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Nurse Education, Foreign Aid and Development: a case study from Bangladesh

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Thesis submitted in partial fulfillment for the Degree of Doctorate of Education

ABSTRACT   *Patricia Robson*

Nurse Education, Foreign Aid and Development: a case study from Bangladesh

Over an eight year period, from 1990 onward, British Government Technical Co-operation Training (TCT) awards were provided to Bangladeshi trained nurses for study at post-graduate level in the UK. From 1994 the TCT awards were incorporated into a UK donor-funded project Strengthening Nurse Education and Services (SNES). The design of the project envisaged that by providing the awards, a "critical mass" of educated nurses would be created and empowered to lead the nursing profession out of its very weak position within Bangladesh's health system. My thesis will argue that this initial vision is still far from realisation and will analyse the many interrelated factors hindering its achievement.

The investigation covers four perspectives: a) the way nursing developed on the Indian Sub-continent and historical factors in Bangladesh that impinged on the project; b) issues surrounding foreign aid to developing countries generally and to Bangladesh in particular; c) the design of the project and its place within the Bangladesh health system; d) the outcome of the project and suggestions for further research.

It will be argued that shifts in aid policy together with the nature of foreign aided "projects" contributes to a lack of sustainability. This puts any actual or potential gains from such investments at risk. Over time, aid priories change in response to the political environment. In 1995, the thrust of the UK's Department for International Development aid policy was "to improve the quality of life of people in poor countries by contributing to sustainable development and reducing poverty and suffering" A key strand in this policy was to "help people achieve better education and health and widen opportunities - particularly for women." To this end, the project being evaluated in this thesis fits comfortably by seeking to improve the capacity of nurses to deliver quality health care through enhanced professional education. In the process it sought to widen opportunities for women who form 90% of the nursing workforce in Bangladesh. As the project drew to a close at the end of 1998, there was very little evidence to suggest any improvement in nursing care had occurred. However a later examination suggests some positive featured had emerged.

DECLARATION

None of the material in this thesis has been previously submitted for a degree at Durham or any other university.

Patricia Robson   **June 2005**

Acknowledgement

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CONTENTS

Legend:
- — — International boundary
- — — District boundary
- 0 National capital
- · District capital

Map labels:
NEPAL, INDIA, DINAJPUR, RANGPUR, BOGRA, SYLHET, MYMENSINGH, RAJSHAHI, TANGAIL, PABNA, KUSHTIA, DACCA, COMILLA, FARIDPUR, JESSORE, RAMGARH, KARNAPHULI RESERVOIR, CALCUTTA, KHULNA, BARISAL, NOAKHALI, RANGAMATI, PATUAKHALI, CHITTAGONG, BANDARBAN, BAY OF BENGAL, BURMA

Inset: PAKISTAN, INDIA, NEPAL, BHUTAN, BANGLADESH, BURMA

AUTHENTICITY OF BOUNDARIES NOT ESTABLISHED

88   92
24   24

CHAPTER 1

INTRODUCTION

The aim of this work is to review the role of foreign aid in developing countries and its contribution to nurse education and professional development. It takes the form of a case study defined by Robson (1993 p5) as *"....a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence"*.

Research Method

In contrast to the standard survey, the case study method involves an in-depth exploration of a particular milieu rather than one which uses standardised instruments and draws on a wider random sample of individuals. Although more limited than the social survey, Bulmer and Warwick (1993) suggest case studies lend themselves to a deeper interpretation of the data and a more penetrative analysis. I believe the case study approach also allows the researcher to incorporate personal experience whilst safeguarding the problem of personal bias. My first involvement with Bangladesh was in 1977 when, over a six-month period, I assisted the World Health Organisation (WHO) with establishing the first four training schools for medical assistants, one in each of the country's four political and administrative divisions. The assignment involved considerable travel at a time when Bangladesh was still recovering from its civil war with Pakistan and recurrent natural disasters. Two senior nurses were designated by the Ministry of Health and Family Welfare (MoHFW) as my traveling companions throughout the assignment. This has provided me with a lengthy perspective on the country and its characteristics and allowed me to establish a long-term rapport with the nurses of Bangladesh and with other health service providers. In 1987 - 1989 I worked on a long-term project funded by three European donors in the area of family planning and the health of women and children. Although I did not work directly with the nurses as health providers in either of these projects, I continued to build up a good relationship with them as they were naturally involved in adjoining areas of the health service. From 1990 I worked more closely with the nurses in Bangladesh as part of a team implementing the *Strengthening of Nurse Education and Service* (SNES) Project. See Annex 1 for list of abbreviations used in this thesis and Annex 2 for a glossary of frequently used

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terms.

As Gomm *et al* (2000) suggest, a case study draws on a repertoire of methods to gather data including informal discussions most often with knowledgeable informants in the setting in which the study takes place. I included the latter, especially with donor representatives, whose time was usually limited, and I also used semi-structured interviews with a wider range of respondents at various stages of the research between 1993 and 2003. Their status and interview schedules are shown at Annexes 3 to 10 and include focus group question guides and responses: the questions were tailored to particular elements in the project. For example, an early focus group discussion took place in June 1993 at Queen Margaret College (QMC) in Edinburgh with nurses studying for either the Diploma in Primary Health Care or the Diploma in Advanced Nursing. The focus group questions were designed to explore the role of relatives in providing bedside care to their family members in the wards of public hospitals in Bangladesh and to identify the process through which information about care was passed among the various providers. The results of the focus group interviews were intended to compliment a literature review of related research and observations made in a number of hospitals during a 1990 assessment of nursing care in Bangladesh: this revealed that "hands-on" care by nurses was apparently rare in the country's public hospitals. Here the overall objective of the focus group was to develop a research proposal to look more specifically at the strengths and weaknesses of relatives providing patient care. If it appeared feasible, the proposal could be developed as a research study within the SNES project. This focus group was facilitated by myself and a QMC colleague with eight Bangladeshi graduate nurses all of whom had recently worked in hospital wards. The session was tape-recorded and lasted around one hour.

My colleague and I were both involved in teaching one or another of the diploma courses mentioned above but I believe any manipulation of the group responses was avoided, first, by the fact that not only the 1990 assessment but several other fields of enquiry had suggested the predominance of care being provided mainly by relatives and, second, by our sharing and clarification of the results with the focus group members themselves. The first focus group question guide and responses by the

nurses are shown in Annex 3. Although the number involved was within the range recommended for focus groups, there was a great deal of lively, and often noisy, interaction among the participants that produced a dense account but prevented completion of the schedule. In retrospect, given the group dynamics, it was too ambitious for a single focus group session. However we were provided with a clear account of the process by which relatives were involved in caring for their family members. The responses were transcribed by myself with some difficulty and have been edited to provide some coherence. They included information, not uncovered in the 1990 assessment, about different forms of communication in the hospital ward. For example, that nurses advised "uneducated" patients or relatives and that doctors advised those who were "educated". And that, in the absence of a trained nurse, ancillary staff could take responsibility for managing the wards - an event linked to the shortage of qualified nurses.

Several other focus group interviews took place at certain stages in the SNES project's life. For example six senior nurses from the Directorate of Nursing were in the UK for a study tour in the middle of 1994: this was part of the professional capacity-building function of the project. Their presence also coincided with the appointment to the SNES project of four nurses from the UK's Voluntary Services Overseas (VSO). An opportunity was taken to hold and record a focus group interview with the senior nurses, again at QMC, to establish the nature of nursing care in Bangladesh but this time to also raise the envisaged role of the VSO nurses. Much of the information revealed by the June 1993 focus group interview was confirmed but the seniority of the respondents provided a historical dimension to the care of patients in Bangladesh. Although at the outset the senior nurses stated that hospital-based nurses provided *all* hands-on care, probing very quickly led to a rich description of the reality of care. This is captured in an excerpt of the transcript contained in Annex 4. Again, I facilitated this focus group interview with a colleague familiar with SNES project.

A further focus group interview took place in Bangladesh later in 1994. The purpose of this intervention was to ascertain the feasibility of providing specific resources within the SNES project for the professional development the Public Health Nurses

(PHNs) one of whom was allocated to each of the country's 64 administrative districts. This focus group involved seven of the country's 58 then employed PHNs and complimented a semi-structured questionnaire sent to all the public health nurses during the previous month. This resulted in a 84% response rate and was used alongside other semi-structured interviews held with key informants between 9 and 15 September 1994. The PHN questionnaire and focus group question guide, which included an pyramidal exercise designed to explore consensus and variation in experience among the focus group members, are at Annex 5 and 6 whilst the key informant guide to coding the responses is at Annex 7. The position of key informants with interview notes is at Annex 8. The PHN questionnaire was offered in Bangla and English and I conducted this focus group with a Bangladeshi translator because most of the participants used Bangla entirely in their day-to-day work and were presumed to be less confident in using the English language than Dhaka-based nurses. In fact this was only partially true and all the questionnaires were completed in English.

The outcome of the investigation suggested that donor agencies, even those working in the field of primary health care, and some Bangladeshi informants, had either no knowledge or a very weak knowledge of the role of the PHN. For their part, the PHNs were confident in their role at district level but were unable to fulfill that part of their job description which required them to supervise health centre staff in rural areas because they had no access to transport needed to get them from the district towns to the rural areas. The result of this piece of work was a decision by SNES project advisors not to build any special provision for them into the SNES project because, on the evidence provided, they appeared to be well integrated into the health system at district level and that allowed them to concentrate mainly on essential preventive child health services among the urban population. Apart from this, the SNES project was now underway and already experiencing implementation problems which will be described below.

At other stages of the SNES project, focus groups were used to assess progress following in-service training. For example, in 1998 a focus group discussion was held with senior staff at the Directorate of Nursing to gauge the effect of recent

management training provided through the SNES project. This was accompanied by individual interviews conducted by myself which involved the use of concept mapping to ascertain the most significant gains for individuals working at the DNS: the interviews were recorded. The technique of concept mapping had previously been introduced to the managers as a way of generating and linking various ideas with specific events. Although as originally devised, concept mapping was advocated as a method of generating understanding of science concepts in the primary school (Novak and Gown 1984), it has been used to explore the integration of perceptions, feeling and action across a range of disciplines. It is particularly useful with participants working in English as a second language as it is able to generate perceptions of experience using words or expressions significant to the respondent. These can be used by the researcher as visual triggers that can be followed up, for example, by on the spot observations and interviews with external informants. As mentioned below in Chapter 9, visual tools were used during the DNS training in 1998 and were found to be particularly useful in "unpacking" complicated ideas. The interview schedule and a sample transcript of the recording is at Annex 9.

Towards the end of 1998 concept mapping was also used evaluate the experience the MSc graduates whilst they studied in the UK. The outcome of this particular evaluation is briefly described in Chapter 8. One of the concept maps is at Annex 10a.

In 2003, I visited Bangladesh with the intention of finally concluding my thesis. During this visit I provided a semi-structured questionnaire to 18 nurses who had completed their MSc course at QMC or at another higher education institution in the UK. The purpose was to assess the contribution the MSc award had made to their career and any personal satisfaction gained in the years subsequent to the award. The majority had graduated from QMC and all were working in Dhaka. Subsequent conversations with graduates outside Dhaka suggested that the Dhaka-based graduates could be considered as representative of all MSc nurse graduates in Bangladesh. The questionnaire is at Annex 10 and the response is described in Chapter 10. Some information was also obtained during an informal discussion with a group of eight MSc graduates working at the College of Nursing (CoN) in Dhaka

after they had completed the interview schedule. This confirmed the information provided in the completed questionnaires but added information about the career development of QMC graduates working outside Dhaka, five of whom were working in Saudi Arabia and one in Australia. Further, since 2000 Adelaide University in Australia had offered a distance education MSc in Nursing to 10 CoN graduates nurses each year, thus offering opportunities to qualify for promotion in Bangladesh and/or to work abroad. There had also been a rapid increase in both private nursing and medical schools since the mid-1990s. The latter had implications for the employment of nurses trained in the public sector hospitals and will be expanded upon in later chapters.

In addition to the methods mentioned above, the study involved perusal and analysis of documentary evidence that, in this case, included a wide range of printed material comprising books, journal articles and theses: together these provided an underpinning literature review of salient areas. I have also included some visual material in Annexes 11 and 12. Particular attention has been paid to foreign aid to developing countries generally and more specifically to its application in Bangladesh in recognition of the key role foreign aid played in supporting the SNES project. A historical background to nursing on the Indian Sub-continent is also provided by rather limited resources. A very large part of the document review comprised SNES project reports and other reports and documents, all of which are in the public domain although, at times, difficult to access. As far as possible I also drew on materials produced by members of the nursing profession in Bangladesh and the country's Ministry of Health and Family Welfare. These have been incorporated into the case study the features of which share many of those associated naturalistic enquiry, that is, it makes use of a natural setting and draws on my own and other people's resources for primary and secondary data gathering. Although quantitative data have been used to some extent, it relied mainly on qualitative inputs because of their flexibility and adaptability in what turned out to be a shifting field of enquiry. Although the work began with a somewhat loose research question, the boundaries of the work were not set in advance but rather emerged as the enquiry unfolded. The original question posed was, "to what extent did a particular foreign aid project meet its goal and purpose?" This generated other questions usually in the form of "why"

and "how" asked both by myself, the project managers and the main subjects of the case study. One other point needs to be made in relation to the case study method: Robson also points out (p160)

> ... A case study is not a survey, where reliability relies crucially on the characteristics of the data collection instruments. The case study relies on the trustworthiness of the human instrument (the researcher) rather than on the data collection techniques per se.

He refers to Miles and Huberman's (1984) observation that the researcher needs to be familiar with the phenomenon and setting being studied whereas other characteristics of the case study researcher include "....doggedness, the ability to draw people out and the ability to ward off premature closure" (p46). To this extent I believe I fulfilled the criteria suggested by Miles and Huberman mainly because of the rapport I had established with participants in the SNES project over a long period of time and because of my familiarity with the project environment.

One of the alleged drawbacks of case studies is that, because of their individualistic nature, it is difficult to generalise from them. However as Donmoyer (2000) and Schofield (2000) suggest this is not necessarily so where a collection of single case studies examining the same phenomenon is concerned. Indeed, over many years, case studies have informed important areas of state policy in areas such as education, community health and social services. Early examples include Jackson and Marsden's (1962) study of working class boys in the grammar school system and Robb's (1967) study of the care of elderly people in hospital. There are now a large number of case studies, more usually described as "accounts" of interventions that have involved the application of foreign aid and associated technical assistance to developing countries. These include specific interventions in Bangladesh (Sanyal 1991, Rounaq 2003). A common thread running through most of the studies is the problem of lack of sustainability once foreign aid is withdrawn which, in turn, is often attributed to a faulty project design compounded by insufficient involvement of the beneficiaries as primary stakeholders. Another theme is the hidden agenda of foreign aided projects, for example the role of commercial investment and support for their own institutions by the donor countries (Sogge 2002). These observations will be expanded upon in Chapters 5 and 6.

As suggested above, case studies normally include participation in the "case" by the author of the study. This creates a potential drawback, especially where the author has been an active participant in activities or interventions captured in case study. In this case I was heavily involved in the SNES project over several years from the authorship of the original assessment of the nursing profession in Bangladesh in 1990 to having a leading part in the project's subsequent implementation. However, I believe personal bias has been avoided by the nature of the project. This was a "process" project that depended on much sharing and exchange of information at frequent intervals and a critical and responsive attitude to both the primary stakeholders, the nurses of Bangladesh, and to my professional colleagues. Throughout the study, I have discussed and shared my findings with people working in the same field, including donor representatives and external evaluators and have often incorporated their suggestions and opinions into my account.

This case study has taken several years to complete and has been episodic. I believe this may have added rather than detracted from the work in that it has allowed a consideration of long term policy changes and a more active acquaintance with the Bangladeshi nurses over a longer period than was originally envisaged. This has resulted in a more optimistic outcome than would have been the case if the study had been completed within two or three years. I became interested in the subject precisely because of my familiarity with it and the setting within which the case study developed. However putting flesh on the bones of the study only became possible as time went by. As with Geertz (1973) in relation to his own work over many years, much more was discovered after the original event. I believed this has enriched the study rather than detracted from it.

Quite apart from the problems of development projects generally, the SNES project in particular suffered from a lack of cultural awareness or misinterpretation among its designers and implementers. Here I am using the term "culture" as described by Geertz (1973) as a system of signs and symbols. Unlike Geertz however I believe that, in the case of the SNES project, these signs and symbols can be causally attributed to behaviours and institutions found

within the project environment. In this sense "culture" is the context within which the signs and symbols associated with the project can be discerned. However, and importantly, Geertz points out that interpretations of "cultures" by outsiders can only ever be of a second or third order, the first order interpretation belonging to those who are the subjects of the interpretative exercise. This thesis therefore takes a humble approach to its subject matter, content to acknowledge it will not be the last word. The thesis deals loosely with "cultures" and again I borrow from Geertz who in turn drew on Weber's concept of humans as "animals suspended in webs of significance they have spun for themselves". As Geertz regards culture to be those webs, he sees any analysis of culture to be not an "experimental science in search of law but an interpretative one in search of meaning" (p5). This thesis uses the "webs of significance" belonging to several different cultures and attempts a description of the linkages between them. The cultures include agencies which govern the transfer of foreign aid from developed to developing countries, institutional cultures such as those embodied in UK higher education, and the culture of the beneficiaries for whom the project was ostensibly created. When the project was being designed less was known about the cultural setting in which it would be located. This was learned later, sometimes much later. As Geertz (1973) again observes:

> ...our knowledge of culture...grows in spurts. Rather than following a rising curve of cumulative findings, cultural analysis breaks up into a disconnected yet coherent sequence of bolder and bolder sorties. Studies do build on other studies, not in the sense that they take up where others leave off, but in the sense that, better informed and better conceptualised, they plunge more deeply into the same things (p25).

Nothing could be more true of the foreign-aided project culture. This work is therefore about the process of interpreting cultures and their associated signs and symbols some time after an intervention that was designed to influence them. It takes the form of what Geertz calls a "thick description". It triangulates the somewhat disparate elements that go to make up a project, namely, aid policy, the stakeholders' perspectives and the infrastructure within which the project was set. It concludes that although at the outset the nurses in Bangladesh were identified as the primary stakeholders, and there have been some sustainable gains to individual nurses, the major benefits in terms of income and kudos went

to the UK institutions charged with the management of the project.

The purpose of this case study is to illustrate the pitfalls of designing and implementing aid projects in unstable and poorly understood environments. It may serve as an object lesson for foreign aid projects in general and for those involving technical assistance in particular.

Background to the Project

The Bangladesh project *Strengthening Nurse Education and Services* (SNES) was first conceived in 1990 as a result of a wide-ranging assessment of nursing provision within in the public sector health service of the Government of Bangladesh (GoB). Although there were grounds for optimism, the overall findings suggested a demoralised profession largely neglected by its overseer, the MoHFW. Very poor levels of nursing care were compounded by low standards of nurse education and training, chronic under-funding, and an over-stretched and barely functioning professional and legal support system. In terms of trained nurses to population ratio, Bangladesh compared very poorly with other countries both globally and within the South Asian region. The 1990 assessment and a proposal for donor-funded assistance were well received by the UK's Overseas Development Administration (ODA)[1] and fitted its own overall mission *"to improve the quality of life of people in poor countries by contributing to sustainable development and reducing poverty and suffering".* A key strand in this policy was to *"help people achieve better education and health and widen opportunities - particularly for women"* (ODA 1995). To this end, the project fitted comfortably by providing for enhanced professional education focused on health and by its concern with widening opportunities for women who formed 95% of the nursing workforce in 1990.

The project was designed to cover all the aspects of the nursing profession mentioned above: their education and training, the professional and legal framework within which they functioned, the issue of under-staffing, and their relationship with

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[1] ODA was renamed Department for International Development in 1997

the MoHFW. The *goal* of the project was to reduce preventable morbidity and mortality among patients needing hospital care. The *purpose* of the project was, simply, to improve the delivery of nursing care. There was some quantitative baseline data with which to measure progress in relation to recruitment, curriculum and deployment of the nurses but very little qualitative data with which to assess progress towards the *goal* and little was produced throughout the life of the project. Although it was envisaged that the purpose of the project would be measured against a 25% improvement in six quality indicators developed by a nursing audit system, the indicators never materialised. The only other indicator of project achievement was that all vacant nursing posts classified as "matched to need" would be filled by the end of the five years by the MoHFW. However "need" was not defined so that the usefulness of this indicator was doubtful. The total cost of the project was estimated at £7.85 million in 1990 to which ODA would contribute £4.4 million with £2.1 million from International Development Assistance (IDA), the soft loan arm of the World Bank. A contribution would be provided by WHO to cover study tours for senior nurses and the cost of several nurses to study for an MSc in Thailand. The Bangladesh government would also contribute £0.5 million with close to £1 million being transferred from earlier but uncompleted nursing projects to cover various areas of curriculum development. The financing of the project should be seen in the context of the country's overall health sector budget of which it formed only a small part: over the period 1992 to 1996 GoB was planning to spend US$1.5 billion on health and family planning. It should also been seen in the context of public expenditure on health which had traditionally been low in Bangladesh. In the period 1990 to 1997 this sector represented only 1.2% of GDP whereas for European countries over the same period the figure was around 6 – 7%.

The overall professional management would be handled by the Nursing Advisor at the British Council headquarters in Manchester whilst the British Council in Bangladesh would undertake the local management of ODA's technical assistance.

It usually takes two to three years to get a donor-assisted project from its initial conception to implementation. During this period there is normally a period of

learning by both the donors and the project beneficiaries together with other stakeholders. So it was with the SNES project. Key institutions and personnel to manage the project had to be identified and the project needed a formal appraisal of financial feasibility and technical soundness. The project then had to go out to tender and invitations to bid for the work had to be sent out to institutions pre-selected by the donor. The institutions, in turn, were required to demonstrate their understanding of the project, their mode of implementation and the resources available to them.

The original proposal called for in-country technical assistance in the form of a well-qualified expatriate nurse educator and a project co-ordinator with good management experience. They were to be backed up by a number of trained nurses recruited by the UK's Voluntary Service Overseas. Recognising that the WHO had had long-term nursing advisors in Bangladesh since the pre-independence 1950s it was envisaged that the WHO would also provide technical assistance through its own advisors. All this assistance would be supported by a UK higher education institution with a strong background in nurse education and good links to organisations dealing with the legal and professional framework of nurses in the UK. Although the institution had not been formally identified in the original 1990 proposal there was a tacit understanding that the institution employing the assessor and the team leader of the subsequent project appraisal exercise would be considered when the time came for putting the project out to tender.

As part of the technical assistance, it was planned to support both the Bangladesh Nursing Council (BNC) and the Directorate of Nursing Services (DNS) through strengthening their capacity to improve the position of the nursing profession. IDA would undertake extensive rehabilitation of the College of Nursing in Dhaka. Twenty Nursing Institutes (NIs) used as schools of nursing would also be renovated and once completed they would each be provided with textbooks and a trained library assistant. Additionally IDA would fund the building of least four continuing education centres for nurses outside Dhaka, a centre for training in rural health and the renovation and re-equipping of around 100 *Upazilla* health

centres (UHCs)[2] which comprised a quarter of the country's total stock of UHCs.

As to training, the project would provide a series of professional study tours for eight of the senior-most nurses at the CoN, the BNC and the DNS and would provide funds to allow twenty nurses to study in the UK over two years for both a Diploma in Advanced Nursing and a Masters degree in International Health. Another 50 nurses would attend management courses in the UK. Training within Bangladesh would be provided for 125 nurse educators, some of whom would work at the refurbished NIs, and 125 nurse managers who would work as supervisors, also at the refurbished UHCs. The salaries of both the 125 educators and the 125 managers would be funded by the project. After the project closed the Bangladesh civil service would absorb them.

After a series of false starts the ODA contract was eventually awarded to a partnership of the British Council, as senior partner, and Queen Margaret College (QMC) in Edinburgh. The former would manage the project on behalf of ODA, that is, handle the contracts of Dhaka-based project staff and any UK-based consultants, the project budget, travel and procurement needs. The College would manage all the training and education aspects of the project and provide the majority of consultants. The project was inaugurated in Dhaka in late 1993. By the time the project got underway there were numerous stakeholders with the primary stakeholders or beneficiaries being identified as the nursing profession in Bangladesh. Secondary stakeholders included the British Council, QMC and the MoHFW.

During the first two years, the SNES project was dogged with frequent changes of civil servants at the MoHFW including those with overall responsibility for the Directorate of Nursing. The *Director* of Nursing also changed several times. The WHO advisor left and was only replaced after a long delay and the original British expatriate staff departed the project earlier than anticipated. VSO nurses were gradually appointed but there were also early resignations among them. The

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[2] An Upazilla is a local government sub-district serving a population of between one and three million. The health centres have facilities for outpatient care and 36 beds for inpatient care. The UHCs are often referred to as Thana Health Centres (THCs). A Thana is a police district.

working relationships among the Dhaka-based expatriate project staff, their colleagues at the British Council, local stakeholders and with the WHO nursing advisor were also strained during the early years of the project. This is not unusual in projects that bring different cultures together and especially where a deliberate and sustained effort at team building is not undertaken at the outset. As Morris (1991) points out, culture clash within projects arise not only among foreign 'experts' and local people but also between local interests and different groups of expatriates at the same time. Hofstede (2001) and Rigby (1986) also regard multinational team-working as a challenge whilst providing some useful guidelines on conflict resolution and team development. In its day-to-day working, the project also had to contend with regular periods of political turbulence that resulted in frequent nation-wide general strikes or *hartals* among public sector workers. These kept people off the streets for days on end and compromised any travel both within and outside Dhaka. They also made communications among the various stakeholders particularly difficult. In summary, the SNES project was launched and implemented in an unstable environment during which time most stakeholders experienced a steep and sometimes traumatic learning curve.

The SNES project was one of 66 sub-components of Bangladesh's 4th five-year Health and Population Programme funded by a consortium of 10 international donors during the 5 years 1992 - 1997. One of these sub-components, a project entitled Further Improvement in Medical Colleges (FIMC) closely mirrored the SNES project. The primary stakeholders in this project were doctors teaching in one or another of the country's eight medical schools. The FIMC project was also to be managed by the British Council with the University of Dundee being responsible for the education and training aspects of the project. Both the SNES and the FIMC projects fitted the human resource development goal of Bangladesh's 1992 - 1997 plan and, as mentioned above, the SNES project reflected ODA's aid mandate to specifically further the development of women in Bangladesh. The FIMC project was more limited in design but its goal and objectives were similar, nevertheless there was little in the way of joint development between the two projects although they shared the same office

building in Dhaka, had students in Scotland at the same time and were within an hour's travel of each other. This in itself is a symptom of the isolation often brought about by the "projectization" of human and institutional development and will be explored more fully in later chapters.

Over the next five years there continued to be changes among key staff associated with the SNES project within Bangladesh and in the UK. However it eventually stabilised and several key components of the project got underway. These included the masters degree-level training in the UK for selected Bangladeshi nurses, study tours in South Asia and the UK for the country's senior-most nurses, and a series of UK-based certificate courses for middle-level nurse managers and educators. The basic nurse curriculum had already been re-designed by WHO advisors. In addition, although much later, the degree-level curriculum at the College of Nursing was re-designed by the SNES project to incorporate interactive teaching and learning methods with a thoroughly up-dated content. At the same time, consultants assisted the Bangladesh Nursing Council to strengthen their legal role in managing the regulation of the nursing profession in Bangladesh and some specific support was given to management strengthening at the Directorate of Nursing Services. As mentioned above, almost all the project activities were managed on a consultancy basis by Queen Margaret College in Edinburgh and the British Council. Overleaf I have set out the main components of the SNES project.

Table 1.1 Main components of Strengthening Nurse Education and Services Project

Location	Capital Expenditure	Technical Assistance	Training
Upazila Health Centres	Refurbishment and re-equipping of 100 UHCs	Recruitment and appointment of 125 nurse supervisors after in-service training.	In-service training via consultancies
Hospitals/NIs/Basic Training	Refurbishment and equipping of 20 NIs Building and equipping of two Rural Training Centres	Recruitment and appointment of 125 nurse educators after in-service training	In-service training via consultancies Train 20 Asst. librarians in-country via British Council Appointment of 8 VSO nurses to set up demonstration units for students' clinical training
College of Nursing	Building extension and refurbishment of library, dormitories, kitchens etc. Provision of up-to-date text books and regular journals	Assistance with curricula development and interactive methods of teaching and learning.	In-service training Professional education for Principal via Study Tours UK and South Asia In-service training Training librarian UK or in-country
Directorate of Nursing Services	Refurbishment and enlargement of premises	Development of MIS Management training Assistance with policy and planning for their own sub-sector and contribution to the wider health sector	In-service training. Professional education for senior nurses via Study Tours UK and South Asia
Bangladesh Nursing Council	Refurbishment of premises	Assistance with drafting of legal powers (Nurses Act) and strengthening of other responsibilities for accreditation of NIs, management and surveillance of examination system and registration of practitioners	Professional education for Registrar and deputy via study tours UK and South Asia. Consultancy support from British Council and QMC
Continuing Education	Building and equipping of 4 Continuing Education Centres		
Basic Nurse Education	Building and equipping a Rural Training Centre		
Postgraduate training		Assistance to lift professional and academic level of 20 selected graduates nurses	Diploma in Advanced Nursing & MSc International Health at QMC

This thesis will explore the strengths and weaknesses of development projects recognising that project activities are notoriously difficult to sustain once donor funds are withdrawn. There are many reasons for this but the main problem is their status as "discrete particles of development" largely unconnected to other elements in a country's infrastructure (Rondenelli 1993). Since the early '90s

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when the SNES project was conceived, donors have had to re-think their approach to development. Briefly, there has been a move away from "projectised" assistance to a "programme aid". This takes bilateral aid agencies, such as the UK's Department for International Development (DfID), some way back to the situation that existed in the 70's and early 80's when donors worked more closely with national and local governments. At that time interventions were designed as broader and more inclusive programmes rather than being implemented through isolated projects in which national and local government involvement is frequently limited to a tacit agreement that the national government will co-operate with donors in a closely defined area and, usually, through a single ministry or government department. More recently a "Sector Wide Approach" (SWAp) to development has been proposed by various donors. In this case a whole sector, such as health, education or agriculture is examined to ensure a best fit for aid interventions to avoid overlap and isolation and to create a more integrated sectoral development. Even more recently, "budget support" has become the aid mantra described as "a new way of doing business for aid donors" (Booth 2003). Here, the donors will support the budgets of developing countries, leaving them free to set their own development agenda provided they pursue the World Bank and International Monetary Fund's Poverty Reduction Strategy (see Glossary at Annex 2). The proviso is however a severe curb on the independence of many developing countries wishing to pursue their development on their own terms.

I will go on now with an analysis of the situation of the primary and other major stakeholders and remind the reader of the point made above, that most of the project learning occurred after the project design was implemented and often quite late in the project's life. Chapter 2 begins with an account of political and social factors in Bangladesh and Chapter 3 provides a historical background to nursing on the Indian Sub-continent prior to independence and partition in 1948. A more recent account of nursing in Bangladesh is provided in Chapter 4.

In Chapter 5 I examine the role of foreign aid first globally and then in Chapter 6 more specifically its application to Bangladesh. Chapters 7, 8 and 9 deal with the

implementation of the project. The SNES project closed in 1998 but I have visited Bangladesh subsequently and have provided a post-script in Chapter 10. The conclusion at Chapter 11 suggests ways in which another researcher might wish to approach the study.

CHAPTER 2

BANGLADESH: POLITICAL BACKGROUND

Historical factors in the development of Bangladesh account for various elements in this case study as explained below. The country is a creature of the 1947 partition of India that created Pakistan as a Moslem state and then divided Pakistan into the two wings of East and West Pakistan 1000 miles apart (see Map at frontispiece i). Generally regarded as being politically and economically neglected by the larger and wealthier West Pakistan, East Pakistan was however distinctive in terms of its own language, Bengali rather than Urdu or Punjabi, a rich culture in terms of literature and poetry, and a more liberal orientation towards Islam. In November 1970, a cyclone with ensuing floods and famine created a major humanitarian disaster to which West Pakistan was slow to respond and which strengthened the perception of East Pakistan as being neglected by the West. This, combined with the success of the leader of East Pakistan's Awami League, Sheikh Mujibur Rahman, in the 1970 national elections, and West Pakistan's rejection of the results, pushed the East towards a declaration of independence in early 1971. A nine-month civil war with West Pakistan followed that was marked by much violence including the killing of many Bengali university students and intellectuals. Violence against women, in particular, was widespread and included torture and an estimated 200,000 rape victims (Waylen 1996). In similar communities, women who are sexually violated are usually cast out by their families along with any children conceived as a result of rape. So it was in Bangladesh: a powerful illustration of the inter-relationship between violence, gender and culture as thousands of destitute women were ejected from their villages. The civil war also created 10 million refugees who on return from India found their houses burned to the ground and their livestock slaughtered. These events together with the destruction of many public buildings, including schools and health facilities, added greatly to problems in the post-war period. However, more positively, they also created some of the strongest home-grown, non-governmental organisations in the world and which have continued to assume responsibility for the health and welfare of some of Bangladesh's poorest people (Chen 1985).

Assisted by India, the East finally gained independence from Pakistan and emerged as Bangladesh in December 1971. It immediately inherited an international debt of US$ 500 million, minuscule by today's standards, but on almost every socio-economic indicator it was one of the poorest countries in the world. Independence brought other problems for the new state. The killing of intellectuals and the withdrawal of West Pakistani senior civil servants and professionals from the East meant that the new country was left with a minimum of people experienced in government and administration. Most Bengali civil servants were based in the Pakistani capital of Islamabad and at the outset of the war were either gaoled or put under house arrest. Many did not return to Bangladesh until 1973 or as late as 1974. This slowed down the development of Bangladesh in its early years but when it eventually established itself, contemporary observers suggest that the newly created Bangladesh civil service was highly susceptible to political corruption (Mukherjee *et al* 2001). The Awami League politicians demanded preferential treatment for themselves and their families in the competition for government positions and access to a lucrative means of profit through the allocation of import licenses. Further, although Mujibur Rahman was elected prime minister in March 1973 on the promise of multi-party democracy, in December 1974 he suspended Bangladeshi constitutional rights and banned all political parties other than the Awami League (Nyrop *et al* 1975).

In August 1975, Sheikh Mujibur Rahman was assassinated in a military coup that opened up many years of coup and counter-coup, political assassinations, corruption and endemic political factionalism. During the first 15 years if its independence it was ruled by various authoritarian regimes linked to the military or economically and politically elite families but during the '90s Bangladesh achieved a measure of democratic government. By this time, administratively and geographically, the country was composed of four divisions[3] and 64 districts and retained much of its British colonial structure with continuous reliance on district commissioners and civil surgeons as part of a very large civil service to which, as

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[3] Recently increased to six divisions.

indicated above, most government health workers belong. Similarly, Bangladesh inherited a health service structure from its colonial period during which time, as East Bengal, her major hospitals were built and to which were attached the country's medical schools. However, even after the free parliamentary election of 1991, the system of favoured provision for those with access to power and authority continues in Bangladesh and permeates its institutions, most especially the civil service which includes the bulk of health care providers. For many nurses, doctors and other civil servants, special pleading for particular appointments to those with influence is systemic. Posts in Dhaka or other cities that are relatively well provided with educational and health facilities and civil service housing are vigorously pursued. One of the results of this is that the majority of nurses in Bangladesh are concentrated in urban areas and in hospitals rather than in the community. There are other geographic and social variables that have shaped Bangladesh's recent history and explain some of the tensions governing it. These are explored below.

Geographic and Social Characteristics of Bangladesh

Geographically, the country is situated around the largest delta in the world, a factor that makes it prone to natural disasters. Within four years of independence the country suffered another cyclone, which killed a quarter million people and permanently maimed thousands more. It continues to suffer environmental catastrophes that most years rob thousands of its families of their homes and livelihoods and contribute to the chronic poverty of millions of its citizens. Notwithstanding its periodic misfortunes, for most if its history Bangladesh has experienced rapid population growth: its present population is 140 million resulting in an estimated 1042 people per square kilometre of land area (World Bank 2002)[4]. Apart from the island states of Singapore and Hong Kong, this makes it the most densely populated country in the world. Population growth combined with a culture that allows deeply established discrimination against females has had significant implications for the health of its people. At the time the project was being designed in 1900/92, 850 women died in childbirth for

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[4] For comparison, the UK has a population of 59 million and a population land density of 244

every 100,000 children born alive making the maternal death rate one of the highest in the world. With regard to child deaths, in 1992 an estimated 108 died annually under the age of one. For every 1000 children born alive several hundred more, using the same denominator, died before the age of five. On these three measures of human development Bangladesh was worse than Pakistan and neighbouring India. However, in all three countries deaths among children at all ages was, and remains, higher among girls than boys, a reversal of the situation in the rest of world including other, even poorer, developing countries (UNICEF 1998). This is widely regarded as an outcome of discrimination against Bangladeshi and other South Asian girl children in terms of their long-standing failure to access health care and adequate nutrition (Jahan 1995). Another aspect of this difference is suggested by data that shows that over a very long period and at all levels of the school system female pupils were and remain in the minority (DfID 2002)

Although international donors have invested much research and project activity in identifying and dealing with gender inequities, the country's UN-defined Gender Development Index (GDI) of 0.459 ranks Bangladesh only 121 on a range of 1 (Norway with a GDI of 0.937) to 148 (Niger with a GDI of 0.260). This and other indicators of human development put Bangladesh behind other South Asian countries including Nepal, Pakistan and India as shown in Table 2.1 overleaf. Note that the composite Human Development Index (HDI) is again the lowest in the region.

India's population is 1,048,000,000 (over one billion) with a population density of 353

Table 2.1 South Asia Human Development Indicators

Country	GDI value in 2000	HID value 2000	Life expectancy at birth in 2000	% Adult literacy in 2000	Combined Primary/ secondary/ tertiary ratio female (%) 1999
Bangladesh	0.459	0.478	59.4	41.3	37
Bhutan	N.A.	0.494	62.0	47.0	33
India	0.560	0.577	63.3	57.2	55
Iran	0.703	0.721	68.9	76.3	73
Maldives	0.739	0.743	66.5	96.7	77
Nepal	0.470	0.490	58.6	41.8	60
Pakistan	0.468	0.499	60.0	43.2	40
Sri Lanka	0.737	0.741	72.1	91.6	70
UK	0.920	0.930	77.2	NA	NA

Source: UNDP 2001/2002

Some donors underplay gender discrimination as a major factor in the persistent poverty and slow development of Bangladesh and undoubtedly there are other reasons, however one long-standing donor to Bangladesh, the UK's DfID, stated in its Country Assistance Plan for 2003 - 2006 that:

> *Gender inequality is a constant constraint to poverty reduction. Girl child mortality in under-fives is one third higher than that for boys, and the gap between male and female severe malnutrition has risen from 19% to 26% (1996-99). The quality of girls' and boys' primary education is low, and the experience and outcomes of education for girls is particularly poor. Households dependent on female earners have a higher incidence of poverty than those dependent on male earners. 45% of mothers are malnourished. Maternal mortality remains stubbornly high at 400 per 100,000 births. As a result, Bangladesh is currently not on track to meet the maternal mortality MDG.* [5]
> Source: DfID 2003 p4

Whereas gender is crucial in explaining the weak position of nursing in Bangladesh, foreign aid donors have also contributed to its frailty through a diversity of health interventions which have fragmented the health system and impacted most severely on the health of women and children. I will return to this

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[5] Millennium Development Goals: see Glossary at Annex 2 and Annex 15

issue later but first want to examine other characteristics that have also had an important bearing on nursing development and the SNES project.

As suggested above, unbalanced access to education has resulted in a wide literacy differential between men and women. As the project was being drawn up, the country had a combined male and female adult literacy rate of only 32.4%.[6] However the adult female literacy rate at this time was a mere 17%. The implementations of the IMF structural adjustment policies from the early 'eighties did not help by insisting on the household payment of education fees at all levels. This exacerbated the disparity between boys and girls from 1988 onward (ODA 1995). By the mid-nineties there were 34% more boys than girls enrolled at primary level, 70% more at secondary level and 128% more at tertiary level (UNICEF 1998). As seen in Table 2.1 above, females remain disadvantaged.

The implications of the situation outlined above were not fully understood at the time the project was being designed but it meant that the educational level of most young women coming into nursing, normally at the age of 16, was going to be low when measured against their learning requirements. This was particularly so given the insistence by senior nurses in Bangladesh that English be used as the teaching and learning medium in nurse education and training. The students coming into nursing were from a system where pupils were almost all schooled in Bengali and from an educational system that was, and remains, grossly under-resourced. It also meant that young women completing their education through to 16 were a very small proportion of all young women and this affected the recruitment of nurses by limiting selection choice. For most of the period after independence, as in pre-independence India, girls in school in Bangladesh either came from ethnic, Hindu and Christian minorities or were from a few elite Moslem families. Finally it meant that women entering nursing, unlike medicine, were also likely to be from minority groups, which together accounted for only a steady 10% of the population in Bangladesh. This made a positive regard of the profession by the majority population difficult to achieve. Although in the late

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[6] Adult literacy in this context is defined as the ability to read and write a simple letter.

'80s men were recruited into nursing, they accounted for only around 5% of the total in 1990[7] this proportion rose to 10% later in the '90s: although they were no better qualified than female nurses, they were eventually over-represented among the Bangladesh nurses receiving awards for study in the UK thus reflecting their gender power in securing a favourable decision. I will now step back and analyse the features of nursing in Bangladesh as mediated through its history as a pre-partition province of India.

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[7] Unlike several Islamic countries and regions where men dominate the nursing profession e.g. in the Middle East, Palestine and the northern states of Nigeria.

CHAPTER 3

BACKGROUND TO NURSING ON THE INDIAN SUB-CONTINENT

This chapter raises some of the cultural and historical variables out of which the SNES project developed. It focuses especially on the environment in which nursing grew and which may account for some of the constraints it has faced in the past and continues to face today.

Islam and Hinduism are the dominant religions of South Asia although Buddhism flourished for several hundred years between 500 BC and 300 AD and remains the majority religion in Sri Lanka. I shall attempt to show that although there are differences between Hinduism and Islamic belief systems; "pollution avoidance"[8] is a characteristic of both belief systems. As suggested above, among a range of cultural variables, gender has also had significant influence on the health and welfare of women and girls in Bangladesh and this has interacted with pollution avoidance to create a set of circumstances which gives nursing in this part of the world a unique character. And it is because nursing remains, mainly, a female profession that I believe gender when combined with notions of pollution has had a negative influence on the authority nurses have been able to wield in developing their own profession.

It is a mistake to assume that there is a universal pattern to the development of modern nursing. Whilst organisations such as the Geneva-based International Council of Nursing has achieved an almost world-wide coverage of affiliated national associations to promote and monitor nursing standards, there is a wide diversity in the way nursing is practiced and the route people take to enter the profession. In most of the world, people train as a nurse primarily for economic reasons rather than solely out of a sense of vocation. Although the importance of vocation was stressed by Nightingale and is revered as a principle almost universally in the west, it has little relevance in many of the world's poorer countries, although lip service is often paid to it. This is a point often missed by those designing health projects for developing countries which include a nursing

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[8] "Pollution" in this context includes bodily excrements - faeces and urine - and includes menstrual

component. For example, the way in which nursing developed in parts of South Asia had a strong bearing on the eventual implementation and sustainability of the SNES project. This was recognised in the 1990 assessment but not taken fully into account in the design of the project. For this reason, a brief overview is provided of the development of nursing in India, and what was eventually to become Bangladesh.

From around 1500 BC, the practice of treating the sick was based largely on Hindu mythology involving animist beliefs and exorcising harmful spirits. At about 700 BC the practice of caring for the sick passed to the Hindu Brahmin caste. This caste was revered as scholars and priests and became principally associated with the development of the *Ayurvedic* system of ancient medicine which incorporated both curative and preventive elements. The former included surgery in most of the specialisms we recognise today in allopathic or western medicine as ophthalmology, plastic surgery, and neurosurgery, details of which are preserved in treatises on Ayurvedic medicine such as the *Samhita*. Preventive measures such as inoculation against smallpox were combined with strict dietary rules and various forms of deity worship (Wilkinson 1958). The practice of Ayurvedic medicine continues today throughout India and within the Hindu Diaspora where it is often used alongside allopathic medicine (Armstrong and Robson 2003). Today medical schools to train doctors in one or another system exist throughout India. But more specifically, the origin of nursing in India can be found in the construction of *"halls of healing"* and in ancient definitions of the various types of carer. Chapter 9 of the *Charaka-Samhita,* for example, defines the four characteristics of an attending nurse as a combination of technical skill and attitude:

> *knowledge of the manner in which drugs should be prepared or compounded for administration, cleverness, devotedness to the patient waited on and purity (in mind and body).*

> Translation of the Charaka-Samhita Vol. 1 in Indian Medical Review 1935 p 169 and quoted by Wilkinson (1958).

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blood, birth products such as the placenta or afterbirth, and suppurating or necrotic soft tissue

Wilkinson (1958) and Somagee (1991) identify the later period 500 BC to 300 AD as associated with the rise and development of Buddhism in South Asia. During this very early period a public health system was built up which included hospitals and medical schools to nurse the sick and train physicians, all reflecting the Buddhist principle of responsibility for the collective public health of their citizens. At that time, those we recognise as nurses today were described in ancient texts as "physicians assistants" with well defined characteristics very similar to those identified above in the Charaka-Samihita. All this changed with the decline of Buddhism and the eventual resurgence of Hinduism around 800 AD. This brought with it an extraordinary emphasis on the norms of hierarchy and a strict conformity to pollution avoidance most clearly manifest in the caste system. This put physicians and their assistants, traditional healers and midwives within a rigid framework of what could and could not be physically touched with respect to the body and, especially, its birth products and highly polluting excrements. Somgee (1991) suggests this created a setback to the development of care by those who had nursed the sick as part of a civic and collective responsibility.

As the Buddhist public health system began to fade and hospitals closed, tasks that would have been carried out by a single nurse or assistant had to be allotted among others as specific caste functions. Given the polluting nature of many of the tasks, this made caring for the sick an occupation only for lower castes and Harijans or "untouchables". Care of the sick was now transferred to the family and managed through hiring helpers who were already associated with pollution in its many forms. Care was also split along gender lines as various service castes emerged, for example as lower caste male barbers, male and female masseurs, sweepers[9] and low caste female *dais* and *ayahs* The latter confined respectively to midwifery and to child care. The Mugal invasion from the north around AD 1000 added to the decline of the Buddhist system of public health. From this time until the late 19th century, in both Hindu and Islamic communities, men attended to men and women attended women. For most of India's history, women's access

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[9] Originally drawn from the "untouchables" but still survive in non-Hindu Bangladesh to handle the disposal of polluting elements and more generally manage "dirty work".

to male doctors was forbidden and the higher the caste and the more elite the Moslem families, the more insulated women were from medical care by men. This was eventually modified as India was again opened to external influences through trade and colonialism.

The effect of colonialism

The effects of the changes described above were long lasting and it was not until the re-emergence of public health alongside colonialism in the 19th century that some opportunity to transcend the barriers of religion, caste and gender in caring for the sick emerged. The need to staff re-established public hospitals and an increasing number of facilities founded by foreign medical missions, created a demand for the type of trained nurses already being produced in Britain in response to the Nightingale reforms. Before the close of the 19th century, both the management of nursing and the training curricula being used in India reflected the contemporary position of nursing in Britain. However, pollution prohibition remained very strong. For this reason, higher caste Hindu women on the one hand and Moslem women within a purdah system on the other were unable to enter nursing. Instead, nurse training and nursing work, usually in civilian and missionary hospitals, drew on Christian women, often converted by missionaries from among the Harijan, tribal minorities, Parsee[10], and Anglo-Indian women. From the middle of the 19th century the religious missions also provided nurse training and employment for a large pool of abandoned women and young orphans. Thus in India, hospital nursing became associated with women who were socially marginal although this was mitigated, to some extent, by the steady import of trained British nurses brought in by the colonial administration and the missionaries as matrons, ward sisters and nurse tutors for both civilian and military hospitals.

As with the Nightingale "ladies" the British nurses in India did not provide "hands on" nursing care but managed and supervised care through ward orderlies and, yet again, relatives and helpers drawn from the lower castes and other minority groups. This model of providing institutional nursing care through

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[10] A minority population of Persian origin and followers of the disciples of Zoroaster

others came to the Indian sub-continent regardless of any pollution concerns. But it eventually made entry into nursing easier for Moslem and higher caste Hindu women because even as student nurses they could distance themselves from the body of a sick person and its polluting elements through the use of various low status attendants. However, in spite of this physical distancing, the common perception that a nurse could not possibly be of a high caste or from an elite family continued to hold sway and did not really change until well after India's independence in 1947. However, as Somgee (1991) points out, pollution avoidance did not apply to doctors who fitted into the ancient mould of Brahminical teaching and healing, whether or not they were of the Brahmin caste. Thus although the introduction of allopathic medicine brought with it diagnostic requirements that called for detailed examination of a patient's body, including their orifices, physicians were regarded as socially distanced enough to have a kind of *"non-stick, non-polluting armour surrounding them"* (Somgee 1991 p38). Doctors were seen as part of a noble profession in the Brahmin tradition whereas nurses were regarded as coming from a stigmatised and socially marginalised section of the population.

At independence, India, including that part that was to become East Pakistan, and eventually Bangladesh, had a hospital sector staffed with nurses drawn almost entirely from minority groups: 90% were Christian and 80% had trained in missionary hospitals (Fitzgerald 1997). Some of these nurses were fully trained over three or four years and titled "senior" nurses but many more had a shorter training of around two years and were titled "assistant" or "junior" nurses. The latter were drawn from less educated minority women and some men. Somgee points out that even as late as 1975, 65% of the fully trained and registered nurses in India was Christian although the country was predominantly Hindu and still had a sizable Moslem minority. Government reports and those to the Missions' parent bodies suggested that the training of student nurses was founded on the "Nightingale model" but in both missionary and public hospitals close personal care continued to be carried out only by low status helpers. This was an important factor in the reluctance of government to fund a sizable increase in nurse training for the public sector. Why train nurses for three or four years when the bulk of

nursing work could be done by low paid subordinates and unpaid relatives? All that was required was a small but steady stream of student nurses who would eventually be trained to a level where they could competently oversee the management of patient care by others. In terms of qualified nurse to population ratios, doctors far outnumbered nurses just before India's independence as seen in Table 3.1 below. In relative terms this situation remains unchanged in Bangladesh today.

Table 3.1 Health Personnel India: Provider - Population Ratio India and UK in 1946

Health Personnel	Provider: Population	
	India	UK
Doctor	1:6300	1:1000
Nurse	1:43,000	1:300
Health Visitor	1:400,000	1:4770
Midwife	1:60,000	1:618

Source: Jeffery R (1985)

In a bid to improve their own status the nurses moved towards professionalisation and pursued a path similar to that of Britain at the beginning of the 20th century (Abel Smith 1980). They formalised and standardised training, set up legal mechanisms to regulate entrance into the occupation and instituted other methods for controlling and disciplining their practitioners. This was done mainly through the importation of legal machinery modelled on Britain's General Nursing Council so that from the early 1920's an Indian Nursing Council was functioning. After partition, a Pakistan Nursing Council was established and, almost three decades later, similar machinery, albeit weak, was in place for Bangladesh.

In 19th century Britain, Nightingale and her reformers had argued that women should take up hospital nursing because the tasks involved were identical to those, which women already performed in the home and because the caring qualities required of nursing were uniquely feminine. In this way they saw nursing as "femininity in action". As Gamarnikow (1991) points out, the ideology of femininity was used as an enabling device by Nightingale rather than a limiting factor: a means of creating an occupation for women that embraced what was acknowledged as women's work in that period of British history. But within

the norms governing social behaviour based heavily on caste and religious belief and enveloped within pollution avoidance, the western image of the caring nurse could not be activated because the nurses themselves, as elsewhere, were conditioned by the cultural values and beliefs of their own society. Economic need was the driver that eventually brought Indian higher caste Hindu and Moslem women and later Bangladeshi women and some men, into the nursing schools. Much later, when opportunities to enter the global market opened up, nursing became a route to dowry avoidance, a ticket to the USA and a green card.

Finally, it may be tempting to believe it possible that the Nightingale model of nursing could be transferred from one very different culture to another. But was it so different? The nurses who went to the colonies at the end of the 19th century left behind a culture in which dominant and subordinate forms of health care were handled by male doctors and female nurses respectively and in which nursing was therefore a gendered occupation. The nurses left a hierarchical society based on class and one in which nursing itself divided its practitioners into "ladies" and "probationers". As in India, the issue of pollution accompanied care of the sick and stood at the centre of nursing work and threatened it. Before the Nightingale reforms, nursing work in Britain was also carried out largely by poor and marginalised women, and in the case of midwifery, did not shed its handy woman image until the early 1920s when reform came about via the establishment of modern midwifery training schools.

To summarise, the history of caring for the sick in India and, later, Bangladesh had clear implications for the design of the SNES project. Although the Nightingale model was adopted as a characteristic of basic nurse training, it was within a culture where pollution was associated with hands-on care and was therefore rejected by the majority of nurses. Instead care of the sick was managed by nurses through relatives and a collection of socially marginalised attendants from the wider society. In Britain today, hands-on personal care is less likely to be carried out by trained nurses than by nursing assistants drawn from a wider pool of carers who, although not usually regarded as socially marginalised, are

likely to come from minority groups in terms of their educational opportunities, ethnic background and social position.

CHAPTER 4

LATER DEVELOPMENTS IN NURSING CARE IN BANGLADESH

Having re-established hospitals as a base for the institutional care of the sick on the Indian Sub-continent, what of nurse training?

At partition, East Pakistan had only three "junior" or assistant nurse (AN) training schools and only 50 fully trained or "senior registered nurses". With other patient attendants, the assistant nurses were drawn from peripheral groups whilst nursing remained unattractive to most women. Purdah restrictions were still in place and hierarchical distinctions marked Islam as well as Hinduism. Added to the perception of the nurses as being drawn from lower social strata, for Moslems, the work also entailed socially disapproved contact with men who were not their relatives. Not surprisingly, for the few senior East Pakistan nurses during the '50s and '60s, expanding their profession beyond "assistant" status was an up-hill struggle.

However, one "senior" nurse institute (N1) had opened at Dhaka Medical College in late 1947 with the assistance of a British nurse. One mission hospital also trained senior nurses at Rangamati in the Chittagong Hill Tracts. Gradually a still small but steady stream of qualified nurses became available to East Pakistan. Additionally, in 1949, eight young women were selected for training in London and they later returned to eventually take up leadership positions in what was to become Bangladesh. In the meantime, a college for nurse education and management was built in Karachi 1952 with foreign aid and the more senior registered nurses from East Pakistan went to West Pakistan for enhanced training. Later the United States Agency for International Development (USAID) offered scholarships to qualified and experienced nurses from East Pakistan that allowed them to study for undergraduate and postgraduate degrees in nursing in the USA. Most of these nurses also returned to East Pakistan where they closed down the assistant nurse training schools and, in a bid for improved status and professionalisation; they progressively opened another seven NIs. All of these were to train senior nurses and all were in hospitals attached to the medical colleges. But nurse recruitment remained very slow during the '60s although

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attempts were made through "nurses' week", visits to girls schools and even door-to-door visits in areas where possible recruits lived (personal communication Mrs Khatun and Miss Banu DNS, 1990).

Nevertheless, by 1970 there were 600 nurses on the East Pakistan Nursing Council register although only 350 were employed in the government health service. In spite of this very small number, the World Bank funded the building of a college of nursing in Dhaka in 1970 and several more NIs were built with donor funding alongside some of the older district hospitals. By this time the population of East Pakistan was 70 million resulting in a very wide trained nurse:population ratio of 1:116,667. During the '70s recruitment accelerated but the NIs were apparently able to absorb the increasing number of students and provide them with teachers who had graduated either from Karachi, or later, from the college in Dhaka. At this time East Pakistan already had a good infrastructure of hospitals and health centres some dating from the colonial period and others built after independence with the assistance of foreign aid. By 1975, 1000 nurses had completed their 4-year training comprising three years general nursing and one year for midwifery, orthopaedic or psychiatric nursing certificates. One third of the nurses were unemployed although the population had now risen to over 78 million and more young women were applying for places in the NIs than could be provided.

Although nurse unemployment within Bangladesh continued, applications for nurse training increased as demand for qualified nurses grew from countries in the Gulf States, enriched by petrodollars and rapidly expanding their own health services but without an indigenous cadre of trained nurses. In 1980 the DNS was "ordered" by the Ministry of Health to start a "crash" programme of nurse training, ostensibly in recognition of the expanded population (personal communication Mrs Harun and Miss Banu DNS, 1990). But there was also a growing realisation by the Bangladesh government that young women were now applying in larger numbers for training and that people with marketable skills, such as nursing, could bring much needed foreign exchange into the country. The impetus for expansion also came from hospital consultants in Bangladesh and

elsewhere who were demanding trained nurses to assist them in their expanding specialist and clinical areas.

In order to cope with many more students, another 18 nurse training schools were quickly opened in rented premises in sub-district towns where 50-bedded general hospitals existed. However the expansion of nurse training was not part of an overall resource plan, nor was the expansion welcomed by the senior nurses who preferred a more gradual growth in the number of nurses. In the event, the rapid growth was poorly controlled and grossly under-funded and was, retrospectively, claimed by senior nurses and external observers, such as WHO, to have been associated with a significant decline in the quality of nurse education and hence quality of care provided to patients in Bangladesh. At the same time, the government could not fund salaries for all the nurses being trained unless those already in employment took up opportunities to work abroad and thus created vacancies the newly qualified nurses could fill. This was a slow process. First, the would-be middle-east recruits had to gain more specialist skills, improve their English and then negotiate with the civil service commission for protection of their existing posts and their eventual re-entry. This meant they went abroad "on lien" and the posts temporarily vacated could not be filled by others except on an "acting" basis.

Again, the implications of an occupation structure that involved civil service rules and regulations and which covered the majority of public sector health workers in Bangladesh was not fully understood at the time the project was being written up. This dogged progress and certain project aspirations. As seen above, the senior-most nurses in Bangladesh and WHO lamented a fall in the quality of nursing care. But in 1990 the continuing aversion by nurses in the public sector hospitals to hands-on care and, instead, its delegation in the wards to an assortment of attendants was noted. For an illustration of typical patient care by their relatives see Annex 11. If the quality of care had fallen, then it must have been in the quality of care provided by the relatives as communicated to them by the nurses. The 1990 assessment reported that government officials and donor agency representatives often claimed that the nurses did not "care" for their

patients. However at least two observations should be made. First, their own peer group and their supervisors often exerted pressure on nurses not to display any overt signs of warmth or concern for the patients or their relatives - this is not peculiar to Bangladesh and has been the subject of research in Europe and the USA over many years. Second, the nurses' own dignity was often undermined by their more powerful seniors and violence against the female nurses by male relatives and by male doctors was not uncommon (see also Annex 12). In these circumstances, when taken together with cultural beliefs surrounding pollution avoidance, it did not seem unnatural that "caring" as a marker for nursing quality was far from obvious.

Regardless of quality, by 1990 there were 9270 nurses on the BNC register although just under 6000 were employed in Bangladesh. By this time around 2000 of the total were working in the Gulf States and the remainder were working elsewhere abroad, mainly in the UK or the USA. Some worked in the hospitals and clinics of Non-Governmental Organisations(NGOs) within Bangladesh. At this time, applications for nurse training were buoyant and the educational standard of the applicants was rising. In 1990 there were just over 800 applicants for the 20 places at the Mitford Hospital N1 in Dhaka. By the mid-nineties the number of registered nurses had risen to almost 12,000, however more than 4000 were still unemployed and waiting for civil service posts to be created for them. Again, just over 2000 were working overseas mainly in the middle-east. By 1997 the number of registered nurses rose again to 15,734 but, as before, almost one third were unemployed. Even if all the fully trained nurses had been working in Bangladesh, the qualified nurse:population ratio, at 1:9344, would have still been unacceptably wide by international standards. In part this reflected the government's difficulty in generating revenue with which to pay the nurses. However this does not seem to have been a problem with the more powerful medical profession who outnumbered the nurses three to one in the government hospitals and in the network of UHCs. This was a reverse of the situation in the rest of the world, including the rest of the Indian sub-continent, where qualified nurses in government service by now outnumbered doctors by up to 10 to 1.

In spite of the fact that the government either could not, or would not, employ all the nurses already on the BNC register, the nurse training schools continued to produce between 700 and 800 nurses a year throughout the nineties. As mentioned above, as the Gulf States moved further into high technology they demanded more specialist nurses. To meet this demand, several courses were developed in Bangladesh and taught mainly by specialist doctors some of who may have been remunerated by the nurses themselves. At the specialist hospital for cardio-thoracic medicine in Dhaka, Japanese volunteer nurses also assisted with the teaching. Although their quality was never tested and the nursing establishment received no help from outside sources with new curricular or any other resources, the courses were encouraged by the government who, again, saw the opportunity for foreign exchange earnings. The nurses, on the other hand, also saw them as an investment towards their own future earnings abroad and a source of financial assistance to their families.

To summarise, over two decades, the number of fully trained nurses in Bangladesh rose above the ability of the civil service to absorb them all. Even if opportunities to expand their employment had been found, it is not clear that this would have altered the way in which nursing care was delivered, that is that the nurses would have taken over the personal "hands-on" care of the patient from relatives and attendants. As opportunities for work opened up in the middle-east for Bangladeshi nurses many prepared themselves well and left. What is not clear is whether they were able to deliver nursing care through others as they had in Bangladesh or whether they had to provide personal nursing care themselves. This would be a useful area for further research.

I mentioned above the possibility that donor interventions may have further undermined the nurses wish to expand their number as an indication of their strength. Below I explore some of these interventions through examining the background to the provision of health care outside the hospital.

Community Health

So, what of formal health care outside hospitals? Just prior to partition, the Bhore Committee Report of 1946 emphasised India's intention to extend public health services to the country's vast rural population. This immediately opened up further opportunities for women as nurses, midwives, paramedics and other workers, such as health assistants and lady health visitors, the latter already imported by missionary organisations into some parts of India as British health visitors. By the end of the 1960s the rural areas of India, Pakistan and the future Bangladesh had a fledgling infrastructure of preventive and community health services and a slowly expanding cadre of rural health workers.

This was particularly significant because it laid a foundation for a massive drive for population control in rural areas from the early '60s onward and mainly funded by the USAID. In Bangladesh, this created employment opportunities for thousands of young women as family planning workers within their own villages and restricted yet further the pool of young women from which nurses could be drawn. As a consequence of USAID pressure to get a better command of its programme, the Ministry of Health (MoH), previously responsible for all health care in the public sector, was divided into two "wings" or Directorates in 1975: one was referred to as the Population Control Directorate (later referred to as the Family Planning Directorate) and the other became the Health Directorate. The former dealt with activities to bring population growth rates down but also had responsibility for the health care of women and children in the community and trained and managed all family planning workers. The health directorate dealt mainly with hospital care of the sick and public health control programmes for conditions such as tuberculosis, malaria, and leprosy etc. (Khan 1988, BRAC 1990).

The effect of the MoH division was to create two separately funded training and health care systems each with its own staffing pattern and with barely any integration between them. There was a tenuous but unhappy working relationship between the Directorate of Medical Services and the Directorate of Nursing, the latter having gained Directorate status in 1977 but neither had a professional or

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organisational relationship with the Family Planning Directorate (see Diagram at Annex 13) As a consequence of this, nurses had no direct responsibility for either family planning or for the care of mothers and their children in the community. This excluded them from involvement in the childhood immunisation programmes and work involving women's reproductive health such as pregnancy, antenatal care and childbirth in the community. A new vertical structure was set up to train and put in place thousands of workers whose main task was to reduce population growth in rural areas through the vigorous promotion of temporary and permanent methods of contraception or encouraging women to come forward for very early abortion. Monthly targets were set for each level and for each contraceptive method and the efficiency of the family planning workers was judged by how close they came to meeting them. Through USAID, financial incentives were available to both to women consenting to be sterilised or willing to accept long term contraception, to the family planning workers recruiting the women, and to those providing the contraceptive method (Khan 1988). At the same time a large amount of foreign aid went to the family planning directorate towards the capital cost of building yet more training institutions around the country and bringing in vast amounts of equipment and contraceptives from outside the country.

The bifurcation of the Ministry of Health and Family Welfare existed down through all levels of service delivery creating a large imbalance between the amount of aid going to the family planning directorate and that going to the DMS and the DNS. The former was firmly focused on population control and very little was spent on treating the ill health of mothers or their children suffering with anaemia, diarrhoea and malaria for example. At the same time, the nursing directorate struggled to wrest whatever resources it could from the MoHFW for its own development.

Recognising the imbalance of financial and human resources between the two "wings" of the MoHFW, WHO, the World Bank and a group of bilateral donors funded the Directorate of Medical Services (DMS) from 1977 for a large project to train paramedical staff for deployment in rural areas. This brought forward

another burst of capital spending with which to set up at least one purpose-built training institution in each of the country's four administrative divisions. Known as Medical Assistant Training Schools (MATS) the schools ran two year courses and in the space of only six years produced around five thousand, mainly male medical assistants who were registered as such with the Bangladesh Medical Council and posted to pre-existing health centres in rural areas.[11] Part of the popularity of the courses lay in the promise that the training would be the first rung on a ladder to medical school and eventual registration as a doctor. This promise was never fulfilled but in the meantime the nurses now found themselves heavily out-numbered by a widening range of other health providers having regular salaries paid from development budgets funded by the donors. Added to the medical assistants, other donors funded the training of 28,000 peripatetic "palli chikitshok" for the rural areas. Their training lasted only a few weeks and they carried a small kit of essential medicines for local diseases: again they were mainly male and although modelled on the Chinese barefoot doctor they were never so well disciplined. Their kits were rarely replenished and they are lost in the clouds of a vague institutional memory.

To summarise, following partition in 1947 and through to its independence in 1971 and beyond, the number of nurses in Bangladesh increased, very slowly at first and then accelerated as global opportunities for trained nurses opened up. The senior-most nurses laid a foundation for professionalisation but for most of its development nursing in Bangladesh was perceived as a low status occupation, mainly because of its association with pollution and because it was a gendered occupation in a population where discrimination against women and young girls was institutionalised. In the '70s, thousands of other health workers were trained for work in the rural areas through various donor-funded projects that undercut the need for nurses except in the context of foreign exchange earnings.

The design of the SNES project aimed to strengthen the nursing profession in Bangladesh by providing professional education for its senior-most nurses, courses for middle-level managers and nurse educators and graduate education at

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[11] There was a 10% quota for females although this was never fulfilled.

Masters level for around 20 nurses who fulfilled the criteria for admission to higher education in the UK. Together, it was argued, these interventions would create the critical mass of nurses. In turn, the result would be an institutional capacity to take the profession forward and thus gain some control of its own development. The project was not working with an entirely blank sheet however: although weak, the senior nurses mainly funded through WHO, were beginning to strengthen their position. In 1990 they produced the first Journal of the College of Nursing which contained accounts of small-scale research carried out by the nurses themselves and included a Code of Ethics for Nurses (Journal of College of Nursing, Bangladesh 1991).

As described above, the SNES project was funded by several donors and was only one among many projects to be funded through foreign aid in Bangladesh during 1992-1997. However foreign aid is often regarded as a mixed blessing by its recipients and the sustainability of its results are acknowledged to be problematic after aid is withdrawn. I will now turn to examine the role of foreign aid in developing countries in Chapter 5 and go on to draw on the Bangladeshi view of foreign aid more specifically. The remaining Chapters will return to the nurses in Bangladesh and assess how far the project designed to assist them has succeeded. At this point I want to draw attention the concerns of Iredale and Sparkhall (1992) who raised questions as to the appropriateness of exposing students from developing countries to educational institutions and innovations and practices that were often irrelevant or difficult to apply in the students' own environment on their return. Rojas *et al* (1993) were especially concerned about the relevance of management training in the wake of WHO's sponsorship of district health systems in developing countries. These systems required the decentralisation of planning, decision-making and budgets etc. Many of the conditions at district level in developing countries were similar to those of Bangladesh and as the project moved on it became increasingly obvious that Iredale and Sparkhall, and Rojas *et al* were right to question the wisdom of training managers and others so far away from their own workplaces.

CHAPTER 5

FOREIGN AID TO DEVELOPING COUNTRIES

This chapter forms an inclusive analysis of foreign aid drawing on the observations of many observers over the past 25 years: the purpose of covering such an extensive period is to demonstrate the apparently shifting face of aid and yet the persistence of its critics and the form their criticisms take. It can be said of foreign aid that the more it changes, the more it stays the same. I have made clear above that the SNES project was funded from foreign aid with some contributions in kind and commitment from the Bangladesh government. Specifically, external aid was donated by the UK Overseas Development Administration (ODA), now re-named the Department for International Development (DflD) with additional inputs from the World Bank[12] and the World Health Organisation (WHO). Below I will provide a more general examination of aid charting the route aid takes in moving from developed to developing countries and providing an overview of why it so often fails to deliver its promise.

Aid distribution and its route to developing countries

Foreign aid or donor assistance refers to economic, technical or military assistance given or lent by one country or group of countries to another. The traffic in donor assistance is usually one way, from a developed country to a poorer country but there are numerous examples of aid going from one developing country to a similar country usually for disaster relief or military assistance. This is well illustrated by India's support to Bangladesh during its civil war with Pakistan and in more recent times to assist it cope with its many natural disasters. Aid commonly takes one of two forms, *bilateral aid*, where one country aids another or *multilateral aid* such as that typically provided by the European Union, World Bank, International Monetary Fund (IMF) and the UN agencies all of whom disburse loans or grants from the pooled resources

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[12] Also known more formally as The International Bank for Reconstruction.

contributed to them by members of the EU or UN "family". Countries supporting the multilateral agencies are supported by *quid pro quo* arrangements in which their contributions are matched by contracts for business, project hardware such as vehicles, and the hire of their own citizens at UN agencies and EC divisions.[13] In the mid-eighties the UK received back an estimated 120% of its contribution to the United Nations Development Programme (Boyce 2003). Loans and grants to developing countries may also be made jointly by both bilateral and multilateral agencies added to by loans from the regional development banks such as the Asian Development Bank or African Development Bank.

The term "aid" for most purposes covers Official Development Assistance (ODA) made up of either monetary non-repayable grants or concessionary loans to countries on a list which is reviewed annually by a consortium of industrialised countries forming the Development Assistance Committee (DAC), founded in 1962 as a sub-committee of the Organisation for Economic Development and Co-operation (OEDC). Part 1 of the list consists of developing countries divided into the several bands based on their estimated annual per capita income. Part 2 of the list covers "countries in transition" including those in central and Eastern Europe, some former Soviet republics and the Baltic States (see Annex 14 for a recent list). A review of aid-recipient countries and the disbursement of the ODA are decided each spring in Paris at a meeting of all countries represented on the DAC. These meetings, known in aid circles as the "Paris Club", do not usually include representatives of developing countries although consultations may be arranged with them outside formal meetings. The basic criteria for the provision of ODA are that it must be used for the promotion of "economic development and welfare"; categories subject to shifting definitions arrived at by donors and lenders. Within the health and social sectors the mechanism for its disbursement is mainly in the form of grants, "soft" loans[14] and technical assistance, usually delivered via time-bound "projects". As mentioned above, this is achieved either through country-to-country negotiation, for example UK to Bangladesh (bilateral aid) or through various United Nations agencies (multilateral aid) to which all

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[13] The European Commission is the executive arm of the European Union

[14] "Soft loans" are those provided at below commercial interest repayment rates. These are increasingly rare: the World Bank and Development Banks increasingly offer loans at close to those of the international clearing banks.

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DAC member countries, with occasional exceptions, make an annual contribution[15] and the multilateral World Bank and the various regional development banks.

In recent years an increasingly large amount of aid for health and social purposes has been channeled through non-government organisations (NGOs) mainly by those with headquarters in the northern hemisphere. These include agencies such as the UK's Voluntary Service Overseas (VSO) who receive 75% of their funding through DfID (VSO 2003). Save the Children Fund, OXFAM, and Action Aid, with a number of other single purpose NGOs, also receive support for their work via the aid budgets of the DAC countries. In the case of the UK in particular, the British Council and private consulting firms are also contracted to manage various aid projects on behalf of the DfID both in developing countries and in the European transitional economies. These contractor organisations may not receive direct monetary aid but are able to benefit from aid projects through charging management fees that, in some cases, may be substantial at between 15% to 20% of the total value of a project. The EC divides its aid up into "lots" and sets up "Framework Contracts" to run over several years and thus guaranteeing work for various consortia in the provision of consultants and the day-to-day servicing of projects. Many of these firms are multinational companies with wide commercial interests, thus adding to the perception of development as an "aid business".

How much aid is disbursed?

All countries in the OEDC have a target of 0.7% of their GNP earmarked for development aid including their "dues" to the United Nations. In reality, the average contribution within this group of countries is around 0.34 % with only three Scandinavian countries and the Netherlands achieving more than 0.7%. Of the major industrial countries, the USA provides the lowest proportion of its GDP in bilateral aid to developing countries, currently at just under 0.24%, and for many years since the 1950s has contributed much less to the multilateral

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[15] For example, the USA withheld contributions to UNESCO during '70s because of its disapproval of UNESCO's "ideology". More recently the USA has withdrawn some funding from UNFPA for its "pro choice" stand on abortion.

agencies. Until recently the UK contributed only 0.24% of its GDP in aid to developing countries but since 1997 it has increased its aid commitment to £4.6 billion or a proportion of 0.37% for the year 2005/06 (DfID 2003). Between 1990 and 1997, ODA to developing countries (excluding China and India)[16] fell from an average of 4.3% of their GDP to 2.9% or a fall from US$ 15 per capita to US$ 11 per capita (World Bank 1999/2000). For South Asia alone, the fall was even steeper. More recent figures released by the DAC show that aid from their countries has now stagnated at an average of 0.22% of their GNP bringing it to the lowest level ever.

Although as suggested in Chapter 1, the volume of foreign aid to developing countries is falling, it invariably comes with conditions attached. The number and range of conditions has grown in scope over the past 30 years. As suggested above, these include use of the donor's own resources for the implementation of aid projects, for example, expatriate personnel, vehicles, equipment, machinery and the donor's own training and education institutions. In the early '90s, aid to India for basic health and education services was granted on condition that military hardware was purchased from the UK (ODI 1994). The most far-reaching conditions were the Structural Adjustment Programmes (SAPs) drawn up by the IMF in the early '80s and promoted by the World Bank but not all donors. These forbade the use of aid to subsidise basic foodstuffs, education and health care. The conditions for aid involved demands for the privatisation of state-run industries such as transport, energy and communication. Grants and loans were provided by major donors and the development banks for implementing the SAPs. Where implemented, they involved the introduction of user charges for basic health and education and in some countries caused food riots, for example in Zambia where the price of maize rose sharply at the end of the '80s. Others, such as Ghana, were vehemently opposed to SAPs as the price of cocoa, their main export, plummeted on the world market. Very few developing countries were able to fully re-structure their economies in line with IMF conditions but in any event the economies of developing countries stagnated

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[16] Geographically important and with very large populations offering promising export and investment possibilities, these are strategic countries for aid purposes. They are allocated large amounts of aid (to be clarified).

in the '80s and '90s for a variety of reasons including a sharp fall in the price of their primary exports and an increase in oil prices. The only countries to thrive during this period were the "tiger" economies such as Taiwan, South Korea, Malaysia and Singapore[17] who had never been reliant on foreign aid to any great extent.

One of the more recent set of conditions relates to those for debt relief or "forgiveness" under the Heavily Indebted Poor Countries Initiative (HIPCI) and a range of additional policies demanded by donors aimed at reducing poverty levels in developing countries. Since 1999 all countries requesting aid have been required to formulate a Poverty Reduction Strategy Paper (PRSP) within which the country lays down its proposals for reducing its population's poverty levels and for which the World Bank and the IMF will provide credits and loans with which to implement the strategy. The World Bank and the IMF focus on both macro and micro-economic conditions and in recent years have applied their loans to particular sectors of the economy, for example, agriculture, banking and education. The value of setting conditions for aid is controversial. For example, Pronk (2001) argues that well focused aid conditionality is preferable to rigid selectivity in how the aid should be spent" whereas Dijkstra (2003) turns this proposition on its head by arguing that "well-focused aid selectivity is better than rigid conditionality". They are both sides of the same coin, together conveying the message that aid has to be paid for by developing countries in cash, in kind or both.

Since the mid-'90s *good governance* has been added to the foreign aid lexicon. Good governance in developing countries calls for financial probity, the absence of corruption, democratic forms of government, and attention to the fulfillment of human rights as defined in various UN charters including those on the Rights of the Child and the Declaration of Human Rights. Adherence to a substantial body of international law is added. Whilst not disputing the legitimacy of this approach, it is surely ironic that some of its foremost proponents, the USA and

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[17] Although all these economies had a downward spiral in the mid-nineties, they had recovered by the end of the decade.

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the European Union, have their own record to defend.[18] It is also clear that not all aid recipients will be treated equally on their human rights record: as the lifting of sanctions against China showed, human rights can be waived when significant exports and investments are at stake.

As to relationships among donors, the Paris Club provides the appropriate vehicle for them to express their view on the current state of individual developing countries and their prospects in meeting the criteria for loans and grants from the perspective of efficient implementation and the longed for, but often elusive, positive impact of development projects. "Turf wars" are not uncommon as priorities for aid interventions and favoured countries are then decided among bilateral donors usually but, again, not always, following the lead of the World Bank and the IMF. Although the aid agencies formulate their commitments through negotiations with each other, all donors make sure that aid reflects their own country's policies and priorities with regard to specific developing countries. For example the UK concerns are likely to be focused mainly on former British colonies whilst France is more likely to focus attention on Francophone countries. Aid priorities of bilateral donors who do not have a substantial colonial history may be quite narrow in practice: for example, DANIDA (Denmark) and SIDA (Sweden) promote poverty alleviation, a current donor priority, but for them it remains at local project level and these donors rarely seek macro-economic policy changes that would further the cause of the mass of poor people in the countries they support. (Billetoft and Maludorf 1993). For Rondinelli, (1993), and increasingly for donors and aid recipients, this is one of the major problems with "projects" as vehicles for development.

There are many examples of bilateral aid agencies and NGOs working for years in geographically defined areas and apparently with success in meeting their objectives but never managing to "roll out" or replicate their success to the country as a whole. Primary health care projects, projects aimed at local management information systems and a mass of income generation and micro-

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[18] Most recent examples are financial scandals at Enron, Worldcom, Eurostats, support of the death penalty in many US States and the upsurge in human rights violations after 11 September 2001.

financing projects fall in to this category. The latter are aimed mainly at women in an attempt to lift the household income of the poorest, and particularly female-headed families. I will now turn to examine some of the main criticisms of foreign aid that continues to hold so many developing countries in its grip.

Concerns surrounding foreign aid

Jonckers (1996) suggests that any analysis of development aid must start from the premise that aid is the result of a complex and evolving compromise between altruism and self-interest. In fact these motives are not mutually exclusive and there are numerous instances where altruism and self-interest work hand-in-hand. British aid projects in Africa offer clear examples in countries such as Sierra Leone and Nigeria where investments in minerals and oil respectively need protection. Jonckers points out that affluent countries are interested in aiding poorer countries if it strengthens their own leadership, enhances their security and adds to their material well being. However, he also points out that over time, aid is regularly re-compromised: in time of plenty, altruism may be to the fore but in times of insecurity, self-interest becomes dominant.

Turning to the whole philosophy of foreign aid, Bauer (1995) has provided an incisive and sustained attack on the principle of foreign aid. He argued that there are fundamental errors behind an assumption that any country can develop as a result of free or subsidised resources from external sources. For Bauer, aid undermines and discourages the very behaviour which is necessary for economic growth. He argued that aid also politicises life in the third world where the imbalance of power between rulers and ruled is already greater than can appreciated by the donor communities. By increasing the resources available to government, aid exacerbates this imbalance and raises the stakes among those with direct access to it. In these circumstances, people are distracted from productive economic activity by the struggle to obtain access to the levers of political power that, he argued, fuels corruption and may be a matter of life and death in some countries. A narrower argument, made by Arthur and Preston (1996), is the extent to which local officials must service donor-aided projects in

addition to their own workload. Whilst they "are jumping through project hoops" the work of developing their own departments often goes neglected. The work of liaising with donors, briefing consultants, writing reports and providing an often insatiable demand for information diminishes their own work performance and detracts from their own career development.

Clearly, dissatisfaction with this form of development assistance and its outcome is long-standing and is now widespread. It comes from within as well as outside the donor circles. An early analysis of USAID projects by Tendler (1975) demonstrated a number of interrelated problems with technical assistance which are now familiar in all DAC country projects. First, USAID assistance often took the form of large capital-intensive projects, which required substantial amounts of equipment and construction, and were too sophisticated to be absorbed by the institutions of developing countries. Second, it was clear that the design and implementation of some USAID technical assistance projects served the interests of institutions in the donor country, particularly those in the business of exporting equipment and providing consultancy services, rather than the supposed aid beneficiaries. Tendler suggests that US legislative and administrative requirements made the aid projects look more like an attempt to subsidise US exports rather than projects to assist with the economic growth of developing countries. Finally, Tendler pointed out that assistance could be undermined by the "ugly American" type of project professional whose attitude to success was that only the donor country's experience in development counts.

Twenty-five year later, this form of criticism persists among observers in both developed and developing countries with expressions such as "gravy train", "imperialism", "neo-colonialism", "donor hypocrisy" and "consultant tourism" being commonly used in arguments against particular forms of foreign aid (Smillie 1995, Hirchman 2003).

As suggested above, for some donors, political self-interest is uppermost as witnessed in the strategic aid provided by the US, over many years, to both Israel and Egypt in an effort to buy stability in the middle-east. Linked especially to

self-interest is the fact that, historically, de-colonisation destabilised many developing countries but the erstwhile colonisers, now donors, still want to protect their original investment particularly where cash crops, raw materials and precious minerals are concerned. Aid in the early post-colonial era was therefore shaped to buy goodwill from the new rulers and a neo-colonial form of foreign aid emerged as a secular, institutionalised arrangement to ensure this was achieved. During the cold war it was also necessary to prevent third world countries joining the second world, dominated by China and the Soviet bloc, so that from the end of the second world war, led by the IMF and the World Bank, aid became internationalised and politicised through their close co-operation with bilateral donors and multilateral agencies. Few observers seriously acknowledge a fourth world: one inhabited by the chronically dispossessed and marginalised people of the first, second and third worlds although their existence seems to be acknowledged in aid language focused on poverty reduction strategies, capacity building and institutional strengthening. The SNES project, to be discussed more fully below, and the FIMC project referred to in Chapter 1, both focused closely on the latter two concepts in their efforts to strengthen the position of nurses on the one hand and doctors on the other. But both were also examples of "tied aid".

Although DfID, in particular, claim to have dispensed with tied aid or "aid for trade" it continues in many forms. Altruism, as suggested above, covers humanitarian relief such as disaster mitigation and assistance towards basic health and welfare needs. It can also advance a donor's own foreign policy and commercial interests. In the latter case this includes protecting its own markets, encouraging the purchase of its exports and the use by developing countries of the donor's own commercial resources: particularly those associated with infrastructure development such as energy, roads and transport. Although donors may claim to have abandoned it in favour of open markets it continues. For example, surely aid provided to fund places in UK higher education institutions and consultancy services for projects such as SNES and FIMC must be regarded as a contribution to the institutions "trade". Similarly, aid to Bangladesh to enable it to purchase the services of Scottish engineering firms, so as to develop its energy fields, also constitutes aid for trade.

A more positive view of foreign aid can be provided when it clearly represents a sustainable investment in the future welfare of populations in developing countries. Examples abound, particularly those associated with clean water, education and economic development. But the impact of these projects takes many years to achieve - certainly longer than the five or 10 year time frame of most projects. Even without the effect of HIV/AIDS, progress towards a healthy life will still elude the majority of populations in South Asia and most of Africa for decades to come. There are many reasons for this including the millions of US dollars in aid siphoned off into the capacious pockets of leaders in countries such as the Philippines, former Zaire, Nigeria and Haiti. In these countries foreign companies shun investment that could build up a country's own resources. Lengthy internal conflicts in countries such as Angola, Mozambique, Sudan and Somalia have also severely diluted any gains from foreign aid and leave their citizens among the poorest in the world on almost any account.

All this apart, we should reflect that it took only 30 years, between 1920 and 1950, for European countries to halve their infant mortality rates. In the last 30 years the rate in Bangladesh fell by only 20% and in Sierra Leone by only 15%. As McKeown (1976) showed years ago, most of the annual deaths from childhood infectious diseases such as measles and whooping cough fell rapidly in the first half of the 20th century. This was well before the introduction of vaccines to prevent them: conversely, together with malaria these diseases still claim the lives of millions of children in developing countries although their prevention and treatment is well understood, not least through aid-funded research conducted by well-endowed institutions and universities in industrialised countries. The recently constructed Millennium Development Goals, include a goal to reduce infant mortality by two thirds between 1990 and 2015 (see Annex 15) but already anxiety is rising as this and so many of the goals are beginning to slip out of sight.

For Hyden (1995), foreign aid works best when prospective beneficiaries have a clear stake in its investment: when it is adapted to the particular set of conditions

in which it is being dispensed; and when it makes people ready to co-operate to achieve a common objective. But donors have found it difficult to tailor their assistance along these lines. Reasons include suspected or documented cases of corruption, perceived lack of commitment and factionalism among recipients, and increased pressure on donors from their own taxpayers to show results. For all these reasons donors take control over the funds themselves by the use of technical assistance, by channeling them through trusted NGOs or, in the case of the UK, through well-established institutions such as the British Council. However, for developing countries, this inevitably reduces opportunities for learning and involvement in planning and the implementation of aid projects in their own country.

As implied above, the transfer of assistance may take up to several years beginning with the identification of a possible project to the actual start-up. This is the result of administrative complexities on both sides. Many developing countries are regarded, often unfairly, as not equipped to provide the administrative framework needed to qualify for, and then monitor, the resources provided for technical assistance projects. This is now rarely the case although the capacity of developing countries to absorb aid remains a problem. It is however clear that the *modus operandi* and the conditions demanded by the donor institutions themselves contribute to the limitation on resource absorption.

In the next Chapter I draw heavily on Bangladeshi observers to express their own views of foreign aid in relation to its impact on their own country. After many years of working in Bangladesh and other developing countries, I believe they are a fair representation of opinions on aid that can be found in the majority of these countries.

CHAPTER 6

AID TO BANGLADESH

Having examined the role of foreign aid to developing countries in broad terms, I shall now move on more specifically to Bangladesh as one of the world's greatest consumers of foreign aid.

In the mid-nineties, India received the largest share of UK aid in South Asia at £80 million. Bangladesh was the second largest recipient at £50 million of which £20 million was provided as balance of payments support to allow her to pay for essential imports (DfID/ODA 1995). However, give her smaller population, the value of Bangladesh's aid was greater in per capita terms than India's. Since independence in 1971 the largest aid contributors to Bangladesh have been USAID, the multilateral Asian Development Bank (ADB) and the World Bank. As mentioned earlier, at independence Bangladesh already had foreign debts of US$ 500 million carried over from Pakistan and in the intervening years these debts have mounted as an increasing amount of aid to Bangladesh is in the form of loans rather than grants.

Billetoft and Malumdorf (1993) remind us that at independence Bangladesh was one of the poorest countries in the world. They suggest that by the early '90s little had been achieved in spite of significant aid. The country remained heavily dependent on external borrowing and grants, many of which, as seen above, were tied to conditions imposed by the donors. At least four interrelated factors account for this in the Bangladesh context. First, domestic savings until recently have been very low so the government has not had a reserve of its own to draw upon for development purposes. Second, it still has a very narrow human resource base with which to support a modern economy. As seen above, adult literacy rates remain among the lowest in the world. This is compounded by widespread discrimination against the female half of the population both in education and access to health services. Although the recent growth and expansion of the garment industry has increased the proportion of women in the labour force, there is still a deeply rooted cultural resistance against women's participation in other economic activities outside the home (UNICEF 1998, DfID

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2003). Malnutrition, though improving, is still endemic.[19] Third, a major constraint to socio-economic improvement is corruption in the form of nepotism and misappropriation of funds that have become the norm in Bangladeshi bureaucracy at all levels (Mukherjee *et al* 2001). The fourth significant factor is the frequency with which natural disasters weaken the country and divert financial resources from its capital and development budgets. Here however I can add a positive note: in recent years Bangladesh has been able to manage its disasters with very little recourse to external resources. This is largely due to earlier and positive donor support that was invested in disaster preparedness in the form of cyclone shelters, large and well-stocked grain stores and coastal defenses.

Referring to the more negative aspects of aid to Bangladesh, Sobhan (1990), Chair of the Centre for Policy Dialogue in Dhaka, asserts that the more dependent a country is on aid the more submissive the recipients are. US$17.5 billion of aid was committed to Bangladesh between 1971 and 1985: this was made up of US$8.1 billion in grants and US $9.4 billion in loans. Over this period, the inability of the country to absorb its aid meant that the actual disbursement was only US$6.6 billion in grants and US$ 6.1 billion in loans. By June 1984, Bangladesh owed US$4.5 billion to countries or organisations which contributed most of the loans. These countries were primarily Japan, the USA, ADB and IDA. By the time the fourth 5-year Health and Population Plan since independence was being drawn up in the early '90s the sum had reached US$12.7 billion and by 1997 was US$15.1 billion in real terms or 20% of the country's GNP (World Bank 2002).[20] As most loans to Bangladesh, or any other country, have to be re-paid as additions to their national debt, this imposes a serious financial burden on the country which, Sobhan reminds us, will have to be paid back by future generations.

Turning to the anatomy of projects and technical assistance in Bangladesh, Sobhan (1990) suggests there is a general consensus in most sectors of the

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[19] Mainly micro-nutrient deficiency such as iodine, vitamin A, iron and folic acid.
[20] Slightly ahead of India at 18% but less than Nepal (25%) and Pakistan (88%)

economy that many technical assistance projects are over-designed, one aspect of this, as mentioned in Chapter 4, is the heavy use of expensive expatriate consultants where local experts are already available. The phenomenon survives under donor pressure but is also sustained by local agents, contractors and various types of middlemen. Sobhan concludes with Goflee (1994) that, in the Bangladesh context, aid confers more benefits on the givers than on the receivers who, at most, *"will to act as place men for the expatriates in return for access to the crumbs left over from the consultancy budget"* (p46). As an outcome of the aid process, the local agents:

> *acquired a material stake in an aid-dependent regime....Any trend towards abridging external dependence is likely to be directly inimical to these commission agents of foreign suppliers....Their external nest-eggs make it possible for them to travel abroad frequently where they enjoy the lifestyles of the West. They import luxury goods into Bangladesh both legally and illegally and provide a major source of domestic demands for luxury goods. (p47)*

In Bangladesh, as in many other developing countries, aid dependence has become self-perpetuating and is frequently inequitable in bolstering local elites at the expense of the mass of the people (Billetoft and Malumdorf 1993, Boyce 2003)). There are however recent signs that aid dependence may be tailing off as remittances by Bangladeshis working abroad increase and overtake the amount of ODA to Bangladesh as demonstrated in Table 6.1 below.

Table 6.1 Relationship between Bangladeshi Remittances, ODA and Gross National Income (GNI)

Indicator	1990	2000
GNI at current prices in US$ million	30,600	47,900
ODA in US$ million	2,140	1,171
Aid dependence as % of GNI	7.0	2.5
Remittances in US$ million	763	1,882
Remittances as % of GNI	2.5	3.9
Remittances as % of ODA	35.7	160.7

Source: DfID 2003

For many years the World Bank has co-ordinated foreign aid to Bangladesh but has rarely had consistent support from other donors for all aspects of its work. In the early '90s, for example, a group styled the Like Minded Countries (LMCs)

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comprising Canada, Denmark, Netherlands, Norway and Sweden, and covering 38% of aid interventions at that time, put emphasis on the projects that emphasised socio-economic aspects of development at grass roots level. Although interviews conducted by Sobhan at this time suggested Bangladesh senior officials saw donors as conspiring against them, the reality was that within the aid group itself there were diametrically opposed views. There were clear cases of some LMCs acting in direct contradiction to the Bank's position particularly where their own country's policy differed from that of the USAID and the Bank.

As mentioned above, donors tend to claim their own fields of interest, thus the Netherlands main aid intervention in Bangladesh is with flood control, land reclamation and river management, areas in which they have several centuries of experience and leading commercial interests. USAID's main concern was, and remains, with population control. It has also been traditionally involved with the privatisation of food grain marketing and fertiliser distribution, not surprising given that USAID has been the major supplier to Bangladesh since the *green revolution* of the early 1960's. The UK, on the other hand, took the lead on electricity, irrigation and railways and more recently has led the exploration for natural gas. Since the early '90s the configuration of aid in terms of overall allocations has shifted somewhat. In recent years, agriculture and rural development have claimed 31% with 22% going to development administration and economic management and another 17.5% allocated to population control. The latter includes not only family planning commodities[21] but also human resource development. Remaining aid went to an assortment of health and social welfare projects including local NGO development.

The interviews conducted by Sobhan in 1990 and the opinions of other, mainly Bangladeshi respondents interviewed by Murshid 10 years later, revealed the long-standing complexities of foreign aid and particularly the resentment aid produces (Murshid 2000). The employment of foreign consultants as part of technical assistance remains contentious. Not surprisingly, some donors saw

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[21] Aid term for contraceptive pills, condoms, IUDs, injections, implants etc.

consultants as essential because, in their view, the capacity of local agencies and individuals to provide expert advice was very weak. There was however a range of opinion among donors. In the earlier interviews, one multilateral agency representative claimed that if Bangladeshi intellectuals measured their abilities against those of foreign consultants they would *"certainly find them of very low category"* (Sobhan 1990 p215). Some donors, the Japanese for example, would employ local consultants in preference to their own if they were perceived of equivalent ability. Most donors and recipients felt the solution lay with Bangladesh itself. It was argued she should utilise her foreign aid to create a cadre of consultants that, at least in some fields, could substitute for expatriates. There was also an opinion that Bangladesh could be more assertive with aid agencies that supplied less than useful consultants. The representative of one multinational agency thought Bangladesh must be strong enough to refuse expatriate consultants as part of technical assistance because, through this mechanism, as observed above, *"the donors are taking away the lion's share of their contribution"* *(p215)*. As we have seen, a large part of the donors' aid contribution to Bangladesh is disbursed within the donor country through the use of expatriate consultants, project staff and their own institutions. Together with other conditions incorporated into a project design, this means that a significant amount of aid committed to Bangladesh may not actually be at its disposal. In this context, the SNES project drew heavily on expatriate consultants although, more positively, it also trained and employed local MSc graduates as consultants for most of the project's life.

Turning again to the aid recipients' point of view, Murshid (2000) interviewed a number of Bangladeshi interest groups and individuals: these included, among others, civil servants in the government's economic planning divisions. The consensus of opinion from this group was that development assistance provided help in the short term for closing the savings and trade gaps, assisting with economic growth and facilitating skill transference. However, questions were raised as to long-term gains and as to whether the country was being exploited in the name of technical assistance. Ten years on, Muzaffa Ahmed, Professor of

Economics at the Institute for Business Administration in Dhaka echoed Sobhan's view expressed in 1990 and in much the same vein:

> *Of the total aid we receive 60% is wasted.....For US$1 aid to our country, the donor country gets US$0.40. The terms of trade go against developing countries because of such form of assistance. We can definitely do without development assistance. Although we take soft loan, it is fast taking the form of a debt burden... ... Today we are not strong enough to say 'no'. And that is why we could not reap the benefits. We have been dictated to. Also in accepting development loans we are burdening the poor as we are charging higher taxes to repay loans. This would cause poverty to deepen.* (p5).

The Bangladesh Rural Action Committee (BRAC), the largest and most powerful NGO in Bangladesh, was built up on both multilateral and bilateral aid in the aftermath of the civil war and now occupies the status of a parastatal. Fazle Hasan Abed, the founder and executive director, had this to say:

> *I think development assistance has played an important role in our development process since the inception of Bangladesh. If we look at the success we have achieved in various fields such as food production, life expectancy, fertility reduction, poverty alleviation and so on we can see the contribution development assistance has made in these fields... ... in 1972 the average fertility rate per woman was over 6. This has now declined to about three children per woman over these intervening years. I would doubt very much that without development assistance in population control, Bangladesh would have made much progress in this dimension.* (p61)

Hasan Abed might have acknowledged that "population control" had received the lion's share of aid going to the Ministry of Health over many years and that the successful influence of the World Bank and USAID in dividing the Ministry of Health into two "wings" resulted in a serious under-funding of other activities which have had long term consequences - not least for the very slow improvement in women's health, notably at childbirth.

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Kushi Kabir is chairperson of another NGO, Nijera Kori[22]. This NGO unlike BRAC does not receive any direct aid from multilateral agencies but receives some aid from northern NGOs who in turn are assisted by bilateral donors. Ms Kabir was less sanguine about the benefits of development assistance:

> *Assistance is provided in different sectors like industry, power, energy, service, infrastructure, finance and so on. In recent years there have been drastic changes in the pattern of multi- and bilateral aid. It is now directed to poverty alleviation, participation of the community in decision making and upgrading the social sector. The basic critique here is who set the paradigm for the development programme. More often it has depended more on the donor than on the recipient. The recipient felt vulnerable because they are dependent on the donor for their existence... ....The problem is immense. And these point at lack of government democracy. Whoever makes a decision, it goes haywire because there is no accountability, no access to information. I, as a citizen of Bangladesh, cannot question how much money is being spent on what: what uses there are. Aid is basically dependent on lobbying of interest groups.... What has to be done here is to ensure our control. We need to be more aware and in control of what is happening. Today our government is vulnerable as well. We, as citizens, should stand together with the government so that they feel stronger. We have to be more accountable, more transparent, effective and efficient. (p62)*

Mashiur Rahman, Secretary at the Economic Relations Division of the Bangladesh government was, perhaps naturally, more concerned with the effect of aid on the country's economic performance. Like the civil servants in the planning division, he saw aid as part of the external resources flowing into the country which if borrowed on the commercial market would cost much more in interest re-payments. He also believed that Aid met the gap between domestic savings and investment and the gap between imports and exports. He went on to comment on current shifts in donor policy:

> *A country's access to aid will be linked with quality of policy and efficient use of resources including aid. The donors insist on improvements in those areas, which reduces dependence on aid: good policies; better revenue mobilization; fiscal and monetary restraint; efficient use of resource; export growth. You can hardly quarrel with that, at least at the general*

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[22] Translates as "we assist ourselves".

prescriptive level. On details of policies, sequencing and speed, there will however be differences. (p63)

Both Rehman Sobhan and Abu A Abdulla, Director General of the Bangladesh Institute of Development Studies, were cautious about the effects of any rapid withdrawal of aid to Bangladesh. Sobhan however felt that in extreme circumstances Bangladesh could cope but that a wide cross-section of the community would suffer, particularly the Vulnerable Group Development programme which was aimed at large numbers of poor women who were dependent on it for their survival. The programme itself relied entirely on foreign aid although Sobhan could envisage its survival, without donor assistance, if the Bangladesh government could plan for such an aid reduction by making more efficient use of resources the government already had in place. As in his observations 10 years earlier, he was again wary of donor interference and the dependence it created:

> *Advice from donors is often bound by conditions. Most of such advice may be useful but has proved ineffective. Unfortunately, Bangladesh's melancholy experience with donor driven reforms has not inspired our donors to re-think their policy advice so that such reforms are more readily implementable. The effort by donors to influence decisions through aid conditionality took away responsibility of the government. They encouraged the government to feel they were not responsible for policy reforms or for its implementation. Reform without local ownership is recognized today by the donors to be counter-productive. It is a pity they did not discover this truth over the last 15 years when they were attempting to impose reforms on Bangladesh through use of aid conditionality.* (p63)

However, as we shall see below, reform in the way aid is managed by donors and government remains elusive.

Abu Abdulla also felt that aid withdrawal would not be catastrophic provided the government were able to restructure its approach to personal savings, tax collection and foreign exchange. He was in favour of encouraging investment rather than relying on aid:

> *Although foreign investors take back the profits they make here, the interest burden is not there. Also it creates a*

*transference of management skills and promotes foreign
exchange... ... A more realistic way would be to phase out the
process of development assistance, in which case we would
be able to adjust, provided we have the will and desire to do
so.* (p64)

Both the internal and external views of aid to Bangladesh, uncovered by Sobhan
and others, have bred a fatalism among the country's policy makers about the
need for aid and have bred an acceptance of donor interference in the country's
domestic affairs. Billetoft and Malumdorf argued in 1993, that the country's
susceptibility to donor pressure derives from a long history of political weakness
and internal dissension. Little has changed in spite of political "democratisation".
Only during the early part of the country's independence struggle were successful
political regimes able to draw full support from the Bangladesh people. Since
then government has been reluctant to take the population into their confidence
and to demonstrate that they are committed to the welfare of the mass of people
rather than to the fortunes of the few. In these circumstances, they argued,
regimes such as that of Bangladesh, alienate their own people and then look to
donor countries to underwrite their political survival and poor economic
performance. On the other hand, support for foreign aid among Bangladeshi
officials comes mainly from those who see opportunities for consultancies,
overseas study and the contracting possibilities created by aid projects. Sobhan's
own conclusion based on years of observation is that donors will impose
themselves on Bangladesh to the extent that Bangladesh allows them to do so. As
he points out, *"as long as they* [developing countries] *remain dependent on aid,
donors will shape their foreign and domestic policy for them."*

Billetoft and Malumdorf comment that:

*Even within the limits set by their dependence on external
resources, the manifest inability of Bangladesh to improve its
economic performance from within and to better the lot of
the majority of its citizens.... not only accentuates the
country's need for aid but makes them vulnerable to internal
and destructive factionalism which can be witnessed at all
levels of Bangladeshi society.* (p10)

In fact, recent evidence from Bangladesh is mixed. A recent briefing paper from DfID (2002) admits that some formidable problems remain. They maintain that most of constraints holding back Bangladesh are rooted in social and political processes and although institutional weaknesses contribute they are of secondary importance. Of greater concern is that gender inequalities dog poverty alleviation and that this will slow progress towards achieving all the Millennium Development Goals in Bangladesh. This leads DfID to assert that in view of the failure of poor women and girls to fully benefit from the numerous development interventions in the past, all future programmes should focus support on the poverty reduction strategy to advance the position of women. In a positive vein, they acknowledge, rightly, that the Bangladesh government is far from monolithic and that there is therefore a possibility of building coalitions and finding agents of change within the country. They go on to observe that some of the country's institutions can contribute to improvement through their experience in advocacy and in providing support and services for the country's poorest people. Almost certainly DfID is referring here to the country's NGOs. However they conclude their briefing on a depressing note:

> ... *many (institutions) are either ineffective, or used for purposes that serve predatory and often corrupt patron-client relationships rather than development objectives. Improving institutional performance, not least in the public sector where there are deep-seated and systemic problems (many with their roots in the political process), is needed not only for overall development, but also for the effective use of aid.... With weakly formulated and implemented policy and poor governance targets [this] will not be achieved and the scale of deprivation and environmental degradation in Bangladesh will continue at appalling levels (DfID 2002).*

I believe this view of Bangladesh is unduly pessimistic. Whilst the volume of aid to Bangladesh has gradually fallen over the past 10 years and her very low HDI and GDI reflect the fact that the country has not dealt with gender inequality, there is some scope for optimism. For example, her Gini-index suggests a more equitable distribution of income than in many other developing countries, and some developed countries. This may be partly because her abundant human resources working outside the country contribute through remittances to the welfare of many of the country's poorest families.

On the other hand, I illustrate below some of the tensions, the waste and the covert nature of technical assistance projects by briefly reviewing a recent attempt to implement the SWAp in Bangladesh.

An important objective of the SWAp is to ensure that public health expenditure is targeted at priority health services, which in most countries includes primary health care and reproductive health delivered through the implementation of health sector reform. It was estimated that if the reforms were to be fully implemented through a SWAp, Bangladesh would require US$3.37 billion over the five years 1998-2003. Significant policy and organisational changes were agreed between donors and the Bangladesh government as early as 1995 and incorporated into the Bangladesh Health and Population Sector Strategy (HPSS) as described by Jahan (2003). Briefly, they represented the implementation of health reform measures outlined in Chapter 1: a move away from projects, including those targeted at women's health, to integrated programmes emphasising gender mainstreaming; the unification of the health and family planning directorates or "wings" at the MoHFW with a unified management structure from top to bottom; involvement of communities and other stakeholders in the formulation of health programmes and their monitoring through civil society involvement; and decentralised health management and planning. Although strongly supported by the then current government at the end of the '90s problems arose. Although the sector-wide approach was co-ordinated by the World Bank and, at the time of its initiation, included eight other funding agencies, it was weakened by the reluctance of around 40 other funding agencies to contribute time or finance to the SWAp. Significantly USAID, mentioned above as one of the largest and most long-standing contributors to the health and population sector, declined to support the SWAp (Shiffman and Wu 2003).

The SWAp involved the creation outside the MoHFW of a semi-autonomous unit to manage the Health and Population Sector Plan (HPSP) and its budget. In a reflection of observations made by Mushid and Sobhan above, retired, high level civil servants housed in offices close to the World Bank staffed the unit. This

presented a threat to the MoHFW civil servants and their new political masters elected in 2001. Under the SWAp arrangements the civil servants would loose day-to-day control of the health service programmes. Specifically, the conditions for implementing the HPSP threatened a loss of power by civil servants at both local and central government level and, in particular, those attached to the family planning wing of the MoHFW who, under the HPSP design, would be merged with the health wing. The move from projects to the programmes was also strongly opposed by civil servants in Bangladesh's Planning Commission who had traditionally scrutinised, negotiated and finally approved projects. With the SWAp, all negotiation over programmes of work would be carried out jointly by the donors and the MoHFW. Nevertheless, in spite of this opposition, headway was made on implementing some aspects of the HPSP although significant areas, such as gender mainstreaming and the involvement of civil society faded as the health reforms became increasingly donor-government driven. Importantly, a key element in both gender mainstreaming and a fully integrated Ministry of Health was the focus on the totality of women's health rather than solely on family planning. This was strongly supported by the Swedish, Dutch and Canadian donors included among the eight donors supporting the SWAp but rather less so by other donors including DfID and the World Bank. After the national elections in 2001 the in-coming government, bowing to pressure and perhaps re-paying their supporters, shelved all arrangements for a sector wide approach to health reform. They were helped in this by an analysis of data carried out by a joint government and donor review in 2002 that pointed in both directions on a number of performance indicators.[23] Finally it was agreed by donors and government that *"the goals and targets of HPSP are commendable but could not be reached during the first five-year programme. Indeed, some of the targets established in the performance indicators were considered too ambitious"* (Jahan 2003 p189). The programme was halted at mid-point and there is no information on how much of the earmarked US$3.37 billion was used or how it was used.

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[23] Contraceptive prevalence and fertility rates were either stagnant or barely increased. Antenatal care increased, severe malnutrition and female infant morality decreased.

This brief account of donor-government relations confirms some of the concerns voiced in the interviews conducted by Sobhan in 1990 and those shared with Murshid 10 years later.

To summarise, for the Bangladeshi observers, foreign aid was a mixed blessing. This mirrored the situation in other parts of the world in its use as an instrument of social and economic policy. Whilst aid was helpful in closing trade gaps and building infrastructure, it also fueled mistrust and its disbursement added to the factionalism already endemic in Bangladesh. A large part of the aid was not at the disposal of Bangladesh but was retained by the donors and boosted the income and standing of their own institutions. As I will show in the following Chapters, all these characteristics applied to the SNES project. Of interest is Table 6.1 above which, again, shows a tailing off of aid and its replacement by the remittances of Bangladeshi workers abroad. I will return to this later in discussing the outcome of the SNES project but first will go on to describe the various parts of the Bangladesh health system to which its nurses contributed and to which the SNES project directed its resources.

CHAPTER 7

BANGLADESH HEALTH RESOURCES

In this chapter I will describe the locations and the interventions addressed by the SNES project in greater detail and will include the major issues arising from the implementation of the project. I will first go into detail about the physical and human resources influencing the design of the project to strengthen nurse education and services in Bangladesh. It is largely descriptive but in the process I will endeavour to analyse some of key aspects of the project design. Much of the content is based on the 1990 assessment of nursing in Bangladesh supported in great part by the interactive research methods described in Chapter 1 and reflected in Annexes 3 to 10.

The original goal of the project was to *"contribute to a reduction in mortality and morbidity rates among hospital inpatients"*. This reflected a well-established relationship between a fall in hospital mortality and morbidity and good nursing care: the morbidity rates in particular included hospital-acquired infections.[24] Note here that the word *contribute* is an important qualifier. The prevention of hospital mortality and morbidity involves many factors which increase a patient's vulnerability: these include their condition on admission, for example, chronic under-nutrition and concurrent infection such as that caused by the human immune-deficiency virus or tuberculosis. Other circumstances increase risk, such as extensive soft tissue injury and complicated fractures, all too common in the massive toll of road traffic accidents in developing countries. Crucially, prevention of hospital-induced deaths and infections also depend on *all* the patient's carers - attendants, doctors, relatives and ancillary staff - taking action that will. contribute to improvement in this sensitive quality indicator.

Although the goal seemed reasonable in the project's early design, it was too ambitious given the growing evidence of very poor quality hospital care, which often seemed to lie outside the nurses' direct control. As seen above, most hands-

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[24] The spread of both Sub Acute Respiratory Syndrome (SARS) and Methicillin-Resistant Staphlococcus-aureus (MRSA) are associated with faulty hygiene practices within hospitals.

on care was given by attendants and relatives who may themselves have been in poor health. Additionally, on many wards even basic hygiene requirements such as running water and soap were missing. Several years after the project activities commenced, this often remained the case. At an early stage in its implementation the project logframe was re-drawn and the goal re-stated as *"[the] organisation and education of nurses directed at improved standards of care"*. At the same time the original purpose of the project, *"To create a critical mass of nurses who would provide professional leadership"* was replaced with ... *"Develop the competence of the BNC, DNS and CoN"*. However, the vision of a critical mass of nurses in place at the end of the project remained and underpinned the considerable project resources devoted to academic and professional education. The project was designed, root and branch, to cover every aspect of nursing in Bangladesh that had been identified as problematic in 1990, and again in 1993. The locations of the project's input are listed below. A schematic view of these locations is shown overleaf at Figure 7.1.

- Directorate of Nursing Services (DNS)
- Bangladesh Nursing Council (BNC)
- College of Nursing (CoN)
- Assistant Director Nursing Services (ADNS)
- Nurse Institutions and the their associated hospitals (NIs)
- Upazila Health Centres (UHCs)

There were two additional layers of health care provision below the UHCs, first, the Union Health and Family Welfare Centres (UHFWCs) and, second, the electoral Wards or Mouzas containing a variable number of villages with small dispensaries dating from the colonial era. Both of these levels were staffed mainly by the family planning wing of the MoHFW and were not included in the SNES project.

Figure 7.1   **Distribution of Nursing Resources**

Central (Dhaka)

| DNS | ◄──► | BNC | ◄──► | CoN |

Divisions (4)

ADNS

Districts/Zilas (64)
throughout Bangladesh

District Hospitals+ NIs,
DPHNs

Upazilas/Thanas (507)
throughout Bangladesh

Upazila Health Centres

Unions (4484)

Union Health and
Family Welfare Centres

Wards/Villages (59990)

Family Planning Workers
+ occasional satellite
clinics

Key

◄·················► Tenuous communication: no nurses below Upazila

◄───────► Formal communication

I will now briefly describe the structure shown above in relation to its main features as they impinged on the practice of nursing in Bangladesh. This is based not only on the reports of 1990 and 1993 but also on the definition of nursing roles as contained in the Bangladesh Ministry of Health Orders 1979 and up-dated several times during the life of the project. The physical condition of the buildings at the various levels was poor, badly maintained and projected a poor image of both the staff and their work. The College of Nursing, as mentioned above would benefit from the IDA loan and would be extensively refurbished. Physical improvement was also required at the Directorate of Nursing and the Bangladesh Nursing Council. All three buildings were in different parts of Dhaka's large commercial area so economies of scale were not possible.

The Directorate of Nursing Services The main function of this department was to appropriately deploy nurses throughout the country; to recommend them for promotion to the civil service commission according to their years of service; to keep confidential yearly reports on the progress of qualified nurses; and to invoke disciplinary procedures where necessary. The department also recruited and allocated student nurses to NIs around the country. The physical condition of the DNS was very poor: located in a high-density commercial area of Dhaka on the eighth floor of a crowded multi-purpose building. The Director of Nursing and her three deputies had partitioned offices but a large number of clerical staff worked in a dark and cavernous main hall with no access to natural light. Its barely functioning bathrooms were often without running water and there was no separate area for taking food. At any one time the department was full of visitors, mainly recently qualified nurses, usually with a male relative, desperately seeking employment.

More positively, within the department's files scrupulous records were kept of the location of registered nurses in various parts of the system together with information on post-registration courses taken in Bangladesh and abroad. This provided a useful amount of baseline information although it needed collating and presenting in a more accessible form. The project intervention here would be to re-furbish the department, assist with the rent of another floor above to create more working space and assist with development of a management information system.

The Bangladesh Nursing Council The BNC had an ill-defined and insufficient legal responsibility for overseeing the training of nurses with regard to monitoring the curriculum, setting the examinations, arranging for their conduct and for the assessment of the results on the basis which the BNC registered the nurses to practice. The BNC also registered the several thousand Family Welfare Visitors, who trained and worked in rural areas under the family planning wing of the MoHFW. The Council's role in the accreditation of training facilities was unclear and so too was its position with regard to discipline. The BNC was not far from the DNS and was housed on the third floor building shared with the

Bangladesh Medical Council and the Bangladesh Dental Council. The BNC was smaller and better lit than DNS but was also neglected and revealed years of wear and tear. It was staffed with a Registrar, well over retirement age, her deputy and a handful of clerks.

In 1990, neither the DNS nor the BNC had any computerised facilities, sufficient basic stationary or even enough functioning filing cabinets. Again, the copious hand-written and typed records were well kept, usually informative and, based on local knowledge, could be judged accurate. Taken together however, the physical condition of these buildings projected a poor image of the senior-most nursing institutions in the country. In this they were not much different from many public building ravaged by the climate, neglect and termites.

The College of Nursing was located in another commercial area of Dhaka. The building being used at the time of the assessment in 1990 was opened several years previously as the second IDA-funded College of Nursing in the city. The first was built in 1970 and was only a few hundred yards away but had been abandoned although it was still in reasonable structural condition. Lack of finance for either maintenance or extension of the older building meant more capital outlay for the new one although the loan plus any interest would add to the country's climbing debt. As noted in Chapter 5, this is another illustration of the preference of the lending agencies, including the World Bank and ADB, for funding numerous capital projects rather than recurrent expenditure to maintain those already in place. Such projects are also attractive to decision-makers in recipient countries because commission charges from building contracts and the licenses for the importation of essential equipment provide low paid civil servants with the additional incentives (Mukherjee *et al* 2001*).*

The College's "official" intake of registered nurses was 120 comprising 60 BSc students per year for a two-year course divided equally between those taking the nursing management option and those opting for public health nursing. Note here that there were only 64 posts for public health nurses in the whole country and they were usually filled. For this reason, most of the public health graduates were

appointed teaching post in the NIs. Although both courses included tuition in management there was little with respect to teaching and learning methods. In 1990, 185 students were at the college putting great pressure on its already fragile facilities: dormitories were grossly overcrowded and exacerbated by the ad hoc lodging of various friends and relatives from further afield. Facilities were well below normal standards for a relatively young building, for example, cooking was done on a wood-burning stove, water supply was erratic and food storage and garbage disposal rudimentary. The library was staffed by an unqualified assistant and had seats for only 25 readers, it was rarely open to the students and, apart from some supplied through the British Council, the books were mainly out of date and reflected disease patterns of industrialised countries. Absolutely no journals were available. The 1990 assessment of the CoN library found:

> *Although many of the libraries in the NIs have problems... ... we saw few in the older NIs that were worse than that of the College of Nursing (Robson 1990 p35)*

The problem of books and equipment being locked away reflected a civil service rule that placed responsibility for all equipment and other physical resources firmly with the person "in-charge". Anything stolen, such as books, would be blamed on the principal and the value deducted from her salary. Whether or not deductions ever occurred, the threat was enough to avoid the possibility by keeping as much as possible under lock and key.

As mentioned above, a social science-based, community-oriented revision of the basic nurse curriculum had been completed in 1989 with assistance from WHO and was apparently being slowly introduced county-wide to the NIs. However, nothing had been done to up-date the CoN curricula, dating from 1947 and still being used to provide the next generation of teachers and managers for the NIs and hospitals.

The acting principal had an office of her own but the 10 lecturers and 4 instructors shared one office and there was no space for individual tutorials. With regard to their qualifications, although the GoB Orders called for the possession

of a Masters degree by all teaching staff, only four were so qualified and none of the tutors had a formal teaching qualification. Rote learning and excessive note taking was the norm: the teachers read from texts in English and provided explanations in Bangla. The students relied heavily on lecture notes circulated by the teachers from year to year and students usually passed their own notes on to the next year's student intake. Although modern teaching aids had been provided by various donors over several years, they were all locked away partly to avoid theft but also because often spare parts were not available and no instruction on their use had ever been provided.

The majority of the CoN teaching staff were over the age of 35 in 1990 so under ODA's Technical Co-operation rules could not qualify for scholarships to study abroad, a factor that added to their low morale and depressed their motivation to improve their situation. Although five more lecturer posts had long been approved by the civil service commission, there was no budget to fund them. At one time or another in the CoN's history it had been provided with donor-funded vehicles for conveying their students to various fieldwork areas but by 1990 all but one of the vehicles had been taken for their own use by more powerful individuals, either in the Ministry of Health or at the University of Dhaka. This restricted the amount of field exposure that could be offered to the students although those wanting to teach in the NIs could gain some practice in the two Dhaka NIs or those just on the outskirts of the city. It was observed during the 1990 assessment that their prepared lessons incorporated material that was often well out of date and bore no relationship to the new basic nurse curriculum just being introduced in the NIs.

Although the CoN was a constituent college of the University of Dhaka the relationship between the two was weak. There was no regular contact between the Principal and the Dean of the medical college and no institutional monitoring by the University or review of the BSc courses. Yet in spite of all its shortcomings, staff at the DNS and CoN urged consultants assessing the financial feasibility of the project were urged by the DNS and BNC to fund the introduction of a Masters level degree at the college. Although this might have

helped those lecturers who did not qualify for training abroad by providing advanced study *in situ*, there was already a multi-disciplinary Masters degree available at the National Institute of Preventive and Social Medicine (NIPSOM) in Dhaka. The four CoN lecturers referred to above held the NIPSOM degree and there was no barrier to others accessing the course. It attracted a wide range of students, doctors, dentists and people with undergraduate social science degrees, and the content of the course reflected the primary health care approach supported by member states of WHO, including Bangladesh, after the 1947 Alma Ata Declaration. [25]

In summary, the 1990 assessment found the CoN unsatisfactory as an educational resource responsible for preparing the country's nurse managers, public health nurses and nurse teachers. It begged the question of what had happened to the considerable human and material resources provided by WHO on a continuous basis since the CoN's establishment in 1970.

Perhaps inevitably, recommendations for enlarging the physical structure of the CoN received priority from the World Bank with the IDA stepping in with yet another loan for capital expenditure. As explained in Chapter 1, this part of the project and all other interventions involving construction and capital equipment were handled separately outside the ODA component of the SNES project and it was only in the closing stages of the project, when building work was completed in 1997/8, that attention was focused on improving the quality of teaching and learning within the college.

Divisional-Level Assistant Directors of Nursing Services

These women inhabited a professional backwater. Their official role was that of a decentralised supervisor and the DNS's representative in one of the four political and administrative divisions of Bangladesh. All were in a very weak position. Although at one time all four had a donor-provided vehicle with which to

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[25] See Glossary at Annex 2

facilitate supervision of the 15 or so districts they were responsible for the vehicles, as at the CoN, they had been commandeered by their more powerful colleagues. Apart from all this, the ADNSs had no budget with which to fuel or maintain the vehicle. Their living and office accommodation was makeshift at best, and when assessed in 1990, these four 1st class civil service positions were filled but not confirmed and largely non-functional. The SNES project design called for the appointment of four additional ADNSs to be funded from the development budget provided by the project. As one of the project conditions, they would eventually be absorbed into the civil service revenue budget. In the meantime in preparation for their role, they would be provided with professional study tours to the UK and elsewhere in South Asia. In fact the additional positions never materialised because of a fears that when the project closed, the MoHFW would renege on the commitment to absorb them into the revenue budget. This fear proved to be justified given the Ministry's financial weakness.

The 64 Districts of Bangladesh

By 1990, all of the administrative districts of Bangladesh had at least one hospital and 48 had a nursing institute. The older district towns had hospitals of around 200 beds and those with the country's eight attached medical schools had up to 600. Both hospitals and the nursing institutes were of varying quality in terms maintenance, cleanliness, equipment, staff and student accommodation. The newer NIs had all be provided through ADB or IDA loans but those visited in 1990 already showed rapidly deteriorating fabric: exposed electric wiring, rotting window frames and broken and non-functioning bathroom fittings were common.

The smaller district towns usually had 50 to 100 bedded hospitals. From the mid-eighties when as mentioned in Chapter 4, the government encouraged the opening of new nursing schools, the 50-bedded hospitals created NIs but, given the limited bed capacity, these schools could only offer the first two years of the three or four years training after which the students transferred to one of the larger institutions. In 1990, the conditions in which the young women lived and studied in these small NIs represented the worst of third world conditions. They

were usually housed in poorly built, locally rented premises, grossly overcrowded and most without internal bathrooms. As in many small towns in Bangladesh, sewage disposal and water supply were rudimentary. Positively, it was to the credit of the senior nurses at the DNS and BNC that, in spite of great pressure from the MoHFW, they successfully insisted that the entire period of nursing training could not be accomplished at the 50-bedded hospitals.

In addition to the hospitals controlled by the Ministry's health wing, the family planning wing also had facilities in the district towns: these were the Maternal and Child Welfare Centres (M&CWCs) staffed with Family Welfare Visitors and a one or more female doctor plus the usual sweepers and ayahs all employed through the family planning wing. These centres provided child health clinic services and eight to 12 beds for childbirth and surgery to provide permanent methods of family planning, such as tubal ligation or "sterilisation". The M&CWCs varied greatly in the quality of care provided but occasionally they functioned well and attracted local women for childbirth. As elsewhere within the health system there was practically no liaison between the clinics and the local hospitals although the better clinics would have made excellent learning venues for the student nurses at the NIs and district hospitals and especially for the student midwives.

Upazila Health Centres

Below the sub-district there was a network of comprehensive Upazila Health Centres (UHCs). All had outpatient provision and 31 beds for inpatients, six of which were reserved for childbirth. In 1990 the UHC served an average of 600,000 people. At this level the UHC staffing pattern was divided between those employed by the family planning wing and those employed by the health services wing which included general medicine. The majority of the UHCs beds were grossly under-utilised and their medical staff were frequently absent: the latter recently referred to as "ghost doctors" in a background paper for the 2004 World Development Report (Chaudhury and Hammer 2003). Despite the gap in time since the 1990 assessment the paper, 13 years later, suggests little has changed.

Although the UHCs could serve up to a million people, in 1990 they lacked blood banks, facilities for general anaesthesia and there were severe shortages of clinical equipment and bed linen. Staff accommodation was built at the same time as the UHCs but was insufficient for the nine doctors, five nurses and four family planning workers appointed to the facilities, a factor that, among others, accounted for high absentee rates among the staff. As with other physical structures, water supply was often erratic and waste disposal rudimentary.

At all health facilities some waste could not be disposed of because of the government rule that all broken or damaged equipment could not be removed unless approved by the government's "Condemnation Board". In 1990 it took at least five years to reach this point because lying around Bangladesh there was a huge backlog of broken equipment, vehicles, machinery, rusting beds, and even soiled and torn linen beyond further use. Not surprisingly the grounds and wards of most health facilities were strewn with assorted detritus, a symptom of a foreign aid system that, again, provides an initial capital input but no budget for its maintenance or replacement. Most of the UHCs and hospitals put in regular requests to the MoHFW for ambulances whilst those provided earlier by UNICEF or WHO lay abandoned for the want of a wheel or two and some spare parts.

Union Health and Family Welfare Centres

Five to ten Union Health Centres were located below the level of each Upazila level of local government. The majority of staff in these facilities were, again, employed under the family planning wing of the Ministry of Health. Like the M&CWCs in the district towns, they had a specific role in the provision of family planning and the care of mothers and their children. As with the UHCs however, they were under-utilized and although enough staff were available they were frequently closed due unauthorised staff absence. The key staff were the Family Welfare Visitor (FWV) and the Medical Assistant (MA). Both had a basic training of two years. As mentioned above, the former was registered on qualification by the Bangladesh Nursing Council and the latter by the Bangladesh

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Medical Council. Although the FWV and the MA worked together, their training institutions were constructed separately by the World Bank, the Asian Development Bank or one or two bilateral donors. As the bulk of the training for both FWVs and MAs was also donor funded, the buildings were left empty once funding was exhausted or sufficient numbers had been trained. Under government rules a donor-funded building created for one purpose could not be used for another even where the purposes were closely related. It is quite possible that such orders originated with the lenders particularly if different donors were involved and they had been built with loans. Medical assistant training ceased for several years during the '80s but as seen above, although the nearby nursing institutes were often in a very poor, even dangerous state, advantage could not be taken of purpose-built buildings vacated by the FWV or MA training programmes. Another example of the tortuous nature of foreign aid referred to above.

Other Health Resources

In addition to the facilities described above, there were other government hospitals and clinics. These included specialist hospitals for mental health, infectious diseases orthopaedics, paediatrics, cardiovascular disease, ophthalmic conditions and endocrine diseases such as diabetes. With the exception of the hospital for mental health, all were located in Dhaka as was a hospital specialising in post-graduate medical research and training. A large hospital with an attached nursing school for the armed forces was also in Dhaka and scattered throughout the country were small hospitals available only to the police, railway employees and armed forces and their families.

At the beginning of the '90s there were a few private hospitals in Dhaka and the second city of Chittagong but several missionary organisations had hospitals throughout the country. Various international and local NGOs also had clinics and small inpatient facilities in different parts of Bangladesh. The majority of the mission hospitals provided good examples of nurse training and quality of patient

care with high and apparently appropriate bed occupancy rates.[26] However, these hospitals were not popular as workplaces for nurses: they could not provide the long-term benefits that government employment brought to them as "service holders" and they were more disciplined both in terms of hands-on care required of the nurses and in workplace attendance. Although some nurses would accept temporary employment in the non-government sector, they did so reluctantly whilst waiting out the two to five years for an appointment in the government sector.

I mentioned in Chapter 1 that donor interventions in the training of various types of health worker undermined the senior nurses drive to expand their own numbers by persuading the civil service commission to create more government posts for the several thousand nurses without work by the end of the '90s. As Table 7.1 below shows, by 1999 there were far more family planning staff employed that any other category of worker in the health system.

Table 7.1 Human Resources for Health 1999

Registered Nurses/midwives	17,446
Family Planning Personnel	93,460
Medical Assistants	5,500
Registered Physicians	30,864
GoB Medical Schools	13 (8 in 1990)
Private Medical Schools	11 (0 in 1990)
GoB Nursing Institutes	42
GoB College of Nursing	1
Armed Forces Nursing Institute	1
Private NI	1 (0 in 1990)

Although the earlier 3:1 gap between the registered doctors and the registered nurses had closed somewhat, the opening of five new government medical schools and 11 private medical schools from the mid-nineties onward suggested the gap would re-open. However the question to be asked was how did all these workers contribute to the people's health in Bangladesh? Like the nurses, several

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[26] Missionary Organisations working in Bangladesh included American Baptists, Lutherans and Catholics. International NGOs included the Swedish Save the Children Fund, Red Cross/Red Crescent,

thousand doctors were also unemployed. On the other hand, possibly all the family planning staff were employed from village up to district-level. The medical assistants were also close to full employment throughout the network of UH&FWCs and in some of the outpatient departments at the district hospitals. Given that all the "sanctioned" posts created by the civil service were already saturated with staff and several hundred other posts were filled on an "acting" basis, the question arose as to where and how could all the registered nurses be employed. The nurse:bed or nurse:patient ratio looked unfavourable in comparison to international standards but not in all hospitals when set beside low bed occupancy rates particularly in the UHCs and smaller district hospitals. Even where the ratios were acceptable, as they were in the teaching hospitals and most of the specialist hospitals, there was clear evidence, again, that the nurses did not carry out nursing care but rather managed it through the patients' attendants or had it done for them by junior doctors and medical students. (Robson 1990, Hadley 2002 Leppard 2000).

The question arose as to how many trained nurses were really needed in the Bangladesh hospital system? For many years, the health services in the industrialised countries had not deemed it cost-effective to use fully trained nurses, many increasingly from graduate programmes, to deliver basic personal care to patients, for example, their bathing, toileting, assistance with feeding, and the recording of simple physiological measurements such as body temperature. Why then did the SNES project concentrate so closely on the need for qualified nurses in Bangladesh to be involved in activities that their colleagues in developed countries had already delegated some years earlier to less qualified personnel? In retrospect, greater attention could have been given to the *management* of care by attendants.

The District Public Health Nurses

Although the 1990 assessment of nursing had envisaged measures to strengthen the position of the country's District Public Health Nurses (DPHN) one of whom was located in each of the 64 districts, they were relatively autonomous from the rest of the nursing organisation and for the most part seemed to work in harmony with the District's chief doctor, the Civil Surgeon. That part of the DPHNs job description that called for her to supervise the 6-8 Upazila Health Centres under the District was almost impossible because of the cultural constraints on women traveling alone outside the main towns. and a lack of transport. Instead of investing in the DPHNs, it was decided by the project designers to fund an additional nurse to the UHC who would function as a supervisor of the five senior staff nurses already employed there. One hundred and twenty five such posts were to be provided throughout the life of the project at a rate of 25 per year for each year of the five-year project.

Summary

As described above, given the disease pattern Bangladesh, and, with some exceptions, the *quantity* of physical and human resources with which to deliver health care was probably sufficient at the time of the 1990 assessment. A large amount of foreign aid from independence in late 1971 onward had provided capital for the building and equipping of training institutions. Although the bulk of the aid going to the MoHFW was aimed at curtailing population growth and channeled via the family planning directorate, capital was also provided via the health and the nursing directorates for building and equipping various training facilities. However, in most cases, buildings, vehicles and equipment fell into disrepair rapidly for the want of recurrent funds for their routine maintenance. Although technical assistance had been provided to the DNS, the CoN and the BNC by WHO over many years, and they. funded regular study tours for the senior-most nurses and regularly brought in nurse consultants to provide training events, its only solid achievement was the production of the new basic

curriculum for the NIs in 1989/90. However this would take several years to implement fully because that of the CoN, producing the country's nurse teachers and managers, dated from a much earlier period. This aside the WHO curriculum provided a model of nursing care that demanded close interaction with patients and their relatives. As Leopard's study at the end of the '90s shows and Hadley's (2002) observations confirm, this is still far from the case. As also shown above, the health system itself was dis-articulated by the functional separation of services provided by the family planning, health and nursing Directorates under the Ministry of Health. Finally, as seen in Chapter 6, an attempt to fully integrate the Directorates through instituting a donor-led, sector-wide approach was thwarted.

CHAPTER 8

INTRODUCING THE SNES PROJECT

This Chapter demonstrates the instability of projects as vehicles for development. Concerns about the viability of the SNES project, and factors that would threaten its sustainability once completed, were identified even before the work commenced in early 1994. They confirm most of the issues surrounding foreign aid projects raised in Chapter 5. These include "turf wars" over project activities, the ambivalence of aid recipients suggested by Hyden (1995) and issues of "transparency" or possible corruption. The first year of implementing a project usually starts with an inception mission or visit to the project site with the main stakeholders. The purpose of the mission is to re-visit the project goal and purpose and to ascertain the level of commitment and resources that will be available to the project.

The inception mission took place in November 1993 and included the designated project manager at the British Council in Manchester; the head of the department managing the educational and consultancy inputs at Queen Margaret College in Edinburgh and the designate project co-ordinator and nurse educator. The two latter members would take up their positions in Dhaka in January 1994. The team also included a Bangladeshi senior nurse who had been appointed as Project Director and who would manage the IDA capital inputs separately from the rest of the SNES project.

The mission identified a formidable list of risks to the project some of which have been identified in the previous chapter. These are set out separately below.

Risks and Assumptions

1   There was no strategic plan for increasing the nursing workforce and a very weak information system for human resource planning. Enlargement of the nursing workforce was perceived only in the context of employment abroad. This raised a serious question over the project's

justification. Its aim was to create a critical mass of nurses who through education and training would be in a position to strengthen the nursing services *in Bangladesh*. The project intended add to the number and quality of nurse managers and nurse educators at middle-management level by funding 250 positions over the next five years at various NIs, hospitals and UHCs. One of the most expensive components of the ODA contribution to the project was the MSc level training at QMC. The fear was that all the training would be completed and the nurses would immediately leave for work abroad. As I mentioned above, nurses were already funding their own courses in specialist hospitals with the intention of leaving the country so this was a justifiable concern.

2   The promotion of nurses was based on length of service rather than merit. This was inflexible and prevented younger and more able nurses being appropriately employed in key areas. The allocation of nurses to different parts of the country and different institutions was also inefficient in the absence of an adequate management information system and the inability of the divisional ADNSs to supervise the district level facilities. Promotion rested on the civil service rules and posed a problem for the younger nurses: they wanted to be part of the civil service for the benefits it brought to them and their families but they were bitterly opposed to the rules being "service holders" brought with it. The project was powerless to do anything about this but it was to be raised again as private health facilities gradually grew in numbers alongside private nursing schools.

3   On the role of English, the senior nurses were committed to keeping English as the language of management and education but the standard of English was very low and it was envisaged that this would present problems for students coming for training at QMC. It was agreed that substantial resources would need to be put into language training if the nurses were to benefit from advanced courses in the UK. Since the 1990 assessment, 30 hours per year of English language had been added to the student nurses curriculum. This could not touch the problem but the issue

of language would dog the UK training. A note on the problem is in the postscript to the project. in Chapter 10. The manager and staff of the British Council English Language Testing Centre in Dhaka had repeatedly expressed concern that many of the nurses who had already been assessed had a limited knowledge of English and their scores were so low many would have to be rejected. There was no budget provision in the project to support English language teaching so there was a need for a major input from other sources if the situation was to be ameliorated and the objectives of the project achieved.

4   Through an earlier British Council project, new curricula had recently been developed for the 4th year post-basic training. This was an effort to wean the female nurses off taking the midwifery diploma, for which there was a dearth of opportunities to gain any practical training. At the same time it was hoped to strengthen the nursing care of sick children and people requiring orthopaedic treatment - both priority areas in Bangladesh. Although the nurses could choose any of the three they were still opting for midwifery as it was perceived, correctly, as necessary for employment abroad.

5   The new posts to be created through the project and referred to above had already been advertised. These were confirmed as 125 nurse educators for the NIs, 125 nurse supervisors for the UHCs and four additional ADNSs. These were to be recruited gradually over the next five years from nurses in existing posts. This would allow for in-service training prior to their appointment. Although these represented promotion, very few nurses had applied for the positions because potential candidates feared the posts would disappear at the end of the project. Again these were key elements in the project, designed to lift the quality of teaching in the NIs and the quality of nursing in the UHCs. In order to recruit for the posts a firm commitment was needed from the government to continue paying the salaries of these nurses after the project ended. As seen above, recurrent expenditure was already a problem.

6   The Bangladeshi project director had already taken up her position and had appointed 126 non-nurse project co-ordinators to oversee the IDA construction component. There was no indication where their salaries were to come from as they were not included in the project budget. She also requested two vehicles to facilitate visits to the various construction sites around the country but these had not been budgeted for either. I mentioned above the preference by governments for projects requiring capital investment particularly in construction. The fact that this part of the project was being handled separately from the ODA component left it outside the influence of either the British Council or the SNES project team. It is possible that the salaries of the men would be paid out of the IDA budget and any vehicles would come from the same source. On the other hand they may have been paid out of the GoB's £0.5 million contribution to the SNES project. In any event, separating the capital and the technical assistance element and keeping them at a distance from each other made integration of project activities cumbersome and blunted transparency.

7   The former nursing director, who had co-operated in the 1990 assessment, had retired and the appointment of her successor had not been confirmed. There were competing claims to the post by several senior nurses, including the Bangladeshi project director on grounds of seniority. This was already creating dissatisfaction, which could have an adverse effect on the project because of the need for the SNES project team to work closely and co-operatively with the DNS.

8   A Nursing Task Force composed of senior nurses from the CoN, medical college hospitals, the DNS and BNC had recently been set up and led by the WHO nursing adviser with the objective of producing a National Plan for Nursing. The task force had three working groups addressing nursing concepts, the content of a national plan for nursing and HIV/AIDS. The inception team was impressed by the enthusiasm and commitment of the

members but were concerned that it would duplicate and even undermine the role of the National Nursing Policy and Planning Committee (NNPPC) to be set up by the SNES project. In the event the WHO advisor assured the mission that the task force would report its finding at the end of March 1994 and it was agreed to wait for its recommendations before starting work on the NNPPC. However there were other areas of concern.

9   The mission found the attitude of senior nurses working with the WHO-task force ambivalent about external assistance and wanting the project delayed until the task force completed its deliberations. Confirming the attitude at the CoN, they also perceived their educational needs to be the immediate development of a Masters degree programme in nursing based in Bangladesh rather than the strengthening of nursing education at foundation and first degree level as a basis for eventual progress to higher degrees. The mission felt more could be achieved by the immediate appointment of the expatriate project co-ordinator and nurse educator who could work alongside the task force providing inputs to support to support the task force's recommendations. Again, the DNS attitude was alarming because it suggested the senior nurses were not fully committed to the SNES project whose task was to improve the quality of nursing throughout the health care system.

10   The Bangladesh Nursing Council had a central role to play in the future development of nursing, but was constrained in its activities both by deficient financial resources and the limitations of the current Nurses Act which did not provide adequate powers for the regulation of nursing. Additionally, the current registrar worked alone and was already physically frail and well beyond retirement age. For this reason it was decided to postpone any work with the BNC until later in the project's life by which time the registrar would have finally retired and one of the senior nurses completing their study tours abroad could be appointed as registrar.

11   On a number of occasions during the mission's visit, the academic qualifications of the designated nurse educator were raised as an issue by senior Bangladeshi nurses. She had already been in Bangladesh for a year working on the British Council project to develop the 4th year curriculum mentioned above. The British Council responded that their consultants were recruited on the basis of their general and professional qualifications and experience but this was not a good sign. The government had the power to reject expatriate consultants they did not consider suitable. As seen in the Chapter 5 both Sobhan (1900) and Mushid (2000) revealed reservations about the employment of consultants perceived to be under-qualified. It had been planned that the nurse educator would just transfer from the curriculum project to the SNES project but doubts were now raised about how much co-operation she would receive from the senior nurses.

Other matters relating to project implementation

The College of Nursing would need major construction work to enlarge and enhance the accommodation for staff and students. As mentioned above, this was to be managed separately from the rest of the project. With this in mind it did not seem feasible to start work on redesigning the CoN curricula before the building work had been completed. This part of the project was therefore postponed until the later years of the project.

The manager of the FIMC project mentioned in Chapter 1 was already in post and had secured office accommodation that could be shared by with SNES project once they started work. The mission members and the FIMC discussed possible linkages among other ODA projects to be funded under HAPP4. These included shared use with FIMC of the clinical training sites at the model clinic at Dhaka medical college hospital and the medical college's rural placement areas. Other possible linkages included those to ODA projects covering neonatal paediatrics and health economics. Such links are important in reducing the isolation of projects and providing examples of inter-disciplinary co-operation.

The British Council confirmed that they had the local capacity to undertake a library needs assessment of the 20 NIs scheduled for refurbishment and the CoN at an early stage of the project. It was essential that this assessment covered the physical structures of libraries in the NIs because additional library stock could not be put in place until adequate premises were available either in existing buildings or in the new centres for continuing education to be undertaken as part of the project's construction element.

By the end of the visit the inception team had formed a view that maximum project effect would be achieved only if inputs were co-ordinated with those anticipated by the WHO-led task force. The sequence of some of these inputs could be altered as necessary once the outcome of the task force's work was known in March 1994. At the end of the inception mission the members drew up list of actions to be completed before the project co-ordinator took up her position in January 1995. It also confirmed that, given the risks faced by the project, developments at the CoN and the BNC would be deferred until the later years of the project. It was agreed that the VSO would allocate the first four nurses to the project in June 1994 and the second four in September 1994. In the meantime the following selections should be made:

- A trainee librarian for overseas training
- The first two groups for management training at QMC
- The first two groups for MSc training at QMC
- The senior-most nurses at the BNC, CoN, DNS and at divisional level for study tours in the UK and South Asia.

As shown above, the SNES project was already risky before project activities began. The response was to postpone major activities until later in the project's life and to introduce others slowly and in a sequential pattern so that problems could be dealt with in one area before moving on to another. The project was already displaying some of the troublesome features identified in a National Audit Report on ODA projects two years later. This will be described at the beginning of the next chapter which analyses the areas to be addressed in more detail.

CHAPTER 9

IMPLEMENTING THE PROJECT

The weakness of both nurse education and practice in Bangladesh has been described in earlier chapters. This was compounded by long delays between the completion of nurse training and securing a post as senior staff nurse and low motivation stemming from the application of civil service rules. The practice of nursing care was also subject to a culturally based "pollution avoidance", described in Chapter 3, that distanced nurses from their patients and left personal care in the hands of relatives or low status attendants. Recognising this position, the project design could not alter the nurses' status as civil servants but could contribute to an improvement in educational standards in the NIs and the quality of nursing care in the hospital and UHC. It also envisaged a systemic strengthening of the profession's key institutions, the DNS, CoN and BNC.

The project considered that although Bangladesh is an Islamic country, and not withstanding the ascribed low status of nursing, the opportunities it held for women were less constricting than in other countries with a Moslem majority. However, their status as *women* was recognised as a brake on the nurses' ability to interact and work in an assertive, professional manner with the largely male doctors and even with the very large numbers of men working at subordinate levels of the civil service hierarchy. It was reasoned that an educational experience that concentrated on improving the capacity of senior nurses to be involved in the development and implementation of nursing policy, and in the country's health policy more generally, would improve their self-esteem and self-confidence and so assist them to a more equal footing with their male counterparts.

The project inputs and its progress are set out below but I will start with a 1995 review by the UK's National Audit Office (NAO) of ODA and the management of its Health and Population Division (HPD) projects in developing countries, one of which was the SNES project already being implemented. The Audit provides a useful although retrospective framework for an analysis of project performance.

The NAO was particularly concerned about how ODA monitored the progress of its projects against measurable targets and how it took remedial action where necessary. In view of the large volume of funds channeled to the health and population sector, the NAO also focused on how ODA could justify the use of these funds in terms of project success and sustainability after ODA withdrawal. The review covered a sample of 15 projects across India, Pakistan, Kenya and Zimbabwe and examined the various stages of the project planning cycle widely used by both multi and bilateral aid agencies as shown in Figure 9.1 below.

Figure 9.1 The Project Cycle
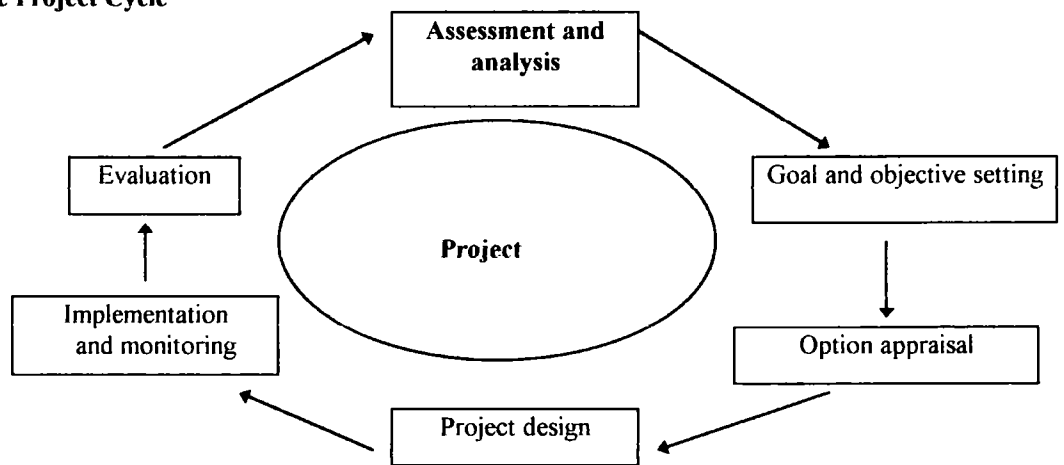
One of the main NAO criticisms was ODA's neglect, at the option appraisal stage of a project, to fully consider alternative routes to meeting the project's goals and objectives and therefore a failure to ensure that the approach adopted would be the most cost-effective. At the implementation and monitoring stage, there was a failure to set measurable indicators of progress, particularly of institutional development in the public health sector. In particular, NAO argued that project designers often neglected to collect baseline data which would allow realistic and measurable targets linked to the project objectives. Commonly used quantitative indicators were often inappropriate either because they were too broad or because they were unrelated to project impact. For example, a commonly used health sector indicator was the number of clinics built rather than numbers of clients using the clinics or the types of treatment provided. Other indicators, such as improvements in health status, were

also criticised because of the difficulty in relating health status to project activities given the multiplicity of variables associated with this particular indicator.

Lack of guidance on the format of progress reports and the non-existence of a common format for ODA's internally managed projects were also identified as problems. The NAO found that monitoring was focused too much on inputs and associated delivery problems rather than on progress towards project objectives and targets. In the case of project slow-down or derailment, remedial action occurred either too late or was not taken at all. They found this due in part to poor definition of responsibility for remedial action and a focus on achievement rather than on dealing with problems encountered. With regard to sustainability, the NAO found insufficient attention was paid to this most important aspect of project design: this was particularly in relation to assessment of the recurrent costs of a project and the capacity of aid recipients to meet them after project completion.

As to project management, the NAO found a reluctance to assess value for money in project management, for example by considering the use of contracted-out resource centres vis-à-vis in-house management[27]. In 1995 this was due, in part, to the failure to account for and cost the ODA advisors in-house inputs into various aspects of the project cycle. With regard to financial management, the NAO reported that for many projects there was a lack of cost and spending details on individual project components. For those projects concerned primarily with research, they had a limited impact on policy formulation either at national level or within aid agencies.

The NAO criticisms were clearly discernible across a whole range of donor-funded projects including the SNES project. It was a large and complicated project and reflected Sobhan's (1990) concern about over-design and use of expensive expatriate consultants. From the outset it was prone to many of the problems raised by the NAO. As with the vast majority of donor-funded projects its documentation included a Logical Framework. This relatively simple 4 X 4 cell paper set out the goal, purpose, outputs and activities of projects. Objective indicators of progress towards

all four areas and the means of verifying them are also included in the logical framework as are a list of risks and assumptions that govern the management of the project (TEAMtechnologies 1994). As seen in the previous Chapter, the list of risks and assumptions in relation to the SNES project was formidable. For a 1995 draft logical framework of the SNES project, please see Annex 16. It is usual for the framework to be revised several times during a project's life as the project environment changes and risks and assumptions identified earlier become more fluid. This was the case with SNES and was triggered as problems surfaced in the process of implementing the project. The project was not directly managed by ODA but, as explained in Chapter 1, was contracted out to the British Council who had many years of experience in various areas of education including nursing and other professional disciplines. The British Council in turn sub-contracted education and consultancy inputs to Queen Margaret College who had experience in developing countries and in professional education. To this extent ODA fulfilled the expectations of the NAO. However in other respects it did not. Although a great deal of baseline data on service provision was collected during the 1990 assessment, nothing was known about the level of hospital mortality and morbidity required to measure progress towards the goal of the project, defined as a reduction in the hospital rates of hospital morbidity and mortality.

With regard to project costs and expenditure, these were hard to track although the project budget was well specified. As mentioned in Chapter 1, the project activities involved inputs from several sources: the British Council, Queen Margaret College, VSO, WHO, the GoB and IDA. Also, as explained earlier, a Bangladeshi senior nurse managed the IDA input but she was housed separately from both the project's expatriate staff and the nursing directorate. The WHO nursing advisor had her office at WHO headquarters in Dhaka and the project manager was based in Manchester. This spatial separation of people managing the various inputs made for problems of day-to-day management of the project particularly as an unreliable telephone system was the main means of communication in the early days of the project.

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[27] Resource centres run on a commercial basis and are used to recruit TA consultants, conduct literature reviews and document searches and to design projects for aid funding. Increasingly they also manage aid projects.

As the NAO suggested, the project should be considered in relation to GoB's ability to incorporate project activities into their own programme after donor withdrawal. The World Bank-led HAPP4 for the period 1992-97 had very substantial recurrent cost implications. These could not be met by GoB from within their own revenue budget so half of the recurrent costs were classified as development expenditure in order that donors could fund them. Budget costings were only accurate to +/-20%, but on the basis of available data, it was estimated that by 1997/8 recurrent expenditure would be 20 million Bangladesh Taka or £336,000 a year (£1.00 = 55 B/Taka). This would include the 250 supervisors and nurse educators for the UHCs and NIs, and four additional ADNSs at divisional level. This is a particularly worrying aspect of project design and management because, as mentioned above, governments can rarely carry the same amount of recurrent costs after donors withdraw. It is a key factor in the lack of project sustainability identified by Rondenelli (1993) who noted that only 14% of World Bank projects were found to be functioning five years after the donors' withdrawal. If, as envisaged new posts were also to be created for half the number of nurses expected to finish their basic training over the next five years, this would add heavily to the recurrent costs of the nursing sector. Other recurrent costs needed to ensure the continued momentum of the project were less significant but nonetheless important, for example the nursing in-service training and continuing education costs. A question hung over the recurrent costs needed to maintain the capital spending outputs incurred by the project, for example, the maintenance of the additional building and renovation at the CoN, the Upazila health centres, the rural training centre and the continuing education centres. Given the neglect of capital projects once buildings and equipment have been supplied, pessimism hung over this aspect of the SNES project from the outset.

Stakeholder involvement in the project

The British Council

The British Council in Dhaka had a major responsibility for managing the ODA inputs into the SNES project. This would include processing the logistics of all the UK-based training, which included managing the delivery of English language training for successful candidates both at pre-departure stage and, in many cases, also on arrival in the UK. They also handled all travel and allowances for the senior nurses' various study tours and had responsibility for training, in-country, the 20 NI librarians called for in the project design. The overall management of the project was based in Manchester but in early 1995, mainly due to organisational re-structuring of the British Council, the management of the project moved from Manchester to Dhaka. At this point, the previous project manager became part of a newly formed British Council Consultancy Group that bid for contracts over a wide range of development activities. She was however still available to the project as a consultant and continued to work closely with Queen Margaret College on consultancy support to the Bangladesh Council of Nurses. In any event, the British Council's fees for managing the project were high at around 18% of the ODA total cost. Again, this demonstrates the point made by Muzaffa Ahmed in Murshid (2000) in relation to the proportion of the donor's contribution being used outside the recipient country.

Voluntary Services Overseas

As I have indicated above, one of the project's major proposals was to create demonstration units in existing hospitals and NIs for improvements in clinical training and patient care. Although around 20 were originally recommended only eight hospitals with their attached NIs were eventually selected although the 20 were selected for additional nurse educators. This reflected competing claims on the project budget, resource constraints on the GoB and the weak infrastructure of the nursing establishment that prevented rapid expansion. As mentioned above, many of the existing NIs were in such poor physical condition that they would be unlikely to benefit from the project inputs in its early stages. The objective of this part of the

project was to provide assistance to the Bangladeshi nurses that would help them to bridge the gap between the training of the student nurses in the classroom and its application to care of the patient in the ward. The VSO nurses in the demonstration units would handle this part of the project on a day-to-day basis with support from the expatriate nurse educator in Dhaka. Four VSOs would be recruited in the first year of the project and four in the second. The project plan was that examples of good practice developed in the demonstration areas would be cascaded via a system of in-service and continuing education to 20 district and medical college-based NIs. This would be facilitated when the newly re-trained teachers and managers to be appointed to these NIs arrived in post and as upgrading of their physical facilities and libraries was achieved via the SNES project. It was recognised that the rate at which construction occurred would be outside the direct control of the SNES management but depended on the disbursement of IDA loans and their construction schedules. Crucially it would also depend on the willingness of newly trained teachers and managers to take up new appointments.

The criteria for NI selection rested on their record of conducting better than the country's average basic nurse education programmes, having physical facilities that allowed a relatively early implementation and an in-patient size that allowed for a range of clinical experience. VSO would provide their nurse-recruits with pre-departure training including some basic introduction to Teaching English as a Second Language (TESL) in recognition of the English language difficulties of the Bangladeshi nurses. Tuition in Bengali would be provided for the VSO nurses over several weeks in Dhaka before they started work in their respective hospitals and Queen Margaret College would provide an orientation to health and the nursing profession in Bangladesh. All the nurses were appointed as clinical teachers had recent clinical experience although only one had experience in teaching in a school of nursing. None had had work experience in a developing country.

Although the recruitment of the VSO nurses was relatively uncomplicated, their deployment in Bangladesh created problems for themselves and the project. All were posted separately outside Dhaka, most at a distance that would present a challenge should they want to return to Dhaka from time-to-time or communicate with each

other. Most suffered some form of culture shock in spite of their orientation to Bangladesh and their several weeks in Dhaka: in particular, loneliness and isolation characterised a good deal of their early experience.

The concerns of the VSOs were identified at the beginning of April 1995 at which time four were working in different areas of Bangladesh but were reported to have been in Dhaka "for several weeks pending clarification of their role in the project". The expatriate nurse educator who should have had a mentoring and supportive role with them had already left the project and had so far not been replaced. Their job descriptions were "in abeyance" pending the outcome of an imminent day-long team-building workshop involving a large number of stakeholders from the Bangladesh and the UK. The VSO's needs echoed the NAO's concerns over project management more generally. They needed clear objectives and agreed indicators of success, clarification of their task, the scope of their work, and any autonomy they might have. They articulated their need for professional guidance and development and some idea of their own role within the wider SNES project. They wanted assistance to draw up work plans and also wanted an exchange of views on the inter-linking of project objectives with project activities. In general, their demands reflected what the NAO had identified as "project slowdown" or "derailment" with remedial action being attempted rather late in the project's life. The project eventually decided to pair the VSO nurses in an effort to overcome their isolation from one another and rented an apartment in Dhaka, which they could use for "rest and recreation" purposes.

An additional but muted factor in the VSO's unhappiness was the wide disparity between the living conditions of the expatriate project staff in Dhaka and their own situation in the remoter area of Bangladesh. It is not unusual for volunteer staff to eventually resent the life style of very well paid expatriate staff on the same project - their houses, servants, cars, drivers and provision of business-class flights when returning to and from the UK, all serve to upset the project equilibrium. In recent years, VSO has recruited volunteers from developing countries elsewhere in Asia and in Africa where their VSO allowances are usually in excess of what they might hope for at home. In that respect the volunteers may be less mindful of the marked

differences in life style among project staff. It is however a very sensitive area and one that deserves greater attention in the design of projects and the preparation of volunteer staff (personal communication N. Burnett, Human Resource Planning VSO).

In the context of Bangladesh culture, the posting of young, assertive, unmarried women to relatively isolated areas should have been better thought through.

Inclusion of VSO nurses was one of the more overly optimistic project inputs and the arrangement suffered also from instability among other parts of the project based in Dhaka, including the quantity and quality of support available to them from the project managers. By the time 1997 arrived there were only two VSOs still in Bangladesh. They were a retired and very experienced husband and wife team, both with teaching qualifications, who worked together to improve the care given to patients in the only remaining demonstration area in Chittagong. With the help of two MSc graduates working in the NI, they established a nursing demonstration unit on one of the wards, referred to as a model ward, and used this to coach the student nurses in the various procedures contained within the curriculum. They also assisted with the in-service training of the managers and nurse educators called for by the SNES project. They left at the end of their contract and the project towards the end of 1998 and, as with so many project activities, the model ward proved unsustainable in a relatively short time.

When I re-visited the area in 2000, the demonstration unit had been abandoned. Although, through persuasion from the SNES project, the model ward had been generously staffed, the nurses staff complained they had to work harder, and without recognition, than those on other wards. In an attempt to motivate them, it was suggested they would be given the opportunity of a study tour to other demonstration units in the region, such as those in Bangkok or Singapore. In the event, only nurses from Dhaka accessed the study tours. After this the Chittagong nurses refused further work on the model ward and it reverted to its usual status as just another ward with universally poor standards of care. The problem of student access to clinical instruction on the wards remained. At this point it seemed the ward staff were

unwilling to offer guidance to the students without incentive payments and that any attempt by NI tutors to provide instruction on the wards was bitterly resented and likely to be sabotaged by ward staff. Clearly, at this point, the purpose of the SNES project had not been realised. What of progress elsewhere?

Queen Margaret College

The project came to Queen Margaret College just after the dissolution of the "binary line" that separated higher education in the university sector from that managed by the Central Council for Academic Awards. This gave colleges such as QMC more freedom to design their own courses and, importantly, innovate with methods of income generation including promoting full cost, unsubsidised courses. The college had four years experience of delivering a Diploma in Primary Health Care, at close to full cost, which attracted students from developing countries, including Bangladesh, and had staff with working experience in developing countries including Bangladesh. It was therefore in a useful position to design a Masters degree programme, the first at QMC that could absorb students with awards under the SNES project and provide other diploma and certificate courses for the middle managers. It was to organise and oversee professional study tours in the UK for the country's senior-most nurses and provide observation placements in various Scottish hospitals and nurse training schools at some point in the courses.

Professional Study Tours

Study tours are a commonly used device in foreign aided projects for professional education and institution strengthening, particularly for senior-most personnel who are unable to spend a long time away from their workplace. They are however subject to lack of direction and abuse if not designed and carefully managed. The project design included the provision of study tours for groups of senior nurse managers, the objective of strengthening their capacity to develop the DNS, the CoN and the BNC by exposing them to examples of good practice in professional and institutional development. Eight to ten senior nurses came in two groups to QMC for four to six weeks in the mid-'90s. They had a well-designed programme that

provided for interactive visits to a number of key institutions in the UK including the UK Central Council for Nursing, Midwifery and Health Visiting which had legal responsibilities for the registration of all nurses in the UK and for the handling of disciplinary matters where necessary. Although this was of special importance to the BNC, the senior nurses visited all of the institutions together in order observe their inter-linking responsibilities. Visits were also made to the Department of Health in London to observe the working relationship between the chief nurse and her professional colleagues, and to the then English and Scottish National Boards whose major responsibility was for the standard setting and the accreditation of various levels of nurse education. The Royal College of Nursing was included in the study tours for their experience in professional education and their work with overseas nurses. Similar tours were organised within the South Asia region.

At the beginning of 1997 six senior nurses had an eight-day study tour of Myanmar and Nepal. This tour was organised by the SNES project-co-ordinator and the WHO nurse advisor. The purpose was to share information on the experience of all three Councils, particularly that relating to their legal status and other areas of responsibility such as progress in formulating a Code of Ethics, quality control mechanisms, membership and organisation of the Councils and the nurse registration systems of the Councils. At this point the BNC had still not achieved a strengthened Nurses Act and admitted to not being able to inspect NIs outside Dhaka because of lack of transport. Another study tour, this time to Pakistan took place at the end of 1997 and covered much the same ground as the other tours. A short account of one study tour is provided within the SNES Newsletter (p13) at Annex 18.

Following up the study tours was the responsibility of the QMC consultants. The objective being to take examples of good practice and attempt, as necessary and as far as possible, to adapt them to the institutional situation in Bangladesh - primarily to the BNC and the DNS. As noted above however, the South Asia tours came rather late in the project's life, and given the slow pace of change and the continued presence of the not yet retired but increasingly frail registrar at the BNC, there was little possibility of any major improvement in the near future.

Certificate in Management

Of the three levels of educational activity, the certificate-level management training at QMC proved the most difficult. This was a six-month course that had been approved by the College's academic board and external assessors. It focused heavily on quality and human resource management, communication skills and information systems but where possible it took into consideration the level of resources available to nurses in Bangladesh. As mentioned above, it also included several weeks based in a Scottish hospital or nursing school where the participants could observe the day-to-day management of relatively low technology wards and departments and educational management.

It was clear that most of the first group of nurses coming for their management course at QMC were close to retirement and would therefore have a limited time span left to them to implement any management improvements at their workplace. Although I mentioned, above, the age of 35 as being the upper limit for candidates funded by ODA/DfID for UK training, it is not unusual to find the rules are often circumvented by other considerations when their selection is made by their own line managers. Often such training is seen as "reward" towards the end of a career (Iredale and Sparkhall 1992). As mentioned above there is also a form of special pleading in Bangladesh by would-be candidates either on their own behalf, by their relatives or influential civil servants (Mukherjee et al 2001). In an effort to maintain an often delicate working relationship with their national counterparts, expatriate project managers may also be persuaded to agree the inclusion of people well beyond the formal age limit. Towards the end of the management course at QMC all participants were required to produce a "plan of action" for improvements in either patient care or some aspect of nurse education in their own workplace. Again the activities were tied to what might what be possible with limited resources. A typical plan might include introducing hand-washing routines; introducing a verbal and written staff handover between shifts; setting up a quality circle; and mentoring student nurses.

Responsibility for following up the implementation of the action plans was devolved to the long-term SNES project co-ordinator and the project nurse educator in Dhaka. It rapidly became clear that this was not feasible. The need to get to workplaces in various parts of the country, taking account of regular *hartals* was extremely time consuming whilst at the same time they had to manage other aspects of the project including consultancy arrangements and in-country training.

The second six-month certificate course came closer to its original conception: the participants were younger and more obviously drawn from the middle level of teachers and nurse managers. As with the first group the subject matter was tailored to their needs and their action plans mirrored what might be possible within their resource constraints. Given that the in-country project staff were unable to follow-up the outcome of the first group's action plans, arrangements were made to have a QMC consultant travel at a later date to conduct a follow-up evaluation of the second group. This took place three months after the course finished and was accomplished over several days. The evaluation showed that at this time only 40% of the course graduates had even begun to implement their action plans. It was felt that although the plans were within the resources available when they were constructed, instability and lack of agreement and teamwork among their colleagues in Bangladesh undermined their implementation. This finding confirmed a belief, already taking root at both QMC and in Dhaka, that conducting such courses so far from the site of their application was a costly and unhelpful intervention - confirming the point made by Iredale and Sparkhall (1992) and Rojas *et al* (1993) in Chapter 4 and Tendler (1975), referred to in Chapter 5. At this stage it was decided that all further middle-management training would be conducted by QMC consultants in Bangladesh and as close as possible to the workplace of the participants. The course was shortened from six months to 14 weeks with breaks at the end 3 to 4 weeks during which time the participants were required to implement an agreed management improvement, again, possible within their own resources. From an average cost per participant at QMC of £10000, the cost of the whole course within Bangladesh was calculated at £3669 and the bulk of this was accounted for by the consultancy fees, subsistence and travel

costs. Not withstanding the fact that length of the course had been halved, this was still a substantial saving.

The move to Bangladesh coincided with the completion of one of the IDA-funded Continuing Education Centres (CECs) at Chittagong. As they included accommodation for up to 16 participants the CECs offered an ideal venue for further training. Other benefits followed in that the earlier MSc graduates could assist with the training and, importantly, pass on their own learning experience in the UK. Six of the MSc graduates had had training of trainer courses earlier in the year, provided in Dhaka as a QMC consultancy, and this proved a very useful project input towards the end of 1997 and most of 1998 when their was an upsurge of various training courses in Bangladesh.

As mentioned above, there had been some concern in the early '90s about the outcome of UK-based education and training programmes in terms of the benefit gained by the "sending countries". In addition, Furey (1993) argued for *third country* training for students with ODA Technical Training awards. At that time around 8500 students from developing countries received such awards annually and in 1993 only 80 were studying in a third country. A third country being one that was not providing the award and was not the candidate's own country. Third countries tended to be those that had emerged from being regarded as "developing countries" to a stage where they able to provide a good educational, or vocational experience. Such countries included Thailand, Malaysia and South Africa, the latter still having development problems within its population. Whilst recognising some disadvantages such as resource shortages, the problem of quality assurance, monitoring and evaluations, and outdated teaching and learning methods.[28] Furey felt these problems were not insurmountable if sound partnerships could be developed between institutions in developed countries and those in developing countries. Since 1993, such partnerships have become more common assisted by the rapid development of communications technology that has allowed for elements of distance education to be incorporated into education, training and professional development. Note, for

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[28] These are not confined to developing or "third countries" of course.

example, my observation in Chapter 1 that a distance education MSc in nursing was being offered to Bangladeshi nurses by Adelaide University.

Diploma in Advanced Nursing and MSc in International Health

The final major input by QMC into the Bangladesh project was the provision of training for an advanced Diploma in Advanced Nursing and an MSc in International Health. Again both courses were accredited and open to all qualified applicants. A total of 26 Bangladeshi nurses completed either one or other of the awards and but most completed both. Four nurses came to the MSc from other courses in the UK, two in paediatric nursing and two in midwifery studies. Those coming direct from Bangladesh came in groups of six to eight and joined other international and European students on both courses. The majority were at QMC for two years but unavailable to Bangladesh for an even longer period because of lengthy periods of ESL courses both in Bangladesh and in Edinburgh. During their time in the UK their civil service posts were frozen making their experience in Edinburgh a considerable investment.

The Diploma in Advanced Nursing was of nine months duration and included modules in nurse and ward management, clinical nursing, quality assurance and biology. As suggested above, the year-long MSc in International Health was especially designed for students coming from developing countries or for others wanting to work in developing countries. The course outline is at Annex 17.

Both the Diploma courses and the MSc encouraged the Bangladeshi students to choose elective modules that could be related to the health system in Bangladesh. They were similarly encouraged to focus their dissertations on areas that would be of use to them on their return to Bangladesh. The teaching and learning methods on both courses were highly participative and, with the exception of the biology module in the Diploma in Advanced Nursing, assessment was continuous. This presented difficulties for the Bangladeshi students who had been used to rote learning throughout their educational experience. Given their very poor English language skills this was the preferred method in their NIs and, as mentioned above even at the

CoN in Dhaka. By working in groups the Bangladeshis were able to memorise whole sections of English text through constant recitation and copious note taking. In many developing other countries, recitation, memorising and rote learning remain the dominant learning method, particularly where teaching and learning resources are scarce. Often dismissed as merely a route to "surface" as opposed to "deep" learning, Zuber-Skerritt (1992) points out that rote learning can be highly effective in some forms of training and can provide the first stage in academic work from which the student is then guided to a more analytic method.

Neither the Diploma in Advanced Nursing (except for the biology module) or the MSc lent themselves to rote learning because of the system of continuous assessment. However the Bangladeshi students would certainly have preferred the biology module type of assessment: in this case an exam paper seen some time in advance and then taken under examination conditions. Continuous assessment was a challenge even as their English gradually improved with almost continuous tuition. This is not surprising as few entered their course with scores above the ESL Band of 5.5 defined as:

> *Modest user. Has partial command of the language, coping with overall meaning in most situations, though likely to make many mistakes. Should be able to handle basic communications in own field.*

A subsequent breakdown of their ESL scores showed that for most students the scores were lowest on listening and reading skills, both of which are essential to a deep understanding of the course content.

Certainly the majority of the Bangladeshi students were hampered by their poor English language skills and most, but not all, struggled to achieve their award. This is suggested by the evaluation of the MSc course carried out in 1998 and discussed below. Language also emerged as a leading concern in a 1997 study of international postgraduate students in Manchester (Graves *et al* 1997). The need to take notes in lectures and submit written assignments created profound anxiety among students for whom English was not their first language. The Manchester study raised a question

about alternatives to written assessments, such as oral examinations but this was not responded to positively by their students. This is an important area for exploration but poor language skills and issues of power distance are likely to remain a problem. However in Edinburgh, the Bangladeshi students did usually achieved higher grades on assignments that demanded a more visually constructive output accompanied by an oral presentation such as a curriculum design or a project proposal.

When in-country senior management training was provided at the DNS later in the project's life, the prepared teaching and learning materials were highly visual and specifically targeted at problems identified in Bangladesh by the Bangladeshis themselves. Standard management tools were included such as SWOT and PEST analysis, logical frameworks, force field analysis, 2 X 2 tables, Gantt charts, algorithms, concept mapping and role-play. Freirian tools such as codifiers and triggers which utilized local audio tapes and photographs were also used and found to be less threatening in that they did not call for extensive pieces of writing or elaborated dialogue and yet proved to be effective teaching and learning tools.

The Experience of Bangladeshi Students in the UK

Apart from language difficulties, like most international students the Bangladeshis also suffered loneliness and homesickness throughout their course. They were prone to many of the experiences students the Nottingham Area Council for Overseas Students Association (NACOSA 1989) drew attention to, particularly the debilitating effects loneliness has on student life. Their varying degrees of academic difficulty added to financial and accommodation problems, cold weather and cultural barriers are known to rapidly alienate a student from their new environment. When one adds racism, often insidious, the barriers to learning become even more apparent. The fact that the Bangladeshi students at QMC were part of a single country group, were accommodated on campus and had no significant financial problems whilst in the UK, did not lessen their vulnerability. They were of three religious groups, Hindu, Moslem and Christian and several were from Bangladesh's ethnic minority groups. They also belonged to one or another of the two, bitterly opposed, professional associations in Bangladesh. The latter contributed to the factionalism mentioned by

DfID (2003) and Mushid (2000). This followed the students to Edinburgh and periodically surfaced in bitter arguments. Unmarried women formed around 20% of the total in the Bangladeshi group, well above the 1.2% of unmarried women in the 25 - 39 age group in the general population of Bangladesh. Some of the less assertive among them therefore suffered the stigma that still clings to women who do not conform to the norm of marriage in their own country. Added to this, of the married students, 83% left young children behind in Bangladesh. A factor that contributed to bouts of anxiety and depression and intensified the level of culture shock - or what Zuber-Skerritt (1992) and Furnham (1997) refer to as uprooting. During their stay in the UK several of the Bangladeshi students had bouts of physical illness, which resulted in hospital admission, a rate well above the European students, which raises the possibility of stress-related illness. Certainly, the fact of having a group of students from the same country together over two years did not guarantee internal cohesion.

In a 1998 evaluation of the education components of the project, the negative aspects of their experience in the UK were evident. In various mapping exercises designed to uncover factors they perceived as barriers to their learning, reference was made to problems of cultural differences including differences in religion and beliefs.
Other responses included:

> *problems with language and accent; inequality of treatment*
> *by the teacher; conflict between friends and non-co-*
> *operation between friends.*

Frustration, depression and loneliness were also identified, as was the fact of having to deal with:

> *different (unfamiliar) style of education system - using*
> *libraries, writing assignments, search the literature in the*
> *CD ROM.*

A little more positively:

> *it provided an opportunity for me to share ideas and*
> *knowledge from a different cultural group of students,*
> *modern educational facilities which were fully used by me,*
> *all the teachers and campus environment was very co-*
> *operative and helpful, the weather was horrible and*

uncomfortable, finally a very painful experience because
away from my family.

The role of language is particularly important in the context of foreign aid to education, the purposes to which it is put and, by extension the projects it supports. For institutions bringing overseas students to the UK, or to other countries where the language of instruction is other than their own, this raises both practical and moral concerns that go beyond pedagogical issues. For example, in practical terms, the ability of the participants to debate and negotiate should have been crucial to the design of the management tasks and follow-up described above. It is possible that had the participants been able to communicate fully in English, or been able to engage with their teachers in their own language, a more realistic outcome of this part of the project would have emerged. This occurred when the middle-management course moved to Bangladesh and was facilitated in the Bangla language by returned MSc students. The special language needs of international students are rarely acknowledged and this, together with a passive disregard for their cultural background probably accounts for the generally poorer academic performance of the Bangladeshi students, although some performed as well or better than the "home" students. Although there are approaches to the teaching and learning of overseas students that could have been drawn upon, they were not used to any extent in either the design or application of the MSc curriculum. These approaches combine theory and practice from non-formal and adult education that, I believe, would have enhanced both the academic and the social experience of these particular students.

The SNES project closed in November 1998. An evaluation by ODA the previous year concluded that the project had not accomplished its original objectives, that the constraints were formidable and were not fully understood when the project was being designed. The evaluator suggested that the most significant internal constraint was the dissension and jealousies within the profession itself (ODA 1997). Although the project had been refined and reduced to selected interventions in strategic areas by 1997, the evaluator noted, more positively, that there was a qualitative difference in the professional manner of those nurses who had benefited from the project. She also noted that in her meetings with the senior nurses in particular that the manner in which they articulated their problems and thought through the solutions *"were light-*

years away from four years ago when the project was just starting." In that all the senior nurses referred to had participated in the various study tours, this suggests that this part of the project had resulted, at least in part, in their professional development: a conclusion supported by an evaluation of their experience mentioned in Chapter 1.

In the next chapter I shall review the post-SNES project experience of the nurses and nursing in Bangladesh. This demonstrates continuing problems but at the same time provides some grounds for optimism.

CHAPTER 10

POSTSCRIPT TO THE SNES PROJECT

The SNES project was replaced by another five-year project funded by DfID but on a much smaller scale. The second project Strengthening the Role of Nurses (SRN) was managed by the British Council but without the assistance of QMC. It would have one expatriate manager, again rely on a number of consultancies and focus on three areas: the DNS, the BNC and the CoN. At the time of the ODA evaluation 1997 some progress had been made in all three areas but there was still much work to be done. In particular, three senior nurses had been prepared through their various study tours and the QMC and British Council consultants to take over the management of the BNC, but as mentioned above, the Registrar, able but physically frail, had still not retired. Her retirement became a condition for ODA agreement to institute the next project. Most of the MSc graduates by this time were appropriately deployed, four had worked as local consultants with the SNES project and, as mentioned above, they assisted with the on-going middle management training. A further return on the project's investment in their training could be achieved by deploying other graduates at the DNS, and at College of Nursing where the BSc curriculum was being re-written. A second condition for approval of the follow-on project was therefore that 10 MSc graduates be appointed to the CoN. By the end of 1998 both conditions had been met and several graduates were working at the DNS.

Towards the end of the SNES project, a way of separating the nurses from the civil service came when the Government approved the conversion of the 600-bedded Institute of Postgraduate Medicine and Research (IPGMR) in Dhaka into Bangabandhu Medical University [29]. It then moved out of government control and was granted autonomous status. This meant that all its employees, including the nurses, were no longer part of the civil service. The move triggered strike action by workers at all levels in the IPGMR including the nurses.

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[29] Father of Bangladesh - Name for Sheikh Mujibur Rahman, assassinated in August 1975

The nurses eventually returned to work after assurances that all the civil service benefits so far accrued to them would be paid and that, once outside government control, their salaries would rise. The IPGMR nurses were not supported by the DNS who instead sent in an "emergency squad" of nurses to cover for the striking nurses. In the years following this, autonomy was granted to more of the medical college hospitals whilst, as mentioned above, there was a rapid increase in private hospitals some of which had attached NIs. In 2003 the government reneged on its agreement to provide employment to around 1500 unemployed nurses graduating from government NIs. Instead it proposed to employ around 2000 nurses from various private NIs around the county. Again this brought the nurses out on strike in various parts of the country (see again Annex 12).

In April 2001, a consultant with the SRN project managed a non-participative study of 291 observer hours carried out by three of the MSc graduates. The study covered a total of 18 hospital inpatient facilities for an average of 16 hours per facility. Semi-structured interviews were used to clarify their observations and quantitative data was collected.

The findings reported were close to my own in 1990. They showed a low level of nursing activity in government facilities in which time keeping was lax, end of shift verbal hand-overs to the next shift did not take place, and the poor level of English language undermined written hand-over notes. The vast majority of hands-on care continued to be provided by attendants and relatives. As in my assessment of 1990, Hadley concluded that on the basis of this study, the "western model" of nursing care did not appear to operate in public hospitals in Bangladesh. Some comparisons were made with NGO hospitals where nurses were found to operate closer to the "western

model" with more personal care and evidence of innovation in ways to deliver nursing care and its organisation.

The nurse's time in the public hospitals was accounted for by an average of close to 50% inactivity on the ward or time spent on refreshment breaks away from the ward. A large proportion of the senior nurses' time was taken up enabling the doctors to perform their work or in a handmaiden function. As in 1990, doctors were observed to carry out functions normally carried out by nurses in other parts of the world.

Hadley's report concluded that there was a marked difference between what nurses said they did and their actual activities and that most of the activities listed in the 1990 senior nurses' curriculum designed by WHO were not being carried out.

Elsewhere, the situation in 2001 was mixed. There was encouraging progress among the nurses who had completed their MSc in the UK most of whom were now deployed in the CoN, the DNS or working as local consultants. However, as suggested above, progress at the level of interaction between nurse and patient was depressing when compared to the purpose of both SNES and the SRN projects. Hadley's report of 2001 also made the following points in relation to the nurses' work in the hospital wards of government hospitals:

- The nature of the nurses' work was perceived by nurses and doctors as being un-rewarding and coping mechanisms were wrapped up in arriving late and leaving early;

- The administrative and clerical work was heavy. It involved paperwork relating to ward admissions and discharges and inventories of ward and hospital equipment, bed linen, crockery etc.;

- The purpose of ward reports was not fulfilled, for example, reports on patients were not passed verbally from nurses on one shift to another;

- Basic nursing care remained very poor - unconscious patients were left lying on their backs as were patients having breathing difficulties and those with eclamptic fits;

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- The continuing role of lay attendants and relatives in patient care was noted. The 1990 report had pointed out that the role of the nurse may be to manage care through the relatives and this was again noted as was the fact that many technical procedures were carried out by support staff, for example, catheterisation by Ayahs and Wardboys;

- There was a need to know what procedures absolutely needed to be carried out by trained nurses and what could be safely carried out by support staff and or the attendants;

- Hadley suggested using nursing care examples of NGOs but admitted these have already been tried by VSO nurses in the model wards and then abandoned;

- The ward "in-charge" needed more independence in running the ward but that would also need strong commitment and support from more senior nurses and doctors.

In 2002, a review of basic nurse education was carried out with an assessment of progress in implementing the basic nurse curriculum developed in 1990 by WHO. The view of the senior nurses in Dhaka was that the curriculum was well designed and reflected the health and disease pattern in Bangladesh and could be implemented within existing resources. But the review revealed that little had changed. The curriculum was still not fully implemented. It detailed each nursing procedure and highlighted the relevant patient care activity including psychological care and providing information to the patient. Yet less than 10% of the student nurse's time was spent anywhere near a patient: this was thought to be due partly to poor training and, again, partly due to a culture rooted in hierarchical inflexibility and pollution avoidance.

Hadley and Thanki (2002) again drew attention to the problem of trying to teach the curriculum in a situation where the students' and the teachers' grasp of English was very weak. They commented, *"Nurses in general, cannot speak or understand English or participate in professional exchanges in English"*. They suggested that lack of English was a barrier to improving standards of nursing care and thus, potentially, raising the status of nurses and nursing in Bangladesh.

It was noted again that examinations were set in English and preparation for them was by rote learning: a system used throughout the education system from primary school through to university.

From 1991 nurses had been allocated 30 hours of English language tuition per year during their first 3 years of basic training. The curriculum was taken from the 1989 Dhaka National Curriculum and Textbook Board and had been evaluated by the British Council in 1996. It was reported that the objectives were clearly stated but *"anyone following the course outline will be unable to achieve them"*. The course had five units that included grammar, translation, composition, prose and poetry. The latter were drawn from different periods of English literature. The consultant observed that the texts were inappropriate and did not provide any opportunity for relevant communicative activities. The level of English required to follow the course was "high intermediate" and the lectures accompanying the texts were based on books prepared for students whose first language was English.

A DfID education advisor had also looked at the assessment system used in the NIs and suggested it encouraged a rote learning approach to texts that the learners did not understand. The approach taken was that the teacher dictated sentences and wrote them on the blackboard and then explained in Bangla. The students' exercise books consisted of lists of sentences often copied from the books of previous year's students. An attempt at checking if the student had learnt the passage was made by using stimulus/response, questions and answers. For example the teacher might recite the first half of a dictated sentence and the students' response would be to chorus the remaining portion.

As noted previously, examination questions could be answered in Bangla or English - most preferred to use English as this is what they had memorised. To answer in Bangla would require them to translate from English into Bangla which would be time consuming if tackled in the examination hall. In 2001, the British Council teaching centre in Dhaka carried out an approved standard diagnostic test used to ascertain whether a candidate was able to take an examination in English. First, the Council tested a random sample of 10% of students and 10% of instructors at one

large medical college hospital. Second, using this test as a model, a test was purposefully developed to assess the English language skills of nurses relevant to their training and curriculum. The consultant was a UK health visitor with a qualification in English language testing and teaching. The test was piloted by re-testing a sample of those nurses who had been tested by the BC teaching centre and comparing the results of the two tests. A scoring mechanism was devised and finally the new tool was used to test a random sample of other nursing institutes to establish the representativeness of the results and to establish patterns, if any, among different categories of institutes and nurses. The result showed that the level of English of the "vast majority" of nurses and their teachers did not allow them to follow a course in English or to teach in English.

MSc Graduates

I visited Bangladesh on a private visit in February 2003 and took the opportunity to meet with the manager of the SRN project and in consultation with her I met with 18 MSc graduates in their various workplaces. They very willingly filled up a questionnaire, which asked for information on their present position and their evaluation of the present situation of nursing in Bangladesh. I asked them to fill out the questionnaire without conferring with each other and to omit their names (see Annex 10). The responses with some typical comments are set out below.

To the Question: "Are you working within the nursing service provided by the MoHFW?"

All 18 responded. 10 were at the College of Nursing and seven were based at the Directorate of Nursing Services, one of whom was a local WHO consultant and one MSc graduate was working as a local consultant with SRN project based at the British Council.

Asked if the MSc had advanced their career

Four answered "no", 14 answered "yes"

"Aid programme did not focus on the career of the highly trained people and issue of recruitment rules of DNS."

"Now I can communicate in positive and constructive manner. Able to put ideas in policy and planning at national level. Active participation in networking ideas of nursing services. Able to co-ordinate national workshops independently although the position is lower than what responsibilities I perform at present."

To the question "Do you think you have had a positive influence in helping the nursing profession in Bangladesh?"

One did not respond but 17 thought they had positively influenced the nursing profession in Bangladesh

"I am responsible to conduct the networking meeting for the nurse educator and managers across the country. It provides me the avenue to talk and discuss about the problems they are facing at their workplace and help them to identify the strategies to solve locally"

To the question "Do you think the award of a Masters degree has given you any personal advantage in the nursing profession relative to nurses who have not obtained a Masters degree?"

16 replied in the affirmative: one answered "no" and one seemed to have mixed feelings:

"this question has no yes and no answer. Sometimes nurses think OK I should do Masters degree, but what happens then, no promotion, no career like other Masters degree nurses... In my opinion, higher education has enriching knowledge, competencies, skills and developed my critical thinking and ability to work planned and continuously. It has also helped the profession in many different ways".

Asked whether factors other than the Masters degree had helped with progress in their career:

One did not respond, one answered "No" 16 answered yes.

"Experience gathered during working for the civil surgeon of a District to help him implement primary health care approach for improving health and situation of the people."

"Family and personal environment assists me a lot in the development program of nursing by giving ideas/views and allowing me to spend time for professional work."

"Masters degree itself help me create excellent image of nursing and within my family and relations that have helped me to contribute to nursing."

To the question "Has the SNES project produced a critical mass of nurses to improve the nursing profession in Bangladesh?"

Eight answered "yes", four answered "yes partially", two did not respond and four answered "no".

To the question "Looking back over the last 10 years, is the nursing profession and the services they provide better, worse or about the same?" the answers were

Better   6
Worse   2
About the same   8
No response   2

The final section asked the MSc graduates to list what actions needed to be taken to strengthen the profession. A representative selection their many responses is shown below:

- Put right person in right job
- Staff development
- Appropriate leadership
- Existing promotion criteria should be changed
- All "acting posts" should be fully fledged
- The Directorate of Nursing should be strengthened by decentralising the administration
- Increase the posts for all categories of the profession
- There should be a strong representation in the health policy implementation
- Mass media should be used to bring positive image towards nursing
- Increasing the accountability and responsibility of nurses top to bottom
- Nurses might not be in the same position
- Proper people should be in proper place through changing the roles DNS
- Staff development, proper leadership, good leadership
- Create more managerial posts in top and middle level in nursing profession in Bangladesh
- Fill up all posts by appropriate experienced, qualified professional nursing officers/personnel
- Eliminate acting provision from all posts and positions
- Bring change in perception of nurses about nursing
- Strengthen the NNPPC
- Need change of recruitment and promotion policy
- Provision for promotion in the right time according to the quality and experience of the person
- Increase the higher posts according to the level

Familiar concerns are contained within the list. The respondents reveal the dilemma the nurses have in clinging to their status as civil servants. The issue of promotion on length of service rather than ability continued to be an issue. The problem of nurses being placed in "acting posts" rather than having their position confirmed, their perception of poor leadership and the continued paucity of posts at senior level was again remarked on. For over 15000 qualified nurses, by this time, there were only 44

first class posts and 13 of them had been vacant over a long period. Of those senior nurses in 1st class posts only 5 were confirmed. There were 233 second class posts but, again, a large proportion were vacant or unconfirmed. However, although mainly stuck at 3rd class level (senior staff nurse) the majority of MSc graduates had found themselves in positions of some responsibility either as local consultants "on lien"[30] to the various project offices of international donors, at the DNS or the CoN. Others graduates were teaching at NIs around the country although as Hadley's report suggests, they could make little impact. Five MSc graduates were working in Saudi Arabia and one in Australia. These include some MSc graduates who were not financed by the SNES.

A high quality newsletter "Focus" was produced from 1996 and over the next two years had acted as a synthesiser, carrying articles and other information in English and Bengali, most contributed by the Bangladeshi nurses themselves (see example at Annex 18). It was edited and its production managed first by the team of local consultants, all of whom were MSc graduates, working at the SNES office and later at the CoN. When the SNES project closed in 1998, the incoming project decided to discontinue it on grounds that the production cost could not be subsidised. It had been distributed free around the country and the SRN project had suggested to its editors that if a charge were made for it, this would contribute towards its production. This suggestion was not acted on and at the time of my visit in 2003 it had ceased publication.

The SRN project did establish a small research unit at the College of Nursing in Dhaka. This encouraged small scale nursing projects most of them managed with the help of the MSc graduates and in 2001 they produced a volume of local nursing studies. This venture was also wound down with the close of the SRN project.

The Directorate of Nursing Services

Funds had been provided by the SRN project for refurbishment of the DNS office. At my visit in February 2003 I found a transformation. They had rented an additional

floor above its original solving to a great extent the overcrowding. It continued to have a large numbers of visits on a daily basis from nurses either seeking employment or a change from their workplace but the visitors were better organised. There were now waiting areas and a backup of visual displays showing the current deployment of nurses in Bangladesh and where vacancies might occur. Computer facilities had been introduced which were used to track changes at the NIs and hospitals. Halogen lighting brightened up areas that were without natural light and several offices had been created around the external walls by good quality partitioning with glass partitions that provided borrowed light into the internal areas of the DNS.

College of Nursing

The building had been renovated and extension built with the aid of the IDA loan. An extra floor had been added which provided additional classrooms and smaller rooms suitable for seminars and tutorials. The teachers also had additional and enlarged office accommodation. However the library was smaller than intended and no books or journals had been added. The librarian who was to be trained by the British Council to manage the library had never materialised and had possibly dropped out of the project timetable when the decision was taken to postpone work on the BSc curricula. Although the curricula had been re-drawn to complement the 1990 NI curriculum and interactive methods of teaching and learning had been introduced, the students were still dependent on the tutor's notes and a handful of textbooks available in the Bangladesh market. No improvements had taken place in the kitchen or the living quarters of either the students or the staff.

Towards the end of 2003, local newspapers reported that the CoN students had been boycotting their classes for some weeks and had issued a demand calling for recent editions of textbooks to be placed in the library and more secure dormitories.

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[30] Working with another organisation in Bangladesh or in another country but their civil service posts protected

CHAPTER 11

CONCLUSION

In this thesis I have examined the nature of foreign aid to developing countries generally and to Bangladesh in particular and have evaluated the background and operation of one project introduced in 1993 and designed to strengthen nursing education and services in Bangladesh. Although the overall aim was to produce a critical mass of nurses who would gain some control over their own profession and improve the delivery of nursing care, by 2003 this still seemed far from sight. The project suffered many of the faults common to other foreign aid interventions as outlined in Chapter 5 and referred to by Bangladeshi observers themselves. Criticism of "projects" as vehicles for development is widespread as is the role of technical assistance. However, as mentioned above, infrastructure projects such as those dealing with basic utilities, roads and public transport are more likely to be sustainable in that they contribute more directly to economic and social development. Research also suggests that interventions that emphasise sustainable primary education and primary health care produce social development, for example, a lowering of infant and child mortality rates, in the absence of significant economic development

Although a larger number of nurses than originally intended have been educated to Masters degree level, and a great deal of time was devoted to various forms of training, a subsequent review suggests the benefits have accrued to individuals rather than to the nursing profession as a whole. It may be tempting to assume this is because of the inadequacy of individuals or their training programmes this is not the case. The limited gains that were made, such as the production of their journal "Focus" and the volume of research findings related to nursing practice in Bangladesh, drew a lot of commitment from local staff. However, both of these achievements were heavily dependent on support from the SNES project and, later, the SRN project, and within these parameters they were far from sustainable. The same can be said of the activities carried out by the VSO nurses and the model wards they created, and within a relatively short time, the same may be said of the construction and refurbishment components of the project.

Other factors characterise Bangladesh and threaten the sustainability of any project gains. As Sobhan (1990), Murshid (2000), DfID (2003), and the nurses themselves confirm, political factionalism is endemic and the nurses are not immune from its effects. In the highly politicised atmosphere of Bangladesh, nurses are just as likely as any other group to engage in struggles that undermine a bid for professionalisation and therefore their integrity. This is demonstrated by the long-running and bitter arguments between the Bangladesh Nursing Association and the Bangladesh Diploma Nurses Association. Quite apart from internal dissension, the project supported with reasonable effectiveness, the formalised but only partially functioning and validated western model of nursing care. In retrospect however, one must question whether this is the appropriate model for Bangladesh. The basic nurse curriculum introduced in 1990 assumed close interaction between the nurse and the patient so that the student nurse could learn the practical and individualised care that matched the theory taught in the classroom. But this has never been a feature of nursing in the public sector hospitals of Bangladesh for reasons of pollution avoidance but also because female nurses, in particular, feel their gender leaves them physically unprotected when engaged in close contact with patients and their relatives. Another, and complicating, characteristic of Bangladesh lies in WHO's observation (1996) that an oversupply of doctors and other health providers in a health system distorts the potential role of nurses by taking over work they might normally want to develop both in the clinical area and in the community.

Again, is the type of project described in this thesis suitable for strengthening professional development that by its nature must constantly adjust to changes in the environment within which it practices? It cannot do this if resources are provided intermittently and there is dissension among donor representatives themselves. Nor can it develop if, in addition to its normal work, the profession has to constantly jump through what Williams (1995) refers to as "the project hoops". As Bauer (1995) observed, this type of foreign aid distracts people from what should be their normal activity. It invites people to fight for access to whatever crumbs fall off the project designer's table and it fuels corruption. The

SNES project was very expensive in relative terms yet much of its design was never implemented, books were never delivered to the libraries, the nurses' living accommodation remains lamentable and not a single development post ever materialised. Each of the MSc graduates cost an average of £32,600 of which academic fees accounted for around £17,000. Added to this were several years of consultancy fees and associated management costs, airfares and various allowances. This must partially support the view of Murshid's respondent in 2000, that the "lion's share" of foreign aid goes back to the donor. And finally, Geertz' observation about the disconnected nature of cultural analysis, and how we plunge deeper and deeper into the same thing must surely, and sadly, be abundantly true of the foreign aid culture and its application in countries such as Bangladesh.

As to the case study itself, I believe it has contributed to a large literature on foreign aided projects and technical assistance although the parameters were too wide for a deeper analysis given the prescribed length of the thesis. Any of the areas covered by the SNES project and shown in Table 1.1 could have formed an area for more concentrated attention. For example, another researcher might want to concentrate only on the senior-most nurses and the three key institutions, the BNC, the CoN and the DNS. This would allow for an examination of the professionalisation process and, in particular, the role of professional education in relation to Bangladesh. The follow-on SRN project did concentrate more resources in this area than the earlier SNES project which cast its net much wider. Although building on earlier work, the SRN project may have been more successful in creating a more responsive nurse leadership notwithstanding on-going and persistent problems in the professional environment.

The whole area of using the English language for professional education where very few people have been adequately schooled in English needs further examination. As mentioned in the previous chapter, medical students and qualified doctors also struggle with learning in English as a second language. A comparative study of nurse education with that of the Family Welfare Visitors (FWVs) could yield important insights into the application of the latter's training

to service delivery in the community. On the whole, the FWV training appears to be carried out more efficiently in the Bangla language and their work in the community is more likely to be documented in written Bangla than in English. Together, these observations may suggest that the FWV based in the community is a more appropriate health worker for Bangladesh than the hospital-based nurse.

Another area for a comparative approach would be the experience of the older state-funded schools of nursing, where practitioners are firmly tied to the civil service, with those more recently established in the private sector. Are there qualitative differences in the education of these two groups of nurses and in its application to their practice? Yet another potential area for research could be to observe whether nurses who leave Bangladesh to work abroad engage in more individualised hands-on care than they do in their own country. How might the differences, if any, be accounted for?

As to the research *methods,* the case study approach, with some degree of participation on the part of the researcher, is well suited to Bangladesh where events are unstable and logistic problems are constant: these factors could make a more quantitative approach difficult. In Bangladesh, the research method needs to be able to move with the events because what is true for today may change by tomorrow: Annex 12 bears this out. One area of qualitative research that needs further consideration is the use of focus groups with participants whose first language and culture differs from the that of the researcher. As mentioned in Chapter 1, I found the transcribing of the hour-long focus group recordings difficult because of the tumultuous response by the participants. A solution may be to have shorter and more focused sessions although that may depress the richness of the responses. My own solution would be to combine the focus groups and support the responses with documentary evidence, including that produced by the subjects themselves, semi-structured-interviews with individual subjects and external observers, and to use materials produced by the subjects themselves and visual evidence, such as newspaper reports, photographs and, where appropriate, video clips. Concept maps and Vee diagrams provided by the subjects add another dimension to the research.

To some extent, I have used this approach as demonstrated in several of the Annexes.

However one area of *quantitative* research that would be useful is an examination of the level of morbidity and mortality in Bangladesh hospitals. As seen above, the original goal of the SNES project was to reduce the morbidity and mortality among hospital patients yet there were no baseline indicators with which to measure progress. Research elsewhere demonstrates the importance of good nursing care in reducing hospital morbidity and mortality and such research could be a first step in demonstrating the value of nurses managing the personal care of patients in Bangladesh hospital wards. Given the observations above, this would of course call for a closer relationship between the nurse and the persons carrying out the care. Generally, I believe the thrust of any further research should be towards improving the quality of nursing care in Bangladesh be that by the nurses themselves or through their role in improving the care given by relatives and other attendants. Here I want to point out that in recent years, in the UK and other parts of the developed world, much routine hands-on nursing in hospital wards, and in the community, has been devolved to ancillary staff. As nurse education has gradually moved into higher education it is no longer deemed cost-effective to have qualified nurses providing low level although essential, personal care and routinely monitoring physiological measurements such as temperature and blood pressure.

Finally, by being unable to achieve its original purpose the SNES project cannot be said to have been cost effective. However it did established an understanding of the particular problems that affect nursing in Bangladesh and the difficulties western cultures and ideologies have in providing solutions. A subsequent aid intervention was able to build on this and make further headway. However, positive change must originate from within Bangladesh given the political, economic, social and professional environment as well as the inherent problems attached to foreign aid. My association with Bangladeshi nurses during the development and implementation of the project, and since, provides grounds for

optimism that progress will be made not quickly but I believe, eventually. The original goal of the SNES, to achieve a critical mass of nurses able to take the profession forward, has been partially achieved and the responses shown in Chapter 10 suggest that the Masters degree graduates, crucially, have a sense of self-esteem which is an important prerequisite for professional development.

However, noting the systemic difficulties described above, it is likely that the nursing profession in Bangladesh will continue to need external assistance. This should build on what has already been provided and draw substantially on their own resources, which as suggested above, represent significant achievement.

Bibliography

1. Abel-Smith B (1960) *A History Of the Nursing Profession*, Heinemann, London
2. Adam C S and Gunning J W (2002) Redesigning Aid: Donors' Use of Performance indicators in Uganda, *World Development* 30 (12) 2045-2056
3. Adnan S, Barrett A, Nurul Alam S M, & Brustinow A (1992*) People's Participation, NGOs and the Flood Action Plan*: an independent review, Oxfam, Bangladesh
4. Ahmed M (1975) *The Economics of Nonformal Education: Resources, Costs and Benefits*, Praeger, New York
5. Akhter M Y (1987) Some Neglected Agents of Political Socialization: a Study of Women in Rural Bangladesh, *The Journal of Local Government*, 16, 2. 67-81
6. Arthur L and Preston R (1996) *Quality in Overseas Consultancy: understanding the issues*, The British Council, Manchester
7. Asian Regional Seminar (1979*) Equality of Educational Opportunity for Women and Girls*, UNESCO
8. Bala P (1991*) Imperialism and Medicine in Bengal: A Socio-Historical Perspective*, Sage, London
9. Bangladesh Rural Advancement Committee (1990) *A Tale of Two Wings: Health and Family Planning Programmes in an Upazila in Northern Bangladesh*, BRAC Publications, Dhaka
10. Basiago A D (1995) Methods of Defining "Sustainability", *Sustainable Development* 3, 3, 109-119
11. Bass S and Dalal-Clayton B Swiderska K and Bass S (2002) *Stakeholder Dialogues on Sustainable Development Strategies: Lessons, Opportunities and Developing Countries*, Environmental Planning Issues No. 26 International Institute for Environment and Development, London
12. Bauer P T (1991*) The Development Frontier: essays in applied economics*, Harvester Wheatsheaf, London
13. Beneria L and Feldman S (1992) Unequal Burden: economic crises, persistent poverty and women's work, Westview Press, Oxford
14. Berg E (1993*) Re-thinking Technical Co-operation: reforms for capacity building in Africa*, 1 UNDP 1993
15. Berlage L and Stokke O *eds* (1992) *Evaluation of Development Assistance: approaches and methods*, Frank Cass, London
16. Billetoft J and Malmdorf T (1992) *Bangladesh: addicted to aid. which way?* CDR Project Paper 93.2
17. Blanchet T (1984) *Women, Pollution and Marginality: Meanings and Rituals of Birth in Rural Bangladesh*, University Press, Dhaka
18. Booth D (2003) Introduction and Overview, *Development Policy Review*, 21 (2) 131-159
19. Boserup E (1996) Development Theory: an analytical framework and selected applications, *Population and Development Review*, 22, 3, 505-515

20. Bossert T J (1990) Can They Get Along Without Us? Sustainability of Donor-Supported Health Projects in Central America and Africa, *Social Science and Medicine* 30 (9) 1015-1023

21. Boulton-Lewis G M, Wilss L and Mutch S (1996) Teachers as adult learners: their knowledge of their own learning and implications for teaching, *Higher Education*, 32 89-106

22. Brown C (1975) *Literacy in 30 hours: Paulo Freire's Process in North East Brazil*, Writers and Readers Publishing Co-operative, London

23. Bulmer M and Warwick D P (1993) *Social Research in Developing countries: Surveys and Censuses in the Third World*, UCL Press, London

24. Burnell P (1997) *Foreign Aid in a Changing World*, Open University Press, Milton Keynes

25. Brown C (1975) *Literacy in 30 hours: Paulo Freire's Process in North East Brazil*, Writers and Readers Publishing Co-operative, London

26. Byram M and Fleming M eds (1998) *Language learning in intercultural perspective: approaches though drama and ethnography*, Cambridge University Press, Cambridge

27. Cassen R and Associates (1986) *Does Aid Work?* Clarendon Press, Oxford

28. Chaudhury R H (1982) The Effect of Mothers Work on Child Care, Dietary Intake, and Dietary Adequacy of Pre-School Children, *The Bangladesh Development Studies* 10, 4, 33-59

29. Chen M A (1987) *A Quiet Revolution: Women in Transition in Rural Bangladesh*, BRAC, Dhaka

30. Chowdhury G (1995) *Engendering Development: Women in Development (WID) in international development regimes* in Marchand M and Parpart J L (1995) *Feminism, Postmodernism, Development*, Routledge, London

31. Clark C and Roy K C (1997) *Comparing Development Patterns in Asia*, Lynne Rienner Publishers Inc. London

32. Collins D (1977) *Paulo Freire: his life, work and thought*, Paulist Press, New York

33. Commission of the European Communities *(1993) Women and Development: A Guide to Gender Issues in Managing European Community Co-operation with Latin American, Asian and Mediterranean Countries*, EEC, Brussels

34. Constantino-David K (2001) Unsustainable Development: the Philippines experience, *Development in Practice*, 11 (2&3) 234-241

35. Cortazzi M and Jin L (1997) Communication for Learning Across Cultures in McNamara D and Harris R (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

36. Craft A ed (1993) *International Developments in Assuring Quality in Higher Education*, The Falmer Press, London

37. Collins D (1977) *Paulo Freire: his life works and thought*, Paulist Press, New York

38. Cortazzi M and Jin L (1997) Communication for Learning Across Cultures in McNamara D and Harris R (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

39. Craft A ed (1993) *International Developments in Assuring Quality in Higher Education*, The Falmer Press, London

40. Davies C Ed (1980) *Rewriting Nursing History*, Croom Helm, London

41. de Rivero O (2001) *The Myth of Development: the non-viable economies of the 21st century*, Zed Books, London

42. de Winter E R (1993) Which Way to Sustainability? External Support to Health Projects in Developing Countries, *Health Policy and Planning*, 8 (2) 150-156

43. Department of Education, London (1997) *Personal Communication*

44. Department for International Development (1996) *Summary Sheets: Gender Training Frameworks and Methods* (unpublished)

45. Department for International Development 2002 *Briefing: Supporting the Drivers of Prop-Poor Change: a new agenda for Development Assistance to Bangladesh*, DFID Bangladesh

46. Department for International Development (2003) Country Assistance Plan (Draft) 2003 - 2006

47. Dingwall R and McIntosh J (1978) *Readings in the Sociology of Nursing*, Churchill Livingstone, Edinburgh

48. Dingwall R Rafferty A M and Webster C (1988) *An Introduction to the Social History of Nursing*, Routledge, London

49. Directorate of Nursing Services, Bangladesh (1994) *National Plan of Action for Nursing Development in Bangladesh*, Ministry of Health and Family Welfare, Dhaka

50. Dobson S M (1991) *Transcultural Nursing*, Scutari Press, Middlesex

51. Elsey B (1990) *Teaching and Learning* in Kinnell M Ed (1990) *The Learning Experiences of Overseas Students*, The Society for Research into Health Education

52. Entwistle N, Thompson S and Tait H (1992) *Guidelines for Promoting Effective Learning in Higher Education*, Centre for Research on Learning and Instruction, University of Edinburgh

53. Escobar A (1995) *Development Planning*, in Corbridge S (1995) *Development Studies: A Reader*, Edward Arnold, London

54. Faaland J and Parkinson J R (1975) *Bangladesh: the Test Case for Development*, University Press, Dhaka

55. Fitzgerald R (1997) *Rescue and redemption - the rise of female medical missions in colonial India during the late nineteenth century and early twentieth centuries*, in Rafferty A M Robinson J and Elkan R ed (1997) Nursing history and the politics of welfare, Routledge, London

56. Foster M (2003) Criteria for Assessing the Case for Overseas Aid: a note, *Development Policy Review* 21 (3) 293-300

57. Frank A G (1992) *The Development of Underdevelopment* in Wilber C K and Jameson K P (1992) *The Political Economy of Development and Under-development*, 5th edition, McGraw-Hill, London

58. Freire P (1972) *Pedagogy of the Oppressed*, Penguin Books, Harmondsworth

59. Freire P (1978) *Pedagogy in Process: the Letters to Guinea-Bissau*, Seabury Press, New York

60. Freire P and Macedo D (1987) *Literacy: Reading the Word and the World*, Routledge and Keegan Paul, London

61. Furnham A F (1997) *The Experience of Being an Overseas Students* in McNamara D and Harris R (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

62. Gamarnikow E, Nurse or Woman: gender and professionalism in reformed nursing 1860-1923 in Holden P and Littlewood J (1991) *Anthropology and Nursing*, Routledge, London

63. Gardner K and Lewis D (1996) *Anthropology, Development and the Post-Modern Challenge*, Pluto Press, London

64. Geertz C (1973) *The Interpretation of Cultures*, Basic Books, New York

65. Geske Dijkstra A (2002) The Effectiveness of Policy Conditionality: eight country experiences, *Development and Change* 33 (2) 307-334

66. Gilson L (1995) Management and Health Reform in Sub-Saharan Africa, *Social Science and Medicine* 40 (5) 695-710

67. Godlee, F (1994) WHO at country level-a little impact, no strategy, *British Medical Journal* 6969: 309 1636-1639

68. Government of the People's Republic of Bangladesh (1979), *Ministry of Health, Population Control and Family Planning - Health Division: Job Descriptions for Nursing Officers and all Categories of Nursing Personnel*, Dacca .

69. Government of the People's Republic of Bangladesh, Directorate of Population Control (1985), *Office Memoranda*, Ministry of Health and Population Control, Dhaka

70. Government of the People's Republic of Bangladesh, Bureau of Statistics (2002) *Statistical Pocket Book of Bangladesh 2000*, Dhaka

71. Graves J, Humphries B, Kamale B, and Martin M (1997) *Overseas Students at Manchester Metropolitan University and Manchester University: A Needs Analysis*, Unpublished Document.

72. Grindle M S (1980) *Politics and Policy Implementation in the Third World*, Princeton University Press

73. Habermas J (1971) *Knowledge and Human Interests*, Beacon Press, Boston

74. Hadley M and Thanki M (2002) Making choices for nurse training and education, Bangladesh Consultant's Report - Unpublished

75. Hancock G (1989) *Lords of Poverty: The freewheeling lifestyles, power prestige and corruption of the multibillion dollar aid business*, Mandarin, London

76. Hanson A (1993) *Culture and Process of Adult Learning*, Routledge)Harris R (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

77. Harris R (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

78. Hartmann B and Boyce J (1983) A Quiet Violence: view from a Bangladesh village, Zed Press, London

79. Hayter T and Watson C (1985) *Aid: rhetoric and reality*, Pluto Press, London

80. Hirschman A D (1967) *Development Projects Observed*, The Brookings Institute Washington DC

81. Hirschman A D (1991) *The Rhetoric of Reaction*, Bekkap, London

82. Hofstede G (2001) *Culture's consequences: comparing values, behaviours, institutions and organizations across nations*, Thousands Oakes/Sage London

83. Holden P and Littlewood J (1991) *Anthropology and Nursing*, Routledge, London

84. Hope A and Timmel S (1984) *Training for Transformation: a handbook for Community Workers,* Mambo Press, Zimbabwe

85. Hossain M (1995) *Aid Conditionalities and Development Imperatives of Bangladesh* in Stokke O (1995) *Aid and Political Conditionality,* Frank Cass, Portland, Oregon

86. Hussain M (1994) *Development Administration in Bangladesh,* Hasan Publishers, Dhaka

87. Hyden G (1995) Reforming Foreign Aid to African Development: a proposal to set up politically autonomous development funds, *Development Dialogue,* 2, 19, 34 -52

88. Iredale R and Sparkhall K (1992) *The Power to Change,* Overseas Development Administration, London

89. Islam M (1985) *Women, Health and Culture,* Women for Women Research and Study Group, Dhaka

90. Islam S (1982) *Exploring the Other Half: field research with rural women in Bangladesh,* BRAC Dhaka

91. Jahan R (1995) *The Elusive Agenda: mainstreaming women in development,* University Press Dhaka

92. Jansen E G (1987) *Rural Bangladesh: competition for scarce resources,* University Press Dhaka

93. Jarvis P (1987) *Twentieth Century Thinkers in Adult Education,* Routledge, London

94. Jeffery R (1985) *Health and the State in India,* PhD Thesis, University of Edinburgh

95. Jordan Smith D (2003) Patronage, Per Diems and the "Workshop Mentality": The Practice of Family Planning Programs in Southeastern Nigeria, *World Development* 31, 4 pp 703-715

96. Kanji N (1989) Charging for Drugs in Africa: UNICEF's "Bamako Initiative", *Health Policy and Planning,* (2) 110-120

97. Khan M R (1988) *Evaluation of Primary Health care and Family Planning Facilities and their Limitations Specially in the Rural Areas of Bangladesh,* Research Monograph No. 7, Bangladesh Institute of Research Studies

98. Khan S (1988) The Fifty Percent: women in development and policy in Bangladesh, University Press Dhaka

99. Killick T (1999) *Making Adjustment Work for the Poor,* Poverty briefing, Overseas Development Institute, London

100. King K (1991) *Aid and Education in the Developing World,* Longman Group, Harlow, Essex

101. Kinnell M Ed (1990) *The Learning Experiences of Overseas Students,* The Society for Research into Health Education

102. Kirkwood G and Kirkwood C (1989) *Living Adult Education: Freire in Scotland,* Open University Press, Buckingham

103. Knowles J (1975) *Self-directed Learning: a guide for learners and teachers,* Follett, Chicago

104. Kosack S (2003) Effective Aid: how democracy allows development aid to improve the quality of health, *World Development* 31 (1) 1-22

105. Leppard M (2000)…… PhD Thesis London University School of Tropical Hygiene and Medicine

106. Leys C (1996) *The Rise and Fall of Development Theory,* James Curry Ltd, London

107.Mabud M A (1985) *Women's Development, Income and Fertility in Bangladesh*, Planning Commission and Canadian International Development Agency.

108.Makepeace E (1989) *Overseas Students: Challenges of Institutional Adjustment, Paper No. 56*, Standing Conference on Educational Development, Birmingham

109.Mandelbaum D G (19) *Society in India* Vol 1 and 2

110.Marchand M and Parpart J L (1995) *Feminism, Postmodernism, Development*, Routledge, London

111.Martin I and Hume D (2003) Programs for the Poorest: learning from the IGVGD program in Bangladesh, *World Development, 31, 3 pp 647-665*

112.Matomora M K S and Petit P L (1994) *The Need to Integrate Nonformal Training Methods in Health Training Institutions: a case study of Tanzania*, Unpublished paper

113.Maxwell S (2003) Heaven or Hubris: reflections on the new "new poverty agenda", *Development Policy Review*, 21 (1) 5-25

114.McDonald J (198) *Adult Education*, University of Manchester

115.McNamara D and Harris R eds (1997) *Overseas Students in Higher Education: issues in teaching and learning*, Routledge, London

116.Mezirow J (1978) Perspective Transformation, *Adult Education* 28, 100-110

117.Mezirow J (1991) *Transformative Dimensions of Adult Learning*, Jossey-Bass, San Francisco

118.Morris T (1991) *The Despairing Developer: diary of an aid worker in the Middle East*, I B Taurus & Co London

119.Morrissey O, Smith B, Horesh E (1992) *British Aid and International Trade*, Open University Press, Milton Keynes

120.Moser C O N (1993) *Gender Planning and Development: Theory, Practice and Training*, Routledge, London

121.Mosse J C (1993) *Half the World, Half a Chance: an introduction to gender and development*, Oxfam, Oxford

122.Mukherjee R Gokcekus O Manning N and Landell-Mills P (2001) *Bangladesh: the experience and perceptions of Public Officials*, The World Bank, Washington DC

123.Mushid N (2000), Bangladesh Development Assistance: a dialogue among the actors, *Development* 43 (4)

124.Nottingham Council Overseas Student Affairs (NACOSA) 1987

125.Novak J D and Gowin D B (1984) *Learning How to Learn*, Cambridge University Press

126.Nyrop R F (1995) *Area Handbook for Bangladesh*, The American University, Washington DC

127.Overseas Development Administration (1993) *Helping Overseas Students to Succeed* ODA 94 Victoria Street, London

128.Overseas Development Administration (1995) *Affording the unaffordable: Planning and Financing Education systems in Sub-Saharan Africa*, Occ Papers in Education, Serial No 7 ODA 94 Victoria Street, London

129.Overseas Development Administration (1995) *Aid to Education on the 90's, Education Policy Paper* ODA 94 Victoria Street, London

130. Qadir S R (1987) Rural Women and Income Generation Skill in Bangladesh, *The Journal of Local Government* 16, 2, 158-169

131. Rigby J M (1986) The Challenge of Multinational Team Development, *Journal of Management Development*, 6, 3, 65-72

132. Robson C (1993) *Real World Research: a Resource for Social Scientists and Practitioner-researchers*, Blackwell, Oxford

133. Robson P (1990) *Nursing Education and Services in Bangladesh*, ODA and World Bank (unpublished)

134. Robson P (1995) *Evaluation Report: District Public Health Nurses Bangladesh*, Queen Margaret College Edinburgh and The British Council Manchester (unpublished)

135. Robson P and Watt S (1998) *Evaluation of DFID-funded Masters degree-level training in the UK*, Queen Margaret College Edinburgh and The British Council, Manchester (unpublished)

136. Rogers A (1992) *Adults Learning for Development*, Cassell, London

137. Rojas, Z Sandiford, P and Martinez, J (1993) Training Health Managers for Developing Countries: Fish Out of Water? In Malek M, Rasquinha J and Vacina P (1993) *Strategic Issues in Health Care Management*, John Wiley and Sons, London

138. Rondinelli D (1993) *Development Projects as Policy Experiments: an adaptive approach to development administration*, Routledge, London

139. Rounaq J (2003) Restructuring the Health System: experiences of advocates for gender equity in Bangladesh, *Reproductive Health Matters*, 11 (21) 183-191

140. Sanyal B (1991) Antagonistic Co-operation: a Case study of Non-governmental Organisations, Government and Donors' Relationships in Income Generation Projects in Bangladesh, *World Development* 19, 10 1367-1379

141. Sattar E (1978), The Position of Women in Secondary School Education in Bangladesh: a case study of Dacca Division in *Women for Women*, Bangladesh Books International Ltd. Dacca

142. Scott P (1995) *The Meanings of Mass Higher Education*, The Society for Research into Higher Education, London

143. SEARO (1985) *Women in Health and Development in South-East Asia*, WHO, New Delhi

144. Sen A (1983) *Development: Which Way Now*, Cambridge University Press

145. Sen B (2001) *Bangladesh Human Development Report*, Asian Development Bank

146. Simkins T (1976) *Non-formal Education and Development*, University of Manchester Monograph 8

147. Smillie I (1995) *The Alms Bazaar: altruism under fire: non-profit organisations and international development*, IT Publications, London

148. Smith D J (2003) Patronage, Per Diems and the "Workshop Mentality": The Practice of Family Planning Programs in South Eastern Nigeria, *World Development* 31 (4) 703-715)

149. Sohban R (1982) *The Crisis of External Dependence: The Political Economy of Foreign Aid to Bangladesh*, Zed Press, London

150. Sohban R (1990) *From Aid Dependence to Self-reliance: development options for Bangladesh*, Bangladesh Institute for Development Studies, Dhaka

151. Somjee G (1991) *Social Change in the Nursing Profession in India,* Chapter 3 in Holden P and Littlewood J (1991) *Anthropology and Nursing,* Routledge, London

152. Spouse J (1990) *An Ethos for Learning,* Scutari Press, London

153. Stefanini A and Ruck N (1992) Managing Externally-Assisted Health Projects for Sustainability in Developing Countries, *International Journal of Health Planning and Management,* 7, pp 199-120

154. Stiglitz J (1998) *Assessing Aid,* World Bank, Washington DC

155. Stiglitz J (2002) *Globalization and its Discontents,* Allen Lane, London

156. Taylor P (1993) *The Texts of Paulo Freire,* Open University Press, Buckingham

157. *The British Council Annual Report 1996/7,* The British Council, London

158. The British Council (1998) *Strengthening Nurse Education and Services Project: Achievements 1993-1998,* The British Council and Queen Margaret College, Edinburgh, Unpublished

159. Thomson W W (1998) *Consultancy support for Bangladesh Nursing Council: report of a visit 3-15 May 1998,* QMC/The British Council (Unpublished)

160. Thorpe M, Edwards R and Hanson A (1993) *Culture and Process of Adult Learning,* Routledge

161. Tinker I (1990) *Persistent Inequalities: Women and World Development,* Oxford University Press

162. Turner and Hume D (1997) *Governance, Administration and Development: making the State work,* Palgrave Press, London

163. United Nations Development Program (2002) *Human Development Report,* Oxford University Press, Oxford

164. UNICEF (1998), *The State of the World's Children,* Oxford University Press, Oxford

165. Walt G (1994) *Health Policy: an Introduction to Process and Power,* Zed Books, London

166. Wang'ombe J K (1995) The Permanent Project Syndrome: a Counter-productive Consequence of Philanthropy, *Social Science and Medicine* 41, 5, 603-604

167. Waylen G (1996) *Gender in Third World Politics,* Open University, Milton Keynes

168. Whelan R (1996) Foreign Aid: who needs it, *Africa Financing Review,* 3,6

169. White S (1992) *Arguing with the Crocodile: Gender and Class in Bangladesh,* University Press, Dhaka

170. Wilber C K and Jameson K P (1992) *The Political Economy of Development and Under-development* (5th edition), McGraw-Hill, London

171. Williams P (1995) in Arthur L and Preston R (1996) *Quality in Overseas Consultancy: understanding the issues,* The British Council, Manchester.

172. World Bank, (1994) *Higher Education: the Lessons of Experience,* Development in Practice Series

173. World Bank (1995) *Toward Gender Equality: The Role of Public Policy, World Bank,* Washington DC

174. *The British Council Annual Report 1996/7,* The British Council, London

175. White S C (1992) *Arguing with the Crocodile: gender and class in Bangladesh,* University Press Dhaka

176. Wilkinson A (1958) *A Brief History of Nursing in India and Pakistan*, The Trained Nurses Association of India, New Delhi

177. Wood R E (1986) *From Marshall Plan to Debt Crisis: Foreign Aid and Development Choices in the World economy*, University of California Press

178. World Bank (1994), *Higher Education: the lessons of experience* Development in Practice Series, Washington DC

179. World Bank (1995) *Towards Gender Equality: the Role of Public Policy,* Washington

180. World Bank (2000) *World Development Report 1999/2000,* World Bank, Washington DC

181. World Bank (2001) *Bangladesh: The Experience and Perceptions of Public Officials,* World Bank Technical Paper No. 507

182. World Health Organisation (2000) *The World Health Report 2000,* WHO Geneva

183. World Health Organisation (1996) *Nursing Practice* WHO Technical Report 660, Geneva

184. World Health Organisation (1994) *Nursing Beyond the Year 2000* WHO Technical Report 842, Geneva

185. Yaxley I (1998) *Report on evaluation of impact of in-country middle management training,* QMC/British Council (Unpublished)

186. Zahid A S J (1996) *Development Planning and Project Management in Bangladesh,* BARD, Comilla, Bangladesh

187. Zamel V and Spac R (1998) *Negotiating Academic Literacies: Teaching and Learning Across Languages and Cultures*

188. Zuber-Skerritt O (1992) *Action Research in Higher Education: examples and reflections,* Kogan Page, London

Audio

Armstrong S with Robson P (2003) Himalayan Healing BBC Radio 4, 2100, 1 October

Web Sites used

http:/www.dfid.gov.uk/News/Press Releases/files/pr13_1may03.html

http:/www.devdata.wo...

http:/www.transparencyinternational

http:/amg.dynamicsweb.dk/default.asp

ANNEX 1   ABBREVIATIONS

ADNS	Assistant Director Nursing Services
AN	Assistant nurse
BC	British Council
BRAC	Bangladesh Rural Advancement Committee
BNC	Bangladesh Nursing Council
CNAA	Council for National Academic Awards
CoN	College of Nursing
DAC	Development Assistance Committee
DANIDA	Danish Development Agency
DfIID	Department of International Development
DNS	Directorate of Nursing Services
EC	European Commission
EU	European Union
FP	Family planning
FPA	Family Planning Assistant
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GDI	Gender Development Index
GoB	Government of Bangladesh
HA	Health Assistant
HAPP4	Health and Population Programme 4th Five Year Programme
HDI	Human Development Index
IDA	International Development Assistance
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MIS	Management Information System
MLSS	Member Lower Subordinate Staff
MO	Medical officer
MoHFW	Ministry of Health and Family Welfare
NAO	National Audit Office
NGO	Non-government Organization
NI	Nursing Institutes
ODA	Official Development Assistance
ODA	Overseas Development Administration
OECD	Organisation for Economic and Co-operation and Development
PHC	Primary Health Care
PHN	Public Health Nurse
QMC	Queen Margaret College
SAP	Structural Adjustment Programme
SIDA	Swedish International Development Agency
SNES	Strengthening Nurse Education and Services
SRN	Strengthening the Role of Nursing
SSN	Senior Staff Nurse
SWAp	Sector-Wide Approach
UHC	Upazila health complex
UHFWC	Union Health and Family Welfare Centre
UNFPA	United Nations Fund for Population Activities
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSO	Voluntary Service Overseas
WHO	World Health Organization

ANNEX 2 GLOSSARY

1. **Accountability** Obligation to demonstrate that work has been conducted in compliance with agreed rules and standards or to report fairly and accurately on performance results vis-à-vis mandated roles and/or plans. This may require a careful, even legally defensible, demonstration that the work is consistent with the contract terms.
2. **Activity** Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilised to produce specific outputs.
3. **Aid Co-ordination** A good framework for aid co-ordination will enable leadership by partner governments, simplify working relationships and create flexibility where it is missing. It will also facilitate dialogue between donors and civil society and the private sector in a partner country.
4. **Aid Modalities** Development assistance can be provided in many forms, with different management structures, accounting arrangements and funding mechanisms. Broadly speaking there are three ways in which aid is delivered: project aid, (sector) programmes and budget support. Donors will typically rely on a variety of these modalities even within a single country.
5. **Appraisal** An overall assessment of the relevance, feasibility and potential sustainability of a development intervention prior to a decision of funding.
6. **Assumptions** Hypotheses about factors or risks, which could affect the progress or success of a development intervention.
7. **Audit** An independent, objective assurance activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to assess and improve the effectiveness of risk management, control and governance processes.
8. **Baseline Study** An analysis describing the situation prior to a development intervention, against which progress can be assessed or comparisons made.
9. **Basic Nurse Training** an educational programme, leading to qualification as a nurse, which provides a broad foundation for both the practice of professional nursing and post-basic education.
10. **Benchmark** Reference point or standard against which performance or achievements can be assessed.
11. **Bilateral Aid** Financial or Technical support provided by one country to another, usually but with exception from a developed country to a developing or under developed country. Most aid is in the form of non-repayable grants but may come with several conditionalities, normally to bring the beneficiary country into line with current World Bank and IMF policies.
12. **Budget Support** Providing funds to the central budget (general budget support) or a sector ministry (sector budget support). *General budget support* consists of financial assistance, which allows the partner country to increase public spending in general and often given as support to the partner's national poverty reduction strategy. *Sector budget support* is budget support earmarked to finance the expenditure plan of a specific sector or sub-sector. It is most often one component in Sector Programme Support.
13. **Civic/Civil Society** Structures, formal and non-formal which lie outside government: comprise a wide range of institutions including NGOs, community organisations, political associations and special interest groups including trade unions. In recent years donors have set some store on gauging the response of civic society to their various programmes. Given the variety of institutions involved the process is time-consuming and likely to get mired down on power struggles and special pleading.
14. **Conditionalities** Stipulations or provisions, that need to be satisfied before project or programme funds are released.
15. **Continuing education** A structured learning process that follows initial training and continues throughout the career of the health worker: designed to assist health workers maintain and improve their competence and to acquire new knowledge and skills. It may be within the formal educational system or outside it but within programmes related to specific disciplines such as health care. It may be of a non-formal nature and include self-directed learning.

16. **Country Assistance Strategy (CAS)** The World Bank's central tool for over-seeing and piloting its country programmes for IDA and IBRD borrowers. The aim of CAS is to identify key areas where World Bank efforts are likely to have the greatest impact on reducing poverty. A CAS document should (i) describe the World Bank's strategy based on assessments of priorities in the country, and (ii) indicate the level and composition of efforts based on the strategy and the country's performance.

17. **Country Assistance Paper (CAP)** Individual bilateral donors produce papers which set out their aid programmes in light of the World Bank's CAS. Since the mid 1990's these have attempted to demonstrate a "pro-poor" stance and to pay special attention to redressed gender inequalities.

18. **Cross-cutting Issues**. Three main cross-cutting issues, which are to be pursued in all preparation and implementation of programmes and projects a) promotion and strengthening of gender equality; b) promotion of environmentally sustainable development; and c) promotion of the respect for human rights, good governance and democratisation/participation.

19. **Dai** A low caste or low status women who handles births and is responsible for cleaning up all the supposed pollution attending the birth. Usually an older woman. Under WHO/UNICEF programmes some have had a simple training focusing on hygienic practice and when to refer difficult births to more qualified practitioners. After training they are usually known as Traditional Birth Attendants (TBAs). WHO and UNICEF would like to see them replaced with well-trained community midwives.

20. **Decentralisation** The dispersion or distribution of functions and specifically the delegation of power and associated budgets from a central authority to regional and local authorities. Is one of the main planks in the IMF Structural Adjustment Programmes.

21. **Devolvement** Usually used in a similar way to decentralisation but used to denote that responsibilities and powers have been transferred to the periphery.

22. **Development Assistance Committee (DAC)** Department in the OECD (Organisation for Economic Co-operation and Development) that handles aid co-operation issues related to developing countries. DAC's role is one of co-ordination and integration, promoting effectiveness and providing sufficient funding in support of sustainable economic and social development

23. **Effectiveness** The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance.

24. **Efficiency** A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results. Efficiency, thus, means comparing outputs against inputs.

25. **Element** A coherent group of activities (policy framework development, human resource development, investment projects, recurrent activities, etc.) forming part of a National Sector Framework.

26. **Evaluation** The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors.

27. **External Evaluation** The evaluation of a development intervention conducted by bodies and/or individuals outside the donor and implementing organisations.

28. **Gender Development Indicator** Comprises a long and healthy life, knowledge and a decent standard of living. Indicators are female life expectancy at birth; male life expectancy at birth; female adult literacy rate; male adult literacy rate; female estimated earned income; male estimated income

29. **Gini Index** The result of a mathematical measure of income distribution within deciles or quintiles of a population. An index of 100 represents implies perfect inequality while an index of 0 represents perfect equality.

30. **Goal** The higher-order objective to which a development intervention is intended to contribute. Related term: development objective.
31. **Good Governance** Supporting democratic institutions with universal franchise, the rule of law, independent judiciary, transparency in financial transactions, free from corruption. Around 5% of aid budgets in 2000 went towards promoting good governance
32. **Guideline** Outline of policy or conduct.
33. **Harmonisation** The operational policies, procedures, and practices of donors with those of partner country systems to improve the effectiveness of development assistance.
34. **Heavily Indebted Poor Country (HIPC)** A debt relief-initiative that for the first time includes the multilateral debts of the poorest and most indebted countries. The aim is that funds released by providing debt relief should result in increased social spending in absolute terms as well as a proportion of the overall budget.
35. **Human Development Index** Comprises a long and healthy life, knowledge and a decent standard of living. Indicators are life expectancy at birth; adult literacy rate; gross school enrollment ratio; and GDP per capita
36. **Impact** Positive and negative, primary and secondary long-term effect produced by a development intervention, directly or indirectly, intended or unintended.
37. **Indicator** Quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of a development actor.
38. **Input** The financial, human, and material resource used for the development intervention.
39. **International Development Association (IDA)** An organisation under the World Bank Group, which helps the world's poorest countries reduce poverty by providing "credits," which are loans at very low or zero interest with a 10-year grace period and long term maturities.
40. **Logical Framework (LFA/Logframe)** Management tool used to improve the design of interventions, most often at the project level. It involves identifying strategic elements (inputs, outputs, outcomes, impact) and their causal relationships, indicators, and the assumptions or risks that may influence success and failure. It thus facilitates planning, execution and evaluation of a development intervention.
41. **Mainstreaming** Used in different ways. In projects usually used to emphasise, e.g. mainstream gender by making it a major component of all programmes and not just a single project.
42. **Millennium Development Goals** (MDG) An ambitious international development agenda for reducing poverty and improving lives that world leaders agreed on at the Millennium Summit in September 2000. The eight goals are loosely defined and therefore have drawn pessimistic comment. For each goal, one or more targets have been set, most for 2015, using 1990 as a benchmark (see Annex 5). **Monitoring** A continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds.
43. **Non-Governmental Organisation** NGO An independent (from the state or government), not-for-profit organisation. NGOs are wholly or partly dependent on charitable donations and private funds but may also receive sizable support from government. The term NGO includes a wide range of organisations, such as large established charities, research institutes, churches and lobbyist groups. In Bangladesh one large and long-standing NGO had achieved an ascribed status as a parastatal.
44. **Outcome** The likely or achieved short-term and medium-term effects of an intervention's outputs.

62. **Recommendations** Proposals aimed at enhancing the effectiveness, quality, or efficiency of a development intervention; at redesigning the objectives; and/or at the re-allocation of resources.
63. **Relevance** The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies.
64. **Resources** In relation to a project usually means money but may include human recourses i.e. people.
65. **Results** The output, outcome or impact (intended or unintended, positive and/or negative) of a development intervention.
66. **Sector** A coherent set of activities which can be distinguished in terms of policies, institutions and finances, and which need to be looked at together to make a meaningful assessment.
67. **Sector Wide Approach (SWAp)** A method of working together between government and development and development government partners, a mechanism for coordinating support to public expenditure programmes, and for improving the efficiency and effectiveness with which resources are used in the sector. The SWAp is an approach rather than a blueprint, flexible and adaptable to a changing environment.
68. **Stakeholders** Agencies, organisations, groups or individuals who have a direct or indirect interest in the development intervention or its evaluation.
69. **Steering Committee** Decision-making body above the daily management level established for the purpose of joint management by the partner, e.g. Bangladesh and DflD and other donors or/and NGOs when relevant.
70. **Sustainability** The continuation of benefits from a development intervention after major development assistance has been completed.
71. **Target Group** The specific individuals or organisations for whose benefit the development intervention is undertaken
72. **Technical Assistance** in relation to a project, programme etc. usually refers to the provision of an "expert" sent from the north to the south. Often a very costly ingredient of foreign aid to developing countries.
73. **Terms of Reference (TOR)** Written document presenting the purpose and cope of an assignment, the methods to be used, the resources and time allocated, and reporting requirements.
74. **Validity** The extent to which the data collection strategies and instruments measure what they purport to measure.

Source: various including DAC, DANIDA, UNDP Human Development Report 2002

45. **Output** Is "what happens". The products, capital goods and services which result from a development intervention; may also include changes resulting from the intervention which are relevant to the achievement of outcomes.

46. **Ownership** Appropriation or taking of responsibility for a certain endeavor. Ownership implies formal or real authority as well as effective self-authorisation to assume management responsibility.

47. **Partners** The individuals and/or organisations that collaborate to achieve mutually agreed upon objectives. In development usual to refer to donor and beneficiary as partners: possibly overworked expression.

48. **Peon** One who carries messages on foot: a worker almost at the bottom rung of an organisational hierarchy in Bangladesh. Usually men.

49. **Performance** The degree to which a development intervention or a development partner operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

50. **Performance management** A management strategy focusing on performance and achievement of results in accordance with stated goals or plans.

51. **Performance measurement** A system for assessing performance of development interventions against stated goals.

52. **Performance monitoring** A continuous process of collecting and analysing data to compare how well a project, program, or policy is being implemented against expected results.

53. **Performance Review** An assessment of the overall country programme framework and the management of the country programme by the beneficiary country by the donors.
   Poverty Reduction Strategy (PRS) Describes a country's structural and social policies programmes to promote growth and reduce poverty, as well as associated external financing needs. PRS papers are prepared by governments through a participatory process involving civil society and development partners, including multilateral (the World Bank and the International Monetary Fund) as well as bilateral partners. A PRS is a precondition for receiving debt relief under the HIPC initiative and being granted access to development loans from the World Bank and IMF.

56. **Poverty Reduction Support Credits (PRSCs)** A series of annual programmatic structural adjustment credits to support implementation of a country's poverty reduction strategy with clear performance benchmarks, including results indicators and policy measures within the areas of the World Bank's primary responsibility. The series of PRSCs would be intended to cover the three-year life of the PRSP, would be synchronised with the government's budget cycle, and would be embedded in the Country Assistance Strategy.

57. **Primary Health Care** Defined at WHO 1978 conference in Alma Ata (Russia) "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation....."(WHO 1978). Was to be the key to achieving the target of *Health for All by the Year 2000* but since largely abandoned as over-ambitious.

58. **Programme** A time bound intervention involving multiple activities that may cross sectors, themes and/or geographic areas.

59. **Programme Country** A low-income country supported by a particular donor (DfID, DANIDA, USAID etc.) through a multi-year development strategy and programme.

60. **Project** An individual time-bound development intervention designed to achieve specific objectives within specified resources and implementation schedules, often within the framework of a broader programme.

61. **Quality assurance** Quality assurance encompasses any activity that is concerned with assessing and improving the merit or the worth of a development intervention or its compliance with given standards.

Focus Group Guidelines Queen Margaret College June 1993
Participants 8 Facilitators 2

AIMS: To identify:

- ways of acknowledging and understanding the role of relatives in 'nursing care' and to account for their role in the design of the curricula for nurse education;
- the process through which nurses give information to relatives and identify ways in which this process may be used to improve the quality of care given to the patient by their relatives
- ways by which nurses can provide culturally appropriate care
- the opportunities for health promotion in the hospital wards

QUESTIONS TO BE ADDRESSED

1. What is the division of labour between professional and relative and other generic carers?
2. What sort of care is regarded by nurses as inappropriate for relatives to carry out i.e. when do nurses take over?
3. Are there certain (caring) tasks which it is considered inappropriate for Bangladeshi nurses to carry out for patients?
4. Are there any existing obligations on relatives to care for patients in hospital?
5. Does generic or lay care contribute to the overall quality of care?
6. If relatives and generic carers contribute to the quality of care, how can we acknowledge and promote such care?
7. How should knowledge derived from the proposed research be used to inform the philosophy of the nurse curriculum?
8. How do nurses share professional knowledge with the relatives to enable relatives to provide effective care?
9. How can nurses be facilitated to share information about professional care with relatives in order that the standard of care can be improved?
10. What developmental problems or needs is the (SNES) project aimed at?

Responses to questions 1 to 6 and 8 and 9

Process through which relatives gain access to the hospital wards

No policy on the role of relatives in hospital wards;
Practice varies from hospital to hospital - professional concerns - one nurse may allow relatives in whereas another does not;
The level of care provided by a relative depends on the doctor caring for the patient i.e. consultant - educated male relatives talk with doctor, uneducated relatives speak with nurses;
Usually allowed in for a sick child and sometimes for adult but usually only one adult allowed in;
Relatives are needed to go and buy drugs – they make up for a shortage of medicines and nurses - relatives have to buy everything;
If communication between the staff and the patient is difficult, relatives will be allowed in to assist;
Relatives are necessary for psychological support especially when there are language difficulties;
The nurse's point of view different from relatives. Relatives expect nurses to do all the care and sometimes get angry when they cannot;
Relatives do not mind buying things but they are angry that they have to do care also - nurse's status is involved because if relatives do nursing care, where are the nurses? Relatives see nurses being given orders by doctors and resent it when the nurses then ask them to do the task;
Nurses sometimes caught in middle - doctors may allow relatives to stay with certain (private) patients while hospital rules say differently and nurses get told off by matron.
Doctors are bribed by relatives to allow a patient admission and their continued stay;

Humanity, culture and religion are involved in allowing relatives in to care for patients - nurses are not inhuman.

What kind of care do relatives and staff provide?
Women relatives do most of the caring - they are normally not economically productive;
Mothers do a lot - they can perform peritoneal dialysis on babies, count fluid measure of peritoneum input and output but do not change the bag (which holds peritoneal fluid);
Mothers also give children oral rehydration salts (for diarrhoea), bathe baby and wash their clothes, keeping baby clean;
Where very low staffing levels, relatives will help but cannot touch canulars (intravenous needles) *or adjust monitors* (i.e. speed of intravenous infusion);

In the case of operations e.g. Caesarean section - nurses and relatives both provide care - relatives or patients can also pay for special female helper - an ayah - they have usually had some hospital training but relatives cannot remove sutures relatives - they are afraid.
Relatives do not provide such care in private hospital;
Relatives bring the patient to hospital and stays with patient during investigations (e.g. X-Ray);
In the case of babies, relatives do everything - tepid sponge, naso-gastric feeding, including passing tube (into stomach) *and aspirating it but in some cases doctors and nurses introduce naso-gastric tubes;*
In the case of diabetic patients, the relatives may give insulin and manage the diet;

Bangladeshi nurses give therapy, give bed baths, provide mouth care and set up blood transfusion. Enemas are not done by nurses - only by "sweepers"[1]. Sweeper's role with patients is giving urinals and bedpans, lifting patients etc. Will also assist with taking patients to X-ray, bringing drugs from pharmacy, running errands for patients.
In Bangladesh, auxiliary nurses can function as trained nurses if no trained nurse available; Nurses heavily involved in paper work - described as a 'non-nursing' duty – this is why they can't always care for patents – they also count sheets, crockery etc - if relieved of this routine work could do more nursing;
Known that wards clerks are employed to do paper work in private hospitals in Bangladesh;
Nurses spend more time as doctor's helpers or on clerical tasks.

Are there certain areas that relatives cannot help with?
Relatives not allowed in operating room, post-operative recovery room, delivery room, or intensive care units but relatives are near to hand and may communicate with the patient;

How is information passes between staff and relatives?
Doctors see patients and write instructions. During morning and evening rounds they prescribe treatments;
Doctors talk with relatives if patient's condition is serious, otherwise relatives get thrown out of the ward before the doctor's ward rounds;
Nurses teach relatives how to administer care, sometimes doctors also but mostly nurses;
Need a doctor to discuss the condition of patient with relatives;
Doctors often not necessary to explain care to relatives;
Nurses have skill and teach relatives without permission of a doctor;
Mothers are shown how to give photo-therapy (ultra-violet light). *This is timed by the nurse and mothers taught to count* (to gauge time) *e.g. 3 minutes for an egg to boil;*
Information provided to relatives: what they are told depends on patients condition; Patient's relatives will consult nurses about signs and symptoms and nutritional needs - most of the time food is provided by relatives;

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[1] Very low-level staff – also referred to as "menials".

Doctor may provide nutritional prescription for relatives because - insufficient food in hospital;
This could be reinforced by trained nurses.

Do nurses have the skills to teach relatives?
During placement in Ayr (Scotland) *saw a scheme where nursing auxiliaries involved in teaching relatives;*
In Bangladesh, need more improvement in this area;
Some nurses communicate better than others - need more on teaching and communication;
Depends on educational level of relatives - easier with educated relatives, however uneducated relatives most likely to be giving care.

ANNEX 4

Focus Group Interview at Queen Margaret College 1994
Senior Staff Directorate of Nursing and Divisional Level

Participants 6 Facilitators 2

Aim of Focus Group: to prepare ground for inclusion of VSO in SNES Project with particular emphasis on the role of relatives and ward staff other than relatives in the care of hospital patients.

Responses are in italics.

At present, who provides most of the hands-on care in hospitals?
"nurses" (chorus) staff nurses, student nurses, assistant nurses, ayars, sweepers, wardboys, menials, physiotherapist. Ward supervisor is one to five or three wards, medical students, sometimes social worker.
Of all these, who gives most care?
Nurses followed by relatives.
The VSOs will be teaching in the wards. Where are VSO nurses going to work?
One already placed in Mymensingh in professor's surgery ward. The medical director was very helpful and called the professor of surgery to help. Two will go to Rajshahi, two to Chittagong and another to Mymensingh.
What role will the VSOs have in Bangladesh?
Clinical work and teaching. She can work on surgical wards. She can be interested in helping the nurses. All the nurses are happy and so are doctors - they have been interested to help. She can be a model nurse. In clinical work, she can give advice she can provide a model.
About others working in the wards, what sort of things to do ayahs and sweepers do?
Take people to other departments. Bring food from trolley in ward to bedside
Who would feed patients?
Mostly relatives.
Are there any wards that relatives are not allowed in?
Intensive care - relatives cannot step inside. Really not allowed but because of shortage of nurses they get in.
Do they sleep in the ward?
Yes. They can get a pass.
What do the sweepers do?
Clean the spit bowls, bathrooms, latrines, floors. All the dirty work.
So the nurses don't do this kind of work?
There is only one nurse to 30 – 40 patients, how can the nurses do this work? Sometimes, but if nurses do these kind of things the patient would not take food from the nurses hand. This is according to social culture
Are the sweepers all males?
No, some females. Females in female wards.
What about the assistant nurses? How many are there? Are they working?
Not trained now. Were trained for 6 months. Trained in local hospitals and some then trained at Pabna mental hospital. But after three years working can be re-trained as registered nurse. Now they are registered with BNC as assistant nurses.
How many are there?
About 900 - most are working
Would assistant nurses give hands-on care?
Sometimes, yes.
Are they mainly males or female? Is there a demand for training (from assistant nurses)?
Mostly males. Not a great demand for training as at present 4000 trained nurses are unemployed and waiting to get a job.

If they have a course, could they do teaching in the ward?
Yes.
About the division of work between paid and unpaid helpers. Do the relatives do total care of the patient? For example would a relative empty the bedpan?
Sometimes.
And would that relative feed the patient?
Yes. Previously we did all the care - in Pakistan time. But not now.
Another problem for nurses is (counting) bed sheets, pillowcases and everything and she has to pay for anything lost. All equipment has to be counted ...she also has to say how many diets are required
How can nurses be freed from this work?
Could be housekeeper or ward clerk - like private hospitals
What is the possibility of appointing a ward clerk to take over counting inventories?
We are trying, we have given suggestion to the higher authority – local authority at divisional level
So, what kind of work do they, the relatives, do?
Heat treatment, exercises, massage.
Is there a physiotherapist in every hospital?
Yes.
Do the physios show relatives how to do exercises?
Yes, in orthopaedic wards
What can relatives do in the wards, realising that nurses are very short?
Yes, one nurse for 80 patients
Can nurses teach relatives?
If they have time they may teach in the afternoon. One nurse to eighty patients – how can she do?
But there is not much in the present curriculum on how nurses can develop skills to teach relatives.
They are doing health education to different groups.
Teaching relatives to care for the patients is different from health education. Is it possible that relatives can be taught in the hospital to give physical care for the patient at home?
We don't have home nurses. Nurses do teach relatives not directly but indirectly.
Would nurses have time to teach relatives?
Yes, but they have no time. We don't have enough time.
Could assistant nurses teach?
Yes, they are also busy.
Would the nurses benefit from having teaching skills to teach relatives?
Assistant nurses? They don't have skills. If they had a course they could teach relatives and patients.
Do relatives ever do total care? For example would they empty bedpans and feed the patient.
Yes.
Do medical students provide any care for patients?
Previously in Pakistan period they shaved patients, did normal deliveries and filled in all the forms by hand, medical students have to do 5 normal deliveries, nurses have to do 10. Only doing case studies now. They don't do caring of the patients. In Pakistan time they did they did.
About the general work on surgical wards, for example, who removes sutures on these wards?
The surgeon assisted by the nurses. With the ligation patients in THCs, the nurses remove the sutures - this is because there is no doctor.
Who takes blood pressure?
The doctor. In Sardar (district) hospital nurses may do all of this. In intensive care units nurses do all this. In Kulna Sardar hospital nurses do all the work because there are no doctors - they even take blood for investigation. Nurses are helping everyone but no one helps the nurses.

Can nurses choose where they work?
Yes, they can apply.
Who makes a decision on where nurses work?
The DNS but not for 1st class, ministry makes that decision.
Are you all first class?
Some but we are acting only. Many civil servants working in acting positions – civil surgeons, deputy directors, all working against Class 1 but not confirmed.

About THCs, why are some THCs empty and others full? If the quality of nursing in THC was better, would people would go?
People prefer to go to the district hospital, sometimes there is no doctor at THC and they don't have enough facilities – they can't do operations.
There should be nine doctors (appointed) but only five nurses. But only three doctors are usually there... Nurses are not getting housing at THC and have no security - they don't want to work there except it might be their own district.

ANNEX 4 (Cont.)

If outpatients come to THC, can the nurses treat them? Can they give drugs if doctor not there?
No, not in government hospital, but in some NGOs they can. They can give advice
Would there be a lot of relatives at the THC?
Yes. Everywhere!
Is there anything else we can say on this - what about the students nurses? How old are they when they start?
16 or 17
When do they start working on the wards?
After 3 months if they pass their exam. When on the wards they have to make beds, give medicines, give bed baths
Who teaches them to do that? Do they learn theory and then go to practical work?
Sister tutor and some times senior staff nurse but the equipment is not available.
Do the relatives bring in bowls for washing etc. - do they have to bring sheets, pillows?
No, they are not allowed, sometimes.

Tape ran out and interview wound down

ANNEX 5

Public Health Nurses: Semi-structured Questionnaire September 1994

1   **Please print your full name**
     ছাপার অক্ষরে আপনার পুরানাম লিখুনঃ

2   **Workplace & Home Address**
     কর্মস্থল ও বাসস্থানের ঠিকানা ঃ

     Work: কর্মস্থল ঃ

     Home: বাসস্থান ঃ

3   **Date of Birth**
     জন্ম তারিখ ঃ

4   **Date of registration as a nurse in Bangladesh**
     বাংলাদেশে নার্স হিসাবে যে তারিখে রেজিস্ট্রেশন পাইয়াছেন ঃ

5   **Do you hold a BSc in Public Health Nursing ?**
     আপনি কি পাবলিক হেলথ্ নার্সিং এ বি,এস,সি ডিগ্রীধারী ?
          Yes   No
          হ্যাঁ   না

     If "yes" please state which year you graduated
     হ্যাঁ হলে আপনি কোন বৎসর পাশ করেছেন উল্লেখ করুন ঃ

6   **Please write below the date you started work in your present post**
     বর্তমান পদে কবে থেকে আপনি কাজ শুরু করেছেন, নিম্নে তারিখ লিখুন ঃ

7   **Please state below where you obtained any other professional qualifications
     and the date:**
     অন্য কোন প্রশিক্ষণ গ্রহন করিয়া থাকিলে নিম্নে তাহাদের বর্ণনা দিন।
          Qualification   *Place obtained*   *Dates*
          যোগ্যতা   স্থান   তারিখ
     (a) Registered Nurse
     (ক) রেজিষ্টার্ড নার্স

     (b) Any other qualifications
     (খ) অন্যান্য যোগ্যতা

8   **In the table below, please state which positions you held before your appointment as a Public Health Nurse**

পাবলিক হেল্থ নার্স হিসাবে চাকুরীতে যোগদানের পূর্বে আপনি কোন পদে বহাল ছিলেন নিচের ছকে তাহা উল্লেখ করুন ঃ

	Position পদ	Dates তারিখ
i		
ii		
iii		
iv		

9   **Have you had any professional education outside Bangladesh ?**

বাংলাদেশের বাইরে কোথায়ও আপনি কোন প্রশিক্ষণ গ্রহন করেছেন কি ?

Yes   No

হ্যাঁ   না

If "yes", please state

যদি হ্যাঁ হয় তবে -

    i   where your professional education was obtained

    ক)   আপনি কোথায় এই প্রশিক্ষণ গ্রহন করেছিলেন ?

    ii   date you obtained your professional education outside Bangladesh

    খ)   বাংলাদেশের বাইরে আপনি যে প্রশিক্ষণ গ্রহন করেছেন তার তারিখ ঃ

    iii   qualification you obtained outside Bangladesh

    গ)   বাংলাদেশের বাইরে যে যোগ্যতা আপনি লাভ করেছেন তার নাম ঃ

10   **Please describe your day-to-day work as a Public Health Nurse in the space below.**

পাবলিক হেল্থ নার্স হিসাবে আপনার দৈনন্দিন কাজকর্মের একটি বিবরণ অনুগ্রহ করে নিম্নের খালি অংশে লিপিবদ্ধ করুনঃ

ANNEX 6   Focus Group Questions for District Public Health Nurses

    1   Welcome: Introductions

    2   Introduce the purpose of the meeting

    3   A: Pyramid exercise (15 minutes)
               (Write questions/answers in Bangla or English)
               Q.   what is the best thing about my job?
               Q.   what is the worst thing about my job?
               Groups 1 > 2 > 4 > 8 > all

    4   B: Pyramid exercise
               Q. if I could do only one part of my job description which part would I choose?
               Why?
               Groups 1 > 2 > 4 > 8 > all

    5   Group feedback on all three questions:

    6   **C: Focus group**

a) Thinking back to the CoN, how many of you intended to take the BSc PHN when you first joined. Would you prefer to be working in a clinical area E.G. THC or hospital?

b) How did you get on to the BSc course at the CON? Did any of you do you PHN course outside of Bangladesh?

c) How did you come to be working as a DPHN at the place you are now?

d) Did your BSc/PHN course prepare you for the job you are now doing? Can you think of anything you learn as part of your that you sue now in your day to day work?

e) Tell me about any of the short courses you have done since your appointment as a PHN. Have they helped you with your work? Explain how.

f) Who provides the greatest support in your work? If you have any problems with your work, who do you go to?

g) Are there any groups of worker in the community that DPHNs could work with?

h) What do you require to increase your job satisfaction?

i) Would you recommend public health nursing as a job to a person who is qualified to do it?

j) Do public health nurses get support from people in the community?

k) Working as a DPHN, do you face any problems as a woman?

l) Should men be appointed as DPHNs?

m) What do you think you will be doing 10 years from now?

ANNEX 7

Evaluation of the DPHN: September 1994

Key Informant Guideline

		Score				
1	**Name of Informant**					
2	**Position**					
3	**Knowledge of DPHN**	0	1	2	3	4
4	**Origin of DPHN**	0	1	2	3	4
5	**DPHN Training**	0	1	2	3	4
6	**DPHN Job Description**	0	1	2	3	4
7	**Possible development of the DPHN**	0	1	2	3	4
8	**Overall Score**					

Key
0 = No knowledge
1 = Knowledge but no view on role
2 = Knowledge but vague view of role
3 = Grasp of issues/suggested role
4 = Good knowledge/clear view of possible role

Key Informants Bangladesh 9 September - 18 September 1994
Evaluation of District Public Health Nurses Role

Bangladeshi Informants
Director of Nursing; Assistant Director: Nurse Education; Joint Secretary MoHFW
Director of Public Health MoHFW; Project Director SNES; Assistant Project Director SNES; Registrar Bangladesh Nursing Council; Director Bangladesh Academy of Rural Development Comilla; Civil Surgeon Feni; Civil Surgeon Comilla; Civil Surgeon Noakhali; Civil Surgeon Dhaka.

Donor Representatives in Bangladesh
Project leader GTZ Comprehensive Community Health Project: funded by German government
Second Secretary Aid Management Office British High Commission Dhaka Manager Management Development Unit, Dhaka: funded by DfID
Programme Manager UNICEF Dhaka
Health Advisors (3) World Bank Dhaka
Team Leader, Thana Functional Improvement Project: funded by Dutch Government
Chief Nurse WHO
Project Manager, Save the Children Fund (UK)
Programme Manager National Institute of Population Operational Research and Training: funded by USAID

Evaluation of District Public Health Nurses Role: Summary of informant interview notes

- The majority of informants know very little, if anything at all about the DPHNs. Senior nursing personnel had no role or only a small role in the original decision to appoint PHNs - possibly for this reason there is no mention of the PHNs in the current National Plan of Action for Nursing Development.
- She is not identified as a resource in the revised senior registered nurse curriculum. Bangladeshi counterparts in major population projects had never heard of them. The GTZ project manager was working on a PHC project in several Upazilla (Thanas) and would have valued the involvement of a public health had she known they existed.
- Many informants working in the field of public health had only a vague knowledge of the PHNs existence - could not contribute to questions about their role and function.
- Exceptions are the UNICEF observers and two informants at the World Bank who see a role for PHNs in projects aimed specifically at the health of women and young girls - especially reproductive health.
- Director of Public Health Institute thought they could be used as health promoters and motivators especially with struggling MoH vertical programmes such as IDD.
- All Civil Surgeons value the PHN who they depend on to implement MCH programmes – on the whole have a good relationship with each other – sharing office etc.
- WHO observer felt there is no need for a separate category of public health nurse as all nurses have strong element of public or primary health care in their training and should be able to function is this capacity led to discussion of proposed Project 2000 in UK and similar proposals for nurse education elsewhere. Agreed Bangladesh a long way from this as serious human resource and material shortages in the hospital sector.
- Main conclusion is that PHN is almost invisible as a community health resource but when acknowledged has potential ally in improving female health and assisting community-based projects.

Interview Schedule and Notes with Senior Staff at DNS Dhaka: May 1998

1. **Recall using concept map (10 mins)**
2. **Application of DNS training to subsequent Study Tours**
3. **Application of DNS training to workplace (evidence-based)**
4. **Barriers to application of training**
5. **Factors facilitating application of training**
6. **Further opportunities to transfer and apply learning**
7. **Overall comments on the strength and weakness of the DNS learning**
8. **Contribution of DNS training to a vision of the future**

We went to Nepal and Myanmar. DNS training was helpful because we saw the things we learned being used - such as records - before the course we didn't know.
Have been helped by other staff at the DNS - professional and clerical.
Leadership training was good, importance of feedback on performance

Have put up notice boards with information for people visiting the DNS (relatives and employed and unemployed nurses). Have created a waiting area for above. Created a new organogram (for structure of nursing services).

Very helpful in managing the new Continuing Nurse Education Centres and the Rural Health Training Centre. Quality assurance and management very helpful (as part of DNS course). We have provided teachers with clinical teaching guidelines and management guidelines for supervisors.

Still some problems: not enough money. Not having meetings to arrive at decisions. Shortage of staff.

Strengths of DNS training: *preparing teaching material using whatever modern technology is available. Have used methods introduced in DNS course. We learned how to manage, how to present a paper and how to use teaching technology such as OHP. We also learned to do "hokey kokey" - also good learning how to relax. Also learning to present information - visual, use of notice boards. How to manage meetings.*
Weaknesses - *classroom not so good. First room was alright, second room was too small and noisy. No books provided. Time was too short -only in the afternoon (not the trainers fault). Course ran alongside own work - office in morning, training in the afternoon.*
What vision of nursing do you have the year 2000?
"It should be OK but we need some change to the system - e.g. admission to nursing schools, promotion -people still promoted on merit. There is some group commitment to work with DMS. We need supervision. I have prepared job descriptions for the DNS and made visits to Thana Health Complexes but they are in a terrible state. No operations, no Caesarean sections, patients are not going there. Some very crowded - patients on the floor. We can solve some local problems but larger problems we need help (external assistance)."

ANNEX 9a

MSc Graduate Evaluation 1998

Key Informants June 1998: Evaluation of MSc Training: Dhaka

Bangladeshi Representatives

SNES Project Director
Director of Nursing Bangladesh
Principal Collage of Nursing Dhaka
Consultant Bangladesh Institute of Management
Deputy Director Gender and Nursing MoHFW
Medical Director: Chittagong Medical College Hospital
Nursing Director: Chittagong Medical College Hospital
Medical Director Opthalmic Hospital Sher-e-Bangla
Nursing Director: Opthalmic Hospital Sher-e-Bangla

Donor Representatives

Project Co-ordinator SNES
Gender and Governance Adviser The British Council Dhaka
Nursing Advisors WHO Bangladesh
First Secretary, AMOD, British High Commission
Consultant: CON Curriculum Development

Interview Notes

All informants see the potential of a "critical mass" of MSc-level nurses in terms of raising the quality of nursing education and services in Bangladesh. All aware of constraints - mainly inappropriate placements and, apart from those working with the SNES project, lack of follow-up. Stakeholders who have been working with the graduates are pleased with the qualitative contribution they have made to various projects. The Director of Nursing is especially appreciative of graduate working in the DNS. All Bangladeshi stakeholders, including the nursing directors and medical directors see the importance of appropriate higher education for nurses - not only to improve the quality of nurse education but to contribute to raising the status of nursing and to strengthen the gender position of (female) nurses.

Noted that MSc nurses have contributed articles to the Nursing in Focus newsletter and have provided valuable support to external consultants. As some have also had a training of trainers course so they have also been able to teach at the Continuing Education Centres. Recognised that benefits will take several years to be realised and they will need external support at least for the next five years. Most of the donor representatives point to the problem of factionalism among the nurses undermining progress - endemic generally in Bangladesh. Deputy Director Gender and Nursing at MoHFW - female - is negative about the prospects of nurses being regarded as "professionals" for this reason.

ANNEX 10

QUESTIONNAIRE FOR MSc GRADUATES

Dear ...

It is now some years since you finished your MSc in International Health at Queen Margaret College in Edinburgh. A few of you obtained your Masters degree at Manchester but you were all funded the DFID Technical Co-operation Training (TCT) award scheme managed by the British Council. As you know, in June 1998, we retrospectively evaluated your experience of studying for the Masters degree and your progress since your return to Bangladesh. The original objective of awarding TCT for study in the UK was that it would build up a "critical mass of nurses" who would be able to carry forward lasting improvements for both the nursing profession and for the nursing services they provide. We would now like carry to out a follow-up to the 1998 evaluation. As part of this later evaluation we would be grateful if you would fill out the attached questionnaire.

1   Are you working within the nursing service provided by the MOHFW?

        Yes?   No?   *Please circle your choice*

        If "Yes" please state where you are working now, what position you hold and what civil service class level you are at.

        If "No", please state where you are working now and what position you hold

2   Looking back, did the Masters degree help to advance your career?

        Yes?   No?

        If "Yes" can you explain in your own words how you progressed?

        If "No" can you explain in your own words why your career has not progressed?

3   Do you think you have had a positive influence in helping the nursing profession in Bangladesh?

        Yes?   No?

        If "Yes" " can you explain in your own words in which way you have positively influenced the nursing profession in Bangladesh?

        If "No" can you explain in your own words what has prevented you having a positive influence?

4   In your opinion, do you think the award of a Masters degree has given you any
     personal advantages in the nursing profession in Bangladesh relative to nurses who have not
     obtained a Masters degree?

     Yes?   No?

     If "Yes" can you explain in your own words what those advantages have been?

     If "No" can you explain why the Masters degree has not brought you any advantages?

5   Apart from the Masters degree, have there been other factors in your life that have helped your
     progress in your profession?

     Yes?   No?

     If "Yes" , please explain the factors in your own words

6   One of the SNES objectives was the create "a critical mass" of nurses to improve the nursing
     profession in Bangladesh. Has this been achieved?

     Yes?   No?

7   Looking back over the last 10 years, is the nursing profession and the services they provide for
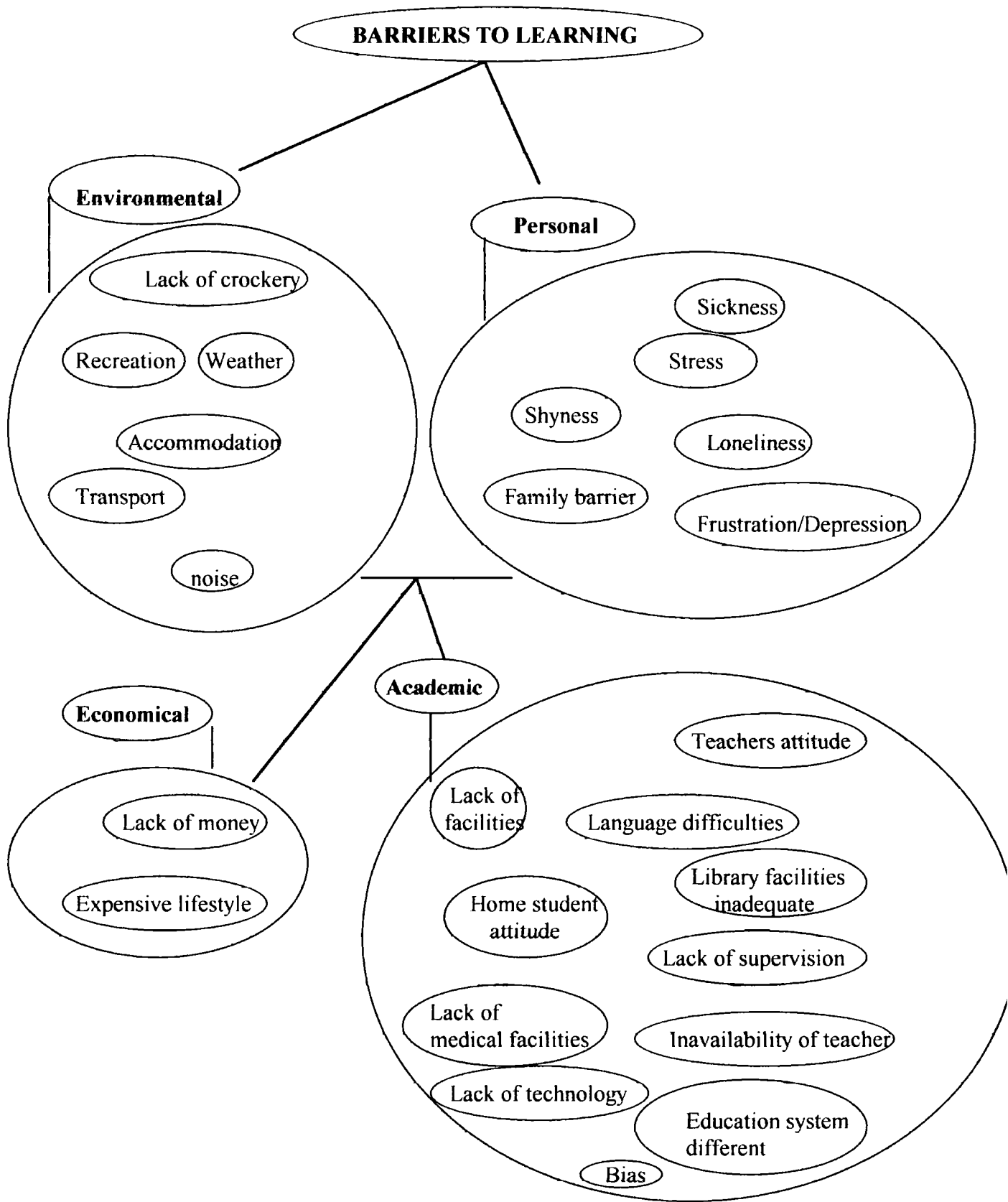   their patients:

     better ?

     worse ?

     about the same ?

Please comment

8   Please list below what actions need to be taken to strengthen the position of the nursing
     profession in Bangladesh.

     Patricia Robson

BARRIERS TO LEARNING

Environmental

Lack of crockery

Recreation Weather

Accommodation

Transport

noise

Personal

Sickness

Stress

Shyness

Loneliness

Family barrier

Frustration/Depression

Academic

Economical

Lack of money

Expensive lifestyle

Lack of facilities

Teachers attitude

Language difficulties

Home student attitude

Library facilities inadequate

Lack of supervision

Lack of medical facilities

Inavailability of teacher

Lack of technology

Education system different

Bias

1997: BANGLADESH: PROVISION OF PATIENT CARE

Above: Son provides passive exercises for his father. Other family members stand by.

Right: Washing his brother's hair. Note the bed-roll on the floor ready for his night watch.

BANGLADESH UNEMPLOYED NURSES PROTEST 2003

Bangladesh Diploma Unemployed Nurses Association passed its 3rd consecutive day of hunger strike programme on Monday at the Central Shaheed Minar in support of their various demands. —OBSERVER

Appointment of 1500 nurses cancelled

The appointment procedure of 1500 senior staff nurses in the Nursing Directorate under the Ministry of Health and Family Welfare has been postponed due to some procedural complications, reports BSS.

The appointment procedure of the 1500 senior nurses and the advertisement published in this regard were cancelled in public interest , said a Press release of the Nursing Directorate in Dhaka on Monday.

Nurses
(From Page 1 Col. 8)

The nurses were locked in an altercation with police when police tried to intercept the procession at Doel Chattar.

About ten nurses were injured when riot police baton charged the procession of the agitating nurses as they tried to proceed by breaking police cordon near High Court at about 11:00 a.m.

One of them Salma was severely injured and under going treatment at DMCH in a critical condition.

Sources said the nurses were going to besiege the office of Directorate of Health Service to register their protest against a governmental decision for appointing about 2000 nurses who passed from different private nursing institutes of the country.

Bangladesh Diploma Nurses Association formed a human chain on Wednesday in the city protesting police attack on nurses. . —OBSERVER

10 injured
Police swoop on nurses rally
Staff Correspondent

At least 10 female nurses received injuries when riot police indiscriminately baton charged a procession near High Court in the city on Wednesday morning.

The road traffic in the entire came to a total halt for about two hours when angry nurses instantly observed a sit-in programme in protest against the police action.

Later, the nurses withdrew their sit-in programme when high officials of police rushed to the spot and assured them to take necessary action against those responsible for untoward situation.

According to eyewitnesses, a big procession comprising unemployed members of Diploma Nurses Association and Diploma Student Nurses Association from Dhaka Medical College Hospital (DMCH) Nursing Institute was going towards the Directorate of Health Service at Motijheel.
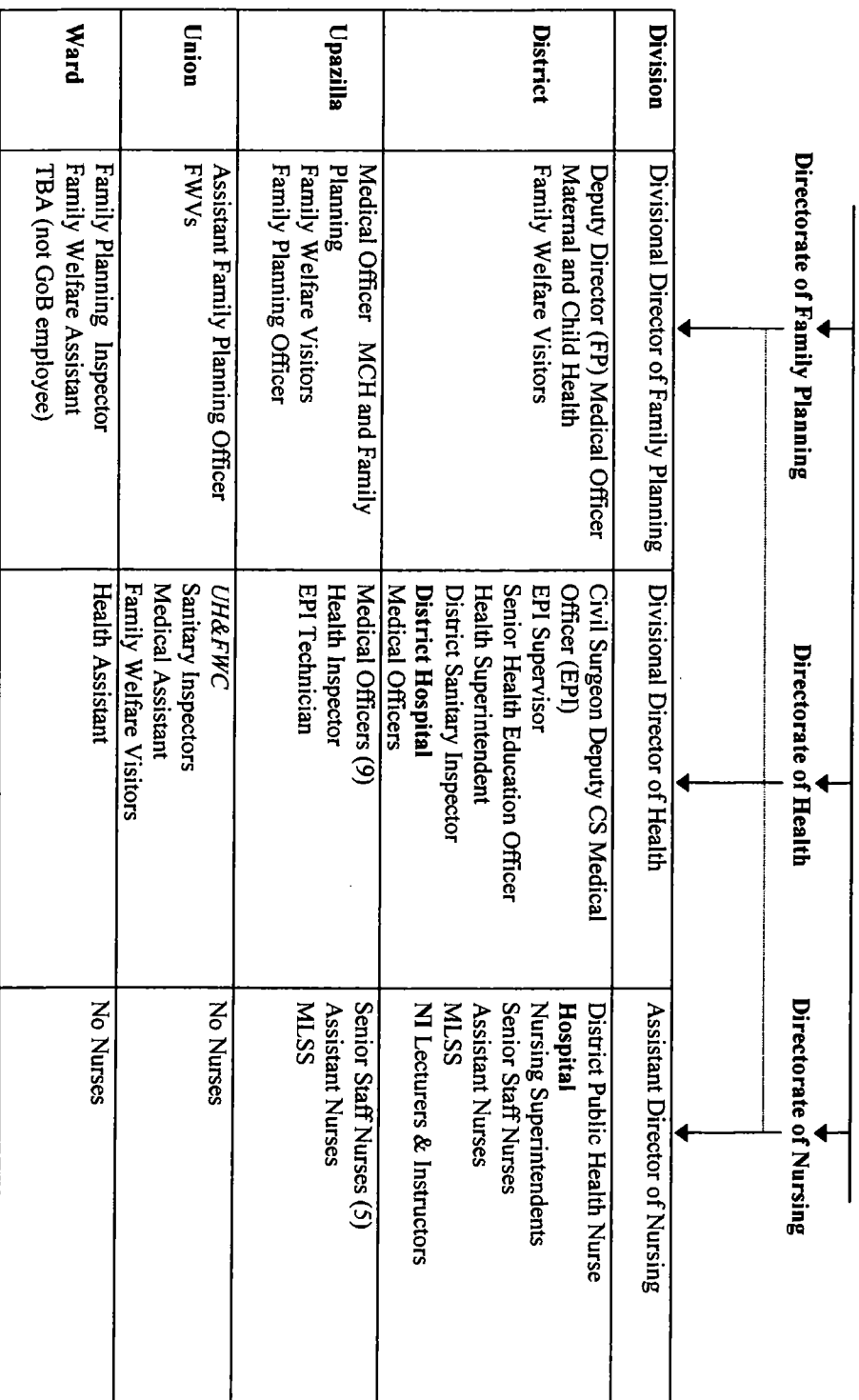
GoB HEALTH SERVICES SHOWING SEPARATION OF HEALTH AND FAMILY FAMILY PLANNING DIRECTORATES AND NURSING DIRECTORATE

Ministry of Health and Family Welfare

	Directorate of Family Planning	Directorate of Health	Directorate of Nursing
Division	Divisional Director of Family Planning	Divisional Director of Health	Assistant Director of Nursing
District	Deputy Director (FP) Medical Officer Maternal and Child Health Family Welfare Visitors	Civil Surgeon Deputy CS Medical Officer (EPI) EPI Supervisor Senior Health Education Officer Health Superintendent District Sanitary Inspector **District Hospital** Medical Officers	District Public Health Nurse **Hospital** Nursing Superintendents Senior Staff Nurses Assistant Nurses MLSS NI Lecturers & Instructors
Upazilla	Medical Officer MCH and Family Planning Family Welfare Visitors Family Planning Officer	Medical Officers (9) Health Inspector EPI Technician	Senior Staff Nurses (5) Assistant Nurses MLSS
Union	Assistant Family Planning Officer FWVs	*U/H&FWC* Sanitary Inspectors Medical Assistant Family Welfare Visitors	No Nurses
Ward	Family Planning Inspector Family Welfare Assistant TBA (not GoB employee)	Health Assistant	No Nurses

Tenuous working relationship

ANNEX 14

Countries Represented on the Development Assistance Committee 2004

1	Australia
2	Austria
3	Belgium
4	Canada
5	Denmark
6	Finland
7	France
8	Germany
9	Ireland
10	Italy
11	Japan
12	Luxembourg
13	Netherlands
14	New Zealand
15	Norway
16	Portugal
17	Spain
18	Sweden
19	Switzerland
20	UK
21	USA

MILLENNIUM DEVELOPMENT GOALS & TARGETS

Millennium Development Goals (MDGs)	
GOALS AND TARGETS	**INDICATORS**

GOAL 1:	**ERADICATE EXTREME POVERTY AND HUNGER**	

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below $1 per day 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children (under-five years of age) 5. Proportion of population below minimum level of dietary energy consumption

GOAL 2:	**ACHIEVE UNIVERSAL PRIMARY EDUCATION**	

Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	1. Net enrolment ratio in primary education 2. Proportion of pupils starting grade 1 who reach grade 5 3. Literacy rate of 15-24 year olds

GOAL 3:	**PROMOTE GENDER EQUALITY AND EMPOWER WOMEN**	

Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	1. Ratio of girls to boys in primary, secondary and tertiary education 2. Ratio of literate females to males of 15-24 year olds 3. Share of women in wage employment in the non-agricultural sector 4. Proportion of seats held by women in national parliament

GOAL 4:	**REDUCE CHILD MORTALITY**	

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	1. Under-five mortality rate 2. Infant mortality rate 3. Proportion of 1 year old children immunised against measles

GOAL 5:	**IMPROVE MATERNAL HEALTH**	

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	1. Maternal mortality ratio 2. Proportion of births attended by skilled health personnel

GOAL 6:	**COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES**	

Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	1. HIV prevalence among 15-24 year old pregnant women 2. Contraceptive prevalence rate 3. Number of children orphaned by HIV/AIDS
Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	4. Prevalence and death rates associated with malaria 5. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 6. Prevalence and death rates associated with tuberculosis 7. Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)

GOAL 7:	**ENSURE ENVIRONMENTAL SUSTAINABILITY**	

Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	1. Proportion of land area covered by forest 2. Land area protected to maintain biological diversity 3. GDP per unit of energy use (as proxy for energy efficiency) 4. Carbon dioxide emissions (per capita) *[Plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases]*
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water	5. Proportion of population with sustainable access to an improved water source
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	6. Proportion of people with access to improved sanitation 7. Proportion of people with access to secure tenure *[Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]*

GOAL 8:   DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT*

Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally

Target 13: Address the Special Needs of the Least Developed Countries

Includes: tariff and quota free access for LLDC exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous oda for countries committed to poverty reduction

Target 14: Address the Special Needs of landlocked countries and small island developing states

(through Barbados Programme and 22nd General Assembly provisions)

Target 15: *Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term*

Some of the indicators listed below will be monitored separately for the Least Developed Countries (LLDCs), Africa, landlocked countries and small island developing states.

Official Development Assistance
1. Net oda as percentage of DAC donors' GNI [targets of 0.7% in total and 0.15% for LLDCs]
2. Proportion of oda to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
3. Proportion of oda that is untied
4. Proportion of oda for environment in small island developing states
5. Proportion of oda for transport sector in land-locked countries

Market Access
6. Proportion of exports (by value and excluding arms) admitted free of duties and quotas
7. Average tariffs and quotas on agricultural products and textiles and clothing
8. Domestic and export agricultural subsidies in OECD countries
9. Proportion of oda provided to help build trade capacity

Debt Sustainability
10. Proportion of official bilateral HIPC debt cancelled
11. Debt service as a percentage of exports of goods and services
12. Proportion of oda provided as debt relief
13. Number of countries reaching HIPC decision and completion points

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Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

14. Unemployment rate of 15-24 year olds

Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries

15. Proportion of population with access to affordable essential drugs on a sustainable basis

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Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

16. Telephone lines per 1000 people
17. Personal computers per 1000 people

Other Indicators to be decided

* The selection of indicators for Goals 7 and 8 is subject to further refinement

Source: OECD-DAC

ANNEX 16   1995 LOGICAL FRAMEWORK SNES PROJECT

Narrative Summary	Verifiable Indicators	Means of Verification	Important Assumptions
Goal			
Preventable morbidity and mortality amongst patients needing institutional are reduced	1.1	1.1	
Purpose 1 Delivery of nursing care improved	1.1 25% improvement in six key quality care by EOP indicators developed by the Nursing Audit System 1.2 Nurse deployment to matched posts needs	1.1 Nurse Audit Reports 1.2 MIS Reports and staff surveys	**(Purpose to Goal)** 1 Support of Bangladesh General Nursing Council 2 Complementary inputs available to schedule as agreed under overall project by GoB. WHO. IDA
Outputs 1 College of Nursing strengthened and expanded 2 Nurse Institutes strengthened and expanded 3 Management of the Nursing Sector improved	1.1 Revised and implemented BSc curriculum producing 60 graduates per year 1.2 20 nurses trained to MSc level and deployed as tutors 1.3 Re-organised CoN management 1.4 Upgrade library with trained and deployed librarians 1.5 New teaching materials developed 2.1 Restructured 4th year options implemented 2.2 NIs established as demonstration units of good practice and education 2.3 20 libraries upgraded and 20 assistants trained 125 CoN trained to BSc level nurses deployed as teachers 3.1 Nursing Policy Planning Committee established 3.2 MIS established 3.3 Nurse Quality assurance and audit system established 3.4 Divisional Deputy Directors Nursing trained and deployed 3.5 125 UHC Supervisors trained and deployed 3.6 Revised job descriptions for District Public Health Nurses 3.7 200 nurses complete management and clinical modules **Total Project costs:** 7.42 m ODA Contribution 4.4m GoB 0.507m IDA 2.1m WHO Complementary TC values at 0.819	1.1 Annual Project Review 1.2 Bi-annual co-financiers review. BC returnee monitoring system	**(Output to Purpose).** 1. Timely input by GoB/IDA tobish CoN 2. Appropriate staff selected for overseas and in-country 3 MSc training and return to appropriate posts. Losses minimized by conditions that they return for 2 years 3. Trained staff retained in appropriate posts for a suitable duration 4. Complimentary training inputs by WHO 5. Timely inputs by GoB/IDA to refurbish NIs 6. Complimentary training inputs by WHO. 7. VSO availability 8. 4th year curriculum review by British Council and accepted by BNC 9. Co-operation of Civil Surgeons and medical profession in general 10. Creation of additional nursing posts in Government service 11. New staff are selected and trained before deployment

MSc INTERNATIONAL HEALTH

COURSE OUTLINE

SEMESTER	MODULES	CREDIT POINTS (M)	CREDIT TOTAL
	Induction Week <u>Four Core Modules</u> International Health Issues Health Related Research Health Policy & Planning Health Services Management	 15 15 15 15 60	 60

Award of Postgraduate Certificate

	MODULES	CREDIT POINTS	CREDIT TOTAL
	<u>Elective Modules</u> *3 chosen from:* • Project Design and Management • Theory & Methods of Teaching & Learning • Independent Study • International Perspectives on Nursing • Population & Reproductive Health • Nutrition, Health and Development • International Health Economics • International Health Financing	15 per module 45	105

Award of Postgraduate Diploma

	MODULES	CREDIT POINTS	CREDIT TOTAL
	Dissertation / Project Proposal	75	180

Award of MSc

NEWSLETTER

FOCUS ON NURSING

Strengthening
Nursing Education
& Services Project

(The British Council)

Directorate of Nursing
Bangladesh

সম্পাদকীয় Editorial

সম্প্রতি নোয়াখালী জেনারেল হাসপাতালে রাত্রীকালীন কর্তব্যরতা সিনিয়র স্টাফ নার্স সান্তনা হাওলাদারকে দুজন বহিরাগত মাদকাসক্ত প্রথম প্রচেষ্টায় পেথিডিন ইনজেকশন চেয়ে না পেয়ে গভীর রাত্রে পুনরায় জোরপূর্বক তা সংগ্রহ করতে ব্যর্থ হওয়ায় তাকে গলাটিপে ধরে (ভোরের কাগজ ২১-১১-৯৭)। এ ঘটনার রেশ যেতে না যেতেই গত ৩-১২-৯৭ বরিশাল মেডিকেল কলেজ হাসপাতালের প্রথমবর্ষের জনৈক ছাত্রী নার্স তার কর্তব্য শেষে ওয়ার্ড থেকে ফেরার পথে দিনেদুপুরে চতুর্থ বর্ষের ছাত্র নার্স আবু জাফর এমরান তাকে অর্থোপেডিক অপারেশন থিয়েটারে নিয়ে জোরপূর্বক ধর্ষণ করে। এ কাজে তাকে পাহারা দিয়ে সহায়তা করে একই বর্ষের ছাত্র নার্স কুদ্দুস হাওলাদার (দৈনিক ইত্তেফাক ১২ই ডিসেম্বর)।

জাতীয় পত্রিকায় প্রকাশিত উল্লিখিত ঘটনা দুটি ছাড়াও এমনতর অনেক ঘটনাই ঘটছে যা স্থানীয়ভাবে জানাজানি হলেও প্রচার মাধ্যমে প্রচারিত না হওয়ার কারনে নার্সসহ জনগণের অগোচরে থেকে যাচ্ছে। এছাড়া প্রতিনিয়ত ঘটছে নার্স তথা মহিলাদের লাঞ্ছিত, অপমানিত করার অসংখ্য ঘটনা।

বাংলাদেশ আমলে সামাজিক অবক্ষয়, নৈতিকতা ও মূল্যবোধের ঘাটতি, নারীদের অবস্থান ও অধিকার পদদলিত হওয়া, রাজনৈতিক জটিলতা বৃদ্ধি ইত্যাদি দিকগুলো ক্রমাগত বৃদ্ধি পেয়ে আজ সর্বগ্রাসী রূপ লাভ করেছে। আজ তাই নার্সিং পেশায় পুরুষ নার্সদের অবস্থান বৃদ্ধির দিকটিও বুমেরাং হয়ে দাড়িয়েছে। এই সামগ্রিক সর্বগ্রাসী অবস্থার শিকার বাংলাদেশের নার্স সহ নারী সমাজ।

বাংলাদেশের কর্মজীবি মহিলাদের অন্যতম বৃহৎ ক্ষেত্রটি হচ্ছে নার্সিং। সরকারী কর্মচারীদের মধ্যেও মহিলাদের সর্ববৃহৎ ক্ষেত্র এটি। শুরু থেকেই এই পেশা বিভিন্ন পর্যায় অতিক্রম করে বর্তমান সময়ে আসার এই সুদীর্ঘ পরিক্রমায় সামাজিক ভাবে অবহেলা, উপযুক্ত দায়িত্ব, ক্ষমতা ও মর্যাদা না দেওয়া, নার্সিং কর্তৃপক্ষের স্বতন্ত্র-দৃঢ়-বলিষ্ঠ-কর্তৃত্বকারী নেতৃত্বের ভূমিকা না থাকা, সরকারের উদাসীনতা ও দায়সারা গোছের গতানুগতিক ভূমিকা ইত্যাদি এই নার্সিং পেশাকে এবং এর সাথে জড়িত মহিলাদেরকে মর্যাদাশীল অবস্থানে না নিয়ে বিপর্যস্ত করেছে। তদুপরি হাসপাতাল নিয়ন্ত্রনকারী ডাক্তারসহ সরকারী কর্মকর্তাদের পেশাগত ও লিঙ্গগত দ্বন্দ্ব এবং প্রশাসনিক ক্ষমতার প্রশ্নে এ সমস্যা আরো বৃদ্ধি পেয়েছে। সেই সাথে নার্সদের সমস্যা, সমাধান ও প্রয়োজনের প্রেক্ষিতে দাবী দাওয়ার ভিত্তিতে গড়ে ওঠা আন্দোলনকে স্থিমিত, ক্ষতিগ্রস্ত ও ব্যর্থ করার জন্য সরকার ও প্রশাসনের গৃহিত বিভিন্নমুখী পদক্ষেপ সমূহ, মেয়েদের প্রতি কর্তৃত্ব করার মানসে হাসপাতালের কর্মচারীদের দ্বারা সৃষ্ট পরিস্থিতি এ অবস্থাকে আরো জটিল করেছে। পাশাপাশি নার্সিং পেশার সংগঠন সমূহের মধ্যে অন্তর্দ্বন্দ, কোন্দল, বিভক্তি, যোগ্যতার ঘাটতি, নিক্রিয়তা, সুবিধাবাদী ও ব্যক্তিস্বার্থ প্রতিষ্ঠার মনোভাব, রাজনৈতিক দলের লেজুড়বৃত্তি ইত্যাদি ক্রটি-বিচ্যুতি ও ব্যর্থতার জন্য সমগ্র নার্সিং সমাজ ঐক্যবদ্ধভাবে স্বীয় পেশার মর্যাদা ও অধিকার প্রতিষ্ঠা করতে পারছে না।

এ জটিল, ভয়াবহ অবস্থা থেকে মুক্তি পেতে হলে নার্সদেরকে সচেতন ও ঐক্যবদ্ধ হতে হবে, যাতে করে উদ্ভুত যে কোন পরিস্থিতি মোকাবেলাসহ প্রয়োজনীয় প্রতিরোধ গড়ে তোলা যায়। এ জন্য প্রয়োজন সকল দুর্বলতা কাটিয়ে তুলে আদর্শভিত্তিক, ঐক্যবদ্ধ, বলিষ্ঠ, যোগ্যতর, সক্রিয় নার্সিং সংগঠন। একই সাথে নার্সিং কর্তৃপক্ষকে স্বতন্ত্র কর্তৃত্ব ও নেতৃত্বদানকারী ভূমিকা নেওয়ার উপযোগী হিসাবে প্রতিষ্ঠিত করতে হবে। সে জন্য প্রয়োজন যোগ্যতরদের সামনে আনা সহ নার্সিং ব্যবস্থাপনায় আমূল সংস্কার। এটা সরকারের ভূমিকা ছাড়া করা অসম্ভব। তাই সরকারকে দেশের জনসংখ্যার অর্ধেক নারী সমাজের প্রতিনিধিত্বকারী সর্ববৃহৎ সরকারী মহিলা পেশাজিবি নার্সদের বিদ্যমান সমস্যা সংকট কাটিয়ে তুলতে এগিয়ে আসতে হবে। সেই সাথে স্বাস্থ্য সেবায় নিয়োজিত ডাক্তার কর্মকর্তা-কর্মচারীদের উদার ও ইতিবাচক মনোভাব সহ নার্সদের অগ্রযাত্রায় ভূমিকা নিতে হবে।

[Recently nurses and women are victimised very often at work. It is a consequence of social degradation, low status of nurses and women, devalued women's rights and privileges. To minimise these sorts of occurances and in order to utilise women's (half of the nation) potentialities, the root causes of the problems need to be identified and addressed by the government and concerned authorities. Beside this, men's attitude towards women need to be changed.]

THE NURSING PROFESSION IN BANGLADESH

Mairi Telford Jammeh, Lecturer, CIHS, QMC, Edinburgh, UK

Introduction

This short article describes a number of criteria which members of an occupational group should have in order that the group can be called a profession. It sets these out and then considers whether or not nursing in Bangladesh can be called a profession when assessed against these. Finally it considers how nurses in Bangladesh can contribute to improving the status of nursing to bring it into line with these criteria, thereby raising the professional profile of nurses.

Professions

Internationally certain occupations are described as professions rather than as jobs. The work of doctors, lawyers and teachers are amongst these. Nurses are also described in much of the literature as professionals. In this article we will consider whether or not nurses in Bangladesh are in fact professionals and if not how they could work to ensure that the term professional can be accurately used to describe them.

There are various definitions of the term profession. Let us consider one of these before we go on. The first of these comes from the Collins English Dictionary (1988). It defines a profession as:

> **"an occupation requiring special training in the liberal areas or sciences, especially of the three learned professions, law, theology or medicine. The body of people in such an occupation."** (p566)

According to this definition nursing in Bangladesh could be called a profession since it does require special training in science and is directly related to one of the 'three learned professions' namely medicine. On the other hand, Blanchfield (1978) has agreed that the term profession has been misused and that a profession cannot be defined according to one characteristic alone, but according to many. He set out the following as the criteria which an occupational group must fulfil before it can be called a profession:

> **" 'Profession' cannot be defined in terms of any single characteristic. To justify the description, an occupational group must fulfil not some but all of the following criteria:**
>
> *1. Its practice is based on a recognised body of learning.*
>
> *2. It establishes an independent body for the collective pursuit of aims and objects related to these criteria.*
>
> *3. Admission to corporate membership is based on strict standards of competence attested by examinations and assessed experience.*
>
> *4. It recognizes that its practice must be for the benefit of the public as well as that of the practitioners.*
>
> *5. It recognizes its responsibility to advance and extend the body of learning on which it is based.*
>
> *6. It recognizes its responsibility to concern itself with facilities, methods and provision for education and training future entrants and for enhancing the knowledge of present practitioners.*
>
> *7. It recognizes the need for its members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures"* (Pyne 1981).

Let us now consider nursing in Bangladesh against the above criteria:

1. There is a recognised body of learning for nurses in Bangladesh prescribed by the national nursing curriculum. It shares much of this with the medical profession however and doctors are heavily involved in teaching nurses. This criteria could be fulfilled more fully by nurse educators in Bangladesh drawing more consistently on purely nursing knowledge based on nursing research.

2. There does not appear to be an independent body which aims to ensure that nursing adheres to these criteria in Bangladesh. There is the Bangladesh Nursing Council, although it is only concerned with some of these functions. Initiatives to strengthen the Bangladesh Nursing Council however will address some of the functions not presently being carried out by it.

3. Admission to the Register of Nurses is by examination but experience is not assessed, suggesting that this criteria is only 50% achieved. By addressing the latter point the professional status of nurses could be improved.
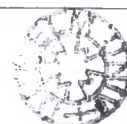
THE NURSING PROFESSION IN BANGLADESH

4. The nurses in Bangladesh are aware that their practice is for the benefit of the public as wells as that of the nurses, however this is not clearly stated in a national code of practice for nurses. Perhaps this is something the Bangladesh Nursing Council should be working towards developing, both by working to produce a Code and by ensuring that knowledge of this is a criteria for registering as a nurse.

5. There is nobody which has responsibility for advancing and extending the body of learning for nurses in Bangladesh. There is no nursing research going on and no funding for this available. There are now a number of nurses in Bangladesh who have the knowledge necessary to carry out small scale pieces of research with support and it may be possible that funding can be found or financed this. This would help ensure that this criteria was being fulfilled.

6. The Bangladesh Nursing Council is to some extent concerned with provision for training future entrants and the Government of Bangladesh (along with donors) has shown some commitment to the education of present practitioners throughout the building of the Continuing Education Centres. Further development needs to take placed to maintain these, develop continuing education further and ensure there is a return for this investment. The Strengthening Nurse Education and Services (SNES) project is funding work on the BSc curriculum in the College of Nursing.

7. Finally there is no Bangladesh Code of Ethics for Nurses nor written standards for professional conduct. There are no procedures in place by which individual nurses can be disciplined for breaching this code or for not following the standards for professional conduct.

Conclusion

In conclusion therefore we can see that nursing in Bangladesh only partly conforms to the criteria of profession. The criteria as set out can help to identify what can be done to strengthen nursing to ensure that in future it can truly be called a profession. Let us hope that the nurses in Bangladesh can work together on this task as a group in order to achieve that aim.

References:

Blanchfield JR (1978) On the abuse of the term profession: letter *The Daily Telegraph*

Pyne RH (1981) *Professional Discipline in Nursing: theory and practice* Blackwell Scientific Publications London

Smith WH & Collins (1988) *Collin's English Dictionary* WH Smith Wrotham England ❏

Dr Sally's visit in Bangladesh

Lori Harloe, Nursing Advisor, WHO

During October, Dr Sally Ann Bisch, Regional Adviser Nursing and Gender Issues visited Bangladesh. Sally is well known to many in this country because she worked here, as the WHO Nursing Adviser to Bangladesh, from 1948 to 1988. In recent times Sally has been developing a significant role in the area of Women in Development. This aspect of her work is complimentary to the work in nursing development in the South East Asian Region.

While in Dhaka, Sally was very busy meeting both nurses and non-nurses to strengthen nursing and patient care as well as women's role in development of health services and women's access to health care. Some of the key meetings Sally attended were that Human Resources for Health and the Gender Issues Working Group, both of which are likely to be funded by the World Bank under the next five year plan, HAP-V.

Sally met with the Director of Nursing Services, Ms Minati Sarma, and discussed the role of nursing under the Essential Service Package (part of HAPV), funding for Human Resources Development and costing estimates for nursing education and service for the next five years. Sally congratulated the DNS for having the National Plan of Action for Nursing Development signed by the MoH&FW and she is eagerly looking forward to some constructive changes for nurses and patient care.

Janet James, Team Leader of the SNES Project, Sally and author discussed among other things, the next meeting of the National Nursing Policy and Planning Committee and the importance of nurses taking control of their own destiny through planned, united and well thought out activities.❏

Chandraghona Christian Hospital is a "Singing Robin"

Aloka Sarker, Sister Tutor, NI, Chandraghona Christian Hospital, Rangamati Hill Tracts.

A Robin is singing in the jungle of Chittagong Hill Tracts for a long time. The travelers listen to it and get great pleasure. Everybody is enjoying its song, but no one knows for whom it is singing so sweet. Only Robin knows and it is singing still now. The Robin is the Chandraghona Christian Hospital. When this Hospital was born in 1907 in the jungle it was only a small cottage of mud and bamboo. Gradually the Hospital was expanded, the cottage was turned into building by the blessing of the God. The Robin is singing only in respect of the God even now.

The Nursing school of the Chandraghona Christian Hospital which could be recognized as the first Nursing School in Bangladesh was started in 1931 by Miss Timmins with a few male nurses. At that time females were not allowed to do nursing because of their insecurity in the society as well as in the services. The Female Junior Nursing Course was started in 1937 by Sister F.G.Cann. Students had to sit for examination at Calcutta. The Government of East Pakistan (now Bangladesh) recognized the school for Senior Course in 1957. There were only 27 students. In 1968 a new block built for the Nursing Training School. Sister Mary White was the Principal till 1968. Then Miss Myrtle acted as a Principal from 1969 to 1975. The results of the school were brilliant. Since 1976 the training school is being run by the National Principal, Mrs. R. Gain (R. Talukder). The school is recognized for Senior Midwifery Course in 1980. Though there are many difficulties the training school is running silently.

Chandraghona Christian Hospital is situated in the south-east part of Bangladesh. It is important for an institution to get favour of the authority. It passed long that the authorities of BNC visited this training institute and hospital. We hope kind concern of our authorities at present and in future.

In-service education is very important for any technical institution as the world is changing day by day. The demand of the people are increasing strikingly with changing thoughts, feelings, resources, environment. Technological advancement is a useful invention of modern age. To cope with new technologies, nursing must steps forward. Nursing is not simple but life saving technology. So in this changing situation inservice education is pertinent in the field of Nursing Services to develop insight, thought, ideas, management and communication skill, and teaching ability, bedside nursing care, capability to work in the community and so on. In case of nursing services in Bangladesh the Registered Nurses work in a post for long time. They are not acquainted with the new information, new ideas, new technologies etc. So it is very very important to update their knowledge and skill, enrich their capabilities and encourage their potentials through inservice education.

If the Directorate of Nursing Services arranges any in-service education programme, the option of including nurses of Chandraghona Hospital in the training programme would be appreciated. It will equip them with the new knowledge as well as assist in building confidence to provide advanced care to the patient as they also deliver health care services to the population like other Government Nurses.

(Editorial note: It is seen that the standard of nursing care in the non-Government sector particularly in the Christian hospitals is comparatively better than that of the Government sector hospitals. The reasons may be: the number of patients are admitted in the hospital is dependant on the available resources, more administrative co-operation such as necessary support and logistic supplies which facilitate nurses to provide better patient care and accountability for their responsibility is maintained. If in the government hospitals these aspects are considered and practiced, the quality of nursing care could be improved.) ❑

Problems Faced by DPHNs in their working situation

Sandhya Rani Sarkar, DPHN, Natore.

Health for all by the year 2000 (AD) was declared by the World Health Organization in the year 1978, which is known as Alma-Ata declaration. In this declaration World Health Organization invited and requested to its member countries for formulating national strategies to reach the goal through Primary Health Care Programme.

The Government of the Peoples' Republic of Bangladesh has taken various steps to materialize the same approach through Primary Health Care Programme. One of those is to recruit and post skilled and efficient officials as per necessity of the programme.

As a part of it, the Directorate of Nursing Services created a managerial post as District Public Health Nurse (DPHN) in each district under administratively controlled by Civil Surgeon in 1984. Senior and experienced nurses are posted against those. But necessary status and authority have not been conferred to the DPHNs as per their recruitment proposal and post. There is no provision for evaluation of **their role for the services and even their role was not focused in the Fourth "Five Year Plan."**

For example, I would like to mention here that although it is specified in section 3 under the Education Functions of the Job Description, **the DPHN will assist in organizing, implementing and evaluating the activities of Primary Health Care for health personnel in the District, especially at Thana and Union levels.** Yet it is not in practice. As she has been trained on that subject and mid level manager she can contribute to this aspect effectively.

A DPHN, during supervision of work of nurses working at District and Thana levels, can only know the problems faced by them and can inform to the concerning authority, but does not have any power to solve those. As a result, she is not held due importance.

In this situation some sort of **administrative authority should be delegated to DPHN** duly endorsed by the Director of Nursing Services to the District and Thana level administrator. The DPHNs should get a copy of any communication made to a nurse and she should be consulted about recommendations and any decision regarding the nurses whenever necessary. This should be communicated to the District and Thana.

The job description of DPHN formulated by the Directorate of Nursing Services is to some extent, not balanced and realistic. For instance,

1. as per provision specified in section No 5 of the job description of DPHNs, her opinion may be sought about study leave, transfer, promotion, maternity leave etc. of nurses working in the thana level, but it is ignored.

Personal file of nurses working at Thana should be passed through her, that she can give opinion in a formal way.

2. under section No 6 of the job description it is said that communication and consultation meeting should be made quarterly with Divisional ADNS, but, in fact, no mechanism laid down there to comply it. To solve this problem ADNS may issue a letter to the DPHN for attending the meeting with necessary reports, noting the time, date and place. DNS may take necessary initiative in this regard.

3. as per provision specified in article No 4 of the job description for DPHN, the annual confidential reports of the Thana level nurses are to be initiated by the DPHN and then sent to the ADNS, division through respective Civil Surgeon, which is not being practiced, as the concerned officials are not instructed about it. So DPHNs are being ignored in this respect. The DNS should take necessary step.

DPHNs are to visit Thana hospital and field level activities of Nurses and Health Personnel. Specified dress meant for nurses is not convenient for public health nurses. So the **Public Health Nurses should have special type of dresses**, for which demand was placed several times but no step has been taken till now. To solve this problem Nursing Council and DNS should jointly take early initiative.

Lack of conveyance is another kind of **obstacle in supervision of activities particularly on a part of a woman.** Sometimes they have to journey by bus, rickshaw, boat even some times walk on foot, but it is woeful that they do not get their due travelling allowances in time due to hazardous procedure.

It is a matter of regret that **since the creation of the post** the nurses have been working against this post, facing several problems, but **they do not get any opportunity to explain their problems**, till now.

At the end hoping that *DNS and other concerning authority will be interested for District Public Health Nurses and take necessary initiatives to solve these problems.*

কর্মক্ষেত্রে জেলা পাবলিক হেল্‌থ নার্সদের সমস্যাবলী

সন্ধ্যা রাণী সরকার, জেলা পাবলিক হেল্‌থ নার্স, নাটোর।

"২০০০ সালের মধ্যে সবার জন্য স্বাস্থ্য" ১৯৭৮ সালে আলমা আতা ঘোষণায় বিশ্ব স্বাস্থ্য সংস্থা প্রাথমিক স্বাস্থ্য পরিচর্যা কর্মসূচীর মাধ্যমে বিষয়টির সফল বাস্তবায়নের লক্ষ্যে সদস্যভুক্ত সকল দেশের প্রতি উদাত্ত আহ্বান জানান।

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার বিশ্ব স্বাস্থ্য সংস্থা কর্তৃক ঘোষিত কর্মসূচী প্রাথমিক স্বাস্থ্য পরিচর্যা বাস্তবায়নের লক্ষ্যে বিভিন্ন পদক্ষেপ গ্রহন করেছেন। কর্মসূচীর চাহিদা মোতাবেক দক্ষ ও অভিজ্ঞ কর্মকর্তা/কর্মচারী নিয়োগ উল্লেখযোগ্য। ইহার এক পর্যায়ে সেবা পরিদপ্তর কর্তৃক ১৯৮৪ সালে জেলা প্রতিনিধি হিসাবে প্রতিটি জেলায় সিভিল সার্জন এর সম্পূর্ণ নিয়ন্ত্রণাধীনে **জেলা পাবলিক হেল্‌থ নার্স** এর পদ সৃষ্টি করে দক্ষ ও অভিজ্ঞ সেবিকা উক্ত পদে নিয়োগ করা হয়।

কিন্তু নিয়োগ বিধি অনুযায়ী জেলা পাবলিক হেল্‌থ নার্সদের যোগ্যতার আলোকে পদমর্যাদা ও ক্ষমতা প্রদান করা হয় নাই। কর্মসূচী বাস্তবায়নে তার সহযোগীতাও মূল্যায়নের কোন সুযোগ রাখা হয় নাই। এমন কি চতুর্থ পঞ্চবার্ষিকী পরিকল্পনায় জেলা পাবলিক হেল্‌থ নার্স এর পদটি তালিকাভুক্ত করা হয় নাই।

পদ সৃষ্টির শুরু হতেই পদে অধিষ্ঠিত সেবিকাগণ নানাবিধ সমস্যার সম্মুখীন হচ্ছেন। কিন্তু এ পর্যন্ত এই সমস্যাবলী তুলে ধরবার কোন সুযোগ তারা পায় নাই। আমি প্রথমেই উল্লেখ করতে চাই যে, জব ডেস্ক্রিপশনে জেলা পাবলিক হেল্‌থ নার্সদের জেলা পর্যায়ের যে কোন স্বাস্থ্য কর্মসূচীর পরিকল্পনা, সম্পাদন ও মূল্যায়নে অংশগ্রহণের কথা উল্লেখ থাকলেও বাস্তবে জেলা পাবলিক হেল্‌থ নার্সরা উক্ত কার্যক্রম থেকে বাদ পড়ে থাকেন। অথচ প্রতিরোধমূলক স্বাস্থ্য সেবা বিষয়গুলোতে যদি একজন প্রশিক্ষণপ্রাপ্ত মিডল ম্যানেজার হিসেবে তাকে যুক্ত করা হয় তবে জেলা পর্যায়ের স্বাস্থ্য কর্মসূচীতে তিনি যথেষ্ট অবদান রাখতে পারবেন বলে আমার দৃঢ় বিশ্বাস।

যদিও জেলা ও থানা পর্যায়ে বিভিন্ন হাসপাতালে কর্মরত সেবক/সেবিকাদের কার্যাদি পরিদর্শন কালে বিভিন্ন সমস্যা সম্পর্কে অবগত হতে পারেন, কিন্তু স্থানীয় কর্তৃপক্ষকে অবহিতকরন ছাড়া সমস্যা সমাধানের কোন ক্ষমতা তিনি সংরক্ষণ করেন না। ফলে কেউ তাকে গুরুত্ব দেওয়া প্রয়োজন বোধ করেন না।

এক্ষেত্রে কিছু প্রশাসনিক **ক্ষমতা** তাদের **প্রদান করা উচিত।** কর্মরত নার্স ও নার্সিং কর্তৃপক্ষের মধ্যে পারস্পারিক যোগাযোগ পত্রাদির অনুলিপি প্রদান এবং প্রয়োজনীয় ক্ষেত্রে পরামর্শ বা মতামত দেওয়ার অধিকার জেলা পাবলিক হেল্‌থ নার্সদেরকে দেয়া উচিত। উপরন্তু স্বাস্থ্য বিভাগের জেলা ও থানা পর্যায়ের কর্মকর্তাগণকেও ডি.এন.এস কর্তৃক তা অবহিত করা প্রয়োজন।

সেবা পরিদপ্তর কর্তৃক পাবলিক হেল্‌থ নার্সদের জন্য প্রণীত জব ডেস্ক্রিপশনটি অতিরিক্ত দায়িত্বপূর্ণ ও কিছু কিছু ক্ষেত্রে বাস্তবতা বর্জিত বলে মনে হয়। যেমন, এর ৫নং অনুচ্ছেদ অনুযায়ী জেলা ও থানায় কর্মরত সেবক/সেবিকাদের উচ্চ শিক্ষার্থে ছুটি, বদলী, পদন্নোতি ও মাতৃত্ব ছুটিসহ অন্যান্য ছুটি-বিষয়ে পাবলিক হেল্‌থ নার্সের সুপারিশের কথা উল্লেখ থাকলেও বিনা সুপারিশে স্থানীয় এবং উধ্বর্তন কর্তৃপক্ষ ব্যবস্থা গ্রহণ করে থাকেন। জেলা ও থানায় কর্মরত প্রত্যেক সেবক/সেবিকার ব্যক্তিগত ফাইল পাবলিক হেল্‌থ নার্সের মাধ্যমে প্রেরণ করা হইলে উক্ত সেবক/ সেবিকার বিষয়ে তিনি প্রয়োজনীয় মতামত দিতে পারেন।

জব-ডেস্ক্রিপশনের ৬নং অনুচ্ছেদে বিভাগীয় সহকারী সেবা পরিচালকের সংগে ত্রৈমাসিকভাবে যোগাযোগ ও আলোচনার কথা উল্লেখ থাকলেও কি পদ্ধতিতে বিষয়টি বাস্তবায়িত হতে পারে সে সম্পর্কে কোন সঠিক নির্দেশনা নেই। প্রতিটি ত্রৈমাসিক মিটিং এর সময় বিভাগীয় সহকারী সেবা পরিচালক কর্তৃক সময় ও স্থান উল্লেখপূর্বক প্রয়োজনীয় প্রতিবেদনসহ মিটিং এ উপস্থিত হওয়ার জন্য প্রত্যেক পাবলিক হেল্‌থ নার্সকে অবহিত করলে বিষয়টি বাস্তবায়িত হতে পারে। এ লক্ষ্যে সেবা পরিদপ্তর কর্তৃক প্রয়োজনীয় ব্যবস্থা গ্রহণ করা আবশ্যক।

৪নং অনুচ্ছেদে উল্লেখিত থানা পর্যায়ের সেবক/সেবিকদের বার্ষিক গোপনীয় প্রতিবেদন একত্রিত করে সিভিল সার্জনের মাধ্যমে সহকারী সেবা পরিচালককে অবহিতকরণের নির্দেশ থাকলেও পরিচালক সেবা পরিদপ্তর কর্তৃক থানা পর্যায়ের কর্মকর্তাদেরকে পাবলিক হেল্‌থ নার্সের বরাবরে প্রতিবেদন প্রেরণের বিষয়টি অবহিত করা হয় নাই। ফলে পাবলিক হেল্‌থ নার্সের বরাবরে প্রতিবেদন প্রেরণের প্রতি কেহই কোন গুরুত্ব প্রদান করে না।

জেলা পাবলিক হেল্‌থ নার্সদের স্বাস্থ্য সেবামূলক কাজে থানা এবং মাঠ পর্যায়ে কর্মসূচীতে অংশ গ্রহণ করতে হয়। সেবিকাদের জন্য নির্ধারিত পোশাক পরিধান করে মাঠ পর্যায়ে গমনাগমনের অসুবিধা হেতু বারবার আবেদন সত্ত্বেও পাবলিক হেল্‌থ নার্সদের জন্য আলাদা পোশাক নির্ধারনের পদক্ষেপ গ্রহণ করা হয় নাই। ফলে তারা বিভিন্ন সমস্যার সম্মুখীন হন। এই অসুবিধা দূরীকরণের লক্ষ্যে নার্সিং কাউন্সিল ও সেবা পরিদপ্তর কর্তৃক যৌথভাবে পোশাক নির্ধারনের পদক্ষেপ গ্রহণ করা প্রয়োজন।
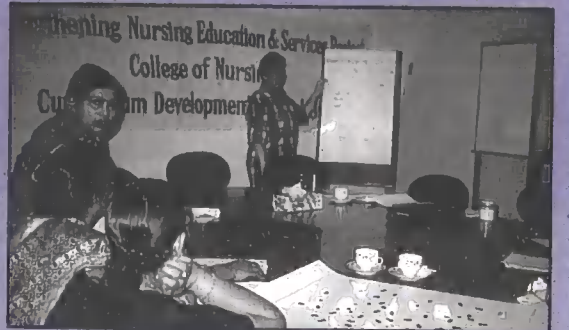
থানা ও জেলা পর্যায়ে বিভিন্ন সেবক/সেবিকা এবং চলতি স্বাস্থ্য সেবা কর্মসূচীতে নিয়োজিত মাঠ পর্যায়ের কর্মচারীদের কাজ পর্যবেক্ষণ, পরিদর্শন ও তদারকির ক্ষেত্রে যানবাহনের কোন ব্যবস্থা নেই। প্রত্যন্ত অঞ্চলে একজন মহিলার পক্ষে যানবাহন ছাড়া ভ্রমন করা দুরূহ কাজ। তারা বাস, রিক্সা, কখনও কখনও নৌকা এবং পায়ে হেঁটে ভ্রমন করলেও সঠিক সময়ে ভ্রমনভাতা পায় না। বিষয়টি নিঃসন্দেহে দুঃখজনক।

পরিশেষে আশা করা যাচ্ছে যে **সেবা পরিচালক এবং অন্যান্য সম্পৃক্ত কর্মকর্তা এই সব সমস্যা দূরীকরণে প্রয়োজনীয় পদক্ষেপ গ্রহণ করবেন।** ▢

বিএনসি ওয়ার্কিং গ্রুপের কার্যক্রম

জাহেরা খাতুন ও রহিমা জামাল আখতার,   সদস্য, বিএনসি ওয়ার্কিং গ্রুপ

নার্সিং পেশা মানুষের জীবন মরনের সমস্যার সাথে সম্পর্কিত। তাই স্বাস্থ্য সেবা সংক্রান্ত যাবতীয় নার্সিং কার্যক্রম দ্বারা যাতে জনগণ ক্ষতিগ্রস্ত না হয় তার নিরাপত্তা নিশ্চিত করা, পেশার মান উন্নয়ন করা এবং সেবাদানকারীর নিরাপত্তা নিশ্চিত করার লক্ষ্যে এই পেশাজীবিদের সকল কার্যক্রম নিয়ন্ত্রিত হওয়া অত্যন্ত গুরুত্বপূর্ণ।

উন্নত বিশ্বের দেশগুলোতে পেশাগত কার্যক্রমের মান নিয়ন্ত্রণ, জবাবদিহিতা নিশ্চিতকরণ এবং সর্বসাধারণের অধিকার সংরক্ষণের প্রয়াসে পেশার মান উন্নয়নে বিভিন্ন নীতিমালা রয়েছে। সাধারনতঃ একটি নিয়ন্ত্রক সংস্থা (Regulatory Body) দ্বারা এই সকল কার্যক্রম নিয়ন্ত্রিত হয়ে থাকে যার অধিকাংশ সদস্যই পেশাজীবি। উক্ত রেগুলেটরী বডি কাউন্সিল, বোর্ড বা ইনস্টিটিউশন নামে পরিচিত।

বাংলাদেশেও বিভিন্ন পেশাজীবিদের জন্য এই ধরনের রেগুলেটরী বডি বা কাউন্সিল আছে যার মাধ্যমে স্ব-স্ব পেশায় কর্মরত পেশাজীবিদের কার্যক্রমের মান নিয়ন্ত্রণ ও উন্নয়ন করা হয়ে থাকে। যেমন, বাংলাদেশ মেডিকেল ও ডেন্টাল কাউন্সিল, বার কাউন্সিল, নার্সিং কাউন্সিল ইত্যাদি।

বাংলাদেশ নার্সিং কাউন্সিল নার্সদের ও পরিবার কল্যাণ পরিদর্শিকাদের নিবন্ধীকরণ করা সহ নার্সিং শিক্ষার মান ও পেশার মান উন্নয়নের ক্ষেত্রে গুরুত্বপূর্ণ ভূমিকা পালনকারী একটি প্রতিষ্ঠান। এই প্রতিষ্ঠানের উদ্যোগে এবং নার্সিং শিক্ষা ও সার্ভিস শক্তিশালীকরণ প্রকল্পের সহায়তায় আয়োজিত ১৯৯৭ সালের এপ্রিল মাসের ২৬-২৮ তারিখ পর্যন্ত তিন দিনের এক কর্মশালায় নার্সিং কাউন্সিলের কার্যবিধি ও কার্যপ্রনালী সমূহকে আরও শক্তিশালী এবং গতিশীল করার লক্ষ্যে বিস্তারিত আলোচনা করা হয়। পরবর্তীতে এই প্রক্রিয়াকে এগিয়ে নেয়ার লক্ষ্যে একটি ওয়ার্কিং গ্রুপ গঠন করা হয়। এই ওয়ার্কিং গ্রুপ বিএনসি ওয়ার্কিং গ্রুপ হিসাবে পরিচিত।

এই ওয়ার্কিং গ্রুপ সেপ্টেম্বর ১৯৯৭ থেকে নিয়মিতভাবে প্রতি পনেরো দিনে একবার বাংলাদেশ নার্সিং কাউন্সিলে আলোচনায় বসছে এবং কাউন্সিলের প্রচলিত কার্যক্রম পর্যালোচনা করে বিভিন্ন বিষয় সমূহের উৎকর্ষ সাধনের লক্ষ্যে কাজ করে যাচ্ছে।

ইন্টারন্যাশনাল নার্সিং কাউন্সিল নামে একটি পরিষদ আন্তর্জাতিকভাবে নার্সিং পেশার মান উন্নয়ন ও নিয়ন্ত্রণের ওপর ব্যাপক পরীক্ষা নিরীক্ষা ও গবেষণার পর এ বিষয়ে একটি নির্দেশিকা তৈরী করেছে। বি.এন.সি. ওয়ার্কিং গ্রুপ এই নির্দেশিকার আলোকে এবং বাংলাদেশের বাস্তবতায় নার্সিং পেশার সমস্যা ও সম্ভাবনার প্রেক্ষিতে বাংলাদেশ নার্সিং কাউন্সিলের বর্তমান কাঠামো ও কার্যসমূহ নিরীক্ষা করে দেখছে।

এখানে উল্লেখ করা প্রয়োজন যে, বাংলাদেশ নার্সিং কাউন্সিলের কার্যক্রমের উৎকর্ষতার লক্ষ্যে ইতিমধ্যে গত ৫ই নভেম্বর ১৯৯৭ তিন জন নার্সিং কর্মকর্তা নার্সিং রেগুলেশনের ওপর প্রশিক্ষণ গ্রহণের জন্য যুক্তরাজ্য গমন করেন। তারা হলেন বাংলাদেশ নার্সিং কাউন্সিলের ডেপুটি রেজিষ্ট্রার জিন্নাতুন নেছা, ঢাকা মেডিকেল কলেজ হাসপাতালের নার্সিং সুপারিন্টেন্ডেন্ট মমতাজ বেগম, নার্সিং ইনস্টিটিউটের শিক্ষিকা গীতশ্রী ঘোষ।

আশা করা যায় যে, ফিরে এসে তারা বিএনসি ওয়ার্কিং গ্রুপের সঙ্গে সমন্বিতভাবে কাজ করবেন। □

কমনওয়েলথ সম্মেলন ও আমরা

হামিমা উম্মে মোর্শেদা ও মালতী মারান্ডী,
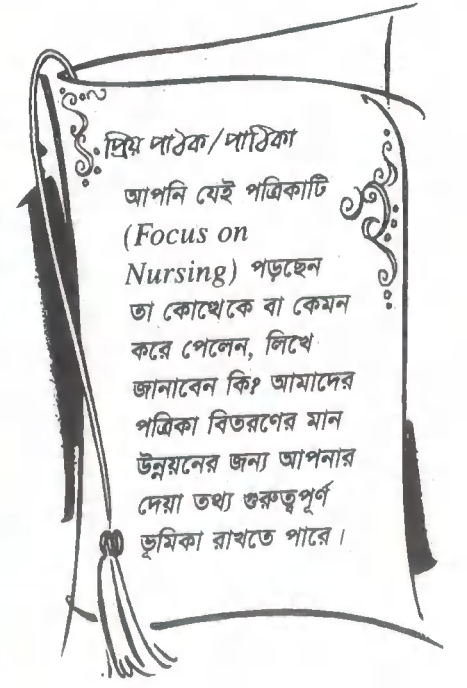ছাত্রী, এমএসসি (ইন্টারন্যাশনাল হেলথ) কুইন মার্গারেট কলেজ, এডিনবরা

গত ২৩ শে অক্টোবর থেকে ২৭শে অক্টোবর ১৯৯৭ পর্যন্ত স্কটল্যান্ডের রাজধানী এডিনবরাতে কমনওয়েলথ কনফারেন্স অনুষ্ঠিত হয়। এ উপলক্ষ্যে বাংলাদেশের প্রধানমন্ত্রী শেখ হাসিনাসহ কমনওয়েলথভুক্ত ৫৪টি দেশের রাষ্ট্রীয় প্রতিনিধিবর্গ যোগদান করেন। এতদুপলক্ষ্যে বিভিন্ন দেশের সাংস্কৃতিক অনুষ্ঠান, ছোটদের চিত্রাংকন প্রতিযোগিতা, আলোচনা সভা ও প্রদর্শনীর মধ্য দিয়ে এডিনবরা শহরটি মাসব্যাপী উৎসব মুখর ছিল। প্রদর্শনীটি ছিল এডিনবরা কমনওয়েলথ সেন্টারে। এই প্রদর্শনীর উদ্দেশ্য ছিল যুক্তরাজ্যের সহায়তায় কমনওয়েলথভুক্ত দেশের যৌথভাবে পরিচালিত বিভিন্ন গঠনমূলক কার্যক্রম জনসমক্ষে তুলে ধরা। আমরা কুইন মার্গারেট কলেজে মাষ্টার্সে অধ্যয়নরতা বাংলাদেশী ছাত্রীগণ কয়েকটি অনুষ্ঠানে অংশ গ্রহনের সুযোগ পাই। প্রদর্শনীতে বৃটিশ কাউন্সিল আয়োজিত একটি স্টল ও Women's Federation for World Peace অন্যতম।

বৃটিশ কাউন্সিল আয়োজিত স্টলে বিভিন্ন দেশে এই প্রতিষ্ঠান কর্তৃক পরিচালিত বিভিন্ন উন্নয়ন কর্মকান্ড উপস্থাপন করা হয় তার মধ্যে বাংলাদেশের SNES Project একটি। অনেক দেশের রাষ্ট্র প্রধানগণ এই প্রদর্শনী পরিদর্শন করেন, যার মধ্যে ২৪শে অক্টোবর যুবরাজ চার্লসের পরিদর্শন উল্লেখযোগ্য। এই সূত্র ধরেই আমরা বাংলাদেশী নার্সরা প্রিন্স চার্লসের সঙ্গে কিছুক্ষণ আলোচনা করার সুযোগ পাই।

আমরা বৃটিশ কাউন্সিল পরিচালিত নার্সিং শিক্ষা ও সার্ভিসেস শক্তিশালীকরণ প্রকল্প কর্তৃক প্রকাশিত সাময়িকী **Focus on Nursing** এবং পোস্টার প্রদর্শনের মাধ্যমে বাংলাদেশের নার্সিং ইনস্টিটিউট ও নার্সদের অবস্থা ও কার্যক্রম সম্পর্কে তাকে অবহিত করি। এ প্রেক্ষাপটে যুবরাজ চার্লস যখন বাংলাদেশের স্বাস্থ্য ব্যবস্থা সম্পর্কে তার ধারণা ব্যক্ত করে উল্লেখ করেন যে, 'বাংলাদেশে ডাক্তারদের তুলনায় নার্সদের সংখ্যা অপ্রতুল', তখন আমরা যার পর নাই অভিভূত ও বিস্মিত হয়েছি তার বাংলাদেশ সম্পর্কে সম্যক ধারনা দেখে।

বিভিন্ন আলোচনার ফাঁকে ফাঁকে তিনি বাংলাদেশের পোশাক শিল্পের অগ্রগতি সম্পর্কে ভূয়সী প্রশংসা করেন। আমরা এখানে কেমন আছি, আবহাওয়ার সঙ্গে নিজেদের খাপ খাওয়াতে কষ্ট হচ্ছে কিনা, বাংলাদেশের কোন প্রান্ত থেকে এসেছি, তিনি এসব খোঁজ-খবরও নিয়েছেন। গত ফেব্রুয়ারী ১৯৯৭ এ বাংলাদেশে ঘুরে আসার স্মৃতি বর্ণনা করতে গিয়ে তিনি সিলেট তথা বাংলাদেশের প্রাকৃতিক দৃশ্যের কথা বলেন।

আমাদের এই গুরুত্বপূর্ণ সাক্ষাৎ ও আলোচনার পাশাপাশি আমরা তাকে জানালাম যেন ভবিষ্যতের নার্সিং শিক্ষা ও সার্ভিসের উন্নয়নে বৃটিশ কাউন্সিল তথা যুক্তরাজ্য সরকারের ভূমিকা অব্যাহত থাকে। □

প্রিয় পাঠক/পাঠিকা
আপনি যেই পত্রিকাটি (Focus on Nursing) পড়ছেন তা কোথেকে বা কেমন করে পেলেন, লিখে জানাবেন কি? আমাদের পত্রিকা বিতরণের মান উন্নয়নের জন্য আপনার দেয়া তথ্য গুরুত্বপূর্ণ ভূমিকা রাখতে পারে।

Continuing Education for Nurses

Rahima Jamal Akhtar, National Nurse Consultant, SNESP

Nurses are the major force in the health care delivery service through out the world. In many countries their contribution is significant in achieving the targets of health for all. However, in Bangladesh nurses' participation and contribution is very limited and only in the institution based services.

In order to participate in the health care services, these professionals need to be equipped with necessary knowledge, skills and attitudes. Their roles being health care providers are numerous and most of the time they have to work without any supervision as there is an acute shortage of supervisory personnel within the service sector. On the other hand, their basic preparation is not adequate enough to take an active part in the health care management because all job related contents are not fully incorporated in the Basic Nursing Curriculum. To carry out the assigned tasks effectively and to work within the changing context of health, nurses should be prepared & equipped.

In addition, in recent years quite rapid changes have been found in the nursing and health sciences throughout the world. The development of new knowledge and skills and of the speed with which existing knowledge becomes redundant is becoming more recognised. Nursing itself changes too. In order to pace with such rapid changes, a life long learning is important if nurses are to respond to challenges. Life long learning is also important for nurses to understand and incorporate advanced knowledge and skills to remain competent in the job.

Thus the provision of post-basic in-service training and education for nurses related to nursing management and care is of utmost importance. Continuing Education

(CE) may facilitate the practice and professional growth of nurses in the changing context of health care. It should not be ignored that continuing education is not just a refresher course or special training. By name and definition it provides the meaning of continuation; it lasts from the completion of the basic training to retirement. Whatever term is used it carries the same message as cited by Clyne (1995):

"it's the way in which professionals keep themselves up-to-date and maintain their standards as professional in the practice of the work that they do." (p15)

The overview of the role of CE shows that it is mostly concerned with preparing, updating and developing professionals in any work oriented environment. Therefore CE is essential for nurses as they are expected to work continuously toward improving the service they offer to the public. A review of literature reveals that a short term CE can make a difference in practice and can improve health care. In most countries employers rely on CE when a change in health care system is imperative.

CE is a structured learning process that follows the basic training and continues throughout the career of health personnel. It involves active participation of the learner. It may either be organised within the formal education system or within the organisation where needed.

Florence Nightingale as cited in Cooper and Hornback (1973) stated that:

"Let us never consider ourselves as finished nurses.... We must be learning all of our lives." (p19)

From this quotation it is clear that Florence Nightingale was also aware and responsive to the need for continuing education for nurses, though the concept of lifelong learning is a relatively recent one. It has seen that rapidly changing technology and the trend toward specialisation makes CE vital for today's nurses. Thus the role of continuing education in relation to the improvement of nurses' role in health management and care should be given emphasis as it addresses and values recent change.

It is a fact that CE provides certificates that have no academic value. Nevertheless, it has professional value. It enables nurses to adapt to changing health needs of the community and to make them competent to perform the job. However, CE does not ensure that the practice will be implemented when the participants return to work. In this concern Thurston (1992) suggests that CE participants need encouragement and supervision to apply new knowledge because the environment to which they return may not be receptive to new ideas or change.

The International Council of Nurses (ICN) also stressed the importance of CE of nurses and midwives in 1975. In Eastern Europe CE is provided for all health workers. In some Nordic countries specific funds are allocated and in Finland CE is mandatory for all nurses and midwives. In developed countries professional nursing organisations are active in developing CE in co-operation with the health and nursing authorities (WHO 1984).

Concerning this in Bangladesh an attempt has been taken by the DNS in collaboration with WHO for the continuing education programme (CEP) since 1985. It appears that

Plans for the four CEC's for

In the SNES project proforma the proposal for four divisional Continuing Education Centres (CECs) for nurses explained that continuing education is vital if nurses are to keep up to date on new developments in nursing and health sciences. In 1986 the Directorate approved a plan for decentralising continuing education and since then most continuing education courses have been taught at the periphery. Nursing Institutes and hostels can not accommodate continuing education and their participants, therefore efforts have been made, under the auspices of the SNES project to construct these four centres. These four centres are Chittagong, Rajshahi, Barisal and Mymensingh.

The SNES project plans to conduct four short nurse teacher in service training courses in 1998. These will be in Nurse Institutes with newly built CECs attached to them. So far three of the planned CECs have been completed and the fouth is to be completed in May of next year, despite the fact that it was scheduled for June 1997.

the news of this planned training and were happy to learn that the training was for all the nurse teachers in the Institute and that it has been proposed to have two
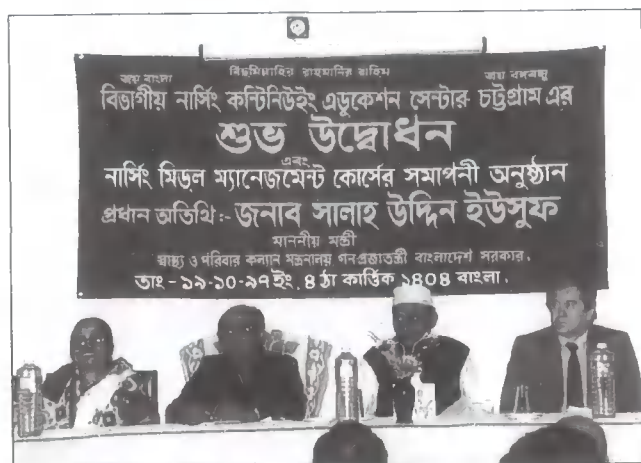

Divisional CEC for Nurses, Chottagong

Opening ceremony of CEC, Chottagong

The CEC in Chittagong, as many of you will know, was used for the Middle management training which took place from July to October 1997. There are several other training activities planned for 1998, mainly for the nurses based in Chittagong MCH.

Rajshahi Nursing Institute's CEC is complete and was visited in December of this year. In May 1998, **a two-week nurse teacher's training course** will be conducted there as well as **a two-week course for Thana Health Complex Nurse Supervisors.** The Training will be carried out at different times but will see the first of the continuing education activities for nurses to be held in Rajshahi. On the recent visit to the nursing institute there the nurse teachers welcomed

nurse teachers from the Christian Mission Hospital (also in Rajshahi) to take part in the training.

A Senior Nurse Tutor from Holland, Ms Maria Gosker, is currently based at the Christian Mission Hospital, Rajshahi to work with the nurses there for at least the next 4 years and she is looking forward to establishing working relations with the nurses from the Government sector based in Rajshahi in particular. Maria has been working for the last twelve years in Mali, North Africa involved in Community Health

Maria Gosker, Teacher, Christian Mission Hospital, Rajshahi

Divisional CEC for Nurses, Rajshahi

urses in Bangladesh

Carol Chamberlain
Nurse Educator, SENSP

Programmes and her experience there has taught her about realistic expectations in relation to capacity building.

Nowshina Banu, a recent returned Masters graduate nurse will be given the opportunity to participate in a training of trainers course planned for January 1998.

Barisal's centre is complete and fortunate enough to have two nurses who recently participated in the middle management training course held in Chittagong, namely Roseliand Biva Baroi and Haridas Adikhari. Originally both of the participants were selected because they were both based in the Nurse Institute there and had been actively involved with project nurses who were previously involved in earlier project activities in an attempt to improve the delivery of education in the Institute .

Unfortunately Roseliand's long sought after promotion came at an unexpected and at a rather untimely point, as she was no longer the Acting Principal of the Nurse Institute, but the Nursing Superintendent of the Hospital. Hopefully, however this will aid in establishing and promoting links between the nurses, students and teachers of the NI and MCH in Barisal.

Rajshahi, NI

Minati Mazumder, a returned Masters graduate nurse is now the Acting Principal and it is anticipated that she will participate in a training of Trainers programme to take place in mid January 1998 so that Barisal will have the opportunity to develop a core group of nurses with which to develop the area in which they work.

Mymensingh, unfortunately is quite a bit behind in terms of the construction of the CEC. This may prove a problem for the planned training activities to take place but with a bit of pressure from the Project Director, hopefully this can be resolved and the building will be ready for the training to take place in may or June of next year.

Divisional CEC for Nurses, Mymensingh

All the nurses in Mymensingh Institute as in the other three Institutes with CEC's were asked to identify the training needs that can be addressed in the two week course planned for next year. All nurse teachers have been requested to submit these needs in time for the overseas consultant, who will be responsible for delivering the short course, to develop and design an appropriate training course which will address the areas identified and prioritised by the nurse teachers. There is also a Masters graduate nurse based in the MCH in Mymensingh, Modhu Sudon Chakraborty, who will be invited to participate in the training of Trainers programme. He will be able to assist in the training next year when two overseas consultants arrive to deliver the training for the nurse teachers and for the Thana Health complex Nurse Supervisors.

Finally in Chittagong, where the CEC is established and has held one successful training course, nurses there have identified their training needs and will be the first to be receive the training in March next year. Two Masters graduate nurses have been invited to participate in the ToT, and it is hoped that they will contribute to the development of nursing in Chittagong NI/MCH. ❑

Necessity of special training for nurses

Saraswati Adhikary, Nursing Supervisor, General Hospital, Narayangonj

Nursing is an important part of treatment. A patient does not recover by medicine alone without the aid of nursing.

Nursing a patient with a spinal cord injury is a specialised area which requires special knowledge and skills to take the challenge of recovery. Spinal cord injury interrupts urinary and bowel functions and normal mobility. In this condition, life style of a patient is totally changed. If such case are not properly managed, the condition becomes worse and life becomes threatening.

In the early stage of spinal cord injury, pressure sores always develop quickly if positioning, lifting and handling is not done properly. Due to poor management other complications can also arise. It appears that pressure sores delay the process of rehabilitation. All the possible complications could be prevented through proper nursing management and care, but this requires adequate and appropriate knowledge and skills.

Training helps participants to improve their knowledge and skills in certain areas and assists to change their attitudes. **The Centre for Rehabilitation and Paralysed, Savar** provides a short course on **Spinal Cord Injury Management for nurses.** Every training course has its special aims and objectives.

This course has been designed to offer nurses to think about patients physical, economical and social needs during and following treatment and management. This course provides:

- knowledge and skills about the management of spinal cord injury;
- knowledge and skills on management, prevention and treatment of pressure sores;
- the overview of related anatomy, physiology and medicine;
- knowledge on physiotherapy and occupational therapy and their role;
- the knowledge regarding the process of rehabilitation;
- guidelines to identify spinal cord injury;
- information and ways of referring

patients to the CRP; and
- knowledge and skills to manage such patients in different hospital settings.

As spinal cord injury has devastating effects on the physical, social and psychological health of the injured person, training provides a special opportunity for Bangladeshi nurses to implement their acquired knowledge and skills on managing such cases in any hospital settings.

If any spinal cord injury case is admitted to the hospital, where I work, I try to adopt all the knowledge and skills acquired during the management course in CRP. It should not be ignored that, nursing services could be improved dramatically if nurses are equipped with update knowledge, skills and information through in service education and training. It also requires strong support, assistance and follow-up supervision from the local as well as the central authority. ❑

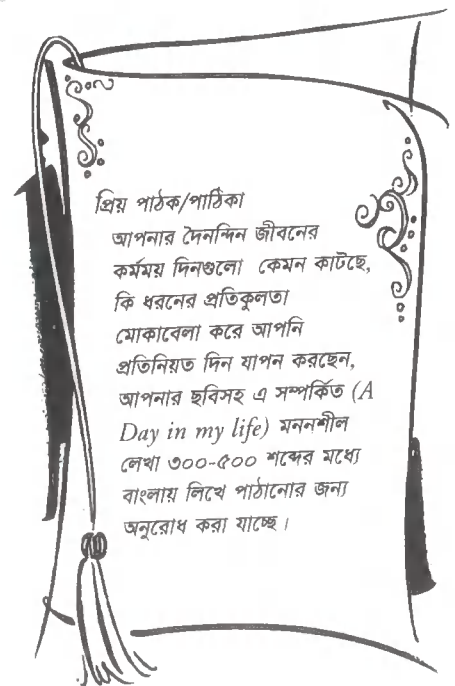## CONTINUING EDUCATION FOR NURSES

cont. from page 9
CEP is only possible to organise when funds are available from the donor agencies. CEP was offered to the Nurses in different areas and the length of the programme was also varied. The number of participants varied and courses were arranged throughout the country.

Recently four Divisional Continuing Education Centre for Nurses have been built by the SNES Project. You can see a report about it in this issue how these CECs could be utilised in 1998 by the SNES Project. A thorough plan should need to be developed by the DNS to use these centres effectively for

nurses' professional growth.

References:

Clyne S (1995) *Continuing Professional Development: perspectives on CPD in practice* Kogan Page London

Cooper SS and Hornback MS (1973) *Continuing Nursing Education* McGraw-Hill Book Company New York

Thurston HI (1992) Mandatory continuing education: what research tells us? *The Journal of Continuing Education in Nursing* 23 (1): 6-14

WHO (1984) *Education and training of Nurse Teachers and Managers with special regard to Primary Health Care: report of WHO Expert Committee* WHO Geneva ❑

প্রিয় পাঠক/পাঠিকা
আপনার দৈনন্দিন জীবনের
কর্মময় দিনগুলো কেমন কাটছে,
কি ধরনের প্রতিকূলতা
মোকাবেলা করে আপনি
প্রতিনিয়ত দিন যাপন করছেন,
আপনার ছবিসহ এ সম্পর্কিত (A
Day in my life) মননশীল
লেখা ৩০০-৫০০ শব্দের মধ্যে
বাংলায় লিখে পাঠানোর জন্য
অনুরোধ করা যাচ্ছে।

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Life Long Learning

Dolon Raihan, B.Sc. Nursing.

Shirin is a life long learner. Taslima wants to be but she is not. Both are nurses who know that it is important for them to update their knowledge and skills. The difference between them is one of attitude.

Shirin believes that it is her own responsibility to learn. Taslima believes it is the responsibility of her autority to put her on a course. Shirin learns informally. she takes every opprtunity to read, to ask questions, to explore and to practicce. Day by day, little by little, she is adding to her knowledge and extending her skills. Taslima waits, waits, always waits to be given a chance. Day by day she stagnates, and is beginning to blame others for her old fashioned knowledge and lack of skills.

Are you learning like Shirin, or are you waiting like Taslima? It is not so difficult to become a life long learner, we can all do it if we choose to. Here are some ideas to get you started.
● Choose a topic to learn about.
● Think of all the ways you could learn more about it.
● Make a plan of what to do to structure your learning.
● Try out in practice the things you have learnt.
● Think about what you have done and identify what you have learnt.

For example, Shirin decided she wanted to learn about time management. Here is what she did. Told her manager what she planned to do.
➤ Asked senior nurses to help her find books and articles on time management.
➤ Read the articles and made notes.
➤ Identified people who seemed to manage their time effectively and talked with them about how they did it.
➤ Kept a time diary recording everything she did for a week.
➤ Showed her time diary to other nurses and discussed with them how to improve her time allocation.
➤ Made a list of tips for time management based upon her readings and her discussions.
➤ Choose one tip each day and tried to put it into practice.
➤ Wrote down her experience noting which tips worked well.
➤ Told her seniors (who helped her) how she was getting on and asked for comments and feedback.
➤ Prepared a teaching session to share what she had learnt with other nurses.

If like Shirin, you are a life long learner, why not send your experiences to this newsletter for others to read. If you are not life long learner, why not become one, and write to tell us how you get on.❏

Study Tour to Nepal & Myanmar

Recently some Senior Managers, Teachers from CoN and Nurse Leaders from different Nursing Organisations have visited to Nepal and Myanmar for a three week study tour. The objectives of this study tour were to have a discussion regarding:

✎ The need for leadership in Nursing and the importance of having a vision for the future.

✎ The ways Senior Nurses identify priorities for policy making and planning and how they negotiate action with the Government.

✎ The advantages and disadvantages of the integration of the Directorate of Nursing into different sectors or divisions of the health services.

✎ The experience of devising a Nursing Act and establishing a Council of Nurses.

✎ Recent developments in Nurse education, especially the introduction of a basic BSc Nursing Course and a post basic Masters course in Nursing.

✎ Recent developments in the Nepal and Myanmar Nursing Associations, their relationship to the Nursing Council and contribution to in-service training, advocacy for nurses and the development of the profession.

The participants were Lila Sarker, Khadiza Begum, Suraiya Begum, Sahana Begum, Taslima Begum, Hosne Ara Begum, Lori Harloe and Janet James. ❏

Management Course and My Experience

Majeda Akhter, Principal, Chittagong NI

The first management course for nurses in Bangladesh was conducted at the Divisional Continuing Nursing Education Centre (CNEC), Chittagong from 6th July to 23rd October 1997. Fifteen participants attended this course including two from Barisal NI and two from MAG Osmani Medical College Hospital, Sylhet. The teachers were Mairi Telford Jammeh, Yan Yaxley and Robert Purvis, Lecturers of Queen Margaret College, Edinburgh, UK. Ira Dibra, Rahima Jamal Akhtar and Saleha Khatun assisted in the course, explained the lectures and did mentor ship during the task weeks very nicely where Nursing Instructor Alo Rudra from Chittagong NI was also actively involved. Project Nurses James Green and Beryl Green were also assisting us throughout the course.

The main objectives of the management course were to develop management skills of Bangladeshi nurses to provide better nursing care to the patients as well as to teach the student nurses in the clinical areas. To fulfil these objectives, we have been taught about communication, planning, time management, delegation, supervision, monitoring, feedback and evaluation, problem solving, disciplining staff, dealing with disputes and conflict. Our teachers taught us in a participatory approach where all participants were actively involved in the session and learnt more. Participants were assigned for group work, task presentation, discussion, role play etc which were very interesting and enjoyable. However, it was difficult to do at the beginning of the course.

In this course we were able to identify the importance of various management aspects on nursing. Good planning, good communication, good supervision and good assessment are essential for providing quality services. I hope every participant understood and realised the necessity of this course. Now we are able to find out the reasons why the quality of nursing is deteriorated gradually and identify the ways and means to

overcome this undesirable situation.

In the first task weeks, I was assigned to investigate support need and services available for the student nurses throughout their training. I identified the problems though observation and interviewing students. On the basis of my findings I made some suggestions for future action e.g., to develop teaching skills of teachers, to train home sister and house keeper how to meet the support needs of the students. Therefore, I have developed an outline proposal for a workshop with aiming to meet the training needs of teaching staff and supporting staff as well.

In the second task weeks, Roseliand Biva Baroi, Nursing Superintendent, Barisal Medical College Hospital and I have prepared a revised allocation of time which will cover clinical and theoretical requirements for one group of students for three years. It has been noticed that theoretical classes and clinical practices are sufficient according to the curriculum requirement. However, clinical teaching and supervision are almost absent in the practice areas.

Due to lack of clinical teaching and proper supervision and guidance students do not follow the correct nursing procedures in the clinical areas. So a three-day workshop will be arranged in the CNEC, Chittagong for teachers, home sisters and house keeper to achieve the task objectives.□

The Course on Management skills in Nursing

Selina Chowdhury, Instructor , CoN, Dhaka

Monindra Baroi, Nursing Instructor (acting), Faridpur NI and I have recently attended a course on **"Management skills in Nursing"** from 6th October to 14th November, 1997 as WHO fellow. The course was offered by the Faculty of Nursing, Chulalongkorn University, Bankok, Thailand.

The course objectives were:

- *to increase knowledge and experiences concerning nursing education and administration including strategic planning, organising, directing, supervising and co-ordinating in Nursing Institution as a higher education level.*

Focus on Senior Management Training

Farida Begum, Nursing Supervisor, DNS Office, Dhaka

A 13-week Senior-level Management Training programme was started at the British Council, Dhaka since 31st August 1997. The aim of the course was to strengthen conceptual understanding and functional capability of the effective and efficient management of human, time and material resources of the Nursing Directorate. The following participants were selected from the national level. They were DNS Minati Sarma, DDNS Shahana Begum, Project Officer of 18 NIs Fowzia Begum, deputed Nursing Supervisors Farida Begum and Lutfun Nessa, SNES Project Director Khadiza Begum, Dhaka Division's ADNS Suraiya Begum and RIHD's Nursing Superintendent Lila Sarker.

The course has been designed into three blocks covering a wider aspect of both strategic and operational planning and policy making. During the course, participants attended in the office before lunch and then they had to attend the course from 1.00pm to 5.00pm. Sometimes it was found difficult to concentrate fully on the course content. First four weeks were considered as a first block to provide the opportunity to share and exchange the constructive knowledge, ideas and opinion beside the theoretical inputs.

To improve the management capabilities some tasks were identified by the participants during the first block. One task was selected by each participant to accomplish it by the first two weeks of second blocks. All these completed tasks were monitored and evaluated by the two UK Consultants in the third week.

This management training can be seen as the first step on the road to strengthen the DNS and moving the profession into a future development and change. In the mean time next tasks were identified to finish by the last week of second block. Third block started on 9th November with the aim of covering project planning, policy formulation and leadership role that are required to put the profession and organisation forward.

The most stimulating thing is that previously we did not get such types of inputs by which we could deal with managing change and shape up our personal career as a successful professional. So we are satisfied with the course content, methods, tools and selection of the facilitators who have the range of knowledge and experience in this particular field. However, it could be better to bring one UK facilitator rather than three for the same course.

The most disappointing thing is that some of the course participants are nominated for the study tours outside the country to enhance their knowledge but some are left which is really unfair.

In considering the above discussion following recommendations can be taken into account:

- This type of management course needs to be arranged further for other senior managers over the country to extend their management capabilities.
- All participants need to take away from their job to put concentration fully on the course contents and assigned tasks.
- More support is needed for the assigned tasks in terms of resources.
- Teacher/facilitator should be consistent throughout the course.
- Prepare national nurse teachers to conduct and continue this sort of management course in future.

We believe that it is a great opportunity for us to have this sort of extensive management training by such experienced facilitators. We are looking forward to writing an article about our achievement in the next issue.□

The Course on Management skills in Nursing

- *to develop an innovative nursing instruction media and enhancing nursing research for improving nursing education and practice. To achieve those objectives a curriculum was developed and implemented. The various methods used were lectures, discussion, practical, tour, visit etc.*

I have learnt the management theories in the classroom and observed the process of application of those theories in the management of nursing education in the Institutions and in the clinical areas of different School of Nursing, College of Nursing and in the Faculty of Nursing of different Universities. The knowledge which I have gained from the course will be very helpful to ensure the quality of management of class teaching, clinical teaching, management of student affairs and to help them to be a responsible citizen. This knowledge will be applicable to plan better learning environment for students and to findout and utilise more effective ways of management of nursing education. This knowledge will be very imperative in self development as well.□

নারী ও সেবা পেশা
Women and Nursing

ইরা দিব্রা, ন্যাশনাল নার্স কন্সালট্যান্ট, এস.এন.ই এস. প্রজেক্ট

নারী ও সেবা শব্দ দুটি যেন একট অপরটির পরিপুরক। পরিবারের কেউ অসুস্থ হলে একজন মা বা পরিবারের অন্য কোন মহিলা তার সেবার জন্য নিয়োজিত থাকেন। বিশেষতঃ মেয়েদের ক্ষেত্রে ছোট হতেই শিশু মনে মায়ের এ ভূমিকার ছাপ পড়ে, যা পরবর্তীতে প্রকৃতিগত ভাবে তাকেও পারিবারিক ও সামাজিক জীবনে একই ভূমিকা পালনে সহায়তা করে। আর নারীদের এই বিশেষ চরিত্র ও গুনের বলেই সকল সেবামূলক কাজে মহিলাদের চাহিদার অন্ত নেই। যেমন- হাসপাতাল ও ক্লিনিকে রোগীদের সেবা প্রদানের জন্য মহিলা নার্স ও ডাক্তার, গ্রামে-গঞ্জে স্বাস্থ্য ও পরিবার কল্যাণ কর্মসূচীতে মহিলা কর্মী, যে কোন ধরনের উন্নয়নমূলক কার্যক্রমে নারী কর্মী, এমনকি উড়ন্ত জাহাজেও সেবামূলক কাজে মহিলাদের চাহিদার শেষ নেই।

বাংলাদেশে নার্সিং একটি জনকল্যাণমূলক স্বতন্ত্র পেশা। চাকুরীজীবি সিংহভাগ মহিলা এই পেশায় নিয়োজিত থেকে নানান প্রতিকূলতার মধ্য দিয়েও দেশের স্বাস্থ্য সেবায় যথেষ্ট অবদান রাখছে। ইতিহাস যদিও প্রমাণ করে যে সেবা কাজ মূলত মেয়েদের দ্বারা শুরু এবং অদ্যাবধি এ পেশায় মেয়েরাই অগ্রগামী ভূমিকা রাখছেন, তথাপি একথা অনস্বীকার্য যে নার্সিং পেশার মান দেশ কাল শিক্ষা ও আর্থ-সামাজিক ব্যবস্থাভেদে পরিবর্বতিত হয়। তাই বাংলাদেশে নার্সিংএর মান পূর্বের তুলনায় বৃদ্ধি পেলেও প্রয়োজন এবং সামাজিক অগ্রগতির তুলনায় তা অপ্রতুল। উপরন্তু আর্থ-সামাজিক অবক্ষয় এবং সরকারী ও প্রশাসনিক ব্যবস্থার অবহেলা ও উদাসীনতার কারনে নার্সদের সমস্যা দিনে দিনে যেমন বৃদ্ধি পাচ্ছে তেমনি তারা বিভিন্নভাবে নির্যাতিত ও আক্রান্ত হচ্ছে, এমনকি জীবন নাশেরও সম্মুখীন হচ্ছে। যেমন কিছুদিন পূর্বে নোয়াখালী সদর হাসপাতালে পেথেডিন ইনজেকশনের জন্য কতিপয় মাস্তান কর্তৃক রাত্রীকালীন কর্তব্যরত সিনিয়র স্টাফ নার্সকে গলা টিপে হত্যার চেষ্টা (ভোরের কাগজ ২১/১১/৯৭ইং)। তথাপি এধরনের আরো নানান প্রতিবন্ধকতার মাঝেও নার্সগণ অন্যান্য পেশাজীবিদের তুলনায় তাদের কর্তব্য দক্ষতার সাথে সম্পাদন করে যাচ্ছেন।

মানুষের মৌলিক চাহিদার অন্যতম হচ্ছে স্বাস্থ্য-সেবা; এ ক্ষেত্রে হাসপাতাল একটি বিশেষ গুরুত্বপূর্ণ প্রতিষ্ঠান। এখানে মানুষ আসে বাঁচার আশায়, সন্তান ভূমিষ্ট হবার সময়, সুস্থ্য হয়ে স্বাভাবিক জীবনে ফিরে যাবার জন্য। সুতরাং এখানে সেবা গ্রহণ করতে আসা জনসাধারনের মাঝে বিভিন্ন ধরনের মানসিক আবেগ ও অনুভূতি কাজ করে।

রোগী হাসপাতালে ভর্তি হয়ে ওয়ার্ডে যে কোন প্রয়োজনের কথা প্রথমেই ব্যক্ত করেন কর্মরত নার্সের নিকট। একজন নার্স সাধ্যমত চেষ্টা করেন নতুন, পুরানো, যে কোন ধরনের জটিল ও সংকটাপন্ন রোগী বা তার আত্মীয় স্বজনকে সাহায্য করতে। আর নার্সদের এই ভূমিকা বিশেষভাবে নির্ভর করে ওয়ার্ডের রোগী ও তাদের আত্মীয়-স্বজনের সংখ্যা, সেবা প্রদানের উপকরণাদি (বিছানা, বালিশ, চাদর, পোশাক, খাবার, ঔষুধ ও অন্যান্য প্রয়োজনীয় যন্ত্রপাতি ও সামগ্রী), সেবা প্রদানকারী নার্সদের সংখ্যা এবং ডাক্তার সহ সাহায্যকারী অন্যান্য কর্মকর্তা ও কর্মচারীদের সংখ্যা, মনোভাব, কর্তব্যবোধ ও দায়িত্ব পালনের ওপর। অথচ হাসপাতালে রোগীর প্রয়োজনের তুলনায় সীমিত জিনিসপত্র ও ঔষুধপত্র সরবরাহ এবং নার্সদের স্বল্পতা, বিদ্যমান সমস্যা ও সংকটের জন্য দায়ী। ফলে উপযুক্ত সেবা না পেয়ে প্রায়শঃই কর্মরত নার্সদের উপর অসন্তোষের প্রকাশ ঘটে।

তদুপরি নার্সদের উদ্যোগী, সক্রিয় ও আন্তরিক ভূমিকায় রোগী ও আত্মীয় স্বজনের কাছে তাদের গ্রহণযোগ্যতা বৃদ্ধি ও হাসপাতালের কর্মকান্ডে তারা কেন্দ্রবিন্দু হিসেবে বিবেচিত হওয়ার আশংকায় ডাক্তারসহ অন্যান্য কর্মকর্তা ও কর্মচারীদের অসহযোগী মনোভাবের প্রেক্ষিতে তাদের ভূমিকা ও কার্যক্রম নার্সদেরকে প্রকৃত সেবা প্রদানে নিরুৎসাহিত করছে। পুরুষ প্রধান আর্থ-সামাজিক ও রাষ্ট্রীয় ব্যবস্থায় সমঅধিকারের ভিত্তিতে মেয়েদের নেতৃত্ব ও কর্তৃত্বকে মেনে নিতে না পারার কারণে এ সমস্যা অব্যাহত থাকছে, বৃদ্ধি পাচ্ছে ও প্রকট হচ্ছে।

এ সমস্যা ও সংকট থেকে উত্তরনের লক্ষ্যে প্রয়োজনীয় পদক্ষেপ গ্রহন করতে হবে। আধুনিক স্বাস্থ্য-সেবা প্রদানের ক্ষেত্রে অগ্রসরমান ও দৃষ্টান্ত স্থাপনকারী উন্নতবিশ্বেও হাসপাতালসহ কমিউনিটিতে প্রাথমিক স্বাস্থ্য-সেবা প্রদানে নার্সরা নেতৃত্বদানকারী ভূমিকা পালন সহ কেন্দ্রবিন্দুতে অবস্থান করছে।

আমাদের দেশের স্বাস্থ্য-সেবা প্রদানের ক্ষেত্রেও নার্সদেরকে ঐরূপ অগ্রগামী ও নেতৃত্বদানকারী ভূমিকায় অধিষ্ঠিত করা সহ ডাক্তার ও অন্যান্য কর্মকর্তা ও কর্মচারীদের বিদ্যমান মনোভাব পরিবর্তন করে সহযোগী মনোভাব নিয়ে এগিয়ে আসা উচিত। এক্ষেত্রে সরকার ও নীতি নির্ধারক মহলের উপলব্ধি ও স্বীকৃতির পাশাপাশি নীতি নির্ধারনী কমিটিতে নার্সদের অংশগ্রহণ নিশ্চিত করতে হবে।

সামাজিক অবক্ষয়ের ফলে একশ্রেণীর পুরুষ কর্মকর্তা-কর্মচারীদের ষড়যন্ত্র-চক্রান্ত ও প্রতিহিংসাপরায়ন পদক্ষেপ প্রশাসনিক ও সরকারীভাবে প্রতিহত করা প্রয়োজন। একই সাথে এ ব্যাপারে নার্সসহ জনগণের ঐক্যবদ্ধ প্রতিরোধ গড়ে তোলা প্রয়োজন।

উপরন্তু নার্সদের জাতীয় পর্যায় থেকে তৃণমূল পর্যন্ত স্বাস্থ্য ব্যবস্থাপনার বিভিন্ন পর্যায়ে - নীতি নির্ধারন, পরিকল্পনা, প্রয়োগ ও মূল্যায়ন - সম্পৃক্তকরন ও প্রতিনিধিত্বের সরকারী স্বীকৃতি ও সুযোগ দিতে হবে।

সর্বোপরি মহিলাদের স্বতন্ত্র পেশা হিসাবে পূর্ণক্ষমতা, কর্তৃত্ব ও দায়িত্ব প্রদানসহ স্বয়ংসম্পূর্ণ একটি নার্সিং ডাইরেক্টরেট জেনারেল পদ সৃষ্টিসহ ইহার পূর্ন কাঠামো প্রবর্তন আবশ্যক যার মাধ্যমে উপরোক্ত সমস্যাবলীর সুষ্ঠ সমাধান সম্ভব।

এতে এই দক্ষ জনগোষ্ঠী নারী হিসাবে নিজেদের অবস্থান ও সমস্যাদির অন্তর্নিহিত কারন চিহ্নিত করে সেগুলো সমাধানের পাশাপাশি পরিবার, সমাজ তথা জাতীয় জীবনে গুরুত্বপূর্ণ অবদান রাখতে পারবে।

(Ira Dibra, National Nurse Consultant, SNESP, analyses critically the present situation of women and nursing in Bangladesh in the context of gender issues. She puts emphasis on the constraints, faced by nurses as being women, related to gender and empowerment which are deeply rooted in health services sector. These prevent nurses from contributing towards health policy, planning, management and evaluation where nurses can show their potentiality. She suggests that by establishing a strong and complete structure and fully functioning separate Nursing Directorate General, with appropriate power, authority, responsibility and accountability, these problems could be handled efficiently.) ❑

Gender Management System in the Health Sector

Rabia Khatun, Lecturer, CoN, Dhaka

The Commonwealth Secretariat in collaboration with the Commonwealth Medical Association organised a follow up workshop in Colombo, Sri Lanka from 24-28 November, 1997. The purpose of the workshop was to develop national action plans for instituting gender management system in the health sector in each participating country. Representatives from Bangladesh, India, Malaysia, Pakistan and Sri Lanka participated in the workshop. Among them Bangladeshis are Joint Secretary (Planning - Family Welfare) Md Mabud, Depury Secretary Safi Ahmed, DNS Minati Sarma, representative from Women's Affairs Dr Gulshan Ara, BMA President Prof. Dr. Rashid-e-Mahbub and the author herself.

The 37 representatives from five SADC countries comprised a multisectroal cross section of senior policy makers and professionals attended the workshop. Each participant took very active role in the workshop. Discussion was very lively.

Gender Management System is an integrated package of principles, procedures, structures and mechanisms which

provides a framework for integrating gender into all government policies, programmes and activities. Although the general principles and polices of gender issues have been incorporated into health sector by the majority of the governments, the remaining challenge is to translate these principles into practical activities. These must be aimed at significantly improving the health status of women and men by recognising their different health perspectives and needs that will comprehensively and equitably address by the health system. This requires institutional infrastructures that support women's participation at all levels of the health system including decision making.

The gender responsive mechanisms must operate at all levels and in all sub-sectors: primary, secondary and tertiary health care, publicly and privately funded provision.

In many countries, initiatives are now under way that address particular issues. At present some countries are trying to introduce reforms of the health sector that are designed to improve the relevance, sustainability, efficiency and cost effectiveness of health systems. This provides an ideal opportunity to ensure that the new frameworks and mechanisms being put in place are fundamentally structured which deal with gender as an explicit and integral component of the health system.

In this regard, Bangladesh is also not at behind. In the Health Sector of Bangladesh many initiatives and attempts have been taken to integrate the gender perspectives in some important areas such as, the functions and status of women as health workers, the reproductive health needs of women etc. Gender in Bangladesh is approximately equal in number. If both gender get equal opportunity in all spheres of their lives, starting from home to national level, they will be able to contribute in the field of education, income generating activities and to all developmental issues equally. In such way rapid economical, social and political growth of a country could be ensured. ❏

নার্সিংয়ে জেন্ডার ব্যবস্থাপনা প্রসঙ্গ
Gender Management Issue in Nursing

ফিরোজা বেগম, শিক্ষিকা, রাজশাহী এন আই

বিজ্ঞানের নতুন নতুন জয়যাত্রা, ক্রমর্বধান প্রযুক্তির উৎকর্ষতা এবং সভ্যতার আলোকে সমগ্র জীবন ও জগত যেখানে উদ্ভাসিত হচ্ছে সেখানে কর্মী ব্যবস্থাপনার পরিধিতেও নতুন নতুন সমস্যা ও সম্ভাবনার দ্বার উন্মোচিত হচ্ছে। যে কোন সংস্থা বা প্রকল্পের পরিপূর্ণ বাস্তবায়নে কর্মী ব্যবস্থাপনায় জেন্ডার ব্যবস্থাপনা প্রসঙ্গ (Gender Management Issue) যে গুরুত্বপূর্ণ ভূমিকা পালন করে তা আজ সমগ্র বিশ্বে স্বীকৃত।

এদেশে বিভিন্ন এন.জি.ও. রা জেন্ডার ব্যবস্থাপনা প্রসঙ্গে বিভিন্ন স্তরের কর্মীদের জেন্ডার ব্যবস্থাপনা প্রশিক্ষণ প্রদানের মাধ্যমে কর্মক্ষেত্রে তাদের সচেতন ও দক্ষ করে তুলছেন এবং বিভিন্ন প্রকল্প বাস্তবায়নে সফলতার ছাপ রাখছেন। বাংলাদেশ সরকারও এ ব্যাপারে সচেতন। যেমন, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ে একটি শাখা আছে জেন্ডার ইস্যু ও নার্সিং নামে।

উল্লেখ্য ১৯৯৩ সালের এপ্রিল মাসে বাংলাদেশ সরকার ও বৃটিশ কাউন্সিল যৌথ উদ্যোগে জেন্ডার ব্যবস্থাপনা প্রশিক্ষণের ব্যবস্থা করা হয়েছিল। সৌভাগ্যক্রমে এদেশের বিভিন্ন সংস্থা থেকে আগত অভিজ্ঞ কর্মজীবি মহিলাদের সঙ্গে আমিও এই প্রশিক্ষণে অংশগ্রহণ করেছিলাম। ঐ প্রশিক্ষণ আমার দীর্ঘ ২২ বছরের দেশে-বিদেশের শিক্ষা ও কর্মজীবনকে নতুন করে ভাবতে এবং দেখতে সাহায্য করেছে। আমার ফেলে আসা জীবনের বিভিন্ন স্তরের অভিজ্ঞতা, নারী পুরুষ সংক্রান্ত হাজার বছরের কুসংস্কার-জড়তা ভেঙ্গে নিজেকে নিজ শক্তিতে শক্তিমান ও বলীয়ান হতে সাহায্য করেছে।

নানারূপ ভুল শিক্ষা ও কুসংস্কার নারী পুরুষ নির্বিশেষে ব্যক্তি, পরিবার, সমাজ জীবন এমনকি কর্মক্ষেত্রেও বিরূপ ও প্রতিকূল প্রভাব বিস্তার করে। কিভাবে এই বিরূপ প্রভাব প্রতিহত করে সুস্থ, সুন্দর, বলিষ্ঠ জীবন ও পরিবেশ সৃষ্টি করা যায় তারই বিভিন্ন দিক নির্দেশনা জেন্ডার ব্যবস্থাপনা প্রশিক্ষণের বিষয়বস্তু। নারী পুরুষের প্রকৃতিগত (Biological & Psychological) ও সামাজিক পার্থক্য (Social Differentiation), ব্যক্তি ও সমাজ জীবনের মৌলিক চাহিদার শ্রেণীবিন্যাস (Hierarchy of needs), SWOT (Strengths, Weaknesses, Opportunities and Threats) বিশ্লেষণের মত আধুনিক বিশ্লেষণধর্মী পদ্ধতিগুলো জেন্ডার কর্তৃক সৃষ্ট সমস্যা সমাধানে ফলপ্রসূ অবদান রাখে।

অধিকাংশ নার্স ও নার্সিং শিক্ষা প্রতিষ্ঠানের কর্ণধার ও শিক্ষিকাবৃন্দ যদিও মহিলা, তবুও কিছু সংখ্যক পুরুষ কর্মচারী দ্বারা পুরো শিক্ষা প্রতিষ্ঠানটি পরোক্ষভাবে নিয়ন্ত্রিত। জেন্ডার কর্তৃক সৃষ্ট সমস্যাগুলো সম্পর্কে নার্স ও নার্স কর্মকর্তাগণ সচেতন না হওয়ায় ও গুরুত্ব না দেওয়ায় এবং প্রয়োজনীয় দক্ষতার অভাবে বেশীরভাগ ক্ষেত্রেই তারা একশ্রেনীর পুরুষ কর্মচারীর হাতের ক্রীড়নকে পরিণত হন। একাডেমিক কর্মকান্ড থেকে শুরু করে অর্থ সংক্রান্ত যাবতীয় ব্যবস্থাপনার সকল স্তরে এদের অনভিপ্রেত ও অশুভ মর্জির ওপর নির্ভর করে চলতে হয় নার্সিং কর্মকর্তাদের। বিশেষকরে পরীক্ষার হলে ছাত্র-ছাত্রীদের ঢালাওভাবে অসদুপায় অবলম্বন করার ব্যাপারে এদের পরোক্ষ ইন্ধন উল্লেখযোগ্য। শিক্ষিকারা বিভিন্ন সময়ে এদের বিভিন্ন কর্মকান্ডের সমালোচনা ও প্রতিবাদ করলেও উর্ধ্বতন মহলের সক্রিয় সহযোগিতার অভাবে সমস্যার সমাধান সম্ভব হয় নাই।

এই অবস্থার পরিবর্তন ও উত্তরণ ঘটাতে গেলে সকল নার্স ও নার্সিং কর্মকর্তাদের প্রত্যেকটি সমস্যা, জেন্ডার কর্তৃক সৃষ্ট সমস্যা ও অবস্থার পুঙ্খানুপুঙ্খ বিশ্লেষণ সম্পর্কে সচেতন হতে হবে এবং ঐক্যবদ্ধ প্রতিরোধ গড়ে তুলতে হবে। সে প্রেক্ষিতে নার্সিং কর্মকর্তাদের কাজের দক্ষতা ও যোগ্যতা বৃদ্ধি সহ দৃঢ়তার সাথে পরিস্থিতির মোকাবিলা করার জন্য কার্যকর পদক্ষেপ গ্রহণ করতে হবে। একই সাথে গৃহীত পদক্ষেপ বাস্তবায়নের নিশ্চয়তা বিধানের লক্ষ্যে উর্ধ্বতন ও সংশ্লিষ্ট কর্তৃপক্ষকে ও সরকারকে ভূমিকা গ্রহণ করতে হবে।

সর্বশেষে উল্লিখিত বিষয়সমূহ বিবেচনায় রেখে নার্সিং শিক্ষা ও সার্ভিসেস শক্তিশালীকরণ প্রকল্পের আওতাধীন সকল প্রশিক্ষণেই কর্মক্ষেত্রে সৃষ্ট জেন্ডার স্পর্শকাতর বিষয় প্রসঙ্গে অবগতি করানো ও তার সমাধানের দিক নির্দেশনা অন্তভূক্ত করা জরুরী প্রয়োজন। আশাকরি এস.এন.ই.এস প্রকল্প কর্তৃপক্ষ এ ব্যাপারে যথোপযুক্ত ব্যবস্থা গ্রহণ করবেন।

(As there is lack of awareness about gender issues among nurses in Bangladesh, Firoza Begum Teacher, Rajshahi NI, proposes that, it would be effective if SNESP includes gender issues and its management into their training courses for Nurses.)❏

C.I.C.I.A.M.S এর ৭ম এশিয় আঞ্চলিক সম্মেলনঃ ব্যাংকক

এগনেস্ হালদার, সদস্য, বাংলাদেশ ক্যাথলিক নার্সেস গীল্ড, ঢাকা।

বাংলাদেশ ক্যাথলিক নার্সেস গীল্ডের সৌজন্যে এবং গীল্ডের জাতীয় আধ্যাত্মিক উপদেষ্টা শ্রদ্ধেয় ফাদার আত্তিলিওর পূর্ণ সহযোগিতায় এই প্রথম আমি বাংলাদেশের বাহিরে আয়োজিত একটি অনুষ্ঠানে অংশগ্রহণের সুযোগ পাই। এই অনুষ্ঠানটি ছিল থাইল্যান্ডের রাজধানী ব্যাংককে অনুষ্ঠিত C.I.C.I.A.M.S এর ৭ম এশিয় আঞ্চলিক সম্মেলন। C.I.C.I.A.M.S - একটি সংগঠনের সংক্ষিপ্ত ফ্রেঞ্চ নাম যার পূর্ণ ইংরেজী নাম হচ্ছে International Catholic Committee of Nurses and Medico-Societal Assistance.

চল্লিশটি দেশের ৩৬০ জন প্রতিনিধি এই সম্মেলনে যোগদান করেন। যশোহর ফাতেমা হাসপাতাল থেকে ৩জন, টাঙ্গাইল থেকে ২জন এবং ঢাকা কলেরা হাসপাতাল থেকে একজন (লেখিকা) সর্বমোট ৬জন নার্স সহ ফাদার আত্তিলিও বাংলাদেশের প্রতিনিধি হিসাবে এই সম্মেলনে অংশগ্রহন করেন।

সম্মেলনের প্রতিপাদ্য বিষয় ছিল **Caring: a path to health and healing.** সম্মেলনে বিভিন্ন দেশের প্রতিনিধিবর্গ যে সমস্ত বিষয়ের ওপর আলোকপাত করেন তা নিম্নরূপ-

- A global Agenda for human caring.
- Caring in nusring practice: what is the essence?
- A healing gift of nursing.
- Pastoral care: Biblical and Pastoral care.
- Therapeutic touch: compassionate caring for healing.
- Ethical dilemmas in caring.
- Human caring in multicultural societies.
- Vision and mission of caring.

উক্ত আলোচনা থেকে আমি নার্সিং পেশার মূল্যবোধ সম্বন্ধে আরো সুনিশ্চিত ও স্বচ্ছ ধারনা লাভ করতে পেরেছি। একজন প্রকৃত নার্সই পারে মুমূর্ষ রোগীকে তার সহানুভূশীল-দরদী সেবাযত্ন পরিচর্যা দিয়ে সারিয়ে তুলতে।

এ প্রেক্ষিতে আমি মনে করি আমাদের দেশের সেবা প্রদানের মান আরো উন্নত করা প্রয়োজন। শুধুমাত্র চার বৎসরের নার্সিং ট্রেনিং নেওয়াই যথেষ্ট নয়। নার্সিং পেশাকে পরিপূর্ণ রূপদান করতে হলে নার্সিং শিক্ষাকে উচ্চতর শিক্ষা হিসাবে পরিগণিত করতে হবে যেখানে Counselling, Interpersonal relationship, Communication skills, Assestiveness বিষয়সমূহ গুরুত্ব সহকারে যুক্ত করতে হবে।

ফাদার আত্তিলিওর অভিমতঃ

সম্মেলন থেকে ফেরার পর ক্যাথলিক নার্সেস গীল্ডের আধ্যাত্মিক উপদেষ্টা ফাদার আত্তিলিওর সঙ্গে এই পত্রিকার সম্পাদকের বিশেষ আলোচনা হয়। আলোচনার ফলশ্রুতিতে তিনি বাংলাদেশী নার্সদের ব্যাপক সমস্যা ও সম্ভাবনা সম্পর্কে নিম্নলিখিত মতামত ব্যক্ত করেন।

Bangladeshi Nurses have lot of potential. They can do a fantastic job but unfortunately the training of nurses are very poor. Once they have finished their training they could not get any chance to get inservice training and education which is essential for the profession where many things change day by day.

Most of the nurses do not have any personal growth as human development which covers the attributes of deep convention, confidence, morale and motivation. There may be many reasons for this. As most of the nurses as being women they are devalued in the society and their work does not get proper recognition as it deserved. Moreover, poor salary structure, low status job, low

social prestige may aggravate the problems which ultimately hinder their personal growth with fullest development as human beings. Unless a vision of life will not be developed, their mental health could not be improved.

Another big problem in that nurses are exposed with a lot of danger and risky environment which nobody bothers and they can be easily blackmailed by doctors, health personnel, patients, relatives and others. These issues need to be recognised and addressed by the government and the policy markers in the planning level.

However, there is an official set up for nurses, but there is no such organisational set up for establishing and burgaining the right of the nurses and nursing profession. Father Attilio suggests that a strong professional organisation could assist to overcome these problems.□

কেমন পোশাক চাই !

বিভিন্ন সময়ে নার্সদের ইউনিফর্ম সম্পর্কিত বিভিন্ন লেখা আমরা পেয়েছি যেখানে লেখকগণ জানিয়েছেন যে, প্রচলিত ইউনিফর্ম সুবিধাজনক ও সময়োপযোগী নয়।

এ সম্পর্কে মত বিনিময়ের লক্ষ্যে বিভিন্ন শ্রেণীর নার্সদের [যেমন সিনিয়র স্টাফ নার্স, নার্সিং সুপারভাইজার, নার্সিং ইন্সট্রাক্টর, জেলা পাবলিক হেল্থ্ নার্স, ডিপুটি নার্সিং সুপারিন্টেন্ডেন্ট, নার্সিং সুপারিন্টেন্ডেন্ট ও প্রিন্সিপাল ও শিক্ষিকা কলেজ অব নার্সিং এবং নার্সিং ইন্সটিটিউট] ইউনিফরম কেমন হওয়া উচিত তার নমুনা নকশা আকারে পাঠানোর জন্য অনুরোধ করা যাচ্ছে। জনমত গড়ে তোলার লক্ষ্যে বাছাইকৃত নকশা ও মননশীল লেখা পরবর্তী সাময়িকীতে প্রকাশ করার উদ্যোগ নেয়া হবে। আশা করা হচ্ছে যে, সেবা পরিদপ্তর ও বাংলাদেশ নার্সিং কাউন্সিল এই গঠনমূলক মত বিনিময়ের মধ্য দিয়ে পোশাক সংক্রান্ত বিষয়ে সময়োপযোগী একটি সিদ্ধান্ত গ্রহণে উপনীত হবেন। ❑

Project Presentation

During the task weeks the participants of the Middle Management Course, held in Chittagong Continuing Education Centre, were divided into several groups and developed projects on selected areas. Among those two projects are selected to present in IPG meeting on 18 December 1997 as these projects have implications on nursing education.

One presentation will be on "a system of block allocation to match students theoretical study and practical experience" by Ms Majeda Akter, Principal (acting), Nursing Institute, Chittagong and Ms Roseliand Biva Baroi, Nursing Superintendent Barishal Medical College Hospital.

Another presentation will be on "clinical assessment for student nurses within the ward environment" by Ms Rubi Datta and Ms Smriti Ghosh, Senior Staff Nurse, Chittagong Medical College Hospital and Mr Haridas Adhikary, Nursing Instructor (acting), Nursing Institute, Barishal.

The purpose of this presentation is to establish a link between the Demonstration Area, the Directorate of Nursing Services and the Bangladesh Nursing Council. It is anticipated that through this attempt necessary attention and suport could be obtained from the concerned authorities to implement these projects. ❑
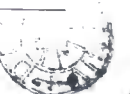
পরীক্ষা কেন্দ্র পরিদর্শন

বাংলাদেশ নার্সিং কাউন্সিল কর্তৃক আয়োজিত চূড়ান্ত পরীক্ষা দেশের বিভিন্ন নার্সিং ইনস্টিটিউটে শুরু হয়েছে। প্রথম দফা শুরু হয় ৩০শে নভেম্বর ১৯৯৭ এ, দ্বিতীয় দফা শুরু হয় ২১শে
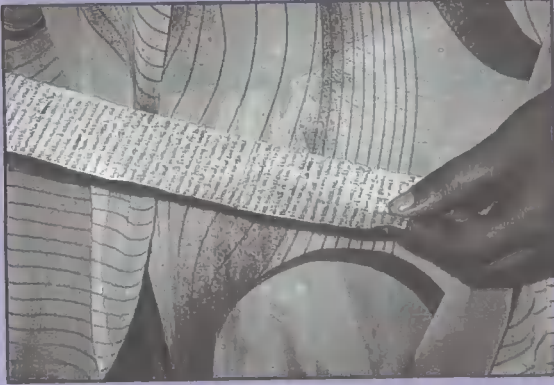
ডিসেম্বর ১৯৯৭ সালে। গত ৩০শে নভেম্বরে ও ২১শে ডিসেম্বরে বাংলাদেশ নার্সিং কাউন্সিলের রেজিস্ট্রার জনাবা জোহরা খাতুন এক সহযোগীসহ দুটি পরীক্ষা কেন্দ্র আকস্মিক পরিদর্শন করে কি পেলেন তা উপরের ছবি দেখে অনুধাবন করুন। ❑

Training on prevention of Substance Abuse

Partcipants (Nursing staff, pharmacists and physicians) and trainers of the first batch of the training programme on **Prevention of Substance Abuse including Alcohol & Tobacco** organized by World Health Organization and Ministry of Health & Family Welfare, held in Central Drug Addiction Treatment Centre, Tejgaon, Dhaka-1208

Welcome Graduates

Congratulation to the returnees ! Recently five nurses have returned to Bangladesh after the successful completion of their studies leading to the award of the Degree of MSc in International Health. They studied in Queen Margaret College, Edinburgh, Scotland, UK.

These nurses are : **Sandhaya Rani Dey,** District Public Health Nurse, Narayanganj, **Rebeka Khanam,** Nursing Instructor, NI, Dhaka. **Marium Banu,** Senior Staff Nurse, IPGM&R, Dhaka, **Md Mofiz Ullah,** Senior Staff Nurse, Thana Health Complex, Tejgaon, Dhaka, **Mst Meftahul Jannat** Senior Staff Nurse, DMCH, Dhaka. ❑

Wishing everyone happy Christmas a productive New Year 1998 and Eid Mubarak.