BHEW

Equity Dialogue

CENTRE FOR HEALTH AND POPULATION RESEARCH

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QUOTATION

"Education is the most powerful weapon which you can use to change the world."
Nelson Mandela, South African President

KNOWLEDGE BASE

Health system

"All the activities whose primary purpose is to promote, restore or maintain health" (WHO 2000). This includes interventions at both the household and community level, and the outreach that supports them, as well as the facility-based system and broader public health interventions, such as food fortification and anti-smoking campaigns.

It includes all categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous. It also includes such mechanisms as insurance by which the system is financed, as well as the various regulatory authorities and professional bodies that are meant to be the 'stewards' of the system. Equally importantly, health systems are a vital part of the social fabric of any society. As such, they "are not only producers of health and healthcare, but they are also purveyors of a wider set of societal norms and values" (Gilson 2003).

Source: "Who's got the power? Transforming health systems for women and children" UN Millenium Project Task Force

Pharmacies in urban Dhaka
Photographs by : Shehrin Shaila Mahmood

Comparison of health-seeking behaviour between poor and better-off people after health sector reform in Cambodia

Yanagisawa S, Mey V, Wakai S.
Public Health. 2004 Jan; 118(1): 21-30.

Abstract:
This study compared health-seeking behaviour between poor and better-off people after health sector reform in Cambodia. The survey was conducted in the Prek Dach Health Centre coverage area, which is located in South-east Cambodia. The study population consisted of 257 housewives of reproductive age, selected at random. Data were collected through household surveys with a structured questionnaire. Data collected included socio-demographic information on the housewives, as well as episodes of illness of family members within 30 days prior to the survey. Two indicators, the floor area of living space and a rating scale on asset ownership, were used to identify poor and very poor people. When a family member became ill, subjects most often used home remedies as a first step, followed by self-medication. Subsequently, people used self-medication or the private health sector. Very poor people used the health centre more often than better-off people as a first step. For the second step, use of the health centre was also high among the poor compared with better-off people, although the difference was not statistically significant. Keeping the treatment fees low and abolishing informal fees maintained the affordability of health-centre services for the poor. However, this benefit diminished quickly with distance from the health centre. The significant difference between poor and better-off people disappeared for villages situated more than 2 km from the health centre. Thus, the health centre in the studied area was shown to be effective in providing primary health care to the economically disadvantaged, but only within a limited geographic area.

BHEW seminar on "Proposal for a monitoring system to assess utilization of the HNPSP* services by the poor"

A seminar on a "Proposal for a monitoring system to assess utilization of the HNPSP services by the poor" was held at the Bangladesh Institute of Development Studies (BIDS) on January 12, 2005. The speakers at the seminar were Dr. Mushtaque Chowdhury, Deputy Executive Director of BRAC and Dean of the James P. Grant School of Public Health of BRAC University and Dr. Abbas Bhuiya, Head of the Social and Behavioural Sciences Unit of ICDDR,B, both of whom are also members of the Bangladesh Health Equity Watch. The seminar was attended by members of BHEW and representatives of relevant national organizataions.

The objective of the project being proposed was to pilot a monitoring system for programme performance in reaching the poor - socioeconomically, by gender or otherwise. The specific objectives of the project were to 1) Identify/develop an equity sensitive rapid assessment tool and help/train the local level health service/programme managers to adopt the tool; 2) Train the relevant personnel to carry out the data compilation, simple analysis and reporting; 3) Carry out a community survey in the catchment areas of health service points to know the distribution of population/households by socioeconomic status; 4) Estimate the cost of the implementation of this monitoring system; and 5) Dissemination of findings.

Components of a monitoring programme, existing monitoring methods, and the indicators to be used were reviewed. Emphasis was placed on using rapid methods for programme monitoring (benefit incidence ratio, Lot Quality Acceptance Sampling (LQAS), free-listing and focus group discussions in the social sciences), and monitoring of intermediate outcomes as opposed to the commonly used lengthy methods (demographic surveillance systems, service records, cluster surveys) and exclusive focus on the final outcomes.

*Health Nutrition Population Sector Programme

Health sector reforms in Bangladesh

A. Mushtaque R. Chowdhury
Dean, James P. Grant School of Public Health, BRAC University

I take the liberty to reminiscence and review some of our experiences on health sector reform in Bangladesh, as a citizen. Over the past few decades, Bangladesh has done quite well in its social indicators. Net enrolment in primary education has exceeded 80 percent with both girls and boys attending school in equal numbers, both infant mortality and fertility rates have been halved since independence in 1971, and extreme poverty has fallen from nearly 70 percent in the 1980s to less than 50 percent in the early 2000s. However, many challenges remain. Maternal mortality remains embarrassingly high and inequities in both health status and access galore.

Bangladesh has a health system which is dominated by the public sector. Like in many other developing countries, the Bangladesh health system also went through a series of reforms. It will be interesting to review the evolution of the reforms that took place in the country over the past two decades, and how different events and interests played particular roles in this. Bangladesh has a chequered history of introducing reforms in its health sector. We inherited a hospital based health system and it was not until the days of malaria and smallpox eradication and mass education of oral rehydration therapy that the people started seeing some fruits of public health.

The Ministry of Health and Family Welfare in Bangladesh has two separate line directorates. With the posting of Family Welfare Assistants under the separate Family Planning Division, and Health

Assistants under the Health Division, the division or schism within the Ministry of Health took a firm root. There were two wings: Health Wing and Family Planning Wing. This division increasingly became very overt and divisive with one wing looking at the other with adversity and mistrust[1]. This is still continuing, and threatening the reform that was undertaken in the 1990s.

The first reform in a real sense was attempted in 1989 by the then Military Government of General Ershad, with the professional and intellectual backing of some non-governmental organizations. One of the most radical and revolutionary propositions in this new health policy was the devolution of the affairs and authority of Health to the local government. The medical community led by Bangladesh Medical Association reacted vehemently against it, which ultimately led to the downfall of the Ershad government and scrapping of the policy.

In 1996, a new government was voted to power. With support of and pressures from the donors, the new government decided to do some reform in the health and family welfare (planning) sector. The essential elements of the reform were: unification of the two wings of health and family planning, and integration of activities from a project or vertical mode to a programme or health system mode. Another important change was the provision of health services under an Essential Services Package or ESP which included among others things Reproductive Health, Child Health and others. It also attempted some decentralization in the form of de-concentration and delegation.

The aim of the latter was to delegate power and responsibility to the *upazila* (sub-district) level. The new role for the Ministry was articulated as policy and strategy formulation, regulation and legislation. The role given to the Directorate was standard setting, performance review, overseeing and providing budgets to districts. However, the government hasn't been able to implement much in this. The districts have been given some authority of higher spending and this is said to be working well. A decentralized system of local level planning was also introduced, with the upazilas given authority to prioritise investments based on local need and community participation. Unfortunately very little of this and other decentralizations have taken place so far. In a few upazilas where this was tried, both positive and negative results have been reported.

The other element of the new reform was the setting up of Community Clinics (one for every 6000 population). This was a one-step facility to provide ESP and done with the aim of bringing healthcare closer to the people. However, there were lots of questions raised about it as well. Some complained that it was done with a motive to distribute political influence. Others questioned the wisdom of this: when the health centres above this (e.g. unions) were not functioning well what is the point in investing so much in this? The other criticism was that the setting up of it led to stopping of home visits by family planning and health field workers. However, the idea was to run the community clinics jointly by government and local people, thus ensuring community participation. It remains to be seen how much of this is done in reality. Lately, the government is thinking of handing over the management of some of these clinics to NGOs.

For safe motherhood, the new programme envisaged creation of a new cadre of community midwives by training the existing Family Welfare Assistants for a further period of six months. Questions are being raised on the wisdom of this, as many of these workers will be retiring soon. Access to skilled birth attendants in the country is only about 15 percent as revealed by the Bangladesh Demographic and Health Surveys and there is a huge inequity in this with most of the services being enjoyed by the well-to-do sections of the community. The challenge is how the access to skilled birth attendants and emergency obstetric care can be increased in the country as a whole and for every group in the population, particularly the disadvantaged sections. Fortunately, the inequity in access to clinical contraceptive devices is much less.

Although there were questions about some of the elements of the reforms, it is probably too early to see any positive or negative impacts. Moreover, it was only a partial reform. About 85% of the population turns to private providers but there hasn't been any move to regulate them through the reform.

In 2001 the government that initiated this reform was voted out of power. The new government decided to take a new look at this. Some of the cadre of workers who were dissatisfied and not taken on board with the reform, particularly the family planning workers who through their unions thought that they were sidetracked and ignored, influenced the new government to put the reforms on hold. There is a kind of a stalemate and indecisions now. A new programme with the inclusion of nutrition, titled Health Nutrition and Population Sector Programme, is being designed, which, the government claims, will take care of the flaws in the previous programme. It has already suspended the unification of the two wings but has not, fortunately, disrupted other changes.

It thus appears that reforms of the kind happening in Bangladesh is influenced by many factors such as political agenda, and professional unionism, and done in haste without much preparation and without a long-term vision. The Bangladesh health system is passing through an interesting phase of evolution. Monitoring the process of the reform and its impacts, particularly on the disadvantaged sections of the community, are necessary through well-designed and focused research

[1]This schism between the two wings is well documented (see: Chowdhury AMR et al. A Tale of Two Wings: Health and family planning in an upazila in Northern Bangladesh, Dhaka, BRAC, 1989).

studies. In this the government, NGOs, research organizations and civil society need to work together.

Access to free education:
Case history of Sobuj Aziz

Mohammad Sobuj Aziz is the second of five children. He was born in 1984 in Dhanmondi in a financially solvent family. In 1984 the family owned a house on a 3 Bigha land in Dhanmondi which had come down to his father by inheritence. But some local leader (mastan) tried to take away their property illegally. To keep their property and to fight off the mastan, they sought the help of a lawyer and filed a case. The expenses of processing the case, however, gradually broke them down financially.

The situation got worse in 1994 when his father died. Sobuj's family thinks that it was a murder as his father's dead body was found on the street. The family became financially paralyzed by losing its only earning member. Eventually they lost all their property. The financial condition of the family forced Sobuj's older brother to stop his education and get a job as a tailor. His brother is still a tailor today.

But poverty could not stop Sobuj's studies. As a student, Sobuj had always exhibited good academic and extracurricular performance and Surovi sponsored his education from Class I up to the present. Sobuj's interests in painting and writing also had the chance to develop. He worked as the editor of Shishu Katha, a children's magazine of Bangladesh Shishu Adhikar Forum in 1993 when he was only nine years old. In 1994 he was awarded a gold medal from his school as the best child artist. Today, Sobuj works as a part-time assistant teacher of Surovi Dhanmondi School. Besides that, he is also appearing in his B.Com examinations.

Sobuj dreams that he will complete his M.Com. and ICMA. He wants to build a career as an officer in a business corporation. He also dreams of having an exhibition of his paintings. His mental strength and perseverance has brought him to where he is today.

Sobuj's is a success story of fighting against poverty. His story tells us that hard work and determination can bring success in life.

Equity in self-reported adult illness and use of health service in South Africa: Inter-temporal comparison

Eyob Zere; Diane McIntyre
JHealth Popul Nutr 2003 Sep; 21(3): 205-215

Abstract:
The study was carried out to assess the magnitude of, and change in, inequities in self-reported adult illness and use of healthcare and to consider the policy implications of the findings. Datasets from three household surveys carried out in 1993, 1995, and 1998 were used. Inequities were measured using illness and healthcare-use concentration indices. Self-reported adult illness was greater among the rich in 1993, but this was reversed to reflect higher levels of reported illness among the poor in 1995 and 1998. Inequities were observed in self-reported injury and disability/chronic illness that favour the rich. The poor also reported more days of sickness compared to the rich. Overall, there were higher levels of use of doctors and hospital services by the rich, relative to their levels of reported illness. In contrast, there was a greater use of public-sector facilities by the poor. The time taken to reach a health facility also had a bias in favour of the rich. Although there were some favourable changes in the levels of inequities between the three time periods, there still remained considerable inequities that favoured the rich in self-reported adult illness and use of health services that need to be addressed. The consequences of higher concentration of chronic illness/disability and injury among the poor have far-reaching negative consequences on the socioeconomic welfare of the individuals and households. Redressing these inequities needs a holistic strategy that transcends the health sector.

The Equity Dialogue is a joint initiative of the Bangladesh Health Equity Watch and the Poverty and Health Programme of ICDDR,B. Bangladesh Health Equity Watch is a collaborative initiative of four organizations that share a common concern for equitable health and development in Bangladesh. The organizations are the Bangladesh Bureau of Statistics (BBS), Bangladesh Institute of Development Studies (BIDS), BRAC and ICDDR,B. The Rockefeller Foundation currently funds the project. The goal of the Poverty and Health Programme of ICDDR,B is to generate relevant knowledge to improve the health of the poor to reduce poverty. The project is presently being funded by the Department for International Development (DFID).

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