Abstract: The present study has been prepared based on an evaluation report (Hossain & Ulvila & Khan 1999) on an international NGO working in northern Bangladesh. The research report was prepared during 1998-1999 by our research team connected to the international research project named ‘NGOs in Development’ at the University of Tampere, Finland. The study was carried out to learn lessons from the Health Programme of the Bangladesh Lutheran Mission – Finnish (BLM-F) for the improvement of future activities. The Mission had anticipated planning for its next phase of activities in the health sector and it considered it timely and appropriate to commission an outside team to academically study and evaluate the past health programme.

In his impressive and thorough analysis, Helmut Anheier (1990) argued that there are actually four basic arguments in favour of the comparative advantage of NGOs in Third World development. These are the social, economic, political, and cultural arguments (see also Mälkiä and Hossain 1998):

The social argument comprises the idea that NGOs try to stimulate the participation of the poor and are able to reach those strata of disadvantaged Third World societies that are bypassed by public service delivery systems. This argument attaches greater social equity to private voluntary efforts than to the public sector. Because of shortages of public funds combined with cultural and social access problems, disadvantaged populations are difficult to reach by conventional service systems

— a problem, which is amplified by elite influences on governmental decision-making. Thus, NGOs are in a better position to reach the poor and the disadvantaged.

The economic argument claims that NGOs are able to carry out services more economically than governments. In addition, as they are not seeking profits out of their actions, they usually aim at self-reliance and self-sufficiency. Just as the social argument refers to equity, the economic argument addresses the greater efficiency of NGOs. Their efficiency could be a guarantor of their operational sustainability and credibility to the donors. Greater efficiency of NGOs is largely based on a major cost advantage, which is related to both lower labour costs and incomplete pricing, i.e., not making provisions for depreciation, relying on voluntary local inputs, not including transaction costs, etc. Moreover, according to this type of argument, failures with NGO-led projects (as compared to failures with government-led ones) have much less impact on the economy as a whole, since nearly all NGO-led development projects are designed and implemented at the micro level. Governments, on the other hand, are often working at the macro level.

The political argument suggests that NGOs are relatively immune from changing political tides, while government policies and agencies are subject to unexpected change. An extension of the political argument refers to the ‘hidden agenda’ and ultimately political motivation of official development assistance if we consider aid as a political tool in global politics. By using NGOs as local and international operators, the problems with hidden agendas can be better dealt with. Thus, in general, NGOs are believed to be more ‘honest’ and less guided by political considerations.

Finally, the cultural argument stipulates that NGOs, embedded in the local culture, are more sensitive to local needs and their articulation. Rather than replacing indigenous social structures by large-scale organizations, NGOs try to nurture local organizations within their own cultural context.
Indeed, recent years have experienced a real developmental concern with NGOs and the developing states in Africa, Asia, and Latin America. According to some analysts the reasons for the emergence of development NGOs since the 1970s are several. Among them ‘market failure’ and ‘government failure’ are considered the leading ones in developing countries. (Anheier and Seibel 1990) Scholars argue that this growth of NGOs is a reflection of dissatisfaction with both state and market. On the other hand, the use of NGOs has been consistent with both the New Right aid policies of governments in the USA and UK and the ‘alternative’ aid policies of the consciences of the donor community in the Nordic countries and the Netherlands. (Hulme 1994) Researchers and policy-makers have begun to re-examine decentralization and privatization and to consider the NGOs a possible remedy for the ‘crisis of the welfare state’ (Anheier and Seibel 1990). The restructuring policies of the World Bank and other influential donor institutions (e.g., in OECD countries) led to a planned reduction of the role of the state in developing countries and increased space for development NGOs. (Tvedt 1998a, 1998b).

Bangladesh case is often cited by scholars in development aid literature in justifying the relevance of NGOs in international development. Also the rapid growth of NGOs in Bangladesh during the 1980s was named the ‘NGO decade’ in recent development aid literature. Indeed, currently NGOs have become permanent partners of development management in Bangladesh. Since independence in 1971, due to the weak status of different governmental agencies, it has also been possible for the international donors to present a comparative advantage of NGOs in development management.

The Study

The present study has been prepared based on an evaluation report (Hossain & Ulvila & Khan 1999) on an international NGO working in northern Bangladesh. The research report was prepared during 1998-1999 by our research team connected to the international research project named ‘NGOs in Development’ at the University of Tampere, Finland. The study was carried out to learn lessons from the Health Programme of the Bangladesh Lutheran Mission - Finnish (BLM-F) for the improvement of future activities. The Mission had anticipated planning for its next phase of activities in the health sector and it considered it timely and appropriate to commission an outside team to academically study and evaluate the past health programme.

The objective of the study was purely academic and connected to the Academy of Finland sponsored research project ‘NGOs in Development’ at the University of Tampere. The objectives of this study on this international NGO were to:

- Analyse the context in which the BLM-F health project is operating
- Assess the relevance of the health services to the rural women and children
- Assess the impacts of the health programme on the lives of the people living in the work area
- Discuss the sustainability of the interventions

Despite presenting these larger issues covered by the evaluation study, the present article is only intended to concentrate on the issues related to sustainability of BLM-F’s health care project.

Outline of the Methodology

The study focused on two Family Welfare Centres (FWCs) established by the Mission, of which one has been handed over to the Government of Bangladesh (Cheragpur FWC) and one was still being operated by the Mission (Musidpur FWC) while this study was carried out. The third clinic studied was the first of the two Community Health Centres (Baiochondi).

The fieldwork and interviews were carried out in the period 12 - 22 December 1998 in the Naogaon district. Relevant officials at the Mission and at government offices were met and two days were spent at each of the clinic areas.
The field work for the evaluation was done by using the approach of Participatory Rural Appraisal (PRA). During the two days spent with each community near the three clinics studied (Cheragpur, Musidpur and Baiochondi), a number of focus group discussions were carried out using visual methods separately with groups of women and men. The PRA tools used included Social Mapping, Venn Diagrams, Pair-wise Ranking of health services, Direct Matrix Scoring of the characteristics of illnesses and Time-Trend analysis of the health issues before and after the development intervention. A separate 96-page report has been prepared and presented with a brief description of the methods and the results of the PRA sessions.

The objective of the present article is to understand the complex issue of sustainability of NGO-led development initiative. However, it should be noted here that changes may have occurred in the studied areas and to the studied organization since 1998, when the main field work was done. The findings of the report reflect the situation in the field as of December 1998. Although the finalisation of the report was done in March 1999, the changes that have taken place after the fieldwork have not been taken into account in this article.

The Main Features of the BLM-F Health Project

The Bangladesh Lutheran Mission-Finnish (BLM-F) is a non-profit organisation that began its work in Bangladesh in April 1981. It is a branch of the Bangladesh Lutheran Mission (BLM), which is the continuation of the work of the Santal Mission of Northern Church. The main objective of the BLM-F is to work for the needy and poor people of Bangladesh in the name and spirit of Jesus Christ, particularly in the areas of health care, education, economics and social welfare. It is registered with the Department of Social Welfare and also with the NGO Affairs Bureau of the Government of Bangladesh. Funding of the activities of the BLM-F is provided by the Finnish Lutheran Overseas Mission (FLOM) and the Government of Finland through the Department for International Development Cooperation of the Ministry for Foreign Affairs of Finland, formerly known as Finnish International Development Agency (FINNIDA).

BLM-F runs mainly health and education-related projects in the district of Naogaon in the Rajshahi Division. Under the Health Programme, BLM-F operates a Family Welfare Centre (FWC) at Musidpur which is run in accordance with the national health care plan and the rules and regulations of the Government of Bangladesh. It was scheduled to be handed over to the Government by the year 2000. There is also a Community Health Service (CHS) centre at Baiochondi, which the Mission runs independently. A second such CHS at Chandan Nagar in Niamatpur Upazila (Sub-District) being constructed by the Mission was scheduled to start functioning by early 1999.

Besides the Musidpur FWC, BLM-F established three FWCs, at Paroil, Cheragpur and Mithapur, which they constructed and ran for six to nine years and then handed over to the Government. According to the Project Proposal, the objectives of Health Projects of the BLM-F were:

- Health and family planning clinical services through FWCs;
- Tuberculosis clinical services;
- Community health services through CHS centres;
- Nutrition programme;
- Day care centre for elderly people.

The first three activities were under way when the study was done but the nutrition programme and day care centre for the elderly have been cancelled due to a lack of resources. At times the Programme has faced serious staff shortages due to unforeseen and even unfortunate events. This has obviously hampered the full implementation of the activities.

Under the education project, BLM-F is running several primary and feeder schools, a hostel boarding children, several adult literacy centres and follow-up groups of adult literacy programme participants.

The Musidpur FWC

Human resources at the Musidpur FWC (at the time of the field work during December 1998):

Government staff having deputation posts:
- Sub-Assistant Community Medical Officer (SACMO)
- Aya (midwife)
Mission Staff:
- Health Teacher
- Service Assistant for TB programme
- Service Assistant for the FWC
- Night Guard
- Aya (midwife)

There was also a post of Family Health Visitor (FWV) which has been vacant for a long period. The salaries of all these staff were paid by the BLM-F.

A patient visiting the Centre goes through registration and is provided with cards for recording clinical follow-ups. In order to reduce the workload, each day 30 cases are handled with serial numbers and in each serial number there may be one or two patients (mother and child).

Each month the FWC is provided with one medicine box, like other government FWCs, by the Upazila Family Planning Office. In addition, BLM-F also provides a monthly allocation of different essential medicines. Patients who cannot be treated in this FWC are referred to Porsha Upazila Health Complex (UHC).

*MCH Care:* Women of 15 to 45 years of age get antenatal care, care during labour, postnatal care, treatment of other general ailments and injectable contraceptives as a family planning method. Due to the absence of an FWV, the family planning services and ante- and postnatal advice are somewhat limited. Children are treated for their ailments but there is no provision for growth monitoring.

*Family Planning:* the government provides Family Planning materials like condoms, oral contraceptives, injections, copper-T (intra-uterine device) etc as needed. But due to the absence of an FWV, counselling sessions are not held and mainly injectable contraceptives are dispensed by the SACMO.

*Emergency Patient Care:* There is provision for treating emergency patients; usually first aid is administered and, if needed, a referral is made. With proper training, the Centre has the facility to treat patients suffering from poisoning, snakebite, diarrhoea, road accidents etc.

*Health Education:* The Centre provides different health-related information to the waiting patients. Patients are being educated with necessary health tips to improve their health condition. The health teacher has the scope to make people conscious about water and sanitation, excreta disposal, personal hygiene, diarrhoea, nutrition, breast-feeding, night blindness, family planning, immunisation, lathyrisim etc.

*Tuberculosis Control Programme:* Twice a week the Centre runs its Tuberculosis Control Programme. The Government, through the Damien Foundation, provides the required TB medicines and other materials. Patients of all ages receive diagnostic and curative care.

*Satellite Clinic:* The FWC is supposed to conduct satellite clinics in different villages and schools. However, during the time this study was made, such Satellite Clinics were not functioning due to the shortage of the required workforce and an excessive workload at the clinic.

**Baiochondi CHS Centre**

<table>
<thead>
<tr>
<th>Human resources at the Baiochondi CHS:</th>
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<tbody>
<tr>
<td>Clinic in charge</td>
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<tr>
<td>Senior Staff Nurse</td>
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<tr>
<td>Clinic Assistant</td>
</tr>
<tr>
<td>Health Teacher</td>
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<tr>
<td>Night Guard</td>
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<tr>
<td>Aya (midwife)</td>
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The Baiochondi Community Health Service (CHS) centre started its operation in December 1996 in Baiochondi village in Hazinagar Union at Niamatpur Upazila. This centre serves eight surrounding villages of Niamatpur and Porsha Upazila.

The CHS provides services to women, children under 10 years and men over 50 years of eight villages surrounding Baiochondi. A patient has to pay two Taka for an identification card. The patient card used to record clinical findings, treatment and follow-ups is kept at the clinic. They also receive medicine by paying forty percent of the cost. This are done in order to recover part of the cost.
Care for mothers: This centre provides antenatal and postnatal care for mothers, but does not provide delivery care.

Child care: Children aged 0-10 years are getting curative care in this centre. Growth monitoring, weighing, arm circumference measurements are not done.

Care for the elderly: Male patients above 50 years can receive treatment from this centre. Women of all ages can receive treatment from the centre.

Health education: A health teacher conducts sessions for the waiting patients about health and related matters. The teacher has the capacity to improve awareness about diarrhoea, worm infestations, skin ailments etc. among villagers in the surrounding areas.

TB drug dispensing: TB patients living near the clinic can have their daily medicines from the Baiochondi clinic after registration by the Damien Foundation TB centre in the Niamatpur Upazila Health Complex.

Satellite clinic: Satellite clinic services are usually held in the surrounding villages. They are arranged in villages mainly during winter because of the poor road connections during monsoons. In the satellite clinics vitamin-A capsules are provided and de-worming programmes are conducted.

Other services: There is also provision for emergency treatment to all. Personnel from the Damien Foundation visit the clinic once in four weeks for the treatment of local leprosy patients and are assisted by the clinic.

The Existing Health Care Institutions in the Studied Area

A major part of the research was an inquiry into the variety of services people use for their health needs. The villagers identified altogether about a dozen different institutions they turn to. Typically the clinics established by the Mission, traditional birth attendants and village ‘doctors’ consulting people and selling medicines at the bazars were identified as the most central ones. Of the governmental services, the health sector field workers, Upazila Health Complexes, Naogaon District Hospital and Rajshahi Medical College Hospitals were mentioned as useful. Also homeopathic practitioners featured in many cases. Traditional health providers included herbalists, faith healers (jharfook) and snake specialists (ojha). These institutions and services are briefly described below.

Village doctors: Village doctors are common in most of the villages in Bangladesh. Most of the doctors have health-related training ranging from three months to one year. Some are also practising with only one month of training. These training courses are usually offered and organised by the government’s health directorate, some private institutions and different NGOs. Apart from their consultation with the patients, typically all of these village doctors also have medicine shops. Some of the doctors practise both allopathic and homeopathic medicine simultaneously.

FWC: Family Welfare Centres (FWC) are Union-based health and family planning institutions that provide services to women and children. So far, these FWCs are affiliated with the Directorate of Family Welfare of the Government of Bangladesh through the District Family Planning Office. One Sub-Assistant Community Medical Officer (SACMO), a Family Welfare Visitor (FWV) with assistants, i.e., Aya, Peon (office assistant) and Night Guard are stationed at these FWCs. These FWCs provide consultation, medicine and other family planning services to the women and children of the community.

TBA: Traditional Birth Attendants (TBA) help the village women during pregnancy and delivery. In Bangladesh these TBAs are called ‘Dai’ or ‘Dhatri’ (midwife). Few of the TBAs receive formal training but most of them work on the basis of their personal experience and self-confidence. Usually these TBAs serve the community voluntarily but receive gifts from the parents of newborns.
Field workers (Family Welfare Assistants, Volunteers and Health Assistants): These are the field-level posts of the Ministry of Health and Family Welfare of the Government of Bangladesh. Family Welfare Assistants (FWA) are the field-level workers of the Family Welfare Directorate and are responsible for family welfare counselling and family planning activities in their working area. Health assistants (HA) belong to the Health Directorate and are responsible mainly for implementation of different health-related activities and delivery of public health education to the community. Volunteers are people from the community who are providing their time and effort in implementing different health-related government and non-government programmes without pay; sometimes with a minimum honorarium. Usually they are all selected to work in the area of their residence.

Homeopathic practitioners: Homeopathic treatment is common among the people in Bangladesh and there is a complete medical college for producing Homeopath Graduates in Medicine. Also there are some other colleges for Homeopaths. However, in practice, most of the homeopath practitioners have no formal training, rather they just read books and attend patients. Usually homeopath practitioners provide consultation and medicine at the same time.

Traditional practitioners (Herbalist, Jharfook, Ojha): The traditional practice of medicine is popular in Bangladesh. Among these, Herbal Medicine Practitioners, Jharfook and Ojha are the most common. Herbalists traditionally use herbs, parts of different vegetation and plants in making medicine. There are some organisations which teach herbal medicine. There also exists established companies that produce herbal medicine on a commercial basis. Usually in rural areas most herbalists work without any formal training. Jharfook is, in fact, the practice of blessing by famous religious personalities. Both Muslims and Hindus have kept this practice from past centuries. The Peers, Imams and other religious personalities for the Muslims, and the Purohit (priest) of Mandirs for the Hindus, give their blessing with water, oil or through some other means, e.g., ‘Tabiz’. Ojha is the Bangla name for snake charmer and a person who can cure snake bite poisoning. Usually they earn their livelihood by snake charming. Snake charming is a popular entertaining event especially in rural Bangladesh. A few ojhas are also famous for faith-healing and practising herbal medicine.

Upazila Health Complex (UHC): The essential unit in the PHC system is the Upazila hospital, providing outdoor and indoor services, administration and technical support, training and supplies, and acting as a referral service for Union Health Sub-Centres and Family Welfare Centres. It is a thirty one-bed hospital run by the Directorate of Health, Government of Bangladesh. Upazila Health and Family Planning Officer (UHFPO) is the PHC team leader at the Upazila level and the health authority in a Upazila. There are eight doctors and one Dental Surgeon in each UHC. In addition, Medical Assistants, some Staff Nurses, Laboratory Technicians along with other support staff are deployed in a Upazila Health Complex. In most of the UHCs there is an X-ray facility, a limited pathology lab facility and an ambulance service. Each UHC serves a population of about 200 000. Besides the doctors, the THFPO is being assisted by a Health Inspector (one HI for three AHIs), a Sanitary Inspector and other staff. In the UHC the Family Planning part of the service is being supervised by the UFPO on the administrative side and an MO (MCH) on the clinical and functional side. S/he is being assisted by a UFPO, FWVs and other auxiliary staff.

Naogaon Hospital: The Naogaon District Sadar Hospital is a hundred-bed hospital which is a secondary-level health-care service provider. The hospital is one of 64 district hospitals sponsored by the government around the country, in this case specifically for the Naogaon district. The hospital has the capacity to provide all sorts of curative medicine through the postgraduate consultants and modern amenities.

Naogaon private doctors: In Naogaon town there are services provided by postgraduate and graduate doctors. Usually they provide their services through private chambers (offices) and clinics. Their consultation fee varies from some 40 to 200 Taka.
Rajshahi Medical College Hospital: The Rajshahi Medical College Hospital is affiliated with the Rajshahi Medical College under the University of Rajshahi and is a teaching hospital. It was one of 13 public medical college hospitals in Bangladesh while this study was done. There exist several departments, e.g., medicine, surgery, gynaecology and obstetrics, pathology, microbiology, pharmacology, physiology, community medicine, etc. Apart from a teaching programme, they also provide health services to the community. The hospital provides tertiary level health care and acts as a referral centre for the primary and secondary level health-care providers.

From the group discussions, a pattern also emerged whereby women found, as expected, the FWCs, Mission CHS centres and TBAs more important than did men. Somewhat unexpectedly, men tended to recognise and appreciate the services of the family welfare assistants and volunteers more than women although they are usually female and supposed to reach out especially out to the ladies. However, probably male domination has lead the field workers to communicate mainly with men and distribute the contraceptives to them as dealing primarily with women could create suspicion and distrust.

Allopathic Treatment is Clearly the Preferred Choice for Most Illnesses

The group discussions also revealed that the preferred method of treatment for all illness is allopathic. They further expressed that they prefer to receive allopathic treatment because of the effectiveness of medicines and due to the availability of village doctors.

For illnesses requiring slow treatment, as well as chronic and incurable diseases, homeopathic and herbal treatments are also considered useful. Such conditions include: jaundice, paralysis, tumours, diabetes, epilepsy, impotence, rheumatism, mental illness, haemorrhoids, night blindness, dysentery, gonorrhoea, hernias, pregnancy-related complications, menstrual complications and leucorea.

In case of paralysis and lathyrysm, people turn also to jharfook. For snakebite there is the special expertise of an ojha – a snake charmer or a snake bite specialist.

The main reasons for using homeopathic or herbal medicine or even jharfook first is that they are cheap, available at hand and people’s faith in a particular method. And when all those fail, they turn to allopathic medicine.

The Sustainability of the BLM-F Health Care Programme: the Achieved Findings

The Sustainability of the Overall Health Programme

Context and Relevance

Many women and children are having consultations and being treated for illnesses and important health information is being communicated to them. Targeting the services on women and children is well justified, as their restricted mobility and access to cash limits the use of commercial practitioners and distant government clinics.

The health services of the Mission have been steered toward women and children. This can be considered well justified, as they are the most vulnerable members of the communities, as indicated by the high rates of infant mortality (IMR) and the maternal mortality ratio (MMR). In 1991, the IMR and MMR in Bangladesh were 92 and 5.5 respectively and in 1997 these were 77 and 3.6 respectively (Directorate General of Health Services 1997). These changes are attributed to the successful implementation of the EPI programmes, the ARI project, the CDD project, health education, the EOC project, family planning programmes, etc. But the rates are still very high.

The health condition of the poor can improve significantly only along with improvements in their socio-economic situation. Although the services of the Mission contribute to the wellbeing
of poor women and children, in the long-run their health condition will not advance significantly if their social, economic and political status does not improve as well. Many important poverty-related factors leading to poor health, such as malnutrition, illiteracy, unemployment and an excessive work-load, are more decisive for wellbeing than access to curative health services. Therefore, it is a positive feature of the Mission work that it works also on education and the promotion of income-generating activities among the same population. However, without addressing also the power structures that keep the adibashis and landless in a marginal position, other activities can hardly bring about significant and lasting changes.

The clinics play a central role in the health of the women, alongside traditional birth attendants (TBAs) and private allopathic practitioners. Establishing the impact of a development project is a very difficult task and hardly ever absolute statements can be made. In the case of this evaluation, the information for assessing the impact was obtained from the local people by conducting PRA group sessions working on a time-trend analysis. Some ten items were compared before and after the intervention and some clear trends emerged. What is written below applies primarily to the FWCs, as the new community clinic has been operating only less than two years.

The health condition of people has improved during the Project period, but the changes can only partially be attributed to the efforts of the Mission. In the time trend analysis, the villagers presented very dramatic improvements in their health condition as measured by the occurrence of diarrhoea, night blindness and maternal and under five-year deaths. Although the information cannot be considered accurate and there is probably a tendency to present the current situation somewhat positively to outsiders, as illness and death can be embarrassing to admit, a clear trend of improved health conditions can be established from the results.

Besides the occurrence of illnesses, also various health-promoting aspects were followed up in the analysis. They included the number of tube-wells, latrines, doctors and the prevalence of immunisation and family planning. Also in all, there has been a remarkably positive trend, most of which can be attributed to private efforts, such as the emergence of village doctors and the construction of tube-wells, or to impressive government campaigns such as EPI and the distribution of family planning advice and contraceptives.

This is not to say that the health programme of the Mission has not played a role in the improved health situation. In earlier years, the clinics were important EPI centres and one of the few sources of contraceptives. The doctors provided by the Mission are comparatively better qualified and the efforts of the Mission in the installation of tube wells and sanitary latrines are part of the movement towards a healthier environment. Therefore, it can be noted that a positive change has been possible because of various simultaneous forces contributing to the same direction, and the Mission has been in its work one of those important actors.

**Sustainability**

There is no universally accepted definition of sustainability. A development programme is considered sustainable when it is able to deliver an appropriate level of benefits for an extended period of time after major financial, managerial, and technical assistance from an external donor is terminated. (OECD 1989, 7) Thus in international development assistance, sustainability refers to the continuation of projects and programmes after the termination of assistance from an external donor. Financial sustainability, institutional sustainability and environmental sustainability play an important role in assessing the sustainability of development intervention. Issues related to financial and institutional sustainability have direct relevance to the BLM-F Health Programme which is analysed below. However, the environmental impact of the project has also been analysed in a separate paragraph.
The shift from partnership with the government (FWCs) to independent clinics (CHS) has reduced the institutional sustainability of the services. In the BLM-F Health Programme, the recent trend is to build and operate independent clinics, which is called Community Health Service (CHS). This CHS approach is different than the former FWC approach – which was built upon partnership with the government. Out of four established FWCs, three have already been handed over to the government. The fourth one, the Musidpur FWC, was planned to be handed over to the government by June 2000.

The FWC approach has clearly a degree of institutional and financial sustainability, since after few years of operation by the Mission, the government is operating them with all relevant expenses. The quality of government-run health services might not be similar to the BLM-F – however, the government services are similar to the other government FWCs in Bangladesh. The transferred FWCs are being run by the government – thus having more or less reached institutional and financial sustainability.

Compared to FWCs, the CHS approach has a high degree of isolation from the government – at present there is no concrete plan to merge these independent clinics with the local government health institutions. Financially also in future, these independent CHS centres would be dependent on the money provided by the Mission, whereas a partnership with the local government health institutions could make a clear difference in terms of the institutional and financial sustainability of the CHS centres.

As the main funding source of the BLM-F’s Health Programme is the Department for International Development Co-operation of the Ministry for Foreign Affairs of Finland, previously known as FINNIDA, its policies have relevance for the sustainability of the activities. FINNIDA considers NGOs as autonomous also when they enter into a co-financing arrangement with the Government of Finland, but it does set criteria against which the funding decisions are made. One of the criteria is not to fund permanent institutions maintained by Finnish NGOs. During past years, the NGO unit of FINNIDA has also been emphasising the policy that local partners, preferably NGOs, should take over the activities and that no FINNIDA funds should be used for indefinite running costs. Therefore, it can be expected that FINNIDA will not consider favourably future applications by FLOM if there are costs for the prolonged running of the Community Health Centres without a plan for handing them over to Bangladeshi institutions.

Factors Which Could Facilitate Sustainability

Traditional birth attendants (TBAs) play a very important role in the health of mothers, new-borns and their families. Presently there are practically no facilities for pregnant women in rural areas to arrange a trained midwife to attend the delivery. TBAs have plenty of knowledge and experience about pregnancy and birth and they are trusted members of the community. The introduction of additional information and basic tools would increase their capacity to ensure safe deliveries and to refer complicated cases to appropriate institutions. The role of traditional birth attendants could be further strengthened through training.

Another suggestion is to further emphasise health education and preventive measures. Most of the visits to the clinics are made by people suffering from communicable diseases which could be prevented through changes in behaviour that are possible without prohibitive cost or unacceptable cultural alterations. These include diarrhoeal diseases, worms and scabies, which can be avoided by using safe water and sanitary latrines and by general cleanliness. Also the vitamin and mineral deficiencies that feature often at the clinics can be prevented by proper diet. Therefore, for the optimal use of the Mission’s resources, further emphasis on health education, particularly on water and sanitation, excreta disposal, personal hygiene, diarrhoea, nutrition, breast feeding, night blindness, family planning, immunisation, lathyrism etc., and preventive measures are highly recommended.
No treatment should be provided without advice on preventive measures. Health education should be practical and communicative. The link with the functional education programme could be strengthened and targets and implementation upgraded.

**Sustainability of the Family Welfare Centres (FWCs)**

**Context and relevance**

Important services are being provided by the Musidpur and Cheragpur FWCs, but the studied clinics are under-performing due to unfilled vacancies. The post of Family Welfare Visitor (FWV) in the Musidpur centre has been vacant for a long time and for a considerable period there has been no Sub-Assistant Community Medical Officer in the Chergpur clinic. As a result, the SACMO of the Musidpur clinic has been under heavy pressure and the services available to the pregnant mothers have been limited. During this study period the team did not find indications that the vacant position would be filled in near future.

The performance of the FWC handed over to the government has expectedly declined, but it continues to deliver on a relatively satisfactory level. The Cheragpur centre was handed over to the government in 1991 and since then it has been fully run and financed by the government. The performance of the centre, in terms of quality and quantity of services delivered, has expectedly declined, as it is being run by less staff and fewer resources, particularly medicines.

The FWCs’ services are not accessible to some groups of poor women (e.g., adibashi). An alarming pattern emerged from the PRA sessions identifying the various health services whereby the adibashi women found the FWCs to be of little or no use to them. The main reason was indecent behaviour from the clinic staff. As a result of this indecent behaviour and inhospitable environment, the adibashi women do not feel comfortable at the FWCs. Therefore they need to contact low-cost traditional local service providers or the village doctors.

The fact that minority communities that tend to be the poorest of the poor are excluded from such services is very worrisome, as one of the rationales for NGO involvement is that they reach out to the lowliest. Unfortunately, it is quite common for development interventions to forget the poorest, as it requires special efforts. However, if NGOs want to justify their existence, they need to address this problem.

As the field organisation of the Ministry of Health and Family Welfare has strengthened (EPI, FWA, volunteers etc.), the importance of the Centres to the people has declined in the field of family planning and immunisation. When the Mission started to establish the Family Welfare Centres they were focal points for immunisation and family planning activities. However, during the past decade, the Government and the donor agencies have provided new resources in these fields for an effective field organisation. The field workers of the Ministry of Health and Family Welfare are providing many basic services, e.g., the distribution of oral contraceptives and condoms, as well as providing family planning counselling, health education, immunisation, etc., on people’s doorsteps. Therefore, the importance of the centres to the people has been declining.

**Sustainability**

Transferred FWCs have reached a degree of financial and institutional sustainability.

As stated earlier, the FWC approach has clearly reached a degree of institutional and financial sustainability. Out of four established FWCs, the Mission has already handed over three to the government after six to nine years of operation. The government is operating them with their staff and relevant expenses. The quality of government-run FWC services might not be that good compared to the BLM-F-run FWCs. However, transferred-FWC services are not worse than other government FWCs in Bangladesh. The fourth FWC was scheduled to be handed over to and then run by the government starting in 2000. It could be said that the three transferred FWCs are sustainable since they are delivering an appropriate level of benefits for an
indefinite period of time, although the financial, managerial, and technical assistance from the BLM-F has been terminated. This is a unique case in Bangladesh—usually other social service institutions are not taken over from NGOs by the government due to their huge running costs.

These FWCs were also set to face a new reality as the two directorates, i.e., the Directorate of Health and the Directorate of Family Welfare of the Ministry of Health and Family Welfare, were to be united. Certainly this change would affect the sustainability and quality of services of these FWCs.

The merging of the Health Directorate and Family Welfare Directorate of the Ministry at the field level posed both risks and opportunities to the continuity of the services at the FWCs.

In the new implementation project (HAPP-5) of the health strategy in Bangladesh to satisfy the needs of the most vulnerable—women, children and the poor, a one-stop delivery of Essential Services Package (ESP) was developed which consists of a) Reproductive health care; b) Child health care; c) Communicable disease control; d) Limited curative care; and e) Behaviour change communication. Integration of the two directorates would most likely respond adequately to the needs of child and maternal health and clinical contraception by increasing the range, quality, and effectiveness of services. It seems likely that the unified structure will enhance institutional co-ordination, support within the sector, referrals and the adequate utilisation of resources.

The Assistant Director (Clinical Contraception), Naogaon, stated that in accordance with the new implementation plan from January 1999 the tasks of every field level worker was to be re-organised. The Upazila and lower-level implementation programmes were outlined. According to the new plan, the Upazila Manager looks after all the activities of the Ministry of Health and Family Welfare. There is provision for a community health centre for every 6,000 people of a Union which will be staffed by a Health Assistant and a Family Welfare Assistant and they will provide the essential services package. Construction of these centres was scheduled to start in 1999. HFWC was set as the referral centre, to be staffed by one medical graduate along with the other staff already in place.

Factors which could facilitate sustainability

The first suggestion put forward by the evaluators was to hand over the Musidpur clinic to the government as planned in June 2000. Although there were some informal requests from the people and the officials that the Mission would continue operating the Musidpur FWC beyond the agreed transfer date of June 2000, the Mission should hand it over to the government as agreed. In the present context, the resources of the Mission will be better utilised in new activities rather than continuing support for the high quality operations and supply of free medicines at the clinic. In the handing-over process, the clinic can help in communicating the wishes of the villagers to the relevant Ministry representatives regarding the staffing and services of the clinic.

Second, it was suggested to appeal to the DD-FP for immediate appointments to the unfilled vacancies of the FWCs. Employing a Senior Staff Nurse temporarily at Musidpur could be considered. Both of the studied FWCs were short of required staff and therefore performing below their potential capacity. Although the Mission is responsible only for the Musidpur FWC, it could use its good contacts with the Ministry to fill vacancies. The Mission could use a similar strategy also for the three other FWCs it has handed over to the government, so that the FWCs do not suffer due to such unfilled vacancies.

Third, it was suggested to support the concerned Union Parshishads (UPS) and members of the communities in their efforts to obtain staff and supplies for the four FWCs. As the Mission
has played an important role in establishing the four Family Welfare Centres, it could continue to communicate with the concerned Union Parishads and villagers regarding the smooth operation of the centres. The Mission could make sure that the UPs and community leaders are well informed about the correct procedures in handling the affairs of the FWCs.

The sustainability of the Community Health Service (CHS) centre approach

Context and relevance

Community Health Service Centres of BLM-F represent an interesting new approach and the centres are performing well and improving. There are complaints about men under 50 years old being excluded from the services and that there is no provision for delivery at the centre. People are pleased that they can avail themselves of the services of the centre; formerly they had to spend a lot of money and travel a long distance for health services. However, they are of the view that the male patients should also get services from the centre and the centre should take care of the women during delivery.

Links to the government structures are limited. The community health services centres of Baiochondi and Chandan Nagar are formally approved by the government and there is constant communication about their operation between the Mission and the officials. Also the locations and the type of services were negotiated with the government. However, the status of the CHS centres is very different from the Mission-operated FWCs which are run by government-deputed staff under the very clear, even strict, guidelines of the government. The FWCs also receive a regular supply of government medicines.

Community participation has been facilitated but to a limited extent. The Baiochondi Community Health Service centre has a local co-ordinating committee consisting of the Union Chairman, Union Council Member, Local Representative (1-2), Clinic-in-charge, Project Officer and Project Director. The committee has met regularly and played an active role in promoting sanitary latrines and constructing the tube well for the clinic compound. The villagers have contributed labour in that construction, and the patients cover part of the costs of the medicines. However, in the crucial decisions such as staffing and operations, the decisions lie exclusively with the Mission.

Sustainability

The CHS approach has a high degree of isolation from the government – at present the government does not have any plans to merge these independent clinics with their existing health institutions. Financially, CHS centres would be dependent on the money provided by the Mission and its donor. The target group’s financial situation also limits them in paying for the services they receive from these CHS centres. However, according to the Assistant Director (Clinical Contraception) of the District Family Planning Office at Naogaon, the government has a plan to establish community health centres for every 6 000 people. The CHS centre/s planned and already established by the BLM-F might have a possibility to become those planned community health centres, if the BLM-F wishes and such an initiative is undertaken by the government. However, it should be mentioned that the BLM-F officials’ wish to carry on their CHS approach independently and flexibly could become a barrier to the sustainability of the health programme. It is also not likely that the official aid from Finland would be provided for these centres for an indefinite period. The NGO-Support Programme of the Department of International Development Co-operation of the Ministry for Foreign Affairs of Finland is the key donor for the BLM-F Health Programme and they typically provide their project support for a specific project for a duration of three years.

The model is not replicable due to relatively high unit costs.

According to the AD (CC) of the District Family Planning Office at Naogaon, the FWC running costs total approximately Taka 367 000 per year (including salary, family planning materials, medicine, maintenance costs, satellite clinic services, and other
utilities). The government is paying all these for the transferred FWCs, as presently they belong to the government. The nature of the CHS centres supported by the BLM-F is independent – they have limited links to the existing health establishment of the government. Each CHS centre’s annual cost would be about the costs required for the FWCs, depending on the amount of extra services BLM-F provides. With an independent approach, it is not likely that CHS centres would be handed over to the government or to the local community and the cost would be covered by the government or by the community. The centres would exist as long as the Mission would like to operate them. Therefore, considering the local capacity, the BLM-F-run CHS model is not a good example to replicate due to relatively high unit costs.

Factors Which Could Facilitate Sustainability

First, it was suggested to arrange stronger community involvement through a Clinic Management Committee consisting of people from all strata of the community. To facilitate the greater participation of the local communities, the local co-ordination committee could be upgraded to a management committee with increasing decision-making powers. It would be advisable to ensure that there is balanced representation of women and minority communities in the committees.

Second, it was suggested to find a local partner organisation, preferably a public one (MoHFW, UP) that would facilitate the sustainability of the CHS approach. A coordinated approach is needed to link the clinic closer with the government to ensure consistency with the national health policy and sustained operation. The Union Parishad could become a strong partner regarding the clinic operations.

Third, it was suggested to consider making services available to men for a service charge and without a supply of subsidised medicine (consultation and prescription only). During labour, women should be able to access the best available services. The Mission could consider an arrangement that would make full use of the delivery skills of the Senior Staff Nurse for the benefit of the pregnant women.

Fourth, it was suggested to upgrade the skills of the clinic staff. Provision for the staff to attend different national and regional scientific courses and seminars organised by the Government and NGOs would also broaden their views.

Conclusion

The Ministry of Health and Family Welfare has assumed responsibility for the financing and delivery of health services in Bangladesh. It finances the health sector directly through taxes and foreign aid. The overall budget for health care is very small—the total government health allocation in 1996-97 was Taka 17 525.9 million. Calculated on a per capita basis, the spending is Taka 142.7 per annum. (Directorate General of Health Services 1997) More than 65% of the development budget in the health sector goes to the family planning programme. 56% of the health budget goes to secondary and tertiary hospitals and 44% goes to clinics, primary and public health. Funds are lacking for increasing the health budget. While the study was done the funding and control of health and family planning services were with the government and donors. The fact that communities and local governments do not play a role in the financing of health services means that the people who use these services are not involved in the management and decision-making processes related to the services.

Over the past few years, the Government of Bangladesh has made considerable progress in building its rural health care system through the development of the services delivery infrastructure. Total human resources available in this infrastructure by 1997 were: Physicians—29 981; Nurses–13 830; Pharmacists/Compounders–7 700; Dentists–1 200; other health providers–60 536. The government plans to build one Union Sub-Centre (USC) or Union Health and Family Welfare Centre (UHFWC) in each union (4 470), one Health Complex in every Upazila (397) and one general hospital in every District (60).
Among these planned ones, 4,062 UHFWCs and Union Sub-Centres; 384 UHCs and 59 District hospitals have already been functioning (Directorate General of Health Services 1997). Together with these, a package of outreach PHC services comprising: immunisation; control of diarrhoeal diseases, malaria and other communicable diseases; antenatal care; health education; and family planning methods are provided through Family Welfare Assistants (FWAs) and Health Assistants (HAs).

There have also been impressive achievements in the BLM-F’s health programme. It should be noted that in a country like Bangladesh with such disadvantaged socio-economic conditions it is not easy to advance only the health conditions of the poor while other necessary requirements of everyday life are absent. The poor usually suffer in silence with a degree of isolation due to their socio-economic backwardness – therefore ensuring that their participation in development intervention is not easy. BLM-F staff and concerned officials have made a significant effort in implementing the health programme. The established health infrastructures, i.e., the FWCs, CHSs will remain to serve the people in the coming years. Depending on the political commitment and the health policy of the future governments in the country and whatever the quality of services might become, people will always get benefits from these centres.

Most of the people in the studied region are either landless or possess a small plot of land and there is water scarcity—people are using pond water and they cannot afford to spend money on health, sanitation etc. Therefore, efforts only on health are not sufficient. The services the Mission is providing are appreciable. Their existing programmes, e.g., health care, literacy, savings, etc. need proper integration with other socio-economic development programmes in the region. This will also make the health programme more stable in the future socio-economic changes and challenges of the region.

The Government has drafted the National Health Policy Principles and Strategies, and has approved the Health and Population Sector Strategy (HPSS). As a result, the implementation plan of a major undertaking, the Health and Population Project 5 (HAPP-5), has been prepared. The key principles of the planned health policy were (Ministry of Health and Family Welfare 1997):

- Integration of Health and Family Planning directorate;
- Implementation of one-stop Essential Services Package (ESP);
- More community participation;
- Inter-sector collaboration;
- Use of outreach centres of the Extended Programme of Immunisation (EPI) for the delivery of PHC services;
- Introduction of an effective referral system.

The studied health programme of BLM-F had come to an end. During the year 2000 the Mission was supposed to decide about its further engagement in the health sector. It is assumed and recommended that the Mission continue its health programme also in the future, at least with the present level of spending. Supporting the Government’s health care policy and facilitating community participation would certainly promote the sustainability of the Mission’s health care efforts in the region. In addition, linking up the BLM-F’s present and future health programme with the existing traditional and modern health care institutions in the region and in the country could be a strategic choice for the Mission in securing the sustainability of their operations.

Acknowledgements
The article is an outcome of the international research project ‘NGOs in Development: A Finnish, Bangladeshi, and Nepali Research Project’ supported by the Academy of Finland at the
Department of Management Studies of the University of Tampere, Finland. The authors wish to acknowledge the valuable contribution from Dr. Iqbal Ansary Khan and A. K. M. Saifullah during the field-work. Assistance from Ms. Jasmine Akhter Khatun, Jarna Pasanen, Ms. Mahmuda Akhter Rupa, Nargis Akhter and Mr. Masud Khan has enriched the work. The authors also wish to acknowledge the review and suggestions from Professor Mohammad Habibur Rahman, University of Dhaka, Bangladesh and from Dr. Govind P. Dhakal, Tribhuvan University, Nepal in finalizing the work.

Note
1. Unions are grassroots based local government units in Bangladesh.

References


SUSTAINABILITY OF THE HEALTH CARE PROGRAMME

**Interviews**
BLM-F
- Mr. Aatu Grön, Chairperson
- Ms. Aili Maria Manninen, Project Director, Health Project
- Mr. Chandon Soren, Administrator
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  Union Parishad Chairman
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  Medical practitioners at Shisha Bazar

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- Ms. Kulsum Nahar, Nurse/Midwife

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- Mr. Mozaffar Hossain Rana, Leader of landless workers’ union
  Medical practitioners at Shibpur Bazar

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Mohadevpur Upazila
- Mr. Shibnath Mishra, Secretary, Nobojug Sangshad Club
  Medical practitioners at Dhanjoil Bazar

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- Dr. Md. ATM Shahjahan Ali, Deputy Civil Surgeon
- Mr. Md. Enus, Deputy Director – Family Planning
- Mr. Paritosh Chondro Paul, Assistant Director – Clinical Contraception