For an effective health and population service programme

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Time has come to review Health and Population Sector Programme (HPSP) and invest renewed energy and resources to replace HPSP by HPCP, i.e, Health and Population Community Programmes. This may fit in our national goal of poverty alleviation, and in a country with resource stringency, people may become a vital source for mobilisation of resources. The need is not to fall in the trap of finding bureaucratic solution (HPSP) but to commit to achieve and build long term and sustainable health and population programmes.

HEALTH and Population Sector Programme (HPSP), launched in the country in July 1998, emphasized on a sector wide approach. It underscored promotion of ESP services integrating dispensation of health, maternal and FP services from the combined health and FP facility extending from the community through union (FWCs), upazila (THCs), district and national levels (hospitals). Programmes in the past hardly focused on the needs of the poor. HPSP specifically targeted the poor.

Health and population programmes in the past have made some significant achievements. The contraceptive prevalence rate (CPR) has increased to more than 50 per cent and the total fertility rate (TFR) has declined to 3.3. Child immunization increased from 10 per cent to 70 per cent and the mortality of children under-five has dropped considerably. Life expectancy has increased by 14 years, and the infant and under-five mortality rates have fallen by almost half. The prevalence of many immunisable diseases has fallen over the last decade, as have diseases caused by micronutrient deficiency. Gender differentials in health remain a major challenge. Maternal mortality has remained almost unchanged for the past few years -- representing one of the highest in the world. The longer-term vision for the health and population sector is to become "responsive to clients' -- especially women's -- needs in the provision of quality services, to obtain adequate delivery capacity and to become financially sustainable."

Since its inception HPSP has passed through a difficult period of reforms and changes, especially changes in the management of health and population programmes. Recently, health and population services have been unified at the upazila level. And according to the major strategies enunciated under HPSP, the unification was to be achieved also at district and national levels. During the last three years of operations of the HPSP, findings of major national level evaluative survey (CIET) revealed that "most of the reasons for non-use of government services are due to lack of medicines, poor treatment, bad behaviour of staff and staff demanding payments". Little over one tenth (13%) of the clients reported visiting government health services for illness in the near past (last month) and the persons using the service reported that there was no health worker to attend them. Both men and women mentioned problems with availability of doctors and other health workers. Most of the THFPOs (doctors) say that they do not foresee any difficulty with the unification of health and family planning services in their upazilas. However, most of them mentioned that financial and administrative problems obstruct implementation of the programmes at that level.

Currently, new public health problems are emerging, such as the threat of HIV/AIDS and the nation wide arsenic contamination of drinking water. Early childhood development, adolescent care, nutrition and increasing injuries are demanding increased attention. The demands for health services have been steadily increasing and over half (55%) of the households are willing to pay for an improved and quality government health service. Health needs continue to change. Non-communicable diseases and trauma are becoming more prevalent, imposing high costs on poor families. However, new treatments will also become available, improving the means to prevent and cure disease. Overall improvement in the literacy level, increasing participation of women (mothers) to income opportunities will enhance their desire and control over the health services they would prefer and seek. "Innovations in health service financing and in health service delivery will be required if Bangladesh is to capture the benefits of technical change, rising incomes and better education." Improved regulation of service quality and price, improved health provider incentive, strengthened management, increased participation of communities including the civil society, in health service delivery, and extended role for private and not-for-profit providers are some of the key innovations required to make health programme benefiting for the people.

Governments accept the duty to guarantee their citizens equal opportunities for good health. In 1997, total annual per capita spending on health in Bangladesh was US$ 10.6, of which 30 per cent was contributed by the government, while the rest (70%) represented purchases by households of health goods and services provided by the private sector, pharmaceutical suppliers, medically qualified and traditional practitioners and NGOs. More than half of this private spending was on pharmaceuticals, modern and indigenous. Delivery of health services all over the world is undergoing qualitative changes. Greater degree of community participation, decentralisation of management and budgetary control, commissioning services from non-government providers and in improving public provider efficiency are some of the measures ensuring increased benefits for the consumers of health services.

HPSP started with lofty goal of overhauling health programmes through programmatic and structural reform measures. Inefficient implementation reinforced by misconstrued frustrations of the providers and programme managers rendered the health service delivery system almost ineffective while implementing the reforms programmes under HPSP. Moves to unify health and population programmes rendered the previously efficient management structure void, while the new system could not successfully replace the old projectised management structure. Bangladesh health programme now stands historically at a critical and transitional phase, when demands for health services by the people are increasing at a greater pace than the efficiency and quality of health service delivery. HPSP was certainly a noble venture, all the ideals of quality health services were documented in the plan. What and where it failed was to translate the ideals into a reality. Of the few major lacunae that the HPSP was encountered with was its singular and extraordinary focus on the need for unification of providers of two separate but allied programmes, like health and family planning. The programme on the other hand seriously overlooked the need for unifying the efforts of the providers with those of the consumers (community).

The issue is how to revitalise health and population programmes at the grassroots level and also the levels above that (secondary: district and upazilas and tertiary: national hospitals and programmes). If again the senior managers and programme implementers along with policy makers and development partners engage themselves on bureaucratic solutions like reviving sector wide approach and thus HPSP, the efforts are likely to be frustrated. Health is today an important issue of the people in Bangladesh. Families worry about the health of the children, which is evident from a very high level acceptance of EPI vaccines, compared to other poor countries in the world. Couples are strongly desirous of having a family (size) manageable within their means, which is again evidenced by higher rates of CPR and sharply falling rates of TFR. Very recently, mothers also worry about the risk of their and child's lives during delivery. Consciousness regarding achieving malnutrition free life is also not lacking, as evidenced from the BINP project areas.

People in Bangladesh are ready to accept modern health care to improve the quality of their life, i.e., to change the situations of both morbidity and mortality. When their major complaints are against the poor quality of services at government sponsored health programmes, the tendency to ignore people as a major player (partner) in the health programme is not only despicable but also self-defeating for the country. Future attempts to revitalise the health and population programmes at various levels, especially under the aegis of a democratic government, should prioritise the role of the community (people) in the implementation of health and population programmes.

Investing time to settle the moribund issues of conflicts between doctors and non-doctors, integrating health and population services through unification of management structures at various levels may become ultimately futile and/or less benefiting in terms of improving people's health status. Creating local level committed leadership imbued with the sense of true partnership between service providers/programme managers and community with provisions for technical support from qualified experts representing the private sector (both not-for-profit: NGOs and profit sector) is a critical strategy. This may be operationalised and tried at micro level, i.e., at upazila level and below. Such a programme must be built on the principle of local level autonomy for programmatic, management and financial decision making through a team of leaders responsible for programme operations. Viewing and organising health programmes through national level interventions have been tried repeatedly in the past and many vertical programmes have also achieved remarkable success. But to ensure development of the total health and population programme at local level on sustainable long term basis is completely a different but fruitful proposition, if people's interest is given priority.

However, the Health Directorate and the Directorate of Family Planning are not devoid of initiatives for establishing or operating health development or FP committees at various levels. But the suggestion here is not constitution of cosmetic community based committees, which end and start with meetings and workshops. The national plan (comparable to that of HPSP) may focus on the interest and possible active roles of the community at not only community clinic level, but also at all levels of management and service delivery including the FWCS, THCs, district hospitals and national hospitals. Unless the overall plan delineates the details of structure and operations and TOR of the tripartite partnership of programme managers/service providers, community and the private sector including NGOs, the seriousness of the agenda to establish linkages between public, private and community will be totally lost. One may ask, how does one reach this ideal management system? The answer is not short, but also not difficult in the context of Bangladesh health and FP programme development. Over the years, series of experiments have been undertaken in this line of programme development by various projects and NGOs (experiences of LIP, BRAC, Gano Shastya, Grameen and many others), which may be reviewed, and an experimental plan designed with consensus of all the stakeholders. Besides, research findings suggest succinctly that many young energetic programme managers (doctors and non-doctors), both within public and private sectors, are poised for taking challenges and are committed to develop local level programmes. Over and above, the studies also demonstrate that people (communities) are today not only willing to pay but also share responsibilities of supporting and implementing health and population programmes at various levels. People will not share and contribute through cosmetic committees.

Time has come to review HPSP and invest renewed energy and resources to replace HPSP by HPCP, i.e, Health and Population Community Programmes. This may fit in our national goal of poverty alleviation, and in a country with resource stringency, people may become a vital source for mobilisation of resources. The need is not to fall in the trap of finding bureaucratic solution (HPSP) but to commit to achieve and build long term and sustainable health and population programmes competent to prioritise people's interest for health and population sector development (HPCP).

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'Seal of Quality' urgently needed to save the shrimp export industry

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According to the Agro-based Industries and Technology Project-Phase II (ATDP-II), the introduction of a "Seal of Quality" programme with strict sanitary standards and an internationally recognized logo is urgently needed in order to guarantee continued access to, and growth of Bangladesh shrimp in the world market. Producers, aggregators, depot owners, ice suppliers and processors must unite in an effort to actively enforce a high standard of quality. Without such a standard, Bangladesh faces possible economic disaster as international buyers threaten sanctions and a ban because of pathogens found in shrimp. Likewise, domestic consumers will use their buying power to stop buying shrimp, if they think the product is unsafe for their families to consume. A "Seal of Quality" programme can save the shrimp industry, the country second leading export at over $260 million a year in sales.

Industries, such as the coffee industry in Columbia, the beef and pharmaceutical industry in the US and the dairy industry in New Zealand have long employed a "Seal of Quality" as a tool for insuring quality, for marketing products and for projecting a positive national image. Internationally the ISO 2000 logo has become a globally recognized "Seal of Quality". In Bangladesh every company has a brand name, but the "Seal of Quality" would supercede these names to act as a common guarantee. No one would be allowed to use it without insuring their product was of irreproachable quality.

ATDP-II, together with the Bangladesh Frozen Food Exporters Association (BFFEA), is spearheading the effort to develop a "Seal of Quality" programme for the shrimp industry. As a first step, on February 5 and 6 in Khulna and Feb. 11 and 12 in Chittagong, a workshop on "Developing A Seal of Quality" was organised for over 80 producers, aggregators, suppliers and processors. The workshop led by two US consultants from Land O' Lakes, the largest farmer owned cooperative in America which possesses its own globally recognized brand name and "Seal of Quality". The outcome of this workshop is that individuals and companies will make an organizational and financial commitment to implementing a "Seal of Quality" programme under the leadership of BFFEA.

Challenges lie ahead in creating a "Seal of Quality". The biggest obstacle is lack of leadership, combined with un-willingness on the part of some in the industry to pay for the necessary changes that need to be made. Some business people continue to believe that the government or donors should finance the changes needed in their industry. On the contrary, in developed countries industries police themselves by developing "Seal of Quality" programmes in order to avoid bureaucratic intervention and heavy-handed regulations by government.

A "Seal of Quality" is a major self-policing effort in which the industry must move ahead of government and set up its own inspection and spot-checking regime, its own product-testing laboratory and impose penalties on members who fail to meet standards. Every aspect of the industry must be organised from production, to transport, to suppliers, to processing. Hence leadership is needed that can organise all and not just one sector of the industry. The problem of uncontaminated shrimp is so interrelated and intertwined that failure to organise one part of the industry can mean disaster for the entire industry. Failure for example to provide bacteria-free water to make ice to keep the shrimp cold can undermine all the best efforts of the producers and processors. Likewise locating farms near latrines can destroy all the work that goes into providing bacteria-free ice and sanitary storage facilities.

ATDP-II estimates the cost of developing a lasting, internationally accepted "Seal of Quality" programme to be approximately US$300,000. This money must come from the industry. Normally in developed countries, industries developing a "Seal of Quality" levy a special assessment on their members in order to cover the initial cost. Thereafter, membership dues and a normal levy on each kilo of product are assessed. The immediate payoff from a $300,000 investment by the industry in Bangladesh would be $30 million. This is how much is currently being lost by the Bangladesh shrimp export industry due to the perception of questionable quality. Thailand, for example receives 10 per cent more for its shrimp than Bangladesh because of the perception that Thai shrimp are of better quality.

The country as a whole would pay a high price for the failure to develop an internationally recognized "Seal of Quality". Unlike the garment industry, all the raw materials for the shrimp industry are locally produced. Thus the foreign exchange earned stays within the country. Further approximately 500,000 people, with 40,000 to 50,000 of them being women, would stand to lose their jobs if this industry failed.

Sarah Sutro, a writer and editor for ATDP-II, based this article on her interview with Dr. Mahmudul Karim, the ATDP-II Fisheries Consultant.

All health information to keep you up to date

Your medicine information

It is a common observation that when some people forget to take the dose of any medicine in the morning, they take two tablets or capsules in the evening just to compensate the missed dose. This is absolutely wrong. The extra dose taken can be harmful and can lead to toxicity or side-effects. Never take more than the prescribed or recommended dose.

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Food is often offered by you when someone comes home. The guest himself requests you to join in and give him company. And in order to oblige him you munch away at some snacks. How often does this happen? Imagine having two or three guests in a day. In such a situation, a lot of items are eaten without having the actual desire to eat then. Nobody will mind if you refuse to eat. They just tell you to join them, as a matter of courtesy.

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