Formulating an Integrated Health Policy

by Dr K M Rashid

In this write-up, Dr Rashid argues for an integrated approach to developing a health policy. In the earlier one, he had touched on various health-related issues integral to formulation of such a health policy. A concluding article will to sum up his arguments in favour of the policy to be developed.

THE Alma-Ata Declaration for achieving the goal of health for all by the year 2000 is the right setting for developing countries to provide adequate health facilities to the people, particularly to the rural millions and the working class.

Some people say that health for all by the year 2000 is nothing but a slogan. Yes, 'Health for All' is a slogan, but not an empty one. It is short, striking with an imaginative set of words, which, given the right context, serves as a rallying point for concerted social action within and between countries, a public relations watchword that fires people's imagination and an expression of the cry for social justice from all those who suffer inequity in health. It is intended to draw attention to the importance of health, to a serious search for new ways of solving the health problems and to help mobilize all available resources for health development.

The slogan does not mean that by January 1, 2000 we shall all wake up free of disease and disability and eventually die in a 'state of health' at the end of our life span. 'Health for All' means that health care has to be brought within easy reach of every one including the poorest members of the society. It does mean that health begins at home, schools and factories. 'Health for All' also implies the removal of obstacles to the elimination of malnutrition, ignorance, superstition, unhygienic living condition, quite as much as it means solution of problems, such as lack of health facilities and services.

To bring about palpable improvement in the health status and health services in the country, movements have to be activated. Appropriate action needs to be undertaken at the policy and operational levels both in the health sector and other health related sectors, because it calls for dramatic change, a social revolution in health development. It aims at changing the attitude of the people, structure of the health system and orientation of the health professionals.

Problems in Formulating Health Policy

The most important features of environment in which policy is to be formulated are as follows :

i. Lack of resources, low priority accorded to health sector, and lack of clear vision on health development;
ii. Inability of the rural poor to identify their priorities and express their needs;
iii. Forces against decentralization, and conflicting ideas and interest of professional groups;
iv. Psychological resistance to any change; change in bureaucratic and professional reorientation is essential;
v. Primary health care service centres are difficult to be establishes as holistic or multidimensional approaches are needed to confront multiple causation of ill health.
vi. Absence of proper mechanism for the formulation and implementation of rational health policy and plans at different levels;
vii. Unrealistic bifurcation of functions of the Ministry of Health and Family Welfare at the operational level;
viii. Lack of inter-and intra-sectoral coordination and cooperation.
ix. Lack of appreciation of the importance of the role of health related sectors and the community involvement in health development.

Involvement of Other Sectors

It is important to realize that provision of services that enable a citizen to lead an economically and socially productive life is not the sole responsibility of the Ministry of Health, and as such policy must go beyond the health sector. Malnutrition, high morbidity and mortality are also related to women's low status, lack of education and employment opportunities. Thus there are health implications for investments in other areas, such as education and employment. Expansion of education-formal and non-formal-particularly of the female section of the population is of immediate relevance.

The role of the health related sectors, such as food and agriculture, education and information, housing, water supply and environmental sanitation are equally important for the health and well-being of the people. In the wake of industrialization of the country, numerous health hazards are being encountered in the production unit. Implementation of various acts and ordinances regulating health, safety and welfare of the workers is the moral responsibility of the industrial units.

A strong non-government sector can be instrumental to substitute private resources for currently used public resources and reallocation of public resources to areas of great priority, and also to expand total resources devoted to health care. In view of scarce resources available in the public sector, involvement of non-government sector in the provision of high-technology and costly services should receive due consideration in the formulation of health policy so that this vast potential can be fully exploited for the overall development of health care facility. The NGOs concerning health should avoid duplication of efforts, and concentrate more on the promotion and development of community-oriented health care for the rural areas, and undertake field operational research for the development of innovative approaches to health care.

Since health is the product of multi-sectoral efforts it is clear that health sector alone is not capable of ensuring health development. It is, therefore, necessary to integrate health policy and plans with those of the socio-economic development plans of the country.

Historical Antecedents of Health Policy

Formulation of the national health policy is an essential step for achieving the goal of 'Health for All by the Year 2000'. Policies which are based on felt as well as expressed needs of the community are derived from different sources. In Bangladesh, since there is no formal document embodying the national health policy, a set of principles generally provided by various documents, such as, the constitution of the country, socio-economic planning document, health charter, pronouncements from the persons in authority and other official documents of the government have governed the health planning and management process.

The Constitution of People's Republic of Bangladesh envisages establishing a society in which fundamental human rights and freedom, and political, economic and social justice will be secured for all the citizens. The fundamental principles aim at: (i) providing basic necessities of life, including food, clothing, shelter, education and medical care; (ii) raising of the level of nutrition and the improvement of public health; (iii) removal of social and economic inequality between man and man; and (iv) promotion of international peace, security and solidarity.

As a member state of the World Health Organization, the Government of Bangladesh has ratified the constitutional provision of the Organization which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every citizen, and the health of the people is fundamental to the attainment of peace and security.

As a signatory to the Alma-Ata Declaration, Bangladesh has pledged to the attainment of the goal of health for all by the year 2000 through the key approach of primary health care.

The objectives of the fourth five year plan (1990-95) of Bangladesh have been formulated keeping in view the broad principles of promoting and supporting development and operation of a national health care system in the context of the national strategy for health for all by the year 2000. However, in the absence of a policy document, the dissemination of policy issues, their implications on the managerial process and their effects on health status of the people have not been adequately articulated and documented. Moreover, some of the policy issues are not uniformly conceptualized across the managerial process, and as such sometimes some of the policy decisions are subjected to changes and shifts impeding proper implementation of programmes. Also there exist a sense of alienation among professional groups as far as the policy and programmes are concerned due to lack of commitment to such policy and strategy.

Health Policy Development Group

In addition to the Ministries of Health and Planning, involvement of relevant institutions and experts from health related disciplines will make the policy broad-based, result-oriented and workable. The group should include policy analyst and research adviser in addition to technical experts, management specialists and representatives of professional groups, such as Public Health Association of Bangladesh, Bangladesh Medical Association, Bangladesh Private Medical Practitioners' Association, Nurses' Association and one of the big NGOs involved in health related matter. It is necessary that the group included adequate number of representatives from amongst the specialists in Community Medicine and Public Health Administrators in order to help reallocate resources between the hospital based on personalized care and the community-oriented primary health care approaches.

The group will be required to analyse the existing documents currently providing direction to national health planning, health status and health care services and resource availability in order to clearly identify issues that would need more emphasis on the policy document.

Objectives of Policy Formulation

Political will and national resolve are the two basic factors in making an ambitions but practicable health policy. The policy should reflect health needs of the people irrespective of their economic status, religious belief, urban or rural setting. The objectives and strategies should include all priority areas, such as primary health care, development of manpower in health sector, strengthening of managerial system, and health care financing.

The objectives of the Fourth Five Year Plan (1991-95) of Bangladesh has been formulated on the broad principles of strengthening of health infrastructures in the country. However, while formulating a comprehensive and people oriented health policy it is important to ensure that the following objectives are duly emphasized:

(a) Development and strengthening of health infrastructure in support of effective delivery of primary health care services. (b) Resource mobilization and equitable distribution of available resources. (c) Development of manpower in health sector particularly keeping in view the need of the rural areas. (d) Control of communicable as well as non communicable diseases. (e) Stabilization of population, and development/strengthening of special services for the high-risk groups, such as mothers and children, youths, elderly and handicapped people. (f) Improvement of the nutritional status, adequate provision of safe drinking water and sanitation. (g) Prevention/control of environment pollution and substance drug abuse. (h) Health services and bio-medical research for health development.

So far as target setting is concerned instead of targets like health centres that are established, personnel deployed, number of family planning acceptors etc., meaningful targets like reduction of infant and maternal mortality, reduction of birth rate and net reproduction rate, reduction of diarrhoeal diseases and vector-borne diseases, immunization coverage etc., should be introduced to help measure the impact. A long-term health development plan needs to be developed reflecting therein the objectives.

Tobacco-free Workplace is Safer and Healthier

by Manuara Begum

THE World Health Organization (WHO) this year has rightly dedicated itself to the cause of establishing a tobacco-free society for the protection and promotion of public health. World No-Tobacco Day has been being observed throughout the world on May 31, since 1988. It is expected that on the occasion of world No-Tobacco Day, adequate public awareness will be generated so that all those who smoke or chew tobacco prepare themselves to giveup their harmful and wasteful behavior.

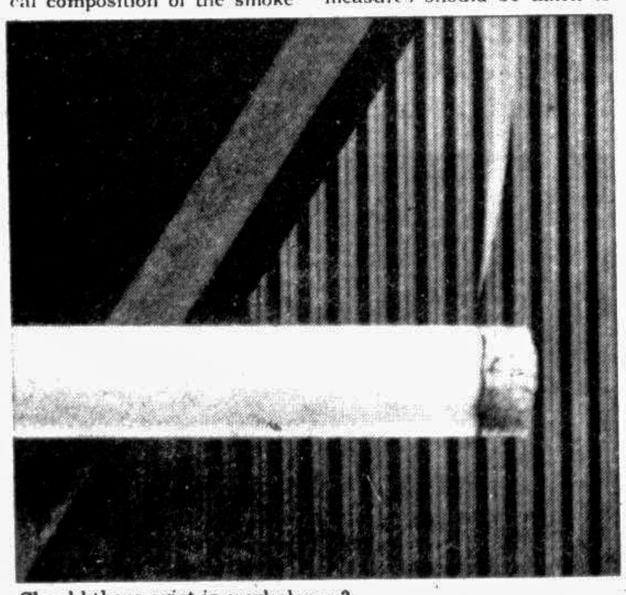
This year the theme, Tobacco-Free Workplace — Safer and Healthier has been adopted by the WHO to advocate for the right and privileges of workers to work in the cleanest environment, unpolluted by tobacco smoke and free from the stress and unpleasant attitude that grows between smokers and non-smokers in a closed workplace.

Significant differences in morbidity and mortality between smokers and non-smokers have been observed in many occupations and have been attributed to a combination of workplace hazards with the detrimental effects of smoking. Coal dust, asbestos, silica, dyestuffs, constituents of rubber on biological dusts are not present in tobacco smoke but a worker exposed to any of these who is also a smoker could acquire diseases from sources and each might contribute separately to the overall effect of health. Alternately one hazard might aggravate the other. In the United States a study over 8500 workers in 31 coal mines showed that the prevalence of bronchitis was higher in miners who were smokers than in miners who were non-smokers. In a study of over 12000 workers exposed to asbestos, only 4 non-smoking asbestos workers had died from lung cancer while 268 who had been smoking died from this disease. A few of the 4000 compounds that have been identified in tobacco smoke, such as carbon monoxide, formaldehyde, acrolein and benzene can also occur in the workplace atmosphere. In that case, a worker who is a smoker would receive the hazardous compound from both sources and on the whole, the situation would deteriorate.

It is well known that in some workplace accidents, fires and explosion can be caused by tobacco use. These kinds of incidents are very much common in many of the workplace leading to human and economic losses that directly affect development process.

Passive Smoking in the Workplace

Passive smoking is attracting concern because there is increasing awareness of its detrimental impact on health. The comparison of the chemical composition of the smoke inhaled by active smokers with that inhaled by involuntary smokers shows that the toxic and carcinogenic effects are equal. Recently it has been recognized that environmental tobacco smoke is a carcinogen. The relative risk of lung cancer among non-smokers living with a smoker is of the order of 1.3 i.e. 30% increase in risk. Several studies have linked passive smoking to an increased risk of heart disease.



Should these exist in workplaces ?

Enactment for Smoking-Free Workplace

In the developed countries tobacco smoke is the most common pollutant of indoor air and is usually a predominant source of exposure to respirable particle air pollution. Since most of the people spend a very high proportion of their time at their workplace, exposure to environmental tobacco smoke is a serious health threat. Therefore, measures should be taken to eliminate exposure to tobacco smoke in the workplace. The workplace is often the place of greatest exposure to tobacco smoke for non-smokers. It is also the longest involuntary exposure. Moreover non-smokers have little control over the environment at work.

Disability and disease among the skilled workforce cause both human sufferings and economic losses to industries and countries. The effects can be severe where occupational hazards are difficult to control. Smoking always adds to disability and disease, but in the industrial workplace its contribution is often compounded by the presence of other hazards. The resulting health and economic costs to industries can be reduced through effective control of tobacco use in the workplace.

In the year 1983 a study carried out in the United Kingdom should 79 per cent smokers acknowledged that non-smokers were entitled to work in an environment unpolluted by tobacco smoke. Two years later the Swedish court of Appeal for Insurance ruled that a case of lung cancer developed by a non-smoker was an occupational disease caused by passive smoking in the workplace.

About 40 countries around the world have enacted legislation to control smoking in the work place. More and more countries already restrict smoking in government buildings and work sites. The rulings apply particularly to hospitals, clinics, health centres and other health institutions and also to schools. In Newzealand, the smoke-free environment act of 1990 requires all employers to draw up a written policy on smoking for every workplace in consultation with the employees concerned. These written policies must prohibit smoking in lifts, in office areas, in at least half the area of any cafeteria and in any part of the workplace to which the public normally has access. Since 1983, Sweden has put limits on smoking at workplace.

Employers have a strong interest in curbing smoking at the workplace not only to safeguard the health of their workers but also to cut down health related costs resulting from the disease and death rates among employees who smoke compared to non-smokers. A study conducted in 1985 in the United States estimated that the cost of smoking-related loss of productivity was between US $ 27 billion and US $ 61 billion annually.

Bangladesh situation

Now, looking at the worldwide dimensions of smoking hazards and the efforts increasingly made by different countries, we should start positive thinking on it without delay. In this country, 70 per cent of the male population smoke and the trend is also increasing among the female population which has adverse effect on health and happiness of the people at large. In many of the countries smoking is becoming a matter of social discrimination with the advancement of civic responsibility and human dignity. Here people smoke everywhere.

It is necessary to create a smoking free environment as well as society for the protection and promotion of public health where the development process of the country is being cultured. The government as the caretaker of people's willbeing has to take all necessary steps in this respect. Necessary rules and regulations may be adopted to make work places tobacco-free. At the same time understanding and cooperation have to be developed at the individual, community and national level for implementation of anti-smoking campaign in the country.

Treatment of Tuberculosis in Bangladesh

by Dr Sakhawat Hossain

BANGLADESH is one of the poorest and most densely populated country of the world. Despite a substantial Population Control Programmes by Government and NGOs over last two decades the population growth rate remains high.

As any agro-based economy of the developing world, majority people of the country are engaged in traditional farming or fishing and often falling outside the economy. About 70% of the people in Bangladesh lives below subsistence level with an average per capita income of US$ 130 and calorie intake of 1800 keal which may be termed as poorest of the poor.

The poverty level prevailing in the country and its impact on public health are easily conceivable. Most of the under five children die of diarrhoea, acute respiratory infection, infection from six preventable child killer diseases, all precipitated by malnutrition. Inadequate supply or safe drinking water, inadequate food intake, lack of health education and its practice, relatively low level political commitment for a tangible and sustainable public health system have contributed to this grim picture.

No wonder, diseases like tuberculosis will find its ground and thrive in the given situation. Public health expenditure is predominantly urban biased depriving rural people from whatever meager facilities are available.

In a given socio-politico economic condition tuberculosis is one of the major public health problems in Bangladesh. In some of the recently conducted sample surveys it has been revealed that there are 500,000 sputum positive cases in the country with a prevalence rate of 5/1000. It has also been revealed that there is a total of 5 million cases of tuberculosis which includes X ray positive cases with a prevalence rate of 5/1000. It is estimated that the annual incidence of sputum positive TB cases is 1,30,000. Findings of those studies also indicate that the prevalence rates, both in urban and rural areas are almost similar and male and elderly people are comparatively more infected by the diseases.

Keeping in mind the fact that most of patients come from rural areas, the National Tuberculosis Control Programme is planned according to the rural upazila based administrative service delivery system which is gradually setting its pace in the country.

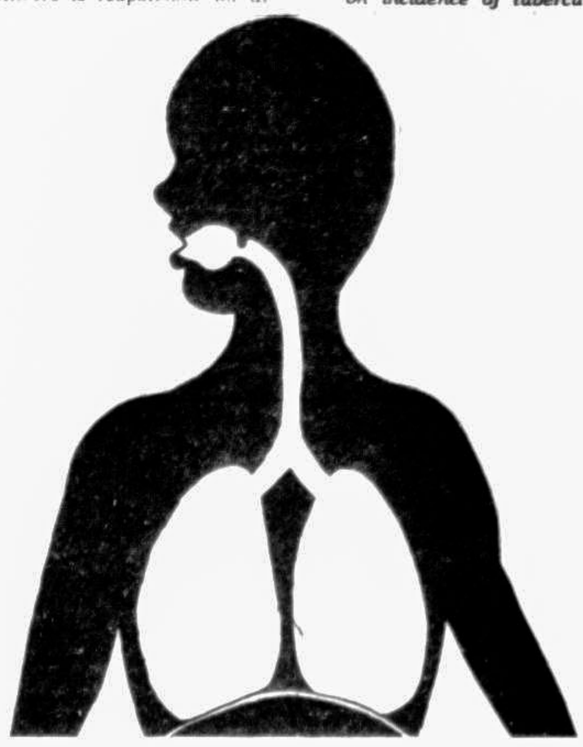
Among the scarce facilities, there is an Institute of Chest Diseases and the Chest Hospital in Dhaka with a capacity of 500 beds. This institute awards post graduate diploma in chest diseases. In the country there are 13 TB hospitals with a total facility of 1000 beds. Added to that, 44 TB clinics one in each of the 44 district towns have facilities for diagnosis and treatment of TB cases. In some of the districts where there is no TB clinic 21 general hospitals are trying to provide the diagnosis and treatment facilities to the patient.

Furthermore, it should be mentioned here that, each of the previously mentioned 460 sub-districts (Upazilas) have one health complex (Rural Health Complex) with eight graduate doctors in each. One of them is especially trained and assigned to TB programme i.e. to diagnose and treat the TB cases in their catchment areas.

The prime objective of the National Tuberculosis Control Programme is to control tuberculosis by interrupting the chain of transmission of the diseases using the existing framework of the general health services integrated with the Primary Health Care through participation of the community. To do this, the prime intervention strategy agreed is to an enhanced level consciousness of the people about TB, create demand for service and to respond to the demand.

The National Tuberculosis Control Programme is integrated with the general health services. The tuberculosis care facilities in all parts of the country offering its services are based on the principle of equity in health for every member of the community. The (sub-districts) UZ Health Complexes cater to the need of 200,000 people on an average in its areas. These complexes are the focal points and nerve enters of TB control activities. These sub-district Health Complexes are responsible for delivering comprehensive health care to the people of the sub-district (UZ).

This general health care encompasses medical, surgical, obstetrical, MCH, Family Planning, Immunization, TB and other diseases control etc. These complexes are provided with eight graduate doctors and a Dental Surgeon having indoor facilities of 31 beds. One of the mentioned medical officers is responsible for diagnosis mainly by sputum microscopy and treatment of TB patients. The Medical Officer responsible for TB treatment is also responsible for relevant data collection, compilation, feedback and evaluation of the activities in his area.



The sub-district health complexes are looked after over by a committee named Disease Control Committee which includes both local government and NGO personnels. The elected people representative i.e. upazila chairman is the chairman of that committee. Each upazila comprises 5 to 10 unions and each union has a Health sub-centre. These are the smallest functional health-out-post which cater to health needs of 20,000 people on an average. Each union is estimated to have prevalence of 100 sputum positive TB cases on an average.

Each of those sub-centres are managed by one medical assistant and a lady home visitor for providing Health and Family Planning services at the grass-root level. Under those sub-centres for each of the 4,000 population there is a multi-purpose domiciliary Health worker designated as *Health Assistant* who is entrusted with the job of immunization and TB control with other services. They are also assigned for collection of malaria slide containment of diarrhoeal disease, nutrition and health education etc.

In the same locality and the same population one family planning worker known as *Family Welfare Assistant* renders family planning services including motivation, distribution of contraceptives and MCH services (antenatal and post-natal care and child health). The above field level health workers work hand in hand with the NGO workers.

The elected people's representative of the locality i.e. the union council chairman, supervises the activities of the health sub-centres.

Recently diagnostic and treatment facilities for TB are being introduced at the union sub-centres which are till now, the lowest level contact point for the primary health care.

It is worthwhile to mention here that, at this grass-root stages NGOs are taking a progressively effective supplementary and complimentary efforts to the National Health activities. Besides, they are also efficiently creating awareness about TB among the community people. They also complement the National Programmes by providing motivation, referral and follow-up services.

NGO workers are also included in the local level policy making committee, thus they are part of the policy-making process. These committees are especially needed and entrusted with the responsibility to solve the unique problems of that specific locality. Although there is a national level uniform policy making system, the real life situation in different localities are quite unique. So to confront those realities at local level, those committees are very much effective.

Sub-district Health (Upazila) Complexes with regard to TB control are as follow:

i. *To diagnose a case of TB through sputum microscopy.*
ii. *To treat a case of TB thus detected.*
iii. *To follow-up the defaulters through the domiciliary health workers and complete the treatment.*
iv. *To carry the message of Health Education on TB in every house-hold.*
v. *To asses and surveillance on incidence of tuberculosis.*
vi. *To receive referred cases from union sub-centres and to refer complicated cases to TB clinics for diagnosis and to TB hospitals for hospitalisation where necessary.*

Of TB Clinics:

i. *To diagnose and treat TB cases in urban and semi-urban areas.*
ii. *To receive all complicated cases from sub-district (upazila) health complexes, general hospitals and medical college-hospitals for diagnosis and trentment.*
iii. *To forward patients to regional TB hospitals for hospitalization where necessary.*
iv. *Training of Medical Officer and microscopist and lab technicians of the district hospitals.*
v. *Promote Health Education on TB to the relatives of the TB patients.*

At the district level there is a committee to supervise and monitor the TB programme and activities. The committee is chaired by the District Magistrate, co-chaired by the Civil Surgeon (Chief district medical officer). Leading NGOs are represented in the committee and discharging extremely important role. NATAB being a lead agency in this field is active all over the country in the above mentioned committees along with the members of national health network of Voluntary Health Services Society (VHSS).

General Hospitals at the district level provide the following services to the TB clinics in case of the absence of TB clinic in that district:

i. *To receive the patient referred by primary level and by private practitioner.*
ii. *To diagnose and treat a case of TB.*
iii. *To refer difficult or complicated TB cases to the TB clinics or regional hospitals for admission in case of need.*

Under the Director General of Health Service the Director of TB & Leprosy Control Directorate is responsible for the programmes on behalf of the Ministry of Health. He is entrusted with the following activities:

i. *Planning and formulating National level policy on TB control and implementation of the same.*
ii. *Procurement of drugs and ensuring its supplies.*
iii. *Imparting training to all categories of staffs active in TB controls activities.*
iv. *Undertaking epidemiological surveys periodically and evaluating the programme.*
v. *Collection, compilation and analysis of all epidemiological information relevant to the TB control programme and feedback to the higher authorities and other allied sectors.*
vi. *Supervision and over all monitoring of the programme.*

All sub-district health complexes prepare their respective monthly reports on tuberculosis control activities to submit a copy of that to the district health office (i.e. to the office of civil surgeon) with a copy of the same at the national level i.e. to the office of the Project Director MBD Control.