHC, the government will have to pursue policy reforms in line with the above mentioned recommendations.

Proposed Policy Model for sustainable Universal Health Coverage



4.4 Lessons Learnt

The issues that emerge from the study leave more to do with skill HRH, adequate funding, and sufficient supply of medicine, accountability and broad institutional policies. Following themes surfaced in the study;

Primary health care service policy of the government is on the right tract but for achieving the target of universal health coverage needs holistic policy approach under the mandate of regulatory and economic control through public private partnership model;

Worthy mentionable very positive note is the client satisfaction with the behavior of the service provider of CC;

Vulnerable section of the society mainly rural women and children are getting benefit of the primary health care facilities through the CC;

Very poor and poor now at least have the access to the health services for their minor ailments;

The inadequate supply of medicine often sparked bad feeling and suspicion among clients, who believed that staff were withholding and illegally selling drugs;

Management group of the CC is less vibrant in terms of raising local fund and organization of meetings regularly;

CC serves as the center of excellence for the EPI programme;

An insecure feeling regarding the service is prevailing in the Service providers of the CC.

Bibliography

Ahmed Syed Masud et al. Bangladesh Health system review: Health System in Transition. Naheed Ahmed ed. World Health Organization: Nassal Institute for Global Health, University of Melborne, : Vol. 5No. 3, 2015.

Al-Sabir Ahmed, Alam Bushra Binte, and El-Saharty Sameh. The role of the private sector in reproductive health services in Bangladesh: Knowledge brief. Dhaka: The World Bank Resident Mission, 2014.

Bangladesh Rural Advancement Committee. Bangladesh Health Watch Report 2011: Moving Towards University Health Coverage, BRAC: BRAC Center, 75 Mohakhali, Dhaka 1212, Bangladesh, 2012.

Bangladesh Rural Advancement Committee. Financing healthcare in Bangladesh for achieving

Bangladesh, Unpublished Master thesis, Auckland: The University of Auckland, 2011.

El-SahartySameh.et al. The Path to Universal Health Coverage in Bangladesh: Bridging the Gap of Human Resources for Health. A World Bank Study, Washington D.C,: The World Bank, 2015.

Greenhalgh, T. Primary health care: Theory and practice, 2008. Available from http://site.ebrary.com: ezproxy.auckland.ac.nz/lib/Auckland/docDetail,.action?docID=1023326&p00=primary%20health%20care.

Hasan Md. Kamrul. "Quality of Primary health care services in rural Bangladesh: Patients' perspectives." From ISSN 1923-6662 (online).Available at http://www.ssrn.com/link/OIDA-Intl-=Journal-Sustainable-Dev.html.

Health Bulleting 2015. Government of the people's Republic of Bangladesh Ministry of Health and Family Welfare. Dhaka: Management Information System, Directorate General if Health services, Mohakhali, Dhaka 1212, December 2015.

Rise Jonathan. Lane M Tracy and Rahman Tashmina. Bangladesh Governance in the Health Sector: A Systematic Literature Review. Dhaka: The World Bank Resident Mission, 2014

Appendix-A

Questionnaire for CHCP

Researcher: Md. Anwar Hossain

Joint secretary

A. Respondents Information

Name of the Respondent----------

Address ----------

Q.1. Gender Male Female

q.2. Education

Secondary

Higher Secondary

Graduate

Post Graduate

Others(Specify---------)

Q.3: Please identify the Services you are providing

Items	Yes	No
Treatment of minor ailments		
Safe delivery		
Childhood illness		
EPL		
Refereing		
Others		

Q.4. Please identify the types ailments you treat regularly

Name of the. cc	Fever	Dysentery	Cough	Asthma	Diarrhea	Allergy	Pain	Skin	Others

Q.5. Please mark the kind of person visit you regularly.

source	yes	no
Female		
Chidren		
Man		
Adolescent		
Others		

Q.6. Please rank the social status of patients visit you regularly.

Types	yes	no
Very Poor		
Poor		
Middle class		
Rich		
Others		

Q.7. Tell about the supply of medicine

Supply	yes	no
Sufficient		
Sufficient		

Q.8. Please identify the types of test you provide

Source	yes	no
Blood pressure		
Lung test		
Blood sugar		
Urine		
Stool		
Others		

Q.9. In case of emergency or difficulties to detect the ailment tell your action

Action	yes	no
Refer to UHC		
Refer to Specialist		
Others(if)		

Appendix-B

Questionnaire for General Respondent

Researcher: Md.Anwar Hossain

Joint Secretary

B. Respondents Information

Name of the Respondent----------

Address----------

Q.1. Gender Male Female

Q.2. Where do you go normally for your treatment

Place/person	yes	no
Upazila Health complex		
CUHFWC		
Community Clinic		
Private Clinic		
Private Doctor		
Medicine Shop		
Homeopathy		
Herbal		
Others		

Q.3. How Frequently you visit Community Clinic

frequency	yes	no
Once in a month		
Twice in a month		
More than twice a month		
More than twice a month		

Q.4. Please mention the causes of visit

Cause	yes	no
Fever		
Dysentery		
Dirrhoea		
Cold Cough		
Throat sore		
Skin Disease		
Allergy		
Gastric(Acidity)		
Diabetics		
Jaundice		
Asthma		
Joint pain		
Eye problem		
Accident		
Appendicitis		
Hypertension		
Pregnancy		
Child disease		

Q.5. Identify Place of checkup for pregnant mother

Place/person	yes	no
Upazila Health complex		
CUHFWC		
Community Clinic		
Private Clinic		
Private Doctor		
Medicine Shop		
No Checkup		

Q.6. Identify place of delivery

Place/person	yes	no
Upazila Health complex		
CUHFWC		
Community Clinic		
Private Clinic		
Home		

Q.7. Identify the place of vaccination of children

Place/person	yes	no
Upazila Health complex		
CUHFWC		
Community Clinic		
Private Clinic		
No vaccination		

Q.8 Tell about the supply of medicine

Supply	Satisfied	Neither satisfied Nor dissatisfied no	Dissatisfied	Can' t say

Q.9 Please level of your satisfaction about Service of CC

	Satisfied	Neither satisfied Nor dissatisfied no	Dissatisfied	Can' t say

Q.10 Please level of your satisfaction about behavior of CHCPs

	Satisfied	Neither satisfied Nor dissatisfied no	Dissatisfied	Can't say

MEDICINE FOR COMMUNITY CLINIC

Purchased by CMSD for LD (CBHC) Program
(For Community Clinics)

PACKING LIST

CARTON NO: 01078 GROSS WEIGHT: 38.4 Kg DATE PACKED: 18.06.16

Sl. No.	Name of Item	Unit	Pack Size	Qty. per carton		Batch No.
				In unit	In Pack size	
01.	Amoxicillin Capsule 250 mg	Capsule	10's X 50 Blisters	500	1 box	16.05.084
02.	Amoxicillin Dry Syrup (125 mg/ 5 ml) 100 ml	Bottle	12 Bottles / carton	12	1 carton	16.05.160
03.	Amoxicillin Paediatric Drop (125 mg / 1.25 ml) 15 ml	Bottle	10 Bottles / carton	10	1 carton	16.04.033
04.	Antacid Tablet 650 mg (Chewable)	Tablet	10's X 100 Blisters & 10's X 50 Blisters	2,000 500	2 cartons 1 carton	16,065,12 16051402
05.	Chlorpheniramine Tablet 4 mg	Tablet	10's X 100 Blisters	1,000	1 box	16.04.022
06.	Ferrous Fumarate and Folic Acid Tablet (200,20 mg)	Tablet	10's X 100 Blisters	2,000	2 boxes	16.04.057
07.	Paracetamol Tablet 500 mg	Tablet	10's X 50 Blisters	2,500	5 boxes	16.05.257
08.	Penicillin V Tablet 250 mg	Tablet	10's X 10 Alu Alu Blisters	100	1 box	16.04.021
09.	Salbutamol Tablet 2 mg	Tablet	10's X 50 Blisters	500	1 box	16.03.015
10.	Albendazole Tablet 400 mg (Chewable)	Tablet	10's X 10 Blisters	100	1 box	16.04.017
11.	Compound Benzoic Acid Ointment 1.0 kg (Benzoic Acid and Salicylic Acid Ointment)	Jar	1 jar	1	1 jar	16.05.552
12.	Chloramphenicol Eye Drop 0.5%, 10 ml	Vial	10 Vials / box	20	2 boxes	15.16
13.	Chloramphenicol Eye Ointment 1 %, 3 g	Tube	10 Tubes / box	20	2 boxes	100.16
14.	Hyoscine Butylbromide Tablet 10 mg	Tablet	10's X 5 Strips	50	1 box	16.02.003
15.	Metronidazole Tablet 400 mg	Tablet	10's X 50 Blisters	1,000	2 boxes	16.05.209
16.	Oral Rehydration Salt (ORS)	Sachet	200's Sachets/carton	400	2 cartons	992.16
17.	Salbutamol Syrup (2 mg / 5 ml) 60 ml	Bottle	24 Bottles / carton	24	1 carton	16.05.032
18.	Benzyl Benzoate Application (25% w/v) 100 ml	Bottle	12 Bottles / carton	12	1 carton	16.05.127
19.	Chlorpheniramine Syrup (2 mg / 5 ml) 60 ml	Bottle	24 Bottles / carton	24	1 carton	16.05.034
20.	Co-trimoxazole Tablet 120 mg	Tablet	10's X 50 Blisters	500	1 box	16.03.019
21.	Co-trimoxazole Tablet 960 mg	Tablet	5's X 20 Blisters	100	1 box	16.03.032
22.	Neomycin and Bacitracin Ointment 10 g	Tube	10 Tubes / box	10	1 box	101.16
23.	Paracetamol Suspension (120 mg /5 ml) 60 ml	Bottle	24 Bottles / carton	48	2 cartons	16050B
24.	Vitamin B-Complex Tablet	Tablet	10's X 50 Strips	1,500	3 boxes	16.05.076
25.	Zinc Dispersible Tablet 20 mg	Tablet	10's X 50 Alu Alu Blisters	500	1 box	16.04.034
26.	Doxycycline Capsule 100 mg	Capsule	10's X 15 Alu Alu Blisters	150	1 box	16.04.007

PREPARED BY: NAME:	SIGNATURE:	DATE: 18.06.16
Declaration: The carton contains all the above components and net weight of the components: 34.5 Kg		
CHECKED & CONFIRMED BY : NAME : M. Habib	SIGNATURE:	DATE:

CONSIGNEE: Community Based Health Care (CBHC)

ESSENTIAL DRUGS COMPANY LIMITED
395-397, Tejgaon Industrial Area, Dhaka- 1208.

MH

Appendix-D: REFFERAL SLIP OF CC