

Getting health to rural communities in Bangladesh

The Gonoshasthya Kendra project in Bangladesh has made great progress over the past four decades in breaking the cycle of poverty and poor health through its network of affordable rural health-care units.

Nazma Begum has come to Gonoshasthya Kendra in Savar with stomach pains, travelling several miles from Dhamrai with her mother, Kajali Begum. “About four to five years ago we heard from our neighbours [that] this hospital was good and offered medical services at a low price,” says Begum, “so we made a ‘book’ [insurance card]. All our family members are in it and can get medical help through it.”

“It’s very convenient,” adds her mother. “All the tests – X-rays, ultrasonograms, blood tests – are done here and the cost is much less than the private clinics; we always tell people to come here.”

Every day up to 300 patients visit the Gonoshasthya (meaning “health for the people”) Kendra (“centre”) outdoor clinic in Savar, about 25 kilometres north-west of the capital Dhaka in central Bangladesh. While government-run hospitals offer low-cost medical care, they are often inaccessible, crowded, understaffed and lacking medicines. Gonoshasthya Kendra serves about 1.2 million people, more than 60% of them poor or very poor.

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Beauty Rani De

Indeed, for four decades the centre has striven to provide primary health care to help break the cycle of poverty and poor health. Centre founder Dr Zafrullah Chowdhury says health care has to be integrated with other social needs – nutrition, clean water, good sanitation, family planning and even

employment. Under the health insurance scheme to which Begum refers, families pay a premium according to their ability to pay and receive essential health care. The centre takes a holistic approach to health and runs several supporting projects, including a university, medical college, vocational training centre, agricultural cooperatives, printing press, community schools and a generic drug-manufacturing plant.

At the centre’s hospital in Savar, patients are treated by women in blue uniforms and white overalls. Known as paramedics, these women receive six months’ basic training, learning how to take and test blood, take urine and stool samples, insert intravenous lines and perform diagnostics for some diseases. Their key role dates back to the start of the project. At that time, few women worked in hospitals – or anywhere for that matter in Bangladesh – and Chowdhury believed it was important to bring them out of their homes to participate in the development process, especially in health care. Their uniform is a statement in itself, setting them apart from nurses and other female workers in government hospitals who wear saris.

During the war of independence in 1971, Chowdhury, then a young surgeon, and a few colleagues abandoned their studies in London to treat wounded freedom fighters and established the 480-bed Bangladesh Field Hospital near the border with India. With no nurses available, Chowdhury trained young women in the refugee camps to give first aid and assist in operations. “The girls learned very fast in treating the patients, cleaning wounds, giving IV [intravenous] fluids etc.,” he says. After the war, the makeshift hospital became known as Gonoshasthya Kendra and was relocated to Savar. Later, two other hospitals, in Shimulia and Dhaka, and sub-centres in 13 surrounding districts were established. Young women who had completed their secondary school certificate were



Zahedul Khan

Beauty Rani De, head of the paramedic training programme at Gonoshasthya Kendra.

eligible for training as paramedics. Aged 18–30, they would travel to villages by foot or bicycle, educating people about basic health care and the services available at the hospital, sometimes providing basic treatments or vaccinations.

Some elders and other villagers frowned on female paramedics talking about family planning and offering smallpox or tetanus vaccinations but in time the people accepted them. “When we first visited these villages,” recalls Beauty Rani De, who heads the paramedic training programme, “almost everybody we met had scabies and ear infections, but within weeks we were able to cure them through simple herbal treatments and teaching them about basic hygiene.”

Apart from pockets of opposition at some pharmacies and private clinics, the paramedics and sub-centres are generally welcomed by the communities there. “While those who are better off may opt for private clinics or hospitals, poor people usually come to our sub-centres or the hospital in Savar,” says Rani De. “Before, expectant mothers were not allowed to go to the doctors by their in-laws; now the in-laws bring

them to the sub-centres for regular check-ups.” Through its community-based approach, she says the centre has played an important role in making the national family planning, immunization and ORS (oral rehydration salts to treat diarrhoeal diseases) campaigns successful.

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Dr Zafrullah Chowdhury

Chowdhury says the centre involves patients, medical staff and local government officials in its governance. He says the centre has put the concept of community health workers on the global map and proved that primary

health care can be sustainable. The centre’s pioneering work in helping form the national drugs policy in 1982 has helped local companies produce essential drugs at lower prices than the multinationals, and its use of paramedics has empowered many women.

Although Bangladesh is a signatory to the Declaration of Alma-Ata, little has been done to make primary health care a significant part of the national health care policy, says Chowdhury, who blames a lack of political will. “In Bangladesh there are 4000 [government-run] family and health-care centres,” he says, “but they are empty most of the time. The doctors come for three to four hours a day; a health centre should run 24 hours a day.”

While this has been true during previous governments, the present caretaker government, through the health ministry, has initiated steps to revamp the rural health centres so that they run more efficiently and are accessible. It is unclear, however, whether a future elected government will continue this work.

While paramedics are at the heart of the centre’s work, they can refer patients to doctors in Savar when the illness requires specialized care. “Over time the doctors have developed a strong commitment to public health



Zahedul I Khan

Dr Zafrullah Chowdhury, a pioneer of primary health care in Bangladesh.

care activities,” says Health Programme Director Dr Manzur Kader, who has been with the centre since 1991.

Outside the centre, however, some doctors are not as enthusiastic. “Medical education in Bangladesh is not community or public health oriented,” Kader says. “Mostly it is clinically oriented. Students study public health care and public health just to pass the examination, but after passing the MBBS [Bachelor of Medicine and Bachelor of Surgery] course, most doctors become involved in clinical practice or acquire a post-graduate degree.”

Doctors who join government hospitals are sceptical about primary health care, says Kader, regarding it as a thankless task and the responsibility of health workers at government centres. Such opposition is a major obstacle to providing universal health care, particularly to Bangladesh’s rural poor. “Hospital- and clinic-based services are definitely necessary at a certain level,” says Kader, “but there are many health problems that could be solved at people’s doorsteps, which the paramedics can do, so time and resources can be saved.” ■

Aasha Mehreen Amin, *Savar*



Zahedul I Khan

Gonoshasthya Kendra’s City Hospital in Dhaka: an employee working at the reception area where patients register and pay fees.