Country Case Studies of Primary Health Care at Scale and the Way Forward
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Bangladesh’s Health Improvement Strategy as an Example of the Alma-Ata Declaration in Action

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Bangladesh, a densely populated lower-middle-income country of 165 million, with gross domestic product (GDP) per capita of US$1,516.51 as of 2017, has achieved considerable progress in health over the past few decades. There was a twenty-seven-year rise in life expectancy and the total fertility rate fell from more than 7 to 2.1 since Bangladesh’s independence in 1971 (World Bank 2017).

The country has recently been applauded as an “exceptional” health performer and credited for achieving “good health at low cost” (Koehlmoos et al. 2011). Bangladesh, despite its relatively lower health expenditure compared to neighboring countries, has made exceptional progress in reducing both fertility and mortality compared to most other countries in South Asia (Balabanova, Mills, and Conteh 2013; Das and Horton 2013). Bangladesh spends three percent of GDP or US$37 per capita on health per year. In contrast, India, Sri Lanka, and Nepal spend 4.7%, 3.5%, and 5.8% of GDP (as of 2014), respectively (Government of Bangladesh 2018b). Despite its low level of health costs, Bangladesh has attained sustained health gains over the past few decades (table 7.1).

This sustained progress in health can be attributed to several factors inside and outside the health sector. The most important among them is that the country, since its independence, gave primary health care (PHC) the topmost priority in health policy. Soon after the Alma-Ata Declaration in 1978, Bangladesh incorporated the concept of PHC in its policy documents, and since then it has been regarded as one of the key strategies for achieving “Health for All.” With a view to attain this goal, the government has developed a countrywide network of health infrastructure and aimed the policy
Table 7.1. Improvement of health status in Bangladesh (1970s–2015)

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<tr>
<td>Population growth rate (in %)</td>
<td>2.09</td>
<td>2.78</td>
<td>2.47</td>
<td>1.96</td>
<td>1.12</td>
<td>1.05 (2017)</td>
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<td>Infant mortality rate (per 1,000 live births)</td>
<td>148.6</td>
<td>133.6</td>
<td>99.7</td>
<td>64</td>
<td>39.1</td>
<td>28.2 (2016)</td>
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<td>Under-5 mortality rate (per 1,000 live births)</td>
<td>222.7</td>
<td>198.6</td>
<td>143.8</td>
<td>87.4</td>
<td>49.4</td>
<td>34.2 (2016)</td>
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<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>3,000(^1)</td>
<td>1,330(^2)</td>
<td>569</td>
<td>399</td>
<td>194(^3)</td>
<td>176 (2015) (196(^4) (2016))</td>
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<td>Life expectancy at birth (in years)</td>
<td>47.14</td>
<td>53.48</td>
<td>58.40</td>
<td>65.32</td>
<td>70.20</td>
<td>72.49 (2016)</td>
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<td>Total fertility rate (birth per women aged 15–49 years)</td>
<td>6.94</td>
<td>6.36</td>
<td>4.49</td>
<td>3.17</td>
<td>2.33</td>
<td>2.10 (2016)</td>
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<td>Delivery care by trained personnel (in %)</td>
<td>2(^2)</td>
<td>5(^5)</td>
<td>8(^6)</td>
<td>11.6(^7)</td>
<td>27.8(^8)</td>
<td>42.1(^9)</td>
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<td>Percentage of fully immunized children (12–23 months)</td>
<td>2(^2)</td>
<td>75(^5)</td>
<td>66(^6)</td>
<td>60.4(^7)</td>
<td>86.0(^8)</td>
<td>83.8(^9)</td>
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**Source:** Most information is from the World Databank of the World Bank (World Bank 2017), except numbered notes.

1 First Five-Year Plan of Bangladesh (Government of Bangladesh 1973).
2 Second Five-Year Plan of Bangladesh (Government of Bangladesh 1980).
4 Bangladesh Maternal Mortality and Health Care Survey 2016 (NIPORT, icddr,b, and MEASURE Evaluation 2017).
5 Fourth Five-Year Plan of Bangladesh (Government of Bangladesh 1990).
6 Fifth Five-Year Plan of Bangladesh (Government of Bangladesh 1997).
8 Bangladesh Demographic and Health Survey 2011 (NIPORT, Mitra and Associates, and ICF International 2013).
9 Bangladesh Demographic and Health Survey 2014 (NIPORT, Mitra and Associates, and ICF International 2015).

focus on the vulnerable sections of the population living in rural areas: the poor, women, and children. Governments irrespective of political regime have largely demonstrated considerable policy continuity and commitment to improve health conditions through PHC. Yet, amid these positive trends, the health system also has many challenges and shortcomings. The current chapter presents Bangladesh’s experience of improving its health indicators by giving emphasis on PHC as described in the Alma-Ata Declaration. It examines the application of the concept of PHC in Bangladesh across the principles of the declaration. We start this chapter by reviewing the operation of
the entire health system with a special focus on the social and political background of PHC as a series of sectoral reforms and the functional features of the health system of Bangladesh. In the second part, we present empirical data collected from Bangladeshi communities who were asked to share perspectives on comprehensive PHC.

Sociocultural, Political, and Economic Background of Primary Health Care in Bangladesh

Colonial Legacy of the Health System in Bangladesh: What Did the British Put into Place?

The history of therapeutics in the region of present-day Bangladesh dates to when Ayurveda and Unani medicine were in practice throughout the Indian subcontinent. The Western medical system was introduced formally in 1714, with the introduction of Indian medical services by the British colonial government. In 1938, the Indian National Congress formed the National Health Subcommittee under the aegis of the National Planning Committee. This committee, popularly known as the Sokhey Committee, under the chairmanship of Colonel S. Sokhey, emphasized maintenance of the health of the people by the state and integration of preventive and curative health services all over India. Another milestone in the history of health services of India was the publication of the Bhore Committee report in 1946, which recommended radical reform of the entire health system for providing community-oriented care for the entire population. The Bhore Committee extensively studied the population health status and health system of India and recommended an integrated public health service amalgamating both curative and preventive services. To achieve broad community coverage, the committee recommended establishing rural health centers and ensuring equity and community participation. Thus, the concepts of preventive care, community participation, social justice, and equity were discussed in the Indian context well ahead of the Alma-Ata Declaration. However, the Bhore Committee report was not acted on because immediately after its publication, the British rule in the Indian subcontinent was terminated. Thus, the British ultimately left a curative, urban-biased, and elite-controlled health care system in India.

In 1947, with the independence of British India, India and Pakistan were founded, with present-day Bangladesh referred to as East Pakistan. The post-revolutionary Pakistan regime did not take immediate steps to indigenize the health care system, whereas India’s founders made health a priority. Pakistan
in the 1950s gave no consideration to implementing the Bhore Committee report and continued with the curative, urban-biased, elite-dominated health care system until the epidemics of diseases like malaria, small pox, and cholera became a serious concern. In 1961, the Pakistani government attempted to implement the Bhore Committee report and designed a rural health center scheme, which was approved in 1967. The scheme required the establishment of a thirty-one-bed thana health complex (THC) in each rural thana (now upazila, or the subdistrict) to provide primary-level care (both inpatient and outpatient) to the rural population. By 1970, in then East Pakistan, now Bangladesh, 140 THCs were built. These hospitals are the predecessors of present-day upazila health complexes (UpHCs).

Impact of Liberation War on Health System

In 1971, Bangladesh gained independence from Pakistan, and the health system that the country inherited from Pakistan was still largely urban biased and curative despite the pilot introduction of THCs. The health system was extremely limited in terms of health infrastructure, workforce, and public health measures such as sanitation and nutrition (Osman 2004). The inherited health infrastructure of the country, inhabited by nearly seventy million people, included eight medical colleges, one postgraduate medical institute, thirty-seven tuberculosis clinics, 151 rural health centers, and ninety-one maternal and child welfare centers. As a result, in the initial years after independence, the health sector policy focus was on building the required health infrastructure, particularly in rural areas, so that the majority of the population could be served. The first national long-term five-year plan (1973–1978) laid emphasis on building a network of THCs. Accordingly, the THC scheme was approved by the government in 1976.

Alongside this, Chowdhury and colleagues (2013) noted that the liberation war led to the beginning of a social transformation process. This process was characterized by social mobilization, institutional pluralism, and civil dynamism, creating space for multiple stakeholders including government, nongovernmental organizations (NGOs), informal providers, international donors, and commercial enterprises. In health service delivery, all these stakeholders collaborated to pursue a pro-equity strategy, concentrating direct action on high-priority health issues such as family planning, immunization, oral rehydration therapy, tuberculosis, vitamin A supplementation, and others.
Historical Evolution of Primary Health Care in Bangladesh since the 1970s

In 1978, Bangladesh became a signatory to the Alma-Ata Declaration and committed to achieving Health for All by 2000. One year later, Bangladesh started piloting PHC in six upazilas (also known as thana at different times), each inhabited by about 250,000 people. The second national long-term five-year plan (1980–1985), being closely influenced by the Alma-Ata Declaration in 1978 and the local context of increased prevalence of communicable diseases, adopted PHC as a policy strategy to ensure Health for All. Building health infrastructure was the key strategy to achieve this goal, with a key focus on constructing one THC in each thana and one union health and family welfare center (UHFWC) in each union by 1985. Conversely, since independence, international donors had been identifying overpopulation, malnutrition, and a high incidence of communicable diseases as the major problems related to the health status of the population of the country. Accordingly, external funds were devoted to address many of these issues. The country, thus, embraced the selective PHC strategy, with a focus on vertical programs including maternal and child health and family planning services, immunization against major infectious diseases, and prevention and control of endemic diseases. These selective programs produced impressive results in maternal and child health.

The 1970s and 1980s saw a trend of growing private sector and NGO participation in health service provision in response to the growing demand for health services that outpaced government investments in new health care resources. In 1982, the government relaxed restrictions on private laboratories, clinics, and hospitals, spurring even faster growth in private sector health care services (Khan 1996). Since the 1980s, the private sector has flourished, and in recent years the country has been experiencing a proliferation of private sector health services, which include mostly clinical services.

The first evaluation of the national Health for All strategy was conducted in 1986, identifying important bottlenecks in implementing PHC in Bangladesh. According to the report, inadequacy in managerial processes, lack of adequate resources, bias toward curative medicine, and a lack of coordination and community involvement were the hindrances to translating PHC into action. Based on the recommendation of the report, the Government of Bangladesh initiated the Intensified PHC Program in two upazilas in two districts, and this method was gradually extended across the country.

A shift of focus took place in late 1990s, from infrastructure building to governance issues and from a programmatic approach to institutional reform.
designed to ensure efficiency and effectiveness of health services. In 1998, PHC was redefined as the essential service package (ESP) in order to prioritize delivery of cost-effective services to the most vulnerable communities. The ESP is built on the commitment to the PHC approach and includes: reproductive health care, including family planning; child health care; communicable disease control; limited curative care; and behavior change communication. Concomitant attempts were undertaken to establish community clinics (CCs) at the grassroots level to provide ESP services such as a one-stop service center, which would replace the long-practiced domiciliary services that had been customary for the rural people.

But in 2001, the newly elected government, led by the Bangladesh Nationalist Party (BNP), abandoned the idea of having CCs established by the previous government, led by the Awami League (AL), partly due to political differences and partly due to the “not-so-positive” outcome of the new initiative. CCs were actually launched at the tail end of the AL regime in 1998 without having the ground ready for implementation, leading to poor performance in the initial days. A study (Osman 2005) found widespread confusion and misunderstanding among the field-level health workers about their roles at the CCs after transitioning from their traditional roles visiting households. Such confusion along with the resentment of the high officials of the Directorate General of Family Planning (DGFP) against the government’s decision to unify health and family planning operations eventually triggered noncooperation of the family planning workers at the field level. This, in turn, culminated into the withdrawal of domiciliary services by the field workers, soon after the initiation of operations at the CCs. The noncooperation of these field workers seriously affected family planning services and behavior change communication activities. From 1996/97 to 2003, many health indicators (total fertility rate and life expectancy) remained stagnant or unchanged while others did not show any significant improvement (Government of Bangladesh 2003; Streatfield 2003). The third service delivery survey report 2003 also found that utilization of government health services decreased from 13% in 1999 to 10% in 2003 (CIET 2003). The new government, led by the BNP, blamed the slow progress of health indicators on the introduction of CCs and the erosion of long-practiced domiciliary services. All these factors were placed by the BNP government as justifications for leaving the CCs and restoring domiciliary services in 2003. Different studies even demonstrated an improvement of health indicators after the restoration of domiciliary services in later years. Comparison of figures between the Maternal Health Services and Maternal Mortality Survey 2003 (NIPORT et al.
2003) and the Bangladesh Demographic and Health Survey 2007 (NIPORT et al. 2007) reveals that total fertility rate was slightly reduced, from 3.3 in 2003 to 2.7 in 2007, and life expectancy at birth increased from 66.9 years in 2003 to 68.4 in 2006 (World Bank 2017). The infant mortality rate and the maternal mortality ratio also saw a declining trend during that period. However, with the AL back in power in 2009, CCs were reinstated and re-vitalized, and both domiciliary and CC-based static services were allowed to continue operating side by side.

National policies (National Health Policy 2000 and 2011) and programs also upheld the concept of ESP and expressed commitments to PHC by making it one of the key policy strategies for ensuring health care for all. The National Health Policy 2011 also reiterates the commitment toward PHC. One of the specific goals of the policy is “ensuring primary health and emergency care for all.”

From time to time, the government has also undertaken various programs/initiatives that support the principles of PHC. For instance, in 2004, in order to reduce the financial barriers faced by poor women in accessing maternal health care and to increase utilization of maternal health services, government, with support from the World Health Organization (WHO), piloted the Maternal and Child Health Voucher Scheme, a demand-side financing initiative that, in 2007, formally launched and scaled up in a large number of districts. Currently, the program is being implemented in fifty-three upazilas of forty-one districts (Government of Bangladesh 2016). The voucher entitles its holder to specific free-of-charge health services including antenatal and postnatal care, safe delivery, treatment for complications including caesarian section, transportation costs, and laboratory tests (Government of Bangladesh 2013). Additionally, the Directorate General of Health Services (DGHS) has been implementing a community-based skilled birth attendant (CSBA) training program since 2003 in order to address the shortage of skilled manpower human resources in remote areas to provide obstetric care. Under the program, community-based health workers, including family welfare assistants (FWAs), women health assistants, and similar health workers in NGOs and the private sector, are provided with midwifery training. The CSBAs are trained to conduct normal deliveries at home and to identify the complicated cases to be referred to the nearby health facilities where comprehensive emergency obstetric and neonatal care services are available (Government of Bangladesh 2013). The CSBA training program is now organized in 465 upazilas of 64 districts (Government of Bangladesh 2016).
A Pluralistic Approach to Primary Health Care

The health system of Bangladesh includes four major stakeholders: the government health system, private providers, NGO providers, and a donor community (Ahmed et al. 2013). The government sector has a mandate to not only set policies and regulate them but also to provide comprehensive health services. The fast-growing private sector offers profitable high-end services for the rich but also includes a vast informal economy of frontline providers retailing services among the poor. The NGO sector focuses on the health needs of the poor, as part of a broader array of development interventions (World Bank 2005). Finally, the donor community exercises disproportionate weight in determining policy and programmatic priorities while orchestrating technical assistance and directing delivery strategies. Altogether, these stakeholders must work together to deliver PHC, though coordination remains difficult.

Organization of Bangladesh’s Public Sector Services

The country is composed of eight divisions, 64 districts, 490 upazilas, 4,553 unions, and 40,977 wards (figure 7.1) (Government of Bangladesh 2018c). The Ministry of Health and Family Welfare is responsible for delivering PHC services through its two wings—the DGHS and the DGFP (figure 7.1). PHC services of both directorates begin at the ward level,* through a set of community-based health staff, with supervisory staff located at the union level (the lowest administrative unit) and referral primary care facilities located at the union and upazila levels (World Bank 2010).

CCs, located at the ward level, are the lowest level of health facility (Government of Bangladesh 2018c), providing PHC services to rural people. CCs are built on a public-private partnership arrangement where community members donate a piece of land on which the government builds the clinic and then provides logistics, human resources, and medicine to make it functional. As per the government policy, for every six thousand rural residents, there should be one CC located within thirty minutes’ walking distance. As mentioned before, these clinics are one-stop service centers that provide basic primary health and family planning services. The CCs also represent the first contact and entry point to the health referral system. While providing treatment for simple ailments, CCs also identify complicated cases and establish a referral linkage with the higher facilities at the union and upazila levels (i.e., the UHFWCs and

*Constituent unit of a union. A union consists of nine wards.
the UpHCs). One community health care provider provides health care services at the CCs six days a week. One health assistant, appointed by DGHS, and one FWA, appointed by DGFP, provide service at CCs three days a week, alternating while they provide services at the household level on the remaining three days. Community health care providers and health assistants are appointed by the DGHS while FWAs are appointed by the DGFP.

At the union level, DGHS operates 87 UHFWCs, while DGFP runs 3,860 UHFWCs, of which 1,500 have been upgraded and are now allowed to provide primary and outpatient care (World Bank 2010). Not all the UHFWCs have medical doctors. Notwithstanding the provision that there should be a medical doctor in each UHFWC, the facilities typically are manned by paramedics and community-level staff, including one subassistant community medical officer, one family welfare visitor, one family planning inspector, one pharmacist, and one office assistant. Family welfare visitors and family planning inspectors are appointed by the DGFP, while others are appointed by the DGHS.

At the upazila level—the apex of the network of PHC facilities—there are thirty-one-bed and fifty-bed hospitals called UpHCs† that provide both out-

†UpHCs were formerly known as thana health complexes (THCs).
patient and inpatient care to an area with a population of about 250,000. PHC in rural Bangladesh has been organized around UpHCs. UpHCs are run by physicians, nurses, and other support staff, the number of which varies depending on the number of beds. For instance, for thirty-one-bed UpHCs there are nine sanctioned posts for physicians, while for fifty-bed UpHCs there are twenty-one physician posts.

Private Sector Role in Primary Health Care

Currently, the majority of health care in Bangladesh is delivered by the private sector, with a formal sector comprising qualified practitioners serving the affluent and an informal sector serving the poor. Formal private sector providers are typically urban and draw staff from public sector personnel who hold dual jobs, working in both public sector and private sector practices simultaneously (Gruen et al. 2002; Bloom et al. 2011). Informal providers lack formal qualifications and are unregistered.

Publicly staffed services at CCs are physically accessible and located within a few kilometers of most rural villagers, but public health facilities remain mostly underutilized due to the perceived low quality of service (Nornmand et al. 2012). Non-availability of physicians, drugs, and other basic amenities could be cited as the prime reasons for low utilization. The public sector employs about 30.5% of all registered doctors in Bangladesh (Government of Bangladesh 2018c). However, many of these doctors do not go to their job locations. This means that these doctors are available on paper but not in reality in the place of their posting. This phenomenon is described by Chaudhury and Hammer (2003) as “ghost doctors.” As a result of insufficient services at public facilities, there has been increased utilization of private formal and informal sector health facilities. According to Bangladesh Health Watch (2007), the “unqualified practitioners” in the private sector are responsible for providing 60% of treatment services in rural Bangladesh. The standards of their services are not effectively regulated, which puts the quality of service in question.

Informal drug sellers are in practice as the frontline care providers for many, particularly the poor, operating in mostly unregulated ways. Unregulated drug selling and consultation by these untrained informal providers exacerbate the already poor health of this vulnerable population. This situation has resulted in high health care expenditures and catastrophic health outcomes (Democracy Watch 2010). The Government of Bangladesh (2018b) noted that both drug vendors and village doctors (informal providers with-
out medical degrees practicing in a rural setting) stock and retail domestically produced modern drugs, the sales of which account for about 69.3% of out-of-pocket health expenditures.

It is difficult to bring informal drug sellers into an accountability framework, as there is no formal mechanism to track these informal, unregistered providers. Moreover, the regulatory mechanism for the production, marketing, and use of drugs is controlled by the Drugs Act of 1940 (and the rules made under it in 1946) and the Drugs (Control) Ordinance of 1982 (Government of Bangladesh 2018a). Reforming the mechanisms for the marketing of drugs is a formidable challenge, as it may affect the interests of powerful stakeholders. Informal monitoring or consumer awareness could also help reduce the vulnerability of the poor to be victimized by this inappropriate use of drugs. Low literacy and low awareness of risks are barriers to achieving accountability through citizen monitoring of service quality (Wolf et al. 2005).

**Nongovernmental Organizations as a Multisectoral Approach to Primary Health Care**

NGOs began to emerge immediately after liberation to provide relief and rehabilitation to the war-affected population. Gradually, the size and scope of NGOs saw expansion into other areas, spanning from microfinance, education services, social safety-net programs, agricultural extension, environmental protection, water and sanitation provision, disaster management, and legal and human rights education to capacity-building. In addition to service delivery, NGOs have also diversified the commercial sector, launching the operation of commercial banks, telecommunications, and more. Ahmed Mushtaque Raja Chowdhury and colleagues (2013) explain the rationale for this as “partly to lessen dependence on donors during a period of economic downturn and develop an independent source of internally generated revenue” (1736). Due to their multisectoral character, NGOs have been able to provide effective services to address community needs. Various innovative efforts have been undertaken by NGOs, including projects to provide water, sanitation, and housing, and to improve child survival, early childhood development, nutrition, health, and community-building (Afsana and Wahid 2013). However, provision of health services has been the second most common area of service activity after microcredit, with nearly 60% of NGOs providing health care–related services (World Bank 2005).
Cooperation between the Government and NGOs Is Common

In response to the low quality of government services and the high cost involved in formal private sector services, a vibrant and large NGO sector emerged in the 1980s as a growing alternative to provide quality services to the poor and marginalized who are underserved by the public and private sectors. Many NGOs focus on smaller geographical areas to provide mainly preventive care. The larger national NGOs (Bangladesh Rural Advancement Committee [BRAC], Gonoshasthaya Kendra, Grameen Bank) have strong organizational and management capacity to provide both preventive and curative services. These NGOs are well equipped with training and research facilities and information management systems, and are mostly financed by donor agencies. Cooperation between NGOs and the government in service provision is quite common in Bangladesh. Recognizing the effectiveness of NGOs in reaching the community since the 1980s, various government and NGO partnership initiatives for delivering basic PHC services, including immunization, family planning, tuberculosis control, distribution of oral rehy-

Urban Primary Health Care: An Example of GO-NGO Partnership

In the 1990s, in urban areas, government expanded its scope of partnership with nongovernmental organizations (NGOs) through complete outsourcing/contracting out public sector services to NGOs. Under this arrangement, the Ministry of Local Government, Rural Development and Cooperatives manages primary health care (PHC) services in urban areas through contractual partnership among urban local bodies and NGOs with financial support from development partners. Two public-private partnership projects have emerged influential with regard to making contributions to urban PHC in Bangladesh. First, the Urban Primary Health Care Service Delivery Project (the successor of the Urban Primary Health Care Project launched in 1998) aims to provide basic PHC services to the urban poor in big cities in Bangladesh. The project provides health care for the urban poor, offering varied service packages free of cost. The project covers more than ten million urban population in the country (Ahmed et al. 2015). Second, the NGO Health Service Development Program, started in 1997, supports the delivery of essential service packages through a national network of NGOs. These NGOs are operating 330 clinics that serve about twenty-three million people, almost 15% of Bangladesh’s population (USAID 2015). As an outcome of the program, NGO facilities have become the most commonly available health service provider, as 58% of slum and 53% of nonslum communities have an NGO facility within one kilometer (National Institute of Population Research and Training, International Center for Diarrheal Disease Research Bangladesh, and MEASURE Evaluation 2013).
dration solution, and urban PHC programs, have been launched. Such “GO-NGO” partnerships have produced a significant number of success stories in health service delivery.

**Multiple Counterparts (Auxiliary Workers)**

The health system of Bangladesh consists of multiple cadres of health care providers employed by the public, private, and NGO sectors who serve the population. The public sector employs physicians and a large number of auxiliary and mid-level staff that include subassistant community medical officers, sanitary inspectors, health inspectors, midwives/nurses, and health technicians. In addition to these, the government also employs a large pool of field workers—one for every five to six thousand people at the ward or village level. Field workers are the key agents providing PHC services in Bangladesh. There are different categories of field workers at the union, ward, and village levels, all of which are community-based, regular government health workers assigned to deliver domiciliary health and family planning services. NGOs also employ and train a large number of community health workers, but the exact number of this workforce is not available. The government has a positive attitude toward community health workers (CHWs) employed by NGOs. NGOs have even partnered with the government to supply village/ward-level workers to temporarily fill critical job vacancies. For example, Save the Children’s Integrated Safe Motherhood, Newborn Care and Family Planning Project (2009–2013) temporarily filled vacant FWA posts in the area covered by their program.

Along with a large number of physicians, the private sector also employs nurses and technologists, who actually serve the majority of the population of the country. As mentioned before, private sector health services are also delivered by a large number of qualified and unqualified practitioners of traditional medicine (including village doctors and kobiraj—a type of traditional healer—drug sellers, faith healers, etc.) known as alternative private providers. Among others, the informal providers—the “village doctors” and drug vendors, who are often the same people—are the main source of health care available to the poor, especially in rural areas. This group forms the largest group of health care providers in Bangladesh. Bangladesh Health Watch (2007) reported that there were around twelve village doctors and eleven sales people at drug retail outlets providing diagnosis and treatment per ten thousand population. A study by Ahmed and colleagues (2013) noted that more than seventy thousand unregistered drug retailers (and village doctors) are the first contact for most people in rural areas. Despite being the largest
group of providers, the government does not have any clear policy guidance regarding these informal health service providers.

**Bottom-Up, Community-Engaged Planning, Organization, and Control**

Community-engaged planning is a significant health policy focus of the Government of Bangladesh. To facilitate the engagement of community members in local-level health plans, both the government and NGOs have various structures/initiatives. NGOs have made key contributions in identifying unique opportunities for meaningful interfaces between the government and communities, and working to institutionalize those models of engagement at district and national scales (Hunter et al. 2015). In general, NGOs provide support to the government structures for community engagement and also develop and implement their own model for community capacity-building and community-led behavior change communication. Community health programs of BRAC, CARE, Save the Children, and so forth are leading examples. It is worth noting that BRAC community health workers, known as the Shasthya Kormis and Shasthya Shebikas, have made notable contributions to improving health awareness and capacity of the community to address diarrhea and tuberculosis.

Both rural and urban local government institutions have built-in structures for community engagement in health planning at the local level. The lowest tier of rural local government, called the Union Parishad (UP), has thirteen standing committees to deal with local development issues, among which one deals with health and family planning services. Additionally, in urban areas, City Corporation (local government institution in large cities) has a standing committee on health, although municipalities (local government institutions in small towns) do not have any such committees.

Each level of the PHC service network in rural areas—from the CCs to the UpHCs—also has community representative committees to encourage community engagement in decision-making. The CCs at the ward level have two committees to ensure community engagement in health service delivery:

1. A thirteen-to-seventeen-member community group, headed by the member of UP representing the concerned ward, with the UP chair

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[^3]: Union Parishad is a directly elected, local government body at the union level consisting of a chairman and twelve members, among whom nine are male and three must be female. Nine male members must be directly elected by the local people, while the female members are elected in reserved seats and may be directly (by the local people) or indirectly (by the
and the CC staff and members of the community as the members, is responsible for supporting the day-to-day management of the CC, preparing local-level plans, including fund generation, use and maintenance, and monitoring and evaluation of performance of the CCs. This committee is supposed to make the CC staff accountable to the UP.

2. A thirteen-to-seventeen-member community support group (CSG) composed of beneficiaries and other community members, with at least one-third women. In the catchment area of each CC, there will be three CSGs, each comprising thirteen to seventeen members. The CSG is responsible for creating health awareness among the beneficiaries about the services provided by the CC especially. The model for these CSGs was adapted from CARE’s community support system and the Narsingdi Model, the Japanese International Cooperation Agency’s (JICA) successful community mobilization model.

Although UHFWCs do not have their own oversight committees, there are three other community committees at the union and ward levels that have representatives from UPs, along with the staff of UHFWCs, the CCs, and finally the community people as members. There is a seven-to-nine-member family planning committee at the ward level; a five-to-six-member UP standing committee on education, health, and family planning, as mentioned earlier; and a twenty-to-twenty-five-member UP family planning committee. These committees are supposed to meet periodically to review the nature and status of services provided by the facilities concerned.

Similarly, at the UpHC, two such committees exist:

1. A twenty-one-member Upazila Hospital Management Committee headed by the local Member of Parliament and upazila chairman, vice chairman, upazila health and family planning officer, and representatives of the community as members, responsible for monitoring health service conditions at the upazila.

2. A five-member Upazila Health and Family Welfare Committee (one of seventeen upazila committees formerly known as standing committees) headed by the upazila vice chairman, with upazila health and family planning officer as member secretary and the local elites as members, responsible for overseeing health and family planning services at the upazila.

male members) elected. Nine male members represent each of the constituent wards of the parishad (numbering nine), while each female member represents three wards.
Although the committees offer the promise of a wide range of community-engaged, bottom-up planning, in reality, they have been largely nonfunctional in terms of ensuring citizen control over services. Most importantly, the poor, who constitute the majority of the service users, often remain underrepresented in the committees. A study on CSG members found that the committee members were generally drawn from the village elite, with significantly higher levels of both education and income than the majority of the clinic users and frequently with strong connections to local power structures (Mahmud 2004). Besides, as Osman and colleagues (2015) observed, the committees do not meet regularly, the members are often unaware of their responsibilities, and in many cases, they merely exist on paper. More importantly, they do not have any executive power over the services they monitor. Such a combination of factors, including underrepresentation of the service users, lack of executive authority of the committees, and reluctance on the part of the members to make the committees effective, has contributed to limiting their effectiveness in mobilizing collective action.

However, despite the fact that the committees have yet to achieve the expected level of performance in ensuring community engagement, their effectiveness in increasing the level of awareness and demand for services among the community has been evident. An increase in facility-based deliveries, from only 27% in 2010 to 47% (14% public, 29% private) in 2016, as reported by the 2016 Bangladesh Maternal Mortality and Health Care Survey, bears testimony to this (National Institute of Population Research and Training, International Center for Diarrheal Disease Research Bangladesh, and MEASURE Evaluation 2017).

Apart from having the aforementioned committees, having CCs at the ward level is another deliberate attempt by the government to improve community engagement. The fourth sector-wide program (2017–2022) currently being implemented by the Government of Bangladesh has stressed the importance of improving community engagement through the CCs. Furthermore, a recent study reveals that proximity of CCs (1–1.5 km distance) to community members has also made health services easily accessible to rural people, removing the physical barriers to access (Osman and Bennett 2018).

A Community’s Perspective on Bangladesh’s Comprehensive Primary Health Care

To gather community-level perspectives on PHC in Bangladesh, we conducted a mixed-methods study on UpHCs (i.e., the hub of the PHC network in Bang-
Bangladesh’s Health Improvement Strategy

Population-Level Responses
Supply of Safe Water and Basic Sanitation

During in-depth interviews, patients expressed satisfaction with the availability of safe drinking water, sanitary latrines, and the spread of handwashing. They also reported that the Ministry of Health and Family Welfare’s responsibilities focus on providing health education concerning water and sanitation and occasional inspection of sanitary latrines during diarrheal disease outbreaks. The interviews aligned with the organizational structure of government services providing safe water and sanitation. In Bangladesh, the responsibility of providing safe water and basic sanitation falls on the Department of Public Health Engineering of the Ministry of Local Government, Rural Development, and Cooperatives rather than on the Ministry of Health and Family Welfare. Many NGOs are involved in providing safe water and sanitation in association with the government, but there are no clear guidelines for collaboration and coordination, as reported by the key informants and physicians.

Immunization

Our household survey results confirmed that vaccination coverage is succeeding in Bangladesh. In-depth interviews with subassistant community medical
officers, paramedics, and field staff revealed good examples of collaboration among the government, NGOs, and the community. The EPI (Expanded Programme on Immunization) staff, most of which are recruited from the local community, were successfully informing the community where and when vaccination outreach events would take place. Prior to a vaccination event, they would organize courtyard meetings in the community and prepare a list of families who have unvaccinated children. If anyone from the list did not show up in the vaccination program, the EPI staff would go directly to their home and vaccinate the child. They also maintained a register of pregnant women in the community in order to give them tetanus toxoid. As CCs are being introduced, these rural facilities are being used as permanent locations for vaccination. Respondents of qualitative interviews from both the study areas (high performing and low performing) identified immunizations against the major infectious diseases to be the most important component of PHC.

**Promotion of Food Supply and Proper Nutrition**

An important finding was prevalent concern that promotion of food supply and proper nutrition was being neglected in the PHC system. The physician respondents noted that some vertical and temporary nutrition projects had been implemented without any follow-up or scaling-up mechanisms.

**Community-Targeted Responses**

Through qualitative observation, we found that an on-site “health education get-together” (*Shastho Shikkhar Ashor*) on the premises of the high-performing Dhamrai UpHC induced high satisfaction regarding health education there. It had high visibility, and its label itself attracted the attention of patients, creating high attendance at the early morning health education sessions conducted by trained health educators. A twenty-one-inch television was kept there to show documentaries covering various aspects of health and healthy living. Apart from the morning session, which takes place every day between 08:30 and 09:00 a.m., doctors are also instructed to provide relevant health education to patients. Five union subcenters are attached to the Dhamrai UpHC. These subcenters also arrange health education sessions and are instructed to maintain a register book to note the topics of discussion, the number of participants, and the name of the instructor at each session. Reflecting on the usefulness of health education programs, one health assistant (government community health worker) commented: “Previously people did
not even know how to use [a] tooth brush. Now you see how commonly they brush their teeth. If you ask any school kid, he or she knows the proper way of brushing.”

Respondents of the study suggested that information and communication materials can play a pivotal role in informing people of their health entitlements. Currently, these materials concentrate on health practices only. Respondents said that these materials can be developed in such a way that they can impart information regarding health entitlements and the facilities and resources available at nearby health centers. There is already a wide network of government health workers who are primarily responsible for disseminating health information. These workers can play a fundamental role by informing people about available services and the entitlement of the people in addition to their usual health education messages. A more active role of local government was recommended for community empowerment. A local government leader, during an in-depth interview, suggested that the local government authorities can organize regular community meetings where health issues can be discussed. These local government meetings can also pave the way for community members to express their complaints and experiences regarding their encounters with health facilities.

Our discussion on the sociocultural, political, and economic context of PHC in Bangladesh illustrates the importance of a pluralistic health system that included a focus on women’s health, gender equity, and community inclusion. For instance, increased participation of women in economic activities, improved communications, and the government policy of encouraging female education helped improve maternal and child health indicators and increased life expectancy. Community-based approaches, such as the vast network of both government and NGO community health workers contributed to the country’s achievements in the fields of family planning, immunization, oral rehydration, tuberculosis control, childhood nutrition, and so forth, to name a few.

It is well worth highlighting that women-focused health services contributed greatly to Bangladesh’s strategy of improving health outcomes. Women determine many intrahousehold health behaviors regarding food, water, and health care seeking. Women’s social networks spread norms of behavior that contribute to population control, primary health and nutrition, disease control, and so on. Another lesson is that a policy environment fostering collaboration between multiple government sectors and multiple stakeholders inside and outside of government services can achieve more.
Challenges Ahead

Amid the noteworthy PHC achievements in Bangladesh described thus far, there remain significant challenges including: (1) addressing inequity and social determinants of health; (2) curbing high out-of-pocket expenditures; (3) providing better services for noncommunicable diseases (NCDs), elderly, disabled, and psychiatric patients; (4) growing the health workforce; (5) improving quality of care; and (6) addressing environmental health threats from climate change. For all these challenges, the platforms used for comprehensive PHC remain quite powerful.

Failure to Address Social Determinants of Health Resulting in Inequity

Bangladesh’s health progress has yet to be fully inclusive—inequity is still a serious concern. The successive health sector plans of Bangladesh have stated aims to channel resources to vulnerable groups including women, children, and the poor, but in reality public expenditure continues to favor the rich relative to the poor. Health care expenditure of the Ministry of Health and Family Welfare at different levels shows that 27% of the primary-level health care allocation is going to the richest quintile and 21% to the poorest quintile (Huque et al. 2012). Out-of-pocket health expenditure is one of the highest in the world (67%), with private health expenditure being almost exclusively out of pocket (93%) (Joarder et al. 2019).

In rural Bangladesh, PHC services appear to be inequitable across significant measures such as access, treatment, and outcome. Various studies show a large disparity in use of maternal care between the rich and the poor (Chowdhury et al. 2006; Anwar et al. 2008). Particularly, the use of antenatal care, skilled birth attendants, and institutional delivery is substantially low in the three lower socioeconomic quintiles (Collin et al. 2007). Facility-based deliveries also show a disparity between the rich and the poor. Wealthier rural residents tend to use facilities for delivery care more than their poor counterparts, with a ratio of six to one (Kamal et al. 2016). Only 15% of pregnant women from the lowest wealth quintile households delivered their babies in a health facility compared to 70% for the richest quintile (National Institute of Population Research and Training, Mitra and Associates, and ICF International 2015). Additionally, in urban areas, a recently conducted Bangladesh Urban Health Survey (2013) reported an improvement in key health indicators of the slum population over the previously conducted survey in 2006. However, despite the improvement in the health status, a wide disparity in
health of slum and nonslum areas is still evident. For instance, between 2006 and 2013, the percentage of women using medically trained providers for delivery has increased from 18% to 37% for slums and from 56% to 68% for nonslums (National Institute of Population Research and Training, International Center for Diarrheal Disease Research Bangladesh, and MEASURE Evaluation 2013).

Special Care for Elderly, Disabled, and Psychiatric Patients

According to the key informants and the physician respondents of the study just described, there was no special care or facility for the elderly or the disabled, except for informal individual benevolence of the providers. NCDs have only recently attracted attention. The government has begun to offer training for doctors on the care of NCDs. There was no facility in the UpHCs to deal with cardiovascular diseases, cerebrovascular diseases, diabetes mellitus, psychiatric disorders, and several other NCDs, which occupy top positions in terms of the current burden of disease in Bangladesh. Inadequate services for NCDs are still found throughout the country.

Shortage of Human Resources and Compromised Quality of Care

Despite the presence of multiple cadres of auxiliary workers, access to PHC services is hampered by a dire shortage of support staff/auxiliary workforce in the health sector and an inappropriate skills mix. Severe shortages of subassistant community medical officers, nurses, and paramedics—particularly in rural areas—affects accessibility to PHC services. Bangladesh has about eight health workers per ten thousand population (Bangladesh Health Watch 2007), while WHO estimated that countries with fewer than twenty-three physicians, nurses, and midwives per ten thousand population generally fail to achieve adequate coverage rates to attain the health-related Millennium Development Goals (World Health Organization 2006).

The inappropriate ratios of doctors to nurses and doctors to technologists have remained another critical problem inhibiting a smoothly functioning team. Particularly, in the current context of PHC provision through ESPs from one-stop centers, an inappropriate skill mix is a great barrier to effective service delivery. Numbers of nurses, paramedics, pharmacists, and dentists are too low compared to that of doctors, whose work they are meant to complement. Currently, doctors make up 70% of the total registered professional workforce, and the remaining 30% are support staff (Government of
Bangladesh 2013). According to a recent estimate (Ahmed et al. 2011), there were about five physicians and two nurses per ten thousand population, while the ratio of nurses to physicians was 0.4 (i.e., 2.5 times more doctors than nurses).

Conversely, the increase in the number of unqualified allopathic providers during the past decade has been phenomenal compared to the growth of qualified or semiqualified allopathic providers. This proliferation indicates the prevalence of a weak regulatory system. These unqualified providers compromise quality of services (Cockcroft et al. 2007).

Addressing Environmental Health Threats from Climate Change

Bangladesh is one of the most vulnerable countries regarding environmental degradation and climate change. An estimated 70% of the population lives in a flood zone and 26% in a cyclone zone. The high population density of the country (1,265 per square kilometer, according to World Bank, 2017) results in a higher risk of mortality and morbidity. Over the past decades, Bangladesh has earned a reputation for managing to limit the devastation of environmental calamities during and shortly after a natural disaster (Cash et al. 2013). Yet, much needs to be done in terms of health systems resilience and long-term preparedness and disaster response.

Conclusion

Overall, Bangladesh is a role model for good health at a low cost. One of the critical determinants of its sustained success is the importance given by its health policymakers to the principles and practices of PHC from the beginning. Since Bangladesh’s independence in 1971, it embraced some of the guiding principles of PHC, such as preventive care, community participation, social justice, and equity. Prior dissemination of the landmark reports by the Sokhey and Bhore Committees had set the stage. Right after gaining independence, Bangladesh directed its focus toward building health infrastructure in rural areas, where the majority of the population lived. As an avid supporter of the Alma-Ata Declaration and the Health for All movement, Bangladesh intensified its PHC endeavor during the successive decades. However, it did not shy away from some of the selective PHC programs addressing maternal and child health, family planning, immunization, nutrition, and so on.

In the 1990s, policymakers shifted the focus of the health system from a mere expansionary approach to building systematic institutional reforms in
order to improve efficiency and effectiveness of health services. CCs were emphasized as a one-stop health solution for every six thousand rural population. The NGO sector also joined hands with the government to provide mostly preventive services to marginalized populations. Overall, the community focus and community-based approach of service delivery has been one of the most effective strategies for achieving health gains in Bangladesh.

PHC in Bangladesh, provided by the government and NGOs, is traditionally characterized by cooperation (not competition) between these two sectors, including multisectoral engagements, community centeredness, and pluralistic service provision (i.e., involvement of various types of service providers working in different capacities, modalities, and locations). These initiatives have resulted in some appreciable outcomes, especially in supply of safe water and basic sanitation, substantial vaccination coverage, and social and behavior change communication, among others.

However, some challenges remain, both at the policy and implementation levels. For example, in many areas, community-level health committees are nonfunctioning. Intersectoral collaborations often falter due to a lack of clear guidelines. Promotion of food supply and basic nutrition is still done using a vertical approach and is widely neglected. Inequity persists in terms of the economy (poor versus rich), geography (rural versus urban), location (slum versus nonslum). The shortage of human resources for health—including inappropriate skill mix, absolute shortage, insufficient training, and lack of regulation—are perpetuating challenges.

At the same time, the new millennium came with its own challenges. The epidemiological transition caused a shift in the traditional disease pattern and the need for response to the increased prevalence of NCDs and injuries. The country was urbanizing at an unprecedented pace, the private sector flourished within an unregulated health market, and out-of-pocket payments crippled health service seekers. With a legacy of admirable success in tackling the communicable disease problems, the country must make a transition to using its PHC platform to address the current health landscape.

We recommend that the fragmented approaches that remain in some aspects of health services (e.g., promotion of food supply and proper nutrition) should be brought further under a comprehensive PHC framework. More robust guidelines for intersectoral collaboration and community participation (and eventually empowerment) need to be devised at the policy level and implemented rigorously. Regulatory frameworks should be reviewed, updated, and strengthened against rapid and unregulated privatization, and resulting high out-of-pocket health expenditures. Policymakers should consult...
with researchers and experts and support local evidence generation in response to newer health challenges (e.g., NCDs, mental health, urbanization, environmental health) in order to keep pace with the burden of these additional health issues.

REFERENCES (SEE PAGE 341 FOR FULL CITATIONS FOR BOXED TEXT)


