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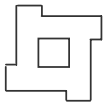

Life in a Health Centre: An Ethnography from Rural Bangladesh

Shahaduz Zaman

June 2001

BRAC
Research and Evaluation Division
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Life in a Health Centre: An Ethnography from Rural Bangladesh

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ABOUT THE STUDY

This is an unusual book. Shahaduz Zaman, who is a physician and a medical anthropologist, studied day to day activities in a rural health centre of BRAC in Bangladesh but he does not limit himself to medical issues. He provides detailed descriptions of many events and 'customs' which at first sight have little to do with the official medical mission of the centre. His focus is on the staff members and their way of life during and outside working time. Three main areas got his attention: 1. Therapeutic activities with an emphasis on the transactions between patients and staff members; 2. Administrative issues, in which he reveals the great impact of paper work on the lives of the health workers and their colleagues; 3. The staff's activities in leisure time.

BRAC's concept of providing a high quality of care to the rural poor puts strong emphasis on the availability of health workers. The organization thus attempts to remedy some of the main weaknesses in the public health system of Bangladesh, which are the continuous absence and low motivation of personnel in rural health facilities.

In the health centre described in this study the staff members are subjugated to a strict work regime. Their presence and various activities are monitored through an elaborate system of administrative accounts. In addition, accommodation contributes to the accessibility of the staff. Most of them live on the premises of the centre and spend their work and leisure time together. A few live nearby the centre. The author thus gives an interesting twist to Goffman's concept of 'total institution': it is not the patients who are under constant surveillance but the staff. The unorthodox approach of the study brings out a number of fresh insights into the set-up and management of rural health centres.

Zaman's study shows in detail how this unique type of community can exist in the wider context of Bangladesh society. Patients, for example, are submissive to the doctor and the nurse in medical matters but are remarkably stubborn and 'assertive' with regard to payment. They enter into lengthy negotiations to have their fees reduced.

The staff members, for their part, feel ambivalent about their situation. On the one hand, they are satisfied, even happy, about their work and feel proud to belong to BRAC. On the other hand, they are constantly on the look out for an improvement of their position and for better career options.

The study contains a number of short portraits of the various staff members providing the reader with moving accounts of how they cope with a combination of private, family and work problems.

The report does not end in clear-cut policy recommendations but leaves it to the reader to draw his/her own conclusions. Its primary aim is to provide a true-to-life description of an original experiment in rural health care.

This touching case study holds out a mirror to all those working with and for the rural poor and helps them to reflect on how their dedication fits into the lives of the people they want to serve.

Shahaduz Zaman conducted this study, under our supervision, in partial fulfilment for the degree of Master's in Medical Anthropology at the University of Amsterdam, The Netherlands.

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PREFACE

This monograph reports an ethnographic investigation done in a rural health centre in Bangladesh, established by BRAC, a non-governmental organization. This study aimed to describe and analyze the social and cultural aspects of a rural health centre in Bangladesh. An earlier version of this study was presented as a thesis in partial fulfilment of a Master's degree with the Amsterdam Master's in Medical Anthropology (AMMA) at the University of Amsterdam, The Netherlands.

I wish to thank Professor Dr. Sjaak van der Geest for his guidance, supervision and critical support during the fieldwork and writing of the thesis. I also wish to thank Dr. Chris De Beet and Trudie Gerrits for their help in developing the proposal of this study. I am grateful to Dr. A Mushtaque R Chowdhury and Dr. Sadia Chowdhury of BRAC for their kind co-operation. I am also grateful to Dr. Richard A Cash and Mr. Hasan Shareef Ahmed for editing this monograph. I am deeply indebted to the staff members and patients of the BRAC health centre in which I did my research. I thank my wife Papreen Nahar for her stimulating support during the fieldwork. Finally I would like to thank Dr. Ria Reis for her continuous encouragement.

BRAC provided the fund which made it possible for me to attend the Amsterdam Master's in Medical Anthropology (AMMA) and to carry out the research.

Shahaduz Zaman

INTRODUCTION

The study of health, illness, and medicine provides us with one of the most revealing mirrors for understanding the relationship between individual, society and culture: it is an exciting task which has just begun.

Margaret Lock
Biomedicine Examined 1988

Ethnographies of a medical setting are relatively rare. To study the domain of biomedicine by investigating hospital or health centre is a new territory for medical anthropologists. This has both theoretical and practical implications.

Theoretical implications

Medical anthropologists devoted much of their energy into exploring healing rituals of exotic cultures, indigenous therapists, lay perceptions of health and illness. They rarely made biomedicine itself a subject for analysis and tended to rest assured that, because it is supposedly grounded in science, it is not a subject for anthropological or sociological inquiry. Biomedicine was believed to be based on value-free knowledge and capable of value-free intervention. However, anthropologists along with other scientists no longer share this view. There is a growing interest in recent years in studying biomedicine as a cultural system and a part of the broader culture. It is argued that biomedical theory and practice is not universal; rather it is a product of particular social, political and cultural conditions. Biomedicine, therefore, is a cultural system comprised of numerous variations. Language, values, metaphors, ritual practices, institutions, social organizations, among other variables contribute to the creation of theory and practice of biomedicine. In contrast to an assumed universal biomedicine there exist many biomedicine's, as it takes a different form in different social and cultural contexts.

The culture of biomedicine is most visibly manifested in any medical setting like hospitals, and various kinds of health centres. Medical settings have formal and informal structures, a set of norms and expectations, rules and beliefs, even rituals that regulate the behaviour of its members. An anthropological study of medical settings, therefore, is an excellent way to gain an in-depth understanding of biomedical culture in a particular context. By situating biomedicine in the heart of culture, these ethnographic studies will further illuminate medical anthropological theory.

Practical Implications

A health centre is a geographical site and an organization that mobilizes the skills and efforts of a divergent group of professional, semi-professional and non-professional personnel to fulfil certain objectives through collaborative activities. The main objective of a medical institution is to provide adequate care and treatment for its patient. A health centre's principle product is medical service to the patient and its central concern is the life and health of the patients. The quality of the product is directly influenced by the process in which it in produced, through a complex of human interactions. A health centre, thus is more than a physical plant and organization of technical facilities, it is also a social system. It is, therefore, crucial to understand the social environment within a health centre as that is also a part of the therapeutic process. In a health centre different individuals are joined together in the repeated performance of certain activities directed towards the goal of providing services to the patients. The relationships between the individuals, role definitions, personal expectations, and organizational setup will influence the quality of service of that health centre. The social environment of health care settings has become particularly important in relation to the difficulties in the implementation of primary health care (PHC) in developing countries.

In addition to the contribution in medical anthropological theory, an ethnographic investigation of a health care setting can provide insights to improve the functioning of health centres and promote culturally sensitive health services.

Relevant literature

There have been few attempts to conduct anthropological studies in medical settings. In 1960s some sociologists pointed out the social and cultural aspects of hospitals (Barnes 1961, King 1962, Freidson 1963). As Standley King (1962:399) comments:

> The hospital is unique as a way of life, a subculture of a sort within the total society. The round of life, the customs, the relationships between people, the particular problems of everyday living are sufficiently different from those of other social organizations to warrant consideration as a unique subculture.

Wilson (1965:233) discusses the social structure of a general hospital. He quotes Dr. Hanrey who speaks of the personality of a hospital. Hanrey observes that each hospital with its tempo of work, emotional atmosphere, its traditions, its community of staff and patients has its own distinguished personality.

There are some examples of ethnographic studies of medical settings around the same period of time. Among these Caudill's (1958) *The Psychiatric Hospital as a Small Society,* Goffman's (1961) *Asylums* and Coser's (1961) *Life in the Ward* are outstanding. Caudill (1958) describes day to day personal relations of people, doctors, ward personnel and patients in a psychiatric hospital. He calls attention to the idea that the hospital is a small society and a complex system of human interactions, within which the performance of technical task takes place, Goffman (1961) analyses the inmate situation of a mental hospital and formulates the characteristics of total institutions. He defines total institution as a place of residence and work where a large number of similarly situated individuals cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Coser (1962) while calling a hospital a tight little island, describes and analyses the social role of the patients in a ward in a general hospital. He discusses the institutionalized behaviour patterns, the value systems that prevail in the ward and relationships that develop among patients and between patients and hospital staff.

Unfortunately, ethnographic research of this kind virtually disappeared after these promising studies. Zussman (1993) argues that declining length of hospital stay, decreasing open wards and the expansion of specialized units in later decades are the main reasons behind the disappearance of this research agenda. Kleinman (l978a:90) pleaded for more ethnographic and cross-cultural research on medical system as cultural systems. He said (1978a:86):

> Our concern will be to understand how culture, here defined as a system of symbolic meanings that shape both social reality and personal experience, mediates between the 'external' and 'internal' parameters of medical system and thereby is a major determinant of their contact effects, and the changes they undergo.

Since the late 70s and early 80s there is a growing interest in studying biomedicine as a cultural system. Authors challenged the widely regarded notion that biomedicine is not susceptible to cultural analysis. Ross et al's (1983) *'The Anthropology of Medicine',* Hahn & Gaines's (1985)*'Physicians of Western Medicine',* Lock & Gordon's (1988) *'Biomedicine Examined'* are worth mentioning. The authors in Hahn & Gaines's edited book 'Physicians of Western Medicine' examined western biomedicine from a cultural perspective and the articles illustrate a variety of sociocultural features of biomedical theory and practice. The various articles demonstrate that biomedicine is a cultural system comprising of numerous variations. The essays in Lock and Gordon's 'Biomedicine Examined' also examine the social and cultural construction of biomedicine. The essays show how twentieth century medicine, is

pervaded by a value system, characteristic of an industrial capitalist view of the world. Few attempts have however, been made, since the 1970s to conduct an ethnography of biomedical setting. The exceptions are Kirpatrick's (1979) *'The Sociology of an Indian Hospital'* that studied the social interaction in a women's ward at an Indian hospital. German's (1979) *'The Cancer Unit: An Ethnography',* which is an ethnographic study in an American hospital, Sciortino's (1992) *'Care Takers of Cure: An Anthropological Study of Health Centre Nurses in the Rural Central Java';* and Van der Geest & Sarkodic's (1999) *'The Fake Patient: A Research Experiment in a Ghanaian Hospital.'* There are some papers that deal with the issues of primary health care centres particularly of developing countries. Van der Geest et al (1990) discussed the problems of PHC centres from various professional and personal perspectives of health centre staffs. Nichter (1986) in his study done in PHC centres of Sri Lanka and India, discussed the prevailing conflict over knowledge, power and status among the personnel. Golomb (1985) mentioned the ill-preparedness of medical officers in Thailand for working in rural medical setting.

All these studies highlight the variations within the biomedical culture in different regions and draw attention to the need for an increased understanding of the social and cultural aspects of medical practice. As Kleinman (1985:ix) says:

> Medicine the whole of it, from sickness to therapy, and including medical settings, roles and attributions - can be (and should be) rethought in the language of social structure and cultural norms of interpersonal transactions and differential access to resources, of cultural symbols and social actions. And this process of making our medicine into a subject of social inquiry (like other ethnomedicine) is significant also because it creates practically useful knowledge, knowledge perhaps that holds the potential of eventually being applied to liberate physicians as well as patients from narrow, dehumanizing form of medical praxis.

The importance of anthropological analysis of biomedical practice and the lack of literature in this area, is the inspiration behind conducting this research. Exploring the social and cultural issues of a Bangladeshi rural health centre may contribute to the contextual understanding of biomedical practice in this country and provide an insight to improve the health centre functioning. The findings may be useful for those developing policies for primary health care.

METHODS

This was an ethnographic study. As Emerson et al. (1995:1) states, 'Ethnographic field research involves the study of groups and people as they go about their everyday lives.... Ethnographers are committed to going out and getting close to the activities and everyday experiences of other people. "Getting close" minimally requires physical and social proximity to the daily rounds of people's live and activities, the field researcher must be able to take up position in the midst of the key events and scenes of other's lives to observe and understand them.'

I tried to do the same and got close to the people of the health centre to observe and understand the staff members who were always at the centre and the patients who were temporary guests. I tried to see from inside how these people lead their lives, how they carried out their daily tasks, what their joys and sorrows were. What I needed was a picture of what people do and think. I used qualitative methods for data collection and did not apply any statistics. I will therefore mainly narrate what I have seen, felt and thought during my study.

To increase the validity of information, I used a triangulation of methods for data collection. The following methods were used:

1. Participant observation
2. Informal conversations
3. Case histories
4. Study of secondary sources

Participant observation

This was the most important method of obtaining information. Initially I decided to stay within the premises of the health centre. However, I came to realize that this would be very difficult since the housing that BRAC managed to rent in the rural areas for health centre were not sufficient for the staff themselves. I therefore decided to stay in the local district based regional office where they have accommodation for guests and selected the nearest health centre to this office. The health centre I selected was 6 km away. Everyday I went very early in the morning, spent the whole day in the health centre and came back at night. Though most of the time I slept in the regional office, a few times I managed to stay in the health centre overnight. On those nights in the centre, we watched the world cup football on TV in the late evening (5 hours time difference with France) along with other staff members. On those days when the medical officer went to Dhaka to attend a training session, I

stayed in his room. This gave me a chance to observe the health centre round the clock.

On the first day I explained to the staff members the purpose of my visit to this health centre. I said I did not know much about the activities of BRAC health centres, so I wanted to learn about it by observing and talking to them. This work was for my MA thesis. This explanation came as close to stating the actual research objective as possible. A researcher is not an unfamiliar person in BRAC, so my work was not surprising to them. Moreover, I knew some of the staff members of that centre, as I had worked with them before. The medical officer was a senior schoolmate whom I last met 18 years ago. This was a good reunion and a friendly environment for me to work in. Unlike other researchers who would come for an hour or two and conduct some interviews, they found me moving around throughout the day and taking notes. This was definitely an unusual experience for them. In the beginning the behaviour of the staff members in the centre was probably affected by my presence. This inhibiting 'observer effect' is, of course, to be expected. But also, as expected, I apparently came to be taken for granted after a while, and the staff members behaved as they would have had I not been there. At times they used to tell me jokingly "Hope you are not writing something that once your paper is published, our jobs are gone." At times when they were engaged in spontaneous gossip they might suddenly stop and say, "Please don't write these things in your paper."

Initially for a couple of days, I observed what was happening around from dawn to dusk. Then I started observing each activity separately and in a more structured way. Though I did not keep any checklist with me, I consulted my proposed checklist every night. During my first meeting with the staff I asked their permission to take notes and when they agreed I openly took notes while observing. During my observations I frequently asked them questions. Though I observed one activity at a time, I kept my eyes and ears open to what was happening around and sometime shifted my focus of observation.

My role in the setting was as a researcher who was studying the functioning of the health centre. Most of them knew my medical background, and sometimes they asked my opinion about some treatment or disease. I spent altogether three weeks in the health centre with a break of one week in June 1998.

Informal conversations

I gained precious information from informal conversations. As I spent the whole day in the health centre I was present in all the day-to-day happenings. I sat beside the desks of staff members while they were working. I ate with them and watched TV with them. I did not conduct any formal interviews. Sometimes I started talking with someone beside

his/her working desk, which continued in the dining table and the issue was even raised while watching TV. I talked informally but remained aware of my research objective while talking. Sometimes I returned to a person with the same topic to clarify certain points. Conversations were usually a mix of topics, current political issues, world cup, various aspects of the health centre, private issues, but I mentally edited the conversation according to my research concern. I found this the most effective way of getting information. In addition to the discussions with the staff, I had informal talks with a number of patients while they were in the waiting room and also at the exit point.

Case histories

I wrote case histories on some selected staff members. I took down their personal and professional background, talked particularly about their life in BRAC, their feelings and impressions on working in this health centre and their future plans. I took the case histories of two medical officers those who were posted in the health centre during my study period, the area manager, the male paramedic, one female nurse, two female programme organizers and the Aya (service staff). The histories were taken in multiple sittings.

Study of secondary sources

The secondaty sources that I have consulted include: annual reports of BRAC, guide lines of BRAC health centre, various registers and formats that are used in health centres and also the yearly book of the Bangladesh Bureau of Statistics.

Limitations

Before presenting the findings I would like to mention what I did not do in this study. I did not concentrate much on the patients; the focus was rather on the staff members. Consequently I did not take many case histories of the patients and their perceptions of biomedicine. I concentrated mainly on the social world of the staff. Their concepts of disease and therapy were not explored due to the limited time of my research. I realize that these concepts would have shed further light on biomedicine in Bangladesh.

THE BRAC HEALTH CENTRE

The rural health centre is a new component of BRAC's health programme. Along with income generation and education activities, BRAC has always had preventive and promotive health components in its community-based development programme. Only since 1995 BRAC has started centre-based curative health services. Since 1997 BRAC has established 40 health centres in different rural areas of Bangladesh. The service package available at BRAC Health Centres (BHC) include, antenatal care, simple delivery with obstetric care for emergency cases, post natal care, family planning (both clinical and non-clinical) other reproductive health services including treatment of STD/RTI, diagnostic and curative care for TB and selected curative care for men, women and children. It provides out-patient and in-patient services, selected pathology laboratory services and medicines. Charges for registration, services and drugs are standardized for all clinics and subsidized for Village Organization (VO) members. In addition, a general annual medical check-up is given only to the VO members by BRAC. The staff of BHC include, one medical officer who is responsible to oversee the functioning of the health centre, one male paramedic, one female paramedic, one programme assistant (PA) to help paramedics in doing the registration of drug dispensing, one laboratory technician and one service staff, called aya, who is currently functioning as a TBA in her area. The primary care services in the community are provided by a separate team of four female Programme Organizers (PO), and one male PO, and an Area Manager (AM) responsible for the supervision of community based activities. Both teams usually live in the same quarters.

The research setting

The study was conducted in the Shambhuganj health centre of Mymensingh district. This health centre is one of the few centres that started in the first phase of BHC initiative and has been active for the past three years. It is one of the oldest and most established health centres of BRAC. The health centre is located near the *thana* bazaar, which is a small village market and placed just adjacent to the highway that connects Dhaka with the northern part of Bangladesh. Most of the houses in the bazaar are tin sheds. There are only three or four brick houses of which the BHC has rented one.

According to the guideline, a BHC should have four rooms, one outdoor-cum examination room (with pharmacy), one ward, one labour room, and one laboratory. In addition there should be a verandah-cum waiting room, two toilets (one female, one male), and one disposal space.

Although the rented house does not always correspond to the prescribed setup of a health centre, this particular health centre had all the required rooms. The kitchen, dining room and accommodation for the staff were also provided by BRAC on the same premise and comprised four separate houses situated around a courtyard. Two were tin sheds and two brick built.

Two teams of staff are working there, the health centre staff include, one medical officer, two female nurses, one male paramedic, one laboratory technician and one service staff (aya). The field team provide primary health services and includes four female programme organizers (PO), one male programme organizer, one male programme assistant, and an area manager. A cook prepares food for the staff members. Some members have private accommodation outside the centre but the rest work, sleep and eat on the same premise. The office has provided field staff with motorcycles.

First, I will narrate an ordinary day in the health centre, after that I will describe separately the various activities at the health centre. I have divided these activities into three categories; therapeutic, administrative and leisure. Finally, I will present the cases of some of the staff members. Findings of the study and emerging ideas and interpretations will be presented simultaneously.

An ordinary day at the health centre

Around 6 a.m. -- Silence all around. The *Muajjin* (Muslim preacher) has called the believers for morning prayers hours ago. Occasional sounds of the heavy lorries on the highway can be heard. All doors are closed inside the BRAC health centre except the door of the kitchen. The cook is the first one to get up. Some movements can be observed in the kitchen. The cook is preparing breakfast for everyone.

Around 6:30 a. m. -- The aya has arrived. She lives a couple of kilometer away from the centre. She sweeps the courtyard, cleans the dust of the furniture, putting the things in order. Others are still sleeping.

Around 7 a.m. -- The staff members are getting up. They move around with their tooth brush and towel. As there is only one toilet, everyone is waiting for his or her turn to come.

Around 7:30 a.m. -- Time for breakfast. Those who will go to the field seem to be in a hurry. As the table is not big enough to simultaneously accommodate all the field staff, some try to eat earlier. Men and women eat together.

Around 8:00 a. m. -- It is busy inside the health centre. Breakfast is over. Those who live outside the centre have come to the office. Someone signs the attendance register, someone fills in the movement register in which all field staff are supposed to write their day's movements in detail. Someone cleans his/her motorbike. The health centre staff members also prepare themselves, arrange required instruments and stationery. The engines of the motorbikes start. The field staff leave the office one by one with their motorbikes. The health centre staff remain in the centre.

Around 8:30 a.m. -- The manager also prepares to go to the field. Among health centre staff one sits in the registration desk, one in the counseling desk, the laboratory technician cleans his microscope. The medical officer exchanges some comments with the manager in his office. The aya arranges the doctor's consultation room.

Around 9:00 a. m. -- The manager has left for the field. The doctor sits at his consultation table, waiting for the patient. There are few patients. The centre is not that busy.

Around 10:00 a.m.-12:30 p.m. -- A large number of patients are in the waiting room. The aya keeps track and serial of the patients. A female nurse gives registration cards, an other is engaged in counseling. The doctor is busy consulting patients. This is the busiest hour of the day.

Around 1:00 p.m.--The patient flow decreases. The staff are more relaxed. The laboratory technician comes out of his isolated laboratory and meets with other colleagues. The daily newspaper is delivered around this time. Staff members read the newspaper sharing the pages.

Around 1:30 p.m. -- The field staff return from the field one by one for lunch. The centre becomes noisy again with the sound of the motorbikes. The manager comes from the field and enters into the consultation room, talks with the doctor and asks about the patient flow. He then returns to his office and takes a rest. One of the staff supplies the newspaper to him. Other field staff go to their respective rooms. Some wash. The doctor still sits in his consultation room and waits for patients.

Around 2:00 p.m.-- Lunch time. As the dining room cannot accommodate everyone at the same time, the staff eat in shifts. The cook serves the food.

Around 3:00 p.m.-- After taking some rest, all are back to their respective desks. However, someone is always there at the registration desk to receive patients. Field workers along with the manager start their motorbikes again and leave for their afternoon field work.

Around 4:00-5:00 p.m.-- Patients come but the flow is slower than the morning. The field staff return from the field for the day around 5:00 p.m.

Around 6:00 p.m.-- The health centre is still open but there are very few patients. The health centre staff start settling their accounts and records. The doctor chats with the manager in his consultation room. The field staff sit in the office and record their days activities in various registers. The manager joins the other staff in the office. He signs various bills and reports. The doctor returns to his room.

Around 7:00 p.m.-- The staff are still busy with accounts and records. The doctor visits the office and signs the accounts of the health centre. The aya leaves the centre for her house.

Around 8:00 p.m.-- Dinner time. The day's work is more or less finished. The staff have dinner again in shifts. They share their day's experiences with each others at the dining table.

Around 9:00 p.m.-- Everyone starts returning to their rooms. The manager, the laboratory technician, and three POs live outside the campus. Among those who live outside, some join the others for dinner and leave the centre afterwards, some leave before dinner to cook for themselves. Within the health centre premises, the women living in the same room sit to watch TV. The doctor returns to his room and study. Sometimes he and the other male staff also watch TV.

Around 10:00 p.m.-- The staff close their doors. Again silence is all around, except for the sound of heavy lorries from the adjacent highway. The cook puts the lock in the office room and goes to bed last.

The BHC can be called a social institution (Hoffman 1991 :15-17), in which an activity of a particular kind regularly goes on, tightly scheduled by a system of explicit formal rules. The staff of the centre form a therapeutic community, who are there to serve a larger community of patients from the neighbouring village. Together with the staff community, the patients, the style of work, the emotional atmosphere and its organizational tradition, the BHC has developed its own culture, which I tried to explore.

I have divided the activities of the health centre in three categories, namely therapeutic, administrative and leisure. I will describe the activities accordingly.

THERAPEUTIC ACTIVITIES

Three types of therapeutic services are offered by the BHC; a) outdoor patients consultation, b) conducting normal deliveries and c) pathological tests. Among these services, outdoor patient consultation is the main activity of the centre.

Outdoor patient consultation

In the morning the nurse, the paramedic, the counselor and the doctor take a seat behind their respective desks. The registers and the instruments are ready. They are waiting for the guests, and the patients who are the clients. After entering the health centre the guest have to pass through certain procedures. First they have to come to the registration desk to pay the registration fee and take a slip, then they wait in the waiting room for their turn. After that they are taken to the counseling room. When the counseling is over they enter the doctor's room for consultation. The patient then returns to the registration desk to buy prescribed medicines and finally leaves the health centre. Let me now follow one patient along these different steps.

On the registration table

It is 3 O'clock in the afternoon. An old woman with a 2/3 year old baby on her lap and a young man arrived. The aya guides them to the registration desk. She asks the woman to take her sandals off before entering the registration room. The man is bare-footed. The woman says *'salam'* (Muslim greeting), the nurse sitting in the registration desk answers with *salam.* The old woman sits on the bench beside the registration desk, the man sits on the other end of the bench keeping a distance. He puts a glass bottle tied with a rope which he was carrying, on the floor near his leg (This is a typical bottle used in the village for carrying kerosene oil, which is a common fuel). The old woman starts explaining what problems the girl on her lap has, who is the actual patient, whom she introduces as her grand daughter. The man is her son and the father of the girl. She starts describing how the little girl has been suffering from fever for a couple of weeks, how she was not eating any food and was getting thinner day by day. The nurse sitting in the registration desk stops her in the middle of her enthusiastic description and says that she should tell all this to the doctor but first she should pay the registration fee and take a slip. The woman stops for a while, looks perplexed but continues again as if she did not hear anything that the nurse said. She continues to tell how she tried other village doctors in vain and finally decided to come to the BHC as suggested by a

neighbour. She tries to show the nurse the medicines tied in a polythene bag given to her by the village doctors. The nurse said, “That’s fine but first you have to pay the registration fee.” The woman looks disappointed by the interruption of her story. She stops and asks in a confused tone “How much should I pay?” The nurse says, “Well that will depend upon whether you are a VO (village organization) member or not. Are you a VO member?” The woman says, “No, I am not but my daughter-in-law is.” The nurse: “Did you bring the VO card?” Woman: “No”. Nurse: “Then how would I know whether she is a member or not?” The woman becomes annoyed and says, “I don’t tell lies. I have faith in God.” The woman also added that, her daughter-in-law would have come but she had lots of works to do at home, that’s why she brought the baby. Then the nurse asks for the name of the VO and also something about the loan-taking system. The nurse then seems convinced to the VO membership of the woman’s daughter-in-law. She says, “Well then give me 15 Taka, if you were non VO member the fee would be 30 Taka.” The woman looks displeased and says, “No, this cannot be, they told me the fee here is 10 Taka.” The nurse: “Yes, it was 10 Taka but as of this month it has been changed to 15 Taka.” The nurse points to a notice attached to the wall announcing the new registration fee. The woman says, “What is the use of showing it to me, can I read?” She looks angry and says, “I don’t understand, everyone told me that the fee is 10 Taka here, why are you charging me more? Well, may be I am new here that’s why you are taking more money from me.” The nurse smiles and says, “Auntie, this is our office rule, this money will not go to my pocket. I will have to submit all the accounts to the office at the end of the day. I don’t have any personal interest.” But the woman is not paying much attention to the argument, she puts a ten Taka note on the table and says, “Sister, we are poor, keep this ten Taka for this time, we will pay more when we come next time”. Nurse: “I can’t do that, there are rules in this office.” The woman still insists on her keeping the ten Taka. The aya standing beside then says, “Don’t waste our time, other patients are waiting.” The father of the little girl had been listening to the conversation anxiously. Suddenly he gets up from the bench with an angry face, preparing to say something or planning to leave. But something happens in between. As he stands up, he hits the bottle near his foot, the bottle falls down and breaks. There is a moment of silence. The old woman, mother of this man says, “You broke the bottle? Your late father used it. This bottle has been with us so long, you are so careless.” This incidence changes the mood of the woman. After a while she says to the man, “OK, forget it, give five more Taka to them and take the slip.” The aya removes the broken pieces. The man takes out money kept tied in his *‘lungi’* (Traditional male dress, for the lower part of the body), gives five Taka to the nurse. The nurse writes the name and address of the patient, mentions about the VO membership in a slip, gives it to the man and asks them to wait in the waiting room. She reminds them that they should come to this desk again after getting the doctor’s prescription to buy medicines.

In the waiting room

The waiting room is next to the registration desk. There are enough benches to sit down. Two or three patients are waiting there. It is afternoon, and not a busy hour. There is a TV set and a video player in the waiting room. The TV is showing the video cassettes of MEENA series made by UNICEF. In these series, through animated stories of a little girl named MEENA, issues on health education and gender issues are highlighted. People who are waiting watching the TV, trying to follow the story. But it is quite noisy outside the window. As mentioned, the health centre is just next to the highway and constant sounds of traffic, and the microphones in the bazaar advertising on-going movies, interrupt the viewing of the TV. Sometime it is hard to hear the dialogue. However, people waiting there seems to be enjoying the animated movements of the characters. The passive feverish girl in her grandmother's lap is also looking curiously at the TV screen. But the old woman and her son do not seem to be interested in TV. I can hear the man saying to the old woman, "You have to go back on foot, it will not be possible to hire a rickshaw after buying the medicines." At this point one patient comes in and wants to keep his jackfruit, which he bought from the bazaar, in the waiting room. The Aya tells him in annoyance, "No that is not allowed, you have to keep it outside." The man still asks, "Just for few minutes, otherwise it might be stolen." The argument goes on. The counselor asks the next patient to come.

The counseling room

The old woman with the little girl and the man enter the counseling room. One nurse is working as counselor. There are some contraceptive devices and flip charts on her table. The old woman sits on the chair beside the counseling desk with the baby in her lap. The man stands beside her. The counselor inquires about the problem. The woman starts again the story about the little girl. How the fever started a few weeks back and the girl became weaker and thinner day by day, but this time she spoke less enthusiastically. The counselor listens to the story, then gives some general advice on child health. She particularly points out the malnourished condition of the baby and talks about food and nutrition. She asks them to feed the girl more vegetables, if possible with egg and milk. The old woman nods her head indifferently. The woman and the man do not seem attentive to the lecture, they look rather confused. After a few minutes lecture on food and nutrition the counselor sends them to the doctor's room. They follow the aya and enter the doctor's room.

In the doctor's room

Finally, they come to the doctor's table. The doctor inquires about the problem. The old woman starts telling the same story about the girl for the third time. Her enthusiasm and voice have gone down. The doctor

listens to the story attentively, asks in detail about the nature of the fever. This time both the old woman and the father of the girl respond to doctor's questions. The doctor takes his time. He checks the fever with a thermometer, and examines the chest with a stethoscope. He asks about previous medication. The old woman shows the doctor the medicines given by the village doctors that she brought tied in a polythene bag. When she opens the bag a few pieces of *'Horitogi'* (an herbal seed), are. also seen in the bag along with the medicines. The doctor asks jokingly, "What are these seeds? Did you give these things to the girl also?" The old woman becomes shy and smiles, "No, no, this is for me. I sometimes take these for my stomach. I found these on the way to this clinic, so I picked them." The doctor says, "Well, don't bring these wild things here." The doctor then examines the medicine given by the village doctor and asks about the doses. He finally says that these were low quality drugs and in the wrong doses. He writes the prescription and asks them to purchase the drugs from the registration desk and reminds them to listen carefully about the doses. He puts the name of the child in the follow-up register, and tells them that a BRAC worker will go to her house within a couple of days to follow-up the patient. The aya takes them to the registration desk again. They look satisfied after coming out of the doctor's room.

Procuring the drugs

The three return to the same registration desk where they had reported first. The nurse looks at the prescription and calculates the cost of the prescribed medicine. She says that the drug will cost 55 Taka, and asks, "Do you want to buy the medicines?" The man says, "OK, give me the medicines, but I will pay 40 taka now, the rest I will pay tomorrow when I come to the bazaar." The nurse says, "Well, I told you before I can't do that, there is no provision for keeping it unpaid." The man, "Don't you trust me, I come to the bazaar everyday." Nurse, "This is not a matter of trust. We have certain rules. I can't go beyond that." The man, "You see, I have something to buy today, if I pay you full, I will be empty handed." The nurse then said, "OK, I am giving you a solution. There is one drug that you can start one or two days later, so tomorrow you come with the rest of the money and take that drug. Today I am giving you the drug that you need immediately, which you can buy within 40 Taka." But the old lady then objects and tells the nurse to give them all the drugs. She then says to her son, "You broke the bottle, you don't have to buy kerosene today and forget the other things, but the medicine first." The man hesitates for a while but finally agrees. The nurse gives the drugs to them and tells them the doses. She asks the old woman to repeat what she said. The little girl starts crying and wants to go home. The grandmother consoles the girl, "We are leaving in a moment dear." All the transactions are over. They leave the health centre, say good-bye to the nurse. It is 3.35 p.m. They have spent 35 minutes in the health centre.

This is one of many cases but it represents many common features of the different stages of out-patient consultation in a BRAC health centre.

House near a graveyard: registration

At the registration desk I have frequently observed this bargain with fees and payments. The recent increase in registration fee created a confusion among the clients, which the nurse in the desk had to clarify each time and more so, during the payment for the prescribed drugs. I have seen the patients either have a shortage of money or they have a tendency to keep it unpaid. Sometimes, the nurse tailors the prescription according to the affordability of the client. I also sometimes noticed that the clients quickly go to the nearby bazaar to borrow the extra money that they need. Once a man, after paying a portion of his bill, started searching for the rest of the money in all his pockets and also on the floor and telling to himself, "Where did I lose the money?" The nurse told me in a low voice, "He is pretending, trying to avoid the payment. He will find it, I will give him time." He did indeed find the money after a while. There are also people who bargain for some time and then take out the money.

How are we to understand this money problem?

First, some of the clients are extremely poor. They are day-labourers, or share croppers, and they don't always have cash in their hand. The money they have, only covers the partial bills of the health centre, which includes a registration fee and the cost of the medicine. It is, therefore, no wonder that they ask for an exemption to some payments. I remember one suspected TB patient who gave the registration fee but could not pay for the TB test. He requested for the test to be done and promised that he will pay for it afterwards, but the nurse refused. The man waited for a while and finally decided to leave. He was very weak and was walking with the help of a stick. I thought he needed the cough-test immediately and I decided to pay for him. The nurse took the money and arranged for his cough-test. However, afterwards she told me, "How many times can you do it? How many times a day? There are so many of them. Sometimes, I also paid for them, sometimes, our doctor examines the patient free of charge. But how many times can we do that? All the day I had to fight and talk a lot to get actual amount of fees and charges. They are really so poor, sometimes I feel if I could give them free service I would be the happiest one. But I see so many of them everyday I become desensitized. If your house is near a graveyard you cannot cry for every death."

Secondly, the village people are generally used to more flexible medical encounters. With the village doctors and other kinds of rural healers, villagers enjoy plenty a scope for negotiation regarding payment. Usually payment is made at the clients' convenience. Even some village

doctors keep records of their treatments and make their payments once a year during the harvest time when people have money in their hands. Not only medical encounters, but almost all aspects of rural life are rather flexible and negotiable. They don't often encounter a strict code of conduct (jackfruit is not allowed inside the room), rigid maintenance of office rules (no provision for keeping payment pending). Entering a health centre is a rather alien experience for the villagers. Kirpatrick (1979:61) who studied the life in an Indian hospital writes:

> Clients and organization staff often entertain contrary definitions of the services encounter situation, dissonance is experienced by both parties to the encounter, and pressure to reduce dissonance cause both to engage in various strategies to accomplish this.

The pretension of losing money can be one such strategy. Finally, I remember a comment by a sociologist of Bangladesh who wrote "Bargaining is a national pastime in Bangladesh." This explains to some extent the bargaining tendency of some people at the health centre. Bargaining is a kind of ritual of shopping in Bangladesh, the practice therefore continues in medical setting.

In addition to the difficulties with the payment; the nurse in the registration desk has to struggle with the VO, non-VO identity of the clients and with different fees and charges. It is not a problem to check with the annual VO member because to receive this service they have to bring their cards along with them and payment is also ensured by the BRAC Development Programme. However, the problem arises with the general patients. Most of the time VO members forget to bring their cards when they come as general patients. The nurse then has to cross check and confirm their identity. It is a big hassle for her. Staff, therefore, say that sitting at the registration desk is the most difficult job in the whole flow of out-patient consultation. Therefore, they have placed the one who is most fluent and capable of dealing with people at the desk. The nurse who sits at the registration desk told me, "*Bhai* (Common way of calling the male colleagues in BRAC, which means brother), I have to talk so much that at the end of the day my mouth aches."

<u>We are suffering: family attendants</u>

Another common feature of the health centre is the presence of attendants of the patients. Patients rarely come alone to the health centre. One, two, or sometimes more family members accompany the patient. In the consultation room all the family members and with the patient collectively present the patient's problems to the doctor. After the consultation the decision regarding procurement of drugs and other related issues are made jointly. Coming to the health centre is, therefore, not an individual but a collective effort. This observation corresponds

with findings of Kirpatrick (1979) in India. She also found that relatives of patients are an integral part of the hospital social system.

Nice to watch, but what is it about? waiting time

Waiting time in BRAC health centre is not long. As the centre is not so busy, the general waiting time is about 5/10 minutes. Occasionally, when the VO members come in a large group for their routine check up, the waiting time increases a little. But I have not seen patients complaining about the waiting time, except once. When there was a sudden rise in patient flow, the husband of a patient became angry, as he thought it was taking too long for his turn to come. He left the health centre along with his wife scolding the staff for wasting his time. The waiting time is used by screening health messages on a TV. In general it keeps people engaged while waiting for their turn to come. They watch the TV, but very few of them were able to tell me what exactly the film was about. The traffic and other noise outside the centre hamper with the communication. Another interesting observation regarding the waiting room was that in this area, the aya, the most marginalized staff member of the health centre exercise a little bit of power. She maintains the order in the waiting room. Some patients want to lie down on the floor after a long walk in the sun, some start smoking or chewing beetle leaf, which is not allowed. The aya monitors this. We also may remember the jack fruit case.

We live on vegetables: counseling

As told by the staff, the idea of counseling was to provide some advice related to disease of the patient before entering to the doctor's room. According to the counselor this is to increase awareness of the patient and make the patient relaxed, so that she opens up more when she goes to the doctor. In most of the cases, however, I have observed patients receive this advise passively and indifferently. Patients come to the health centre with a burning problem and they expect to tell their problem to someone who can give them a remedy. But here it seems that every time they start telling their problem, someone interrupts them, asks for a fee, or gives some kind of advice. I remember one case, when the counselor was giving a lecture about the importance of eating vegetables to a patient, he became impatient at certain point and said, "Sister, we live on vegetables, what is the use of telling me the value of vegetables, would you kindly let me go to the doctor and tell my problems?" It should be noted, however, that the nurse who was doing the counseling is a new recruit and was not skilled enough for counseling. Nevertheless, I noticed that the patients of antenatal care and STD cases are generally very attentive during counseling. Particularly in STD cases I observed that counseling helped them a lot to open up. The other problem with the counseling was that, the nurse sitting in the counseling desk is also responsible for check-up of VO members. Therefore, when the VO

members come she gets involved in check-ups, so counseling is stopped for a while. The patients at that time are passed directly from the registration desk to the doctor.

No negotiation: consultation

I have noticed that, as the patients pass from room to room, their voices get lower and they lose a portion of their spirit as well. So when they finally speak to the doctor they no more hold the voice and spirit with which they entered. But the behaviour of the BRAC doctor is in general, warm and cordial. He encourages the patients to speak. He usually takes time to listen to the history and symptoms of the patients and not only speaks to the patient but to the whole family. I have observed that he tries to avoid technical language as much as possible. The doctor maintains a systematic patient flow and never consults more than one patient at a time. Privacy of patients is maintained. The female nurse accompanies the doctor when he examines a female patient. He frequently uses a stethoscope and blood pressure machine. This is definitely not a typical picture of rural health centres in Bangladesh. BHC is relatively less crowded, the doctor consults only about 25 patients a day. So he can afford to pay much attention to patients. Moreover, BRAC's supervision and commercial interest also play an important role.

As for the doctor-patient relationship, there is not much scope for the patient to choose or participate in diagnostics and therapy. They completely surrender themselves to the doctor and the doctor plays a superior role. Sometimes the doctor tells the patient about the diagnosis of his disease and sometimes not. However, patients are mostly happy with this procedure, and they never show interest in discussing the diagnosis or therapy. Patients were found to be satisfied with the attention they received from the doctor. I agree with the argument of Sachs (1989) in this regard, who studied the doctor-patient relation in a rural clinic of Sri Lanka. She argues that this asymmetry in social relation between doctor and patient is rather a positive element of therapeutic consultation in this context. She observed that communication between patients and their doctors in a rural health unit in Sri Lanka met the expectations of both actors although they seem to base their satisfaction on different concepts of what was going on. She states (1989:346).

> The expectations from both categories of actors, which are based on social relationships among people outside the clinic, seem not possible to meet since an asymmetry of power relations is essential to biomedical care "(help me, I can't help myself-I am going to die-you have the technique and knowledge, I have none)."

She further adds:

> The negative value surrounding the biomedical model in the West is a cultural product in itself that may cover up or make invisible some of its qualities that make it work in various third world contexts.

However, one tendency of the BHC staff members was prominent; to demean indigenous medicine. It was frequently found that before coming to this centre patients had tried various other therapies including herbal and spiritual treatments. Doctors, paramedics, and nurses made negative comments about these kinds of treatment and tried to establish the superiority of biomedicine.

More about patients

How many patients?

The average number of patients per day is around 25. However, I was told that, the number was higher before the registration fee increased. In addition, everyday about 20 VO members get annual health check-up.

Who are the patients?

On an average 70% of the patients are the beneficiaries of various BRAC programmes. Of the total patients, about 60% are female.

How did they come to know about BHC?

Shasthya shebikas (Community health workers) of BRAC are encouraged to refer patients to the centre and are paid with referral fees. Many patients of BHC are therefore referred by the community health workers. Others get information from the patients who visited the centre. Moreover, there are many cadres in the community working for BRAC; the programme organizers of various BRAC projects and the BRAC school teachers act as the source of information about BHC. TB patients are referred by other doctors as well.

Why do they come to BHC?

BHC has increased the therapeutic choice in the community. Most of the patients I talked with have tried other treatments before coming to the BHC. They have tried folk and spiritual therapies and also modern medicines from village doctors and pharmacies. Most of them come to BHC when either other alternative have failed or as a trial while simultaneously using some other methods as well. As Streefland

(1985:1156) comments. "There is this integration of different medical systems, in the minds of people."

Are they satisfied?

Patients are generally satisfied with the services of BHC. They are particularly happy with regard to manner and behaviour of the staff members. One typical comment was: "I haven't seen hospital people talking so cordially to poor people like us." I remember one man who came to the BHC with his daughter. He was a rich man and was proudly declaring that he usually does not visit these small health centres, rather prefers to consult the doctors of medical college hospitals. However, he had come to see how it works as it was situated in his neighbourhood. At one point he saw the medical officer of the BHC passing through the corridor. He asked "Is he the doctor? He is so young he does not look like a doctor." However, he registered his daughter's name, passed through the counseling desk and finally consulted the doctor. When I talked to him in the exit point, he was in a completely different mood. He said "I liked this place, things are so systematic, people are so well-behaved. I have not seen many such institutions in our country." Some patient's idea are based on previous reputation of BRAC. As one says: "BRAC always works for the poor, this is another good initiative for the poor." Some people appreciated the quality of drugs sold from BHC. One of the patient said "The medicine that I procured from BHC works better. They give medicine made by good companies. Our village doctor gave me same medicine but it didn't work, probably the brand was very bad."

What are their complaints?

One major complaint made by most of the patients was against the sudden raise of the registration fee. They told me, they didn't understand why there was this sudden increase in fees, when they were not less poor than before. One commented: "They started with ten Taka, then they made it fifteen Taka, may be after one month they will say that it is twenty Taka and what can we say?" Some of the patients think that the systems of BHC are too formal and too strict. "One should have all the required money in his pocket to come to this centre. They even don't want to give you a credit of 2 Taka." Another source of confusion for many patients was the identity and status of the BHC staff. It is not uncommon that BRAC's staff members sometimes change their roles. Sometimes the male paramedic sits in the registration desk instead of the nurse. When the doctor is absent or busy with some administrative meetings, the paramedic substitute for the doctor. Sometimes in the absence of the paramedic and doctor, the nurse also sits at the doctor's desk. This creates confusion among the patients regarding the position of the staff member, particularly about the identity of the doctor. Once when the paramedic was at the doctor's desk, one revisiting patient told me in the exit door, "Last time I talked with a different doctor, at that

time today's doctor paramedic was sitting at the table (registration table). He took my fees, when I told my complaints to him, he said, 'Don't tell me, tell the doctor inside'. But today he is again sitting at the doctor's desk. Who is the doctor then?"

Obstetric service

Empty beds

Another service offered by BHC is normal deliveries. There is a labour room equipped with facilities to conduct uncomplicated deliveries. There is also a four-bedded maternity waiting room. However, the beds remained empty during my study period. At the end of the month I came to know that no delivery had taken place in BHC during that whole month and there had been only two deliveries the month before. It is obvious that the labour room is the least utilized facility in the BHC. During my stay I could sense a constant worry among the staff regarding the poor flow of delivery patients. The idea was to establish a maternity waiting home to institutionalize the deliveries in the neighbouring villages. But, according to the staff the villagers do not respond positively in this regard. Rural women usually prefer home deliveries. Delivering a baby in the hospital is a culturally alien experience for them. One of the programme organizers of BRAC said that, when she suggested to a woman that she should deliver her baby in the centre, she replied, "Pray to God, that I don't have to go to any health centre." One of her colleague then added that, he had seen a woman taking leave from her family to get admitted in the hospital as though she was taking leave forever. According to the staff even the TBAs trained by BRAC expressed their objections on institutional deliveries. As one of the TBA told them, "Why did you train us if you want to take even the normal deliveries to the hospital?" The staff seemed a bit confused about the future of the maternity waiting homes. Everyday the aya prepares the beds in the maternity waiting room but nobody comes to occupy them.

ADMINISTRATIVE ISSUES

As mentioned before, there are two separate teams working in the BHC. One field team providing primary health services in the community, supervised by the manager, and the other is the BHC team providing clinical services in the health centre, supervised by the doctor.

The main goal of the health centre is to perform the therapeutic activities. However, these therapeutic activities are divided by function and labour of the staff and defined by a hierarchy of authority and responsibility. Various administrative issues are, therefore, involved in the functioning of the health centre.

Pen, paper, stapler

Lots of paper work is involved in the functioning of the health centre. Piles of registers are maintained. Dozens of reports are prepared. If carefully observed it can be noticed how important the role of the pen, paper and the stapler is in the functioning of this centre.

The day starts with two registers. There is a ritualistic assembly around the attendance register every morning. The office formally starts at 8:00 a.m., so everyone is eager to sign the attendance register on time. The other one is the movement register, in which the field staff write their day's movements. Besides these, several other registers are maintained. Here are the names of some of those:

For the health centre:

1. The patient register contains information about the patient's name, address, complaints, diagnosis and treatment. From these registers a selective list of RTI/STD patients and list of patients that require follow up are maintained in two separate registers: (a) The RTI/STD register, and (b) The follow-up register.

2. Three medicine registers include (a) a drug selling register, (b) a drug stock register, and (c) an emergency medicine register.

3. Two registers are maintained for VO member: (a) a VO check-up register, and (b) a register for identified patients from VO check-up.

For the field activities:

1. Household register contains information on household members, their births, deaths, etc.

2. Pregnant mother register contains information on the identified pregnant mothers.
3. TB register for TB patients.
4. Service charge register keeps the accounts of the service charges received for ante-natal care and growth monitoring.
5. A pneumonia register for pneumonia patients.
6. Drug stock register keeps accounts of the drugs for pneumonia, anti helmanthic drugs, iron tablets for pregnant mothers supplied to the community health workers.

Every month staff members send certain reports to the head office. The reports include:

About the BHC activities:

1. Monthly performance report (VO and non-VO patients, ANC, PNC, FP, delivery)
2. Disease profile
3. RTI/STD patients
4. VO checkup report
5. VO morbidity report
6. BHC service charge
7. Cost recovery report

About the field activities:

1. Monthly performance report on the field activities (VO, PHC, delivery, FP, EPI, etc.)
2. Phenomena report
3. TB report
4. Total deaths report
5. Under-five deaths
6. Maternal deaths
7. Family life education and reproductive health education report (A special programme for adolescents)
8. Deworming report.

Every evening the staff members fill out all the registers mentioned above. As I observed, the staff deal with human beings throughout the day and as the sun sets they deal with the registers and papers. Every evening after returning from the field the field workers sit with their respective registers, filling in the information they collected. At 6:00 p.m. the BHC staff sum up their accounts and stocks. Therefore although the formal office time is 8:00 a.m. to 5:00 p.m. for field staff and 8:00 a.m. to 6:00 p.m. for BHC staff, they never finish their office work before 7:00 p.m. Sometimes the office is still busy at 8:00 or even 9:00 p.m. The last few days of the month are the most hectic for the staff, as these are the days when they prepare their monthly reports. The registers and reports are maintained mainly by the junior staff, and medical officers and managers sign and check the paper work.

The piles of registers can be seen stacked in the office. There is also a big board in the office displaying monthly information on various activities. Attention is paid to the maintenance, documentation and display of these registers and reports. Sometimes it seems that the entire concern of the centre is concentrated around these registers and reports. Needless to say these papers are one of the prime indicators of the performance of the BHC and also the reference point for supervisors.

Are they doing their job?

Strict strategies for supervision and monitoring of staff are maintained. There are formal written rules and regulations, guidelines that control the behaviour and work of the staff. The manager supervises the activities of the field staff, he maintains a supervisory check list which he fills out whenever he goes to the field, and sends his findings to the head office every month. It is easy to monitor the activities of the field staff as their everyday movements are written in the movement register. The medical officer's 'field' is the health centre and his subordinates are right in front of his eyes, so it is easy for him to supervise their activities. The manager and the doctor also send a monthly action plan to the head office which in turn helps the head office supervisors monitor their work. The higher level supervisors like the sector specialist, the regional manager (RM), and the programme manager (PM) frequently visit the health centre. They randomly go to the field and check various papers. The Director of the programme also visits the centre.

Visitors

There are frequent internal and external visitors to BHC. Visitors are a big concern. I heard that the centre receives a visitor almost every week. According to the staff, this BHC is one of the oldest and is considered well-established and well-functioning. The BHC has good road communication with the capital city. Along with BRAC's internal visitors, many external visitors also visit the centre. During my stay a number of

visitors came to that centre. The RM paid an unannounced visit twice. He inspected various activities of BHC, had a meeting with the manager and the medical officer in the office. As the doctor was engaged in meeting the RM, the patient consultation at BHC was halted for sometime. Eventually the paramedic took charge of the consultations.

The director of the programme also visited the centre during my stay. Her visit was announced before and I could sense the anxiety and alertness of the staff the days prior to the director's visit. Special attention was paid to the cleanliness of the centre and the maintenance of the registers. Before coming the director sent a massage that she wanted to talk to some of the community health workers (Shasthya shebika or SS) of BRAC. The specially selected SSs came early in the morning on the day of the director's visit. The director came around midday, talked with them in the office room and left. She was accompanied by the programme manager, the regional manager, the medical officer and the manager of the centre. As it was a planned visit, there was no interruption in patient consultation. It was decided earlier that the paramedic would be in charge of the patient consultation as the MO would be engaged with the director. After the director left the centre, there was lot of curiosity among the staff, about what the director had asked and what the SS's response had been. It so happened that during discussion with the SSs, it came out that one of the SSs had recently arranged the marriage of her daughter who is only fifteen years old. The director was annoyed and criticized the SS for arranging the marriage of her daughter at such an early age. After the director had left the staff members started blaming the particular SS for disclosing the fact to the director and was asking her why she didn't avoid the issue of her daughter's marriage?

One BRAC researcher also visited the centre for a while before going to the field to collect data. She spent some time in the centre and gathered information on the field. In addition to the internal visitors, a number of external visitors also came during my study period. A country representative of CIDA, two intern students, one from the USA, one from India and personnel from a local NGO called AVSC visited the BHC as part of their orientation on BRAC projects. The manager and the doctor accompanied the visitors to brief them in the BHC activities; again the activities were halted for some time.

Facing visitors is not a pleasant experience for the staff. It creates a tension among them as they have to show their best and give a good impression. Moreover, most of the time the visits are not announced, and the staff are therefore always alert. Whenever a car stops nearby their office, they become cautious and quickly check whether it is a new visitor. Once a big car stopped in front of the centre with some foreigners. The medical officer was in a meeting with the RM and the paramedic was in charge. The manager rushed to me and asked if I could brief the

activities to the foreigners. He was probably not very confidant of his spoken English, and it is usually the medical officer who deals with foreign visitors. However, finally he realised that the visitors were going to some other place and the BRAC higher official was with them. They had just stopped to get directions. At other times when visitors came I continued with my work, either talking with the patients or sitting beside one of the desks. When the director came she asked me how my work was going, and others wanted to know what kind of research I was doing. Needless to say, these frequent visits interrupt the normal flow of activities in the BHC. Every time the visitors leave the centre, there is a sigh of relief and someone will say, "Well, it is over, let's relax for a while.

What are the agenda today?

Frequent staff meetings are held with both BHC and field team together. Although the BHC and field team work separately, their work is complimentary. Patient flow to the BHC depends on the field staffs activities in the community. Patient follow-up is also done by field staff and they therefore need a mutual exchange.

The meeting I attended was conducted by the manager. The doctor was absent that day as he had left for Dhaka to attend a training session on child health. The manager wanted to start the meeting at 6:00 p.m. but it was delayed for an hour, because the BHC staff were having a difficulty with their accounts at that moment and could not join on time. The manager requested the nurses to stop the work for a while and join the meeting, but it seemed that they didn't care much. They finished the work and came to join the meeting after an hour. It may be mentioned that the nurses are not accountable to the manager and this difference in the line of authority might explain their behaviour.

In the meeting the manager discussed the findings of his previous field visit. He expressed his dissatisfaction as he found a baby in the village whose birth weight was not taken, and a TB patient who had not been given a follow-up on time. However, the manager has a relaxed personality and made jokes in the meeting. He told a story of a man in the village who claimed money from him because the man thought the manager had run over his chicken with the motor cycle and killed it. The manager described how he had managed to make the man understand that there are many people with motorbikes and it was not him who killed the chicken. The story made everyone laugh. Though the manager dominated the discussion, the other staff members, both male and female participated. This meeting was held just before the scheduled date of the director's visit, so the main focus of the meeting was about the visit. The manager asked everyone to check their respective registers so that no mistakes would be found. He mentioned the director's message to bring a few SSs, with whom she wanted to talk. The staff started discussing whom to bring to the office. They were trying to select the best

performing SSs. Finally the manager expressed his worry about the low number of patients in BHC, which was not up to the expectation. The staff said that the BHC was a relatively new form of therapy option for the community and not yet popular enough outside the BRAC beneficiaries. Moreover, the general negative impression on health centres and general preference of patients on informal and popular forms of therapy prevented them from considering BHC as their first choice of therapy. The meeting lasted for about two hours.

Besides this BHC level meeting, there is a monthly meeting conducted by the regional manager held in the regional office where the monthly performances of the BHC and field are discussed. From time to time the head office meetings are held with the programme manager and the director, while representatives from the field attend. These meetings help disseminate information, exchange views and maintain the hierarchy in the organization. One staff member said, "Meetings are scary, for hours you sit right in front of the boss. I try to avoid meetings." Another one said, "It's a break from the monotony. I can meet people from other offices, and this is a chance where I can talk with the higher authority and clarify my confusion."

Tell me the last serial number

Every month the BHC sends a cost recovery sheet to the head office. The costs of the BHC include salary of the staff, depreciation of fixed assets, utilities, incentives etc. The income includes: registration fees and money from selling of drugs, pathological tests and delivery charges. Each month the centre has to show the percentage of cost-recovery. This issue of cost recovery is a special concern among staff. There is constant worry about the number of patients and the income flow of the centre. A higher percentage of cost recovery is considered a success. There is an unofficial competition between the centres on cost recovery. Part of the everyday gossip in the centre is about the patient flow in different BHCs. There is always a comparison, Such as, "Last month the 'X' BHC got 40 more patients than we did" or "This month we must supercede the number of patients we had in the last month." This tension prevails both the in the BHC and the field team. The number of patients is an indicator of performance for both teams.

Interestingly, every time the manager returns from the field for lunch, he asks in an almost ritual way, the last serial number of the patients. Here is a conversation in the office room that I recorded one day (everybody was preparing for lunch):

Manager — Tell me the last serial number.

Accountant — The market is very bad today.

Laboratory Technician — When the patient flow is good, I can sense it even in my laboratory. But today it was quiet.

Manager — Would you please just go and check the last serial number? (Laboratory Technician goes to the registration desk).

Laboratory Technician — It's only 10.

Manager — Well that's not bad, at least it reached up to two digits.

I noticed that staff members from other BHCs who visited the centre, after exchanging initial greetings, asked about the patient flow. This reflects the anxiety on patient's attendence.

She left the job, he is transferred

After my first phase of data collection when I returned to the centre, I found a change in the staff members. The regional manager and the medical officer were changed. The nurse who used to sit at the registration desk had left the job. The previous regional manager, who had worked in this region for more than a year was transferred to another region. After receiving the training on child health, the previous medical officer has been assigned with a new responsibility of a trainer and was transferred to another station. Nobody has any idea about the reason behind these changes. They said, however, that this was nothing new to them. They had experienced these kinds of abrupt transfers before. The nurse got a job with a better salary in Dhaka. It is interesting to mention that the newly posted medical officer was the eighth one since the health centre started in April 1995. Among the previous medical officers some left the job after few months, some were transferred. The staff were not prepared for this change and were not, happy either. An internal evaluation of BHC found that patients attendance is influenced by the length of stay of the staff. It reports that the longer the stay of the MO and paramedic at BHC, the higher the attendance of the patients (Afsana K, et al. 1997).

LEISURE

Life in BRAC health centre is tightly scheduled, but there are still some hours when life is not occupied by patients, fees, and laboratory slides.

World cup! World cup!

My study period was during the time of the world cup football championship. Though Bangladesh does not have a football team of any international standard, people are still highly enthusiastic about football. During the world cup competition, even in that remote village health centre, football was part of everyday gossip. Due to the five hours time difference with France, it was usually midnight when the matches were broadcast. The staff of the health centre watched the matches on the TV spending sleepless nights. Some supported Brazil, some Argentina, some Nigeria. There were two TV sets in the centre. One was provided by the office, the other was owned by one female staff member. The manager who lives outside the premise, had his own TV. The manager, MO, PO all watched the matches together. Sometime they gathered in the office, sometimes in the manager's room. However, the enthusiasm was mainly observed among male staff members, the female staff members were not much enthusiast about football. They were more interested in drama serials which were shown everyday around 8:30 p.m. After dinner the female staff members usually sat together in front of the TV in their room. One of the female staff owned a music system. When all doors were closed and lights were off, I could sometimes hear the music coming from their room.

Ah! Holiday

Friday is the weekly holiday. However, the staff see their freedom as rather limited. They are supposed to inform the authority if they want to leave the station even in holidays. This small piece of formality restricts the free movement of the staff. Usually the staff move out of the centre alternatively. When one goes out, the other remains in the centre. One goes to visit relatives in the nearby town, another one goes for shopping. One Friday during my study period, the manager went to visit his family in a nearby village. He did not or could not inform the regional manager. When he returned he received a letter from RM asking for a explanation for his unauthorized station leave. He was depressed for the whole day after receiving the letter. Sometimes when an emergency pregnant case comes on Fridays the nurse has to attend. She complains, "Even Fridays are not holidays for me sometimes." Particularly in the last few days of the month, staff have to work even on Fridays to prepare the monthly reports. However, in general the Friday is a relaxed day for the staff. They

get up late and do not hurry to sign the attendance register. Some go to the mosque for weekly prayer, some wash their clothes, some watch TV while some others visit a neighbour, particularly the colleagues who live outside the health centre premises.

The topic of their discussion includes the past and present of BRAC and its future projects. The old BRAC members take pride in saying how they suffered in the early days of BRAC when it was a small organization with a few hundred employees. It could not even provide a bed for each of them. Many times they spent their night on the floor. Now BRAC owns two 20 storied buildings with thousands of employees. Some take pride in being a member of the largest NGO of the country, even of the world. However, some complain about BRAC's low payment. They talk about organizational changes, about the shift of authority from medical to non-medical professionals. Another major topic of discussion is the national politics of Bangladesh. Great enthusiasm can be observed when they discuss politics. They divide into groups and keep on arguing with each other for and against the government.

Every evening when both male and female staff do their paper work in the office room, various casual talks and jokes take place. However, I have rarely seen men and women sitting together and chatting outside the office. I never saw a man enter the woman's living area. Women usually go for shopping with a female colleague. Though there is a segregation between men and women, mutual respect is evident.

Although hierarchy of positions is not very prominent in the day-to-day life, the manager and medical officer receive more attention. When chairs are placed in the courtyard to have a chat in the open air and if there are two chairs with cushion and two without, the cushion chairs are always reserved for the manager and the medical officer.

Time to eat

During meals the staff members do not get involved in any kind of official work. They have a common dining room and a cook paid by the office. Except for a few who stay in a private accommodation, all eat in the same dining room. The kitchen and the dining room are the same room which is therefore very congested. The air and lighting in the room is also not sufficient. However, in that congested dining room the staff members spend some relaxed moments during the meal. As the table is small, they eat in shifts. Usually one of the staff is the mess manager for one month by rotation. During meal time they sometimes make friendly criticisms or jokes about the food. There was one field staff who always returned from the field just at 1:00 p.m. as the lunch time starts at 1:00. The others make fun about him "We don't have to look at our watches, whenever we see 'S' in front of the dining room, we understand that it's lunch time."

Male and female staff members of different level usually dine together, though the MO and the manager generally sit in the first shift. Moreover, when the regional manager has his meal at the centre, it is only the manager, the medical officer, and myself as a guest from the head office who join him. The rest of the staff have their meal afterwards. Aya and the cook are always the last to have their food.

THE ACTORS

Hear them speak, who make the centre

So far I have discussed various activities of the BHC. But I think, the people who perform these activities and build the image of the centre demand special attention. They all work in a group but each of them has his/her individual expectations, joys and worries. So far we have seen them in action, now I would like to focus on them as persons and present deeper aspects of their lives and let them speak for themselves.

The aya

The aya is at the bottom of the staff hierarchy. She is about 40 years of age, quite energetic and well mannered. She worked as a TBA (Traditional Birth Attendant) and community health worker before she joined the staff as aya. As the best performing community health worker she was selected as the aya of BHC. She is paid on an hourly basis. Her time of arrival and departure is recorded by the paramedic or nurse, and at the end of the month she is paid according to the total amount of hours she worked. With a rate of three Taka per hour she usually earns about Tk. 800/- (US$15) per month. She is responsible for keeping the BHC premises clean. She guides the patient to different desks and maintains the order of patient flow. She also helps the MO and paramedic in examining the patients and assists in conducting delivery, pre- and postnatal care.

Her husband is a rickshaw puller, who is about sixty years of age. The man married her after divorcing his first wife. She has two daughters and two sons. Recently she arranged the marriage of her eldest daughter who is now 16 years old. Her younger daughter stays at home and looks after her household. Her 10 years old eldest son works in a tea stall and her youngest son goes to school. Everyday she starts about 6:30 a.m. from her house and it takes her half-an-hour to reach the health centre. She leaves the health centre after 6:00 p.m. Her 12 years old daughter cooks for the whole family and the husband brings the food for her during lunch.

How does she like the work?

"I was very poor, my husband is an old man, who cannot work regularly and earn money. We couldn't even have food regularly. We became more solvent after I joined the BHC as an aya. I saved Tk. 15,000 from my earnings, with which I managed to bear the costs of my daughter's marriage. I took a loan from BRAC and bought one rickshaw, which my

husband now paddles. He managed to build a tin-shade house from his earnings."

Does she have any regret?

"I have to spend the whole day here in the health centre. I can't spend time with my family. Now I have nothing called family."

"I can't attend deliveries in my village anymore, for which I was once known to everyone. I used to get gifts after conducting deliveries, which I don't get anymore. My neighbours miss me. They say you are no more with us, previously we used to ask you for advice on our children, but now there is no one like you in our village."

"Sometimes I feel depressed, I do a very small job here, and the doctor, and the manager sometimes scold me in front of the others. I feel insulted. In the village I had honor, people respected me, but here I am just a small employee."

The nurse

She is 26 years of age and intelligent. She studied a four-year diploma in nursing and worked in a clinic in Dhaka before joining the centre. She used to work in the clinic on call. She was looking for a regular job and applied when she saw BRAC's advertisement in the newspaper. Her parents live in Dhaka. She has five sisters, one of them is also a nurse, receiving training in Europe at the moment. She has been working here for about three years. When there is a delivery patient she is solely responsible for her. Otherwise, she usually sits at the registration desk and maintains the daily transaction of BHC. She also assists the doctor and sometimes replaces him.

Is she satisfied with her job?

"Not really. There is no fixed job to do and no timetable here. Everyday I have to do two to three hours of paper work after the health centre closes. I can never go to my room before 8:00 p.m. Sometimes I have to work on Fridays as well. Freedom is also limited here. This office and that bed room are our whole world. If we want to go out even in the holidays we need to inform the authority. Though they say it is not a question of asking permission but to keep the authority informed of our whereabouts. I think this is a violation of personal freedom. I enjoyed more freedom when I was working in a clinic. Nobody bothered what I am doing after office hours."

"The accommodation is poor. Four of us are living in a small room, which is congested. We don't have any guest room. Last week my father came to visit me. I couldn't give him a place to stay."

"Sometimes I feel as if I am just a shopkeeper. I am taking fees and selling drugs. It seems I am forgetting all what I have learned in nursing school. I can't remember the names of the instruments on the operation table, while those were once on the tip of my lips. The whole day I just talk and talk with people. I was not trained for that."

Does she also have positive experiences in BRAC?

"Yes, it is a nice experience to work with the villagers. I never worked in rural area, to tell you the truth. I learned to respect patients. In the clinic where I worked, we didn't have much time to listen to the patients, or rather we did not want to. Here we have to satisfy the patients. We have to keep BRAC's image up and to increase the patient flow. Good behaviour towards patient is therefore a must."

"I feel secure working here. My family was worried to let me go far away from home to work. It is a small rural town and I don't know anyone here. But I found the office environment safe and friendly. If the colleagues were not so supportive, it would be very difficult for me, being a women, to work here."

Does she want to continue here?

"Probably not. If I get a better offer I will resign. I want to get a government job and to work in a large hospital. I have seen in the newspaper that the government has promised to employ 3,000 recently graduated nurses. I hope I will get a job."

Before I finished my field work, the nurse left the job and joined a private hospital in Dhaka.

<u>The female programme organizer</u>

She is a thirty years old pale looking woman. She joined BRAC in 1985 and stayed for more than 12 years. She joined as a health worker in the Oral Therapy Extension Programme (OTEP) of BRAC, where she traveled to different parts of the country and conducted house-to-house teaching on diarrhoea and oral rehydration therapy (ORT). She then worked in different health projects of BRAC. She got married in 1995. Her husband is a businessman, living in a coastal district, 300 km away from the place she is working. That is the place where her parents also live. She has a daughter one-and-a-half years old. She has rented a room outside the BHC premises, where she lives with her daughter. Her husband visits her once in every three or four months. She keeps a baby-sitter.

How is her experience of working with BRAC?

"I have seen so many changes in BRAC. When I joined we didn't have any fixed place to stay; sometimes we had to sleep on the floor. I traveled miles on foot. Now I ride motorcycle. At that time I worked only on diarrhoea, now I work on so many issues. Once people used to tease us, because it was unusual at that time for a woman to work like this. Now people appreciate us."

"I have worked more than a decade with BRAC. I enjoyed working here. I always felt secure. Other organizations may give better salary but they don't provide these facilities. BRAC provides accommodation and a cook, which is very important. Otherwise it would be impossible for a woman to work in such a remote place."

"Now after I got married and had my baby, it's really becoming difficult for me to manage everything. I can not use the BRAC accommodation any more, the office premise is too small. I had to rent a separate room outside. Every morning I used to get up at 5:00 a.m. and cook. I completely depend on the baby-sitter for my daughter. I meet her only during lunch. Usually I left my daughter sleeping at home in the morning when I leave for office. Again I found her sleeping when I return from office around 8:00 p.m. In fact, I have a sleeping daughter. After returning home I cook my dinner. When I finally go to bed it's already 11 p.m. I feel very tired."

What is her future plan?

"I don't know how long I will be able to manage like this. It's also not possible for my husband to come here and leave his business. My daughter misses her father and she is growing up. I have to think about her schooling as well. Can I bring her up here in this village? BRAC has taken projects in my home district. I wish they would transfer me to that project. I could get support from other members of my family. I made a request to our regional manager a few months ago but haven't got any reply yet. If I were transferred my life would be a bit easier, otherwise I do not know how long I will be able to continue?"

<u>The male paramedic</u>

He is 38 years of age. In 1983 he joined BRAC's Oral Therapy Extension Programme. He worked as a programme organizer for many years in BRAC's Health Programme. He then received a week-long paramedic training. In addition he attended a short training on TB, ARI and diarrhoea. He is also receiving on-the-job training from the medical officer.

He is the only son of his parents. He had to take a job for financial reasons after passing higher secondary school. He got married in 1990, but doesn't have any children. His mother is suffering from various senile diseases and his father is also getting old. As he is the only child of his parents, there is no one else to look after his parents. His wife stays with his parents to look after them. He visits his family once every three/four months. They all live about 200 km away from his working place.

What is his experience working with BRAC?

"Sometimes I wonder how time flies. It seems as if I joined BRAC just recently but so many years have passed. It was a very hard working job when I joined BRAC. Many times I decided to leave the job, but some how I continued. I learned so many things. I never thought of treating patients in my life. Now I have become a partial doctor. I am grateful to BRAC that they have selected me for paramedic training. Though I am still not very confident prescribing medicine. I feel that I need more training."

"I worked as a PO under the supervision of the manager, now I am working as a paramedic under the supervision of the doctor. For me having both supervisors in the same place is not a good experience. According to me a single person can supervise both teams, which will help the centre function better."

What is his future plan?

"I have various worries. I got married about eight years ago, but my wife did not become pregnant. In fact we hardly lead a family life. It took some time to get the permission from the authority to bring my wife to my work place (permission is required to bring the family and live outside office premises). However, after I got the permission, my mother had a heart attack. She is almost bed-ridden now. There is no one to look after her, but my wife is taking care of her. My father is 70 year old and he can't work anymore. We have some land property and my father wants me to take charge of the small farm. My wife also complains and asks how long we must be separated like this. I am constantly stressed and confused about what to do?"

<u>The manager</u>

He is around 40, a jolly fellow jokes with everyone. He joined BRAC in 1986. He worked as a programme organizer in BRAC's Health Programme, and as monitor in BRAC Research and Evaluation Division. He is married and has a five-year old son. He lives outside the BHC premises. His son and wife used to live with him, but now his wife and son are staying in a nearby town, where she works as a teacher in a primary school. He visits them at the weekends.

How is his experience with BRAC?

"It is a long time that I joined BRAC and I have seen so many changes in the organization. From a small committee it has became the largest NGO of the world. In those days life in BRAC was extremely hard. New people complain about BRAC but we had tougher time. We had to travel to remote areas of Bangladesh, and worked for day and night. We couldn't leave the station during any holidays. Now life at BRAC is quite relaxed and comfortable. The organization has provided the staff with accommodation, although it is not sufficient and not of a good standard. We cannot however find a better house in such a rural area. This is in fact the best house available in this locality. We live like a family."

What does he think about the manager-doctor relation?

"I think the doctor should be in charge of BHG. To tell you the truth how much do I know about medical science, how can I supervise a health centre? I will always depend on the medical officer. I think I have a good understanding with the medical officer. We have a high rate of dropouts of doctors. I think more facilities should be given to medical officers, so that they continue with BRAC. We need doctors for our BHC."

What is his future plan?

"I have spent 12 years with BRAC. I have become accustomed to it. Moreover, I don't have sufficient academic qualifications to look for a better job. Doctors have many options, but as for me, I don't see any alternative at this moment other than continuing with BRAC."

<u>The medical officer 1</u>

I met two medical officers during my study period. The one whom I met first was transferred to a new place and a new medical officer was appointed.

As I mentioned the medical officer whom I met first was my ex senior schoolmate. We met after almost 18 years. We shared lot of our past memories. I was surprised to find him there and wanted to know his story. He passed out medical college in 1984 and joined the government service. He worked with government health centres for four years. He then got an offer to work in a hospital in Iran with a high salary package. He decided to leave the government job and left for Iran where he worked until 1995. When the Iranian currency was devalued and his salary was reduced, he decided to return to Bangladesh. After returning he worked with ICDDR,B for few months in a research project, and attended a short course on tropical disease in London. In 1997, he and his wife who is also a doctor joined BRAC. They were employed in two health centres

which were nearer to each other. They used to live together but attended two separate offices. However, after a few months his wife left the job. She took leave to get her daughter admitted in a Kindergarten school in Dhaka, but could not return on time. She had a dispute with the regional manager regarding this matter and submitted her resignation. His wife is now staying in Dhaka with their daughter and he is continuing here.

How is his experience in BHC?

"After working abroad for so many years in a highly sophisticated hospital it is hard to adjust in such a rural health centre. Moreover, I am quite senior compared to other medical officers in BRAC, even my supervisor doctor is junior to me. It is not easy to adjust to all this. It is unfortunate that I had to come back from Iran, but I did not have any alternative. I can't get my government job back. I will have to do something in the private sector. We both (husband and wife) got job in BRAC. I thought it would be good for us, but it did not work. My wife could not cope with the bureaucracy here."

"Have you seen the room they have provided for me? It is a store cum bed room. Around my bed there is a broken motorcycle, some sacs of rice and packs of medicine. Can this be a room for a medical officer?"

How about the manager-doctor relation?

"I have a good relationship with the manager. He is a nice person. Moreover, since the responsibilities are divided, there is less scope for conflict. However, in the other office where I joined first I had some difficulties with the manager. In that office the manager was in-charge of the office and I had to report to him. He used to assign unnecessary work to me, may be just to irritate me. They used to say, I must have earned a lot in Iran, so why was I working in such a project. He probably was jealous and wanted me to leave that job."

Does he want to continue here?

"If someone wants to be a real clinician, do you think it is possible to develop his career here just by treating worms and scabies? Moreover, my wife and children are in Dhaka. How long can I stay here like this? However, I talked with the director, if I am transferred to Dhaka I may continue. Otherwise I will leave the job and start private practice in Dhaka."

The medical officer was transferred from the health centre and was given a new responsibility of providing training to the government doctors on child health. He now has frequent trips to Dhaka. He seems happy with the new responsibility and plans to continue with BRAC.

The medical officer 2

The new medical officer who replaced the previous one was relatively young and recently graduated. He was working in a nearby BRAC health centre. He passed out medical collage in 1996 and joined BRAC immediately after completion of his course. He has worked for more than two years with BRAC. His parents and the only brother live in Dhaka.

How is his experience in BRAC?

"I enjoy the work here. It is nice to work so closely with rural people. This is completely a new experience for me. Moreover this is the first job in my life, so I have a special attachment to BRAC."

Does he have any criticism about BHC?

"I think frequent changes in staff and decisions, sudden meetings with higher authorities, and regular visitors to the health centre interrupt the normal flow of our work."

How does he feel about doctor-manager relationship?

"Previously the BHC was supervised by the manager, a non-medical person, and the doctor was accountable to him; which does not make sense. Now the doctor is in charge of BHC, which is how it should be. The relationship with the manager I think depends fully on the person involved. I know there are some problems in some centres in this regard, but I would say I have a very good relationship with the manager."

What is his future plan?

"If someone wants to develop his career in medicine or surgery it is not possible to do it here, and by treating just outdoor patients. In fact I am forgetting many things about clinical science. However, this is a good place to develop a public health career. If I want to be a public health physician it is good to have some experience with an organization like BRAC. I am still confused which line I should take. My friends discourage me to work with public health. They say there is no future and no money in public health. My parents also want me to go back to Dhaka and work in some big hospitals. They ask, "What are you doing in that village?". Now, if I want to go for a higher degree in medicine, I need to have a government job. I am still undecided. This is a turning point in my career. I have to choose the right path. I know I don't have much time in my hands and I will have to decide very soon."

Teamwork is the cornerstone of the functioning of a health centre however, teamwork is definitely influenced by the worries, expectations,

dreams and confusions of the individual team members. The above-mentioned life stories reflect the variety of personal concerns of BHC staff. The aya, though financially benefiting from joining the BHC, lost a portion of her dignity that she enjoyed as a resource person in the community. The nurse was concerned about losing her skills and is bothered that she does things that she was not trained for. The female programme organizer is worried about the future of her daughter, the male paramedic is constantly in tension regarding the health of his parents and their childlessness. The manager though loosing some of his previous authority, tries to adjust to the organizational decisions and maintain his job, the medical officer is in a dilemma about whether to continue in public health or in clinical medicine. We must not forget, when an individual performs his/her professional role, he/she also carries these personal concerns along with him/her. Therefore, until these personal issues are settled, it is unlikely that they would properly function professionally.

DISCUSSION AND CONCLUSION

In this study a medical set-up in Bangladesh was taken as the subject of anthropological inquiry. The medical set-up selected was a rural health centre established by BRAC. The activities of the BRAC Health Centre (BHC) were presented in three different categories; therapeutic, administrative and leisure activities.

The main therapeutic activity of the centre is providing consultation to outdoor patient. It was found that most patients of the centre were female and were somehow beneficiaries of various BRAC projects. Before coming to this centre most of them had tried some other therapies which failed. In this centre there are certain procedures which the patients have to follow. First, they go to the registration desk to pay the registration fee, then after waiting for a while in the waiting room they go to the counseling room, and once counseling is over they are asked to see the doctor.

On average, only about 25 patients visit this centre per day. The doctor is, therefore, not too occupied with patients. He has time to listen to the patients and examine them carefully. The patients don't negotiate with the doctor about the diagnosis or treatment, they just accept what he says. However, they are not as passive when paying for the consultation. They bargain, and try to find ways to get exempt from paying for the fees. Poor patients try to save the little money they have. Another interesting feature is the role of family members of the patient. Family members don't just accompany them, but take part in counseling and consultation with the doctor.

The staff members usually show good attitude towards the patients and try to please them. Although a common tendency of all the staff members is to devalue indigenous and spiritual therapies taken by the patients. Patients are satisfied with the services of BHC, but they feel uncomfortable with its strict formalities. The counseling is meaningless to some, others complain about the sudden raise in the registration fee of the centre.

The centre also has a laboratory that supports outdoor patient services with pathological tests. The laboratory provides an effective service to the TB control programme of BRAC. In addition, the centre offers facilities for normal deliveries, but it seems that the villagers are not very keen to use the facilities. It appears from the discussion of the staff members that there is an inherent resistance among the villagers about having a hospital delivery. As a result the labour room remains empty most of the time.

To perform therapeutic activities, BHCs rely a great deal on formal rules, regulations and authority to control the behaviour and work relationships of its members. Various administrative issues are, therefore, involved in the functioning of the health centre. There are two teams working in the centre. One field team providing health services to the community, supervised by the manager and the other team is in the health centre providing clinical services, supervised by the doctor. Strong emphasis is given on maintaining records. Piles of registers are kept containing all kinds of demographic and health information about the community. Each month the staff members have to send a number of reports on various activities of the centre to the head office. The reports monitor the progress of the project and work as a reference for the supervisors. There is a strict supervision mechanism in the centre. The field staff record their everyday movements. The manager monitors their work with a supervisory check list. The doctor routinely supervises the activities of the health centre staff. Above the centre level there are multiple levels of supervisors; the sector specialist, the regional manager, the programme manager, and the director. The higher level supervisors frequently visit the centre to oversee the activities. There is great concern among staff regarding the visits of the supervisors.

It was observed that great importance is given to the economic sustainability of the centre. Staff members are encouraged to find ways to increase the flow of patients in the centre. There is even an unofficial competition between centres regarding the number of patients per day. Staff turnover and transfers were also observed. As the role and authority of the staff members is clearly defined, and there is a close supervision system, conflict between staff members over status and power is absent.

A characteristic feature of BHC is the community life of its staff members. Most staff members work, eat, sleep and gossip on the same premises. Few of them have a private accommodation nearby. One has to ask for permission from the authority to live outside the official premises. Those who live outside are married and generally live with their children. Husbands or wives of most of the married staff members live far away in some distant town. The staff members are supposed to ask for permission to leave the station even during holidays. Most staff members, therefore, spend their leisure time within or around the centre. They watch TV, listen to music and converse with each other. The staff, whose relatives live in a nearby town, sometimes visit them on weekends with prior permission. Others attend weekly prayers and wash clothes in the weekends. The staff, whose family live far away, visit them once in every three or four months. During general socialization in leisure time staff members mostly talk about BRAC, its past, present and future. They also talk about current national political and international issues. Mutual coordination and respect was observed among male and female staff.

From the discussion with individual staff members it appears that everyone has his/her own personal expectations, worries and problems. Some complain about poor living conditions in the centre, over work, or restriction of movements. On the other hand, they are also proud of being a member of a highly regarded organization. The female staff members are particularly satisfied about the security of work place and cooperation of male colleagues. The technical staff like doctors and nurses look for better job options. Medical officers, in particular, are confused about their career plans. The non-technical staff who have fewer job options try to adjust themselves to the organizational changes. Those who are married have special worries since they miss their families. Their spouses live hundreds of miles away and they visit them occasionally. Some of them have children, and depend on somebody to take care of them as most of the time they stay away from home. They are always worried about family matters. Among the issues that emerged from the exploration of life in the BRAC health centre, there are four on which I would like to make some concluding remarks:

1. The 'total institution' type of life of the staff members.
2. The strong focus on economic viability of the centre.
3. The staff member's pursuing of individual interest.
4. The submissive yet bargaining attitude of patients.

As the points overlap each other I will discuss them simultaneously. A unique feature of the BRAC health centre is the commune type of living of the staff members. Unlike the traditional structure of a family, people from different backgrounds come together and form a type of extended family. They share the same office, dining and living room. They also spend their leisure time together. There is a strong emphasis on the total availability of the staff members. If someone wants to stay outside the commune, formal permission is required. There are restrictions in movement as well. Emphasis is made on keeping the authority aware of the whereabouts of the staff. Whenever a staff member moves out of the premises he/she writes the particulars of his/her destination. They are also asked to inform the authority if they want to move out during their off time. "This office and that bed room is our world. If we want to go out even in holidays we need to inform the authority...." (Nurse). We remember that the manager of the centre received a warning notice for his unauthorized station leave on a weekend. Higher officials visit the centre frequently to oversee the activities. We may recall the tension among staff about the passing cars on the highway. High emphasis is put on paper work. Every activity of the centre is documented and constant monitoring and feedback is provided to staff from the higher management. This situation resembles Goffman's (1961) concept of "Total Institutions".

He writes:

> A basic social arrangement in the modem society is that the individual tends to sleep, play, and work with different co-participants, under different authorities, and without an overall rational plan. The central feature of total institution can be described as a breakdown of the barriers ordinarily separating these three spheres of life. First, all aspects of life are conducted in the same and under the same authority. Second, each phase of the members daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aim of the institution (Goffman 1961:17).

The result of such conditions is the total availability of the members involved. The idea resembles the situation in the BRAC health centre. Goffman applied his concept to the inmates of a mental hospital. According to him these inmates live in a 'total institution' which is partly a residential community, partly a formal organization. He, therefore, calls it a 'social hybrid'. Interestingly, in the BRAC health centre it is not the patients but the care providers, who live in a 'total institution'. This 'total institution' type of life in this particular health centre which demands the total availability of the staff members cannot be understood in isolation from the overall development initiatives of BRAC and the history of its growth as a non-government development organization (NGO). NGOs in Bangladesh were developed to supplement and complement the huge gaps in the economic and social development initiatives of the government. As Streefland and Chowdhury (1990:264) comment:

> One major explanation for the present position and role of NGO in Bangladesh is the existence of an unmet need to take care of social development. This is created by the ineffectiveness of the state in realizing its service delivery responsibilities under conditions of massive and growing poverty.

BRAC as a donor-dependent growing private organization took up this task with limited resource and manpower. It had also faced resistance from government departments, radical political parties and Islamic fundamentalists. To compensate for the limitations of a private organization and to have the best utilization of its limited resources it applied some regimentation and demanded the total availability of the staff. By ensuring the total availability of the staff members it has succeeded in accomplishing ambitious programmes such as the Oral Therapy Extension Programme (OTEP), where the staff taught millions of

mothers all over the country how to make simple rehydration solution at home in case of diarrhoea. "...We were under strict rules, we always moved together, had the same kind of dresses and lived in the same place...," said the PO. "....We could not read newspapers, could not leave the station even on any holiday," said the manager while remembering their memories of working in OTEP. Community living is one of the effective ways to ensure total availability. It however, solves some practical problems as well. Usually it is extremely difficult for each individual staff member to arrange accommodation in the rural areas where the BRAC projects are usually situated. It is also unsafe for a woman in Bangladesh to live alone in such a remote area. Community living therefore solves these practical difficulties. Most female staff mentioned about the safety of work place as an advantage of their work with BRAC.

Community living also contributes to the economical viability• of the centre which is my second point of focus. We have observed the keen interest of the staff in the number of patients ("Tell me the last serial number"). This has to do with the economic sustainability of the centre. The more patients it attracts, the more profit it makes. Attracting patients requires satisfying the patients. The staff members try their best to please the clients. They maintain good manners and treat their patients with respect and patience. The rich people who came to test the centre were impressed by the behaviour of centre's staff. This illustrates the difference between public and private hospital services in Bangladesh. In most public hospitals where services are provided free of cost, the staff members do not bother to please their clients. There are newspaper reports that describe the abuse and exploitation of patients in public hospitals. The level of supervision and accountability is low. In contrast to total availability, sometimes there is almost total absence of staff in public health centre. In a study done in a rural health complex on the two wings of Ministry of Health and Family Welfare of Bangladesh, a dismal picture emerged (Chowdhury, 1990). The study found the large number of field staff to be spending less than half of their scheduled working time on the job. Many of the assigned duties were not done, or done partially. The nurse of the centre who once worked in a public hospital said, "....We did not have so much time to listen to the patients, rather we did not want to..." She admitted that while working here she learned to respect patients.

Community living contributes to pleasing the patient in a way that helps maintain a code of conduct among staff. The visible effect of community living also creates an impact in the locality. The image resembles missionary hospitals of the past where people with a spiritual calling would live a community life to serve the ill. It would be hard to find such hospitals anymore in the west, but they still exist in many developing societies.

The third point of focus is the way in which staff members pursue their individual interests. It is interesting to observe that the staff members in the health centre try to form a family, since the 'real' families are far away. That real family and their personal concerns are always in the back of their minds. The aya spends the whole day in the centre while her twelve year old daughter takes care of her house. She misses her family and the villagers also miss a resource person. She says, "...Now I have nothing called family." The female programme organizer has a 'sleeping daughter', as she stays out of home most of the time when the daughter is awake. She is worried about proper care of her daughter. The paramedic hardly spends time with his wife, who is taking care of his parents. They do not have children, and he is constantly stressed because of that. The manager meets his family once a week or fortnight. Moreover, his pleasure of seeing his family may be ruined by an official warning for unauthorized movement. The nurse is unhappy because she cannot enjoy her personal time. The medical officer thinks he should move to Dhaka where his wife and child live. Many of them are confused about their future. "...1 don't know how long I will be able to continue like this..." (Female PO). "...I am constantly stressed. I am really confused about what to do" (Paramedic) ". . .1 am still undecided. This is a turning point of my career" (MO). But they continue. Some get good financial benefit by working here. "...Now I am a bit solvent" (Aya). Some think that working with BRAC will be helpful for their career. ". . .If I want to take a public health career it is good to work with BRAC..." (Medical Officer). Some take pride in working with a reputed organization. ". . .From a small committee it has become the largest NGO in the world" (Manager). As there is a scarcity of job and social security is under threat, they all sacrifice comfort and accept this troublesome life. But those who get a chance opt out. The nurse took a better job in the capital city, and the medical officer was transferred to a better place. This situation is paradoxical. On the one hand they bind themselves to the community in the centre and to BRAC as an organization, on the other hand they are constantly looking for a better position.

Another paradox applies to patients, which is my last point of discussion. The patients of BHC are poor villagers inspired by BRAC's reputation in rural development. They submit themselves totally to the doctor of the centre. They are happy on the services of the centre, but they are not as passive when it comes to payment. They bargain or try to find ways to avoid paying the full fee. We remember the old woman with her grand daughter, who tried to persuade the nurse at the registration desk to lower the fee. We also remember how they were trying to adjust their plan with their limited money. ("You have to go back on foot, as it will not be possible to hire a rickshaw after buying the medicine," said the son after paying the registration fee). We also remember the patient who pretended that he lost his money. It is their extreme poverty that forced them to behave this way, to bargain, or to pretend to have no money. This is a country with great poverty, where resources are scarce,

and opportunities are limited for patients as well as for health personnel. Within these limitations everyone is trying to make the best out of his/her situation.

It is evident that the biomedical practice in the BHC has taken a definite shape due to some particular social and cultural factors. The culture of biomedicine in the BHC is shaped by the total availability of staff members, the strong emphasis on client satisfaction, the emphasis on economic viability of the centre, and an entrepreneurial attitude of the staff members and patients to make optimal use of the scarce resources which are open to them. All this has contributed to form the distinguishing characteristics, which Wilson (1965) called the 'personality' of the BHC, a personality which is different from biomedical services in another cultural contexts. Clearly, the specific organization of this centre and the BRAC 'ideology' of community life, total availability and economic viability greatly contributed to the quality of medical care. This ethnography also intended to explore how improvements could be made to make the services culturally more sensitive and adjusted to local expectations.

The way medicine is practiced in this health centre, portrays the values and culture of Bangladesh society. It shows how people survive in a difficult social situation, and find ways to maintain their existence. In that way the study of medicine helps us to understand people in the context of society and culture. I would, therefore, finally recall the observation by Margaret Lock, which started my report:

"As the practice of modern medicine becomes increasingly a technical enterprise, it is more incumbent upon us that to recognize that the human body is not a machine, that health and illness are not merely biological state, but rather that they are conditions which are intimately related to and constituted by the social nature of human life. The study of health, illness, and medicine provides us with one of the most revealing mirrors for understanding the relationship between individuals, society and culture: it is an exciting task which has just begun" (Lock 1988:8).

REFERENCES

Afsana, K. et al. 1997 *Quality assessment of BRAC Health Centre.* BRAC research report.

Barnes, E. 1961 *People in the hospital.* London: Macmillan.

Chowdhury, AMR. 1990 *A tale of two wings: health and family planning programme in an upazila in northern Bangladesh.* Dhaka: BRAC. Rural Study Series no.6.

Caudill, W. 1958 *The psychiatric hospital as a small community.* Cambridge: Harvard University Press.

Coser, R. 1962 *Life in the ward.* East Lansing: Michigan State University Press.

Ellen, R (ed). 1984 *Ethnographic research: a guide to general conduct.* London: Academic Press.

Emerson, R. et al. 1995 *Writing ethnographic field notes.* Chicago: The University of Chicago Press.

Freidson, E. (ed). 1963 *The hospital in modern society.* London: The Free Press.

Geest, S. van der et al. 1990 Primary Health Care in multi-level perspective: towards research agenda. *Social Science and Medicine.* 30:1025-34.

Geest, S. van der and Sarkodie S. 1998 The fake patient: a research experience in a Ghanaian Hospital. *Social Science and Medicine.* 47:1373-81.

Germain, C. 1979 *The cancer unit: an ethnography.* Wakefield: Mass Nursing Resource Institute.

Goffman, E. 1961 *Asylums.* Harmondsworth: Penguin Books.

Golomb, L. 1985 *An anthropology of curing in muti-ethnic Thailand.* Urbana: University of Illinois Press.

Hahn, R.A. and A. D. Gaines (eds). 1985 *Physicians of western medicine: Anthropological approach to theory and practice.* Dordrecht: Reidel.

King, S. 1962 *Perception of illness and medical practice.* New York: Russell Sage Foundation.

Kirkpatrick, J. 1979 *The sociology of an Indian hospital.* Calcutta: Firma KLM Private Limited.

Kleinman, A. 1978a Concepts and model for the comparison of medical systems as cultural systems. *Social Science and Medicine* 12:85-93.

Kleinman, A. 1985b Preface. In: Hahn, R. A. and A. D. Gaines (eds). *Physicians of Western medicine: anthropological approach to theory and practice.* Dordrecht: Reidel.

Latour, B. and S. Woolgar. 1979 *Laboratory life: the social construction of scientific facts.* Beverly Hills: Sage Publications.

Lock, M. and R.D. Gordon (eds). 1988 *Biomedicine examined.* Boston: Kluwer Academic Publishers.

Lupton, D. 1994 *Medicine* as *culture: illness, disease and the body in western society.* London: Sage Publications.

Nichter, M. 1986 The primary health centre as a social system: primary health care, social status and the issue of team work in the South Asia. *Social Science and Medicine.* 23:347-55.

Romanucci, R.L. et al. (eds). 1983 *The anthropology of medicine: from culture to method.* South Hadley: J. F. Publishers.

Sachs, L. 1989 Misunderstanding as therapy: doctors, patients and medicines in a rural clinic in Sri Lanka. *Culture Medicine and Psychiatry.* 13:335-49.

Sciortino, R. 1989 *Caretakers of cure: an anthropological study of health centre nurses in rural central Java.* Bulaksumur: Gadjah Mada University Press.

Streefland, P. and M. Chowdhury. 1990 The long-term role of national non-government development organizations in primary health care: lessons from Bangladesh. *Health Policy and Planning.* 5(3):26 1-6.

Wilson, R. 1965 *The social structure of a general hospital.* In: Skipper, KJ and C.R. Leonard, J. (eds). *Social interaction and patient care.* Philadelphia: JB Lippincott Company, PP.233-234.

Zussman, R. 1993 Life in hospital: a review. *The Milbank Quarterly.* 71(1):167-85.