Rural Placement of Doctors in Bangladesh: Conflict between Institution and Individual Rationality

by

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Public Policy & Governance Program
North South University

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Dedication....

To my parents

Declaration

I declare that the dissertation entitled ‘‘Rural placement of doctors in Bangladesh: Conflict between institution and individual rationality’’ submitted to the PPG Program of North South University, Bangladesh for the degree of Master in Public Policy and Governance (MPPG) is an original work of mine. No part of it, in any form, has been copied from other sources without acknowledgement or submitted to any other university or institute for any degree or diploma. Views and expressions of the thesis bear the responsibility of mine with the exclusion of PPG for any errors and omissions to it.

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Signature with date

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December 2017 **Abdullah Shibli Sadiq**

Abstract

This research is about to explore the factors those drive doctors to leave the rural areas to the urban posting places. Managing rural placement of doctors is a great concern for Bangladesh. Two-fold problem is observed in this regard: absenteeism and retention. Vacant posts and absenteeism rate are higher in the rural areas than the urban areas in Bangladesh. On the other hand, sometimes urban health facilities are overcrowded by the doctor.

Total sanctioned posts for the doctors in Upazila level are 10,639. Among those available doctors are 5,154 and vacant posts are 5,485 (Directorate general of health services, 2017d). It means 51.6% posts are vacant in Upazila level. On the other hand, only 6.88% posts for doctors are vacant all over the country (Ministry of health and family welfare, 2016). It indicates that, most of doctors are working in the urban health facilities. The policies and authorities are there to govern the health sector, but it seems that everything is not functioning properly or doctors are not interested in rural placement. Therefore, questions arise: why doctors are not interested in rural placement? Is there any lack of institutional support, for what doctors are not motivated to serve in the rural areas? This paper, will give a scope for better understanding whether individuals' utility maximizing behaviour or lack of institutional support make doctors disinterested to rural placement.

The dependent variable of this study is rural placement of doctor's in Bangladesh. The independent variables are income opportunities, personal affinity, institutional support, professional development and stakeholders' concern. Qualitative research method has been used in this study and primary data are collected through in-depth interviews. Besides, secondary data also taken from different official websites newspapers and other publications.

It is found from this research that doctors are disinterested in rural placement mostly because of lack of institutional support like logistic, infrastructure, inadequate incentives etc. Improper implementation of policy is also a reason behind doctors' disinterest in rural placement. Moreover, weakness in monitoring leads to higher absenteeism. There are some hints of individuals' rational behaviour in the findings but those could be overcome by proper institutional support like logistics and infrastructural support. However, it is also found that income opportunity for doctors in the rural areas has very insignificant affect on doctors' decision for placement, rather children's education, spouses' job, proximity of family residence and scope of higher education have very high impact. Although, health sector is being managed by traditional authority system, but introduction of professional management system may be a solution of this problem.

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Abbreviations and Acronyms

AC Land:	Assistant Commissioner, Land
AHI:	Assistant Health Inspectors
AIDS:	Acquired Immunodeficiency Syndrome
BCS:	Bangladesh Civil Service
BMA:	Bangladesh medical association
BSMMU:	Bangabandhu Sheikh Mujib Medical University
CC:	Community Clinic
CHCP:	Community Healthcare Provider
CT scan:	Computed Tomography scan
CVD:	Cardiovascular Disease
ECG:	Electrocardiography
EPI:	Expanded program on immunization
DGHS:	Directorate General of Health Services
FRCS:	Fellow of the Royal College of Surgeons
FRCP:	Fellow of the Royal College of Physicians
HA:	Health Assistants
HIV:	Human Immunodeficiency Virus
HMIS:	Health Management Information System
HNP:	Health, Nutrition and Population
IDI:	In-depth Individual Interview
Km:	Kilometre
MBBS:	Bachelor of Medicine and Bachelor of Surgery
MD:	Doctor of Medicine
MDG:	Millennium Development Goals
MLSS:	Member of Lower Subordinate Staff
MO:	Medical officer
MRI:	Magnetic Resonance Imaging
MS:	Master of Science
MoH & FW:	Ministry of Health and Family Welfare
NHP:	National Health Policy

NGO:	Non-governmental Organization
RMO:	Resident Medical Officer
SACMO:	Sub-Assistant Community Medical Officer
SDG:	Sustainable Development Goals
UHC:	Upazila Health Complex
USC:	Union Seb-centre
UHFWC:	Union Health and Family Welfare Centre
UH & FPO:	Upazila Health and Family Planning Officer
UN:	United Nations
UNICEF:	United Nations International Children's Emergency Fund
UNO:	Upazila Nirbahi Officer
WHO:	World Health Organization

Chapter 1
Introduction

1.1 Introduction

Bangladesh health sector suffers from multi-faced problems due to limited resources, inadequate infrastructures, shortage of manpower and so on. Healthcare providers both public and private, faces the shortage of manpower, more specifically inadequate doctors. Number of registered doctors all over Bangladesh per 10,000 population is 4.90 and number of doctors working under the ministry of health and family welfare (MoH & FW) per 10,000 persons is 1.43 (MoH & FW, 2016). This ratio is not equally applicable for rural and urban areas. Rural areas are deprived of quality health services because of inequitable distribution of human resources. The health policy of the government of Bangladesh intends to make up the gap between urban and rural areas in terms of providing quality health services. Therefore, government is trying to send doctors to the rural areas as many as possible. Still, the vacant posts are more in rural areas than that in urban areas. Absenteeism is also higher in the rural areas compare to urban. Bangladesh is now in the path of achieving the third goal that is ``to ensure healthy lives and promote well-being for all at all ages'' (United Nations, 2017), stated in Sustainable Development Goals (SDG)[1], but it will not possible to meet achieve the targets without ensuring equal health facilities in rural and urban areas.

However, equal and quality health services delivery for all will not be possible without adequate manpower in rural areas. On the other hand, it is found that, doctors are not interested to work at rural health facilities.

On this backdrop, this study attempts to find out the reasons why doctors are more interested in urban placement than rural placement. This chapter aims to discuss the introductory aspects of the study. The chapter starts with general context and background of the study and then it explores the problem statement. It also specifies research objective, research questions and significance of the study. It also identifies scopes and limitations of the study. The chapter ends with shedding light on the organization of the chapter of this thesis.

1.2 Background of the study

Bangladesh is one of the countries that have shown a tremendous success in achieving Millennium Development Goals (MDG)[2], especially the targets in the health sector. Bangladesh is well on track in meeting the target of the goals related with health like reduce child mortality, improve maternal health and combat HIV/AIDS, malaria, and other diseases.

Maternal mortality ratio (deaths per 1,00,000 life birth) was 569 in 1990 and 399 in the year of 2000. The rate sharply dropped down to 176 in 1995 (Directorate general of health services, 2017a), which was one of the highest in the world, whether the MDG target was 144 (United Nations, Bangladesh, 2017). Bangladesh achieved the MDG target of reducing the under-five mortality rate (deaths per 1,000 live births) before the stipulated time. The rate was 133 in 1993 which has come down to 46 by 2014 (Directorate general of health services, 2017a), whereas MDG target was 50 (United Nations, Bangladesh, 2017).

Despite this achievement, a large number of people in Bangladesh are still out of quality health coverage, especially the rural areas. One of the main reasons of this is the scarcity of doctors in the rural areas. As the rural health facilities are located in very remote areas, so the people of those areas are already suffering from inadequate supply of logistics and infrastructures because of their remoteness.

Moreover, scarcity of doctors is added more pressure in getting quality health service in those areas. Doctors are supposed to provide services irrespective of their working places. Sometimes, it is found that doctors are eager to manage a better posting for their personal interest. It may hamper of providing quality service to the patients. Patient's service may be interrupted because of their utilitarian behaviour. Private practice is also can be a factor for doctors' personal interest over patient's interest. Because, if doctors try to practice privately more than to concentrate on their duties, then the patients of public health facilities do not get proper service. Moreover, service can be expensive which is not desirable.

Above all, Individuals are supposed to behave rationally for their personal interest. However, if doctors concentrate on their personal interest ignoring professional duties, then that can create many problems. As doctors are part of an institution, so they are not supposed to go out of institutional norms to maximize their personal gain. Still, sometimes doctors show disinterest in performing duties in rural areas. This study tried to find out the factors those influence the doctors to leave the rural places to urban areas to satisfy their preference for personal gains. It also investigated the institutional factors which are responsible for doctors' disinterest in rural placement and allow them to be absented.

This study used rational choice theory as this theory deals with the individual's behaviour. According to this theory, individuals behave rationally to maximize their personal gains. Rational behaviour sometimes conflicts with the institutional rules and regulations when the individuals are belonged to an organization. The personnel's (doctors) of health sector are no exception of that. Therefore, to counter that theory institutional theory has been used also in this study.

1.3 Problem statement

An effectively performing health sector is an essential precondition for the overall development of a society, especially primary healthcare. Chan (2017, p.8) utters in a report ‘‘When countries at the same level of economic development were compared, those with health care organized around the tenets of primary health care produced a higher level of health for the same investment.’’ However, it is found that primary healthcare facilities are suffering from different problems. One of the most critical challenges faced by the health sector of Bangladesh is in the arena of human resources for health, especially in the rural areas. Absenteeism of key health human resources (doctors) often makes matters worse (WHO, 2015). Recently a circular (See: annex A) has been issued by ministry of health and family welfare indicating absenteeism in health facilities, which showed that, countrywide absenteeism rate for the doctors was 59.75 percent and highest rate is 69.47 percent in Mymensingh division.

Shortage of manpower also is a great concern for providing proper health service. According to World Health Organization doctor-patient ratio should be 1:600 (WHO, 2015), but this ratio in Bangladesh is 1: 1,893 (MoH & FW, 2017a). This situation turns into worst in the rural areas when the health complexes suffer from the absenteeism of doctors. Besides, doctors’ tendency not to stay in rural areas and preference to take posting in the urban areas accentuate the problem. Health governance also suffers because of the scarcity of doctors in the rural areas.

As the health sector of Bangladesh suffers from shortage of manpower, so a large number of doctors are being recruited every year. To ensure the doctors presence in the remote areas, policy has been formulated accordingly to make them available in the rural health facilities. According to the posting policy for doctors in Bangladesh, entry-level medical officers (MO) are bound to serve for the first two years of their job (See: Annex B).

However, it is found from the literatures and also from government circulars that the health sector faces a problem of vacant posts and absenteeism. These problems are observed in the rural areas more than the urban areas.

It assumes that doctors tend to use their posting places to maximize their benefits. Infrastructure, logistics, transportation facilities are not adequate in rural areas as in the urban areas. Besides income opportunity for doctors is an issue because of their technical expertise. Therefore, they may tend to move to the places where there are better opportunities. As rural areas do not have enough facilities to maximize their utility, so doctors may tend to move towards the urban areas. It cannot be denied that doctors may use their posting places to maximize their personal benefits. Moreover, institutional support also plays a crucial role on employees' preference on posting. Employees usually are attracted to the places where institutional support is better. Therefore, institutional weakness may lead doctors to leave the rural posting places in Bangladesh.

When individuals belong to an institution, they need to follow the formal rules and norms. However, utilitarian behaviour may make the doctors to break those rules. Consequently, they try to ensure their placement in urban areas where they can maximize their benefits.

Because of doctors' utilitarian behaviour, the health sector governance is suffering. The rural areas are facing the scarcity of doctors and quality health services. The health services are being more expensive. Beside the doctors' utilitarian behaviour, there are some problems in institution as well which may lead the doctors to influence them to head towards the urban areas.

So, the research objective is to find out the factors those drives them to leave rural areas to urban areas. This study explores whether it is their utility maximization behaviour or poor institutional support that does not incentivize the doctors to stay in rural areas.

1.4 Objectives of the study

The main objective of this study is to find out the factors behind doctors' disinterest in rural placement. This study also tried to understand the incentives those drive the doctors to urban placement. It further investigated the institutional factors those are creating scope for their utility maximization.

1.5 Research questions

To achieve the research objective, the following research questions have been addressed: The broad research question of this study is: what are the factors behind doctors' disinterest in rural placement?

To supplement the main research question, this study came up with three specific research questions. Those are: Do the doctors prefer urban posting places mostly for income maximization? Do doctors use posting places to maximize other utilities than income? Does institutional weakness allow doctors to avoid their duties in rural workplaces?

1.6 Hypothesis

To achieve the aforementioned research objective and to clarify the research questions, this study attempts to address the following hypotheses:

Hypothesis 1: Better Income opportunity may lead doctors to move to urban areas.
Hypothesis 2: It assumes that doctors tend to use their posting places to maximize their utility.
Hypothesis 3: Institutional weakness may lead the doctors to leave rural workplaces.

1.7 Significance of the study

Individual rationality that hampers organization's goals is not acceptable when individuals work under an institution. It is supposed to follow the institutional norms by the employees rather than following their rationality when they belong to an institution. Still, some individuals behave as to maximize their personal gains. It may be because of institutional weakness or utility maximizing behaviour of doctors.

Health sector governance is a growing concern in our country because of unavailability of doctors in rural areas. However, very few literatures have been found concerning this issue. It is need to be investigated the actual reasons behind the doctors' disinterest in the rural placement. It may be because of institutional weakness in our country or may be the doctors' behaviour that accentuates the problem. So, this study tried to explore the reasons behind such attitude by the doctors which may help to bring back proper governance in the health sector by formulating policy accordingly.

1.8 Rationale of the study

Most of the people of Bangladesh are living in rural areas. Their medical facilities are not adequate. In spite of many limitations, government is trying to ensure proper health services in the areas. However, the sector is facing several problems. One of the problems is inadequate doctors in rural areas. Government is trying to solve this problem with different policies. However, sometimes, it does not work. As it is observed that, doctors are may not interested to stay in the rural health complexes. If the policy makers cannot identify the conclusive reason of their disinterest to serve in the Upazila[3] or Union[4] level, then it is not possible to formulate exact policy to make them stay in the areas.

Therefore, this study may help to find out the reasons behind doctors' attitude toward rural placement, which may help policy makers to formulate policy accordingly.

1.9 Scope and limitations of the study

This study is about to explore the factors that drives doctors to leave the rural posting places to urban areas. Although this is very familiar phenomena in Bangladesh, but very few study has been done in this issue, especially on doctors' behaviour. This study has examined in the Upazila and Union level health complexes in Ghatail Upazila of Tangail district[5].

It would be better if this study could deal with the doctors' overall behaviour towards maximization of benefit, but because of time constraint, it deals with only the attitude of doctors towards rural placement. Targeted groups are busy with their duties and their disinterest to answer the questions is another limitation of this study.

1.10 Organization of the chapters

The present study is divided into six chapters. The first chapter contains background of the study, statement of the research problem, objectives and significance of the study, scopes and limitations of the research, research questions and hypothesis. Second chapter of this thesis presents the overview of health sector of Bangladesh which includes different level of health facilities and authorities, policy and regulations related to health sector, and a brief discussion about study area.

Chapter three of this study discussed related literatures on different aspects of institutions and previous studies regarding doctors' behaviour which helped the researcher to be familiar with the influencing factors of research problem. Theoretical discussion also included in this chapter. Rational choice theory and institutional theory has been used in this study as theoretical framework. According to rational choice theory, individuals choose the best options among the available alternatives. It seems Bangladesh health sector also may have implication of this theory. This study tried to see the relationship between institution and individuals, which is how individuals behave within institutional structure. Therefore, institutional theory also used in this study.

The fourth chapter deals with the methodology of this thesis which includes analytical framework, data collection method etc. The fifth chapter presents the data gathered from the field and its analysis in the basis of analytical framework. The sixth and final chapter attempts to summarize the findings. This chapter also make a discussion on theoretical implications and policy implications.

1.11 Conclusion

Health sector is a very important sector for every country and doctors are one of the main driving forces of this sector. Therefore, it is very important to know about the problems related with the doctors to provide better service delivery. This research bears a significance to investigate the reasons behind the doctors' disinterest in rural placement as very few studies have been done before in this regard. To find out that, this research takes a broad research question that is: why doctors are not interested to the rural placement? This research takes the main hypothesis in this regard that: it assumes that doctors tend to use their posting places to maximize their personal gains.

Government employees are bound to serve where they are posted. Doctors are no exception of that. Still, doctors may try to take a suitable posting where they can maximize their benefit. It may arise a conflict as doctors are supposed to abide by the norms of an institution. So, this study attempts to find out the reasons behind the doctors' behaviour towards rural placement. This chapter gives an idea of the research problem and importance of this study. It also tries to provide the scope and limitations of the study. Finally, it gives a short overview of the organization of this research where it discussed the chapter's content of this research.

Before going to main discussion, it is important to know about the health system of Bangladesh to understand how the sector is organized, which institutions and mechanisms are involved with it, different rules and regulations and how this sector is performing.

Therefore, the next chapter is going to discuss about the organizational structure of health sector in Bangladesh, health policy, related rules and regulations, different level of health facilities and so on. It will also focus on the logistics and manpower in the health facilities, geography and infrastructures of the study area.

Chapter 2

Overview of the health sector of Bangladesh

2.1 Introduction

This chapter specially aims to gives a brief idea of health sector and the related components in Bangladesh. The organizational structure from the top level to root level will be discussed here to understand supervisory and monitoring system of health sector. It will also discuss the rules and available resources by which the organization provides health service to the people. To explain the findings, it also needs to understand the study area and the structure of health service delivery system in Ghatail Upazila. Therefore, an overview of Ghatail Upazilla health system is also discussed here as well. This chapter also describes the health policy and other rules related with health governance.

The health system of Bangladesh is multi-faced, with four key actors that define its structure and function: government, the private sector, non-governmental organizations (NGOs) and donor agencies. The government or public sector is the first key actor who, by the constitution, is responsible not only for setting policy and regulation but also for providing comprehensive health services, including financing and employing health staff. The MoH & FW, through the directorate general of health services (DGHS) and the directorate general of family planning (DGFP) provides health services. The ministry manages a dual system of general health and family planning services through district hospitals, Upazila health complexes (UHCs), Union sub-centres (USCs), Union health and family welfare centres (UH & FWCs), and community clinics (CC) at ward level.

2.2 Administrative structure of health system

The government of Bangladesh has formulated health policy to provide satisfactory health services and to achieve an acceptable standard of health governance. The main objective of the health policy of Bangladesh is to ensure primary health care and emergency treatment for all. One of the main purposes of this policy is to develop an organized, sustainable and equitable health services for individuals and community in regional level (MoH & FW, 2017b). The policies, plans and decisions at the national level for healthcare and education are implemented by different implementing authorities in the field level supervised by MoH & FW.

There are 9 implementing authorities and 5 regulatory bodies under the ministry of health and family welfare. Those are:

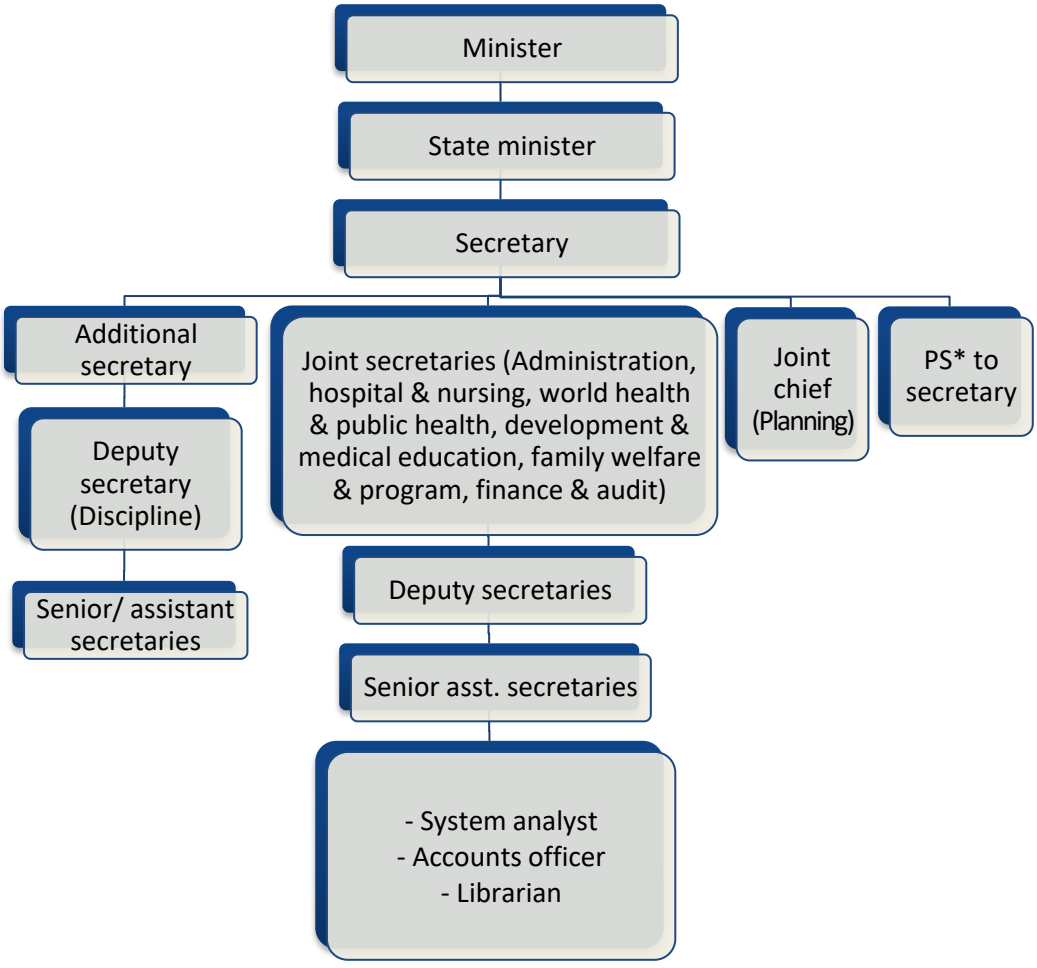
1. Directorate general of health services (DGHS)
2. Directorate general of family planning (DGFP)
3. National institute of population research & training (NIPORT)
4. Directorate general of drug administration (DGDA)
5. Directorate general of health economics unit (DGHEU)
6. Directorate general of health engineering department (DGHED)
7. Directorate of nursing services (DNS)
8. Transport & equipment maintenance organization (TEMO)
9. National electro-medical & engineering workshop (NEMEW)

The regulatory bodies are:

1. Bangladesh medical & dental council (BMDC)
2. Bangladesh nursing council (BNC)
3. State medical faculty (SMF)
4. Homeo, unani and ayurvedic board and
5. Bangladesh pharmacy council

The MOH & FW is responsible for planning and formulating policy. The ministry is headed by the minister and is assisted by the state minister. As the principal executive of the ministry, the secretary works with a team of officials, including additional secretary, joint secretaries/joint chiefs, deputy secretaries/deputy chiefs, senior assistant secretaries/senior assistant chiefs, and others (Figure 2.1).

Figure 2.1: Organogram of the ministry of health and family welfare



Source: Ministry of health and family welfare, 2016

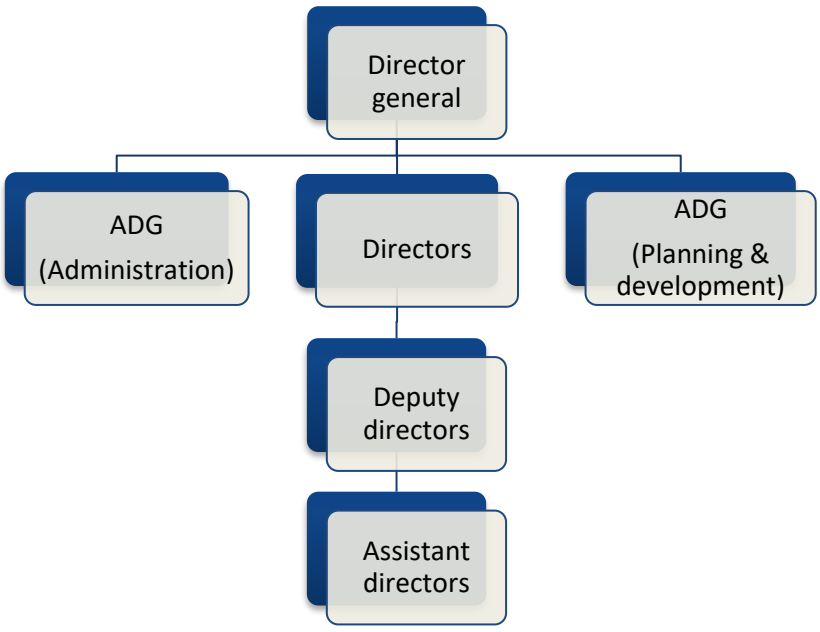
* PS – Private secretary

Responsibility for financing, functionaries, supplies, maintenance and infrastructure development for service delivery lies with the ministry. It also manages appointment, transfer, posting and salary of frontline service providers, although selection of some field-level staff (4th grade) is done at the district level (MoH & FW, 2016).

2.3 Directorate general of health services (DGHS)

As the study area of this thesis is under the DGHS, so here it discussed the organizational structure of this organization only. DGHS is the largest implementing authority under the MoH & FW. Along with the operation of health care delivery systems in the country, the DGHS provides technical assistance to the ministry in undertaking new programs and interventions and for improvements in the existing ones. The healthcare-delivery systems under this authority extend from national to the community level.

Figure 2.2: Administrative setup of the directorate general of health services



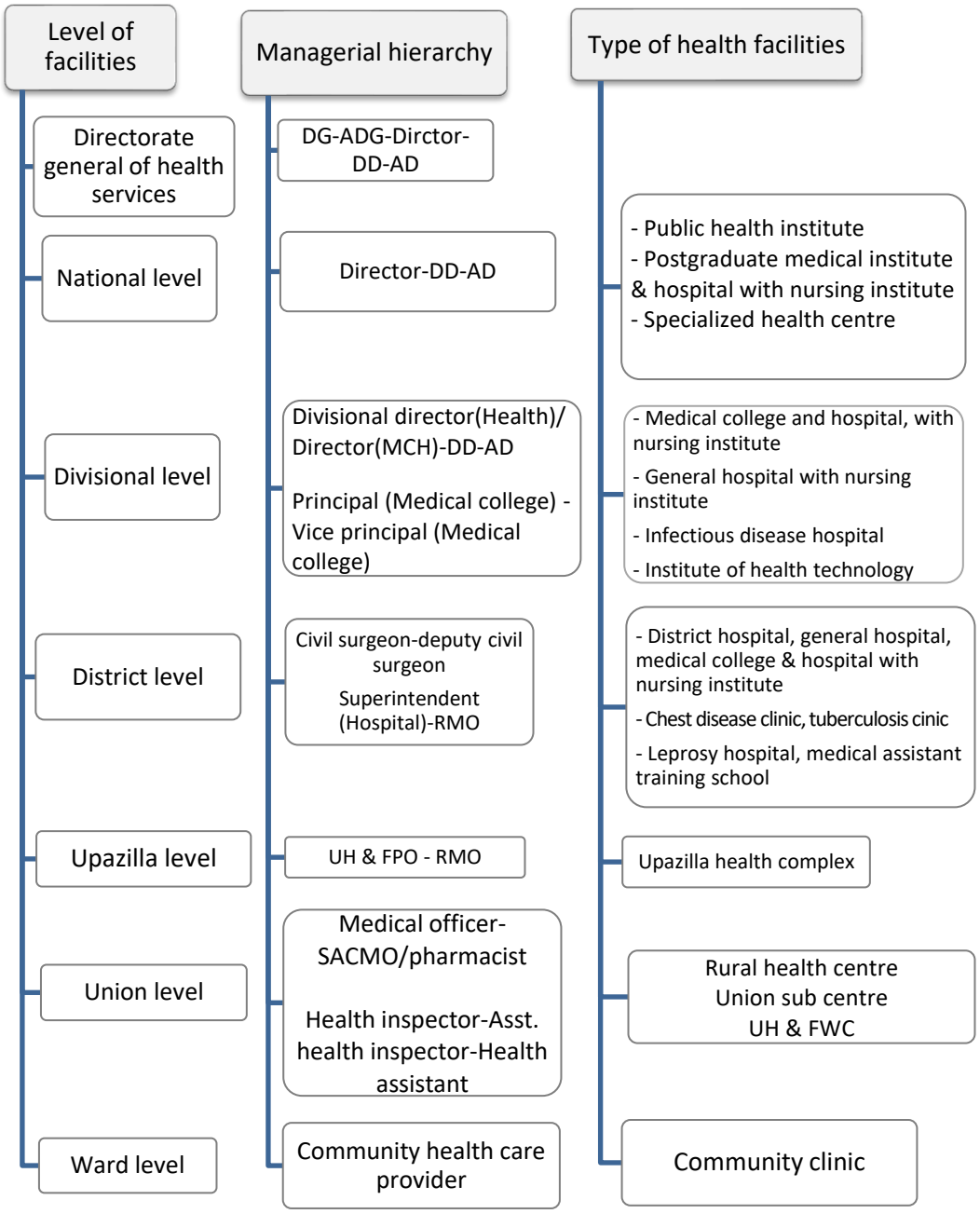
Source: Ministry of health and family welfare, 2016

The healthcare infrastructure under the DGHS comprises six tiers: national, divisional, district, Upazila, Union, and ward (Figure 4.3). At the national level, there are institutions both for public health functions as well as for postgraduate medical education/training and specialized treatment to patients. A divisional director for health in each division governs activities and is assisted by deputy directors and assistant directors. There is one infectious disease hospital and one or more medical college(s) at the divisional headquarters. Each medical college has an attached hospital. Some divisional headquarters also possess general hospitals and institutes of health technologies. Divisional institutes provide basically the tertiary-level care.

The civil surgeon (CS) is the district health manager responsible for delivering secondary and primary care services. In each district, there is a district hospital. Some district hospitals have superintendents to look after the hospital management. In others, civil surgeons look after the district hospitals. Some of the district headquarters have medical colleges with attached hospitals, medical assistants' training schools, and nursing training institutes.

Primary health care is managed by a three-tiered Upazila health management system. Upazila health complex is the main institutional hub providing primary health care. The next step below the UHC is Union sub-centres, those are located at union level, next below in the hierarchy are the community clinics which also provide vertical referral system. Therefore, primary health care is delivered through the UHC, union sub-centres and the community clinics.

Figure 2.3: Types of organizations and facilities under the DGHS from national to the ward level



Source: Ministry of health and family welfare, 2016

(* DG- Director general, ADG- Additional director general, DD- Deputy director, AD- Assistant director)

The MoH & FW planned to establish one community clinic (CC) for every 6,000 people, with a total of 13,861 CCs in the country. The existing Union and Upazila facilities also provide community clinic services. Currently (up to 31 July 2016), 13,336 CCs are in operation (MoH & FW, 2016). These facilities are mainly responsible for delivering primary healthcare services, like EPI (Expanded program on immunization), treatment for common diseases (pneumonia, fever, cough, etc), family planning services, health education, first-aids and serve as the first contact points for patients.

Table 2.1: Infrastructures of health sector in Bangladesh (as on July 2017)

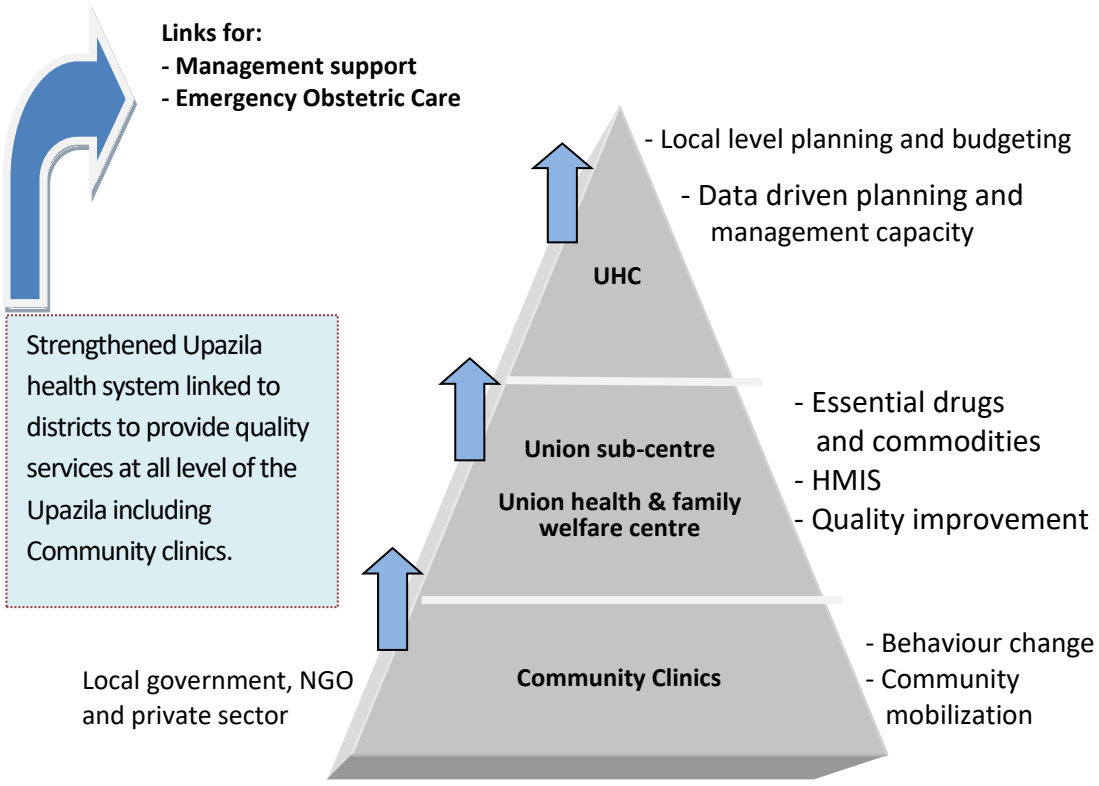
Health expenditure per person	Number of hospitals		Number of beds in the hospitals		Number of registered doctors, nurses and paramedics			Doctor-patient ratio
	Public	Private	Public	Private	Doctors	Nurses	Paramedics	
2542 taka (US $31)	610	4596	48976	78426	87237	41697	11976	1:1,893

Source: Ministry of health and family welfare, 2017a

At the ward or village level, there are also domiciliary health workers – one for every 5,000 to 6,000 people. There are 26,481 sanctioned posts of domiciliary workers under the DGHS: 20,877 health assistants (HA), 4,205 assistant health inspectors (AHI), and 1,399 health inspectors (HI) (MoH & FW, 2016). The DGFP also has domiciliary family planning staff working at the ward level. Currently, the domiciliary staff members from DGHS and DGFP share the responsibility of running the community clinics, along with the community healthcare provider (CHCP).

There are three kinds of health facilities are found at the union level. Those are: rural health centres, union sub-centres, and UH & FWCs. There is a medical doctor among other staff in each union-level health facility. Only outdoor services are available at the union level. Sub assistant community medical officers (SACMO) are employed in all union sub-centres to provide health services (MoH & FW, 2016).

Figure 2.4: Upazila health system in Bangladesh



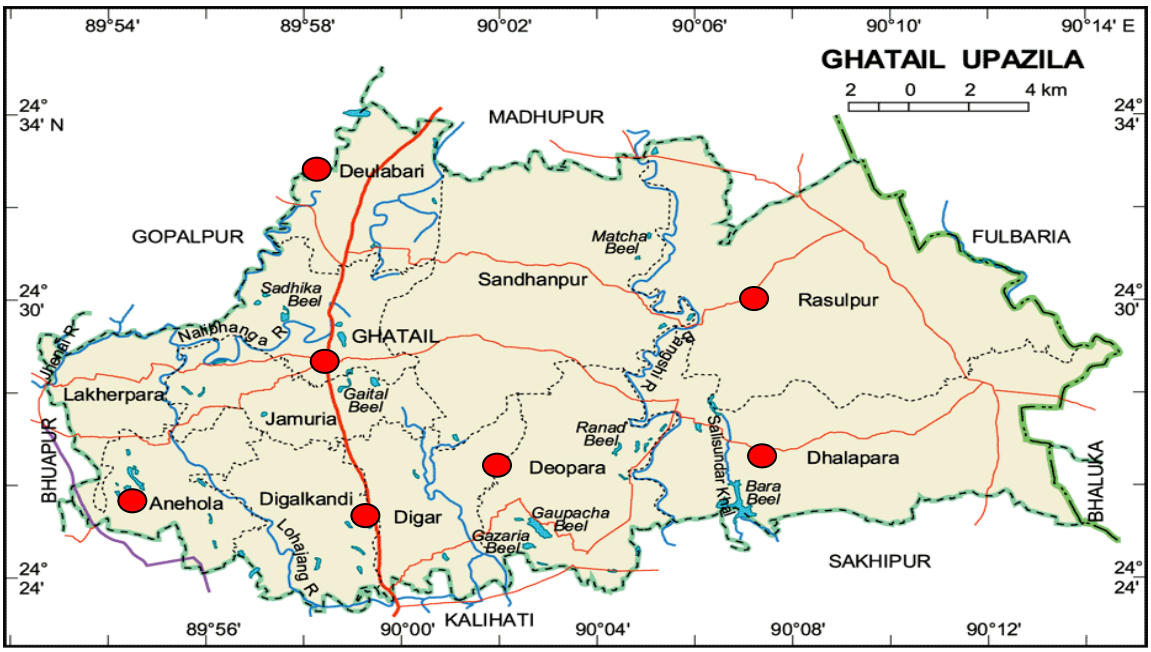
Source: CIDA project, 2017

The health facilities found in the Upazila and Union level are mainly supervised by DGHS and DGFP. This study discusses only about the facilities under the DGHS as Upazila health complex and Union sub-centres are under this organization. At the local level, the health administration is fully controlled by the MoH & FW. The field-level health administration is responsible for implementing government programmes by managing the huge number of health staff and coordinating their activities.

2.4 Ghatail Upazila and the health facilities: at a glance

Ghatail Upazila is located about thirty kilometres far from Tangail. The total area of this Upazila is about 451.30 square km (Bangladesh national portal, 2017). The Northern and western part of this Upazila is low land and plain land. In some portion of the eastern part of it is forests and hill-land. Total population of this Upazila are 4,34,300 among them male are 2,13,526 and female 2,20,804 (Bangladesh national portal, 2017).

Figure 2.5: Map of Ghatail Upazila



Source: Prime minister's office library, Dhaka, 2009

Note: ● indicates visited Unions.

Total length of roads of this Upazilla is 808 km, among those only 191 km roads are bituminous or concrete road (Bangladesh national portal, 2017). So, there are some problems of communication within this Upazila. Besides, the roads of hills and forest area are broken.

Table 2.2: Basic information of Ghatail Upazila

Name of the division	Dhaka
Name of the district	Tangail
Name of the Upazila	Ghatail
Number of Unions	11
Name of the Unions	Ghatail, Jamuria, Anehola, Dighalkandi, Digar, Deopara, Shondhanpur, Rasulpur, Dhalapara, Lokerpara, Deolabari
Number of 50-beded hospital (UHC)	1
Number of Union centre	5
Number of Union sub-centre	6
Community clinics	55

Source: Directorate general of health services, 2016

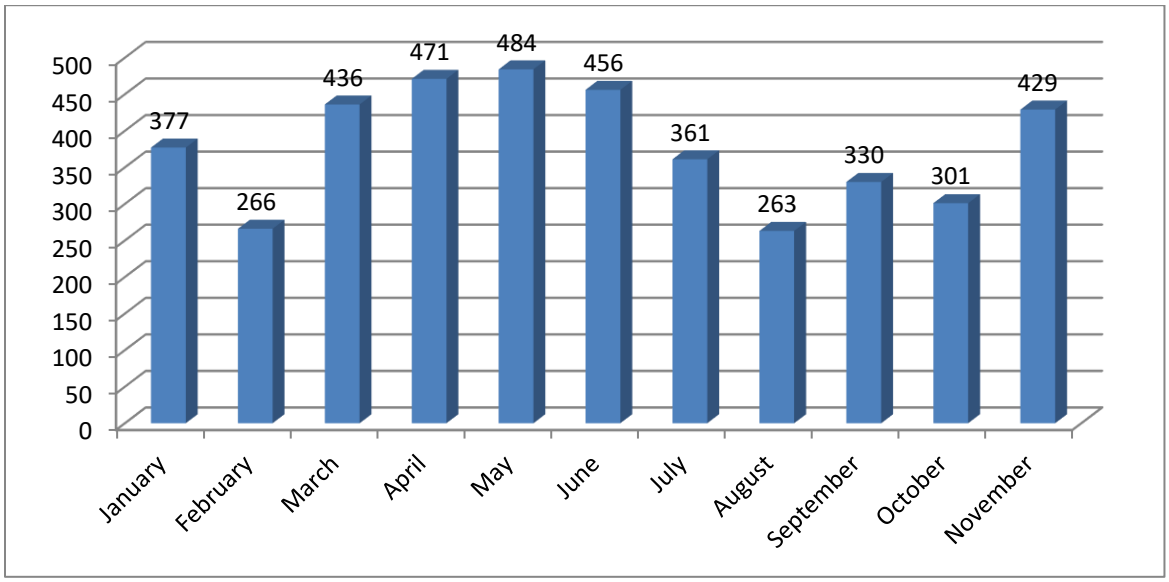
The Upazila health & family planning officer (UH & FPO) is the health manager at the Upazila level. She/he manages all public-health programs, especially the primary healthcare services in the Upazila and also looks after the Upazila hospital. The Upazila where the district headquarter is located does not have an Upazila hospital, and there, the Upazila hospital service is provided by the district hospital

2.4.1 Ghatail Upazila health complex and Union sub-centres (Manpower and equipment)

Ghatail Upazila is very near to Dhaka. As Dhaka is the capital, so most of the doctors are concentrated there. Even though Tangail is adjacent to Dhaka, doctor-patient ration in Tangail is way behind Dhaka district. Number of doctors is 28.64 per 10000 persons in Dhaka, where the number of doctors are only 0.6 for same number of people in Tangail district. The scenario is same in case of hospital beds as well. There are 26.37 beds for 10,000 persons in Dhaka district and only 1.86 for Tangail district (Directorate general of health services, 2017b).

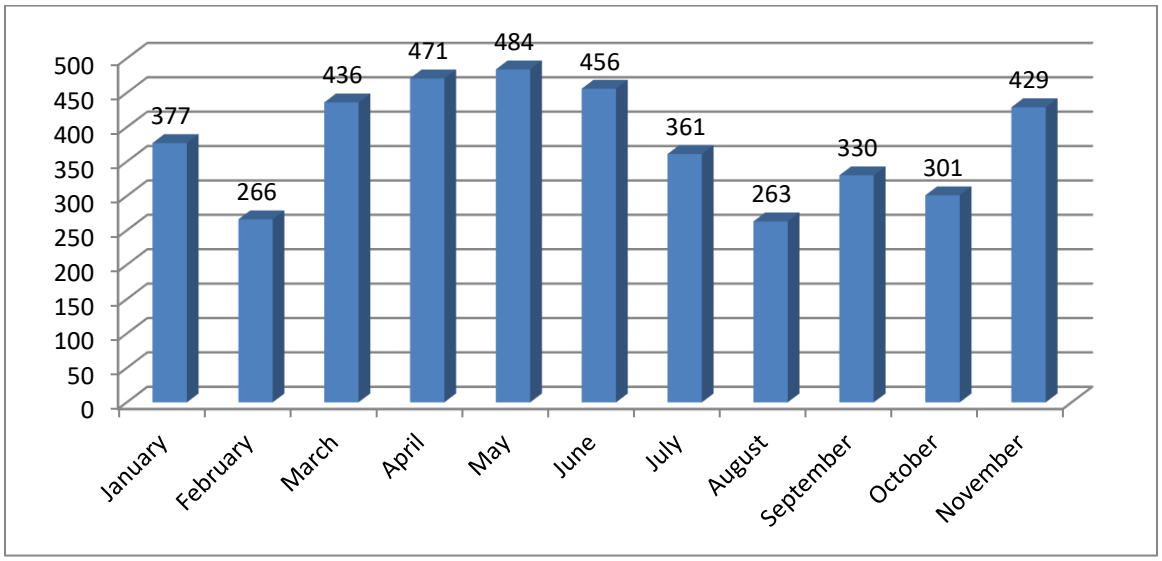
It was found from DGHS (2017) data that on an average over 3,000 patients visits outpatient department (OPD) and around 400 patients visit emergency department in a month (Figure 4.5 and 4.6).

Figure 2.6: Number of patients visit in Outpatient department at Ghatail Upazila health complex in 2017



Source: Directorate general of health services, 2017c

Figure 2.7: Number of patients visit emergency at Ghatail Upazila health complex



Source: Directorate general of health services, 2017c

Abovementioned data of outpatient visit and emergency visit explores that there are significant number of patients visit UHC every day. To provide proper health service to this large number of patients, adequate doctors are needed. However, the sanctioned posts for the doctors are 32 and available doctors are 19 in UHC. It means 40.63% posts are vacant (Table 4.3).

Table 2.3 Manpower structure (Doctors) of Ghatail Upazila health complex

Total Sanctioned	32
Total available	19
Total vacant	13
Total vacancy (%)	41
UH&FPO available	1
RMO available	1
Junior consultant sanctioned	10
Junior consultant anesthetist available	1
Junior consultant obstetrician/gynaecologist available	1
Grade 9 doctor sanctioned	21
Grade 9 doctor available	13
Grade 9 doctor vacant	8
Grade 9 vacancy (%)	38
BCS 33 doctor available	7
Junior consultant anesthetist available	1
Junior consultant obstetrician/gynaecologist available	1

Source: Directorate general health services, 2017b

Among the available doctors, sometimes some are absented from the duty. Besides, there are some consultant posts in Upazila level, but many of those posts are vacant. These statistics indicate the scarcity of doctors in this Upazila.

Table 2.4: Manpower data of Union sub-centres in Ghatail Upazila

Facility name	Designation/ Group	Sanctioned	Filled	Vacant
Anehola	Medical officer	1	-	1
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	3	1
Brahmmonshashon	Medical officer	1	-	1
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	3	1
Deopara	Medical officer	1	-	1
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	3	1
Dhalapara	Medical officer	1	-	1
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	3	1
Pakutia (Deolabari)	Medical officer	1	-	1
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	3	1
Raghunathpur (Rasulpur)	Medical officer	1	1	-
	Pharmacist	1	1	-
	SACMO	1	1	-
	MLSS	1	1	-
	Sub-total	4	4	-

Source: Ghatail Upazila health complex's manpower report, 2017

There are six Union sub-centres in this Upazila. Each USC has a medical officer post. Among those USCs, only one MO is available and others are vacant. On the other hand, SACMOs are available in each Union facility.

2.4.2 Equipment at Upazila health complex

Health related equipment is part and parcel of better service delivery. Medical devices allow doctors to perform their functions effectively and efficiently. Table 4.5 shows the state of equipment in Ghatail UHC.

Table 2.5: Number of equipment in Upazila health complex

Equipment	No. of available	No. of functional	No. of repairable
Ambulance	1	1	0
Anaesthesia machine	0	0	0
Autoclave	0	0	0
Defibrillator	0	0	0
Desktop computer	8	8	0
Diathermy	0	0	0
ECG	1	1	0
Endoscopy	0	0	0
Microscope	5	5	1
X-Ray	1	1	0
Ventilator	0	0	0
CT scan	0	0	0
MRI	0	0	0
Ultra sonogram	0	0	0

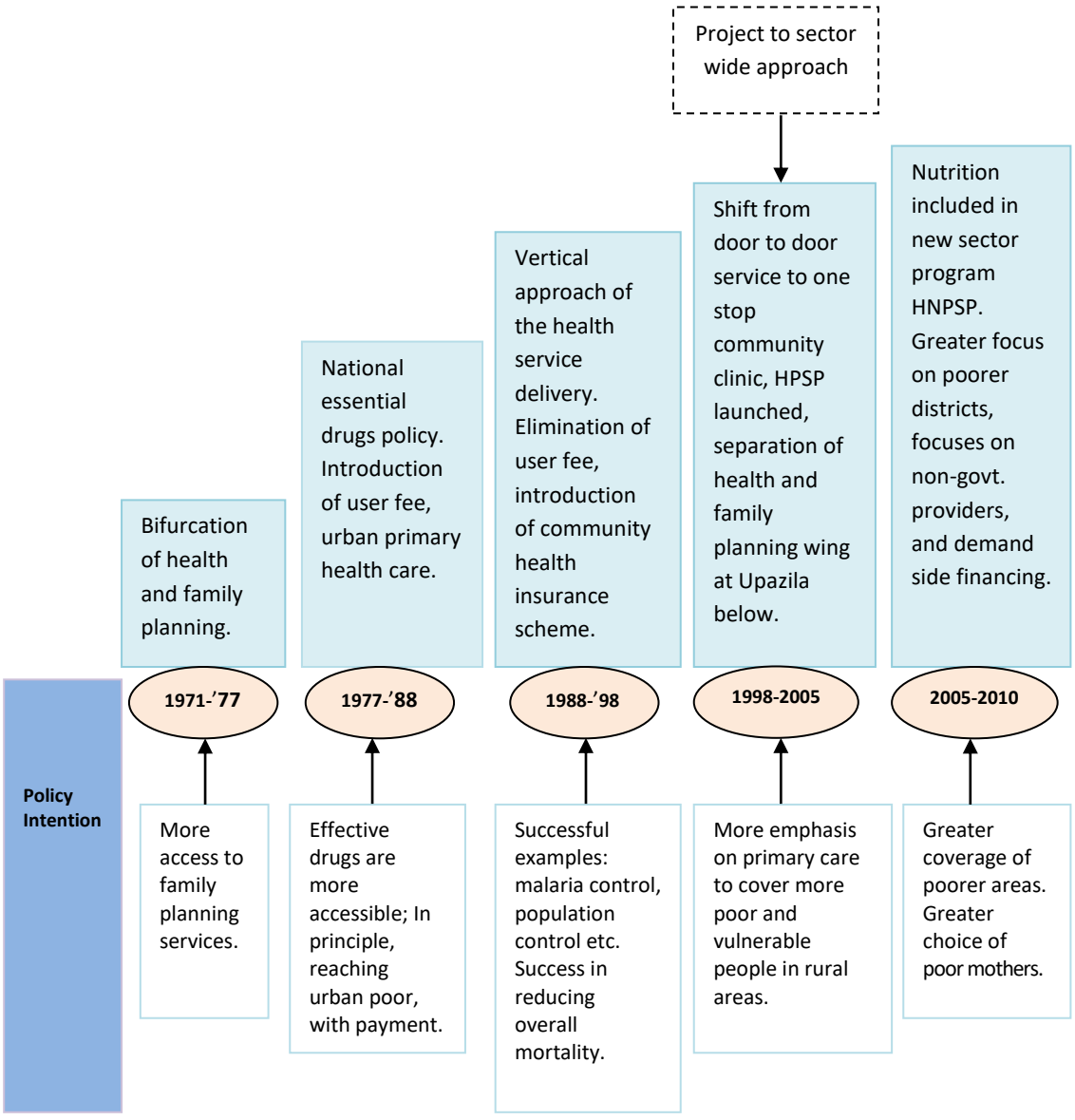
Source: Directorate general of health services, 2017c

To meet up the demand of large number of patients, equipment is not adequate in UHC and Union sub-centres. There is only one ambulance for entire Upazila. So, it cannot ensure emergency service for critical patients. There are many necessary medical equipment those are not available in this UHC, i.e.: anesthesia machine, endoscopy, CT (Computed tomography) scan, MRI (Magnetic resonance imaging) machine, ultra sonogram etc.

2.5 Health policy and its' reforms

The constitution of Bangladesh (section 2, article 18) asserts that the state shall raise the level of nutrition of its population and improve public health as some of its primary duties (The people's republic of Bangladesh, 2014). In line with this broad legal framework, the health sector has developed policies and programmes which are implemented through the central control of the MoH & FW.

Figure 2.8: Major shift in Bangladesh health sector



Source: BRAC (Bangladesh rural advancement committee), 2012

Bangladesh did not have a consistent health policy for the first three years of independence. Immediately after the independence, population control received the top most priority. An objective was assert in first five-year plan (1973-1978) to create rural health infrastructure for providing better services. The World Bank became involved with an appraisal for a first population project which was based on vertical family planning service delivery and the bifurcation of the health and family planning services of MoH & FW. The family planning programme was largely supply-driven and incentive-based since the mid-1970s until 1990s. In the early 1980s, Bangladesh led the world in formulating an essential drug policy, the national drug policy (Drugs control ordinance, 1982). Health and population sector programme (HPSP) was launched in 1998 for five years to improve the health of women, children and the poor. During HPSP the policy was targeting more resources towards facilities at Upazila and below as lower income groups predominantly use these facilities. Nutrition and population sector programme (HNPSP) started after 2003, when HPSP ended (BRAC, 2012).

Prior to the sector-wide approaches, health sector interventions were carried out mainly by the successive Five-year plans since independence. In each of the Five-year plans, focus in health sector was primarily made towards provisioning primary health care, though the modalities of service delivery shifted from time to time (Haque, 2015, pp. 24-25).

The latest revised health policy is known as national health policy (NHP) 2011. It was first approved by parliament in 2000. The key objectives of the first policy include: providing basic health services to the people at all levels, particularly to the poor; ensuring the availability of primary health-care services at the union and Upazila levels; improving maternal and child health and reproductive health services; and strengthening family planning services. The latest policy revision in 2011 emphasized primary health and rural health, include the provision of health cards for the ultra-poor and deprived.

The main objectives of this policy are to ensure primary health and emergency treatment for all, to increase and expand the availability of service receiver-centric quality health service on the basis of equality and to motivate the people to receive service on the basis of right and esteem to prevent and control diseases (MoH & FW, 2017b). To achieve those objectives, there are some principles and strategy has been taken. One of the most important principles of this policy is to deliver primary health service to every citizen in Bangladesh. Besides, it also gives emphasis to ensure the use of limited resources to solve the most important health related problems of deprived, poor, marginal, aged, physically and mentally challenged people.

It is also taken in consideration in the principles to engage the people in every sphere of planning, management and service delivery system to decentralize health management. Besides, this policy also concentrates on fair and expectable administrative re-arrangement, decentralization of service delivery system by formulating human resources development strategy which is compatible with necessity.

The objectives cannot be achieved if the implementing agencies do not comply the principles of policy. Therefore, the policy is discussed here as this study examined the compliance of the rules and regulations in the field level.

2.6 Regulations

Several laws, rules and regulations are there to control, manage and ensure quality health services. Parliament has enacted various acts in this regard like drug control acts, medical education acts, health practice acts and environmental health acts. The parliamentary standing committee also constituted for the ministry of health and family welfare under the rules of procedure of Bangladesh parliament, 2007 (rule 246) which serves as a watchdog of the ministry.

There are some ordinances as well to regulate health service activities like drug ordinance of 1982, the Bangladesh college of physicians and surgeons order 1972 (presidents order number 63 of 1972), Bangladesh nursing council ordinance 1983, medical practice, private clinics and laboratories ordinance 1982 etc.

2.7 Conclusion

The public health system of Bangladesh is highly centralized, with planning undertaken by the MoH & FW and little authority delegated to local levels. The health information system suffers from the separation of the ministry into the DGHS and the DGFP, with separate and distinct reporting systems for each. While there exists a number of acts and ordinances to regulate the health system, including regulation of different types of providers, practice facilities and NGOs, many of these legal instruments date from several decades ago. Separate councils for the registration and licensing of medical practitioners, dentists, and nurses have been established, but their authority to investigate and discipline providers is weak.

This chapter gives a glimpse of Bangladesh health sector and overview of the study area. From the above discussion, it is found that there is a great deal of deficit in desirable manpower in health sector and also scarcity of equipment and logistic support. Although, the policy and rules related to Bangladesh health sector are aiming to provide necessary health service for all but the logistic support are not enough to achieve that goal. It is really a great challenge for Bangladesh health sector to provide essential and quality service with inadequate manpower and logistics support. However, policy, rules and institutional capacity sometimes can create an arrangement to reach organizational goals with its limited resources. The next chapter will discuss how those factors are functioning in providing health service according to health policy. Finally, the chapter will discuss theoretical and analytical framework used in this study.

Chapter 3

Literature review and theoretical discussion

3.1 Introduction

Individuals always tend to behave rationally to maximize their personal gains. Before taking any decision, individuals calculate cost and benefit of their decision. They prefer the way which gives them the maximum benefit. Doctors also may face this tension of decision making in case of their placement. If they are posted in the rural areas, the placement may not provide the maximum benefit that doctors would prefer. However, as part of institutions, it is not desirable that doctors are behaving rationally to maximize their personal benefits. They are supposed to provide service following the rules and regulations of the institutions they belong to. Still, it is seen that, sometimes doctors are not interested to rural placement and try to avoid to be posted there.

The objective of this chapter is to offer a literature review which is related with the doctor's behaviour towards utility maximization in Bangladesh and other countries as well. This chapter also talks about the theories related to 'choice behaviour' and institutions from which independent variables of the present study have been picked up to analyse the research problem thoroughly. After reviewing the related literature and theoretical models, an analytical framework has been developed to understand the factors affecting doctors' behaviour.

3.2 Literature review

According to Aminuzzaman (2011), literature review provides a scope to look at the findings of other researchers and also limit the scope of inquiry, which helps the researcher to focus on the researchable topic. It also helps to find out which area of a particular topic should be researched on. The principle aim of this section is to discuss the related literatures of the doctors' benefit maximization and find out the research gap.

3.2.1 Rational behaviour of doctors

This study focuses on the disinterest of doctors in rural placement. Because of their lack of interest in rural posting, two major situations derive -absenteeism: doctors are posted in a station but not attending there regularly and withdrawing: doctors withdraw themselves from a posted place to a better posting place.

Chaudhury and Hammer (2004) also identifies two problems related with providing public service in rural areas. One problem is unwillingness of doctors: that is, many employees are not interested in rural placement. As a result of their disinterest those posts are vacant. The other is that even when the post is filled, 'the provider often fails to show up'. They also came up with two hypotheses those are related to the difficulties in retaining doctors in the rural medical centres in Bangladesh. One hypothesis is that ''most medical practitioners in developing economies are urban-born and reared, are highly educated compared with the population as a whole, and have skills that are highly marketable''. As most of the doctors are habituated in urban life and got quality education, so they want to provide same opportunity to raise their children with the same advantages they got before. Another hypothesis is that, ''as medical skills are marketable and greatly in demand, there is usually a ready opportunity to make money as a private provider outside (and sometimes inside) the public clinic, whether legal or not'' (Chaudhury and Hammer, 2004. pp. 3-4). They conclude with two major problems: one is unavailability of doctors to serve in rural areas and another is to have them give up their private earning opportunity to provide services in the public facility.

Hossain et al. (2007) conducted a study to explore the incentives and constraints of government doctors in primary healthcare facilities in Bangladesh. They found in their study that social, personal and domestic factors influence doctors' motivations to be present or to perform in rural health facilities. The social factors they identified are: mismatch of social status and level of income, and also living conditions. Weighing up the relative advantages of private and government medical service, ethical and professional status issues also considered by the doctors. Besides, moral and humanitarian considerations sometimes are the sources of motivations for working in the low-paid government health service. Job security, regular pay and benefits, and the important status of government doctor are identified as positive aspects of working in government health facilities. The main domestic factors are high quality schools for children's education and spouses jobs.

Liu and Mills (2007a, p. 186) state that, the nature of doctors utility function can be understood through investigation into the doctors' objectives in medical contact with the patient, the expectation of the doctor in the process of interaction with the patient, and the arguments that may enter into the doctor's utility function. They also identified doctor as an economic individual. Therefore, the income-seeking motive is a stimulus for their work.

They characterized doctors' behaviour by three approaches: utility maximization models, income maximization models, and target income models (Liu and Mills, 2007b, pp. 196-198). According to the utility maximization hypothesis, doctors would behave to make the effort (including inputs such as time, working intensity, and monetary inputs) up to the point where the marginal utility of each unit of effort is equal for the different elements of the utility function. The implication of this hypothesis is that the doctor's behaviour cannot be directed only by monetary incentive. Regulations or policies that focus on other elements of the utility function may work equally well. The income maximization models assume that income (or profit) is a dominant element that affects the doctor's behaviour, that the doctor's behaviour is driven by income. The target

income hypothesis predicts that, if the doctor is paid less than he expects, he will behave like an income maximizer and do what he can (e.g., inducing patient demand) to maximize his income. If paid the target income or more, the doctor will be more likely to behave in a way that satisfies other wants and needs.

From the above literature, it is found that if doctors' have any opportunity then they may seek that opportunity to maximize their utility or income. This utilitarian behaviour not only towards to income but that may also for family or other non-monetary advantages.

From the above literature, it is found that if doctors' have any opportunity then they may seek that opportunity for utility or income maximization. This utilitarian behaviour not only towards to income but that may also for family or other non-monetary advantages.

World Bank (2007) conducted a survey on strengthening management and governance in health, nutrition and population (HNP) sector of Bangladesh to offer the Government to improve HNP service delivery for all, particularly for the poor and vulnerable. The survey found extensive private practice by Upazila doctors during office hours. The main findings are: doctors engage in private practice inside and outside the Upazila health complex; doctors actively encouraged public patients to visit them in their private offices; private practice within the UHC is an "open secret"; fee-paying patients go directly to the doctor's room, while others must wait for care. It also found that, private practice during office hours is a leading cause of absenteeism.

Rajbangshi et al. (2017, pp. 51-58) conducted a research on rural recruitment and retention of health workers across cadres in India to identify motivations for, and challenges of rural recruitment and retention of health workers including doctors, nurses. They found that health workers' decision to join rural service is strongly associated with rural background and community attachment, regardless of cadre or contract. On the other hand, the challenges the study found in this regard are poor

working and living conditions; low salary and incentives; and lack of professional growth and recognition. The lack of educational opportunities for children in rural areas was explicitly expressed as a major challenge to rural service. On the contrary, opportunity to serve and represent their own community was a specific motivation that brought health workers to rural service.

Table 3.1: Summary overview of literature review on doctors' rational behaviour

Name of authors	Major findings
Chowdhury and Hammer (2004)	Doctors have to give up private earning opportunity to provide services in the public facility.
Hossain et al. (2007)	Social, personal and domestic factors influence doctors' motivations to be present or to perform in rural health facilities.
Liu and Mills (2007)	Identified doctor as an economic individual.
World Bank (2007)	Private practice during office hours is a leading cause of absenteeism
Rajbangshi et al. (2017)	Health workers' decision to join rural service is strongly associated with rural background and community attachment.

Source: Depicted by author

3.2.2 Literature review on health sector of Bangladesh

Health sector is very important sector in order to promote sustainable development. The constitution of Bangladesh also to ensure a healthy nation. According to the constitution of the people's republic of Bangladesh (2014):

> Article-15: ``It shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of

> living of the people, with a view to securing to its citizens - (a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care;''
>
> Article 18 (1): ``The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of drugs which are injurious to health.''

In spite of constitutional urgency, quality health service is not ensured, especially in the rural areas. Bangladesh government is increasing the coverage every year, yet this coverage is not adequate for the poor. Historic achievements in the MDGs and smooth transitioning towards SDGs are guiding Bangladesh to achieve a healthy nation. But rural areas are still facing the inadequacy of doctors because of absenteeism and vacant posts.

Chaudhury and Hammer (2004) made a survey to health clinics in Bangladesh to determine the absenteeism rate. They found that the absentee rate was 35 percent irrespective of job categories and types of facilities. At the larger clinics, the rate of absenteeism for the physicians was 40 percent, whereas the rate was found 74 percent at the smaller sub centres with a single physician. He showed that, whether the medical provider lives near the health facility, the rate and pattern of absenteeism are highly correlated with the opportunity cost of the service provider's time, accessibility of roads, and rural electrification.

World Bank (2007) conducted a survey and collected information from employees about their reasons for absenteeism. It found the following major reasons of doctors' absenteeism:

- Irresponsibility and negligence of duty (16%)
- Not working in a preferred work place (13%)
- Being out of town / outside the duty station (19%)
- Personal business (29%)
- Administrative weakness (26%) and
- Private practice (29%).

Hossain et al. (2007, pp. 25-26) found that posts for the specialists are unlike to be filled in Upazila level as well as the post for doctor in Union health facilities. Moreover, the doctors who are present in the rural health facilities have to work in tremendous pressure with significant physical and resource constraints. They also indentified a high level of absenteeism in rural health facilities, and most of the cases the absence is not permitted by higher authority. They explored the factors behind absenteeism are postgraduate training, low levels of job satisfaction, the weakness of disciplinary actions against absenteeism.

In Bangladesh, numbers of sanctioned post of doctors are 24,028; filled-up post 22,374 and vacant posts 1,654; which means 6.88 percent posts are vacant. But in Upazila level, the vacancy rate is 51.5 percent (MoH & FW, 2016). These data show that there is scarcity of doctors in the rural areas in Bangladesh in one hand, and on the other hand doctors have tendency to be absented or disinterest in rural posting.

An effectively performing health sector is an essential precondition for the overall development of a society. Doctors' disinterest in rural placement and preference in urban posting hamper the overall performance of health sector. Consequently, health governance suffers because of the scarcity of doctors in rural areas.

3.3 Research Gap

It is found from the literature review that, the researchers find out the factors of doctors' general tendency those may influence them for utilitarian behaviour. The researchers find out the factors of doctors' general behaviour those may influence them for utilitarian behaviour. However, the researchers did not attempt to theorize their behaviour in the rural areas with any theory. Besides, there were less focus on institutional constraints; those could restrict individuals from utilitarian behaviour.

Therefore, this study tried to investigate why doctors behave rationally to maximize individual utility despite institutional constraints. This study also attempts to theorize those factors in light of rational choice theory. It also looks at the institutional theory to find out the institutional weaknesses those allow doctors' rational behaviour for maximization of utility.

3.4 Theoretical discussion

Theory plays an important role in social science research. According to Aminuzzaman, theory explains the relationships, causality and dependency of certain variables. It also predicts the possible direction or momentum of those variables under study. Theory helps to draw predictive, causative and conclusive judgments towards a broad generalization. (Aminuzzaman, 2011. p.12).

This study attempts to find out the doctors' behaviour towards utility maximization. So, behavioural theories are needed to explain their behaviour. Here are some theories discussed related with human behaviour those incentivizes their actions.

3.4.2 Herzberg's two factor theory

Herzberg's two factor theory is one of the most important theory relevant to motivation for job satisfaction through job redesign and job enrichment (Sutaria, 1980). The basic propositions of the two factors theory are:

(a) Satisfaction and dissatisfaction factors are distinct from each other. (b) Satisfaction derives from "motivators" or factors intrinsic to work and dissatisfaction stems from "hygiene" factors which are extrinsic to work itself. There are two kinds of factors those affect individuals' bahaviour:

Hygiene factors: The factors those are essential for the existences of motivation are called hygiene factors. These factors do not lead to positive satisfaction for long-term. But the absent of these factors may lead to dissatisfaction in the workplace. If hygiene factors are available in a job, then employees do not get dissatisfied. Salary or wages, job security, working conditions, company policies, interpersonal relations, fringe benefits, status, working conditions are some examples of hygiene factors.

Motivational factors: The motivational factors are called satisfiers. The presence of these factors leads a better performance from the employees. These factors are rewarding to the employees. Promotional opportunities, achievement and rewards, responsibilities, recognition are some examples of motivational factors.

3.4.1 Incentive theory of motivation

Incentive theory of motivation started to emerge during the 1940s and 1950s.This theory is based on the drive theories that is established by psychologists such as Clark Hull and later developed by B.F Skinner. Two people may act in different ways in the same situation based entirely on the types of incentives that are available to them at that time (Cherry, 2017).

There are two types of incentives: positive and negative incentives. According to incentive theory people go toward the behaviours that lead to rewards and avoid the actions that might lead to negative consequences. Important observations about incentive theory are: incentives can be used to get people to engage in certain behaviours, but

they can also be used to get people to stop performing certain actions; incentives are effective only if the individual show importance on the reward and rewards are used to motivate the individuals.

3.4.3 Max Weber's bureaucracy

Different types of management styles are followed by different organizations. Max Weber (1922, pp. 956-958) described characteristics of bureaucracy. He narrates that, in bureaucracy there are specific jurisdictional areas which are governed by rules, that is laws or administrative regulations. He identified three elements those define bureaucracy:

i) In a bureaucratic structure, regular activities are assigned as official duties.
ii) To discharge official duties, the authority distributes duties and gives commands. Duties are strictly determined by rules.
iii) There are some pre-defined and structured method follows for fulfillment of assigned duties.

Lutzker (1982, p. 125) states that, Weber emphasized rational aspects of bureaucracy. This style of bureaucracy is based on structure, rules, and precedents. Therefore, Weberian bureaucracy contains well-defined and structured hierarchy, rule-based specification of duties. However, it cannot ensure that, structured or rule-based organizations produce the optimum result. It may vary from organization to organization.

The health sector of Bangladesh apparently guided and supervised by Weberian bureaucracy. In authoritarian bureaucratic structure, decision and instructions come from the top. Therefore, it is a complex and time consuming process. Although this structure is effective for many sectors, it may not be effective for health sector as there need to take many decision in periphery level those are not always rule-bound.

3.5 Chosen theories

This study takes the rational choice theory and institutional theory to analyse the doctors' behaviour. The variables are taken from these theories. Rational choice theory is one of the important theories in social science. The rational choice theory helps to understand the behaviour of individuals. This theory gives the idea about the reasons behind any action of individuals. According to Scott (2000), in rational choice theories, individuals are identified as rational being who are motivated by their necessities according to their 'preferences'. They act within specific, given constraints and on the basis of the information that they have about the conditions under which they are acting. Doctors are also seem to act rationally. Their preferences may undermine their imposed duties if they act to maximize their utility. In case of the doctors' choice between rural and urban placement, they may prefer the option that gives maximum benefits. So, rational choice theory was used to understand the behaviour towards doctors' preferences.

On the other hand, doctors' individual preference of choice may conflict with the institutional norms and goals. Hence, the institutional theory also used in this study to see the influence of the institutions on doctors' behaviour as the institutions rectify the rational behaviour of the employees with institutional rules and regulations.

3.5.1 Rational choice theory

Rational choice theory explains the behaviour of the individuals towards their personal benefit. Doctors also sometimes behave rationally to maximize their utility. When doctors are posted in the rural areas, they need to take decision whether they want to stay in rural areas because they need to leave some benefits that they could gain in urban areas. Therefore, doctors may face the conflicts between urban and rural placement. As it is not possible for individuals to achieve all of the desires, they must make choices in relation to both their goals and the means for attaining those goals.

Rational choice theories says that individuals must anticipate the outcomes of alternative courses of action and calculate that which will be the best for attaining goals. Rational choice theory deals with the individuals' behaviour. According to this theory, individuals behave rationally to maximize their personal gains. Elster (1986) mentioned the rational choice theory as normative theory. It does not describe what should be the goal or objective of individuals rather this theory tells us the means to achieve an aim or targeted objective by the individual. So, the rational choice theory basically focuses on the way to achieve a result.

According to Elster (1989), ''when faced with several courses of action, people usually do what they believe is likely to have the best overall outcome.'' This is the main essence of rational choice theory which also may happen in case of doctors' behaviour for their personal gains.

Rational behaviour sometimes conflicts with the institutional rules and regulations when the individuals are belonged to an organization. The personnel's (Doctors) of health sector are no exception of that. Coleman and Fararo (1992) show a relationship between individual's rational action and institutional or social behaviour in case of rational choice theory. They said that rational choice theory is the transition between the micro level of individual action and the macro level of system behaviour. Here macro level can be described as the institutional structure, and the micro level as the behaviour of the actors within such a structure.

3.5.2 Institutional theory

Institutions play important role on individuals' behaviour. Institutions are run by the norms and regulations and employees are supposed to follows those. If employees do not follow the rules of the institution and try to maximize personal benefit avoiding their stipulated duties then conflict arises. It may happen also in case of doctors when they belong to an institution. Doctors are supposed to stay in the posting places and

serve where the government assigned them. Sometimes it is found that they are not happy with their placement, so they remain absent or withdraw themselves from the posting places to favourable areas. So, institutional rules and regulations bar them to behave rationally. If the institutions fail to do so, then the employees may take that opportunity to maximize their personal benefits. Therefore, this study also used institutional theory, to understand whether there is lack of institutional capacity that cannot prevent the doctors' rational behaviour.

North (1990, p.97) introduced institutions as 'humanly devised constraints' that shape political economic and social interaction. He states that, institutions constraints both formal rules and informal constraints. Here, formal rules indicate constitutions, laws etc. and informal constraints consist customs, tradition, code of conducts and so on. He argued that by modifying the environments within which agents make choices, institutions ameliorate market failures, align the pursuit of private interest with the social welfare, and thereby enhance the performance of economies. As doctors are behaving towards their own interest, it may because of institutional weakness. So, institution can make the situation better with its regulations.

Hall and Taylor (1996, p. 939) says ''institutions affect behaviour primarily by providing actors with greater or lesser degrees of certainty about the present and future behaviour of other actors. More specifically, institutions provide information relevant to the behaviour of others, enforcement mechanisms for agreements, penalties for defection, and the like. The key point is that they affect individual action by altering the expectations an actor has about the actions that others are likely to take in response to or simultaneously with his own action''.

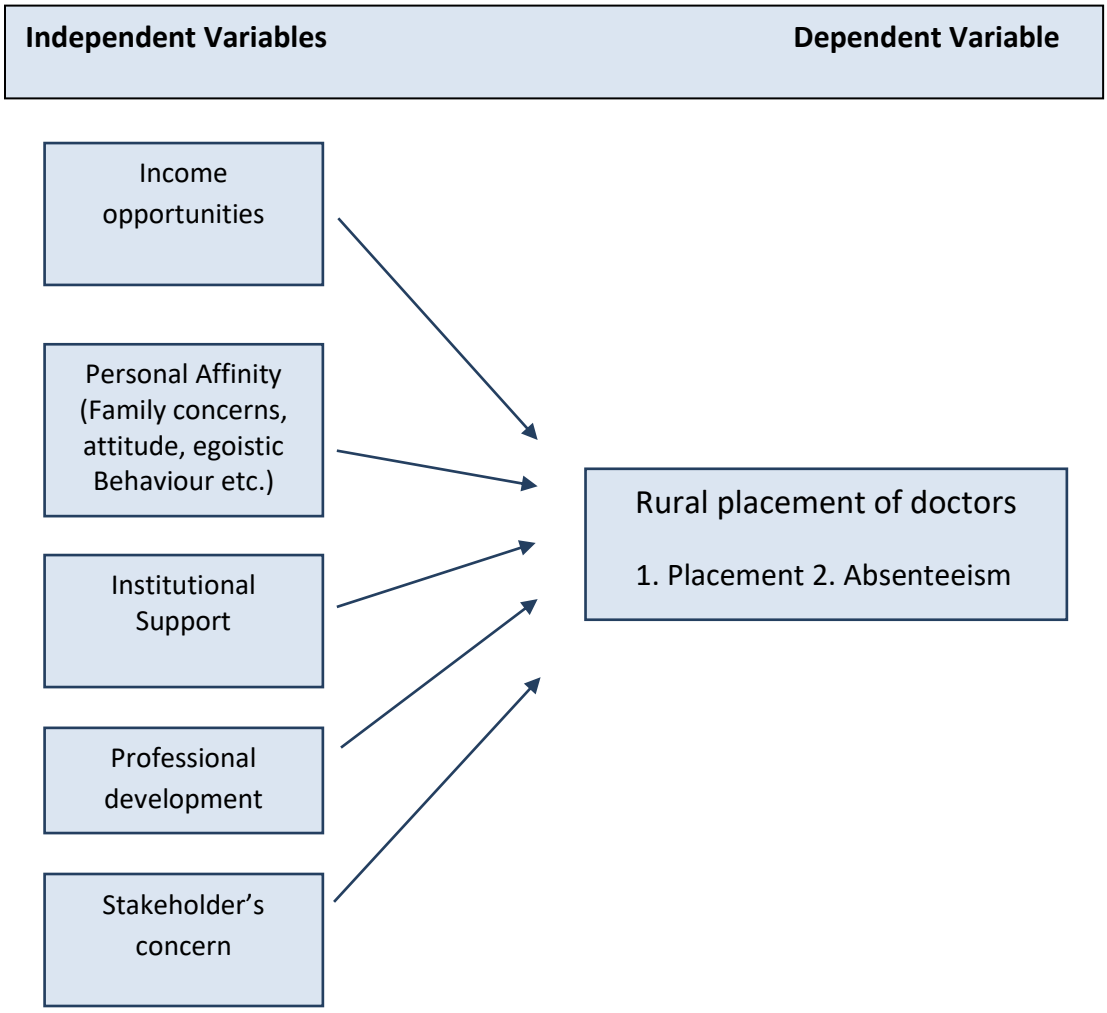
They also describe rational choice institutionalism which is draws heavily from rational choice theory although not identical to it. According to them, under rational choice institutionalism, relevant actors have a fixed set of preferences or tastes (usually

conforming to more precise conditions such as the transitivity principle), behave entirely instrumentally so as to maximize the attainment of these preferences, and do so in a highly strategic manner that presumes extensive calculation (Hall and Taylor, 1996).

Institutions play an important role on the employees' behaviour. As, employees are directed and supervised by the norms and rules of the institution they belong to. If there is lack of supervision or there is any gap in the regulation then the employees may use that gap to maximize their benefit. This paper investigates if doctors are not attending in or leaving the rural posting places, because of institutional weakness. For that purpose, this study also needs Institutional theory as well. According to Elster (1989, p. 14), ''actions are explained by opportunities and desires- by what people can do and what they want to do.'' Doctors also have desire to gain extra benefit with their action, but if there is restriction to do that then they cannot take that opportunity. Doctors' rational or utilitarian behaviour can be restrained by institutional mechanism. But, if there is institutional weakness then doctors also tend to take opportunity to maximize their benefit which can hamper the institutional goals.

3.6 Analytical framework

Figure 3.1: Analytical framework of the study



Source: Depicted by author, 2017

3.7 Operational definition and measurement indicators of variables

The dependent variable of this study is doctors' disinterest in rural placement and the independent variables are: income opportunity, institutional capacity, communication facility, logistic support. These independent factors can influence the doctors to take a decision.

As doctors have the capability for income other than government job, so they may take that opportunity to income. Other than income opportunity, some other factors also may influence doctors' decision towards placement.

In many cases it is found that, the family of the doctors live in the urban areas. So, they want to leave their posting station every weekend to visit their family. If the communication facilities are not good enough, then that may influence their decision to leave the rural posting places to the urban areas where their families live. In the same way lack of logistics support, institutional weakness also may create scope to leave the urban posting places. On the basis of above discussion, the operational definitions of the variables are as follows:

Rural placement: Upazila and Union level health facilities are considered as rural placement for this study. Doctors are posted in metropolitan, district, Upazila or union level. This study focuses on only Upazila and union level posting. This was measured by the duration of current posting place and previous posting places. Recently the government has taken a policy that the newly appointed doctors initially will be posted in the rural areas. Other than newly appointed doctors, experienced doctors are also posted in the rural areas. This study focused on the length and number of time doctors was posted in the rural areas and the frequency of cancellation of posting. Examples of rural placement are: Upazila health complex, Union health centre, Union sub-centre, Union health and family welfare centre , community clinic etc.

Income opportunity: Doctor's and additional income opportunity other than their principal source of income. They can practice in private clinics or in their own private arrangement, from there they can income more than their salary. It seems that urban areas give the better scope of income. It refers to the scope of private practice and other extra income facilities in the rural areas. Doctors have the capability to income other than their stipulated salary. They can income from private practice or from the private clinics. So, to measure this variable, the study tried to find out the extra income other than the salary. It considered the comparative study of the number of patient, amount of visit in rural and urban areas. The study also investigated the comparative opportunity of income between urban and rural areas. Because, sometimes, it is found that the rural areas give more opportunity of income because of scarcity of doctors. Still, doctors have tendency to move to the urban areas. So, it indicates that there may be other reasons beyond economic factors, which influence the decision making of doctors. So, this study concentrates on the other factors as well.

Personal affinity: Personal affinity for this study indicates doctors' personal interest or disinterest out of their professional life. It includes affinity to children, family, residence, prestige, social recognition etc.

Communication facility: Usually rural areas are suffering from lack of communication facility. So, doctors may not be interested to go to the rural areas. Besides, if the family of the doctors live in the urban areas then it is difficult to take care of the family because of weak communication facilities. It refers to the distance of the office from temporary living place or from where the family lives. Most of the rural posting places has inadequate transportation facilities. Thus, doctors face problems to go to their assigned duties and also to communicate with their families. Families of the most of the doctors usually live in urban areas, so if there is lack of communication facilities doctors

may not be satisfied with their placement, which may lead them to leave the rural posting places. So, this study considers the families staying areas and the influence of that on doctors' decision making.

Institution: Institutions are made up of formal and informal rules and regulations, belief etc. Here, institution mainly indicates ministry of health and family welfare (MoH & FW), directorate general of health services and UHC.

Institutional support: It refers to policy, rules and regulations related to ensure rural posting and institutional supervision. Moreover, logistic support, monitoring, managers capability also included in institutional support. Institutional capacity means proper rules and regulations, oversight capacity etc. This study attempts to find out the weaknesses in case of ensuring rural posting of the doctors. One of the indicators of institutional capacity is supervision capability. Because of lack of supervision, doctors may try to maximize their personal benefit. On the other hand, if there is strong or moderate supervision in the urban areas, it may fluctuate in rural areas. So, it needed to compare the supervision capacity in both areas. Besides, there may be difference of level of accountability for the supervising authorities in urban and rural areas.

Utility maximization: Individuals usually tend to strive obtaining the greatest amount of profit or value possible when investing in something. Maximization of utility for this study refers to maximizing doctors' benefit, in other words, doctors' priority on individual benefit over their stipulated duty.

Logistics support: It refers the working environment and other logistics i.e. number of supporting staff, security, electricity, toilet facility etc. of the rural offices. It also includes housing facilities, schools for the children etc.

Stakeholders: There are different stakeholders involved with health sector of Bangladesh. For this study, stakeholders are: policy makers, patients, local leaders, social workers, academicians and so on.

3.8 Conclusion

It was found from the literature review that the absenteeism rate for doctors is higher in rural areas than urban areas. It was also found that, income opportunity may drive the doctors to the desirable places. So, it is important to investigate the reasons why doctors in Bangladesh are showing disinterest to stay in the rural area. Theory is an important aspect of any research. It guides a researcher to be concentrated on the main track. The theory gives a framework for a research. As this study tries to investigate a particular rational behaviour towards maximization of their utility, so this study has taken the rational choice theory. Besides, to explain the role of institutions on the doctors, this study also used institutional theory.

This chapter tried to provide the readers the review of related study of health sector and doctors' behaviour along with the related theories of rational behaviour and institutions. Finally, it attempts to develop an analytical framework evaluating the theories and related literature with independent variables to find out their influence on doctors' utilitarian behaviour in Bangladesh. It also operationalizes the terms those are used in the analytical framework.

Chapter 4

Research methodology

4.1 Introduction

This study attempts to find out the reasons behind a particular behaviour of doctors (i.e.: doctors' disinterest in rural placement). This study uses rational choice theory and institutional theory as theoretical framework. The dependent variable of this study is rural placement of the doctors and independent variables are: income opportunities, personal affinities, institutional support, professional development and stakeholder's concern.

There are many health facilities in Bangladesh those are located in rural areas. It is found from the literature review and from empirical evidence that doctors show disinterest to stay in the rural posting places. Even if they are posted, the absenteeism rate is very high in rural areas compare to urban areas. From literature review, it is found that there are many reasons behind the disinterest in rural placement. Some are personal reasons like lack of income opportunities, some are structural like communication facilities, logistics support and some are institutional like lack of proper supervision. This study tried to find out those reasons behind doctors' attitude towards rural placement in Bangladesh.

A research needs some methodology to follow which reveals that how researcher is going to achieve his/her objectives of the related study. To systemically solve the research problem and to make it understand scientifically, a research methodology

should be followed. This chapter aims to present and justify all the tools and techniques used for the research. The chapter also discusses the research methodology used in this study. The geographical area where the study was conducted, the study design and the population and sampling method are described in this chapter. The instrument used to collect the data, including methods implemented to maintain validity and reliability of the instrument are also described in this chapter. The research shall be mostly designed such manner that it provides explanation of events by exploring the factors those influence the dependent variable.

Aminuzzaman (2002) defines a research design as 'a plan of proposed research work'. He describes research method as 'the functional action strategy to carry out the research in the light of the theoretical framework and guiding research questions and/or proposed hypothesis.' There are three types of research design: qualitative, quantitative and mixed approach.

Qualitative research is used for exploring and understanding the meaning individuals or groups ascribe to a social or human problem and Quantitative approach is mainly used to for testing objectives theories by examining the relationship among variables. On the other hand, mixed method research approach combines both qualitative and quantitative forms (Creswell, 2009, p. 4). In the current study, qualitative research method has been followed.

Although, it is easier to analyse the data in quantitative method and it helps to minimize the human faults, but this method has some limitations as well that can be overcome by the qualitative approach. Quantitative method sometimes cannot present the complete information those are taken from case studies, interviews and observations. On the other hand, there is a scope of one to one conversation between the respondents and researcher in qualitative approach that gives an opportunity to capture the inner views of the respondents to a particular topic. As this study needs to understand the actual

reasons behind doctors' disinterest in rural placement so it needed to gather data from insight views of them. Therefore, qualitative study was used in this study and data was collected through in-depth interviews. It also needed to analyse secondary data to have a broader picture of Bangladesh health sector and other related information. Secondary data has been collected from books, journals, reports, documents, different websites etc.

4.2 Study area

There are different types of healthcare facilities in an Upazila, i.e.: Upazila health complex, Union health centre, Union sub-centre, Union health & family welfare centre and community clinic. Among those facilities, Union health & family welfare centres are under directorate general of family planning, community clinics are running under a government project and rest of the facilities are under the DGHS. This study focused only Upazila health complex and union sub centres because of time constraint. Besides, there is no posting for the doctors in community centres and as UH & FWCs are co-ordinate by the DGFP, so these facilities also were not included in this study.

The primary data was collected from six Union sub-centres and Upazila health complex of Ghatail Upazila in Tangail district. The Upazila sadar is well connected with Tangail-Mymensingh highway but most of the union health centres are located in very remote areas. The people living surrounding sub- centres have very few options to depend for their health service. As remote areas have the scarcity of doctors and as well as the infrastructure and logistics facilities are inadequate so this study area gave the scope to thoroughly research the causes behind doctors' disinterest in rural placement. Besides, because of their remoteness, those medical sub-centres are out of proper supervision of the higher authorities. It was also convenient for the researcher to understand whether the communication facilities also influencing the doctors' decision.

4.3 Research design

Research design provides a framework to the researcher to navigate the journey in the process of collecting data at field and finally to execute the whole data. The main intention of a research work is relevant with getting answers of the research questions. According to Creswell (2009, p. 4), ‘‘research designs are plans and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis’’.

Qualitative research design is followed in this research. This design was selected because it provides an accurate portrayal or account of the characteristics, for example behaviour, opinions, abilities, beliefs, and knowledge of a particular individual, situation or group. This design was chosen to meet the objectives of the study, namely to determine the knowledge and views of doctors and patients with regard to the utilitarian behaviour of the doctors.

4.4 Data collection methods

The data was collected from primary and secondary sources. Primary data has been collected through in-depth interview method. Secondary data was collected through different documentary sources include published and as well as unpublished materials, books, journals, reports, documents etc. Secondary data helped to identify and understand the relevant concepts and theories of this research. It also helps to find out the adequate data line with current study’s objectives.

4.5 Data collection techniques

There are different techniques for primary data collection like questionnaire survey, case study, interview, observation etc. A combination of observation and in-depth interview has been adopted for this research to take advantages of their respective strengths and overcome the limitations of others.

The use of in-depth Interview method is common and very effective in social science research. Aminuzzaman (2011, p.114) states that ``well-structured interview is much more effective than `oral questionnaire.' Many types of information and even data can be produced by face-to-face contacts with people, especially data related to personal history, opinions and attitudes''. Structured and unstructured interview method was used in this research.

4.6 Sampling method and population size

Purposive sampling method was used to select the sample so that appropriate respondents can be incorporated in the research. In purposing sampling method ''the researcher purposively choose persons who, in his judgement about some appropriate characteristic required of the sample members are thought to be relevant to the research topic and are easily available to him'' (Ahmed, 2010, p.99).

The major reason behind using this kind of sampling is to cover major stakeholders related to the research work and those who could be easily available. As doctors are very busy and are not easily available in the rural areas, so availability of the respondents was a major concern for this study. Besides, most of the Union sub-centres are vacant, that is why it needed to interview of the doctor who was previously worked here and they are posted in different places. So, it could not possible to get them easily. The respondents who were available, were included as sample.

To attain the objective of this study respondents are divided into four major categories: i) Doctors ii) Patients iii) Health centre personnel and iv) other stakeholders. For in depth-interview, 26 persons have been chosen for the current study shown in table 4.1.

Table 4.1: Sample size of the respondents

Population sample	Data collection method	Number
Doctors	In-depth interview	8
Patients	In-depth interview	6
Other stakeholders (Local leaders/Academicians/Policy makers/Social workers)	In-depth interview	7
Health centre personnel	In-depth interview	5

Source: Author's field study, 2017

There is a post for a doctor in each of the six union sub-centres. Some of those are vacant and some others are filled up. The sub-centres those are filled up with doctors are also suffering from the absenteeism of doctors. Therefore, the researcher tried to take in-depth interviews of the doctors from each of the six sub-centres to understand reasons behind their absenteeism or disinterest in rural placement. As some of the sub-centres are vacant, so researcher tried to take interview the doctors who were previously posted there. As the Upazila is also considered as rural area, so the researcher took interview of doctors from the UHC of the study area.

The research is further needed to enquire whether the patients of the study area are getting proper service from doctors or not. Therefore, this study incorporates six patients from each of the union sub-centres.

Local leaders, social workers, policy makers and other stakeholders play an important role in ensuring the service of doctors. Therefore, to understand the views of the stakeholders, the researcher interviewed them. It could be better if the researcher would able to take interviews of more persons. Because of time constraints, the researcher interviewed only seven stakeholders.

4.7 Fieldwork

Doctor's absenteeism, retention, ethical issues are now-a-days a burning subject in Bangladesh. Mass people along with government, media, and social workers are very concern with this issue. Therefore, interviewing of doctors and their authority was very challenging as it is very sensitive to them. Because, they also know that they are enjoying unauthorized absence.

This study covers Ghatail UHC and six USCs of this Upazila. Many of the doctors posted in Union sub-centres are women. Most of them were posted there and now transferred to urban health facilities. During their period, they hardly went to their stipulated posting places. When they were asked to be interviewed they avoid the researcher and made many excuses not to be interviewed even after explaining that this interview would be used only academic purposes. It seemed they are scared and embarrassed to made an interview. Some of them suspect it as a probe of their absenteeism.

Interviewing the male doctors was also not easier. It had to interview the doctors who were previously posted in Union level. They are currently working in urban areas and some are working in the capital. Therefore, it was difficult to make an appointment with them. However, interviewing male doctors working in the UHC was much easier although, it was required to gather permission from the UH & FPO.

Gaining permission and conducting interviews of some officials of DGHS was difficult. A high-ranked official asked the researcher to seek permission for interview and to collect documents through right to information act (RTI)[6]. Besides, the researcher needed to go through some circulars, working papers and some other contents to analysis, but it was difficult to collect those papers from DGHS. However, the officials of MoH & FW were very helpful in this regard.

As some of questions of this study were directly related to absenteeism, income, personal interest, ethical issues of doctors, therefore it was very sensitive to them and to some extent embarrassing. Therefore, interviews and informal conversation approach were most applicable to gaining access to and collecting data from the doctors, patients and the authorities. These techniques were employed to collect the views and narratives of the interviewees about doctors' disinterest in rural placement.

Before starting an interview, ethical guidelines of this study were informed to the interviewees, so that they feel comfortable to answer the questions. Specially, anonymity and confidentiality were ensured informing that, the collected data would be used in academic purposes and the respondents' name, designation or any other personal information would be kept in secret. It was also informed to the respondents the nature and scope of the study at the beginning of the interview.

Patients, local leaders, social workers had no objection about using their identities. On the other hand, doctors were very aware of anonymity and confidentiality. Even some doctors did not allow recording their audio voice. As the interview was informal conversation manner, so the questionnaire only used as the researcher's guideline which helped to understand what to ask and which data should collect. In some cases, respondents asked to see the questionnaires and it was provided them to read.

Respondents were interviewed individually and separately. The doctors were selected purposively who have working experience in rural health facilities; and randomly according to their availability. Among the eight doctors four are working in Ghatail UHC. A doctor was interviewed in Tangail general hospital, who is currently working there and previously worked at USC in Ghatail Upazila. Another doctor was interviewed in Dhaka who was previously posted at an USC in Ghatail Upazila; now he is in study deputation

for post-graduation. Two more doctors were interviewed in Dhaka who has experience of working in the rural areas, but not in Ghatail Upazila. The researcher selected them as respondent to understand the situation of the other rural health facilities.

Patients were also selected randomly; at least one from each USC, ensuring gender balance: three female and three males. Among the six patients, five were interviewed in health facilities' premises who came to visit a doctor. Another interview was taken in a nearby *bazaar* (small market place in rural areas), who used to visit government health facilities.

Interviews of this study were conducted mostly based on structured and open-ended questions. There some supplementary questions as well to understand more and insights of the respondents' views.

4.7.1 Interviews of doctors

Before starting the fieldwork, the researcher discussed with two doctors informally to understand the general views of doctors to rural placement. Besides, there was a discussion with a doctor working in a government hospital, located in the capital and a retired additional secretary who provided some insightful thoughts those helped a lot to organize the data collection process. Moreover, there was a field testing of questionnaires to organize the questions in a systemic manner. The questions for the doctors were divided into two parts. First part consists questions related to doctors' personal history like marital status, number of children, home district, family residence, length of services, status of higher study, status of private practice, income from private practice etc. Second part of the interview is mainly related to their job, institutional support, work environment, policies, job-satisfaction etc. Finally, they were asked to explain their views on rural and urban placement, which was the main objective of this study. They were also asked whether the policies are need to be revised or new incentives to be introduced to motivate doctors for rural placement.

4.7.2 Documents collection

Secondary data also used for this study, in addition to primary data. Secondary literatures are mainly collected from libraries, internet and MoH & FW. Government circulars, posting policy, transfer policy, promotion policies are collected from MoH & FW. Besides, some official letters issued to warn the doctors also collected from the ministry. The officials of the ministry were very co-operative, so it was easy to collect those documents. However, DGHS authority was unwilling to provide any documents or even made an interview. In addition to abovementioned contents, reports of newspapers also helped a lot to gain data.

4.8 Data processing and analysis

Data analysis is one of the most important parts of a research. Data analysis generally comes after identifying research questions, review of literatures, presentation of hypothesis, description of data and methods to be used. The field data obtained for this study has been analysed qualitatively. As the sample size of the research is less than 20, so it did not require using special data analysis software. The understanding of each informant carries value and thus qualitative research is more important here.

4.9 Duration of data collection

The duration of data collection was for one month starting from 15 July to 14 August 2017. Researcher visited Upazila health complex and union sub-centres in Ghatail Upazila to collect data during this period of time. After that period, the researcher visited DGHS and Bangladesh secretariat to collect documents and interview the stakeholders, i.e.: Policy makers, central authority etc.

4.10 Ethical consideration

To conduct every research, not only the expertise and diligence but also honesty and integrity are important factors. It is needed to recognize the sources that have been used in a research. This study properly recognized the sources and the contribution of others those are used in this research.

Written permission to conduct the research study was obtained from the program office of Master in public policy and governance in North South University. The subjects were informed to the interviewees to voluntarily consent or decline to participate, and to withdraw participation. Subjects were informed about the purpose of the study, the procedures that would be used to collect the data, and assured that there were no potential risks or costs involved.

The personal information provided by the respondents should not be reported publicly as promised confidentiality. In this study, confidentiality was maintained by keeping the collected data confidential and not revealing the respondents' identities when reporting or publishing the study. Anonymity and confidentiality were maintained throughout the study. In this study anonymity was ensured by not disclosing respondents' name.

Honesty is regarded as a very important ethical responsibility when conducting research. The researcher tried to avoid any form of dishonesty by recording the answers of the respondents without their permission. The open-ended questions which were analysed by the researcher were checked by the supervisor for confirmation of credibility.

4.11 Reliability and validity of data

The respondents were selected in order to have a better understanding the factors impacting rural placement. The criteria for the expected respondents to qualify in this research were set in such a way that the respondents provide at least reliable data. The

key respondents i.e. doctors are taken only who have served in the Studied Upazila, so that their observations and opinions are based on perspective of that Upazila and Union health facilities. It gave the opportunity to understand extensively the problems in that Upazila and Union level as they had already faced those problems. The reason behind that is to ensure that the knowledge and perception of the respondents about the rural health facilities did not varied to a great extent. Moreover, the sample was purposively selected from two areas: Upazila sadar and Union level; so that the factors in deciding rural placement from both areas can be found.

Validity is related to the trustworthiness of data which is need to accuracy of the information. Therefore, validity depends on how accurately phenomena are measured. The major challenge in ensuring validity of the findings was ensuring personal impartiality of the respondents. In order to enhance the trustworthiness of data, various documents were collected and same questions were asked to different respondents.

4.12 Challenges faced in data collection

The researcher faced some challenges during data collection. Undoubtedly ethical matter was a sensitive issue. Other than that, it was found people specially the doctors bear different perception about their personal matters. Besides, some union health complexes are situated in remote areas where the communication facilities were very bad. Moreover, some respondents (doctors) of USCs do not live in the study area; some of them live far from their posting place. Therefore, it took long time to meet and interview them. To some people it was not very important to talk about the issue, so they showed indifference to be interviewed. In-depth interview takes long time; therefore, busy people were not interested to be interviewed. Besides, some bureaucratic behaviour of some officers also hampered data collection.

4.13 Conclusion

This chapter has introduced all the methods and techniques that have been used for this study. It describes the research methodology, data collection methods, sample of the population etc. Explanatory research design has been taken in this research as this research design gives the scope to explore the views of the doctors for their utilitarian behaviour. There are two sources used for collection of data: primary and secondary sources. To collect the primary data, in-depth interview technique was used. The questions were structured and unstructured so that the unstructured questions minimize the limitations of structured questionnaires for thorough understanding of views. As the data size is very small, this research did not use any specialized statistical software. To incorporate the appropriate respondents in the research, purposive sampling method was used. The respondents are categorized into four major categories: doctors, patients, health centre personnel and other stakeholders (i.e. local leaders, academicians, policy maker etc.). As there was time constraint therefore only 26 respondents were chosen for the current study.

The methodologies have tried to omit errors as much as possible. However, it may be affected by limitation of the study which is mentioned in the first chapter and human errors which is avoided by researcher through checking, rechecking and rectifications with the help of supervisor and others. Collected data is going to be presented in the next chapter. That chapter also will analyse the data and make interpretation on the basis of analysis.

Chapter 5

Data presentation, analysis and interpretation

5.1 Introduction

This chapter discusses and analyse the data found in the field to reveal the major factors behind doctors' absenteeism and disinterest in rural placement. The following findings give a scope to discuss the main issue that is conflict between institution and maximization of benefits of the doctors. It also tries to focus on the weakness in the institution that creates opportunity for the doctors to behave rationally.

There are some factors found during study those influence doctors' decision making towards placement used in this study as variables. One of the main concerns for the doctors' is income opportunity which likely to influence the doctors' decision in choosing placement. They may decide to take posting in the areas where income opportunities are higher. Besides, personal affinity also one of the reason of the doctors' rational behaviour. Beside professional life, everyone has family or social life. Therefore, they always try to keep in touch with them. Hence, doctors' affinity to their family leads to find a working place where they can take care of their family. Another variable that is very close to personal development and professional as well is post-graduation degree. To be promoted in the job, this degree is mandatory for doctors. Moreover, for better affiliation to patients this degree helps a lot. Hence, the scope of getting post-graduation degree sways the doctors to urban placement. Apart from those, doctors attitude, egoistic behaviour, feelings of self-esteem, facilities for children's education also guide to decide where to take posting. It was found that many doctors whose children are school-going or about to start to go to school are trying to move to urban areas.

The study has been conducted in the rural area to experience the field level problem practically. The study area was Ghatail Upazila in Tangail district. The study was conducted in six unions and as well as in Upazila sadar of Ghatail. It also conducted interview of officials of the controlling authority of health system. In-depth interviews have analysed and processed using qualitative method to find out the result. After analysing the data found from the interviews, interpretation has been drawn later in this chapter.

This study collected data from the field level on the basis of three research questions. One is: do the doctors prefer urban posting places for utility maximization? This questions basically tried to find out the factors and incentives those influence doctors to move to the urban areas. Another question is: Do doctors use posting places to maximize other utilities than income? Finally, the thesis tried to find out the answer of the question: does weakness of institutions create opportunity for the doctors to avoid their duties in rural areas? This one mostly investigated the institutional capacity of supervising doctors to attain the institutional goals.

Analysing those data, basis on research questions, this study found some significant findings those guide doctors making decision towards their placement. It was found that most of the cases young doctors have better opportunities of income in rural level as urban people prefers to visit the doctors who has more experience and professional degrees like FCPS, FRCS, MD etc. The common perception of the people to doctors' interest in urban area for income opportunities is very insignificant. Moreover, it was found in this study that income from private practice not only depends on location or degrees but also on the familiarity of doctors and the length of services in a particular area.

One of the major findings that hampers the health governance and consequently creates scope for the doctors to leave rural areas is the local authority's decisions those are contracted with government policy.

One of the main targets of the government's policy is to ensure root level medical services so that the inhabitants get proper treatment. However, it was found that local authority withdraws the doctors from union sub-centres to the UHC as there is scarcity of doctors at Upazila level as well.

Beside the personal affairs, the prominent factor is institution that creates environment or hinder to perform duty. The institutional factors found in the field study are poor monitoring, irregular promotion, cadre discrimination, logistics support, lack of instruments and diagnosis facilities etc.

Stakeholders are integral part of health governance. This study found that in the remote areas, patients are happy with some basic medicines when they visit the health centre. They have very little demand of MBBS (Bachelor of medicine and bachelor of surgery) doctors; rather they think that SACMO is enough for their treatment as they are getting free medicines. So, the pressure for doctors' presence is not there. It creates the scope for the doctors to avoid duties in those areas. On the other hand, stakeholders monitoring also plays a crucial role. In some areas there are strong monitoring from the local leaders and social worker whether doctors are available in duty time or not. The absent rate and vacancy rate is lower in those areas than other areas where there is poor monitoring by the stakeholders.

This chapter is going to thoroughly discuss all the field data and analysing the data based on analytical framework later in this chapter. The chapter is divided into different parts to present and explain the collected data. The discussion mainly consists of profile of the respondents, analysis of findings and interpretation. Unit of analysis of this study is doctors. Therefore, the discussion on field data is mostly from doctors' interviews. Interviews of doctors give a partial view of the real scenario of pros and cons of rural placement. Because, the persons who are related with health governance: i.e.: policy makers, the service receivers, local leaders, even the staffs of the health centres may have different views. That is why, apart from doctors the stakeholders are important source of information. This chapter also describe the respondents' view beside doctors.

Collected data needed to be presented and processed properly for drawing meaningful inferences and comprehensive conclusions (Aminuzzaman: 2011, p141). Therefore, the analysis part is discussed later after presenting the data. Finally, this chapter concludes with the summarization of research findings and interpretation.

5.2 Profile of the respondents

Profile of the respondents describes the profession, designation, place of posting, area of living etc. This study aims to find out the doctors' view on rural placement and the institutions' role on placement. There are many stakeholders related with health system in Bangladesh. That is why, this study conducted interviews of the related stakeholders as well.

The respondents are divided into 4 categories. Those are: doctors, patients, health centre personnel/ staff and others. The respondents are categorized to facilitate the collected data at ease and to group the findings to analyse easily. Health centre personnel were taken as respondent as they are very important source of information. Besides, most of the cases health centre personnel are found regular in the health facilities and they are working for long, so significant data was gathered from their experience and observations.

Moreover, it is important to know the view of the patients as well to understand the situation of health governance in the study area. Health governance is also monitored by stakeholders, i.e. local leaders, social workers, academicians and so on. Hence, they were also interviewed in this study. The following table shows the full list of the respondents that describes relevant information about them:

Table 5.1: Respondents' profile in brief

S/N	Category	Designation/ Occupation	Posting place/ Address	BCS batch/Age/ Length of service
1	Doctors	Medical officer	Ghatail	29th
2		Medical officer	Ghatail	20th
3		Junior consultant	Ghatail	24th
4		Junior consultant	Ghatail	22nd
5		Medical officer	Tangail	31st
6		Study leave	Dhaka	29th
7		Medical officer	Ghatail	29th
8		Medical officer	Dhaka	30th
9	Patients	Housewife	Ghatail	-
10		Housewife	Ghatail	-
11		Farmer	Ghatail	-
12		Farmer	Ghatail	-
13		Businessman	Ghatail	-
14		Day-labourer	Ghatail	-
15	Health centre personnel/ staff	SACMO	Ghatail	10 years
16		SACMO	Ghatail	23 years
17		SACMO	Ghatail	6 years
18		Pharmacist	Ghatail	20 years
19		MLSS	Ghatail	27 years
20	Others	UH & FPO	Ghatail	20th
21		UNO	Ghatail	27th
22		Mayor	Ghatail	-
23		Social worker	Ghatail	-
24		Resident medical officer (RMO)	Ghatail	33rd
25		DG health personnel	Dhaka	Director
26		Joint secretary	Dhaka	MoH & FW

Source: Author's field data, 2017

Data were collected by in-depth interviews of the respondents. There is rational behind taking the stakeholders other than doctors as respondents. Doctors are the key informants of this research. So, they provide their opinions on rural placement from their point of view. On the other hand, there is another point of view that is stakeholders' perspective. That perspective is important as well. Because, they provide the supplementary data those are absent in doctors' interviews.

Moreover, concrete data on dependent variable like, absent rate, vacancy is needed to analyze the findings. Major portion of those data were collected from other respondents like patients and health centre personnel.

Policy plays an important role in regulating institutions. If there is any gap in policy or in implementation of policy then the institution cannot function properly. In this regard, understanding the policy perspective also important. So, policy makers are chosen for respondents. In addition, local leaders have crucial role in monitoring the doctors and health facilities in rural areas. So, to understand their role and their opinion on doctors' rural placement, local leaders also taken as respondents in this study.

5.3 Findings and analysis

To understand the views of the respondents thoroughly, this study uses in-depth interview to gather qualitative data. Qualitative data includes In-depth interview of 26 respondents. Among them eight (8) doctors were interviewed to understand their views on the preference and reasons of choosing rural or urban placement. Patients also interviewed to understand the service their getting from the doctors.

Data were mostly collected from in-depth individual (IDI) interviews to understand the behaviour of the doctors. Although IDI interview is time-consuming and need extra effort but it allows for spontaneity, flexibility, and responsiveness to individuals (Carter, et al. 2014). Therefore, in-depth analysis in this study gives different view-points of different persons.

The empirical data found in the field are triangulated with the theory and other research. This study uses rational choice theory and institutional theory to guide the research. That is why, gathered data was analyzed in light of the theories. Besides, the findings are needed to see with other research to validate data. This study found that doctors' preference in urban placement is more for lack of institutional support in rural areas than to maximize individual benefits. This chapter is going to discuss those findings and analyse those data thoroughly.

5.3.1 Dependent variable: Rural placement of doctors

The rural areas of Bangladesh are suffering from the scarcity of doctors as doctors are not posted or doctors are not interested to be posted in those areas because of some problems. This study aims to find out the reasons of doctors' disinterest in rural placement and also institutional weakness for that doctors are being absent in spite of being posted. The dependent variable of this research is doctors' rural placement. This variable indicates basically fragmented in two parts: one deal with the problems of rural placement another is absenteeism. Therefore, this study tried to elicit the reasons behind the doctors' disinterest rural placement and the reasons why absenteeism is so high in the rural areas. This variable has two measuring indicators: absence rate and vacant posts. The researcher found that out 32 posts, there are only 14 posts are filled up in Ghatail UHC. Most of the union sub-centres also vacant.

The absenteeism rate is very high, even if doctors are posted in rural areas. On the other hand, some are managing to withdraw themselves from the rural areas and taking posting in urban areas. Therefore, the scope of this study is both placement and absenteeism.

There are different factors behind absenteeism and disinterest in rural placement. The researcher in this study only tried to focus on individuals' behaviour and institutional factors that allows the doctors to be absented or to be disinterested in rural placement.

5.3.2 Independent variable

Independent variables of this study are mainly taken from literature reviews, rational choice theory and institutional theory. There are five independent variables used in this study. The questions were asked to the respondents in line of those variables to understand how those variables influence the dependent variable. The independent variables are: income opportunity, personal affinity, institutional support, professional development and stakeholders' concern.

5.3.2.1 Income opportunities

The assumption of this study was that doctors tend to use their posting place to maximize their benefits. Benefits can be two types: benefit in cash and benefit in kind. As the doctors are professionals so they have the opportunity to income from private practice other than the income from the job. Therefore, it may affect on their decision making in case of placement. As it is directly related to doctors' benefit, so this is an important factor in this study. There are different views found on this ground. To find out the views, some questions were asked to doctors like, do you practice privately or visit other clinics? What is your income other than your government salary? If it is a matter of income opportunity, then which place is convenient for you - rural or urban areas?

Some doctors claim that there are ample opportunities of extra income in rural areas but some others are against that claim. According to them, private practice opportunities are more in the urban areas than in the rural areas. Whatever the scope of private practice in rural or urban areas, most of the doctors conclude that income opportunities or scope of private practice does not play an important role in decision making for placement.

The income from private practice does not depend only on the place of service. There are many factors behind it. Patients of the rural areas sometimes rely on the urban doctors on the Upazila level doctors: patients have more trust on urban doctors than the rural doctors.

Before discussing all other factors, it is needed to know about the organogram for the doctors in Upazila level. The entry level post in Upazila and union level is medical officer. The next post in this level is junior consultant. No higher post is there in the Upazila health complexes. The junior consultants have very few opportunity for income in urban areas, as patients in the urban areas are very conscious and they try to visit a consultant, associate professor or a professor. So, the scope of income for the rural level doctors in urban areas is limited. Rather, there is ample opportunity of income in the rural areas for the junior doctors.

Besides, scarcity of doctors creates more opportunity of income in rural areas. As there is scarcity of doctors in the rural areas so many consultants are going every weekend. Therefore, if the junior doctors stay in posting place and operate private practice, then they also can income handsome amount. The researcher tried to understand patients' view on it. When a patient was asked, why doctors are not interested to work in the rural areas? He told ``the urban areas have more opportunity of income, on the hand there are limited opportunity of income in Union or Upazila level. May be for better income opportunity, doctors try to stay in urban areas.'' Same response was found from a health centre personnel. However, another staff of Union health centre said, ''the SACMO of this Union has a private chamber and he earn a handsome amount of money in every month. If a doctor stays here and practice regularly, then he/she also have opportunity to income in this area. So, it is not money, rather may be some other factors influence them to go to urban areas. Doctors do not have residence in Union level. There is no good quality school here, where their children can go. Even, markets are very far from this sub centre.''

Therefore, the statements of the respondents indicate that, there is opportunity for the doctors in rural areas as well, but because of lack of other facilities they are not interested to stay in rural areas.

5.3.2.2 Personal affinity

Everyone's workplace or job is influenced by his personal affinity, personal life, family life, attitude etc. and vice versa. Doctors are no exception of that. Their affinity to their parents, wives, children, permanent residence also are deciding factors for the placement location. This study found that most of the doctors are keeping in mind those factors in case of taking posting. Moreover, doctors attitude towards the job, their ego etc. also guide in posting preference. Therefore, this study tried to find out those deciding factors in preferring urban or rural placement. To explore the views of doctors towards personal factors the researcher tried to know about their marital status, family residence, number of children, spouse's employment, children's education etc.

5.3.2.2.1 Proximity of family residence

Here proximity means the distance between a doctor's working place and where his/her family live. Doctors do not always live in working area with their family. Most of the doctors' family live far from the posted area. So, doctors generally visit their family every weekend. Besides, most of the doctors' spouses are also in service and they live different places. If the transportation facilities are not good, it is difficult to take care of their families. Usually communication facilities are very poor in the Upazila or rural level. So, the doctors are disinterested to take posting in the rural areas as they cannot visit their family regularly. Hossain et al. (2007) also found that spouses' jobs are also a consideration for doctors that explain the rationale behind their placement and transfer.

5.3.2.2.2 Children's education

Children are very important affinity for everyone. As the doctors are highly educated so, they always want to bear up their children with quality education in a sound environment. Most of the Upazila can provide the facilities for quality education to the doctors' children. Chaudhury and Hammer (2004) also came up with same hypothesis that:

> ''Most medical practitioners in developing economies are urban-born and reared, are highly educated compared with the population as a whole, and have skills that are highly marketable. If they have children, they are likely to want the same advantages for them'' (Chaudhury and Hammer, 2004. p. 424-425).

During interview, doctors and many other stakeholders also admit that one of the major causes of doctors leaving the rural places is inadequate facility of quality education for their children. The education facility for the children is not enough in the Upazila level. There are better opportunities for quality education in the urban areas than in the rural areas. Therefore, for the betterment of their children's future doctors always interested to move to urban areas.

5.3.2.2.3 Attitude

Sometimes doctors are not interested to stay in rural areas as they feel that doctors are not needed in union health facilities. They feel that a SACMO is enough as only primary treatment is provided by USCs. A doctor working in Ghatail UHC was asked about the reasons why doctors are not interested to go to Union level. He says:

> ‘‘Union health facilities only provide primary treatment and some sorts of medicines. If there is any further necessity rather than only having primary medicine or treatment, then patients move to the UHC as there is no diagnosis facility in USCs. Therefore, there is little necessity of an MBBS doctor in union Level. Logistics support should be ensured before sending the doctors to the union level’’.

However, some doctors feel that there is necessity of an MBBS doctors for better treatment and suggestions. Sometimes, SACMO cannot identify the main problem of a patient and provide some common medicine that is not proper. So, specialized doctors are needed in the rural areas as well for better service.

5.3.2.2.4 Social recognition

Some doctors raise an issue that as doctors belongs to Bangladesh civil service (BCS) so, they may feel insulted to work at union level. Because, other cadres are not going to the union level. Besides, they cannot avail government vehicles or security to go to the union level. On the other hand, some officers of other cadres getting vehicle and security when move outside of the Upazila centre. Liu, X and Mills (2007) also identified that, apart from income, achieving and maintaining ideal social status and recognition may be one of the important objectives of the doctor’s medical practice. As doctors feel that, they are not having social recognition as expected, so they are not interested to stay in rural areas.

5.3.2.2.5 Habituated in urban life

During their student life, doctors live in urban areas with lot of facilities for a long period of time. So, they are habituated with that lifestyle. After coming in rural areas with fewer facilities or even sometimes lack of basic facilities like residence, it become very difficult for them to cope up with rural environment. It is one of the causes that influence doctors to leave rural areas to urban area. Doctors said during interview that, if infrastructures and some basic facilities were ensured in rural areas, then doctors would not be disinterested in rural placement.

5.3.2.2.6 Scope of exit

Doctors have numerous options to switch their job as they have enough scope to manage other income facilities than depending only on government job. Doctors have the technical expertise in medical sector (Chowdhury and Hammer, 2004). Therefore, doctors' affinity to the government job is less than other government employees.

An official of MoH & FW was asked about higher absenteeism in rural areas that what actions are usually has been taken for absenteeism. According to the official, because of the scope of exit, it is tough to control them strictly. Sometimes, it may difficult to take any action against unauthorized absence. That is why; the absence rate is very high in health sector, especially in rural areas.

Box 5.1: Statement of a respondent (Policy maker)

Mr. Lutfar Rahman (Pseudo name), is working in MoH & FW as Joint Secretary. He has the opportunity to closely monitor the doctors.

''We are very much concern about doctors' absenteeism and disinterest in rural placement. We know that the doctors are not attending the health centres regularly. Sometimes, we are unable to take any action in this regard because they have the abundant scope of exit. If we take any action against them, sometimes it is found that they quitted the job as they have various options to income.

A doctor came to me last month about his transfer. He has been working in a remote place. He was requesting me to bring him in divisional hospital. He told me that if he could not manage to be transferred then he would leave the job.''

He also mentioned that, not only in Bangladesh, as the doctors have specialized knowledge so they have ample opportunity in abroad as well. Some doctors find that opportunity more lucrative than a government job. Hence, if anyone do not get desirable posting, he/she sometimes tries to move to abroad. In the interim period of going abroad, they do not perform their duty attentively; rather they are busy with processing their visa and other necessary job. As a result of that the health centres suffers from absenteeism. The opportunity, the doctors are getting in any point of their service life is rarely have for other service-holders. As other government employees have not that much technical expertise, so their scope of exit also limited. Therefore, very few are leaving their job. after 4/5 years of service life. On the hand, many doctors are leaving the government job if it is not suitable for them.

5.3.2.3 Institutional support

Institutional support is an important factor for an employee to create proper environment for work. Employees are part of an institution, so institution's characteristics and norms guide its' employees. Lack of institutional support or institutional weakness can lead to employee's dissatisfaction. Institutional support can be tangible and intangible. Tangible supports are logistics, infrastructure etc. and intangible supports are like rules and regulations, promotion policy, monitoring and so on. As institutional support influences employees' performance and decision making therefore this study look upon those factors.

There are some problems with policy and regulations which are not compatible with the health governance. There are many factors found from the field study related with institutional support, those will be discussed later in this section.

A discussion with a joint secretary of MoH & FW clearly indicates that there are weaknesses in institutional support and the government also aware of it. Because of monetary capacity the government cannot afford to provide all the support needed in the rural areas. Although other officials also facing some problems in the rural areas, but the rate of absenteeism is lower for those sectors. Besides, very few posts are vacant in other sectors

Box 5.2: Statement of a respondent (policy maker)

A joint secretary working in the Ministry of Health and Family Welfare (MoH & FW) found the capacity of our country is not adequate to provide all the facilities. He states that:

''Bangladesh has done a great job in achieving MDG goals. Infant mortality rate, child mortality rate have significantly dropped down. We have done great also in other indicators. Now we are working to achieve the SDG goals. Until now, the initiative is admirable to achieve the SDG goal in line with health sector improvement. The government has taken a great initiative to provide doctors in the Union sub-centres to ensure medical facilities for the rural people, because the people who are living in the remote areas are deprived of proper health facilities. However, it is undeniable that the infrastructure and logistics support is not adequate in the union health centres.

Of course, an inadequate facility is a hindering the process but we have to take the economic capacity of our country in consideration because, this country has not the capacity to provide all the facilities in every unions. The doctors also need to understand the condition and need to be rational in this regard so that the patients do not be affected.

There are many sectors in Bangladesh those are not getting enough facilities, and support to run smoothly. When we were posted in the field level we also faced many problems, especially in case of logistics support. Even now, there are many UNOs, AC lands, and other government officials are not getting enough logistics support, but still they are performing their duties. Everyone has their own problems, but there is no scope to avoid duties''.

5.3.2.3.1 Weak monitoring and management

An institution can be properly run with its strict monitoring system. It seems that monitoring in rural level is very weak. Upazila health complexes are directly supervised by civil surgeons from districts with the help of UH & FPO at Upazila level. It was found that monitoring is very weak in the rural areas. UH & FPO usually does not visit the USCs regularly. The sub-centres personnel claim that the UH & FPO very rarely inspect physically. As a result of that, there is no one to monitor the doctors in union level. Most of the doctors posted in union level do not stay at station. They come from very far. So, it is not possible for the doctors to attend every day in the centres. Most of the doctors of union sub-centres attended once or twice in a week or even in a month. As the UH & FPO is not monitoring properly or there is lack of monitoring so the doctors take the chance to be absented and they utilize that time for their personal benefits, i.e.: study, private practice etc.

It was also found that, doctors somehow manage the local authority (UH & FPO) to be absented from the duty as their family live in urban areas. If UH & FPO is weak in management and biased to sub-ordinates then it allows doctors' unauthorize absence.

5.3.2.3.2 Security

Security is a great concern for doctors in rural areas. Almost every doctor admitted during interview that, they feel insecure working at rural health facilities as the local leaders, influential and powerful persons or local people sometimes may aggressive if there any accident occurs. There are many incidents of physical assault of doctors by the relatives of patients. Doctors working at rural health facilities are in stress from fear of security and thus they cannot perform their duty as it should be. Consequently, in some cases, doctors intentionally refer patients to the district hospital to avoid any unwanted situation, which could be cared at UHC.

A study by Hossain et al. (2007) also found similar findings that vandalism or violent attack, public grumbling, physical assault to doctors are very common incidents in Upazila level health facilities.

While a doctor was asked about this issue, he admit that, working in rural areas is riskier than that of urban areas. He said that:

> ``We try to provide our best to serve the patients in spite of scarcity of logistics support. However, sometimes we do not take any risk even we know that there is treatment of that particular problem in local level. Still, we do not take any chance in case of critical patient; we refer directly to district or divisional level. Because, if any accident happens, the local leaders or patients attack doctors even if there is no negligence from doctors. By doing this, we are in safe side, but patients are being suffered; they are being deprived of proper health care. For example, if a patient who has cardiovascular disease (CVD) comes with a sudden heart-attack, needs special care of him with delicate equipment. Rural healthcare centres usually do not have those facilities, so we cannot provide exact treatment. In that case if the patient dies, relatives of the patient or local people may blame us for negligence. Therefore, we may refer the patient immediately to district hospital as a safeguard. Hence, to ensure proper healthcare in the rural level, security for doctors also need to be ensured along with other support.''

Moreover, women often need to serve in very remote areas. They need to travel alone to that place. But there is no security. Besides, if there is any incident happens with patients then there is no one to save a doctor. Therefore, it is riskier for them to work without any security. On the other hand, other officers in Upazila level are getting security when they move for duties, especially where there is a chance of hazard.

5.3.2.3.3 Promotion policy

Promotion is an important motivational factor for the employees**.** Promotion policy is not favourable for doctors. They are not being promoted regularly. As a result of that, they are demoralized. Therefore, they try to escape from their duty or performing duty only to save their job.

As they are not getting promotion on time and working in same position for long time so they are not being honoured socially, so they are depressed. One of the doctors says:

> ‘‘If a doctor posted in a rural health facility after being promoted, then it may motivate to stay there. As doctors are not getting promotion and working in the same position for long time in a same centre, therefore socially they are not being received cordially. They cannot mix with other officers freely in the rural areas’’.

As a part of society, every doctor expects social recognition and honour. Because of irregular promotion they feel that they are deprived and are not being accepted in society with honour. Therefore, there are two affects of irregular promotion, one is lack of social recognition and another is de-motivation. Consequently, doctors try to avoid duties and behave rationally so that they can be benefitted other ways like monetary benefit.

5.3.2.3.4 Less scope of application of theoretical knowledge

A junior consultant who belongs to 22nd BCS working in Ghatail Upazila health complex is highly depressed with his placement. He was never been posted in urban areas as he claim that he has no connection with any influential person or higher authority who can favour him to provide a suitable posting. He told that he completed his post-graduation in 2009 and after that he got promoted as junior consultant from medical officer. He is specialized in cardiology but the logistic support does not permit him to apply his theoretical knowledge. He says:

> ‘‘Medical science is not static. It is changing course with time. But I am detached with the recent development of medical science living here in the rural areas. I do not have the diagnosis machines here or any logistics support to analyse a patient with care. I only can suggest going to the urban health centres or to the consultant living in the district level. I only prescribe some common medicine like a medical officer, as

I do not have adequate logistics support for the proper treatment of a patient. So, I almost forgot everything what I have learnt in my post-graduation level. My knowledge has no use here''.

5.3.2.3.5 Corruption of local authority

The corruption of local authority creates a scope for the doctors to avoid their duties. Higher authority also aware of these types of incidents. One of the high officials of DGHS said that somehow doctors in rural areas manage their direct authority by giving monetary benefit or by pressure from higher authority. He says:

''There are some managerial problems in the field level. If a manager (UH & FPO) is strict enough to monitor or supervise his/her sub-ordinates then they cannot avoid their duties and cannot leave the posting places. In most of the cases, doctors make liaison with UH & FPO and leave station with the consent of him. Sometimes, the UH & FPO take monetary benefits from the doctors to allow them illegal absence. So, it is sheer failure of that UH & FPO''.

This study found that an UH & FPO used to take fixed amount of money every month from the doctors and allowed them scope unofficial absence. Consequently, doctors enjoyed opportunities to be irregular in duties. A local leader also supported this statement and told that, one of the UH & FPO used to take a certain amount of money from the doctors monthly and allow them unofficial leave.

5.3.2.3.6 Contraction with government policy

One of the main visions of the health policy of Bangladesh is to provide adequate and proper health service to the root level people. Therefore, government send newly recruited medical officers to union level. Disregarding the policy UH & FPO bring them to the Upazila health complex and attach there for duty as there is scarcity of doctors in Upazila level as well. Therefore, the doctors work in the UHC in lieu of union sub centres. As a result of that, the people of the remote areas are being deprived of proper health service.

5.3.2.3.7 Doctor-staff relationship

The doctor-staff relationship sometimes is not friendly. Sometimes SACMO, working at USCs are not receiving doctors cordially because they are familiar as a MBBS doctor to the rural people. They have chambers in rural areas. If a doctor posted there and work regularly then SACMO would not be welcomed to the patients as now. They would not be honoured and thus will lower the SACMO's income.

5.3.2.3.8 Cadre discrimination

As there is very high discrimination among different cadres so, doctors are embarrassed to work in Upazila level. Need to work with junior UNO (Upazila nirbahi officer). So, even UH & FPO do not get expected honour from the other employees and even from the mass people. The main discrimination they feel in case of: vehicle, security, promotion, residence etc.

In Ghatail Upazila, the UH & FPO belongs to 20th BCS and the UNO is 27th BCS. Some doctors said that, it is very derogatory for the doctors to work in an environment where the juniors from the other cadres are enjoying more facilities, privileges and honour than the senior doctors. Therefore, doctors do not feel comfortable to work with the juniors.

5.3.2.3.9 Scarcity of the doctors

One of the criteria to be promoted to junior consultant or assistant professor is to complete the post-graduation degree. But, after completing the post-graduation degree, sometimes the doctors intentionally do not submit their certificates to the authority as they might be promoted and posted in the rural areas as consultant. So, they hide their certificates from the authority and when they can manage a favourable posting, and then they submit their degree completion certificate and take posting. As a result of that, many posts are vacant in the rural areas. One of the main reasons found behind doctors' scarcity in the rural areas is, Medical Officers (MO) are not taking promotion as junior consultant intentionally and thus most of the junior consultant posts are vacant in the Upazila health complex.

In the Upazila level, consultants supposed to work only in outdoor and in case of emergency call. So, they are not available always in the health complex. Besides, if a doctor promoted as consultant and posted in a suitable rural area, then it gives motivation and job satisfaction. As they are not being promoted on time so they are being de-motivated and trying to escape their duties. As there is scarcity of the doctors in Upazila level, so the UH & FPO withdraw the doctors from the Union level doctors to serve in Upazila health complex, which he cannot do officially.

5.3.2.3.10 Lobbying

In this study, lobbying means persuasion for better placement. Personal relationship with higher authority or political leaders plays a crucial role in case of placement. The doctors who have strong lobbying with higher authority or leaders or have a strong connection with medical association, they have scope of better placement. Even they can manage not to attend in the rural centres regularly. In some cases, they only go to the sub-centres once or twice in a month to draw their salary. For example: A doctor of 20th batch is working in UHC told that, he has no back up or political connection by which he can peruse for better posting. Even no higher authority is close to him who can favour to provide a better posting. As a result of that, he never was posted in district or divisional level. He has been serving in Upazila or Union level since he got the job. Therefore, he is very depressed with his job. On the other hand, a SACMO told that, a doctor was posted in a union sub-centre. She is a relative of a high official. So, after being posted in the sub-centre, very soon she could manage to take a posting in a hospital in the capital. Even, before taking posting in the capital, she was very irregular in the union sub-centre. These examples indicate that, the doctors who have strong lobbying can avail a better placement.

Haque (2015, p. 12) in his recent research paper states that: ‘‘Placement of doctors to key or preferred work stations are influenced by political decisions. The professional associations such as Bangladesh medical association (BMA)[7] also play key role in such influence system. Many positions of medical officers or doctors at Upazila remain vacant due to political tadbir or due to managed-transfer to a preferred location which may result in a denial of services to citizens.’’

5.3.2.3.11 Residence

During the interview, almost every doctor mentioned the problem with residence. The condition of residence facility in rural areas is very poor. There is no provision of residence for the doctors in union level. There is a dormitory in Upazila level but the doctors are not satisfied with its facilities. The numbers of rooms are not adequate for the doctors. In some cases, there is no electricity or water supply. Therefore, it is difficult for doctors to spend a night or even perform duty properly. Because of the poor condition of residence doctors are not interested to stay there.

5.3.2.3.12 Logistic support

Doctors are not satisfied with the service they are providing to the patients in the rural areas. They cannot provide proper treatment/service to the patient due to lack of equipment, testing facilities, medicines etc. A doctor says:

> ‘‘If there is necessity diagnosis or check-up rather than only providing some primary medicine or treatment, then patients move to the Upazila health complex as there is no test or diagnosis facilities in union sub-centres. If logistics support is not there then there is little necessity of an MBBS doctors in union level as a SACMO can provide primary medicines. Doctors are also not satisfied with the service they providing to the patients’’.

This study found that logistic support is inadequate in the union sub-centres. There are some health centres where there is no electricity or even pure drinking water is not available. Some centres do not have toilet facilities. Besides, doctors do not have necessary equipment for proper treatment. Unavailability of these facilities makes the doctors disinterested in rural placement.

To monitor whether the doctors are performing their duties regularly, an UH & FPO needs to visit the unions sub-centres frequently, but he has no official facilities of vehicles. Therefore, the authority is not interested to pay regular visit to monitor the doctors’ presence in USCs.

5.3.2.3.13 Special type of duty schedule (roster duty)

Medical sector has special kind of schedule of duty that is roaster duty (see: annex G). Doctors have shifting duty at night and day. Some doctors who live far from Upazila health complexes, they take duty 24 hours in a row and leave the station managing the authority. So, sometimes it also creates scarcity of doctors because of their absence.

There are three shifts in a day; each one is 8 hours shift. If a doctor is assigned to duty every day or every alternative day, then he/she cannot leave the station. Rather, it is found in the study that unofficially doctors take duty in a row. Therefore, after completing their duty doctors leave the station. It creates pressure on other doctors to perform their duties. As there is scarcity of doctors, absence of some more doctors affects quality service delivery.

5.3.2.3.14 Distance of the Unions from the Upazila sadar

There are some sub centres in Ghatail Upazila those are located in hill area and distance from Upazila sadar is about 20 kilometers (Table 5.6). Moreover, transportation facilities are very poor as the roads are broken. Sometimes, during rainy season doctors even cannot go to the centres when roads are under water.

Table 5.2: Distance of the Unions from Upazila sadar

S/N	Name of the Union sub-centres	Distance from Upazila health complex
1.	Digar (Brahmonshashon)	6 Km
2.	Pakutia (Deulabari)	7 Km
3.	Anehola (Ekashi)	10 Km
4.	Deopara	13 Km
5.	Dhalapara	15 Km
6.	Rasulpur	19 Km

Source: Google maps, 2017

The lowest distance of a Union sub-centre is 6 kilometres and the highest distance is 19 kilometres. Among those six unions, only Digar (Brahmonshashon) and Pakutia Union sub-centre is located beside a highway and others are located in very remote areas. Deopara, Dhalapara, Rasulpur sub-centres are located in the hill area and people communicate with auto-rickshaw. The roads are broken, so it is very tough to communicate. That is why; doctors are also not interested to go there and most of them are being absented regularly.

5.3.2.4 Professional development

Apart from social recognition, one of the main reasons for a doctor to join in government service is to have the opportunity of post-graduation training. The doctors need to complete their post-graduation degree to get the first promotion - it is mandatory for them. No other cadres' members have such kind of requirements for their promotion. Therefore, doctors are prone to take placement in urban areas, especially in capital or in divisions to complete their post-graduation degrees. So, it seems that after getting a promotion this degree is not a significant factor for the disinterest of the doctors in rural placement. Still, there is another dimension of being promoted as junior consultant and posted in Upazila health complexes. Junior consultants are specialized in a certain area. So, they have the capability to investigation a patient thoroughly instead referring a critical patient to the district hospitals. However, as there are not adequate facilities of diagnose a patient because of lack of modern instruments like ECG (Electrocardiography), X-ray machines, so the doctors are bound to send the patients to the district level. Even, sometimes the doctors intentionally refer the patients to the district or divisional hospitals to protect themselves from any unwanted situation.

5.3.2.5 Stakeholder's concern

Along with doctors, there are some other parties in health governance of Bangladesh who directly or indirectly affected by the health sector. They also can play an important role on the service delivery or planning system. Stakeholders in health sector are divided in two groups, external and internal. Policy makers, higher authority of UHC administration, health centre personnel are the internal stakeholders. On the

other hand, local leaders, social worker, senior citizen, patients are external stakeholders who also affect the organization's service delivery process. Patients' awareness also plays an important role in this regard. External stakeholders are integral part of health governance, especially in case of monitoring and guiding the organization in the rural areas.

5.3.2.5.1 Less pressure from the demand side

Patients are happy with the treatment and medicines they getting from the union sub-centres. People are also habituated what they are getting. As the people do not demand so other stakeholders i.e.: local leaders, policy makers do not feel the urgency. A statement of a patient is described in box 5.3 in this regard.

Box 5.3: Statement of respondent (Patient)

Mrs. Amina Khatun (Pseudo name) age of 40 came to visit a sub-centre with her baby suffering from fever. She told that she visit this sub-centre almost in every month.

While asking about the service about the sub-centre, she told that she was very satisfied with their service as they provide. She is very happy as she gets free medicines here. She also mentioned that the staffs are very helpful here. She did not face any difficulties to have treatment in that centre.

She once visited UHC with her relative. Her relative was suffering with major problems in stomach. She found that the doctors in the UHC are helpful as well but the doctors did not have adequate time to spend with the patients because of large number of patients. So, she had to hurry. She also visited a private clinic with the same case and found that the doctors stipulated enough time for patients.

While asking about doctor's presence, she indicated the SACMO and told that she always found 'Doctor' in sub-centre.

From the patient's interview it is clear that 'SACMO' of a Union sub-centre is familiar as a 'Doctor' in rural areas, so patients feel that they are visiting a doctor, which they are rally not. This ignorance also creates a problem. The researcher found from the patient register that about thirty to hundred patient visits in a union level sub-centres every day. It indicates that there is necessity of doctors for better health service but because of ignorance the people in the remote areas do not feel that urgency. As the people are habituated with the service they are getting, so their expectation is not high. Consequently, the demand for a doctor in remote areas is less than a forward area.

5.3.2.5.2 Lack of monitoring from stakeholders

In a union that is about 20 kilometres far from the Upazila sadar and transportation facility is very poor, it was found that the doctors usually do not get absented even this sub-centre is located in a very remote place. According to the patients and the health centre's staffs, the reason behind is the chairman, members and the senior citizens regularly visit that sub-centre. If a doctor is absent, they immediately inform the UH & FPO.

The statement of the staff of that sub-centre indicates that if the local leaders and other stakeholders monitor the sub-centres, the rate of absenteeism supposed to be lower than the other health centres. Besides, the chances of vacancy also lower if stakeholders are involved in monitoring.

There also local committee in Upazila level those are known as 'Upazila hospital management committee' to provide quality health services and for proper hospital management. The local member of the parliament is the chairman of this committee. This committee is a forum for community participation to improve health service delivery. The committee meetings are supposed to be held in every month. There is scope of community participation through which accountability can be ensured. It was found from the discussion with the committee members that many issues are raised and decisions are taken including shortage of manpower, absence of doctors in every meeting, but the decisions are hardly implemented. Therefore, problems with vacant posts and absenteeism of doctors are continuing over the years.

Box 5.4 Statement of a respondent (Health centre personnel)

Mr. Jamal Hossain (Pseudo name) age of 50 is a staff of a Union sub-centre. He has long experience in service in different Union sub-centre. He also admitted that doctors are not regular in attending in sub-centres, especially the doctors whose family lives far. Some doctors visit sub-centres once a week, even some of them once in a month. There are some female doctors who only come to withdraw her salary from Upazila and visit the sub-centre rarely. She also mentioned that a female doctor was not coming for three months after being posted. She has good rapport with medical association.

She also told that the scenario can be different if the local leaders and influential persons of the area are conscious of the absence of doctors. She says, "If a medical officer is posted here, he/she visit this centre regularly because the chairman and members are very concern about the people and their health service. They regularly visit this centre to monitor the presence of doctor. If doctor is absent, they directly complain to the UH & FPO and raise the issue in monthly co-ordination meeting hold in Upazila every month. So, the doctors are aware of their duty.

When the post become vacant, the local leaders pursue the authority continuously to fill the post. So, it takes less time to get a doctor posted here.

From the above interview, it can be understood that stakeholders can play an important role to monitor the absence of doctors. Local leader can pressure the authority if any post is vacant or if there is any negligence in duties. This study also found that if local leaders or any other pressure group actively monitor the health centres then the absent rate is lower and or vacant posts are also filled up promptly. If they are not aware of what is happening in the health centres then there is some mismanagement.

5.4 Summary of main research findings

The research found high level of absenteeism and vacancies in the studied area. Various factors are associated with absenteeism include postgraduate training, low levels of motivation, family residing far from posting place, weakness of monitoring and disciplinary actions. There is found a unofficial arrangement of absenteeism: that is, doctors manage UH & FPO and remain absent in the working place, which is officially not permitted.

Table 5.3: Summary of findings

Independent variables	Higher impact factors	Lower impact factors
Income opportunity	Not very significant to young doctors in deciding rural placement	
Personal affinity	Children's education, family residence	Scope of exit, egoistic behaviour, habituated in urban life
Institutional support	Weak monitoring, poor residence, lack of equipment and logistics, security, lesser scope of professional development, contraction with government policy etc.	Posting policy, promotion policy, cadre discrimination etc.
Professional development	Very significant to doctors in deciding rural placement	
Stakeholder's concern	Less pressure from demand side, lack of monitoring by the stakeholders	

Source: Depicted by author

The main reasons behind high level of vacancy in rural areas are: lack of logistic support and physical infrastructures, especially doctors are very dissatisfied with the accommodation arrangement. Besides, service delivery is hampered for lack of equipment even there is specialized doctor available, therefore doctors are not interested to work there with the constraints. The incentives also too poor to attract doctors in the rural areas. Lack of proper implementation of policy is another problem for rural placement.

5.5 Interpretation

This study tried to find out the factors related to institutions and personal as well, those affect on the decision of the doctors. Analysing those factors this study attempts to explain the main reasons of the doctors' disinterest in rural placement which ultimately answer the research questions.

So, there are two main components of this study. Those are utility maximization and institution. Here utility maximization means the maximization of benefits through individual rationality and institutional weakness means the lack of support or weakness of rules and regulations of the controlling authority of rural health centres. Institution plays an important role on individuals' behaviour with its norms and regulations. If institution fails to monitor the employees properly then the individuals' behaviour may prevail to maximize their own utility over institutional benefits. So, there is a conflict between those two components that is: conflict between institution and individuals' rationality. Peters (1999, p.3).) pointed out that:

> ''The mercurial and fickle nature of individual behaviour, and the need to direct that behaviour toward collective purposes, required forming political institution''.

Therfore, individuals' behaviour can be controlled by the institution. It seems from the field study that doctors' disinterest in rural placement derives not only from their utility-maximizing but also from the institutional weakness of regulating or monitoring them. So, there is a clear conflict between these two concepts: Institution and rationality.

After analyzing the data, it is found in this study that the doctors are mostly behaving in rational way because of institutional weakness. Institution is failing to control them to work for the collective benefit. So, main interpretation of this study is that: doctors are disinterested in rural placement or being absent from the workplace mostly because of institutional weakness. According to field data, the doctors have desire to work in the rural areas but they are losing their interest as institutions fail to support them.

Basic instinct of men is to behave rationally. The rational behaviour is not harmful. When individuals behave rationally it may affects on collective interests. A very important assumption drawn by Zey (1998, p.1) about rational behaviour of the individuals. She says that:

> ''If individuals behave rationally, the collective will benefit; therefore, individuals should not be interfered with by the collective, except when individual behaviour undermines collective interests''.

Individuals' rational behaviour is not detrimental until it affects others. If doctors' rational behaviour affects the service to the patients, then their actions should be controlled by the institutions. Doctors are part of an institution. So, they are supposed to guide by the norms and rules of that particular institution. When the individual rationality of the doctors affects the service or rational behaviour is deviated from the set-goal, then that affects collective interests. In this case, rationality conflicts with institutional goal.

There are some limitations and weaknesses of institution found in this research, those creating scope for the doctors to behave in benefit maximizing ways. Besides, there are some factors those influence the doctors in rational behaviour which are beyond institutions' control. These are discussed here under some broad areas.

5.5.1 Compliance of policy

There are some discrepancies between policy and its' implementation in the field level. The reason behind this discrepancy is scarcity of doctors. There are only 14 doctors posted in Ghatail Upazila health complex, where actual posts are 32. It means more than fifty percent posts are vacant. Therefore, the UH & FPO bring the doctors from union sub-centres to provide service at UHC. As a result of this, union level USCs are practically vacant. On the other hand, the policy of the government is to ensure health service in remote areas but in some cases it is not being abided by the local level authority.

For proper governance, implementation of policy is very important. In rural areas, there are two types of challenges in implementing the policies and enforcing the rules; one is structural and another is administrative challenge. Here, structural challenge mainly indicates the structure of manpower in rural level. Administrative challenges are weak monitoring and weakness of authority to administer the manpower.

5.5.2 Enforcement of rules

Rules and regulation plays a crucial role in providing proper health care. Rules guard the employees from mismanagement in providing health care facilities. That is why; rules are developed and implemented in all levels of government organizations.

Rules are necessary to ensure compliance of government policy. The regulatory agencies monitor the doctors and other staffs to provide quality services. There are nine regulatory agencies in Bangladesh under MOH & FW who ensures the functions of the health sector according to health policy. DG health office is responsible to monitor and supervise the field level Upazila and Union health units whether the subordinate offices are abide by the rules and regulations. In the local level, civil surgeon and UH & FPO oversight the activities on behalf of regulatory agencies. If the rules are abided in all sphere of health sector, the mismanagement in this sector could have been avoided.

It is found that, in some cases, rules are not enforcing uniformly. It varies person to person. The urban medical centres are over populated with the doctors where the rural centres are suffering from scarcity of doctors. One of the main reasons of that is, many doctors are working in attachment but they are actually posted in rural health centres. The doctors who have the good relationship with higher authorities or who have the power to influence the higher authority are taking this opportunity. Therefore, enforcement of rules is not uniform for all. It is hampering the goal of the health policy to ensure health service in root level. It is difficult to ensure the rural placement of the doctors as long as the rules are not uniform for all.

5.5.3 Centre of primary health care

The health facilities in the rural areas basically provide the primary health care. Therefore, the specialized doctors have a little scope to do anything more than providing primary health care. Consequently, specialized doctors who are posted as junior consultant are not interested to stay there because of logistics support.

5.5.4 Lack of motivation

Lack of motivation in the rural areas is mainly derived from lack of incentives, lack of esteem or social recognition, cadre discrimination, lack of promotion etc. As different facilities and opportunities in the rural areas are less than the urban areas, so other incentives are needed to retain the doctors. As there is lack of incentive in rural areas, which could motivate them so doctors are not interested in those placements. Liu and Mills (2007b, p. 196) utter that, doctors are not always motivated by pecuniary incentives. Doctors try to maximize their utility by not only income but also with other incentives. According to them, utility maximization model indicates that the doctor's behaviour should be managed or controlled by using multiple countermeasures. Only financial incentive excluding other elements may result in failure to fully motivate the doctor's positive behaviour.

Apart from the doctors, there are other civil servants working in the Upazila level. Different cadre services have different sources of motivation. For example: An administrative cadre officer's motivation may be his timely promotion. They know that after a certain period of serving in the field level, they might be promoted or their might be better posting. Moreover, he is holding and exercising the designated power in the field level, which may also a source of motivation for the administration cadre. On the other hand, doctors neither exercise executive power, nor they have ample opportunity of promotion. Hence, their source of motivation is professional development and the scope of that is absent in rural areas. Thus, doctors are interested in urban placement.

5.5.5 Less expectation of the service receivers

There is very little demand for a doctor because the patient's expectation is very low to a sub-centre. The union level sub-centres provide only primary care and primary medicines. Because of the structural set-up of a union sub-centre, it only facilitates preliminary care and patients are aware of it. As a result of less expectation the patients are satisfied with the service of sub-centres. Consequently, the demand of a doctor is very low or unknown to the patient and it allow the institution a scope to let a union sub-centre vacant or a let a doctor absented.

5.5.6 Post-graduation policy and promotion policy

The need of higher study for the doctors is undeniable. Most of the doctors join in service after completing the graduation degree that is known as MBBS. This particular degree meets the minimum qualification criteria to join as ``Medical officer'' in government service. However, it is required a post-graduation degree for promotion in government service. The doctors also need to complete this course for their professional development. They pursue those courses taking education leave or with deputation. Some medical colleges, institutes alongside Bangabandhu Sheikh Mujib medical university (BSMMU) offer those degrees and courses. As these facilities are not available in the rural areas so, doctors are need to move to those institutions to get admitted themselves in those courses.

According to the ''Post graduation for medical education and training (Inside country) related deputation policy -2013'' usually a doctor will be eligible to pursue those courses after successfully completed 2 (two) years period, with some exception, service in Upazila or union level health centres. As it is related with promotion, so after completing two years in rural areas the doctors try to get admitted in one of those courses. The rural areas are already suffering with scarcity of doctors and this step of the doctors worsens the situation. If there was no obligation of post-graduation degree, the doctors may not hurry to have the degree.

5.5.7 Inadequate incentive, rationality and institution

It is needed to bear in mind that medical service is special type of good: that is called credence good. Decision about buying these goods is not taken on the basis of buyer's experience, rather buyer need to rely in the seller's experience or expertise (Sloan, 2001).

Public sector seems not fully capable to provide adequate health service. So, private sector is offering that service introducing system. As a result of that doctors are taking that opportunity of incentives to maximize their personal gain. A very recent study on credence goods shows how incentives plays role on opportunistic behaviour if institutional regulations are not strong enough. Baniamin and Jamil (2017, p.1) in their recent research state that:

> ''The introduction of an incentive system for service providers may be problematic, as it may encourage service providers to act in opportunistic ways for the sake of personal gain. Opportunistic behaviour may become more prevalent where there is problematic governance and comparatively loose regulation. In this type of situation, an opportunistic expert can exploit the information asymmetry for personal gain''.

This statement also supports that because of institutional weakness individuals try to maximize their benefit using existing opportunity. As public sector cannot fulfill their expected incentives so they are trying to gain it from private sector and loose regulation and monitoring creating that opportunity.

5.5.8 Unequal power and resource distribution

The employees in different level hold different power. Power also gives the feelings of honour and prestige to an employee. Because of different level of power, there may create inequality which may leads dissatisfaction and consequently hampers an institutional goal. It may create conflict among the employees. According to Zey, (1998, p. 60):

> ‘‘Conflict arises when two actors seek the same goal and cannot attain that goal at the same time, to the same extent (e.g.: two parties that cannot hold the same office; two employees who cannot hold the same position; [….] The less prone the two parties are to evaluate their gains and losses through economic calculation, the higher the level of conflict’’.

There are mixed of cadres working in an Upazila administration like administration cadre, agriculture cadre, health cadre and so on. It is seen that, every cadre officials expect honour and same facilities in same environment. But some cadres exercise more power than others and that creates inequality. Consequently, the deprived cadres feel themselves inferior and try to incentivize themselves in other ways that may benefit them.

5.5.9 Conflict between principal and agent

The relationship between the government and the Doctors can be shown within principal-agent framework. Here the government can be said a principal and the doctors can be identified as an agent working on behalf of the government. As Gibbons (n.d.) describes:

> ‘‘The central idea behind the principal-agent model is that the principal is too busy to do a given job and so hires the agent, but being too busy also means that the principal cannot monitor the agent perfectly’’.

Principal-agent conflict is a significant factor of doctors’ behaviour in case of rural placement. So, he doctors are supposed to work as the government directs. In some cases, doctors acting as principal which leads to mismanagement of health sector. The perfect example of this statement is: sometimes doctors’ decision conflicting with the government policy. This study found that the authorities who are responsible to supervise and monitor the doctors showing negligence. The government of Bangladesh is trying to take the medical service in the door steps of remote villagers. One of the main actors to implement this policy is UH & FPO in the urban level who manage and supervise the Upazila Health complex and the union level sub-centres.

But the view of UH & FPO is to cover the service of the Upazila level first. As there is scarcity of doctors in Upazila level, so they are concentrating on Upazila health complexes avoiding union sub- centres. As a result of that the root-level people are being deprived of proper health facilities. Not only in the Upazila are level but also district and divisional authority sometimes showing same attitude that is conflicting with government's strategy. So, this contraction between two parties creating opportunities for the doctors to move to the urban areas from rural areas.

5.5.10 Traditional versus contemporary authority

The health sector of Bangladesh is not following modern managerial system. It is following traditional authoritative system. It seems that, the government of Bangladesh is practicing traditional bureaucratic system in health sector. From the top level to the root level there is a hierarchical structure in monitoring and supervising. However, system somehow is not functioning properly for health sector management. The authority of this sector wants to continue traditional bureaucratic system, but the reality is different. The characteristic of institutions, service delivery system is changing day by day. So, it is need to change the authoritative system from traditional to modern, otherwise there may have problem in monitoring and controlling.

Moreover, health sector is completely different in nature from other administrative sector. So, traditional hierarchical bureaucracy, which is Weberian bureaucracy, seems ineffective for health sector management.

Naranjo-Gil, Sánchez-Expósito and Gómez-Ruiz (2016) conducted a study on management control practices for developing countries. This study compares the between traditional and contemporary management system in achieving policy goals for public health sector. The study analyzed how two different uses of such practices facilitate the achievement of public health policies. The findings show that contemporary management control practices are more suitable than traditional practices to achieve public health policies. Moreover, results show that public health

policies are better achieved when managers use management control practices in an enabling way rather than in a coercive way. Therefore, to achieve better result contemporary management system may effective in context of Bangladesh health sector.

5.6 Conclusion

It is a widespread perception in Bangladesh that the doctors behave rationally to maximize their benefit. Human being is always rational. Still that rationality of the members of an institution can be controlled by the rules, regulations and the proper implementation of those and with proper monitoring. It seems that the institution is not functioning well in this case. There is no question about the other officers in the rural level about their irregular attendance. The other organizations like office of the UNO, agriculture office or in any other offices in the Upazila, the personnel are attending regularly or more regular than the doctors. May be, those institutions have strict monitoring system and incentives as well. As the doctors have the opportunity to utilize their time with the weakness of the institution, they are using it.

It can be inferred that income opportunities for the junior level doctors are higher in the rural areas than in the urban areas. For the young doctors, income opportunity is better in the rural areas than the urban areas.

As there is scarcity of the doctors in the Upazila level, so the income opportunities of the doctors (General MBBS) are very much higher than the metropolitan or in the big districts. General MBBS has rarely scope of private practice in the urban areas. Because the urban people usually visit a professor or assistant professor or a consultant for their problems.

If a doctor is interested to practice privately or to work for the private clinics after their stipulated duties then there is adequate chance in rural areas as in the urban areas. Therefore, it seems that the significant reason for the doctors in preferring the urban placement may not the income opportunity rather it is institution that's failure leads the doctors to behave to maximize their benefit. It is obvious that public servants can be utility-maximisers. As Niskanen (1973 cited in Felkins, 1997) describes:

> ‘‘It is the behaviour of public sector bureaucrats which is at the heart of public choice theory. While they are supposed to work in the public interest, putting into practice the policies of government as efficiently and effectively as possible, public choice theorists see bureaucrats as self- interested utility-maximisers, motivated by such factors as: "salary, prerequisites of the office, public reputation, power, patronage...and the ease of managing the bureau."

So, as a public servant to behave rationally or to be a utility-maximiser is very much expected. But it is sometimes harmful because the patients directly suffer from doctors’ utilitarian behaviour. That behaviour can be checked by proper implementation of institutional norms and regulations. As the institution is not functioning as it should have been, so the health service is suffering.

This study found that, most of the doctors are dissatisfied as they are not having adequate support from the institution to create proper environment to make them stay in the rural areas. So, there are two situation stands for the doctors. Firstly, the doctors who have the exit-opportunity from the rural areas are taking the opportunity to place themselves in urban areas. Secondly, some have no exit-opportunity; so, they are bound to stay there, even if they cannot maximize individual benefits. On the other hand, if institutional support is adequate, supervision and monitoring is strong enough then individual rationality cannot prevail.

It can be concluded that the doctors would not behave rationally to maximize individual benefit that is harmful for the collective, if the institution would have worked properly. Therefore, it seems institution has lacking to control the rational behaviour of the doctors that is detrimental for the society.

Chapter 6
Conclusion

6.1 Introduction

The aim of this chapter is to summarize and draw overall conclusion of entire study. More specifically, this chapter provides the answers of the research questions like: what are the factors behind doctors' disinterest in rural placements? Do the doctors prefer urban posting places mostly for utility maximization? Does institutional weakness create opportunity for the doctors to avoid their duties in rural areas? In this chapter, researcher also tried to review the theories and methodologies applied in this research.

The main objective of this study is to examine the factors those make doctors disinterested to rural placement. It also examines the incentives those drive the doctors to urban areas. Besides, this study tried to explores the factors related to institutions those may affect doctors' decision in regard to placement. Based on theoretical review some variables were selected to test the interrelationship between dependent and independent variable. Based on these variables, this study developed some assumptions and tried to test their relationships as per the empirical analysis of data. For this, rural placement of doctors is considered as dependent variable. Whereas, income opportunities, personal affinity, institutional support, professional development and stakeholder's concern were selected as independent variables of this study. This research conducted on explanatory design with qualitative approach to test the impact of explanatory variables i.e. independent variables on dependent variable. Independent variables of this study were derived from the rational choice theory, institutional theory and related literatures.

6.2 Individual factors affecting decision making

This study examined the factors affecting decision making towards rural placement from two perspectives: one is individual and another is institutional. It is found that the both factors play a significant role in case of rural placement. The individual factors mainly related with doctors' family. Doctors consider the proximity of living place of their family from their posting place before having a placement. Most of the cases families of the doctors live in different place from doctors' posting area. Therefore, if doctors can visit their family frequently and with at ease, they consider that posting somehow acceptable. Besides, children's education is also a big concern for them. As there are limited opportunity for quality education for the children, so doctors leave their family at least in district level.

The assumption of this study was that the doctors' income maximizing behaviour may lead them to urban areas. However, it is found that the young doctors have more opportunity of income in the rural areas than urban areas as the people of urban areas are interested to visit the doctors who have more professional degrees. Besides, income from private practice does not depend only on placement, rather it also depends on familiarity of a doctor, length of practice in a particular area, reputation and so on. Therefore, the income opportunity has very insignificant role in case of rural placement.

Apart from these, most of the spouses of doctors are working in urban areas. Therefore, doctors cannot afford to stay with their family in rural areas. This is also a factor for doctors heading to urban areas.

6.3 Institutional factors affecting attitude towards rural placement

Institutions play an important role on doctors' placement in rural areas. There are some factors which force them to leave the rural areas. Besides, there are some weaknesses of the institution because of those it fails to control the absenteeism. Weak monitoring in local level creates the scope of absenteeism. It is found that, managerial

incapability or weakness in the local level is very high in rural areas, therefore they cannot oversee the sub-ordinates properly. Besides, mangers do not have enough logistic support, i.e. vehicle support to monitor the presence in the Union level.

Health policy of Bangladesh included some provision to ensure doctors' availability in rural areas. However, some policy like promotion policy conflicts with the health policy as doctors need to complete post-graduation to be promoted. That is why, as soon as they complete mandatory two years' service in rural areas, doctors try to move to urban areas. Moreover, local authority's decision also conflicts with country's policy which hampers the process of ensuring proper health service in rural areas.

6.4 Re-examining the research questions

As identified in chapter one, the foremost objective of this study is to find out the factors behind doctors' disinterest in rural placement. The broad research question of this study in this regard is: what are the factors behind doctors' disinterest in rural placements?

To find out the answer of main research question, there were also three specific research questions. The first specific research question was, do the doctors prefer urban placement mostly for income maximization? A very interesting finding came out from this study that, income opportunity has very insignificant impact on disinterest in rural placement. The reason behind this finding is: most of the doctors who posted in rural areas are young. Therefore, they have very limited income opportunity in urban areas as urban people are interested to visit the senior doctors like senior consultant, associate professor, professor or who has a professional degree. As young doctors has limited experience and in some cases no professional degree, so they have very limited scope of income from private practice. Besides, income from private practice does not only depend on rural or urban placement. There are other factors like goodwill, length of private practice in a particular area, good relation with patients etc. Therefore, it can be inferred that doctors of rural areas are not choosing the urban placement for better income opportunity.

The second specific research question was: do doctors use posting places to maximize other utilities than income? It is found that, the incentives given by the institution for doctors in the rural areas are very limited. Therefore, doctors try to maximize their other utilities those are benefited for themselves. Most of the utilities for doctors related with family concern and professional development. Proximity of family residence from posting place and children's education is a great concern for them. As there is very limited scope for quality education for their children, so doctors are not interested to be posted in rural areas. Moreover, doctors cannot take any professional degree from rural areas, which is very important for their professional development, so they try to manage a placement in urban areas.

Third specific research question was: does institutional weakness create opportunity for the doctors to avoid their duties in rural areas? This study found that, there are some factors those are related to individuals' rational behaviour that is very general, but most of the cases institutional weakness has high influence on doctors' behaviour to move to urban areas. Lack of institutional support like, residence, promotion policy, cadre discrimination, logistics support, security play significant role to make doctors disinterested to rural areas. Besides, stakeholders' awareness also has some impact in ensuring presence of doctors in health facilities.

6.5 Theoretical notions

Theoretical framework developed in this study was based on rational choice theory and institutional theory. These two theories have been helpful in explaining the study problems. Proposition of hypotheses based on the theoretical arguments and test of these research questions by the empirical findings tried to establish relationships between independent variables and dependent variable.

North (1990) argues in institutional theory that institutions consist of formal and informal rules. This study revealed that, in local level there are some informal rules are prevailing those are not compatible with formal rules which allows absenteeism in rural level. On the other hand, institutions use some constraints to guide or control the individuals. In some cases, those constraints (i.e. strict monitoring, actions against

discrepancy etc.) are ineffective which also creating opportunity for doctors to be unaware of their duties. Although, Upazila and union health centres' employees are the participants of rules-based institution but there is deficiency in implementation of the rules. It also can be said that there is lack of commitment in the participants to abide by the rules.

Peters (2000) addresses that a rational institution deals with its' employees with constraints and incentives. On the other hand, rules-based or normative institution supervises and controls the participants of an institution with rules and regulations. He also suggests that if the rules are not obeyed by the participants, those may not call rules. So, rational institutions use incentives to motivate the employees. It is found in this study that the presence of incentives in Upazila level is very little which cannot motivate the doctors. It means, the doctors are not interested to rural placement because of the scarcity of incentives.

6.6 Policy implications

The health policy of Bangladesh formulated to ensure availability of doctors and proper health service in rural areas. However, there are some conflict with the health policy and promotion policy, also with higher education policy, which creates some problems in rural areas. It is also found that; improper implementation of policy also has significant impact on placement and presence of doctors at workplace.

The incentives to attract the doctors are very few in rural areas. Government may introduce proper incentive policy to motivate doctors to stay in rural areas. Lack of right kind of incentive may hamper the desired outcome as well.

As Benyamin and Jamil (2017, p.1) describes ''the introduction of an incentive system can be a big challenge, especially when trying to devise the right kind of incentive in order to achieve a better outcome''. Therefore, incentive system also should be introduced carefully to ensure doctors' staying in rural areas.

According to Liu and Mills (2007b, p. 197), ‘‘the income maximization hypothesis predicts that the doctor will behave in a way that maximizes his or her income, and that proper design of remuneration methods and financial incentive schemes can direct a doctor’s behaviour.’’ As there is lack of incentives in rural areas and doctors need to sacrifices many things to serve there so, financial incentives may motivate them to choose rural placement.

6.7 Future scope of research

There is scope of further research to investigate thoroughly to have the complete picture of rural level administrative or managerial system. This current study was done to explore the factors of doctors’ disinterest in rural placement. However, the other cadre officials are attending regularly in Upazila level offices. They are bound to serve in the rural posting. May be there are other incentives those drive them to stay in rural areas or there may be strong managerial system those can control officials efficiently. Therefore, a comparative study between health cadre and other cadre in Upazila level can be done to explore the factors those efficiently making other cadre officials to stay in rural areas.

End notes

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[1]Sustainable Development Goals (SDGs): Sustainable development goals (SDGs) was adopted by world leaders in September 2015 at an UN summit for sustainable development by 2030, which officially came into effect on 1 January 2016. SDGs included 17 goals, which eye for ending all forms of poverty, fighting inequalities and tackling climate change to ensure that no one is left behind. Among those Goals, number three is related to health that is ``to ensure healthy lives and promote well-being for all at all ages''. There are many targets under this goal like, by 2030, to reduce the global maternal mortality ratio to less than 70 per 100,000 live births, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births etc. (United Nations 2017).

[2]Millennium Development Goals (MDG): In September 2000, 189 countries signed the United Nations Millennium Declaration (See: Annex N) committing themselves to eradicating extreme poverty in all its forms by 2015 (UNICEF, 2017). MDGs include eight goals, twenty-one targets and sixty indicators for measuring progress between 1990 and 2015, when the goals were expected to be met. Among the goals three of those are related with improving the health as reduce child mortality, improve maternal health and combat HIV/AIDS, malaria, and other diseases. There are six targets and nineteen indicators under those goals. Some of those indicators are maternal mortality ratio, proportion of births attended by skilled health personnel, under-five mortality rate, infant mortality rate etc.

[3]Upazila: Upazila is an administrative set up at sub-district level in Bangladesh (Haque, 2015). For this study Upazila refers to 'rural area'. There are 491 Upazila in Bangladesh (Bangladesh national portal, 2017).

[4]Union: Union is the lowest tier of administrative unit in Bangladesh. There are 4554 Unions in Bangladesh (Bangladesh national portal, 2017).

[5]District: An administrative unit of Bangladesh. There are 64 districts in Bangladesh.

[6]Right to Information Act (RTI): The act is enacted in 2009 in Bangladesh to make provisions for ensuring free flow of information and people's right to information (Source: Information commission, 2017).

[7]Bangladesh Medical Association (BMA): BMA is the national associations of the physicians in Bangladesh.

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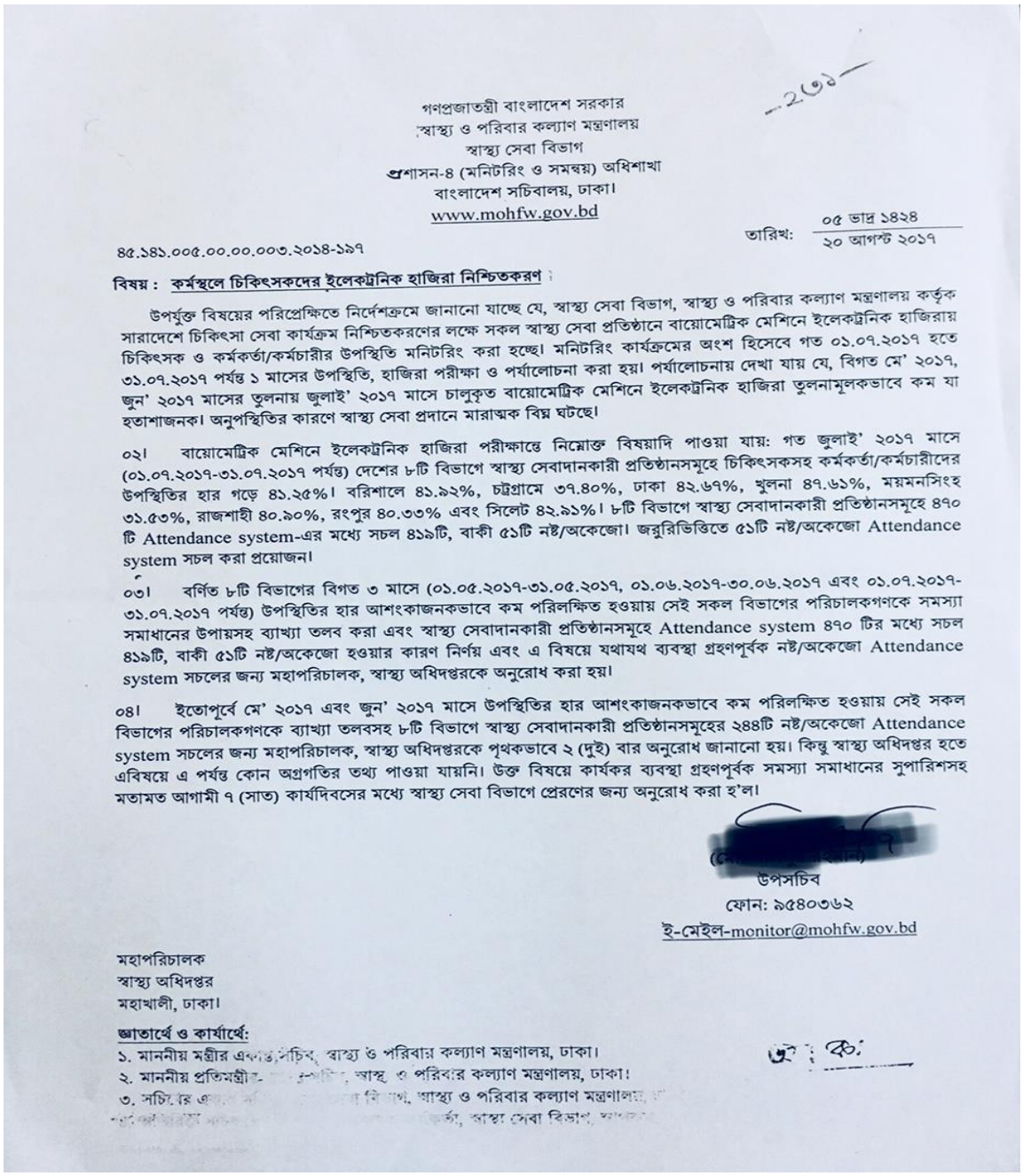
Annexures

Annex: A letter issued by the ministry of health and family welfare about absenteeism



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স্বাস্থ্য সেবা বিভাগ
প্রশাসন-৪ (মনিটরিং ও সমন্বয়) অধিশাখা
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৪৫.১৪১.০০৫.০০.০০.০০৩.২০১৪-১৯৭

বিষয় : কর্মস্থলে চিকিৎসকদের ইলেকট্রনিক হাজিরা নিশ্চিতকরণ

উপর্যুক্ত বিষয়ের পরিপ্রেক্ষিতে নির্দেশক্রমে জানানো যাচ্ছে যে, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক সারাদেশে চিকিৎসা সেবা কার্যক্রম নিশ্চিতকরণের লক্ষে সকল স্বাস্থ্য সেবা প্রতিষ্ঠানে বায়োমেট্রিক মেশিনে ইলেকট্রনিক হাজিরায় চিকিৎসক ও কর্মকর্তা/কর্মচারীর উপস্থিতি মনিটরিং করা হচ্ছে। মনিটরিং কার্যক্রমের অংশ হিসেবে গত ০১.০৭.২০১৭ হতে ৩১.০৭.২০১৭ পর্যন্ত ১ মাসের উপস্থিতি, হাজিরা পরীক্ষা ও পর্যালোচনা করা হয়। পর্যালোচনায় দেখা যায় যে, বিগত মে' ২০১৭, জুন' ২০১৭ মাসের তুলনায় জুলাই' ২০১৭ মাসে চালুকৃত বায়োমেট্রিক মেশিনে ইলেকট্রনিক হাজিরা তুলনামূলকভাবে কম যা হতাশাজনক। অনুপস্থিতির কারণে স্বাস্থ্য সেবা প্রদানে মারাত্মক বিঘ্ন ঘটছে।

০২। বায়োমেট্রিক মেশিনে ইলেকট্রনিক হাজিরা পরীক্ষান্তে নিম্নোক্ত বিষয়াদি পাওয়া যায়: গত জুলাই' ২০১৭ মাসে (০১.০৭.২০১৭-৩১.০৭.২০১৭ পর্যন্ত) দেশের ৮টি বিভাগে স্বাস্থ্য সেবাদানকারী প্রতিষ্ঠানসমূহে চিকিৎসকসহ কর্মকর্তা/কর্মচারীদের উপস্থিতির হার গড়ে ৪১.২৫%। বরিশালে ৪১.৯২%, চট্টগ্রামে ৩৭.৪০%, ঢাকা ৪২.৬৭%, খুলনা ৪৭.৬১%, ময়মনসিংহ ৩১.৫৩%, রাজশাহী ৪০.৯০%, রংপুর ৪০.৩৩% এবং সিলেট ৪২.৯১%। ৮টি বিভাগে স্বাস্থ্য সেবাদানকারী প্রতিষ্ঠানসমূহে ৪৭০ টি Attendance system-এর মধ্যে সচল ৪১৯টি, বাকী ৫১টি নষ্ট/অকেজো। জরুরিভিত্তিতে ৫১টি নষ্ট/অকেজো Attendance system সচল করা প্রয়োজন।

০৩। বর্ণিত ৮টি বিভাগের বিগত ৩ মাসে (০১.০৫.২০১৭-৩১.০৫.২০১৭, ০১.০৬.২০১৭-৩০.০৬.২০১৭ এবং ০১.০৭.২০১৭-৩১.০৭.২০১৭ পর্যন্ত) উপস্থিতির হার আশংকাজনকভাবে কম পরিলক্ষিত হওয়ায় সেই সকল বিভাগের পরিচালকগণকে সমস্যা সমাধানের উপায়সহ ব্যাখ্যা তলব করা এবং স্বাস্থ্য সেবাদানকারী প্রতিষ্ঠানসমূহে Attendance system ৪৭০ টির মধ্যে সচল ৪১৯টি, বাকী ৫১টি নষ্ট/অকেজো হওয়ার কারণ নির্ণয় এবং এ বিষয়ে যথাযথ ব্যবস্থা গ্রহণপূর্বক নষ্ট/অকেজো Attendance system সচলের জন্য মহাপরিচালক, স্বাস্থ্য অধিদপ্তরকে অনুরোধ করা হয়।

০৪। ইতোপূর্বে মে' ২০১৭ এবং জুন' ২০১৭ মাসে উপস্থিতির হার আশংকাজনকভাবে কম পরিলক্ষিত হওয়ায় সেই সকল বিভাগের পরিচালকগণকে ব্যাখ্যা তলবসহ ৮টি বিভাগে স্বাস্থ্য সেবাদানকারী প্রতিষ্ঠানসমূহের ২৪৪টি নষ্ট/অকেজো Attendance system সচলের জন্য মহাপরিচালক, স্বাস্থ্য অধিদপ্তরকে পৃথকভাবে ২ (দুই) বার অনুরোধ জানানো হয়। কিন্তু স্বাস্থ্য অধিদপ্তর হতে এবিষয়ে এ পর্যন্ত কোন অগ্রগতির তথ্য পাওয়া যায়নি। উক্ত বিষয়ে কার্যকর ব্যবস্থা গ্রহণপূর্বক সমস্যা সমাধানের সুপারিশসহ মতামত আগামী ৭ (সাত) কার্যদিবসের মধ্যে স্বাস্থ্য সেবা বিভাগে প্রেরণের জন্য অনুরোধ করা হ'ল।

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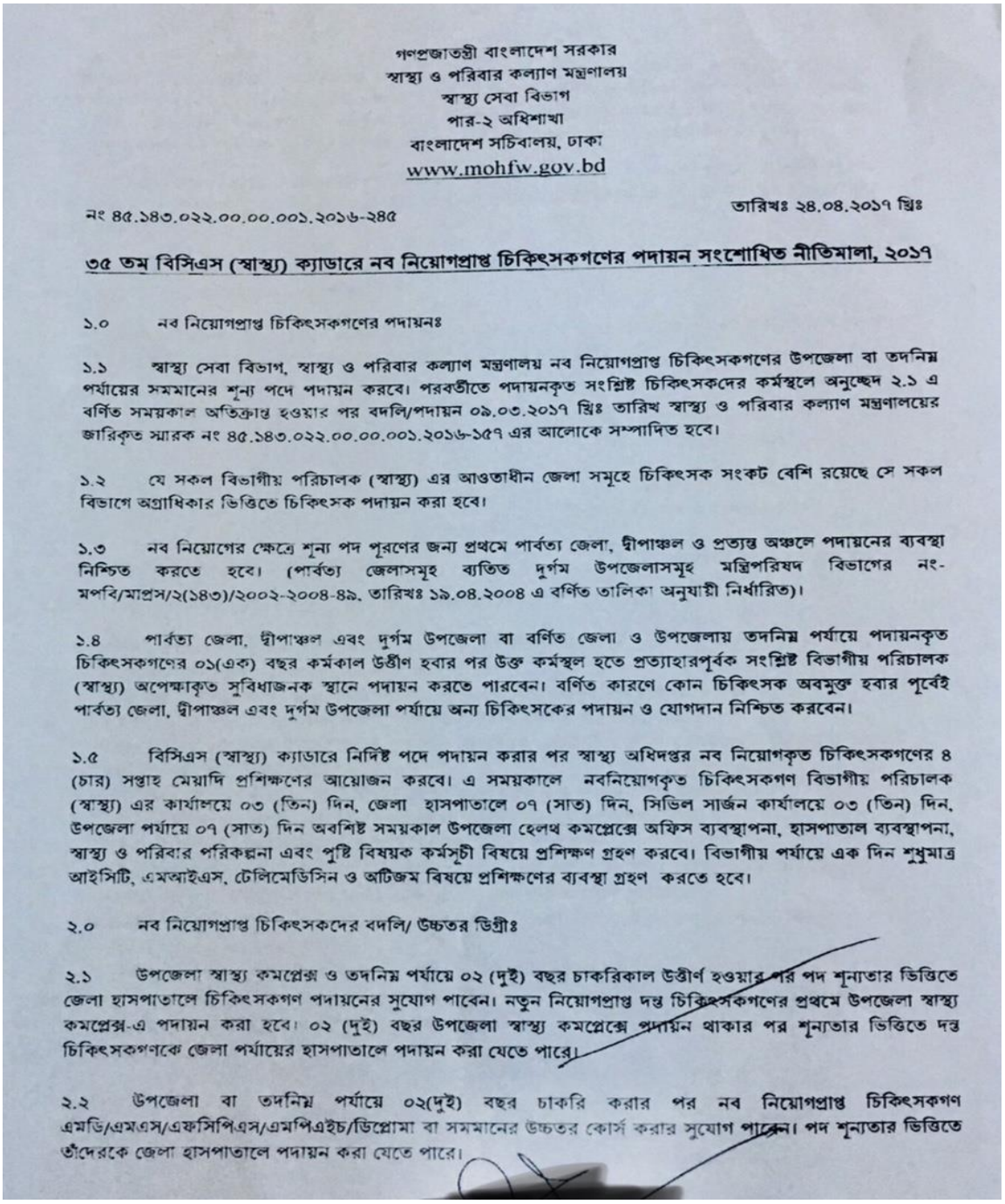
জ্ঞাতার্থে ও কার্যার্থে:
১. মাননীয় মন্ত্রীর একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
২. মাননীয় প্রতিমন্ত্রী- [illegible], স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৩. সচিব, [illegible], স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, [illegible]
[illegible] [illegible], স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য [illegible]

Source: Ministry of health and family welfare, 2017

Annex B: Posting policy, 2017 for newly-recruited physicians (Bangladesh civil service: Health cadre)



গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
স্বাস্থ্য সেবা বিভাগ
পার-২ অধিশাখা
বাংলাদেশ সচিবালয়, ঢাকা
www.mohfw.gov.bd

নং ৪৫.১৪৩.০২২.০০.০০.০০১.২০১৬-২৪৫

তারিখঃ ২৪.০৪.২০১৭ খ্রিঃ

৩৫ তম বিসিএস (স্বাস্থ্য) ক্যাডারে নব নিয়োগপ্রাপ্ত চিকিৎসকগণের পদায়ন সংশোধিত নীতিমালা, ২০১৭

১.০ নব নিয়োগপ্রাপ্ত চিকিৎসকগণের পদায়নঃ

১.১ স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় নব নিয়োগপ্রাপ্ত চিকিৎসকগণের উপজেলা বা তদনিম্ন পর্যায়ের সমমানের শূন্য পদে পদায়ন করবে। পরবর্তীতে পদায়নকৃত সংশ্লিষ্ট চিকিৎসকদের কর্মস্থলে অনুচ্ছেদ ২.১ এ বর্ণিত সময়কাল অতিক্রান্ত হওয়ার পর বদলি/পদায়ন ০৯.০৩.২০১৭ খ্রিঃ তারিখ স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের জারিকৃত স্মারক নং ৪৫.১৪৩.০২২.০০.০০.০০১.২০১৬-১৫৭ এর আলোকে সম্পাদিত হবে।

১.২ যে সকল বিভাগীয় পরিচালক (স্বাস্থ্য) এর আওতাধীন জেলা সমূহে চিকিৎসক সংকট বেশি রয়েছে সে সকল বিভাগে অগ্রাধিকার ভিত্তিতে চিকিৎসক পদায়ন করা হবে।

১.৩ নব নিয়োগের ক্ষেত্রে শূন্য পদ পূরণের জন্য প্রথমে পার্বত্য জেলা, দ্বীপাঞ্চল ও প্রত্যন্ত অঞ্চলে পদায়নের ব্যবস্থা নিশ্চিত করতে হবে। (পার্বত্য জেলাসমূহ ব্যতিত দুর্গম উপজেলাসমূহ মন্ত্রিপরিষদ বিভাগের নং-মপবি/মাপ্রস/২(১৪৩)/২০০২-২০০৪-৪৯, তারিখঃ ১৯.০৪.২০০৪ এ বর্ণিত তালিকা অনুযায়ী নির্ধারিত)।

১.৪ পার্বত্য জেলা, দ্বীপাঞ্চল এবং দুর্গম উপজেলা বা বর্ণিত জেলা ও উপজেলায় তদনিম্ন পর্যায়ে পদায়নকৃত চিকিৎসকগণের ০১(এক) বছর কর্মকাল উত্তীর্ণ হবার পর উক্ত কর্মস্থল হতে প্রত্যাহারপূর্বক সংশ্লিষ্ট বিভাগীয় পরিচালক (স্বাস্থ্য) অপেক্ষাকৃত সুবিধাজনক স্থানে পদায়ন করতে পারবেন। বর্ণিত কারণে কোন চিকিৎসক অবমুক্ত হবার পূর্বেই পার্বত্য জেলা, দ্বীপাঞ্চল এবং দুর্গম উপজেলা পর্যায়ে অন্য চিকিৎসকের পদায়ন ও যোগদান নিশ্চিত করবেন।

১.৫ বিসিএস (স্বাস্থ্য) ক্যাডারে নির্দিষ্ট পদে পদায়ন করার পর স্বাস্থ্য অধিদপ্তর নব নিয়োগকৃত চিকিৎসকগণের ৪ (চার) সপ্তাহ মেয়াদি প্রশিক্ষণের আয়োজন করবে। এ সময়কালে নবনিয়োগকৃত চিকিৎসকগণ বিভাগীয় পরিচালক (স্বাস্থ্য) এর কার্যালয়ে ০৩ (তিন) দিন, জেলা হাসপাতালে ০৭ (সাত) দিন, সিভিল সার্জন কার্যালয়ে ০৩ (তিন) দিন, উপজেলা পর্যায়ে ০৭ (সাত) দিন অবশিষ্ট সময়কাল উপজেলা হেলথ কমপ্লেক্সে অফিস ব্যবস্থাপনা, হাসপাতাল ব্যবস্থাপনা, স্বাস্থ্য ও পরিবার পরিকল্পনা এবং পুষ্টি বিষয়ক কর্মসূচী বিষয়ে প্রশিক্ষণ গ্রহণ করবে। বিভাগীয় পর্যায়ে এক দিন শুধুমাত্র আইসিটি, এমআইএস, টেলিমেডিসিন ও অটিজম বিষয়ে প্রশিক্ষণের ব্যবস্থা গ্রহণ করতে হবে।

২.০ নব নিয়োগপ্রাপ্ত চিকিৎসকদের বদলি/ উচ্চতর ডিগ্রীঃ

২.১ উপজেলা স্বাস্থ্য কমপ্লেক্স ও তদনিম্ন পর্যায়ে ০২ (দুই) বছর চাকরিকাল উত্তীর্ণ হওয়ার পর পদ শূন্যতার ভিত্তিতে জেলা হাসপাতালে চিকিৎসকগণ পদায়নের সুযোগ পাবেন। নতুন নিয়োগপ্রাপ্ত দন্ত চিকিৎসকগণের প্রথমে উপজেলা স্বাস্থ্য কমপ্লেক্স-এ পদায়ন করা হবে। ০২ (দুই) বছর উপজেলা স্বাস্থ্য কমপ্লেক্সে পদায়ন থাকার পর শূন্যতার ভিত্তিতে দন্ত চিকিৎসকগণকে জেলা পর্যায়ের হাসপাতালে পদায়ন করা যেতে পারে।

২.২ উপজেলা বা তদনিম্ন পর্যায়ে ০২(দুই) বছর চাকরি করার পর নব নিয়োগপ্রাপ্ত চিকিৎসকগণ এমডি/এমএস/এফসিপিএস/এমপিএইচ/ডিপ্লোমা বা সমমানের উচ্চতর কোর্স করার সুযোগ পাবেন। পদ শূন্যতার ভিত্তিতে তাঁদেরকে জেলা হাসপাতালে পদায়ন করা যেতে পারে।

Source: Ministry of health and family welfare, 2017

২.৩ এনাটমি, ফিজিওলজি, ফার্মাকোলজি, বায়োকেমিস্ট্রি, মাইক্রোবায়োলজি, প্যাথলজি, কমিউনিটি মেডিসিন ও ফরেনসিক মেডিসিন বিষয়ে এমএস/এমফিল/ সমমানের ডিগ্রী অর্জনকারী নব নিযুক্ত চিকিৎসকগণের মেডিকেল কলেজে পদায়ন করা যাবে। বর্ণিত বিষয়সমূহ ব্যতিত অন্য কোন বিষয়ে স্নাতকোত্তর ডিগ্রী অর্জনকারীগণ এ শর্তের সুবিধা প্রাপ্ত হবেন না। সংশ্লিষ্ট বিষয়ে পদ খালি না থাকলে অন্য বিষয়ের পদের বিপরীতে এ ধরনের পদায়ন করা যাবে না।

২.৪ এ্যানেসথেসিয়া বিষয়ে এমডি/এফসিপিএস/ডিএ/সমমানের ডিগ্রি অথবা ন্যূনতম এক বছরের প্রশিক্ষণ প্রাপ্ত চিকিৎকগণকে উপজেলা পর্যায়ের নিম্নে পদায়ন করা যাবে না। প্রয়োজনে তাঁদেরকে ইওসিভুক্ত উপজেলা/ জেলা সদর পদায়ন করতে হবে।

২.৫ স্বামী-স্ত্রী সরকারি চাকুরিজীবী হলে বিধি মোতাবেক একই কর্মস্থলে পদায়নের বিষয় বিবেচনা করা হবে। তবে এক্ষেত্রে অনুচ্ছেদ ২.১ এর বিধান অনুসরণ করতে হবে।

২.৬ জনপ্রশাসন মন্ত্রণালয়ের ২ এপ্রিল ২০১৭ তারিখের ০৫.০০.০০০০.১৪৭.৩৫.০০৬.১৬-৮২ নং প্রজ্ঞাপনের অনুচ্ছেদ (ঝ) ও (ট) এ বর্ণিত বিধানাবলী বিভাগীয় পরিচালক (স্বাস্থ্য) এর দপ্তরে সম্পন্ন করা হবে।

স্বাক্ষরিত/-
(মোঃ সিরাজুল হক খান)
সচিব
স্বাস্থ্য সেবা বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

নং ৪৫.১৪৩.০২২.০০.০০.০০১.২০১৬-২৪৫/১(১৪) তারিখঃ ২৪.০৪.২০১৭ খ্রিঃ

অনুলিপি অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য প্রেরণ করা হলঃ

১। সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
২। মহাপরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা।
৩। অতিরিক্ত সচিব (সকল), স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৪। যুগ্ম-সচিব (সকল), স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৫। উপপরিচালক, বাংলাদেশ ফরমস ও প্রকাশনা অধিদপ্তর, তেজগাঁও, ঢাকা (প্রজ্ঞাপনটি গেজেটের পরবর্তী সংখ্যায় প্রকাশের অনুরোধসহ)।
৬। যুগ্মসচিব (পার-১/২), স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৭। উপসচিব (পার-৩), স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৮। পরিচালক (প্রশাসন/এমআইএস), স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা।
৯। পরিচালক (স্বাস্থ্য), ঢাকা / চট্টগ্রাম / রাজশাহী / খুলনা / বরিশাল / সিলেট / রংপুর / ময়মনসিংহ।
১০। মাননীয় মন্ত্রী/ প্রতিমন্ত্রীর একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
১১। সিনিয়র সহকারী সচিব (চিশি-১/চিশি-২/প্রশাসন-১), স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
১২। সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
১৩। সিস্টেম এনালিস্ট, কম্পিউটার সেল, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় (প্রজ্ঞাপনটি মন্ত্রণালয়ের ওয়েব সাইটে প্রকাশের অনুরোধসহ)
১৪। অফিস ফাইল।

Source: Ministry of health and family welfare, 2017

Annex C: Citizen charter of Upazila health project

উপজেলা স্বাস্থ্য প্রকল্পের সিটিজেন চার্টার

‡mev MÖwnZv †h mKj †mev cviqvi AwaKvi msi¶Y K‡ib

১. উপজেলা স্বাস্থ্য প্রকল্পে আগত নারী-পুরুষ, বৃদ্ধ-যুব-শিশু সকলকে প্রয়োজনীয় স্বাস্থ্য সেবা প্রদান করা হয়।

২. দিবা-রাত্রি ২৪ ঘণ্টা জরুরী বিভাগ খোলা থাকে এবং আগত রোগীদের জরুরি চিকিৎসা সেবা প্রদান করা হয়।

৩. ডায়রিয়া রোগীদের জন্য ওআরটি কর্ণার চালু আছে।

৪. হাসপাতালে আগত ও ভর্তি রোগীদের প্রয়োজনীয় প্যাথলজি পরীক্ষা ও এক্সরে করা হয়।

৫. দিবা-রাত্রি ২৪ ঘণ্টা ই.ও.সি. সেবা (প্রযোজ্য ক্ষেত্রে) প্রদান করা হয়।

৬. ভর্তি রোগীদের বিশেষজ্ঞদের তত্ত্বাবধানে মেডিসিন চিকিৎসাসহ জেনারেল সার্জারি ও গাইনির মেজর ও মাইনর অপারেশন করা হয় (প্রযোজ্য ক্ষেত্রে)।

৭. জাতীয় যক্ষ্মা ও কুষ্ঠ নিয়ন্ত্রণ কার্যক্রমের আওতায় যক্ষ্মা রোগীদের কফ পরীক্ষার জন্য কফ কালেকশন করা হয় এবং যক্ষ্মা ও কুষ্ঠ রোগীদের বিনামূল্যে ঔষধ সরবরাহ করা করা হয়।

৮. ইপিআই কার্যক্রমের আওতায় প্রতিদিন মা ও শিশুদের প্রতিষেধক টিকা দেওয়া হয়।

৯. আগত রোগীদের স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্য শিক্ষা দেওয়া হয়।

১০. নারী বান্ধব হাসপাতালের কার্যক্রম পরিচালনা করা হয় (প্রযোজ্য ক্ষেত্রে)।

১১. শিশু বান্ধব হাসপাতালের কার্যক্রম পরিচালনা করা হয় (প্রযোজ্য ক্ষেত্রে)।

১২. স্কিল বার্থ অ্যাটেনডেন্টদের প্রশিক্ষণ কার্যক্রম পরিচালনা করা হয়।

১৩. আগত কিশোর-কিশোরী ও সক্ষম দম্পতিদের মধ্যে প্রজনন স্বাস্থ্য ও পরিবার পরিকল্পনা কার্যক্রম পরিচালনা করা হয়।

১৪. আগত রোগীদের মধ্যে দেশীয় ভেষজ চিকিৎসাকে জনপ্রিয় করার লক্ষ্যে ভেষজ চিকিৎসাও প্রদান করা হয়।

১৫. বিভিন্ন উপ-স্বাস্থ্য কেন্দ্র ও স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র থেকে রেফার্ডকৃত রোগীদের গুরুত্ব সহকারে স্বাস্থ্য সেবা দেওয়া হয় এবং প্রয়োজনবোধে কোন কোন রোগীকে জেলা হাসপাতালে রেফার করা হয়।

১৬. সরবরাহ সাপেক্ষে ঔষধসমূহ সেবাকেন্দ্র হতে বিনামূল্যে প্রদান করা হয়। তবে চিকিৎসার প্রয়োজনে কোন কোন ঔষধ কেন্দ্রের বাহির হতে সেবা গ্রহিতাকে ক্রয় করতে হতে পারে।

১৭. বিভিন্ন ওয়ার্ড/বিভাগে মজুদ ঔষধের তালিকা, প্রদানকৃত সেবাসমূহের তালিকা, সেবা প্রদানকারী চিকিৎসকের তালিকা টানানো আছে।

সেবা গ্রহিতার কর্তব্য

সেবা প্রদান কারীগণ সেবা গ্রহীতার নিকট হতে সৌজন্যমূলক আচরণ প্রাপ্তির অধিকার রাখেন।

Main features of the citizen charter of Upazila health project

- 24/7 service delivery system for all
- Arrangement of pathological test and X-ray
- Women and children friendly service delivery system
- Training for skill birth attendant
- Free medicine (Depends on availability)
- Education for the patients on health, nutrition and reproductive health

Source: Ministry of health and family welfare, 2017

Annex D: Citizen charter of health sub-centers

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

স্বাস্থ্য উপকেন্দ্রের সিটিজেন চার্টার

‡mev MÖwnZv †h mKj †mev cvIqvi AwaKvi msi¶Y K‡ib

১. স্বাস্থ্য উপকেন্দ্রে আগত নারী-পুরুষ, বৃদ্ধ-যুব-শিশু সকলকে প্রয়োজনীয় স্বাস্থ্য সেবা প্রদান করা হয়।

২. ডায়রিয়া রোগীদের জন্য ওআরএস সরবরাহ করা হয়।

৩. হাসপাতালে আগত প্রসূতি রোগীদের এন্টিনেটাল চেকআপসহ প্রয়োজনীয় উপদেশ দেয়া হয় এবং আয়রন ট্যাবলেট সরবরাহ করা হয়।

৪. জাতীয় যক্ষ্মা ও কুষ্ঠ নিয়ন্ত্রণ কার্যক্রমের আওতায় যক্ষ্মা রোগীদের কফ্ পরীক্ষার জন্য কফ সংগ্রহ করা হয় এবং যক্ষ্মা ও কুষ্ঠ রোগীদের বিনামূল্যে ঔষধ সরবরাহ করা করা হয়।

৫. শিশু ও মহিলাদের ইপিআই কার্যক্রমের আওতায় প্রতিষেধক টিকা দেওয়া হয়।

৬. উপস্বাস্থ্য কেন্দ্রে আগত রোগীদের স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্য শিক্ষা দেওয়া হয়।

৭. উপস্বাস্থ্য কেন্দ্রে আগত কিশোর-কিশোরী ও সক্ষম দম্পতিদের মধ্যে প্রজনন স্বাস্থ্য ও পরিবার পরিকল্পনা কার্যক্রম পরিচালনা করা হয়।

৮. প্রয়োজনে রোগীকে উপজেলা হাসপাতালে রেফার করা হয়।

৯. আগত রোগী ও তাদের আত্মীয়স্বজনগণ স্বাস্থ্যসেবা সম্পর্কে প্রয়োজনীয় পরামর্শ ও উপদেশের জন্য সংশ্লিষ্ট চিকিৎসকগণের সাথে সহজেই যোগাযোগ করতে পারেন।

১০. উপ-স্বাস্থ্যকেন্দ্রে প্রয়োজনীয় সংখ্যক নোটিশ বোর্ড সবার দৃষ্টি গোচর হয় এমন জায়গায় স্থাপিত আছে। নোটিশ বোর্ডে প্রয়োজনীয় তথ্য লিপিবদ্ধ আছে।

১১. সরবরাহ সাপেক্ষে ঔষধসমূহ সেবাকেন্দ্র হতে বিনামূল্যে প্রদান করা হয়। তবে চিকিৎসার প্রয়োজনে কোন কোন ঔষধ কেন্দ্রের বাহির হতে সেবা গ্রহিতাকে ক্রয় করতে হতে পারে।

১২. বোর্ডে মজুদ ঔষধের তালিকা, প্রদানকৃত সেবাসমূহের তালিকা, সেবা প্রদানকারী চিকিৎসকের তালিকা টানানো আছে।

সেবা গ্রহিতার কর্তব্য

সেবা প্রদান কারীগণ সেবা গ্রহীতার নিকট হতে সৌজন্যমূলক আচরণ প্রাপ্তির অধিকার রাখেন।

Main features of the citizen charter of sub-centres

- Necessary health service provides for all
- Oral rehydration solution (ORS) provides for diarrhea patients
- - Free medicine (Depends on availability)
- Education for the patients on health, nutrition and reproductive health
- Patients are referred to UHC, if necessary

Source: Ministry of health and family welfare, 2017

Annex E: Pictures of a Union sub-centers

Dhalapara Union sub-center (Source: Field data, 2017)

Anehola (Ekashi) Union sub-center (Source: Field data, 2017)

Annex F: Pictures of Ghatail Upazila complex and Tangail general hospital

Upazila health complex, Ghatail (Source: Field data, 2017)

Tangail general hospital (Source: Field data, 2017)

Annex G: Sample of roster duty of doctors' in Upazila health complex

Government of the people's republic of Bangladesh
Office of the Upazila health and family welfare officer
Ghatail, Tangail.

Memo no. . . . . Date: 01/08/2017

Subject: Monthly duty roster of doctors in emergency department

Date	**8 AM – 2 PM**	**2 PM – 8 PM**	**8 PM – 8 AM**
Saturday	Dr. A (Consultant)	Dr. B (Medical officer)	Dr. B (Medical officer)
Sunday	Dr. C (Medical officer)	Dr. D (Medical officer)	Dr. C (Medical officer)
Monday	Dr. A (Consultant)	Dr. E (Medical officer)	Dr. B (Medical officer)
Tuesday	Dr. E (Medical officer)	Dr. E (Medical officer)	Dr. C (Medical officer)
Wednesday	Dr. A (Consultant)	Dr. X (Medical officer)	Dr. E (Medical officer)
Thursday	Dr. B (Medical officer)	Dr. X (Medical officer)	Dr. X (Medical officer)

Friday

Date and Time	8 AM – 8 PM	8 PM – 8 AM
04/08/2017	Dr. E (Medical officer)	Dr. X (Medical officer)
11/08/2017	Dr. D (Medical officer)	Dr. X (Medical officer)
18/08/2017	Dr. D (Medical officer)	Dr. X (Medical officer)
25/08/2017	Dr. C (Medical officer)	Dr. X (Medical officer)
01/09/2017	Dr. A (Consultant)	Dr. X (Medical officer)

Duty doctor, working in emergency department, cannot leave working place until the arrival of the reliever.

(N.B: The author used roman letters instead of doctors' original names to secure their privacy.)

Source: Upazila health complex, Ghatail, 2017

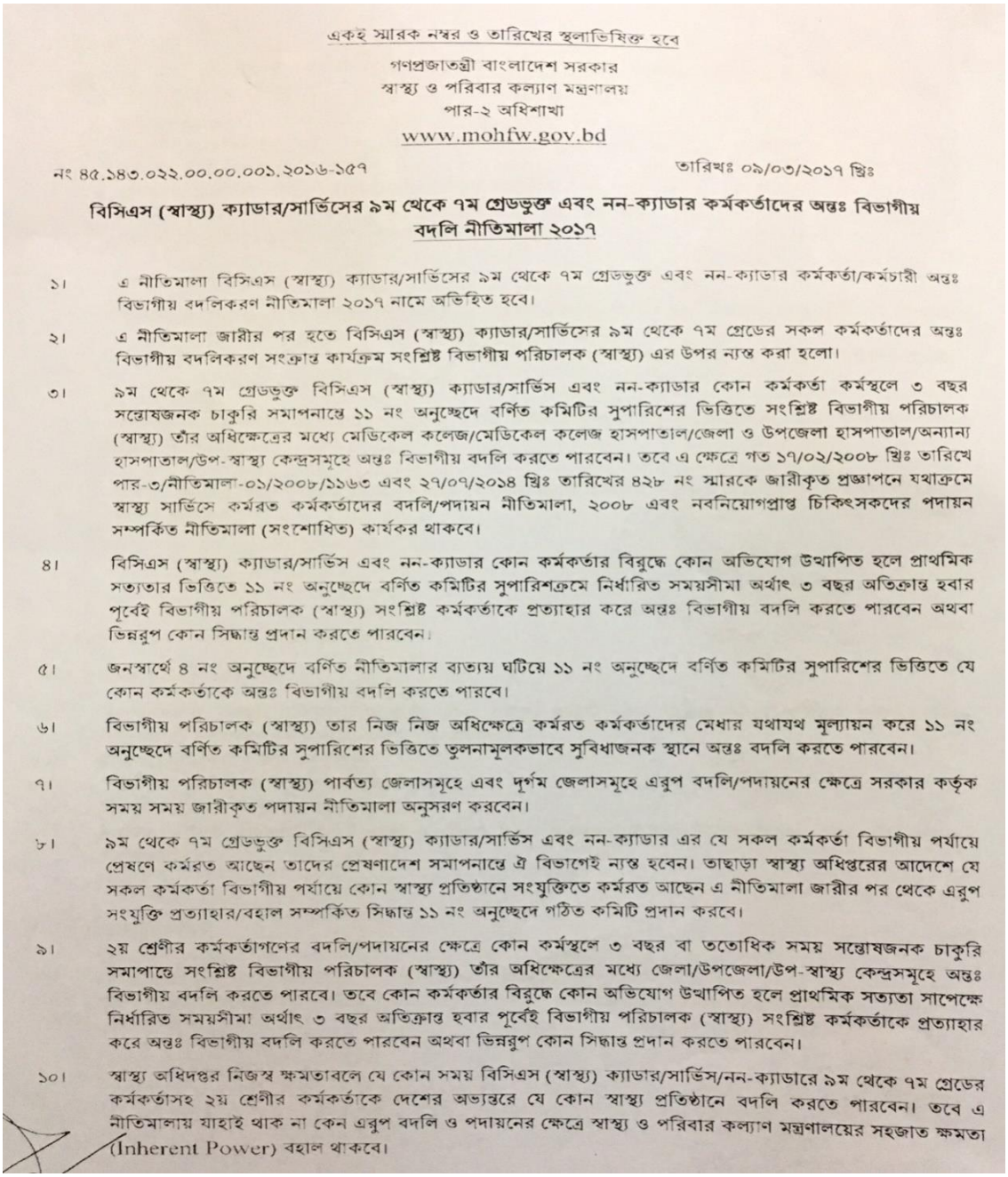
Annex H: Promotion policy of Upazila level physicians

1	2	3	4	5
B	(i) Deputy Civil Surgeon; and (ii) Thana Health & Family Planning Officer.		By promotion from amongst the following :— (i) Senior Clinical Pathologist; (ii) Resident Physician and Resident Surgeon (Except IPGM&R). (iii) Medical Specialist, Thana Health Complex, (iv) Surgical Specialist, Thana Health Complex; (v) Gynae Specialist, Thana Health Complex; (vi) Anaesthesia Specialist, Thana Health Complex.	5 years' experience in the concerned Service. Preference will be given to those having Post-graduate Degree or other equivalent qualification recognised by the B.M.D.C.][8]
6	(a) Resident Physician of Hospitals (except IPGM&R); (b) Resident Surgeon of Hospitals (except IPGM&R); (c) Deleted[9] (d) Senior Clinical Pathologist;		By promotion from amogst Assistant Surgeons.	[4 years' experience in the concerned Service.][11]

1	2	3		
	(e) Medical Specialist, Thana Health Complex; (f) Surgical Specialist, Thana Health Complex; (g) Gynae Specialist, Thana Health Complex; (h) Deleted[10] (i) Resident Medical Officer of Hospitals (other than Thana Health Complex); (j) Junior Lecturer, MATS.			
7	Assistant Surgeon	–	As per Bangladesh Civil Service (Age, Qualification and Examination for Direct Recruitment) Rules, 1982.	

Source: Ministry of health and family welfare, 2017

Annex I: Transfer policy of Bangladesh civil service (health cadres): (from ninth to seventh grade)



একই স্মারক নম্বর ও তারিখের স্থলাভিষিক্ত হবে

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নং ৪৫.১৪৩.০২২.০০.০০.০০১.২০১৬-১৫৭

তারিখঃ ০৯/০৩/২০১৭ খ্রিঃ

বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিসের ৯ম থেকে ৭ম গ্রেডভুক্ত এবং নন-ক্যাডার কর্মকর্তাদের অন্তঃ বিভাগীয় বদলি নীতিমালা ২০১৭

১। এ নীতিমালা বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিসের ৯ম থেকে ৭ম গ্রেডভুক্ত এবং নন-ক্যাডার কর্মকর্তা/কর্মচারী অন্তঃ বিভাগীয় বদলিকরণ নীতিমালা ২০১৭ নামে অভিহিত হবে।

২। এ নীতিমালা জারীর পর হতে বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিসের ৯ম থেকে ৭ম গ্রেডের সকল কর্মকর্তাদের অন্তঃ বিভাগীয় বদলিকরণ সংক্রান্ত কার্যক্রম সংশ্লিষ্ট বিভাগীয় পরিচালক (স্বাস্থ্য) এর উপর ন্যস্ত করা হলো।

৩। ৯ম থেকে ৭ম গ্রেডভুক্ত বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিস এবং নন-ক্যাডার কোন কর্মকর্তা কর্মস্থলে ৩ বছর সন্তোষজনক চাকুরি সমাপনান্তে ১১ নং অনুচ্ছেদে বর্ণিত কমিটির সুপারিশের ভিত্তিতে সংশ্লিষ্ট বিভাগীয় পরিচালক (স্বাস্থ্য) তাঁর অধিক্ষেত্রের মধ্যে মেডিকেল কলেজ/মেডিকেল কলেজ হাসপাতাল/জেলা ও উপজেলা হাসপাতাল/অন্যান্য হাসপাতাল/উপ-স্বাস্থ্য কেন্দ্রসমূহে অন্তঃ বিভাগীয় বদলি করতে পারবেন। তবে এ ক্ষেত্রে গত ১৭/০২/২০০৮ খ্রিঃ তারিখে পার-৩/নীতিমালা-০১/২০০৮/১১৬৩ এবং ২৭/০৭/২০১৪ খ্রিঃ তারিখের ৪২৮ নং স্মারকে জারীকৃত প্রজ্ঞাপনে যথাক্রমে স্বাস্থ্য সার্ভিসে কর্মরত কর্মকর্তাদের বদলি/পদায়ন নীতিমালা, ২০০৮ এবং নবনিয়োগপ্রাপ্ত চিকিৎসকদের পদায়ন সম্পর্কিত নীতিমালা (সংশোধিত) কার্যকর থাকবে।

৪। বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিস এবং নন-ক্যাডার কোন কর্মকর্তার বিরুদ্ধে কোন অভিযোগ উত্থাপিত হলে প্রাথমিক সত্যতার ভিত্তিতে ১১ নং অনুচ্ছেদে বর্ণিত কমিটির সুপারিশক্রমে নির্ধারিত সময়সীমা অর্থাৎ ৩ বছর অতিক্রান্ত হবার পূর্বেই বিভাগীয় পরিচালক (স্বাস্থ্য) সংশ্লিষ্ট কর্মকর্তাকে প্রত্যাহার করে অন্তঃ বিভাগীয় বদলি করতে পারবেন অথবা ভিন্নরূপ কোন সিদ্ধান্ত প্রদান করতে পারবেন।

৫। জনস্বার্থে ৪ নং অনুচ্ছেদে বর্ণিত নীতিমালার ব্যত্যয় ঘটিয়ে ১১ নং অনুচ্ছেদে বর্ণিত কমিটির সুপারিশের ভিত্তিতে যে কোন কর্মকর্তাকে অন্তঃ বিভাগীয় বদলি করতে পারবে।

৬। বিভাগীয় পরিচালক (স্বাস্থ্য) তার নিজ নিজ অধিক্ষেত্রে কর্মরত কর্মকর্তাদের মেধার যথাযথ মূল্যায়ন করে ১১ নং অনুচ্ছেদে বর্ণিত কমিটির সুপারিশের ভিত্তিতে তুলনামূলকভাবে সুবিধাজনক স্থানে অন্তঃ বদলি করতে পারবেন।

৭। বিভাগীয় পরিচালক (স্বাস্থ্য) পার্বত্য জেলাসমূহে এবং দূর্গম জেলাসমূহে এরূপ বদলি/পদায়নের ক্ষেত্রে সরকার কর্তৃক সময় সময় জারীকৃত পদায়ন নীতিমালা অনুসরণ করবেন।

৮। ৯ম থেকে ৭ম গ্রেডভুক্ত বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিস এবং নন-ক্যাডার এর যে সকল কর্মকর্তা বিভাগীয় পর্যায়ে প্রেষণে কর্মরত আছেন তাদের প্রেষণাদেশ সমাপনান্তে ঐ বিভাগেই ন্যস্ত হবেন। তাছাড়া স্বাস্থ্য অধিপ্তরের আদেশে যে সকল কর্মকর্তা বিভাগীয় পর্যায়ে কোন স্বাস্থ্য প্রতিষ্ঠানে সংযুক্তিতে কর্মরত আছেন এ নীতিমালা জারীর পর থেকে এরূপ সংযুক্তি প্রত্যাহার/বহাল সম্পর্কিত সিদ্ধান্ত ১১ নং অনুচ্ছেদে গঠিত কমিটি প্রদান করবে।

৯। ২য় শ্রেণীর কর্মকর্তাগণের বদলি/পদায়নের ক্ষেত্রে কোন কর্মস্থলে ৩ বছর বা ততোধিক সময় সন্তোষজনক চাকুরি সমাপান্তে সংশ্লিষ্ট বিভাগীয় পরিচালক (স্বাস্থ্য) তাঁর অধিক্ষেত্রের মধ্যে জেলা/উপজেলা/উপ-স্বাস্থ্য কেন্দ্রসমূহে অন্তঃ বিভাগীয় বদলি করতে পারবে। তবে কোন কর্মকর্তার বিরুদ্ধে কোন অভিযোগ উত্থাপিত হলে প্রাথমিক সত্যতা সাপেক্ষে নির্ধারিত সময়সীমা অর্থাৎ ৩ বছর অতিক্রান্ত হবার পূর্বেই বিভাগীয় পরিচালক (স্বাস্থ্য) সংশ্লিষ্ট কর্মকর্তাকে প্রত্যাহার করে অন্তঃ বিভাগীয় বদলি করতে পারবেন অথবা ভিন্নরূপ কোন সিদ্ধান্ত প্রদান করতে পারবেন।

১০। স্বাস্থ্য অধিদপ্তর নিজস্ব ক্ষমতাবলে যে কোন সময় বিসিএস (স্বাস্থ্য) ক্যাডার/সার্ভিস/নন-ক্যাডারে ৯ম থেকে ৭ম গ্রেডের কর্মকর্তাসহ ২য় শ্রেণীর কর্মকর্তাকে দেশের অভ্যন্তরে যে কোন স্বাস্থ্য প্রতিষ্ঠানে বদলি করতে পারবেন। তবে এ নীতিমালায় যাহাই থাক না কেন এরূপ বদলি ও পদায়নের ক্ষেত্রে স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের সহজাত ক্ষমতা (Inherent Power) বহাল থাকবে।

Source: Ministry of health and family welfare, 2017

Annex J: Questionnaire for doctors

Name: Age:

Address: Phone no.:

1. How long are you in government job?
2. How long are you posted here?
3. Where was your previous posting?
4. How long were you there?
5. What is your home district?
6. What is your marital status?
7. Where do your family live?
8. Do you have children?
9. Are your children studying? If yes, then where?
10. Do you stay near in your posting place or you come from far?
11. Have you completed your post-graduation? If not, then when are planning to?
12. Do you practice privately or visit other clinics?
13. What is your income other than your government salary?

a. Less than 20000 b. 20001-50000 c. More than 50000

14. If it is a matter of income opportunity, then which place is convenient for you? Rural or Urban areas?
15. Which posting places do you prefer more? Urban or Rural? And why?
16. Which major problems do you face while working in rural areas?
17. Is the logistics support adequate for performing your duties?
18. If you are provided all the facilities needed to provide proper treatment, then will you be more interested in rural placement than urban placement?
19. What is your opinion on institutional capacity of your organization?
20. Is there any institutional weakness that may influence you to leave the rural posting places?

21. What are the factors influencing your decision to take posting in rural or urban areas?
22. Do your authority/people's representative visit your working place regularly?
23. What is your opinion on doctors' placement/promotion/transfer policy? Is there any change needed?
24. How is doctor-staff relationship in sub-centre?
25. How do you deal with an Upazila nirbahi officer who is junior to you?
26. Other than administrative set-up is there any other way to take desired placement?
27. What kind of incentives be a solution to make the doctors interested in rural areas?
28. Women doctors are appropriate for union level. But rural placement is not suitable for women. How to deal with this problem?
29. What should be done to solve the prevailing problems?

Annex K: Questionnaire for health center personnel

Name: Age:

Address: Phone no.:

1. How many patients visit in this centre par day? (In average)
2. Do the doctors come here regularly?
3. What testing facilities/ instruments (i.e.: blood test, sugar test, x-ray) are available in this centre?
4. What are the factors you think may influence the doctors not to attend regularly in the health centres?
5. Do the people representative and the high officials visit health centres regularly?
6. Do your centres have enough infrastructure facilities that attract the doctors to serve here?
7. Do you think doctors are not interested to be posted in rural areas because of lack of income opportunities? Please explain.
8. How is the relationship with the staffs and doctors here?
9. Do you think the doctors are more interested in urban posting for their family, training or income facilities?
10. What can be the probable solution to attracts the doctors in rural placement?
11. If doctors are regular in rural posting place, then does it hamper your income opportunity?

Annex L: Questionnaire for other stakeholders (i.e. Local leaders/Upazila nirbahi officer/ Social worker)

1. What is your role on guiding/supervising/inspect the health centres?
2. How frequently do you visit the health centres?
3. What is your role to influence/supervise the doctors to guide them to stay in the rural areas?
4. What are the means used to control absenteeism?
5. Do you think the provided incentives are available to attract the doctors to stay in the rural areas?
6. What factors do you think influence the doctors not to be interested in rural placement?
7. Is there any institutional weakness that you observe that gives scope the doctors to avoid their duties?
8. Do you think doctors are interested in urban placement as they are getting more personal benefits than rural posting?
9. What initiatives should be taken to attract them in rural areas?
10. Are the logistics adequate for the doctors to serve the patients properly?
11. Do you show your power in the medical centres?

Annex M: Questionnaire for patients

Name: Age:

Address: Phone no.:

Q1: How frequently you visit Union/Upazila health complexes?

Q2: When did you last visited Union/Upazila health complexes?

Q3: Did you find a doctor there every time you visited?

Q4: If not, then who take care of your problems?

Q5: Which health center do you prefer most?

i) Government ii) Private clinics

Q6: Why do you prefer that most? Please explain.

Q7: Are you satisfied with the behavior of the doctors in Union/Upazila health complexes?

Q8: If not, then what do you think the doctor's attitudes should be?

Q9: Are you satisfied with the services of the doctors in Union/Upazila health complexes?

Q10: If not then why?

Q11: If you are not satisfied with the treatment, then how do you react to the doctors? Do you misbehave with him?

Annex N: United Nations Millennium Declaration (Source: United Nations, 2017)

Resolution adopted by the general assembly
[without reference to a Main Committee (A/55/L.2)]
55/2. United Nations Millennium Declaration

The General Assembly

Adopts the following Declaration:

United Nations Millennium Declaration

I. Values and principles

1. We, heads of State and Government, have gathered at United Nations Headquarters in New York from 6 to 8 September 2000, at the dawn of a new millennium, to reaffirm our faith in the Organization and its Charter as indispensable foundations of a more peaceful, prosperous and just world.

2. We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs.

3. We reaffirm our commitment to the purposes and principles of the Charter of the United Nations, which have proved timeless and universal. Indeed, their relevance and capacity to inspire have increased, as nations and peoples have become increasingly interconnected and interdependent.

[…….]

III. Development and poverty eradication

11. We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.

12. We resolve therefore to create an environment – at the national and global levels alike – which is conducive to development and to the elimination of poverty.

13. Success in meeting these objectives depends, *inter alia*, on good governance within each country. It also depends on good governance at the international level and on transparency in the financial, monetary and trading systems. We are committed to an open, equitable, rule-based, predictable and non-discriminatory multilateral trading and financial system.

14. We are concerned about the obstacles developing countries face in mobilizing the resources needed to finance their sustained development. We will therefore make every effort to ensure the success of the High-level International and Intergovernmental Event on Financing for Development, to be held in 2001.

15. We also undertake to address the special needs of the least developed countries. In this context, we welcome the Third United Nations Conference on the Least Developed Countries to be held in May 2001 and will endeavor to ensure its success. We call on the industrialized countries:

• To adopt, preferably by the time of that Conference, a policy of duty- and quota-free access for essentially all exports from the least developed countries;

• To implement the enhanced programme of debt relief for the heavily indebted poor countries without further delay and to agree to cancel all official bilateral debts of those countries in return for their making demonstrable commitments to poverty reduction; and

• To grant more generous development assistance, especially to countries that are genuinely making an effort to apply their resources to poverty reduction.

16. We are also determined to deal comprehensively and effectively with the debt problems of low- and middle-income developing countries, through various national and international measures designed to make their debt sustainable in the long term.

17. We also resolve to address the special needs of small island developing States, by implementing the Barbados Programme of Action and the outcome of the twenty-second special session of the General Assembly rapidly and in full. We urge the international community to ensure that, in the development of a vulnerability index, the special needs of small island developing States are taken into account.

18. We recognize the special needs and problems of the landlocked developing countries, and urge both bilateral and multilateral donors to increase financial and technical assistance to this group of countries to meet their special development needs and to help them overcome the impediments of geography by improving their transit transport systems.

19. We resolve further:

• To halve, by the year 2015, the proportion of the world's people whose income is less than one dollar a day and the proportion of people who suffer from hunger and, by the same date, to halve the proportion of people who are unable to reach or to afford safe drinking water.

• To ensure that, by the same date, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling and that girls and boys will have equal access to all levels of education.

• By the same date, to have reduced maternal mortality by three quarters, and under-five child mortality by two thirds, of their current rates.

• To have, by then, halted, and begun to reverse, the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity.

• To provide special assistance to children orphaned by HIV/AIDS.

• By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers as proposed in the "Cities Without Slums" initiative.

20. We also resolve:

• To promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable.

• To develop and implement strategies that give young people everywhere a real chance to find decent and productive work.

• To encourage the pharmaceutical industry to make essential drugs more widely available and affordable by all who need them in developing countries.

• To develop strong partnerships with the private sector and with civil society organizations in pursuit of development and poverty eradication.

• To ensure that the benefits of new technologies, especially information and communication technologies, in conformity with recommendations contained in the ECOSOC 2000 Ministerial Declaration, are available to all.

[……]

8th plenary meeting
8 September 2000

Annex O: National health policy 2011

(Source: Ministry of health and family welfare, 2017)

জাতীয় স্বাস্থ্য নীতি ২০১১

সুস্বাস্থ্য উন্নয়নের হাতিয়ার

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

প্রস্তাবনা

স্বাস্থ্য হচ্ছে একটি পরিপূর্ণ শারীরিক, মানসিক ও সামাজিক সুস্থ অবস্থা; শুধুমাত্র রোগব্যাধি বা দুর্বলতার অনুপস্থিতি নয়। স্বাস্থ্য সেবা মানুষের অন্যতম মৌলিক অধিকার। তা নিশ্চিত করার জন্য প্রয়োজন সুষ্ঠু অর্থনৈতিক অবস্থান ও রাজনৈতিক অঙ্গীকার। মানব উন্নয়নের গুরুত্বপূর্ণ সূচক হিসেবে স্বাস্থ্য সর্বজনীনভাবে স্বীকৃত। গণপ্রজাতন্ত্রী বাংলাদেশের সংবিধানের অনুচ্ছেদ ১৫(ক) অনুসারে চিকিৎসাসহ জীবনধারণের মৌলিক উপকরণের ব্যবস্থা করা রাষ্ট্রের অন্যতম মৌলিক দায়িত্ব এবং অনুচ্ছেদ ১৮(১) অনুসারে জনগণের পুষ্টির স্তর-উন্নয়ন ও জনস্বাস্থ্যের উন্নতি সাধন রাষ্ট্রের অন্যতম প্রাথমিক কর্তব্য। বিশ্ব স্বাস্থ্য সংস্থার প্রাথমিক স্বাস্থ্য সংক্রান্ত আলমা-আতা ঘোষণা, জাতিসংঘের সার্বজনীন মানবাধিকার ঘোষণার অনুচ্ছেদ ২৫(১), আন্তর্জাতিক অর্থনৈতিক, সামাজিক ও সাংস্কৃতিক অধিকার সম্মেলনের অনুচ্ছেদ ১২, শিশু অধিকার সনদের অনুচ্ছেদ ২৪, নারীর প্রতি সর্ব ধরনের বৈষম্য দূরীকরণ সংক্রান্ত কনভেনশনের অনুচ্ছেদ ১২ এসব আন্তর্জাতিক ঘোষণায় স্বাক্ষরদাতা দেশ হিসেবে বাংলাদেশ স্বাস্থ্য সেবা উন্নয়নে অঙ্গীকারাবদ্ধ। ২০১৫ সালের মধ্যে সহস্রাব্দ উন্নয়নের লক্ষ্যমাত্রা অর্জনেও বাংলাদেশ অঙ্গীকারাবদ্ধ।

আগামী ২০২১ সালে স্বাধীনতার সুবর্ণ জয়ন্তীতে এক অসাম্প্রদায়িক, প্রগতিশীল ও গণতান্ত্রিক কল্যাণ রাষ্ট্র বিনির্মাণের ক্ষেত্রে বর্তমান সরকারের রূপকল্প (ভিশন ২০২১) অনুযায়ী স্বাস্থ্য সেবার ক্ষেত্রে ২০২১ সালের মধ্যে দরিদ্র জনগোষ্ঠীর জন্য দৈনিক ন্যূনতম ২১২২ কিলো ক্যালরির উর্ধ্বে খাদ্যের সংস্থান, সকল প্রকার সংক্রামক ব্যাধি সম্পূর্ণ নির্মূল করণ, সকলের জন্য প্রাথমিক স্বাস্থ্য সেবা নিশ্চিতকরণ, ২০২১ সালের মধ্যে গড় আয়ুষ্কাল ৭০ এর কোঠায় উন্নীতকরণ, শিশুমৃত্যুর হার বর্তমানে হাজারে ৫৪ থেকে ক্রমান্বয়ে ১৫তে হ্রাসকরণ, মাতৃমৃত্যুর হার ৩.৮ থেকে ১.৫ শতাংশে হ্রাসকরণ এবং ২০২১ সালে প্রজনন নিয়ন্ত্রণ ব্যবহারের হার ৮০ শতাংশে উন্নীতকরণের লক্ষ নির্ধারণ করা হয়েছে।

সুস্বাস্থ্য শুধুমাত্র রোগ চিকিৎসার মধ্যেই সীমাবদ্ধ নয়। সুস্বাস্থ্যের জন্য বিশুদ্ধ পানি, যথাযথ খাদ্য, দূষণমুক্ত পরিবেশ ইত্যাদি প্রয়োজন। স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় রোগ চিকিৎসা ও কিছু প্রতিরোধমূলক কাজসহ চিকিৎসা শিক্ষার দায়িত্বপ্রাপ্ত। স্বাস্থ্যের অন্যান্য উপাদান নিশ্চিতকরণের জন্য স্থানীয় সরকার বিভাগ, খাদ্য ও দুর্যোগ ব্যবস্থাপনা মন্ত্রণালয়, কৃষি মন্ত্রণালয়, মৎস্য ও প্রাণিসম্পদ মন্ত্রণালয়, পানিসম্পদ মন্ত্রণালয়, পরিবেশ ও বন মন্ত্রণালয়, মহিলা ও শিশু বিষয়ক মন্ত্রণালয়, শিক্ষা মন্ত্রণালয়, সমাজ কল্যাণ মন্ত্রণালয় ইত্যাদির সম্পৃক্ততা রয়েছে।

দেশের বর্তমান স্বাস্থ্য ব্যবস্থায় অনেক সমস্যা রয়েছে যেগুলো সমাধান করে স্বাস্থ্য সেবার বর্তমান অবস্থাকে আরো সন্তোষজনক পর্যায়ে উন্নীত করা প্রয়োজন। স্বাস্থ্য সেবা প্রদানকারী খাত ও সংশ্লিষ্ট সকলকে কর্ম-উদ্দীপিত ও আশান্বিত করার মাধ্যমে মানুষের চিকিৎসা ও সুস্বাস্থ্য নিশ্চিত হয় এমন একটি নীতিমালা প্রণয়ন ও বাস্তবায়ন করা প্রয়োজন। বর্তমান সরকারের নির্বাচনি ইশতেহার অনুযায়ী সকলের জন্য স্বাস্থ্য সেবা নিশ্চিত করার লক্ষ্যে জাতীয় স্বাস্থ্য নীতি ২০০০ পুনর্মূল্যায়নপূর্বক যুগের চাহিদা অনুযায়ী নবায়ণ করে জাতীয় স্বাস্থ্যনীতি প্রণয়ন করতে সরকার প্রতিশ্রুতি বদ্ধ। এ লক্ষ্যে প্রণীত খসড়া বিভিন্ন স্তরের জনগণের মাঝে বিশেষত স্বাস্থ্য খাতের সাথে সংশ্লিষ্ট সুশীল সমাজ, পেশাজীবী সংগঠন, বিশেষজ্ঞসহ সমাজের সকল স্তরের জনগণের মতামতের জন্য উপস্থাপন করা হয়। খসড়া জাতীয় স্বাস্থ্য নীতি চূড়ান্ত করার জন্যে সরকার কর্তৃক গঠিত কমিটি বিভিন্ন পর্যায় হতে প্রাপ্ত মতামত ও পরামর্শসমূহের আলোকে খসড়াটি সংশোধন, পরিমার্জন ও পরিবর্ধন করে জাতীয় স্বাস্থ্যনীতি ২০১১ চূড়ান্ত করে। জাতীয় স্বাস্থ্যনীতি ২০১১-এর উদ্দেশ্য ও নীতি সমূহের আলোকে কর্মকৌশলসমূহ বাস্তবায়িত হলে এ দেশের মানুষের প্রত্যাশা এবং প্রাপ্তির মধ্যে সমন্বয় ঘটবে। স্বাধীনতার সুফল সকলের কাছে পৌঁছে দেয়ার ব্রত নিয়ে দিন বদলের লক্ষ্যে জনগণের ঐতিহাসিক রায়ে নির্বাচিত বর্তমান সরকারের অন্যতম অগ্রাধিকার স্বাস্থ্য খাতের গণমুখী উন্নয়ন অর্জিত হবে।

প্রেক্ষাপট

স্বাধীনতার পর থেকে বাংলাদেশে স্বাস্থ্য খাতে উল্লেখযোগ্য অগ্রগতি সাধিত হয়েছে। দেশব্যাপী সরকারি স্বাস্থ্য পরিচর্যা ও অবকাঠামো প্রশংসনীয় স্তরে উন্নীত হয়েছে। তবে সরকারি স্বাস্থ্য ব্যবস্থায় ঔষধ সরবরাহের অপর্যাপ্ততা, জনবলের অভাব, যন্ত্রপাতি ও স্বাস্থ্যকেন্দ্রের স্থাপনায় রক্ষণাবেক্ষণের দুর্বলতা ও প্রশাসনের জটিলতা এবং সুসংগঠিত রেফারেল পদ্ধতি না থাকায় স্বাস্থ্য অবকাঠামোর পূর্ণ সদ্ব্যবহার করা যাচ্ছে না।

বাংলাদেশে ১ লক্ষ ৪৭ হাজার ৫৭০ বর্গকিলোমিটার আয়তনের মধ্যে প্রায় ১৪ কোটি ৬০ লক্ষ লোক বসবাস করে। ঘনবসতির দিক থেকে যা নগর রাষ্ট্র ছাড়া বিশ্বে সর্বাধিক। বাংলাদেশে মোট জনসংখ্যার ৭৬ শতাংশ গ্রামে এবং ২৪ শতাংশ শহরে বসবাস করে। ৪৩ শতাংশ জনগণের বয়স ১৫ বছরের নীচে; প্রতিবছর দেশে প্রায় ২০ লক্ষ শিশু জন্মগ্রহণ করছে যা দেশের খাদ্য, আশ্রয়, শিক্ষা, স্বাস্থ্য ও কর্মসংস্থানের উপর বাড়তি চাপ এবং প্রত্যাশিত অর্থনৈতিক প্রবৃদ্ধি অর্জনের পথে প্রতিবন্ধকতা সৃষ্টি করছে। সঠিক নীতি ও কার্যকর পদক্ষেপ গ্রহণের ফলে জনসংখ্যা বৃদ্ধির হার বিগত বছরগুলোতে ক্রমান্বয়ে হ্রাস পেয়েছে। তবে এ সংক্রান্ত জাতীয় লক্ষ্যমাত্রা অর্জন করতে হলে এ কার্যক্রমকে আরও শক্তিশালী করা প্রয়োজন।

সাম্প্রতিক সময়ে বাংলাদেশের স্বাস্থ্য খাতের সূচকসমূহে গুরুত্বপূর্ণ অগ্রগতি সাধিত হয়েছে। বাংলাদেশে শিশু মৃত্যুর হার ১৯৯৬-৯৭ সালে প্রতি হাজারে ছিল ৮২.২, ২০০৭ সালে তা দাঁড়িয়েছে ৫২-তে। ৫ বছরের কম বয়সী শিশুমৃত্যুর হার ১৯৯৬-৯৭ সালে ছিল ১১৫.৭। ২০০৭ সালে তা হ্রাস পেয়ে ৬৫ তে নেমে এসেছে। এ ধারা অব্যাহত থাকলে সহস্রাব্দের উন্নয়ন লক্ষ্যমাত্রার শিশুমৃত্যু হ্রাসকরণ সংক্রান্ত ৪ নম্বর লক্ষ্যমাত্রা ২০১৫ সালের মধ্যে অর্জন করা সম্ভব হবে। অনুরূপভাবে মাতৃমৃত্যুর হারও হ্রাস পাচ্ছে। বিএমএসএস জরিপ ২০১০ অনুযায়ী মাতৃমৃত্যুর হার ২০০১ সালের তুলনায় প্রতি লাখে ৩২২ থেকে হ্রাস পেয়ে ২০১০ সালে ১৯৪-তে দাঁড়িয়েছে। অর্থাৎ এই হার অব্যাহত থাকলে বাংলাদেশ এ ক্ষেত্রেও সহস্রাব্দের উন্নয়ন লক্ষ্যমাত্রা অর্জন করবে।

বিগত বছরগুলোতে মানুষের গড় আয়ুষ্কাল যথেষ্ট বৃদ্ধি পেয়েছে। বিশেষত অতীতের প্রবণতা ভেঙ্গে বর্তমানে পুরুষের চেয়ে মহিলাদের গড় আয়ু বৃদ্ধি পাচ্ছে। সম্প্রসারিত টিকাদান কর্মসূচির মাধ্যমে টিকা প্রদানের ক্রমবর্ধমান উচ্চহার এক্ষেত্রে উল্লেখযোগ্য ভূমিকা রেখেছে। তবে এখনো সন্তান প্রসবকালে প্রয়োজনীয় দক্ষ কর্মীর অপ্রতুলতা সন্তোষজনক অগ্রগতি অর্জনের পথে অন্তরায় হয়ে রয়েছে।

৫ বছরের কম বয়সের শিশুদের মধ্যে ওজনের স্বল্পতা এবং খর্বতা কমেছে, কিন্তু তা উল্লেখযোগ্য পরিমাণে নয়। ১-৫ বছর বয়সী শিশুদের ভিটামিন এ (ক্যাপসুল) খাওয়ানোর লক্ষ্যমাত্রা পুরোটাই অর্জিত হয়েছে। এর ফলে রাতকানা রোগ উল্লেখযোগ্য হারে হ্রাস পেয়েছে। লিঙ্গ বৈষম্য ও অন্যান্য বৈষম্য দূর করার ব্যাপারে সরকারের বিভিন্ন প্রচেষ্টার ফলে এসব ক্ষেত্রে অগ্রগতি হয়েছে। কিন্তু বৈষম্য দূরীকরণের প্রচেষ্টা আরও শক্তিশালী করা প্রয়োজন।

ম্যালেরিয়ায় মৃত্যুহার হ্রাস পেয়েছে। যক্ষ্মা ও কুষ্ঠ প্রতিরোধ এবং নিয়ন্ত্রণের ক্ষেত্রে উল্লেখযোগ্য সাফল্য অর্জিত হয়েছে। পোলিও নির্মূল করা হয়েছে। বাংলাদেশে এইচআইভি-র প্রকোপ অন্য দেশের তুলনায় এখনো অনেক কম। তবে এর বিস্তারের আশংকা রয়েছে, বিশেষ করে ঝুঁকিপূর্ণ জনগোষ্ঠীর আচরণগত কারণে এক্ষেত্রে ঝুঁকি বিদম্যান ।

গ্রামবাসীর শহর অভিমুখী হওয়া এবং শহরের বস্তিসমূহে অধিক সংখ্যক লোকের বসবাসের ফলে স্বাস্থ্য সেবার চাহিদা সৃষ্টি হচ্ছে যা শহরে স্বাস্থ্য সেবার যথার্থ প্রয়োগকে জটিল করে তুলেছে। অন্যদিকে প্রাতিষ্ঠানিক স্বাস্থ্যসেবা গ্রামের গরীব মানুষের জন্য এখনও সহজলভ্য নয়।

প্রাকৃতিক দুর্যোগ মোকাবেলায় পূর্বপ্রস্তুতি এবং যথাযথ ব্যবস্থাপনার ক্ষেত্রে বাংলাদেশ প্রশংসনীয় অগ্রগতি অর্জন করেছে। জলবায়ুর পরিবর্তন, লবণাক্ততা এবং খরা, স্বাস্থ্যরক্ষার প্রাথমিক পদক্ষেপসমূহকে বাধাগ্রস্ত করেছে। জলবায়ুর পরিবর্তন এবং ভৌগোলিক অবস্থানের কারণে বাংলাদেশ প্রতিবছর নতুন নতুন প্রাকৃতিক দুর্যোগের সম্মুখীন হচ্ছে, যা স্বাস্থ্য সেবার চাহিদা এবং ব্যবস্থাপনায় অতিরিক্ত চাপ সৃষ্টি করছে।

বর্তমানে দেশে সরকারি ও বেসরকারি খাতে যে স্বাস্থ্য সেবা জনগণ পাচ্ছেন তা পরিসর ও গুণগত মানের দিক থেকে আরও উন্নীত করা প্রয়োজন। বেসরকারি স্বাস্থ্য সেবার জন্য উচ্চ ফি এবং অধিক রোগ নির্ণায়ক পরীক্ষাকে ব্যয়বহুল চিকিৎসার একটি বড় কারণ হিসেবে গণ্য করা হয়। বেসরকারি চিকিৎসা শিক্ষা ও সেবার ব্যবস্থাপনা ও মান নিয়েও জনগণ সন্তুষ্ট নয়। জনবলের স্বল্পতা, যন্ত্রপাতি ও অবকাঠামো রক্ষণাবেক্ষণের দুর্বলতা, অপর্যাপ্ত ঔষধ সরবরাহ ও সুষ্ঠু ব্যবস্থাপনার অভাবে সরকারি স্বাস্থ্য সেবাকে দরিদ্র, দূরবর্তী ও ঝুঁকিপূর্ণ জনগোষ্ঠীর নিকট পৌঁছানো যাচ্ছে না।

বাংলাদেশ স্বাস্থ্য সেবা জনবলের ক্ষেত্রে সংকটাপন্ন ৫৭টি দেশের একটি। ডাক্তার ও নার্সের আন্তর্জাতিক স্বীকৃত অনুপাত যেখানে ১:৩ সেখানে বাংলাদেশে সে অনুপাত ১:০.৪৮ যা অনাকাঙ্খিত। ডাক্তার, নার্স এবং অন্যান্য স্বাস্থ্য জনশক্তির স্বীকৃত অনুপাত ১:৩:৫ হলেও আমাদের দেশে চিত্র তার সম্পূর্ণ ভিন্ন। এর ফলে অদক্ষ সেবা প্রদানকারীদের কাছ থেকেই রোগীদের প্রথম সেবা গ্রহণ করতে হয়। সরকারি বেসরকারি সকল স্বাস্থ্য সেবাকেন্দ্র জনগণের সার্বিক চাহিদা পূরণে অসমর্থ হয়। তার উপরে অনেক ক্ষেত্রে পেশাজীবীদের যোগ্যতাও কাঙিক্ষত মানের নয়। এর ফলে স্বাস্থ্য সেবা গ্রহণকারীগণ অতৃপ্ত থেকে যায়।

সরকারি স্বাস্থ্য খাতে চিকিৎসা সামগ্রী এবং উপকরণ সংগ্রহের জটিল ও সময় সাপেক্ষ ক্রয় প্রক্রিয়া বাজেট বরাদ্দের অপরিণত ব্যবহারের অন্যতম কারণ। প্রায়ই অনিয়মিত এবং অপ্রয়োজনীয় সামগ্রী সরবরাহ করা হয়। এছাড়া স্বাস্থ্যকেন্দ্রের ভৌত অবকাঠামো ও যন্ত্রপাতির মেরামত এবং রক্ষণাবেক্ষণ বাজেট ও ব্যয় অপ্রতুল।দেশে স্বাস্থ্য ক্ষেত্রে সৃষ্ট বর্জ্যের ব্যবস্থাপনা পরিবেশ, পেশাগত স্বাস্থ্য এবং নিরাপত্তার দিক দিয়ে সন্তোষজনক নয়।

স্বাস্থ্য সেবার পূর্ণতা অর্জনের জন্য সরকারি এবং বেসরকারি খাতে অর্থের সংকুলান ও ব্যবস্থাপনা অপর্যাপ্ত। বাজেটের মাত্র ৭ শতাংশ স্বাস্থ্য খাতে বরাদ্দ করা হয়ে থাকে, যা জিডিপি-র মাত্র এক শতাংশ এবং অনেক উন্নয়নশীল দেশের তুলনায়ও কম। বর্তমানে সরকারি খাতে স্বাস্থ্য সেবার ব্যয়ের পরিমাণ মাথাপিছু ৫ ডলার মাত্র। বিশ্ব স্বাস্থ্য সংস্থার মতে স্বাস্থ্য সেবায় মাথাপিছু ৩৪ মার্কিন ডলার ব্যয় করতে হবে। বিশ্ব স্বাস্থ্য সংস্থার মানদন্ড অনুসরণ করে বাংলাদেশে স্বাস্থ্য ক্ষেত্রে মাথাপিছু ব্যয়ের পরিমাণ বছরে অন্তত ২৪ ডলারে উন্নীত করার লক্ষ্যমাত্রা নির্ধারণ করা প্রয়োজন।

রূপকল্প

স্বাস্থ্য একটি স্বীকৃত মানবাধিকার। সার্বিক জনগণের সুস্বাস্থ্য অর্জনের লক্ষ্যে সেবা প্রাপ্তিতে সাম্য, লিঙ্গ সমতা, প্রতিবন্ধী এবং প্রান্তিক জনগোষ্ঠীর সেবার নিশ্চয়তা বিধান করা প্রয়োজন। জনগণের স্বাস্থ্য সেবার উন্নয়ন দারিদ্র্য নিরসনে অত্যাবশ্যকীয়।

সুনির্দিষ্ট উদ্দেশ্য

জাতীয় স্বাস্থ্যনীতির সুনির্দিষ্ট উদ্দেশ্যেসমূহ নিম্নরূপ:

১. সবার জন্য প্রাথমিক স্বাস্থ্য ও জরুরি চিকিৎসা সেবা প্রাপ্যতা নিশ্চিত করা।
২. সমতার ভিত্তিতে সেবা গ্রহীতা কেন্দ্রিক মানসম্মত স্বাস্থ্যসেবার সহজপ্রাপ্যতা বৃদ্ধি ও বিস্তৃত করা।
৩. রোগ প্রতিরোধ ও সীমিতকরণের জন্য অধিকার ও মর্যাদার ভিত্তিতে সেবা গ্রহণে জনগণকে উদ্বুদ্ধ করা।

জাতীয় স্বাস্থ্যনীতির মূল লক্ষ্য

প্রথম : সমাজের সর্বস্তরের মানুষের কাছে সংবিধান অনুযায়ী ও আন্তর্জাতিক সনদসমূহ অনুসারে চিকিৎসাকে অধিকার হিসেবে প্রতিষ্ঠার লক্ষ্যে চিকিৎসার মৌলিক উপকরণ পৌঁছে দেয়া এবং পুষ্টির উন্নয়ন ও জনস্বাস্থ্যের উন্নতি সাধন করা।

দ্বিতীয় : জনসাধারণ, বিশেষ করে গ্রাম ও শহরের দরিদ্র এবং পশ্চাৎপদ জনগোষ্ঠীর জন্য মানসম্পন্ন ও সহজলভ্য স্বাস্থ্য সেবা নিশ্চিত করা।

তৃতীয় : প্রাথমিক স্বাস্থ্য সেবাকে প্রত্যেক নাগরিকের জন্য নিশ্চিত করার লক্ষ্যে প্রতি ছয় হাজার জনগোষ্ঠীর জন্য একটি করে কমিউনিটি ক্লিনিক স্থাপন নিশ্চিত করা।

চতুর্থ : জরুরি চিকিৎসা সেবাকে অগ্রাধিকার দেয়া।

পঞ্চম : শিশু ও মাতৃমৃত্যুর হার হ্রাস করা, বিশেষ করে স্বাধীনতার পঞ্চাশ বছর পূর্তিতে আগামী ২০২১ সালের মধ্যে এ হারকে যুক্তিসংগত হারে হ্রাস করা।

ষষ্ঠ : আগামী ২০২১ সালের মধ্যে প্রতিস্থাপনযোগ্য জন-উর্বরতা (Replacement level of Fertility) অর্জন করার লক্ষ্যে পরিবার পরিকল্পনা, প্রজনন ও স্বাস্থ্য সেবাকে আরো জোরদার ও গতিশীল করা।

সপ্তম : মা ও শিশু স্বাস্থ্যের উন্নতির জন্য সন্তোষজনক ব্যবস্থা গ্রহণ করা ও যথাসম্ভব প্রতিটি গ্রামে নিরাপদ প্রসূতি সেবা নিশ্চিত করা।

অষ্টম : অতি দরিদ্র ও অল্প আয়ের জনগোষ্ঠীর মধ্যে পরিবার পরিকল্পনা কর্মসূচিকে গ্রহণযোগ্য করা ও পরিবার পরিকল্পনা সামগ্রীর সহজলভ্যতা নিশ্চিত করা।

নবম : স্বাস্থ্যসেবায় লিঙ্গ সমতা নিশ্চিত করা।

দশম : চিকিৎসা সেবাসহ স্বাস্থ্য খাতের সামগ্রিক ব্যবস্থাপনায় তথ্য প্রযুক্তির সর্বোচ্চ ও সর্বোত্তম ব্যবহার নিশ্চিত করা।

একাদশ : সরকারি স্বাস্থ্য সেবাকেন্দ্র ও হাসপাতালসমূহে চিকিৎসার প্রয়োজনীয় উপকরণ ও লোকবল নিশ্চিত করা এবং ব্যবস্থাপনার উন্নয়ন সাধন পূর্বক সেবার গুণগত মান বৃদ্ধি করা।

দ্বাদশ : বেসরকারি মেডিকেল কলেজ, চিকিৎসা শিক্ষা ও প্রশিক্ষণ প্রতিষ্ঠান, হাসপাতাল, ক্লিনিক, ডায়াগনস্টিক সেন্টারসমূহের সেবার মান নিশ্চিত করা এবং সেবা ও শিক্ষার ব্যয় জনসাধারণের নাগালের মধ্যে রাখা।

ত্রয়োদশ : সকল চিকিৎসা শিক্ষা, নার্সিং শিক্ষা ও মেডিকেল টেকনোলজি ও স্বাস্থ্যসেবা সহায়কদের শিক্ষা ব্যবস্থাকে আধুনিকায়ন ও দেশের প্রয়োজন অনুযায়ী যুগোপযোগী করা।

চর্তুদশ : জনস্বাস্থ্য ও চিকিৎসা সম্পৃক্ত বিভিন্ন মন্ত্রণালয় ও বিভাগ এবং বেসরকারি খাতের সম্মিলিত ও সমন্বিত প্রচেষ্টা নিশ্চিত করা।

পঞ্চদশ : রোগ প্রতিরোধ ব্যবস্থা আরো শক্তিশালী করা এবং এ লক্ষ্যে টিকাদান (Immunization) কার্যক্রমকে অব্যাহত রাখা ও শক্তিশালী করা।

ষষ্ঠদশ : স্বাস্থ্য তথ্য প্রাপ্তিতে জনগণের অধিকার নিশ্চিত করা।

সপ্তদশ : অত্যাবশ্যকীয় ঔষধের সহজলভ্যতা ও মূল্য নিয়ন্ত্রণ নিশ্চিত করা।

অষ্টদশ : জলবায়ু পরিবর্তনজনিত স্বাস্থ্য বিপর্যয় ও রোগ ব্যাধির গতি প্রকৃতি লক্ষ্য রাখা এবং তা থেকে পরিত্রাণ পাওয়ার উপায় উদ্ভাবন করা।

উনবিংশ : বিকল্প চিকিৎসা (ইউনানি, আয়ুর্বেদীয় ও হোমিওপ্যাথি) পদ্ধতি ও শিক্ষার মানোন্নয়নের ব্যবস্থা করা।

জাতীয় স্বাস্থ্যনীতির উল্লেখিত লক্ষ্য ও উদ্দেশ্য অর্জনের জন্য নিম্নবর্ণিত মূলনীতি ও কর্মকৌশলগুলো চিহ্নিত করা হয়েছে।

মূলনীতি:

১. জাতি, ধর্ম, গোত্র, আয়, লিঙ্গ, প্রতিবন্ধী ও ভৌগলিক অবস্থান নির্বিশেষে বাংলাদেশের প্রত্যেক নাগরিকের এবং বিশেষ করে শিশু ও নারীর সাংবিধানিক অধিকার নিশ্চিত করে সামাজিক ন্যায় বিচার ও সমতার ভিত্তিতে তাদের স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্য সেবা ভোগ করতে প্রচার মাধ্যমের সহায়তায় সচেতন ও সক্ষম করে তোলা ও সুস্বাস্থ্যের সঙ্গে সঙ্গতিপূর্ণ জীবন-যাত্রা গ্রহণের জন্য আচরণের পরিবর্তন আনার উদ্যোগ নেয়া।

২. প্রাথমিক স্বাস্থ্য সেবাসমূহ বাংলাদেশের রাষ্ট্রীয় ভূখন্ডের যে কোন ভৌগলিক অবস্থানের প্রত্যেক নাগরিকের কাছে পৌঁছে দেয়া।

৩. স্বাস্থ্য সমস্যা সমাধানের ক্ষেত্রে সুবিধা বঞ্চিত, গরিব, প্রান্তিক, বয়স্ক ও শারীরিক ও মানসিক প্রতিবন্ধী জনগণের অধিক গুরুত্বপূর্ণ স্বাস্থ্য সমস্যাগুলির প্রতি বিশেষ দৃষ্টি দেয়া এবং এ লক্ষ্যে বিরাজমান সম্পদের প্রাধিকার, পূর্ণ বণ্টন ও সদ্ব্যবহার নিশ্চিত করা।

৪. স্বাস্থ্য ব্যবস্থাপনা বিকেন্দ্রীকরণের লক্ষ্যে এবং স্বাস্থ্য উন্নয়নে জনগণের অধিকার প্রতিষ্ঠা ও দায়িত্ব পালনের সুযোগ সৃষ্টি করার জন্য পরিকল্পনা প্রণয়ন, ব্যবস্থাপনা, স্থানীয় তহবিল গঠন, ব্যয়ন, পরিবীক্ষণ এবং স্বাস্থ্য সেবা প্রদান পদ্ধতি পর্যালোচনাসহ সংশ্লিষ্ট সকল প্রক্রিয়ায় জনগণকে সম্পৃক্ত করা।

৫. সবার জন্য কার্যকর স্বাস্থ্যসেবা প্রদান নিশ্চিত করার লক্ষ্যে সরকারি প্রতিষ্ঠান ও বেসরকারি সংস্থাসমূহের সমন্বিত প্রয়াসের সুযোগ সৃষ্টি ও সহযোগিতা প্রদান করা এবং অংশীদারিত্বের সুযোগ সৃষ্টি করা। বিশেষ করে

সরকারি স্বাস্থ্য স্থাপনাসমূহে উচ্চমূল্যের চিকিৎসা যন্ত্রপাতি বেসরকারি অংশীদারিত্বে স্থাপনের বিষয়টি পরীক্ষা করা।

৬. স্বাস্থ্য সেবার উন্নয়ন ও গুণগত মান বৃদ্ধির লক্ষ্যে এবং স্বাস্থ্য সেবার সুবিধা প্রতিটি নাগরিকের কাছে পৌঁছে দেয়ার জন্য সঠিক ও গ্রহণযোগ্য প্রশাসনিক পুনর্বিন্যাস, সেবা দান পদ্ধতি ও সরবরাহ ব্যবস্থা বিকেন্দ্রীকরণ এবং প্রয়োজনের সঙ্গে সঙ্গতিপূর্ণ মানব সম্পদ উন্নয়ন কৌশল গ্রহণ করা।

৭. স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্যের সেবাগুলিকে আরো জোরদার ও সেগুলোর সদ্ব্যবহার নিশ্চিত করার জন্য কার্যকর, ফলপ্রসূ ও সুদক্ষ প্রযুক্তি গ্রহণ ও যথাযথ ব্যবহার, পদ্ধতি উন্নয়ন ও গবেষণা কর্মকে উৎসাহিত করা।

৮. জন্ম-নিয়ন্ত্রণের প্রত্যাশিত লক্ষ্য অর্জনের জন্যে পরিবার পরিকল্পনা কার্যক্রমকে স্বাস্থ্যের সাথে কার্যকর সমন্বয় করা।

৯. পুষ্টি কার্যক্রমকে স্বাস্থ্যসেবার সঙ্গে কার্যকর সমন্বয় করা।

১০. স্বাস্থ্য সেবার সাথে সম্পর্কিত বিষয়ে সকল নাগরিকের অধিকার, সুযোগ, দায়িত্ব, কর্তব্য ও বিধি-নিষেধের ব্যাপারে সচেতন করা।

১১. জনগণের আকাঙ্ক্ষা ও চাহিদা পূরণের লক্ষ্যে সার্বিক সুস্থতা ও সুস্থ প্রজনন স্বাস্থ্য নিশ্চিত করার জন্য প্রাথমিক স্বাস্থ্য পরিচর্যা ও অত্যাবশ্যকীয় স্বাস্থ্য সেবা কর্মসূচি বাস্তবায়নের মাধ্যমে স্বাস্থ্য সেবার অন্তর্নিহিত মূলনীতি স্বাস্থ্য ক্ষেত্রে স্বনির্ভরতা প্রতিষ্ঠা করা।

১২. স্বাস্থ্য সংশ্লিষ্ট জাতীয় লক্ষ্য অর্জনের জন্য সকল স্তরে প্রয়োজনীয় ও মানসম্পন্ন চিকিৎসক ও স্বাস্থ্য সহায়ক প্রশিক্ষিত পেশাজীবী কর্মী-বাহিনী গড়ে তোলা।

১৩. তথ্য ও যোগাযোগ প্রযুক্তির উদ্ভাবনী প্রয়োগ এবং ই-হেলথ ও টেলি মেডিসিনের মাধ্যমে সকল নাগরিকের জন্য মান সম্পন্ন স্বাস্থ্য নিশ্চিত করা।

১৪. অত্যাবশ্যকীয় ওষুধ (Essential Drugs) এর তালিকা হালনাগাদ করা ও সর্বত্র সেগুলোর যথাযথ প্রাপ্যতা নিশ্চিত করা। দেশীয় ঔষধ শিল্পের উন্নয়ন ও প্রসারের জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করা।

১৫. দুর্যোগ কবলিত এবং জলবায়ু পরিবর্তনজনিত বিপর্যয়ের শিকার জনগণের কাছে জরুরি ত্রাণ হিসাবে স্বাস্থ্যসেবা, ওষুধ, যন্ত্রপাতি প্রভৃতি সরবরাহ নিশ্চিত করার জন্য স্বাস্থ্য সম্পর্কিত নিরাপত্তা বেষ্টনী গড়ে তোলা।

১৬. প্রচলিত স্বাস্থ্য সেবার পাশাপাশি বিকল্প স্বাস্থ্য সেবা পদ্ধতিসমূহ (যেমন- হোমিওপ্যাথি, ইউনানি, আয়ুর্বেদীয় ইত্যাদি) অন্তর্ভুক্ত করে স্বাস্থ্য সেবার পরিধি সম্প্রসারণ করা।

কর্মকৌশল:

১. সরকার প্রধানের নেতৃত্বে জাতীয় স্বাস্থ্য কাউন্সিল গঠন করা হবে। এ কাউন্সিলে সরকারের সংশ্লিষ্ট মন্ত্রণালয়-সহ বেসরকারি খাতের স্টেকহোল্ডার ও এ সংক্রান্ত বিশেষজ্ঞদের অন্তর্ভুক্ত করা হবে। কাউন্সিল স্বাস্থ্যনীতি বাস্তবায়নে দিকনির্দেশনা প্রদান করবে। প্রয়োজনীয় ক্ষেত্রে গুরুত্বপূর্ণ অন্যান্য বিষয়ে কাউন্সিলের কাছে দিক-নির্দেশনা চাওয়া হবে।

২. স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের দায়িত্বপ্রাপ্ত মন্ত্রীর নেতৃত্বে একটি নির্বাহী কমিটি গঠন করা হবে। এই কমিটি স্বাস্থ্য নীতি, জনসংখ্যা নীতি ও পুষ্টি নীতির আলোকে কর্মকান্ড পর্যালোচনা করবে। তাছাড়া কমিটি প্রয়োজনীয় অবকাঠামো সংস্কার, জনবল নিয়োগ, স্বাস্থ্য সম্পর্কিত মানবসম্পদ উন্নয়ন পরিকল্পনা ও বাস্তবায়ন, কর্মীদের কর্মজীবন পরিকল্পনা, উন্নয়ন, ব্যবস্থাপনা নীতিসহ স্বাস্থ্যসেবার সঠিক উন্নয়নে পরামর্শ প্রদান করতে পারে। সম্পদের প্রাপ্যতার ভিত্তিতে কমিটির সুপারিশসমূহ পর্যায়ক্রমে বাস্তবায়ন করা হবে।

৩. বিভিন্ন মন্ত্রণালয়ের স্বাস্থ্য সম্পর্কিত কাজগুলো সম্পাদনে স্বাস্থ্য মন্ত্রণালয়কে সম্পৃক্ত করে কর্মপদ্ধতি নির্বাচন করার ব্যবস্থা করতে হবে।

৪. স্বাস্থ্যসেবা প্রদানে প্রাথমিক স্বাস্থ্য পরিচর্যার গুরুত্ব সর্বজন স্বীকৃত। প্রাথমিক স্বাস্থ্যসেবার গুণগত মান উন্নয়ন করতে হবে এবং তা সর্বজনীন করা হবে। প্রাথমিক স্বাস্থ্যসেবা সংক্রান্ত কার্যাবলি বাস্তবায়নে কমিউনিটি ক্লিনিকসমূহই হবে প্রধান ভিত্তি। কমিউনিটি ক্লিনিকসমূহের কর্মকান্ড জোরালো করা হবে এবং স্থানীয় জনগণ ও স্থানীয় সরকার সংস্থাগুলোর অংশীদারিত্বে পরিচালিত হবে। প্রতি ছয় হাজার মানুষের জন্য একটি কমিউনিটি ক্লিনিক স্থাপন করা হবে। তবে বিশেষ ভৌগোলিক অবস্থান বিবেচনায় অপেক্ষাকৃত কম জনগোষ্ঠীর জন্যও (যেমন- চর, হাওড়, পার্বত্য অঞ্চল) কমিউনিটি ক্লিনিক স্থাপন করা যেতে পারে। দ্রুত নগরায়নের ফলে শহরাঞ্চলে মোট জনসংখ্যার সাথে সাথে দরিদ্র মানুষের সংখ্যা বাড়ছে। বিদ্যমান স্বাস্থ্যসেবা ব্যবস্থা প্রয়োজনের তুলনায় অপ্রতুল। এদের জন্য প্রয়োজনীয় পরিবার পরিকল্পনা ও স্বাস্থ্যসেবা নিশ্চিত করা হবে। কার্যকর রেফারেল পদ্ধতির মাধ্যমে শহর ও গ্রাম উভয় ক্ষেত্রেই জটিলতর রোগীদের পরবর্তী ধাপে চিকিৎসার ব্যবস্থা করা হবে।

৫. জরুরি স্বাস্থ্য সেবা জীবন বাঁচাতে পারে বিধায় সার্বজনীন জরুরি চিকিৎসার ব্যবস্থা করা হবে।

৬. 'সবার জন্য স্বাস্থ্য' এ মৌলিক উদ্দেশ্যকে সামনে রেখে রোগ প্রতিরোধ ও স্বাস্থ্য সচেতনতা বৃদ্ধির জন্য বিশেষ গুরুত্ব দেয়া হবে। আরোগ্যমূলক ও পুনর্বাসন সেবাগুলোর সন্তোষজনক প্রয়োগ নিশ্চিত করা হবে।

৭. রোগতাত্ত্বিক পরিবীক্ষণ (Epidemiological Surveillance) পদ্ধতিকে বিস্তৃত করে রোগ নিয়ন্ত্রণ কর্মসূচির সঙ্গে সমন্বিত করতে হবে।

৮. স্বাস্থ্যসেবার চাহিদা পূরণের জন্য স্বাস্থ্যনীতির সঙ্গে সামঞ্জস্য রেখে ঔষধ নীতিকে আরও গ্রহণযোগ্য এবং উন্নত করতে হবে। বর্তমান সময়ের চাহিদা, নিরাপত্তা, উপকারিতা, ক্রয় ক্ষমতার দিকে লক্ষ্য রেখে সর্বস্তরে জরুরি ঔষধ সহজপ্রাপ্যতা নিশ্চিত করা হবে।

৯. জন্মনিয়ন্ত্রণ সামগ্রী ও পরিবার পরিকল্পনা পদ্ধতির বিভিন্ন সামগ্রীর উৎপাদন, সহজপ্রাপ্যতা ও সরবরাহ নিশ্চিত করা হবে।

১০. স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকান্ডের মূল চালিকাশক্তি হিসেবে পুষ্টি, স্বাস্থ্য ও পরিবার পরিকল্পনা শিক্ষার উপর বিশেষ গুরুত্ব দিতে হবে। প্রত্যেক উপজেলায় একটি পুষ্টি এবং একটি স্বাস্থ্য শিক্ষা ইউনিট থাকবে। এগুলোর কর্মকান্ড প্রত্যন্ত অঞ্চল পর্যন্ত পর্যায়ক্রমে বিস্তৃত করা হবে। স্বাস্থ্যসেবার সঙ্গে সমন্বিত ভাবে উপজেলা পর্যন্ত স্বাস্থ্য শিক্ষার ব্যবস্থা করা হবে।

১১. লিঙ্গ সমতা প্রতিষ্ঠা কল্পে জীবনচক্রের সকল পর্যায়ে উত্তম শারীরিক, মানসিক স্বাস্থ্যের উপর নারীর অধিকার নিশ্চিত করা হবে। মাতৃ মৃত্যু ও এক বছরের কম বয়সী শিশু মৃত্যুর হার কমানোর উপর জোর দিয়ে নারীর জন্য প্রাথমিক স্বাস্থ্যসেবা জোরদার করা হবে। নারীদের বিশেষত: গর্ভবতী মহিলাদের পুষ্টি চাহিদা পূরণ করা হবে। সচেতনতা বৃদ্ধির মাধ্যমে নারীদের এইচআইভি/এইডস এবং অন্যান্য যৌনরোগ হতে রক্ষার পদক্ষেপ গ্রহণ করতে হবে। সকল স্বাস্থ্য প্রতিষ্ঠানে নারী বান্ধব কাঠামো তৈরি করতে হবে।

১২. মাতৃ মৃত্যুর হার ও প্রজনন হার উল্লেখযোগ্য ভাবে কমানোর জন্য প্রজনন স্বাস্থ্য একটি গুরুত্বপূর্ণ উপাদান। গ্রাম ও শহর এলাকায় প্রান্তিক মানুষের কাছে এসব সেবা আরও ব্যাপকভাবে পৌঁছে দেয়া হবে। সাধারণ স্বাস্থ্য সেবা ও

প্রজনন স্বাস্থ্য সেবা সমন্বিতভাবে দিলে তা জন-বান্ধব ও ব্যয় সাশ্রয়ী হবে। স্বাস্থ্য ও পরিবার কল্যাণ কর্মসূচি কার্যকর ভাবে সমন্বয় করা হবে।

১৩. একটি সমন্বিত তথ্য ব্যবস্থাপনা পদ্ধতি (Intergrated Management Information System) এবং কম্পিউটার নির্ভর যোগাযোগ ব্যবস্থা সারাদেশে প্রতিষ্ঠা করা হবে, যা কর্মসূচি বাস্তবায়ন, কর্ম পরিকল্পনা প্রণয়ন এবং মনিটরিং-এর জন্য সহায়ক হিসেবে কাজ করবে।

১৪. স্বাস্থ্য সেবার সাথে সম্পৃক্ত সকলের জবাবদিহিতা নিশ্চিত করার জন্য নীতিমালা বা আইন প্রণয়ন করা হবে।

১৫. স্বাস্থ্য খাতে ব্যবস্থাপনার দক্ষতা বৃদ্ধির জন্য ব্যবস্থাপনা ও প্রশাসনিক বিষয়ের উপর চিকিৎসকসহ স্বাস্থ্য খাতে নিয়োজিত অন্যান্যদের প্রশিক্ষণের জন্য বিদ্যমান প্রতিষ্ঠানসমূহকে আরো আধুনিক ও যুগোপযোগী করা হবে।

১৬. বেসরকারি ও এনজিও সংস্থাগুলোকে স্বাস্থ্য সেবায় সম্পূরক ভূমিকা পালনে উৎসাহিত করা হবে। বেসরকারি খাতে স্বাস্থ্য সেবা ও চিকিৎসা ব্যবস্থা রোগীদের সঠিক ও মান সম্পন্ন চিকিৎসা সেবা প্রাপ্তি নিশ্চিত করার জন্য প্রয়োজনীয় বিধি-বিধান তৈরি করা ও প্রয়োগ করার ব্যবস্থা করা হবে। পরীক্ষা- নিরীক্ষাসহ অন্যান্য চিকিৎসা ব্যয় সহনীয় পর্যায়ে রাখার ব্যবস্থা নেয়া হবে।

১৭. স্বাস্থ্য গবেষণার মান ও পরিধি বাড়ানো হবে। এ খাতে অর্থ বরাদ্দ বাড়ানো হবে। জনস্বাস্থ্য, স্বাস্থ্য ব্যবস্থাপনা ও নীতি, সামাজিক ও আচরণগত এবং প্রায়োগিক গবেষণার উপর জোর দেয়া হবে। বাংলাদেশে যে সমস্ত রোগের প্রাদুর্ভাব বেশি, সেগুলোর গবেষণা অগ্রাধিকার পাবে। বিভিন্ন গবেষণা প্রতিষ্ঠান ও সংশ্লিষ্ট ব্যক্তিবর্গের সামর্থ্য ও দক্ষতা বাড়ানো হবে।

১৮. প্রচলিত স্বাস্থ্য সেবার পাশাপাশি আয়ুর্বেদীয়, ইউনানি ও হোমিওপ্যাথি চিকিৎসা ব্যবস্থাকে বিকল্প চিকিৎসা পদ্ধতি হিসেবে সম্পৃক্ত করা হবে। সে লক্ষ্যে আয়ুর্বেদীয়, ইউনানি ও হোমিওপ্যাথি চিকিৎসাকে বিজ্ঞানভিত্তিক ও যুগোপযোগী করে গড়ে তোলা হবে। এ লক্ষ্যে সরকার যথাযথ সহায়তা প্রদান, অনুদান বৃদ্ধি, প্রশিক্ষণের ব্যবস্থাসহ মান নিয়ন্ত্রণের জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করবে।

১৯. স্বাস্থ্য সেবার পূর্ণতা অর্জনের জন্য সরকারি ও বেসরকারি স্বাস্থ্য অর্থ ব্যবস্থা পর্যাপ্ত নয়। স্বাস্থ্যাখাতে বরাদ্দকৃত বাজেটের পরিমাণ প্রয়োজনের তুলনায় অপ্রতুল। গড়ে বাংলাদেশের জিডিপির মাত্র এক শতাংশ সরকার স্বাস্থ্য, জনসংখ্যা ও পুষ্টি খাতে বরাদ্দ করে। স্বাস্থ্য খাতে বরাদ্দ মোট বাজেটের সাত শতাংশ। স্বাস্থ্য, জনসংখ্যা ও পুষ্টি খাতে প্রতি বছর বাজেট বরাদ্দ বাড়ানো হবে।

২০. স্বাস্থ্য খাতে অর্থায়ন একটি সমস্যা। যদিও এ খাতে ব্যয়ের দুই-তৃতীয়াংশই জনগণ বহন করে, তারপরেও সম্পদের ঘাটতি থেকেই যায়। এটি সমাধানের লক্ষ্যে আনুষ্ঠানিক (formal) প্রতিষ্ঠানসমূহের চাকুরিজীবীদের জন্য স্বাস্থ্য বীমার ব্যবস্থা করা প্রয়োজন। প্রয়োজনে পর্যায়ক্রমে অন্যান্য গোষ্ঠীর জন্য স্বাস্থ্য বীমার ব্যবস্থা নেওয়া হবে। আর্থিকভাবে দুস্থ লোকদের জন্য দেশে সার্বজনীন স্বাস্থ্য সুরক্ষা পদ্ধতির অভাব রয়েছে। অতি দরিদ্র ও বঞ্চিত জনগোষ্ঠীর জন্য বিনামূল্যে চিকিৎসা নিশ্চিত করা প্রয়োজন। সরকার কর্তৃক স্বীকৃত উপায়ে এসব জনগোষ্ঠীকে পর্যায়ক্রমে কার্ড দেয়ার ব্যবস্থা করা হবে।

২১. সর্বস্তরে স্বাস্থ্যসেবা প্রদানের ক্ষেত্রে জনগণ, স্থানীয় সরকার এবং বেসরকারি খাতকে সম্পৃক্ত করা হবে।

২২. স্বাস্থ্য সেবা পরিকল্পনা প্রণয়ন ও বাস্তবায়নে বাংলাদেশ মেডিকেল এসোসিয়েশন (BMA), বাংলাদেশ প্রাইভেট মেডিকেল প্র্যাকটিশনার্স এসোসিয়েশন (BPMPA), আয়ুর্বেদিক মেডিকেল এসোসিয়েশন, ইউনানি মেডিকেল এসোসিয়েশন ও হোমিওপ্যাথি মেডিকেল এসোসিয়েশন, নার্সিং এসোসিয়েশন ইত্যাদি পেশাজীবী সংগঠনসমূহকে সম্পৃক্ত করা হবে।

২৩. সকল স্তরের হাসপাতাল বর্জ্যের নিরাপদ, পরিবেশ বান্ধব ও ব্যয় সাশ্রয়ী ব্যবস্থাপনা নিশ্চিত করা হবে। দেশব্যাপী তার বিস্তার করা হবে।

২৪. স্বাস্থ্য বিষয়ক মানব সম্পদ থেকে জ্ঞান ও দক্ষতার সর্বোচ্চ সুফল অর্জনের লক্ষ্যে সর্বস্তরের জন্য একটি সঠিক ও চাহিদাভিত্তিক স্বাস্থ্য বিষয়ক মানব সম্পদ উন্নয়ন পদ্ধতি গড়ে তোলা হবে। চিকিৎসক, নার্স, ফার্মাসিস্ট, ফিজিওথেরাপিস্ট, প্যারামেডিক, টেকনোলজিস্টসহ বিভিন্ন স্বাস্থ্য কর্মীর স্বল্পতা ও অসম বণ্টন ব্যবস্থা, দক্ষতা সংমিশ্রণের ক্ষেত্রে বিদ্যমান ভারসাম্যহীনতা, ন্যায়বিচার ও প্রণোদনার অভাব দূর করার ব্যবস্থা মানব সম্পদ উন্নয়ন কৌশলে থাকবে। চাহিদা যাচাই করে অতিরিক্ত জনশক্তি (ডাক্তার, নার্স, টেকনোলজিস্ট, প্যারামেডিক

প্রভৃতি) তৈরির পদক্ষেপ নেয়া হবে। স্বাস্থ্য জনশক্তির সকল স্তরে নিয়োগ, পদোন্নতি, পদায়ন ও বদলির স্বচ্ছ নীতিমালা বাস্তবায়ন করা হবে।

২৫. চিকিৎসা শিক্ষা, নার্সিং শিক্ষা, প্যারামেডিক ও টেকনোলজিস্টদের শিক্ষা, ফিজিওথেরাপিস্ট এবং অন্যান্য স্বাস্থ্য কর্মীদের শিক্ষা এবং প্রশিক্ষণ ব্যবস্থাকে আধুনিকীকরণ করা হবে এবং গণমুখী ও দেশের প্রয়োজন ভিত্তিক করা হবে। চিকিৎসা জনশক্তির শিক্ষাদানে সেবার মান, রোগীর প্রতি সংবেদনশীল আচরণ, মমত্ববোধ ও নৈতিকতা বিষয়ে সচেতনতা সৃষ্টির উপর গুরুত্ব দেয়া হবে।

(ক) নার্সিং: ডিপ্লোমা পর্যায়ে দেশের চাহিদা পূরণ করার জন্য যথাযথ মানসম্পন্ন শিক্ষা প্রতিষ্ঠান বাড়ানো হবে। হাতে কলমে প্রশিক্ষণ ও আধুনিক প্রযুক্তির শিক্ষায় জোর দেয়া হবে। দেশে গ্রাজুয়েট নার্সদের স্বল্পতা রয়েছে এবং শিক্ষা প্রতিষ্ঠান বৃদ্ধির মাধ্যমে তাদের সংখ্যা বাড়ানো হবে। বিশেষায়িত নার্সিং শিক্ষা (Specialized Nursing) যেমন- কার্ডিয়াক সার্জারি, নিউরো সার্জারি, করোনারি কেয়ার ও অন্যান্য বিশেষায়িত ডিসিপ্লিনে নার্সিং শিক্ষা শুরু করা হবে। নার্সিং শিক্ষকদের স্বল্পতাও প্রকট। পোস্ট গ্রাজুয়েট নার্সিং শিক্ষা বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়সহ অন্যান্য প্রতিষ্ঠানে শুরু করা হবে।

(খ) প্যারামেডিক, টেকনোলজিস্ট সংখ্যা প্রয়োজনের তুলনায় অনেক কম। এ পর্যায়ের শিক্ষা প্রতিষ্ঠানের সংখ্যা বাড়ানো হবে। আধুনিক প্রযুক্তির জ্ঞানসহ দক্ষতা অর্জনের উপর জোর দেওয়া হবে।

(গ) ধাত্রী: সরকারি স্বাস্থ্য সেবায় মাঠ পর্যায় পর্যন্ত ধাত্রীবিদ্যায় দক্ষ জনশক্তি দেয়া হবে। এজন্য প্রয়োজনীয় মানব সম্পদ প্রশিক্ষণের ব্যবস্থা করা হবে।

(ঘ) গ্রাজুয়েট পর্যায়ে চিকিৎসা শিক্ষার মান উন্নয়ন করার লক্ষ্যে আরো মেডিক্যাল বিশ্ববিদ্যালয় প্রতিষ্ঠা করা প্রয়োজন। দেশের প্রয়োজন ভিত্তিক শিক্ষাদান ও হাতে-কলমে প্রশিক্ষণের উপর জোর দেয়া হবে। দেশে প্রচলিত পোস্ট গ্রাজুয়েট শিক্ষা ও বিভিন্ন কোর্স সমূহকে সমমানের করা হবে এবং সমন্বয় করা হবে। এখানেও আধুনিক প্রযুক্তি ও হাতে কলমে প্রশিক্ষণের উপর জোর দেয়া হবে। চিকিৎসকদের পেশাগত মান বজায় রাখার জন্য দেশে ও বিদেশে Continuting Medical Education ও প্রশিক্ষণ এবং মূল্যায়নের ব্যবস্থা করা হবে।

(ঙ) গ্রামীণ জনগণের স্বাস্থ্য সেবা নিশ্চিত করার জন্য ইন্টার্নিশীপ বিদ্যমান এক বৎসরের পরিবর্তে ভবিষ্যতে প্রয়োজনীয় অর্থ প্রাপ্তি নিশ্চিত হওয়া সাপেক্ষে পর্যায়ক্রমে দুই বৎসরে উন্নীত করে তার মধ্যে অন্ততঃ এক বৎসর গ্রাম পর্যায়ের স্বাস্থ্য কেন্দ্রসমূহে তাদের কার্যসম্পাদন নিশ্চিত করা হবে।

২৬. মেডিক্যাল প্রাকটিশনারদের রেজিস্ট্রেশন, পেশাগত মান এবং এথিক্যাল প্রাকটিস সংক্রান্ত বিষয়গুলো সঠিকভাবে তদারক করার জন্য বাংলাদেশ মেডিকেল ও ডেন্টাল কাউন্সিল আরো শক্তিশালী করা হবে। অনুরূপভাবে বাংলাদেশ নার্সিং কাউন্সিলকেও পুনর্বিন্যস্ত ও শক্তিশালী করা হবে। ফার্মাসিস্ট, মেডিকেল টেকনোলজিস্ট এবং অন্যান্য প্যারামেডিকদের সেবা, শিক্ষা ও প্রশিক্ষণের গুণগত মান নিশ্চিত করার জন্য যথাক্রমে ফার্মেসি কাউন্সিল এবং স্টেট মেডিকেল ফ্যাকাল্টিকে পুনর্বিন্যাস করা হবে।

২৭. সুষ্ঠু স্বাস্থ্য সেবা নিশ্চিত করার জন্য মেডিক্যাল কলেজ এবং সংশ্লিষ্ট হাসপাতাল বা প্রতিষ্ঠানগুলোর ব্যবস্থাপনার উন্নতি সাধন করা হবে এবং সেগুলোর যাবতীয় কর্মকান্ড পরিচালনার জন্য অধিকতর আর্থিক ও প্রশাসনিক ক্ষমতা প্রদান করা হবে।

২৮. সরকারি চিকিৎসকদের মধ্যে যে সমস্ত চিকিৎসক বা শিক্ষার্থী সার্বক্ষণিক ও আবাসিক পদে এবং জরুরি বিভাগে কর্মরত আছেন এবং যারা Non-clinical Subject এর শিক্ষক তাদের প্রাইভেট প্রাকটিস থেকে বিরত রেখে নন-প্রাকটিসিং ভাতা প্রদানের ব্যবস্থা করা প্রয়োজন।

২৯. প্রত্যেক সরকারি ও বেসরকারি স্বাস্থ্য সেবা দানকারী প্রতিষ্ঠানে রোগী পরিচর্যার ক্ষেত্রে মান সম্মত সেবা নিশ্চিত করতে হবে। এ লক্ষ্যে প্রত্যেক স্বাস্থ্য কেন্দ্রে স্বাস্থ্য সেবার গুণগত মান নিশ্চিতকরণ, মনিটরিং ও মূল্যায়ন পদ্ধতির উপর একটি সহায়িকা তৈরি করা হবে।

৩০. সর্বস্তরের কর্মকর্তা ও স্বাস্থ্য-কর্মীদের তাদের কর্মস্থলে উপস্থিতি ও সর্বোত্তম সেবা প্রদান নিশ্চিত করা হবে।

৩১. মানসিক ও শারীরিক প্রতিবন্ধী, বয়স্ক জনগোষ্ঠী, পশ্চাৎপদ জনগোষ্ঠী সমূহের স্বাস্থ্য সেবার প্রতি বিশেষ দৃষ্টি দেয়া হবে । এজন্য বিশেষ স্বাস্থ্য সেবা কর্মসূচি তৈরি করা হবে।

৩২. সংক্রামক রোগসমূহ যেমন– শ্বাসতন্ত্রে প্রদাহ, ডায়রিয়া, ডেঙ্গু প্রভৃতি রোগ প্রতিরোধ ও নিয়ন্ত্রণের কর্মসূচি জোরদার করা হবে। যক্ষ্মা, কুষ্ঠ, ম্যালেরিয়া, কালাজ্বর, ফাইলেরিয়া নিয়ন্ত্রণের কর্মসূচি জোরদার করা হবে। সংক্রামক রোগসমূহের নিরাময়মূলক সেবা জোরদার করা হবে।

৩৩. অসংক্রামক রোগের প্রাদুর্ভাব বাড়ছে। সমন্বিত উপায়ে সকল পর্যায়ে প্রতিরোধ, চিকিৎসা ও পুনর্বাসনের ব্যবস্থা করা হবে। প্রধান অসংক্রামক রোগগুলো যেমন– ডায়াবেটিস, উচ্চ রক্তচাপ, হৃদরোগ, আর্সেনিকোসিস সম্বন্ধে সচেতনতা সৃষ্টি করা হবে এবং জীবনধারা পরিবর্তনের উদ্যোগ নেয়া হবে।

৩৪. জলবায়ু পরিবর্তনের ক্ষতিকর প্রভাব থেকে রক্ষার জন্য সমন্বিত উদ্যোগ গ্রহণ করা হবে। স্বাস্থ্যের উপর জলবায়ু পরিবর্তনের স্বল্প, মধ্য ও দীর্ঘ মেয়াদি প্রভাব চিহ্নিত করার লক্ষ্যে মাঠ জরিপ ও সমীক্ষা পরিচালনা করা হবে। জলবায়ু পরিবর্তনের ফলে সৃষ্ট রোগগুলোর বোঝা কমাতে একটি জাতীয় কর্মসূচি গ্রহণ করা হবে।

৩৫. টিকাদানের মাধ্যমে রোগ প্রতিরোধ ব্যবস্থা আরো শক্তিশালী করে যত সংখ্যক রোগ প্রতিরোধ করা যায়, তা পর্যায়ক্রমে নিশ্চিত করতে হবে।

৩৬. ভবিষ্যৎ প্রজন্মের সুস্বাস্থ্যের লক্ষ্যে পূর্ণাঙ্গ স্কুল হেলথ কার্যক্রম চালু করা এবং প্রজনন স্বাস্থ্য শিক্ষাসহ জীবন-যাপনের শিক্ষা সম্বন্ধে সম্যক ধারণা দেয়ার ব্যবস্থা করা হবে।

৩৭. শিল্প ও কৃষি খাতে শ্রমিকদের স্বাস্থ্যের উন্নয়ন নিশ্চিত করা হবে।

৩৮. চিকিৎসা সেবার ক্ষেত্রে নিউক্লিয়ার মেডিসিনের প্রয়োগ সম্প্রসারিত করা হবে। এজন্য দক্ষ জনবল তৈরি ও গবেষণার বিষয়ে গুরুত্ব আরোপ করা হবে।

৩৯. বিদেশ হতে প্রত্যাগতদের মাধ্যমে, বিশেষ করে মারাত্মক সংক্রামক রোগের প্রাদুর্ভাব রয়েছে এমন দেশ থেকে প্রত্যাগতদের মাধ্যমে দেশে সংক্রামক ব্যাধির বিস্তার যাতে ঘটতে না পারে সে লক্ষ্যে স্থল, জল ও বিমান বন্দরসমূহে প্রত্যাগতদের স্বাস্থ্য পরীক্ষার ব্যবস্থা রাখা হবে।

Main features of the national health policy 2011

- To ensure primary and emergency health care for all
- To improve access and quality in the service provision in rural areas
- Strengthening disease prevention system and continuing immunization programme
- To reduce in infant and maternal mortality
- To integrate family planning and reproductive health programs with health services
- Using information and communication technology to ensure quality health service

Challenges in achieving policy goals

- Weak management
- Resource constraint
- Poor service delivery system
- Human resource development and management
- Natural calamity and climate change
-Break-through of new diseases like: Avian flu, Dengue, Nipah virus etc.

Annex P: Location of Ghatail Upazila in Bangladesh map

Source: Microsoft, 2017