

Revitalizing Health for All: Developing a Comprehensive Primary Health Care Model for Bangladesh

Although PHC is the key to improving health status, which is provided via Upazila Health Complexes (UHC) in Bangladesh, the services are not being utilized by all segments of the population. Therefore, our aim was to review the historical evolution of PHC in Bangladesh, detect gaps between Alma Ata principles and present status, measure equity in service utilization and develop an appropriate Comprehensive Primary Health Care (CPHC) model for Bangladesh.

CPHC has been defined as a package or set of activities that: (1) contains a minimum of eight core activities mentioned in the Alma Ata declaration; (2) ensures effective referral system; and (3) considers principles of promotive, preventive, curative and rehabilitative service, equity, appropriate technology, intersectoral collaboration, devolution (instead of 'decentralization'), and community empowerment (instead of 'community participation').

A quantitative screening of 20 UHCs around Dhaka and Barisal districts was done based on WHO Health System Performance Assessment guideline which yielded a 'high performing' and a 'low performing' UHC for 'in-depth' study. The in-depth study included quantitative household survey, participant observation, in-depth interview of stakeholders and PRA as means for data generation. To review the historical evolution of PHC in Bangladesh key informant interviews along with document reviews were done.

Quantitative screening of the 20 UHCs identified Dhamrai (Located near capital city of Dhaka) as the highest and Mehendigonj (a distant upazila in Barisal District) as the lowest performing UHC. The in-depth study helped us to identify the strengths and weaknesses of each of these two upazilas in respect to CPHC and eventually recommend an appropriate model.

Essential Service Package (ESP) is the mainstay of health care delivery in Bangladesh which is done under a Sector Wide Approach (SWAp) known as Health, Nutrition and Population Sector Program (HNPS). The nutrition component is not functioning in most of the UHCs. The supply of safe water and basic sanitation is not the responsibility of the health sector, rather the Department of Public Health Engineering (DPHE). MCH is delivered under the Directorate General of Health Services (DGHS) whereas Family Planning is under the aegis of Directorate General of Family Planning (DGFP). Considering these findings we suggest a comprehensive approach instead of the existing fragmented approach towards PHC. Considering recent trends of demographic and epidemiologic transitions NCDs, elderly health, urban health and the health concerns of the disabled persons should be included in the package.

Long waiting time, less contact time, lack of responsiveness of the service providers, scarcity of medicine and equipment, unavailability of proper HRH and lack of trust provoke people to breach the referral system notwithstanding higher cost. Furthermore if critical patients are referred to higher health facility, it becomes difficult due to unavailability of appropriate referral facility in place. Continuity of care, in addition to comprehensiveness of care, warrants commitment of the service providers, availability and proper management of services, effective HMIS, internal and external monitoring, progressive prepayment based health financing mechanism, transparency, accountability and responsiveness towards the patients' needs. Taking these indivisible issues into account, proper referral mechanism should be integrated in the CPHC model.

A committed and satisfied HRH should be ensured by providing them with basic amenities, hospital autonomy, Local Level Planning (LLP), necessary hospital supplies, up to date training, career planning for both clinical and non-clinical cadres, rural allowance and performance based payment. Non clinical cadre should be separated from the clinical staffs in order to maximize the service quality of both the clinicians and the public health professionals. Appropriate skill mix should be maintained and corruption, red-tape-ism and undue political influence should be removed from the service domain of the HRH. A context specific social incentive mechanism can be developed in order to retain the HRH in the peripheral areas of the country.

Finally, the most important proposition of our CPHC model is the inclusion of 'community empowerment': 1) access to information, 2) participation in decision making, 3) ability to demand accountability from decision makers and 4) partnership with public service. This is noteworthy that we proposed 'community empowerment' instead of 'community participation'. We found the status of community empowerment unsatisfactory except in case of access to information which may be attributed to the use of mobile phones, electronic mass media and the community penetration of the NGOs. In this light we suggest invoking community ownership over the health facilities, involving the media in empowering people, developing BCC materials on health empowerment, and involving the existing government field workers in informing people of their health entitlements. Local government can play a pivotal role in these regards, especially in developing and continuing community based health entitlement meetings.