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

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Background

1960s: New Economic Order, UN:

- Focus towards basic needs; Community centered care instead of individualistic care; Not only medicine but also shelter, food, clothing, safe water, education and health care

1972: Executive board of WHO: Change of focus:

- Towards people who are most in need; Partnership building with interested organizations; Conceptualization toward PHC

1978: Alma Ata, PHC:

- Health of the poor gained importance for the 1st time; Compassionate ideologies of equity and social justice

1979: Debates and criticisms:

- Comprehensive vs. selective; Horizontal vs. vertical; Social justice vs. cost effectiveness; Bottom-up vs. top-down; 'Poor treatment for the poor people'; Too costly and unrealistic for most countries; Irrelevant for developed countries; Clinicians considered it as a threat to their long predominance of medical establishment; Lacked growing concerns for environmental sustainability

Halfdan Mahler and others could not foresee 'free market' paradigm shift:

- Oil crisis; Global recession; Structural adjustment programs introduced by development banks; National budgets cut away from the social services like health care

1980s and 90s: Economic intricacy coupled with neo-liberal politico economic ascendancy lead to:

- 'Efficiency' and 'sustainability' based 'health sector reform' instead of 'equity' and 'social justice' based 'health for all' movement

Emergence of 'Selective' PHC instead of 'Comprehensive' PHC due to:

- Diminishing resources; Preference of OVI by large donor organizations; Emergence of HIV/AIDS; Re-emergence of TB; Failure of malaria control programs

Some selective approaches:

- Child survival revolution championed by James P Grant; GOBI-FFF; Essential Service Package (ESP)

Relative advantages of selective approaches:

- Ability to give impressive output within a short period; Aggressive attack on high prevalence health problems; Readily available support from some donor agencies; Less resource demanding nature; Its ability to enable politicians to exploit people by shifting their focus from the deep rooted and grossly disappointing socio-politico-economical shortfalls

1988: Riga, Latvia: Mid-term review:

- Outstanding achievement of the PHC recognized and highly praised; Slowness and stagnation in some countries pointed out; Revitalization of whole program demanded; Peoples' empowerment, district health system strengthening, emphasizing the issues of the least developed and developing countries suggested

Dr. Margaret Chan in The World health report 2008: Primary health care now more than ever:

> While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true

Therefore we need to understand:

- Current PHC scenario at local level; Its evolution in the light of changing contexts; Strong evidence base for revitalizing and policy making

Teasdale-Corti initiative in 23 countries including Bangladesh

Bangladesh scenario warrants further research

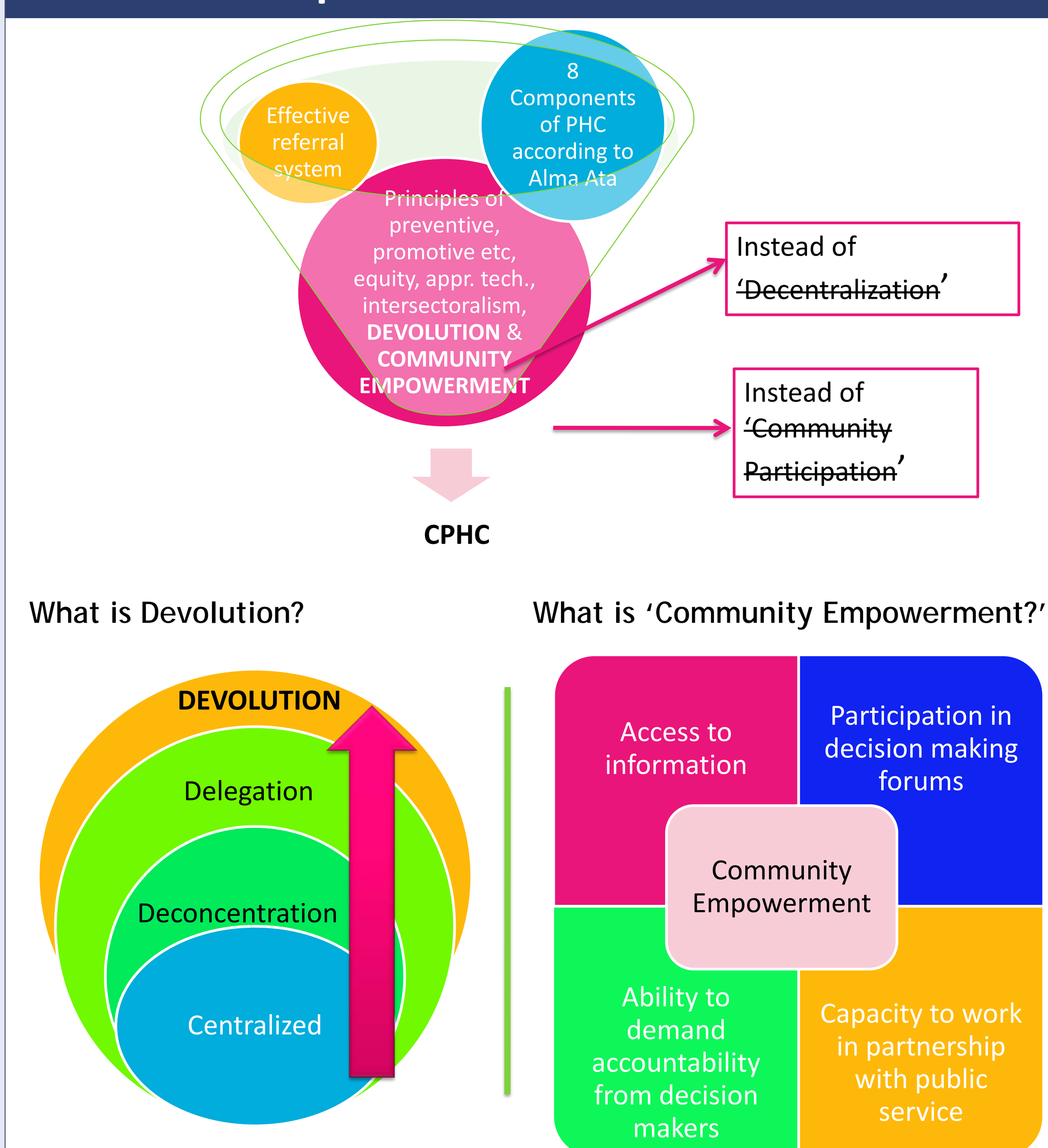
Objectives

General Objective: To design a Comprehensive Primary Health Care model appropriate for Bangladesh

Specific Objectives:

- To review the historical evolution of PHC system in Bangladesh
- Situation analysis of present PHC system to evaluate its comprehensiveness
  - To measure the health system performance of existing PHC delivery centers
  - To find out the weaknesses in existing PHC delivery system in Bangladesh
- To measure equity in PHC utilization in terms of Social Determinants of Health
- To suggest recommendations for developing a CPHC model appropriate for Bangladesh

Proposed Definition of CPHC



Methodology

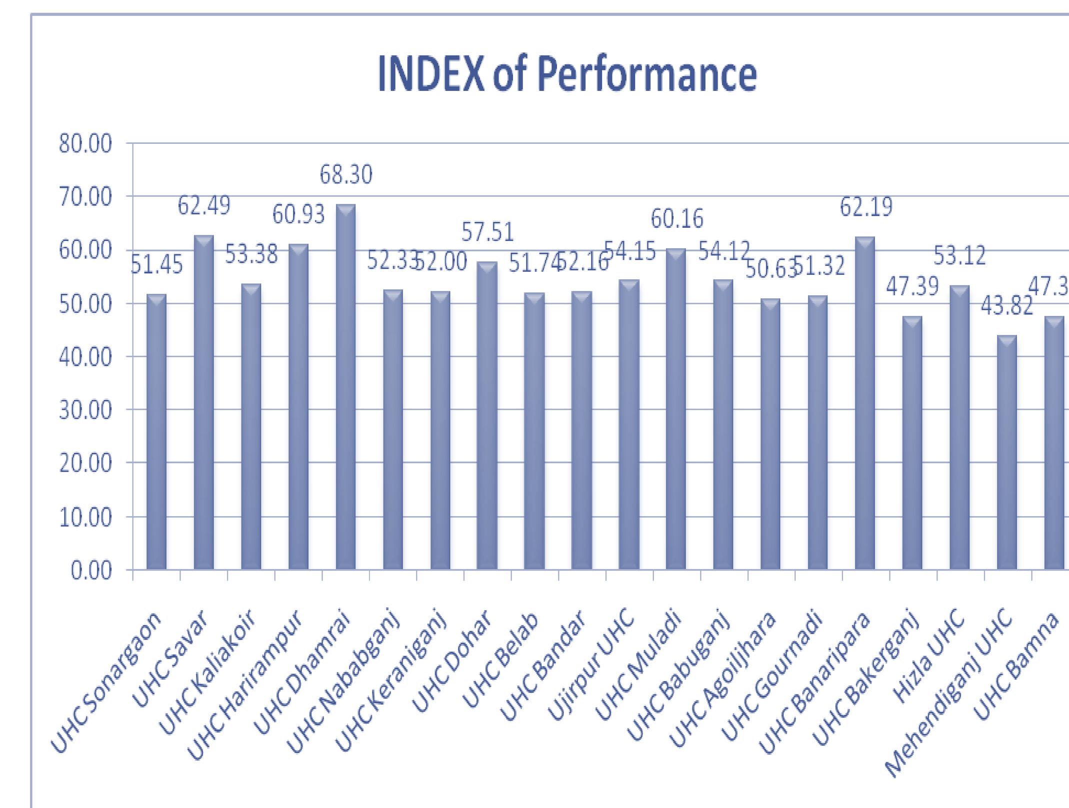
- KII followed by document review and literature review
- Screening survey in 20 UHCs to assess the performance of the UHCs & ranking them. Based on the ranking, selecting the best performing & worst performing UHC for in-depth study
- In-depth interview of the UH & FPO, 2 MO, 1 MA, 1 Field Staff, Local Govt. Leader, 5 Patients from each UHC
- Informal individual & group discussion
- Observation of the UHC
- HH survey of 5% of the population of the catchment area of each UHC
- PRA in catchment area of each UHC

Findings

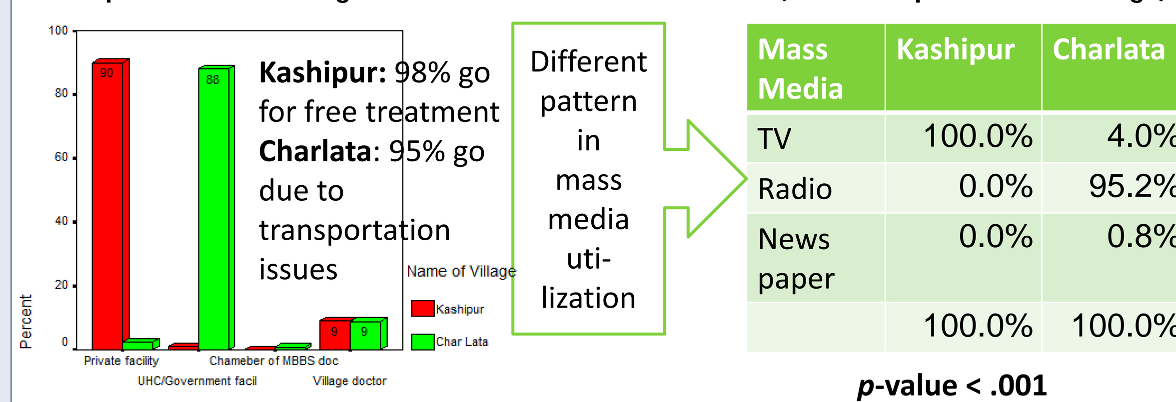
Historical Evolution of Public Health in Bangladesh

Antiquity	Ayurveda and Unani medicine
1714	Indian Medical Service by the British colonial government
1938	Formation of National Health (Sokhey) Sub-committee by INC
1943	Formulation of Health survey and Development (Bhore) Committee
1947	Independence of British India. Bangladesh as East Pakistan
1951	Second All Pakistan Health Conference at Dhaka
1960	Cholera Research Laboratory established (Now ICDDR,B).
1971	War of Independence: Bangladesh as new sovereign country
1978	Bangladesh signed Alma Ata declaration: PHC for achieving HFA2000
1981	Introduction of PHC pilot project in six UHCs
1986	First evaluation of the National HFA strategy
1988	Intensified PHC Program by GoB
1991-DSF; 1994-EOC; 1995-BINP; 1996-HPSS; 1998-HPSP, UPHCP, ESP; 2000-LLP; 2001- IMCI; 2003- HNPSP	
2009	National Health Policy introduced. Reestablishment of CC

Screening Survey at 20 Upazila Health Complexes (UHC)



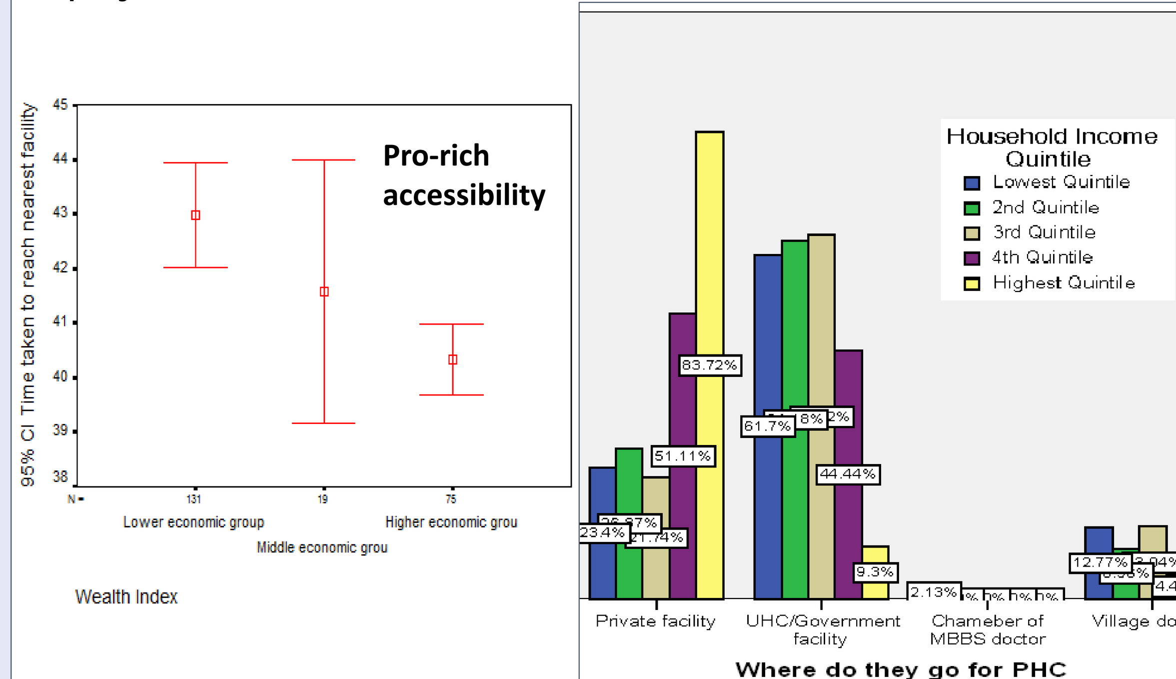
Comparison of Villages across CPHC Parameters (some important findings)



Mass Media	Kashipur	Charlata
TV	100.0%	4.0%
Radio	0.0%	95.2%
News paper	0.0%	0.8%
	100.0%	100.0%

p-value < .001

Equity across Social Determinants



Qualitative Study Finding

Findings related to PHC components

Food & Nutrition: no nutrition activity in any of the UHCs

Water & Sanitation: Under Dept. of Public Health Eng., not health

MCH & Family Planning: Tension between health and family planning cadres

EPI: Best success example, collaboration between govt. NGO & community

Essential drugs: complete ignorance

Findings related to referral

Absence of functional referral linkage

Existence of ambulance where there is no paved way, petrol pump

> *..yes, there is one ambulance for sure. But where is the road here in this desolate island to run this ambulance? Each UHC was allotted one ambulance, so we also got one. No one even thought where the ambulance will run and how patients will be carried from here to somewhere else; there is no road connection from Mehendigonj to any place. Rather we would need a water ambulance*

Findings related to 'community empowerment'

Access to information: govt. made it mandatory to mount 'citizen charter', but people cannot read due to lack of education

Participation in decision making forum: No such forum, only exception was BRAC microcredit 'Village Organization' (VO) meeting

Demand accountability from decision makers: No formal way, giving rise to informal ways e.g. shouting, quarrelling, fighting…

Ability to work in partnership with govt.: during natural disaster only; EPI

Discussion, Recommendation & Conclusion

Comprehensive care

- Selective type of PHC known as Essential Service Package (ESP) is in place in the form of SWAp called Health, Nutrition & Population Sector Program (HNPSP)
- Considering the findings displayed here, 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

Continuity of Care

- Long waiting time, less contact time, lack of responsiveness of the service providers, scarcity of medicine and equipment, unavailability of proper HRH & lack of trust provoke people to breach the referral system
- Continuity of care warrants commitment of service providers, availability & proper management of services, effective HMIS, internal & external monitoring, progressive prepayment based health financing mechanism, transparency, accountability & responsiveness towards patients' needs
- Considering these, we suggest proper referral mechanism as part of CPHC

Commitment of Human Resources for Health (HRH)

- Provision of basic amenities, hospital autonomy, Local Level Planning (LLP), necessary hospital supplies, up to date training, career planning for both clinical & non-clinical cadres, rural allowance & performance based payment essential for committed HRH
- Separation of clinical & non-clinical cadres to maximize service quality
- Appropriate skill mix; controlling corruption, red-tape-ism & undue political influence are essential
- A context specific social incentive mechanism can be developed in order to retain the HRH in the peripheral areas of the country

Community Empowerment

- Status of community empowerment unsatisfactory except access to info.
- May be attributed to the use of mobile phones, electronic mass media & community penetration of the NGOs
- We suggest invoking community ownership, involving media, developing BCC materials on health empowerment, involving the existing govt. field workers in informing people of their health entitlements, & utilizing local government in developing & continuing health entitlement meetings

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