

GONOSHASTHAYA KENDRA (GK)



Study on GK's Comprehensive Primary Health Care
(CPHC) Model: Social Capital, Community Participation, Gender
Empowerment and Health Care Access for the Marginalized

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Acronyms

BBS Bangladesh Bureau of Statistics
BWHC Bangladesh Women Health Coalition
CCDB Christian Community Development in Bangladesh
CPHC Comprehensive Primary Health Care
CWFD Concerned Women for family development
EOC Emergency Obstetric Care
EPI Extended Programme of Immunization
ESP Essential Services Package
FPAB Family Planning Association of Bangladesh
FPI Family Planning Inspector
FWA Family Welfare Assistant
GHRI Global Health Research Initiative
GK *Gonoshasthaya Kendra*
GUP *Ganounnayan Prochesta* (Peoples' Development Initiative)
HA Health Assistant
HFA Health for All
HI Health Inspector
HNPSP Health, Nutrition and Population Sector Pogramme
HPSP Health and Population Sector Programme
HRD Human Resource Development
IMR Infant Mortality Rate
LE Life expectancy
MA Medical Assistant
MBBS Bachelor of Medicine and Bachelor of Surgery
MCH Maternal and Child Health
MDG Millennium development Goal
MMR Maternal Mortality Rate
NCD Non-communicable Diseases
NGO Non-government Organization
NHP National Health Policy
PHC Primary Health Care
RMED Research, Monitoring and Evaluation Division
UP Union Parishad (Union Council)
UHC Upazilla Health Complex
UHFWC Union Health and Family Welfare Centre
USAID United States Agency for International Development
WHO World Health Organization

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Abstract

This present study makes an independent evaluation of the CPHC programme of GK (People's Health Center) a pioneering non-governmental organization (NGO) providing primary health care (PHC) services in various locations in rural Bangladesh. The study is based mostly on qualitative data collected from two intervention villages, from other sources like senior managers, paramedics, government/NGO officials, local representatives, etc. Analysis of data indicates that GK primary healthcare interventions successfully contributed to increased health services for the rural poor. GK's strength lies in combining several features like establishing small hospitals/health centres in remote villages, developing a cadre of female community health workers, and providing door-to-door service, mobilizing community, and raising awareness through them, and working together with government through establishing linkage/network. However GK needs to develop its programme further in various lines in order to increase access of poor community members to health services. Weakness still lies in mobilizing local resources and ensuring fuller participation of rural poor in programme designing, implementing and monitoring. Local public health sector services are often unfriendly towards the poor. GK could play an important role in mobilizing local poor to utilize social capital to increase their access to public health services.

Chapter 1 Introduction and Background

1.1 Introduction

This report presents the findings of an independent investigation into the CPHC Programme of *Ganoshasthaya Kendra* (or GK as it is more popularly known), a leading and pioneering NGO providing health services particularly to the poor, destitute and marginalized population groups in Bangladesh. *Ganoshasthaya Kendra* (GK) was established about 40 years ago, in 1971, the year the country had been fighting for its liberation from the neo-colonial rule imposed by Pakistan (known as West Pakistan at that time). GK started operating as a tiny make shift war field hospital but after the liberation war was over in December 1971, it gradually transformed itself into a development organization to join the greater march for reconstruction of the country. Since then PHC and women's empowerment have been two major areas where *Ganoshasthaya Kendra* has made exemplary contributions, both independently and in collaboration with GO and other NGOs, in practice and at the national policy level.

1.2 Study objectives

The objectives of the present study were:

1. To document the contribution of GK to CPHC.
2. To establish a sustainable CPHC in local communities through efforts to strengthen social capital among them, that is, to:
 - Increase the sense of health ownership among poor people.
 - Increase access to CPHC for the poor.
 - Increase community understanding of the importance of PHC and community-level determinants of health.

The present report aimed at addressing the following research questions:

1. What are the GK's strengths and weaknesses in building CPHC in its health projects?
2. What contribution has GK made, in terms of reaching the poor, to CPHC

The Participatory Action Research (PAR) component of the study, which took place in two villages, was also aimed at the following:

1. To increase the involvement of local people in CPHC planning.
2. To determine the best way of providing CPHC services to the vulnerable, destitute and poor people in these villages.
3. To study the effectiveness of community organizing and PAR activities in improving the social capital among local people.
4. To increase the awareness among poor people of health rights and community-level determinants of health.
5. To develop new community actions to support health rights and reduce community-level inequities in the determinants of health, in ways that create greater village unity and avoidance of group conflict.

1.3 Study Background: The Country and Policy Context

Bangladesh, a tiny deltaic land situated in the northeastern portion of the Indian subcontinent, bordered on the west, north, and east by India, on the southeast by Myanmar, and on the south by the Bay of Bengal. It is a country with one of the highest population densities in the world with current estimated population of about 150 million⁴, implying that on an average 1000 people live in every square kilometre in a small territory which is only about 0.15 million square kilometres in size. The population density would be many times greater if we account for the forests, river bodies, arable land and inhabitable terrains (e.g. hilly districts). If the current growth rate persists, (1.8 million per annum), it is estimated that the population will reach 172 million by 2020⁵.

A huge population cramped in a very small piece of land obviously has its own health implications e.g. on the incidence of communicable disease, degradation of environment, water and sanitation. Economic poverty makes the situation even worse - more than 50 percent of the population of the country living below the poverty line⁶, the majority of them in rural areas (77% of all live in rural areas). Many of the health needs of the poor remain unmet due to lack of affordability. On the supply side, like many other developing countries, whatever health services are available for the population in Bangladesh remain dominated by the public sector. The private health sector, although emerging and growing fast particularly over the last 20-25 years, remains less accessible to the vast majority of the poor population. Quasi-scientific malpractices, miracle and faith healing (like *jhar fuk*, *pani para*, etc.), as practiced by *Kabiraz*, *Fakir*, *Peer* and others, particularly in rural areas, also occupy a significant place in health service utilization by the poor, as such practices are often affordable and accessible. Their influence, however, is now on the wane due to increased health awareness and the spread of scientific medicine practice.

The public health sector has an elaborate scheme of infrastructural facilities and functionaries spread over various administrative units in the country. The major hospitals and care centres are located at Divisional and district headquarters (the country has 6 administrative Divisions and 64 districts). There are 80 district level hospitals, 25 specialized hospitals, and 6 post-graduate hospitals. In addition, the 13 public medical colleges have teaching hospitals attached to them. Beyond the district and divisional cities, the major health care providing centres are known as “Upazila Health Complex” (Sub-district Health Complex) which is basically a 30 -50 bed hospital, with outdoor facilities⁷ and many other programmes aimed at serving the health needs of the respective upazila population (like FW-Maternal and Child Health (MCH) services, Immunization programme etc.). The number of such complexes in the country, known as Upazilla Health Complex (UHC) in short, is 397 (according to the webpage of the Ministry of Health and Family Welfare). Every UHC is supposed to be the hub for organizing PHC in the respective sub-district. It has both in- and out-patient services

⁴ Bangladesh Bureau of Statistics (BBS) (Population Clock of Bangladesh, as on 10 May, 2011) <http://www.bbs.gov.bd/Home.aspx>

⁵ According to Bangladesh Population Policy country’s population has been growing on an average by 1.8 million per annum and total population would reach 172 million in 2020 (Bangladesh Population Policy, Ministry of Health and Family Welfare, GoB October 2004). According to other sources (e.g. Index Mundi http://www.indexmundi.com/bangladesh/population_growth_rate.html), population growth rate prevailing in 2011 is 1.566% which yields a slightly higher annual average growth and estimates a total population of 172.5 million in 2020.

⁶ According to UNICEF, in Bangladesh : “...50 per cent of the population continues to live below the poverty line, on less than \$1.25 a day. 84 per cent of people survive on less than \$2 a day. As food prices rise around the globe, the same income buys less and less each week.” (http://www.unicef.org/bangladesh/overview_4840.htm)

⁷ Outpatient services in Bangladesh are known as outdoor facilities or services.

and care facilities. The UHC is staffed by ten qualified allopathic practitioners and supporting staff. Many UHC Units have a package service called ‘comprehensive emergency obstetric care services’ (EOC). An expert gynaecologist, an anaesthetist and skilled support nurses are supposed to be on duty round-the-clock. There are facilities for running a basic laboratory as well.

Additionally, to reach community with essential services, the government has established 3,375 Health and Family Welfare Centres at union levels (union is the lowest tier of local government in the country). Each such centre, known as Union Health and Family Welfare Centre (UHFWC), has an infrastructure, and is staffed by professionals such as a Medical Assistant (MA/SACMO) and a mid-wife (Family Welfare Visitor), both trained in formal institutions. UHFWCs provide out-patient care only but maintain a network of field-based functionaries to provide home based services. The field-level personnel are known as Health Assistants (HAs) who supposedly make home visits every two months for preventive care services. The other set of field based personnel are Family Welfare Assistants (FWAs) who supply condoms and contraceptive pills. The HAs and FWAs are supervised by a Health Inspector (HI) and a Family Planning Inspector (FPI) respectively.

The public sector contributes more than 71 percent of all hospital beds in the country. For a 10,000 of population, on an average, 2.18 and 1.22 numbers of qualified physicians Bachelor of Medicine and Bachelor of Surgery (MBBS) and nurses are available respectively.⁸. Bangladesh has only around 200 trained stand-alone midwives and 30,000 nurses, who have also one year training on midwifery, against a net demand for 65,000 midwives⁹. While there are no gold standards for assessing the sufficiency of the health workforce, World Health Organization (WHO) estimates that countries with fewer than a total of 23 physicians, nurses and midwives per 10,000 population are unlikely to achieve adequate coverage rates for the key primary health-care interventions prioritized by the Millennium Development Goals (MDGs)¹⁰.

Although we do not have available data on trained health workers at community level, it is reported that the provision of healthcare suffered from shortages of such workers. Rural areas have suffered most, with the majority of those living in rural areas being served by unqualified healthcare providers. Standard training programmes for other healthcare professionals, other than doctors and nurses, have been largely absent. It is reported that public sector healthcare workers were in short supply due to a lack of recruitment and training by the government for more than a decade. NGOs have been attempting to fill some of this gap by developing short-term training courses¹¹.

⁸ For most of the statistics related to the health sector in Bangladesh as described in this section directly derived from or calculated based on data available from the website of the Ministry of Health and Family Welfare (http://nasmis.dghs.gov.bd/mohfw/index.php?option=com_content&task=view&id=388&Itemid=483)

⁹ Bangladesh Info news on Government Plans to develop Trained Midwives, 8 May, 2011, (http://www.bangladeshinfo.com/news/news_head.php?tab=news_head_2&id=1&cat=p).

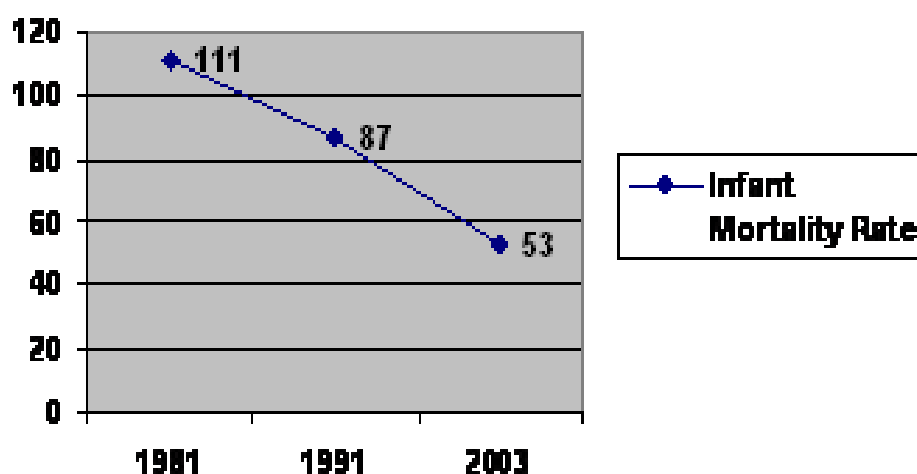
¹⁰ Health workforce, infrastructure, essential medicines, WHO (http://www.who.int/whosis/whostat/EN_WHS09_Table6.pdf).

¹¹ Coherent training for community health workers and paramedics in rural Bangladesh, Global Health Workforce Alliance available at following website: (<http://www.who.int/workforcealliance/forum/2011/hrhawardscs1/en/index.html>)

1.3.1 Health Status of the Population

Bangladesh has made significant progress in population health during the last 20-25 years. All the health indicators show sustainable gains and the overall health status of the population has improved. Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), and Under5 MR have decreased while LE at birth has increased. The country has achieved a credible record of sustainable 90 per cent plus vaccine coverage in Extended Programme of Immunization (EPI)¹². Bangladesh has also made important gains in providing PHC since the Alma Ata Declaration in 1978. Prevalence of low birth weight (weight less than 2,500 grams) has decreased from about 50 percent in 1993-95 to 40 percent in 2005. The percentage of underweight (weight-for-age) children below 5 years was: severe - 12.8 percent, moderate - 47.5 percent; and height-for-age was: severe - 16.9 percent, moderate - 43.0 percent according to the Bangladesh Demographic and Health Survey 2004¹³.

Figure-1: Decline in IMR 1981 - 2003



Source: BBS (cited by WHO)

But the progress and achievements are not even, and there exists inequalities between different groups and geographical regions. Access to, utilization by and benefits generated out of the existing health care system for the poor, marginalized and vulnerable population still remains a major concern for both the programme implementers and the policy makers. In general, although according to the World Bank (2006) the life expectancy (LE) at birth has reached 63.5 years, about 65 (according to BBS 53) infants out of 1000 die and for every 1000 children under 5 years, 88 die. Most of these children are from households living in rural areas and from poor, ultra poor, marginalized and vulnerable population groups. About 51 per cent of the pregnant mothers receive no neo-natal care from a trained provider, again most of them living in rural areas and from poor population groups. Reliable estimates indicate that for every 100,000 live births about 320 women die due to pregnancy related complications (United States Agency for International Development (USAID)). Pregnancy ranks as 6th among the top ten reasons for mortality in Bangladesh, while anaemia continues to be the second in rank among the top ten reasons for morbidity. It is needless to mention that those from destitute, ultra poor and poor households are most affected.

¹² Health System in Bangladesh, WHO Bangladesh webpage, (http://www.whoban.org/health_system_bangladesh.html)

¹³ Cited in WHO Bangladesh webpage (*ibid*)

According to Mannan (quoted in F. Karim et al, 2005) 84 per cent of the rural landless women do not eat any special food during their last pregnancy or whilst breastfeeding. A wide gap exists across the poor, medium and rich households in terms of usage of different health services (BBS and Rahman as quoted in *ibid*). Analysing by wealth quintile, Gwatkin et al. found that uptake of childhood immunization was lower among the poorest people in Bangladesh. According to Sen and Begum (2005), disparity also exists within the poverty groups (as they are divided into moderate and extreme poor). The MDGs emphasize the need to reduce health inequalities between different social groups, but it is argued that unless the special needs of the extreme poor and moderate poor are effectively addressed, the achievement would be at stake (F. Karim et al 2005). According to Hamid (Hamid et al 2010), the unfriendly and unapproachable behaviour of health care providers¹⁴ remain as one of the major reasons behind low levels of utilization of UHCs at rural areas and a majority of patients seek care from private providers. It is understandable therefore that the poor (and more the extreme poor) can barely afford qualified private services (many of them thus resort to less costly ineffective traditional care).

Lower utilization and access for the poor in public health sector

The government staffs working at various rural health outlets are accountable not to the community or local government. Providing service, let alone quality service, or their overall performance has little direct relationship with their salary, promotion, job security etc. In general government staffs consider their jobs as highly secured. It is also noted that MBBS doctors, when posted to a rural upazilla, shows great reluctance to stay there. Doctors are often criticized for neglecting their duties through absenteeism and private practice during office hours. Such practice generally starts from the moment of posting of a doctor to a rural UHC or Union Health Centre. They are either unwilling to join, or they make delay within the loopholes of the system. Neglect of duties of the paramedics and domiciliary staff has also been affecting the policy implementation process (Osman 2004 quoted in Ara 2008). They are often found absent, and not working fulltime. Absenteeism reflects reduced output, and underperformance. It poses a chronic, but often unmeasured, problem in publicly financed health care, and can severely limit patient access to services and suggests corruption (DiTella and Savedoff, 2001 quoted in Ara 2008). A study conducted by UNICEF (1992) showed that our doctors spend 54 seconds per patients at thana (upazilla) hospitals and rural dispensaries; they take 37 seconds per patients to dispense medicine. Qualified doctors frequently moonlight in private clinics compromising their obligations as government employed doctors (Sobhan et al 1998 quoted in Ara 2008). According to Islam and Ullah (2009),

¹⁴ Although the Hamid et al article doesn't provide any details regarding (nature and causalities of) such behaviour this is something which is accepted as a known fact in rural Bangladesh: the poor and socially disadvantaged people are often subject to discrimination which adds to their exclusion at public service delivery points. NGOs have been working to increase their access there. Theoretically it is possible to argue that lack of accountability, lack of local participation and governance in upazilla administration encourages service deliverers to discriminate those otherwise having no political or social influence. Stake on limited resources available are determined based on power relationship and inefficiency and corruption in public service delivery becomes evident. This has led to an emphasis on the need to establish accountability and transparency through good governance in health sector (http://www.unnayan.org/reports/Report_BPC_08.pdf)

“... the Government was not able to provide health services even at the basic level. Various factors are responsible for that. Continuous political intervention in health programs and implementation process and a lack of continuity appear as major impediments. The present study shows that the existing government infrastructure is not used properly due to the irresponsible mentality of the government staff, lack of accountability, mismanagement, and malpractice of doctors and the lack of coordination of the health service providers.”

Media news published regarding situation in public hospitals in Bangladesh

News 1

Syedpur hospital, a 100 bed public hospital for providing referral health services to seven hundred thousand people living in Syedpur and three other adjacent sub-districts, remains deficient of trained physicians/specialists in the areas like Gynecology, Surgery, Anesthesia, Medicine, and ENT. The post of medical officer also remains vacant for many days. In absence of gynecologists people from the poor, destitute population group have been suffering most. Those who can afford are taking services at private clinics but the poor patients have been taking services from nurses instead of trained doctors. Despite being aware of risk of such services (provided by nurses instead of Gynecologists) the patients from poor households are coming to this hospital as they do not have any other alternative.

Translated in brief from the Daily Ittefaq, 12 June, 2011

News 2

The EOC unit in Gaforgaon sub-district UHC. Everyone would think the pregnant mothers and newborns would get all type of necessary health services here. But the reality is completely different. Day after day the operation theatre of this unit remains closed. Valuable equipments remain unpacked. And many of them are now getting out of order as they remain unused. The anesthetist and the gynecologist of this health complex live 40 kilometers away and for this reason maternal and IMR have been increasing.

Translated part of the news published in Daily Ittefaq, 13 June, 2011

Given this situation it is understandable that only those who are socially, politically or otherwise influential in rural areas are somewhat able to secure a better service at public health service centres. As Rahman (Rahman 2006) states:

“It is revealed from Bangladesh political scenario that moneyed men are in centre of politics and they influence in decision-making process. Thus it indicates that political and economic powers are concentrated on a few people...to ensure their part in gaining resources and accessing various public sector facilities”.

According to Ferdous Ara (Ara 2008) Bangladesh inherits a health care service structure that was predominantly elite-biased, urban-focused and curative-care-oriented. Rahman (Rahman 2006) further adds that the bias remains as a reality even

“...though policies stress to the poor....Though the prime concern of the government commitment and desire is for better provision of health service for the masses, the practical scenario is not good enough. It is disheartening and gloomy. The present health system has not succeeded to materialize and to realize the vision enunciated in government plans, policies and programmes. It is only able to provide basic services for about forty per cent of the population [37,51], which indicates that the rest are unable to access the health system, and this may be regarded as a violation of human rights.” (Rahman 2006)

Unfortunately it is the poor who are more prone to illness and diseases than the non-poor. While the poorest households are likely to use health care services, they are less willing (and unable as well) to pay for improved services compared to other socio-economic groups (Jahan and Salehin, 2006 quoted in Ara 2008). Consequently the government health centres remain underutilized, and are perceived as a place in which the poor lack confidence. According to Ahmad (Ahmad 2000 quoted in Ara 2008) this (low confidence and low utilization) results from weak administration and poor accountability. Failure to enforce a system of accountability in the health system is weakening governance. Centralization of authority at the Ministry acts as a major barrier to ensure accountability in administration and to formulate a local health authority with adequate community involvement. The public health sector also lacks a robust regulatory framework for monitoring health services delivery.

1.3.2 National Health Policy (NHP)

Bangladesh is a signatory in various international declarations like Alma Ata 1978, The World Summit for Children 1990, International Conference on Population and Development 1994, and the Beijing Women’s Conference 1995. At a programme level however the Intensification of PHC only started in 1988. Later in 1998 the government formulated Health Sector Reform and a programme approach was taken instead of a project approach. An essential health service package was formulated called Essential Services Package (ESP) that included RH (Reproductive Health), Child Health (CH), Limited Curative Care, Communicable Disease Control, Behaviour Change Communication etc. The ESP components reflect an overwhelming emphasis on PHC. During 1998 -2003 the country’s overall health sector programme was designed in a complimentary way with its population sector programme and called ‘Health and Population Sector Programme’ (HPSP). After modifications and adjustments, and putting emphasis on nutrition it has been reformulated as Health, Nutrition, and Population Sector Programme (HNPSPP) since 2003.

The Ministry of Health and Family Welfare constituted a Committee for preparation of a full-fledged NHP in 1996 with members drawn from various sections of the relevant stakeholders like technocrats, bureaucrats, representatives of civil society and professional bodies. Five sub-committees were formed to study and recommend on:

1. The existing health services and to determine goals
2. Policies to ensure Essential Services
3. Policies to ensure Hospital-based Services
4. Strategies for Human Resource Development (HRD)

5. How to integrate NGOs and the private sector in planning for resources and utilization of funds

The recommendations from various sub-committees were integrated and taken to a cross-section of the society for feedback. A report on the health policy was formulated on the basis of consensus. The Cabinet approved the policy in August 2000. This was the first ever NHP formulated through a formal process.

This NHP 2000 had 15 goals and objectives, 10 policy principles, and 32 strategies. Among the 15 goals most important and pertinent to the present discussion are as follows:

1. To make necessary basic medical utilities reach people of all strata
2. To develop a system to ensure easy and sustained availability of health services for the people
3. To ensure optimum quality, acceptance and availability of PHC, and governmental medical services at the Upazila and Union levels.
4. To reduce the intensity of malnutrition among people, especially children and mothers; and implement effective and integrated programmes for improving nutrition status of all segments of the population.
5. To undertake programmes for reducing the rates of child and maternal mortality within the next 5 years and reduce these rates to be acceptable level;
6. To adopt satisfactory measures for ensuring improved MCH at the union level and install facilities for safe and clean child delivery in each village
7. To improve overall reproductive health resources and services;

The remaining eight goals include objectives like ensuring quality of service, family planning (with an objective of attaining replacement level fertility), geriatric care, medical education etc. It is noteworthy that among the 15 goals, special emphasis is laid on nutrition, RH, child health, and family planning at Upazila and union levels. Thus the NHP 2000 reaffirmed the PHC approach as a strategy to achieve the goal of HFA. It envisaged the delivery of PHC services through a four tier system, namely; a) at the community level - through community health workers, b) at the ward level - through satellite clinics/health posts, c) at the union level -through UHFWC and d) at the Upazila level - through the Upazila Health Complex (UHC).

The HNPS 2003-2010

As with the 1998-2003 HPSP, the 2003-2010 HNPS's goal is to increase availability and utilization of user-centred, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Service Package along with other selected services. According to the HMPSP, within the overall development policy framework of the Government of Bangladesh, the goal of the health, nutrition and population (HNP) sector is to achieve sustainable improvement in health, nutrition and reproductive health status, including family planning, of the people, particularly of vulnerable groups. Such groups include women, children, the elderly and the poor, with the ultimate aim being their economic emancipation and physical, social, mental and spiritual wellbeing. Thus the HNPS focuses on the principles of PHC. Indeed, irrespective of political affiliations, all governments from 1987 onwards have put increasing emphasis on the principles of PHC. This does not mean, however, that they were equally successful in translating this emphasis into practical actions. The present government, after coming to power in December 2008, took initiatives to formulate a new Draft NHP. As a result of this initiative the Draft NHP

2010 was circulated for feedback from various sections of the society but the process of finalization is yet to be completed. This new draft draws more on the HNP 2000, which was drafted and finalized by the same political government that was in power at that time i.e. during 1996-2001. The Draft NHP 2010 indicates a revitalization of PHC.

1.3.3 PHC in Bangladesh: Achievements and Failures

As a signatory to the historic Alma Ata declaration Bangladesh endorsed and accepted the concept of PHC as the strategy for achieving the goal of health for all (HFA). The country started with a pilot project in 6 thanas (sub-districts) in the following year in 1979 that eventually turned into a PHC Program in following years. In accordance with the basic principles of PHC, the government policy for its programme was to reach the un-served and underserved population, in their local communities and at an affordable cost. In order to make programme implementation practicable the government resorted to three important strategies: training staff on the elements and principles of PHC, providing basic essential equipments, and ensuring uninterrupted supply of basic PHC to facilitate effective preventive, curative, and rehabilitative services to the vulnerable, the disadvantaged and the poor. The administrative units at operational level of the programme were Upazilas (sub-districts), Unions, and Wards. The managerial and technical support was provided from district, divisional and national levels.

An evaluation of the national HFA strategy was made in 1986. Results of this study indicated that various constraints such as lack of adequate resources, bias towards curative care, inadequacy in the managerial process, and lack of coordination and community involvement were some of the major challenges in implementing PHC. This led to the initiation of the program known as “Intensified PHC Program” in 1988. It started in two upazilas in two districts and gradually extended to approximately half of all upazilas in the country. It is alleged that the Intensified PHC programme demonstrated some success in developing useful working mechanism at upazila level and beyond.

About ten years later in 1998 the ESP was introduced under the HPSP that included most of the elements of the PHC. The services under ESP were modelled with prioritization given to PHC activities. Later in 2003 the 2003-2010 Health, Nutrition and Population Sector Programme (HNPSPP) was formulated where ESP was remodelled further to include nutrition as one of its core component and named as essential service delivery (ESD) programme. In addition to eight essential elements¹⁵, PHC activities in Bangladesh also cover other elements like prevention and management of non-communicable diseases (NCDs), interventions relating to arsenicosis, environmental and occupational health, geriatric care, adolescents and young health, injury prevention and management and violence against women. Along with the government non-profit organizations have been making substantial contribution to increase peoples’ access, particularly that of poor and marginalized people, to PHC. Prominent among them, are Brac, Ganoshasthaya Kendra, CARITAS, Christian Community Development in Bangladesh (CCDB), RDRS, *Ganounnayan Prochesta* (People’s Development Initiative) (GUP), Dhaka Ahsania Mission and many other national, regional and local NGOs. These NGOs are involved in a wide range of activities related to health education, awareness, training, water and sanitation, advocacy and lobbying for people’s

¹⁵ Eight essential ELEMENTS based on the Alma Ata on PHC are: 1. Health Education, 2. Treatment of Locally Endemic Diseases, 3. Expanded Program on Immunization, 4. MCH, 5. Provision of Essential Drugs, 6. Nutrition, 7. Treatment of communicable and NCD, 8. Safe water and good waste disposal (<http://nurseslabs.com/others/primary-health-care/>)

health etc. Some NGOs like Marie Stopes, Bangladesh Women Health Coalition (BWHC), Family Planning Association of Bangladesh (FPAB), Concerned Women for Family Development (CWFD) are also engaged as direct service providers. *Grameen Bank*, the pioneering microcredit organization, has a sister organisation known as *Grameen Kalyan* that offers health care to its members and to other villagers. Although one cannot generalize, there is criticism that the number and scale of these NGOs deteriorate the PHC system at some points. Many NGOs characterize themselves as working for the poorest of the poor. However, despite having good intentions, they sometimes fail to do so. According to Zaidi et al. the largest NGOs in Bangladesh are reaching less than 20% of landless households and fail to address the actual needs of the people¹⁶. NGOs are blamed for carrying out projects the way their donors require, instead of using the ideas and knowledge of the local people to fulfil their needs. The main reason for the malfunctioning of NGOs includes their donor dependency, leading to short-term specific goals imposed by donors instead of meeting the needs of the people.

The failures of PHC in promoting access for poor, ultrapoor, and destitute

Despite policy level support and commitment by the governments to achieve 'HFA' and implementation of PHC, a significant part of the rural population – the ultra poor, the marginalized, and vulnerable population groups, are far from enjoying benefits of PHC¹⁷. Their access to and utilization of health services are less equitable and the achievements the country made in the health sector do not typically represent their condition. The number of those without land is increasing, and there exists massive illiteracy. The poor - more specifically the ultra poor, the marginalized, the vulnerable and women- have little voice in decision-making. It is unrealistic therefore to think that PHC has a chance to make any significant change in their health status within the conventional government/NGO intervention framework, where participation and voice of poor remain neglected. Although the government and some NGOs have been providing PHC in rural areas, the resources spent often do not reach them fully because of the nature of rural power structures.

Ensuring that PHC (which include not only health care, but also community participation, gender empowerment and other programme activities) extends to all of the poor requires government-NGO partnership and, more importantly, partnership with community leaders and members through processes of building social capital. To ensure effective delivery of CPHC to the destitute, vulnerable and poor people, their participation in PHC planning and implementation needs to be improved. It is also important that appropriate tools are developed to monitor programme impacts, particularly to measure the level of poor people's access to essential PHC services. To achieve greater access for and also utilisation by them, it

¹⁶ Zaidi et al cited in Jessica Maltha, *NGOs in Primary Health Care: A Benefit or A Threat?* Global Medicine, Official IFMSA-NL magazine on global health (<http://www.globalmedicine.nl/index.php/gm7-july-2009/106-ngos-in-primary-health-care-a-benefit-or-a-threat>)

¹⁷ It is reported that since the 1990s the country has made good progress towards reducing poverty, achieving a 1% drop in the proportion of people living below the poverty line every year. About 49 per cent of rural population however still lies below the poverty line. In general the depth and severity of poverty has been reduced more successfully in rural zones than in urban areas. However 20 per cent of rural households live in extreme poverty. They chronically suffer from food insecurity, own no cultivable land/assets, often lack education, and may also suffer serious illnesses or disabilities. The people who are often termed as hardcore ultrapoor, and/or destitute are included in this extreme/hardcore low 20 percent of poor households. The rest 29 per cent (of 49 per cent rural poor) are considered rather moderately poor. They may own a small plot of land and some livestock, but while they generally have enough to eat, their diets lack protein and other nutritional elements (adopted from: Rural poverty in Bangladesh, Rural Poverty Portal, <http://www.ruralpovertyportal.org/web/guest/country/home/tags/bangladesh>)

is necessary to develop greater social capital (networks, support and inclusiveness) amongst local community members to avoid the ‘cliques’ that presently impede access by many of the poorest population in remote villages. It is anticipated that the process of developing greater social capital includes raising poor peoples’ awareness regarding their health rights and entitlements, developing a common understanding and new knowledge of health and its community-level determinants, a new community-based association which would work together to ensure that peoples’ health rights are honoured, and actions on community-level determinants.

Given the above contextualization, the present study will provide a brief review of GK’s contribution, strengths and limitations in building CPHC in Bangladesh, looking especially at how well the organisation has been able to ensure community participation, create greater access for the ultrapoor and the destitute, and effectively monitor the programme. The study also attempts to shed some light on potentials of social capital to ensure CPHC services for the poor.

Chapter 2 Study Methods

2.1 Study objectives

The broader objective of the present study is to make a retrospective assessment of Ganoshasthaya Kendra's (GK) contribution, strengths and limitations in building CPHC in Bangladesh. The study also reviews various methods (tools and means) that GK has developed over the years to measure community participation, health care access, health care impacts and other associated process and outcome measures of CPHC programme. The intent of the study are (i) a better understanding of the means for strengthening CPHC in Bangladesh and (ii) a rigorous review of existing (and development of new) tools that will better inform GK, other NGO's and government-provided PHC services of the extent and effectiveness of their programme.

2.2 Study Methods

The study was based on analysis of both primary and secondary data. However most of the data collected for analysis were qualitative in nature. The historical review of GK's PHC programme involved an analysis of key GK documents and reports pertaining to these projects. It was also supplemented by information collected from elder GK staffs working at various tiers of the organization from the very beginning of its journey.

The study employed a participatory action research technique and collected information through courtyard meetings, focus group discussions (FGD), and participatory rural workshop to collect beneficiary level information. Two villages, namely *Hatiagla* and *Kazirchar* under Sherpur Sadar sub-district, Sherpur district, were randomly selected from among the GK's working areas for data collection purpose. The villages are under the coverage of a GK health centre that has a doctor who provides health services two days a week; three junior paramedics who provide 24 hour health service coverage and one senior paramedic who supervise them. The GK centre has both in-patient (limited) and outpatient facilities along with regular programmes of outreach activities.

Key informant interviews were conducted with GK staffs at various levels that included senior GK health planners, managers, supervisors, and field level workers/implementers, government/NGO health officials at upazilla (sub-district) and union levels, community leaders/union council representatives, etc. A total of 4 (four) group discussions (FGDs) were held in study villages, 2 (two) in each. Every group discussion was participated by 9 -13 individuals. A rural workshop was held in participation of about 25 beneficiaries drawn from poor and ultrapoor households of both the study villages. In addition to FGD and the rural workshop, a few courtyard meetings were held which were more informal and less structured in form. The rural workshop, FGD and yard meetings assessed perceptions of disease burdens and their causes in the villages. The field research process also tried to sensitize communities around issues of access to PHC by the most marginalized in the community; as well as increase their participation in PHC (planning and programmes), identify social determinants of health in their villages, and plan new actions to address these determinants. The research also tried to identify local activists committed to the ideals of CPHC and the intent of improving access to PHC services by the poor.

Table-2.1 Data Collected from Various Sources during Field Survey

SI . #	Source	Method	Numbers implemented in-				Dhaka (Savar/ Shimulia)	Total
			Village		Union	Upazilla (Sub-district)		
			Hatiagla	Kajirchar	Losmonpu	Sherpur Sadar		
1	Beneficiary	FGD	2	2	-	-	-	4
2	Union Council member (UP member)	KII	-	-	1	-	-	1
3	Union HA	KII	-	-	1	-	-	1
4	NGO (VOSD) official	KII	-	-	-	1	-	1
5	Project Manager	KII	-	-	1	-	-	1
6	Project in charge	KII	-	-	1	-	-	1
7	Health workers/paramedics and other field implementers	FGD	-	-	1	-	-	1
8	Family Welfare Officer	KII	-	-	-	1	-	1
9	UHC In-charge	KII	-	-	-	1	-	1
10	Courtyard meeting	Group discussion	2	1	1	-	1	5
11	Beneficiary	Participatory Rural Workshop	-	-	1	-	-	1
12	Programme Director	KII	-	-	-	-	1	1
13	Research In-charge	KII	-	-	-	-	1	1
14	Senior Paramedic (working since 70s)	KII	-	-	-	-	2	2
15	Center In-charge	KII	-	-	-	-	1	1
Grand Total								23

Generating first hand impression, Pre-testing of instrument, and data collection at Dhaka

To make data collection instruments more precise and focused, and also to get a first hand impression / knowledge of ongoing GK health programmes and facilitate the designing of actual data collection at two villages in Sherpur district, the author visited and collected some initial data at a rural location (Shimulia health sub-center, Savar, Dhaka). Some of the GK senior programme staffs were also interviewed at Dhaka, at Savar GK headquarters and at Dhanmondi (GK *Nagar* i.e. City Hospital).

Pre-testing of the draft instruments was done in Sherpur villages before finalizing them.

Consent and level of confidentiality

The data collection was based on full consent of the source individuals. As information revealed did not include anything offensive or risk, the source individuals did not raise any concern about confidentiality of their name and address.

Validation

Data were also collected through individual interview at field level. Various relevant stakeholders like the government, NGO, and GK implementing officials and grassroots workers were interviewed (a complete list of persons interviewed /consulted, both at national level and at field level are given in the annex). The data collected from various sources (beneficiary¹⁸ vs. grassroots implementers, GK vs. government providers) helped the process of validation when compared and contrasted against each other. The final findings were also presented and validated formally before the rural audience.

Ethical issue

GK has an Ethical Review committee. The final proposal of the present research was specified with the requirements for clearance from this committee. The data collection process was based on informed consent of the beneficiary and other sources of data. The action research was also carefully undertaken so as not to instigate any artificial expectation among rural poor.

Support for the present study

The present study work was carried out with support from the Global Health Research Initiative (GHRI), a collaborative research funding partnership of the Canadian Institutes of Health Research, the Canadian International Development Agency, Health Canada, the International Development Research Centre, and the Public Health Agency of Canada. Funding for implementing the study was provided by the Teasdale-Corti Global Health Research partnership program and the International Development Research Centre. GK contributed human resources and logistic support, as and where necessary to implements the study.

¹⁸ The term beneficiary implies GK programme beneficiaries at rural location of survey. In a broader sense, all members of the surrounding rural community of a GK health center/sub-center are benefited from its intervention. But the targeted beneficiaries include community members particularly from the poor, ultra-poor and disadvantaged population groups.

Chapter 3 Brief Review GK Initiatives in CPHC¹⁹

3.1 From Warfield to March for Peoples' Health

Ganoshasthaya Kendra was born during the war of independence in 1971. A young surgeon, Dr. Zafrullah Chowdhury, and a few of his colleagues abandoned their higher studies in London to treat wounded freedom fighters and established a 480-bed Bangladesh Field Hospital in the Tripura state of India. The Bangladesh Field Hospital was a volunteer service. It began with five doctors and a few medical students. With no nurses available, they trained young women in the refugee camps to give first aid and assist in operations. They found the girls very receptive to the training, aptly performing duties like cleaning wounds, giving IV (intravenous) fluids and injections. This experience was encouraging particularly in the context of shortage of skilled and trained doctors. After the war, the makeshift hospital was relocated to Nayarhat, Savar – a rural location about 30 kilometres away from the heart of Dhaka city and was renamed as *Ganoshasthaya Kendra* (People's Health Centre). During later years, two other hospitals, one in Shimulia, Savar and another in Dhaka, and 13 other sub-centres in various surrounding districts were established.

GK has had a substantial growth in terms of its scale of operation and programme diversification since 1972. From 50,000 people in 50 villages in 1972 it now covers over one million population as direct and indirect beneficiary in 592 villages of the country. It is now one of the largest service providers in the health sector outside of the Government of Bangladesh. GK focuses on principles of PHC like community participation, and ensuring affordable and accessible health care to the poor, ultrapoor and marginalized population. It also opened a new approach for providing reproductive health care to the rural women through trained paramedics to substitute for trained physicians. These paramedics, usually recruited from local level and trained in GK's own institute have been working as dedicated cadres to provide services both from rural health centres established by GK in remote villages and through repeated home visits at community level. GK also trained traditional birth attendants to ensure safe delivery at home.

Two major difficulties faced by GK in its early years of inception were: 1) the dominating social norm, particularly in rural areas, that woman should not consult or even come out before a male doctor, and 2) number of trained female MBBS doctors, willing to serve in remote rural areas, which was remarkably low. To accommodate such a reality, and in light of its successful experience at the war hospital, GK trained female paramedics who are able to fulfil the health care needs particularly providing reproductive care for poor rural women. These trained paramedics also perform surgical procedures, when needed, which were previously performed only by skilled doctors. It is noteworthy, as GK research claims, that their performance and infection control exceeds that of trained doctors²⁰. Through years of efforts, particularly based on its dedicated cadre of paramedics and health workers trained and motivated to work with a zeal of dedication for the poor, GK programme areas have now attained significant changes in reducing MMR and IMR. The MDG goals in these areas have been attained (Chaudhury and Chowdhury 2007).

¹⁹ This chapter is based both on grey (printed literature) as well as information obtained from some key, pioneering GK implementers.

²⁰ Susane Chowdhury and Zafarullah Chowdhury, *Tubectomy by Paraprofessional Surgeons in Rural Bangladesh*, *The Lancet*, Saturday 27 September 1975

Ganoshasthaya Kendra (GK) now claims to have built a successful model of providing CPHC to rural population in Bangladesh, particularly for those from poor and marginalized section of population in the country, while playing a significant role in empowering rural woman in its programme locations²¹.

3.2 Getting health to rural communities: the Village Health Program

The beginning of *Ganoshasthaya Kendra* saw a set of impediments including active antagonism by local elites²². The people were either indifferent or reacted in an unfriendly way. Their behaviour were often prejudiced and governed by beliefs and superstitions. There were other impediments as well which not social or cultural but similarly difficult to overcome. For example communication to hospital at Savar was a difficult one. To reach there, one coming from surrounding areas had to cross several rivers and rivulets, and from Dhaka one had to take two ferries. GK workers however were determined to overcome such difficulties.

Young women from the communities were trained as paramedics. During initial years, it was difficult to find young girls from the community with an adequate level of education like S.S.C.²³ or tenth grade completers. Most girls had not even completed five years of formal education. Aged 18–30 and once trained, they would visit door to door, educating people about basic health care, providing basic treatments or vaccinations. It was a difficult task to bring these girls out from homes and make them join a profession that would require travelling to remote villages, organizing courtyard meetings, and facing other challenges and difficulties associated with rural villages. The situation in the early 70s when GK started its programme was that women were discouraged to come out of the home, travel, and consult a male physician even if she needed health care desperately (still even in 2011 this situation persists in some parts of the country e.g. rural areas of Chittagong Division where the traditions of *Purdah* keep women isolated inside their house). In such a socio-religious context, a young girl travelling in remote villages to provide health services was quite challenging. But GK took the challenge and made it possible. As Beauty Rani – one of the eldest field health workers of GK recalled:

”It was Zafar bhai (brother zafar i.e. Dr. Zafarullah Chowdhury the founder of GK) who inspired us to take the challenge for the sake of suffering poor women. We also had zeal of social work in our heart. We were young, devoted and were courageous to take the risk. The challenge was really a big one. But we overcome it gradually. At the beginning none in the village usually welcomed us or even disliked. But gradually things started to change when people found that we are helpful at the time of their crises. The members and chairmen (of local union council) or the aged community leaders did not like us. But through our selfless service we won their heart. Now they started to call us or visit our centres eagerly and their role changed into that of a patron”.

²¹ From *Battlefront to Community: Story of Gonoshasthaya Kendra* published by Ganoproskashoni, Mirzanagar, Savar, Dhaka-1344, undated.

²² According to *Ganoshasthaya Kendra* sources, a local coordinator named Nizam at a rural health center was killed at Simulia when it started health center there (back in 1975). GK recognizes Nizam as a martyr who sacrificed his life for the sake of organizing and taking a stand in favor of poor section of the people. In many other places properties of GK centers were stolen, activists were threatened, and rumors were devised that, in the name of providing health services, GK came to their village to grab their land and property.

²³ Secondary School Certificate

The male paramedics had a more difficult time doing their job. Given the context where women were discouraged to visit a doctor and even not allowed to see a male doctor, it is understandable the male paramedics found it more difficult to provide reproductive health services. People would not let them in to their houses, and they would stand outside and shout out medical and health advices and treatments. Gradually they, too, gained people's trust. In order to ensure better reproductive health services, particularly for the poor and the vulnerable women, GK also sought the help of Traditional Birth Attendants (TBAs), who were trusted within the community. It trained them in improved childbirth and family planning practices; in exchange they offered better access to the community.

Today, up to 300 patients visit the GK outdoor clinic everyday at Savar, about 30 kilometres North-West of Dhaka. In all its programme locations together, GK now serves about 1.2 million people. An overwhelming majority of them are from poor or very poor households. GK has also taken more rigorous and quality training arrangements for its health workers. Now the paramedics of GK must have 10 years of formal education, sit for an admission test and undergo a rigorous training if passed²⁴. GK considers that to become a successful agent for promoting health particularly for the poor and marginalized a community health worker must be skilled to perform following:

- To understand social classes in the community and factors linked with politics and governance especially at local level.
- To communicate with the families effectively
- To make full examination of the person, measurement of temperature, pulse, blood pressure, heart sounds, respiration rate, MUAC (Mid Upper Arm Circumference) and urine examination for sugar using Benedict's solution
- Identification of malnutrition and assessment of pitting oedema
- Full antenatal and postnatal care of pregnant women
 - identification of pre-eclampsia and eclampsia.
 - normal delivery and recording of Apgar²⁵ score.
 - assists TBA if necessary: To work happily with Traditional Birth attendant (TBA).
 - preparation of oral rehydration therapy.
- Immunization and full family planning services.
- To provide physiotherapy and Ayurvedic massages to stroke patients and elderly villagers.
- Diagnosis and treatment of diarrhoea, diabetes, hypertension, bronchitis, pneumonia, asthma, viral fever, malaria, dengue, typhoid fever, night blindness, jaundice, anaemia, eye, ear and skin infection, vitamin deficiencies, tuberculosis, worms (helminthiasis), peptic ulcer.

GK paramedics are trained and motivated to fulfil the PHC needs of rural poor. These health workers also play a key role in involving the community, disseminating health

²⁴ Initially the paramedics receive a 6 months foundation training in basic anatomy, physiology, and other components of primary health care. On successful completion they receive a 12 month practical field training that includes delivery of health service at village level under close supervision of a qualified, senior paramedic. (Chaudhury and Chowdhury 2007).

²⁵ Devised by, and later named after Dr. Virginia Apgar, this score based on certain observations and scaling against those observations and measures help quickly determining the condition of a newborn baby (for details please visit website of CHILDBIRTH.ORG url: <http://www.childbirth.org/articles/apgar.html>)

messages/information and bringing in behavioural changes through sensitization and awareness raising while organizing courtyard meetings²⁶, making door-to-door home visits and contacting poor rural women on one-on-one basis.

3.3 Involving Community for health

During its initial years of programme inception GK followed a systematic way of involving community, particularly the poor and marginalized, into local health initiatives. Through publicly announced meetings GK organised village surveys to assess health needs of different social classes. These surveys were helpful in confidence building and let the poor speak out and identify their own problems. Through such community mobilizations GK developed an integrated health plan for village sanitation and safe water supply; a training program for young village women to become paramedics providing basic curative, preventive, and family planning services; and a training program for existing traditional birth attendants. GK also tried to involve patients, medical staff and local government officials in its governance. It successfully put the concept of community health workers on the global map and proved that PHC can be sustainable. It may be interesting to note that the work of GK in Bangladesh was presented as one of the case studies for discussion at the International Conference on PHC held in Alma Ata in September 1978²⁷.

3.4 Making health more affordable for the poor

GK's health services are differentiated for different economic groups in the rural community. Its experience in dealing with rural communities has led it to classify income groups by the following categories: 1) Destitute (Au), 2) Ultrapoor (Ah), 3) Poor (Ka), 4) Mid income group (Kha), and 5) Rich (Ga)²⁸. According to the principle of primary healthcare GK has

²⁶ *Utthan* or courtyard plays a special role in socio-cultural life of rural Bangladesh. Usually several houses are built around a common courtyard. The courtyard works as a rendezvous or common place for the family members, usually related in blood connection to each other, of these houses. They come out and interact with each other at various levels and in various ways in this meeting place on different occasions. For children, particularly the girls and minors who do not go to the out fields, it provides a place for playing traditional games which are actually designed to be played on such grounds (like *kanamachhi*, *kut kut*, *danguli* etc). For adults it is a place for more serious occasions like *Shalish* (rural social arbitration), for discussing any matter of common interest. For marriage ceremonies, the courtyard becomes a place of festivity.

After mid day when men usually remain out of home and housewives have completed their daily chores, they get together in courtyard and indulge in *adda* or gossip and other activities (e.g. one combing other's hair, young girls learning cottage arts from elders etc). The NGO workers, particularly those with women as beneficiary, found it opportune to make gathering at courtyard at these hours. In the absence of men women had a free environment to discuss reproductive health issues which they shy away from before men. Courtyard meetings thus became a major instrument of disseminating information, raising knowledge and level of awareness of rural women, holding motivational campaigns and meeting any other purposes relevant to programme implementation. Such meetings also provided a good opportunity to gather information from women for various purposes like resource mapping, needs assessment, situation analysis, and programme evaluation. Over the years courtyard meetings have become an indispensable part of NGO activities in rural areas. If one is present to observe such a meeting in today's rural Bangladesh she would certainly find the participating women accustomed with such meeting and participating freely.

²⁷ http://www.novartisfoundation.org/platform/content/element/210/Speech_Chowdhury_%28en%29.pdf

²⁸ The categorization of rural population into five socio-economic groups (Au, Ah, Ka, Kha, Ga) is based on various characteristics that include occupation, income, education, homestead land, house-type, cultivable land, some indicators of standard of living etc. For example, households from Au group do not have any homestead land and agricultural land. Group Ah may have homestead land but own agricultural land only up to 50 decimals, whereas group Ka has homestead land and more than 50 decimals of agricultural land (up to 5 *bigha* or 165 decimals).

If we compare with national poverty classification we may conclude that Au, Ah and Ka groups can be identified as rural poor – from among them Au and Ah are extreme poor and Ka as moderately poor (see footnote 17 above). GK also calls group Au as destitute - 96% of these households are headed by

always emphasized creating greater access for the first three groups. A card system was introduced and each family/household was identified according to its socio-economic category. The households from Au through Ka groups were provided health services free and/or at highly subsidized rate while those from Ka (rich) did not get any subsidy, and those from Mid income groups (Kha) were nominally subsidized.

Table-3.1 Differential Charges for Various Socio-economic Groups
*Consultation fee & Medicine Cost Charged at the GK
 Health Centres and Community Level*

Social class	Percentage of all households	USD for service provided at		If referred to specialist		Medicine cost	
		Centres	Villages	1 st visit	Subsequent visit	Centres	Villages
Ultrapoor	1.43%	0.05	Free	Free	Free	50%	50%
Destitute	0.19%	0.03	0.03	Free	Free	Free	Free
Poor	63.98 %	0.08	Free	0.31	0.23	75%	75%
Middleclass	29.58 %	0.12	0.08	1.15	0.77	100%	100%
Rich	4.82 %	0.18	0.12	1.54	1.15	100%	100%

Source: Dr. Zafrullah Chowdhury (2005)

3.5 The Results Attained

During last 38 years GK has established health centres around Bangladesh in many places. Important among them are Bhatsala, Sreepur, Saturia, Shibjong, Sirajgong, Sonagazi, Parbatipur, Kashinathpur, Coxs Bazar and Charfashion. For establishing health centres and initiating CPHC programme GK selected remote villages where very limited health services were previously available. Through its various programmes GK helped to create access for health care for poor, ultrapoor and destitute populations. The specific areas for which changes are more significant include reproductive health, child health, family planning, water and sanitation, health education and awareness. GK's contribution is indicated by achievements in some of the public health indicators in its programme locations, including near attainment of some of the MDG goals like MMR. It is reported that in 1993-97 GK programme villages had an MMR of about 300 per 100,000 live births. This rate fell to 186 in 2002-2005 which falls short only by 25% of the MDG target of 143 per 100,000 live births by 2015. GK villages are expected to achieve this target much earlier than 2015, if the rate of reduction so far recorded continues (Chawdhury and Chowdhury 2007).

It is difficult however to separate GK's contribution from that of other contributory factors in bringing in these positive changes, particularly the health status of the poor, ultrapoor and marginalized population group. This needs a methodological exercise different from the present one (e.g. multiple regression analysis based on quantitative time series data and/or case-control study taking samples from non-GK locations). However, the qualitative information collected during the present study strongly indicate that GK's contribution in improving the health status of the poor and marginalized population, and empowering

females/widows, they prepare meals once a day, accept alms, and their occupation is either working as household aid or begging. Group Ah is called ultrapoor because of having less than 50 decimals of agricultural land and work, in addition to occupations as destitute, in day labour. Group Ka is called poor and has more than one source of income.

women, was significant. The unique feature of GK is that it took health services for the poor to their doorsteps through developing competent health workers from within the community, at the same time establishing infrastructure for delivery of services in remote villages.

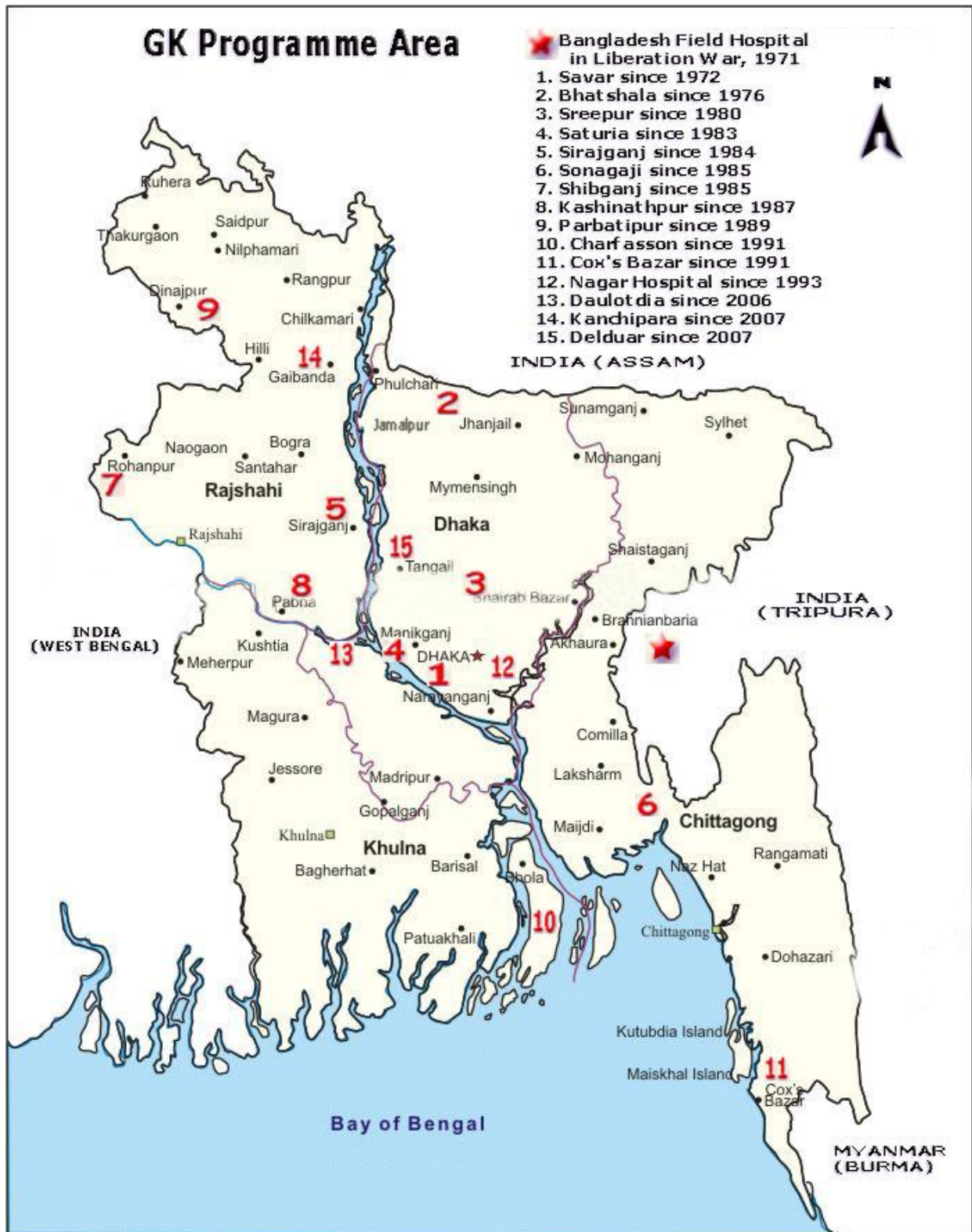
The GK programme has gone through change and adaptations during the years since its inception. According to its implanters it has always been an evolving entity, continuously learning from and adopting to its circumstances with the aim of achieving its goal of HFA. For example, in the early years GK found it more effective to implement and continue its operations independently. Later it developed effective linkage and coordination with government with respect to programmes like EPI, and in implementing community clinics. This was because both the presence and volume of operation by government was insignificant in remote rural villages where GK operates. With an increase of government presence in these rural areas, GK found it more productive to develop linkages/networks with government. It also appears that the emphasis on home visits is not as intensive now as it was 30 -35 years ago. This is because the rural population has gone through many changes over this period. Women are gradually coming out of their old practices and seeking reproductive health services that are no longer considered as shameful as in the 1970s when GK. In general, awareness about health seeking behaviour has increased and women, accompanied by men, now frequently, or not, visit GK health centres. The poverty situation has improved, reducing the need for the quantum of full free services provided by GK.

With the passage of time GK also developed more formal training provisions for developing human resource in health like establishing community based medical college, community based dental college, and an elaborate scheme for training community health workers (paramedics). These provisions added to and reinforced its initiatives for ensuring health for the poor and marginalized. Other NGOs, for example Brac, train their health workers using the GK paramedic training programme, which provides an excellent example of acceptability of the GK approach.

GK maintains an elaborate scheme of programme monitoring. Every three months GK central team sits to review the quarterly progress report where new directions for change, modifications, and improvements are provided. More importantly, whenever any incidence of child death or maternal death incurs, GK organizes local level community meetings investigate causes to prevent future incidents.

Based on field visits and analysis of data collected by field investigators, discussions with various sources of information, literature review, and his own long experience of working in the NGO sector, the author finds that GK interventions are unique in combining features that no other NGO in Bangladesh is undertaking. These innovations include: 1) establishing small hospitals/health centres in remote villages; 2) providing formal training to community health workers from its own paramedic training centre (where health workers from other NGOs now take training as well); 3) providing door-to-door service, mobilizing community, raising awareness through a dedicated cadre of paramedics; and 4) working together with government. According to Gallert (Gallert 1996 quoted in Mercer et al 2005) an NGO's effectiveness in creating a sustainable PHC system is linked with promoting community participation, having close links with the poor, being flexible and having committed staff. As appears from field level data collected during the present study, GK programmes contain all these components. Additionally GK plays an important role in making the public health delivery more effective through working in unison with the existing public health system in the locality.

As GK started its programme more than 35 years ago when the social, cultural and economic situation in rural Bangladesh was far behind compared to today's standard, its contribution in transforming rural health scenario should be considered having historic value. With the passage of time both government and other NGO activities in health sector have expanded but still GK remains a novel model.



Chapter 4 Findings from the field

Field level data were collected from two villages namely Hatiagla and Kazirchar under Losmonpur union, Sherpur sub-district (upazilla) of Sherpur district. Data were collected using various methods that include observation, one-on-one interview (key informant interview), focus group discussion, courtyard meeting, and participatory rural workshop. The sources of data included beneficiaries particularly from poor, ultrapoor, destitute and marginalized households, key informants like community leaders and other informed individuals, health service providers/managers (both government, NGO and GK providers). The present chapter provides findings from data collected from the above sources.

4.1 *Ganoshashthya Kendra*: Its role in promoting people's health

People from both the villages acknowledged that health care services provided by *Ganoshashthya Kendra* (GK) have brought various positive changes over the years. About thirty years ago when GK started its operation in the locality through opening a health centre in the village Kazirchar, few of the rural households were aware about the importance of mother and child's healthcare²⁹. Superstitions were the order of the day governing practices related to pregnancy, delivery, child rearing, and other aspects of rural life, often impacting their health adversely. Beneficiaries (participating in group discussion) mentioned that during those days people believed that a new born baby and her mother should be kept isolated for several days (this practice was called *chhoti utha*), that mother and the new born should be provided restricted food, and the new born should not be given the *shaldudh* i.e. colostrums.

“At that time our people believed that if the new born gets sick it was due to asr of chora churni (evil spirit called chora churni). They hung a piece of iron above the door or placed an iron scath by the side of the bed of the mother and the newborn to keep the evil spirit away”, (FGD).

People also considered diarrhea as resulting from “bad air”, and pox resulting from the curse of a deity called *olautha bibi*. Describing the prevailing situation during those days FGD participants stated that women were not allowed to see a male doctor or that they were shy to disclose their womanly diseases. Unhygienic practices like open defecation at roadside and washing hands with mud and water or only water were also prevalent.

But GK intervention started to bring about changes. During its time of programme inception thirty years ago when GK health workers tried to make home visit to provide health service the villagers did not trust them fully. But within a few years things started to change and people started to respond positively. Realizing the usefulness and benefiting role of what GK brought to them, they now welcome GK paramedics rather than disbelieving or resisting them. Today paramedics and doctors spend busy hours attending rural women, men and

²⁹ When GK started working in 1970s in these villages no other health service provider (GO or NGO) were present there. Later GO health workers started working. After years of this UHFWC was built by the government. Another NGO named VOSD (Voluntary Organization for Social Development) started project activities in these villages about 7 years ago that included providing health education/awareness on nutrition for pregnant mothers. Its scale of operation and magnitude of coverage however is not comparable with GK, which runs an elaborate programme including a health center and a cadre of trained medical professional providing both door-to-door service and center based service.

children visiting GK health centres with various types of health problems ranging from pregnancy related problems, delivery, immunization to minor ailments like cold, fever.

“The apas (paramedics) also organize camp where doctors come and we go there to take treatment. Today if we have any problem in our “lower part”³⁰ we straight go to GK and consult the apas there”.

Table 4.1: Profile of Village Hatiagla and Kazirchar

Indicator	Hatiagla	Kazirchar
Total population	3327	1665
Male	1582	930
Female	1845	735
Households	774	349
Destitute/ultrapoor	12 (1.55%)	4 (1.15%)
Poor	715 (92.38%)	297 (85.10%)
Middle	43 (5.56%)	45 (12.89%)
Rich	4 (0.52%)	3 (0.86%)
UHFWC (government)	1	0
Community Clinic	-	1
GK health centre	-	1

Source: Census conducted by GK Health Center Losmonpur (Kazirchar)

All the households in the two villages are covered by the GK programme.

“When any of our village women becomes pregnant, an apa from GK visits her and continues to visit her time to time during the whole period of pregnancy. They check up her health, provide advice and medicine. The apa also hold meeting with us and tell us ways how to care a pregnant mother and a newborn baby”.

Normal deliveries now occur either in presence of a GK health worker, trained TBA or straight in a GK sub-centre. According to the villagers they also rush to GK health sub-centre for emergency health care need. The information provided by them during FGD shows, that due to improved communication systems and an increased availability, many who can afford to, now travel to nearby urban locations like Sherpur sadar, Mymensingh, Jamalpur and even to remote urban cities like Sylhet/ Dhaka for private and public health care services. However households from poorer sections of the population mostly visit GK health sub-centre to meet their various health care needs as they find it readily accessible and affordable.

According to beneficiaries, GK health care services provide the following services:

- i. Health care services received at home (check-up for pregnant mothers, medicine, awareness raising etc) (8)
- ii. Medicine at reduced rate (10)
- iii. Prescription/advice (9)
- iv. Referral (8)
- v. Service for pregnant mothers and children (10)
- vi. Pre-natal care (2)
- vii. Post-natal care (3)

³⁰ Meaning any womanly illness like that of irregular menstruation, white discharge.

viii. Various services received at GK centres (10)

Note: Figures in brackets above indicate number of participants in group discussion reporting.³¹

Major reported reasons for which the beneficiaries visit GK health centre include various health related problems like weakness, minor injuries, pain in body, upper and lower limbs, any problem of pregnant mother, emergency health care (burn, cut, injury, sever abdominal pain), immunization, advice on family planning/welfare, gastric, malaria, common cold, fever, cough.

The areas for which GK activities have made substantial achievement according to beneficiaries include the following:

- i. Health care services for pregnant mothers (2)
- ii. Safe delivery (4)
- iii. Child health care (8)
- iv. Family planning (6)
- v. General health care (2)
- vi. Emergency health care (2)
- vii. Water and sanitation (10)
- viii. Knowledge on nutrition and food habit
- ix. Birth and death registration etc (12)
- x. Reducing early marriage and men's polygamy (6)
(figures in brackets indicate number of participants in group discussion reporting)

Box 1 The GK Health Centre at a Glance

Area: 26 acres
Number of rooms: 5
Type: Tin shed roof and bricks wall
Sick room 1
Delivery room 1
Operating theatre 1
Doctor's room plus pharmacy 1
Staffs:
MBBS doctor 1
Junior paramedics 3
Senior paramedics 1
Pathological Technician 1
Office attendant /Office assistant (Peon/bearer), /night guard 2
There is a BP machine including a stethoscope set, one weighing machine, one suction machine, patient beds, path test instruments, reagents, various medicines.
Electricity: Connected

FGD participants also reported that GK activities brought change with respect to their, particularly rural women's, health seeking behaviour. Years ago when GK started its activities in the locality women were not encouraged to visit a doctor. Only male doctors were available and "*our elders held visiting a male doctor by a female patient as violation of purdah*". But when GK *apas* (paramedics) started coming to villages this situation changed. The villagers gradually became interested seeing life saving benefits of health care for a pregnant mother and new born child. "*Today our men and women are aware and eager to take health services from GK which is in our own interest*". The senior influential members of the community who once did not like home visit by GK health workers now go to health centres seeking health care from them.

³¹ The total number of participants was 41 in 4 of the group discussions. It should be noted, however, given the rural context and also the overall socio-cultural context of Bangladesh, in any group discussion most of the participants remain silent participants. They prefer not to be vocal or express what they know or believe overtly. This is due to various reasons including their shyness, lack of ability to articulate, and above all lack of tradition (silence is socially appreciated as a virtue and who speaks out bears the risk of being labelled as "talkative" /"chapabaz".) Few participants usually take the lead in any group discussion. Frequency therefore may not be a good indicator with respect to indication of prevalence of an indicator (e.g. prevalence of pre-and post-natal services as above).

The group discussion participants reported changes in disease types prevalent in the locality over the years since inception of GK CPHC programme. According to them in earlier years prevalence of diarrhoea, cholera, pox, and scabies and other skin disease was high.

“But now these diseases are not reported so frequently. *Aizkal beshi dekha jai daibitis, TB, gastriker somossa, hearetr osukh eiguli (more prevalent diseases today are diabetes, tuberculosis, gastric/ulcer, allergy, heart disease)*”(FGD).

According to FGD participants, the GK programme contributed to reduce prevalence of diseases like diarrhoea and scabies in their locality. People’s behaviour with respect to use of safe water, use of sanitary latrine and keeping the environment clean have changed through dissemination of knowledge and campaign. On the other hand adverse factors like the establishment of a tobacco factory have contributed to the spread of new diseases like tuberculosis in the locality.³².

Table 4.2 Healthcare Service Provided During a Week
GK Health Center, Village Kazirchar, Union Losmonpur
September 28 through October 4, 2010

Complaints/Disease	Patients treated			Percentage	Average service charge including medicine (Tk)
	Number				
	Male	Female	Both		
Gastric/ulcer	2	8	10	20.8	86.9
Fever/cough/cold	3	7	10	20.8	66.6
Weakness	2	5	7	14.6	66.9
Diarrhoea/loose motion	2	3	5	10.4	68.4
Irregular menstruation		5	5	10.4	45.4
Burn/cut	2		2	4.2	88.5
Pregnancy related problem		2	2	4.2	45
Asthma		1	1	2.1	55
Boil	1		1	2.1	45
Delivery	1		1	2.1	130
Dysentery	1		1	2.1	30
Ulcer in uterus		1	1	2.1	50
Abdomen pain		1	1	2.1	40
Physiotherapy		1	1	2.1	20
All	14	34	48	100.0	66.6

Source: Calculated from official records, Losmonpur GK Health Sub-center, Kazirchar

Notes: All patients recorded are from poor (Ka) households

The beneficiaries reported that GK health workers have a warm relationship with community members. This was also apparent to the author while he was visiting the two study villages.

³² Villagers work in this factory as labourers now. There is a direct relationship between vulnerability to tuberculosis and tobacco use. People with greater exposure to tobacco smoke and dust often have weakened lungs and show a strong proclivity towards TB infection; and some of the villagers do get infected.

On the way to a courtyard meeting the GK health worker had to stop at many places, exchanging warm greetings with some women she met on the roadside, and providing instant health service. During meetings it was observed that participating women consider the health worker as their intimate, like someone who is a part of their daily life. According to FGD participants and courtyard meetings the GK health workers make regular home visits, enquire about their health, and provide appropriate health advice and medicine at subsidized rate. The visiting paramedics also refer them to appropriate service providers if necessary. GK health care services for pregnant mothers, safe delivery, neonatal care, and immunization. they further identified. However, the beneficiaries also reported that compared to earlier years, the frequency of visit by GK health workers has decreased. According to GK health service providers this reflects “*a shift in service providing strategy*”. During earlier years when the community was indifferent and some even resisting, the home visit frequency was very high to make a successful induction. As community members are now more health aware, their frequency of centre visits has increased and the need for individualized home visits has decreased. The GK paramedics, however, maintain a data base showing which household has a pregnant mother and needs special health care. They also organize courtyard meetings and various types of camps (e.g. immunization, general health check-up, eye camp).

Although GK provides health care services dividing the community households into five different categories and are supposed to provide free health care for those who are in the ultrapoor and destitute groups, beneficiaries report that “for free” health services are no longer available from GK. “*They take money but at a reduced rate (compared to private providers)*” reported some of the women participants in group discussions/courtyard meeting. Local GK service providers, however, stated that the principle of charging discriminatory fees based on socio-economic classification is still applied³³. The disagreement of opinion most likely indicates expectations of the villagers that more and more “poor” should be treated for free and free medicine is provided to them. It appears from group discussions, that they are dissatisfied that at GK sub-centres, only free consultation is provided and, even if at a lower than market rate, some money is charged for medicine from poor patients (free medicine is provided only to the few ultrapoor). The beneficiaries nonetheless stated that the poor, ultrapoor, destitute and marginalized people constitute the majority of rural community members who have benefited due to GK programme coverage. “*Those from mid and high income groups can afford seeing private (MBBS) physicians or going to nearby Sherpur town or even larger cities like Mymensingh where better but costly health facilities are available*”, (FGD).

Regarding the role of community in the GK-run CPHC programme in their locality, group discussion participants stated that the community contributed by donating land for the GK health centre. The land is still used by community members, which keeps the GK-community interface alive. The health centre is built on a huge tract of land, a large part of which is used for cultivation of paddy and other crops on a shared cropping basis. Cattles of local people graze on GK land as well. Community members also participate in implementing GK programme in various ways. The health centre has an 11 member committee where a female member of the local government (union council) is chair. She holds a special position as joint signatory of the GK bank account. Other local leaders/members from local elite also work as members of this committee. However the majority of the members represent poor and

³³ GK divides its beneficiaries into five categories based on socio-economic status and provides health care services on a sliding principle with respect to service charge. It is supposed to provide free health services to those coming from lowest socio-economic strata if registered to GK health center by paying a very nominal membership fee.

ultrapoor households of the villages. The committee is responsible for planning, implementing and monitoring local level programmes. Ordinary community members, particularly the young volunteers, play an active role in implementing programmes like immunization and organizing special camps. The health workers or paramedics are recruited locally, not necessarily from the same village³⁴ but at least from the same sub-district or the neighbouring sub-district. Use of dialect by them makes access to GK health services more convenient for villagers. GK has also provided training on safe delivery to Traditional Birth Attendants (TBA) from villages. These TBAs are playing an important role in reducing maternal mortality in the locality. The location of GK health centres inside the community has made health service available within their reach and available at times of emergency.

4.2 Participatory Rural Workshop

A daylong workshop was organized to sensitize the community regarding issues centring on CPHC in their locality. Villagers from both Kazirchar and Hatialga participated in this workshop. Participants were purposively selected from among the poor, ultrapoor and destitute households of the community. The objective of the workshop was to review the following in a participatory way:

1. Prevailing diseases in the locality, their causes and curative measures
2. The social determinants of these diseases
2. Participants' perception of disease burden
3. Access to PHC for the ultrapoor, destitute and marginalized people.
4. Role of cliques that impede access
5. How to increase their participation in planning and implementation of PHC programme
5. Plan new actions
6. Role of /how to develop social capital, and social network
8. Identify local activists committed to ideal of CPHC
9. Way forward (intent of improving access to PHC service)

4.2.1 Findings of the workshop

The participants of the workshop identified various diseases usually prevailing in their locality in a participatory way that included jaundice, weakness, diabetes, cancer, cold/cough/fever, allergy, gastric, heart disease, paralysis, backpain, tuberculosis, stone, headache, and earache etc. They also identified various reasons or causes for these diseases. It is interesting to note that some of the reasons identified by them still indicate lack of appropriate knowledge and/or superstitions.

³⁴ Young girls with minimum required qualification may not be available from the same village where she is supposed to work.

Table 4.3 Name of Disease and Reasons/Causes

Sl.	Disease	Stated Reasons/Causes	Remarks
1.	Jaundice	-If do not walk without slippers (do not walk on earth directly) -For eating beef -If do not drink safe water -If fever not treated on time	Mix of superstition and knowledge
2.	Weakness	-If do not it nutritious food -If do not get food on time -If do not take food regularly	
3.	Cold/cough/fever	-Usually caught cold from cold -Fever is symptom of various diseases -For smoking -Excessive cold	
4.	Gastric	-If fired items are eaten more -If food not taken on time (regularly) -If slippers not used for going to latrine -If soap not used for washing hand after defecation -If excessive hookworm in the intestine	Confused knowledge
5.	Tuberculosis	-Cough from smoking and if that cough not treated timely -TB may occur from cold cough even if no smoking	Lack of appropriate knowledge; misconception
6.	Cancer	-Smoking -If ulcer not treated -From injury -If wound/boil not treated	
7.	Back pain	-from rheumatism /arthritis -Stone in kidney -If heavy weights carried on head -if any injury at back	Indicates correct observations
8.	Headache	-Inadequate sleep -Tension -If do not bath regularly -If talks too much -If works at bright sunlight	Correct observations
9.	Pneumonia	-If caught cold but proper treatment not done	
10.	Diarrhoea	-from food infested with germ -if hand not washed with soap after defecation	

Curative measures

Various ways of treatment/curative measures as practised by rural people and reported by the workshop participants were wide ranging. It also indicates that their practice/behaviour related to disease treatment/prevention is still dominated by lack of appropriate knowledge and access to appropriate health care. Following table (Table-4.4) reports above.

Table 4.4 Diseases and their Prevention/curative Measures

Sl.	Disease	Prevention/Cure	Remarks
1.	Jaundice	-Initially following are done : +panipara (spelled water) is given from an Imam/Peer (spiritual person) +if above does not work Jharfuk (sort of exorcising) and mala (an indigenous remedy) are used +Arhar juice /Sugarcane juice used as prescribed by kabiraz (indigenous healer) -If any of above do not work the patient is taken to hospital and “treated there by a good doctor”	-Initial measures indicate, most likely, reliance on traditional healing as taking patient to a good doctor is expensive
2.	Cold/cough / fever	-Hot oil massage outside throat -Juice of <i>Tulsi</i> (Basil) leave is parboiled with honey and taken as medicine -Garlic, onion are parboiled in oil and it is massaged on whole body	These practices are preventive as well (prevent infection from common cold) that work effectively (age old traditional treatment in the country)
3.	Headache	-Use garlic paste on forehead -Water bandage on forehead (if headache severe) -Paracetamol on self-prescription (buy from pharmacy) -	
4.	Weakness	-Need to eat nutritious food -Various types of vegetables should be taken -Some herbal juice/syrup (extracts) are useful (like <i>Basak</i> , <i>Kalakachu</i>) - Must take food on time - Must have adequate sleep /rest -If above do not work, must consult a doctor and take treat as the doctor advise	Indicates knowledge of food/nutrition spread through GK and other government/NGO/media health information/education
5.	Tuberculosis	-Years ago herbal juice/syrup was used to treat tuberculosis -Now free treatment from government hospitals are available	<i>Basok</i> and <i>thankuni</i> leaves were used to extract juice but whether the treatment was effective is not recorded
6.	Pneumonia	-If lukewarm oil (warmed on a horn of a buffalo or deer) is massaged on whole body, pneumonia goes away -It is also treated by taking the patient to the nearby hospital	Indicates superstitious belief
7.	Diarrhoea	(Diarrhoea is prevalent more among children) -Home made saline is given -If above does not work, children are taken to hospitals (GK health centre and other government/private hospitals/centers)	Indicates peoples informed practice regarding use of homemade saline from <i>gur</i> and salt

According to participants of the workshop people of this locality usually resort to traditional methods for treatment. They go to an Imam or Fakir, or *Kabiraz* (traditional healer) or a quack³⁵ when someone in the family gets ill. The patient is treated with *panipara* (spelled

³⁵ According to Random House Dictionary a quack is a "fraudulent or ignorant pretender to medical skill" or "a person who pretends, professionally or publicly, to have skill, knowledge, or qualifications he or she does not possess; a charlatan." (quoted in Wiki <http://en.wikipedia.org/wiki/Quackery>) . In Bangladesh context any doctor that does not possess a complete formal training are also mentioned as quacks, depending on their publicly known low quality or lack of efficiency (these doctors are called “hature” meaning one who does not use his education/training but rather provides treatment based on guesswork). These types of practitioners may not be

water) or *Kabirazi* medicine (which is usually herbal) or various methods/medicine as prescribed by the quack. Sometimes they also buy medicine on self prescription for disease for which they have some previous knowledge (e.g. cetamol or paracetamol for headache). When these initial attempts do not work effectively, they take the patient to GK health centre or to other health centers/clinic or hospital. Those who can afford also visit MBBS doctors in their chambers at local *haat* /bazaar. For complicated cases some of them also take patients to larger cities like Mymensingh or Dhaka. Participants also spoke of how at GK health centres they always felt welcome and received sincere, quality services. They commented that at government health centers this was not always so, and even more so if the patient is from a poor and destitute household and seen as socially unimportant. At some places community clinics remain closed, and the situation at the UHFWC is not very encouraging either (lack of attention, presence of discrimination, medicine/doctor not available).³⁶

Social and environmental determinants of health

One important determinant of women's health is early marriage which prevails in the locality for various reasons. Lack of education and awareness is identified as one major reason behind early marriage. But there are other important social and cultural factors as well. Dowry is one such perilous factor. It is a threat to women's health in itself and it also works as a reinforcing factor to increase early marriage. Poor/ultrapoor parents are eager to give their young daughters to marriage early because it decreases the amount of dowry claimed by the potential grooms. As age of a girl increases, her parents are exposed to higher risk of meeting a demand for a greater amount of dowry. Domestic violence due to demand for dowry is still commonplace in rural life that adversely impacts women's health (and children's health as well). However, due to legal measures and an awareness campaign by government/NGO, violence related to dowry is on the decline in this locality.

In general, access to health care services and receiving quality service are subject to socio-economic condition of service seekers. Poor/ultrapoor/destitute does not get equal access and quality service as compared to well off and influential sections of the community.

imposters, however. In many cases persons who once worked as assistants of qualified doctors start working independently later. Both patients and such practitioners are aware about their position with respect to a trained (MBBS) doctor. But patients visit them as they find them less costly compared to an MBBS doctor. A non-MBBS pretending to be an MBBS is still a rarity. Quacks who "graduate" through working with a trained doctor and resorting to independent practice often make a wrong diagnosis, prescribe harmful medicine, or even sometimes make surgical interventions leading to fatal outcomes. It was reported in media that an assistant who once worked for an MBBS surgeon who did Caesarian sections later opened a clinic and started doing surgical interventions. The story eventually became public when a patient died on the operation table and a case was filed. It is difficult for ordinary villagers to discriminate between a clinic that is attended by a skilled MBBS and one attended by a quack.

In the rural context, those who pretend to be experts in other systems of medicine (e.g. alternative system of medicine including Ayurvedic and Unani systems) are potentially more harmful. A fake Kabiraz often knowing nothing or little about Ayurvedic system of medicine can prescribe harmful drugs. Sometimes consultation chambers of these Kabiraz are found crowded as they "specialize" in some ailments /health problems which, in absence of supply of adequate modern services and lack of awareness, attract people easily (e.g. for treatment of sex and venereal diseases, medicine for increasing "sex power"/virility etc). Some homeopathic quacks are also found practising without any formal degree (despite the fact that there are provisions for formal degree in homeopathic medicine in the country) or self-education (through reading one /two books like Homeopathic Material Medica). Their prescriptions sometimes also lead to fatal consequences. Many patients when they see no remedy is available in modern medicine (e.g. some cancer patients) visit these homeopathic quacks as they claim to do what allopathic medicine can't do. Unfortunately the patients treated by such quacks are seen to suffer in terms of deterioration of quality of life or even decreasing lifetime predicted by allopathic medicine.

³⁶ Since this captures responses in workshops organised by GK, there may be biases in these viewpoints; and the possibility that workshops organised by government services would present slightly contrasting opinions.

Environmental changes have also impacted health adversely. New and emerging diseases are reported like allergies. Use of pesticides and other chemicals is proving detrimental to health. Deaths are reported in some cases of agricultural chemical use. Establishment of tobacco factory has contributed to increase prevalence of tuberculosis. On the positive side there are significant changes in areas like water and sanitation contributing to decrease/control of many infectious diseases like diarrhoea, dysentery and scabies. Also there has been some progress with respect to equality between male and female children in the family. Years ago discrimination was almost the norm. But now thanks to increased awareness and greater participation of women in education, work and social life parents have started taking care of girl children more equally than ever before, which will positively impact their health.

Access to PHC

In general the level of access to PHC for poor, ultrapoor and destitute villagers is not an encouraging one. Availability is limited and their ability to afford healthcare from private sources through payment even more so. When community clinics remained closed for about one year due to lack of funding or support from the government, the UHWC provided a limited range of services. At UHC access is influenced by social and economic status of a service seeking visitor. The poor, particularly the ultrapoor and destitute are not always received with welcome and do not get quality service. Although the existence of any clique that impedes access to health care was not explicitly mentioned, it was reported that greater access by the rich and the influential (and lesser by the poor and less influentials) exists as something like a socio-cultural predisposition. As one participant in the workshop remarked:

“harar lagi to kono somossa na....hara hara to ekoi ...sudhu amrar lagi sob kothin”
(For them (meaning the socially influential and the rich) there is no problem (to obtain service at upazilla health complex)...they are (the providers and the rich and the powerful) like feathers of the same bird..... it is difficult for us (the poor and powerless people) only”.

Amid this backdrop the CPHC programme run by GK exists as one window of opportunity for the poor, ultrapoor and destitute villagers. The health centre is within their village that makes physical access convenient, particularly in times of emergency. The health workers from GK also visit their neighbourhood and provide necessary care, medicine and advice. GK has turned into an accessible source of their basic healthcare. Health information /knowledge disseminated by GK has also increased their capacity for self-care and healthy behaviour.

Participation in PHC

According to the Alma-Ata conference in 1978, community participation is an essential component of PHC. In rural Bangladesh, however, local level participation in planning, implementation and monitoring in PHC programme is absent or low. In this case of government programmes the level of participation tends to be insignificant. Government services are given from above and poor members of the society are considered passive recipients. Few are aware that health is a right and that every community member has right to know what he or she is entitled to receive. For example, research findings indicate that few people are even aware in a rural union that they are entitled to free medicine and the union (public) health centre is obliged to show a public notice describing the everyday stock position. For many years they went to the centre and learnt that they would have to buy the medicine from the market, *“medicine not available at the centre”*. This situation changed in some unions when an NGO intervened and developed mass awareness. The UHCs now regularly display the stock position and many gets free medicine (Hassan et al 2010).

According to Islam and Ullah however:

“...the present health policy (of the government) is not people oriented. It mainly emphasizes the construction of Thana Health Complexes (THCs)³⁷ and Union Health and Family Welfare Centers (UHFWCs) without giving much attention to their utilization and delivery of services.”

The “lack of participation in health service is a problem (*in the country*) that has many dimensions and complexities” (Islam and Ullah 2009) (italics mine). Based on analysis of both primary as well as secondary data, they conclude that, “... most of the people are not participating in health services because the participation process is not decentralized. People have no involvement in decision making process and that is why health policy is not people-oriented” (Islam and Ullah, *ibid*). They also suggest, in light of their findings, that NGOs in Bangladesh provide community based health services; they (the NGOs) follow a participatory approach and successfully reach remote rural areas with health services.

Findings of the present study indicate that the GK implemented CPHC programme has some elements of community participation although it needs to be developed further. Poor villagers have a special relation with GK programme implementation staff who are very people friendly. The visiting health workers and other staffs (paramedics, senior paramedic and doctor) are always accessible for advice and help or any assistance when needed. The senior paramedic can be reached over cell phone even if it is mid-night³⁸; and sometimes is called at that time when a pregnant mother is in critical condition needs to be hospitalized. The nature of interaction and relationship is different from what poor community members have with public health service system. As one participant in the workshop mentioned:

“Unagor time to sudhu diner balye...tao oi somoy gelei ze tarare paoa jaibo heidar kono bhoroasha nai...kintu Ganoshashthyer afago dorkar hoilei hater kace pai...hoy amra cuita asi noile afarai asen” (meaning “Their (the government health providers’) schedule is only during daytime and yet there is no assurance that they would be available even at that time...but the GK apas (paramedics/health workers) are available as and when needed, either we rush to them or they come to us”).

For many years the GK staffs has stood beside the poor community members in times of their health needs, which created faith and trust and a cordial relationship. The feeling of alienation has been replaced by a sense of cordiality.

Role of Social Capital, Network and Rights Awareness

The workshop participants underscored the need for the use of social capital/network and raising rights awareness among poor, ultrapoor and destitute population to ensure their greater access to PHC. They opined that from among them those who are more socially connected and have some voice in social life can play an important role to promote their access particularly to government health centres. It is not still widely believed (by the poor)

³⁷ Upazilla health Complex (UHC)

³⁸ Thanks to Prof Yunus and the Grameen Bank the cell phone is now commonplace in rural Bangladesh . Particularly, the use of cell phones by women is a remarkable achievement for which Prof Yunus and the Grameen Bank would be recognized as pioneers for introducing IT to the rural poor (For more information on how Grameen Bank started introducing cell phone to rural Bangladesh visit <http://www.grameentelecom.net.bd/about.html>).

that health is a fundamental right. It is widely acknowledged that, in general, the level of rights awareness of people is low. A study that assessed the state of awareness and knowledge on laws and rights, based on a survey conducted among rural people in three parts of the country, reports: “The inevitable conclusion of our survey is that awareness on human security laws and rights is very limited” (Human Security in Bangladesh, In Search of Justice and Dignity, <http://www.undp.org.bd/info/hsr/Chapter%202.pdf>). The situation is no different with respect to child rights, gender rights, rights to information, education, health and various other sectors. NGOs in Bangladesh have been working to increase peoples’ awareness on rights. It is also now in vogue to discuss and work on a ‘right based approach’.

Workshop participants, thought increasing rights awareness would be most effective if a committee is formed to steer the whole process of organizing, campaigning, and taking other necessary actions. They stated that when a member from a poor household is suffering critically, usually the rich and influential do not come forward proactively to help. If they (the poor, ultra poor and destitute population) have a committee it could take some measure to assist that person at this critical moment. The committee could also disseminate information, take initiatives to make people aware regarding their rights and make advocacy so that poor, ultrapoor and destitute community members are welcome at government health service centres and the service providers treat them on equal footing³⁹.

The workshop identified some capable and enthusiastic persons from among the participants for carrying out the above mission and, formed an eleven member committee to steer activities aimed at ensuring greater access to health care for poor, ultrapoor and destitute during next one year.

4.3 Individual Interviews

A total of six individuals from the study location, various health service providers, from government, GK, and other NGO, were interviewed. This included the Upazilla Health In-charge (Sub-district Health In-charge), Upazilla Family Welfare Officer, HA, Field Supervisor of VOSD (health service providing NGO), the local Programme Manager of GK, and the senior paramedic. A member of the local government (Union Council) was also interviewed. One major objective of these interviews was to validate the data collected through FGD/courtyard meetings, and the participatory rural workshop. These interviews were also aimed at gathering information on the following:

- 1) The level of access for the poor, ultrapoor and destitute to PHC
- 2) The role of GK in promoting PHC in the locality
- 3) Community participation in GK CPHC programme
- 4) Potentials of social capital and network in promoting access

Interview findings more or less corroborated the perceptions of and information provided by the beneficiaries. Information from some of them are reported in the table below.

³⁹ Success of Dhaka Ahsania Mission in promoting poor peoples’ access to health services through formation of committee, developing linkage with GO/NGO service providers, media, etc and making campaign and organizing advocacy workshop (Access Upazilla Yearbook 2009, Mohamamd Rafiqul Hasan and Abdullah Al-Ahsan, Dhaka Asania Mission, 2010)

Table 4.5 Individual Interviews

Individual Interviewed	Positive Comments about GK	Negative Comments about GK
Union Council Member	<ul style="list-style-type: none"> - provides a wide range of services - makes health services available at an affordable price - brings health care services to the doorstep - workers maintain a warm relationship with community members - health care messages are provided at an individual level and through courtyard meetings, increasing awareness and changing behaviour, especially concerning pre natal and neo natal care, safe water and proper sanitation 	<ul style="list-style-type: none"> - GK's community activities have decreased in recent years, i.e. the community clinic closed and the village development committee no longer exists - frequency of door-to-door visits has decreased - courtyard meetings aren't happening as frequently
Health Assistant	<ul style="list-style-type: none"> - GK has made important contributions with respect to prenatal care, delivery and neo natal care, potable water and sanitation - GK provides active assistance to implement government programmes i.e. immunization, family planning and PHC activities 	<ul style="list-style-type: none"> - although GK health services reach the poor, the ultrapoor and destitute are excluded as the services are not free - there aren't enough workers, particularly skilled and educated workers
Upazilla Family Welfare Officer	<ul style="list-style-type: none"> - GK has made important impacts on prenatal and neonatal care and reducing mother and child mortality rates - GK activities are very helpful in implementing and expanding government health programmes - courtyard meetings are very important for disseminating important health care information - GK has contributed to 	<ul style="list-style-type: none"> - inadequate to meet the health needs of the rural poor - community participation is still limited - lack of appropriate training - lack of human resources to meet the community demand

	ending various superstitious beliefs and practices	
Upazilla Health In-charge	<ul style="list-style-type: none"> - GK made significant progress in providing PHC and creating health awareness, especially for pregnant women and newborn children - GK has an excellent relationship with the poor and destitute 	<ul style="list-style-type: none"> - Inadequate to meet the health needs of the poor, ultrapoor and destitute - infrastructural facilities have not been renovated or updated - qualified MBBS doctor is not always available - inadequately skilled workforce - compensation to workers is low and irregular - programme monitoring and documentation are also weak
Senior Paramedic, GK Health Centre	<ul style="list-style-type: none"> - GK helped educate people, especially about safe deliveries and pre natal health care - households all now have pit latrines and general hygiene practices have greatly improved - maternal and infant mortality have decreased dramatically 	
Project Manager, GK Health Programme	<ul style="list-style-type: none"> - GK has contributed to promoting health with respect to nutrition, family planning, potable water, sanitation, safe delivery, reducing early marriage and early motherhood, polygamy and the use of tobacco 	<ul style="list-style-type: none"> - weak management, inadequate workers, low and irregular salaries have impacted programme achievement - GK programme coverage has not expanded throughout the 30 years it has been in existence

Chapter 5 Evaluation, monitoring and system of feedback

GK has an elaborate scheme of research, monitoring and programme evaluation. At its headquarter – Mirzanagar, Savar Dhaka – it has a full-fledged division for Research, Monitoring and Evaluation known more popularly as RMED in the organization. RMED is responsible for routine monitoring and evaluation of all development activities undertaken by GK. It collects data on a periodic basis from grassroots level, analyses them and prepares reports for submitting to appropriate forums for further discussion and feedback. One such major forum is the organization's quarterly meeting. Monitoring reports submitted by RMED is considered an important agenda item there. Guidance to field implementing managers are provided for bringing in necessary changes and adjustments from those quarterly meetings, based on the monitoring and evaluation reports submitted by RMED.

The RMED maintains a database known as “census” of programme locations. Every health center of GK collects data from all the households under its programme area related to a limited set of indicators which is updated periodically. The indicators are gender, date of birth /age, marital status, and income/major occupation for each of the household members. Functional status of the member in the household is also mentioned (head of the household or relation with head of the household). Socio-economic status of the household is also reported based on 5 category divide by GK (Au, Ah, Ka, Kha, Ga). The census data are useful to identify what proportion of the households is poor, ultrapoor and destitute. It also gives a clear picture regarding existing socio-demographic features of the intervention population like distribution by age group, their marital status, male to female ratio, existing literacy situation, and socio-economic condition. Information on major occupation also have important bearing for designing health interventions.

For programme monitoring purposes, GK uses a detailed checklist that includes various pertinent indicators. Details of these indicators are presented in Table 5.1.

Table 5.1 Monitoring Indicators Used by GK Health Programme

Sl. #	Indicator/monitoring information	Method
1.	Whether immunization recorded in card	Check
2.	Monthly report vs. Follow-up card	Compare
3.	Monthly Report vs. Couple Registrar	Compare
4.	Signature of attendants in resolution book (of meeting on child death)	Check
5.	Signature of attendants in resolution book (of meeting on mother's death)	Check
6.	Insurance book and Monthly report	Compare
7.	Family card renewal	Check
8.	Family card/immunization card vs. Current Family size	Check
9.	Age in immunization card and present age (of family members)	Check
10.	Record of death and birth	Check
11.	In and out migration record	Check
12.	Accuracy of entry on birth, still birth, child death and maternal death recorded	Check
13.	Health worker's knowledge on side effects pill	Check
14.	Household awareness on insurance (card) renewal	Check
15.	Date of expiry of card and signature of in-charge	Check
16.	Valid cards reported in monthly report	Check
17.	Villagers knowledge/awareness on facilities of insurance (card)	Check
18.	Monthly report and neonatal card	Check
19.	Renewal of Pregnant registrar	Check
20.	Update of pregnant at risk registrar, supervisors countercheck	Check
21.	Number of Neonatal mother without card in the village	Check
22.	Classification of households is correctly done (into 5 types as per GK definition)	Check
23.	Availability of report format file	Check
24.	Monthly work plan done	Check
25.	Movement registrar and its use	Check
26.	Field workers visit to villages with 21 types of medicines	Check
27.	List of 21 drugs available in respective project	Check, investigate why not if not
28.	Receipt for cash sale	Check
29.	Patients get subsidy as per their socio-economic group	Check
30.	Leave registrar and its use	Check
31.	Stock registrar and its use	Check
32.	Working days and training received (for health workers)	Check
33.	Meeting on maternal and neonatal deaths	Check
34.	Signboard of health centre/sub-centre	Check
35.	Health messages are disseminated regularly	Check
36.	Use of bicycle by health workers	Check

RMED of GK uses various methods to implement monitoring of health interventions including data analysis, record comparisons, individual interviews, FGDs, PRAs/ RRAs, participatory workshops, and case studies. There are nine pre-designed formats used by field offices to record in and out migration, maternal death, child death, immunization card, insurance card, pregnancy registration card, monthly reporting format, and birth/death registrar. The RMED use these formats both for collecting data and for checking and comparison. Most of the indicators relate to programme/project activities. Some of these are designed to serve administrative /managerial purposes. Few of the monitoring indicators are helpful to understand the level of access and community participation, particularly for those who are poor/ultrapoor and destitute.

Chapter 6 Conclusion and Recommendations

6.1 Conclusion

The major objective of the present study was to make an assessment of GK's contribution, strengths and limitations in building CPHC in rural locations of Bangladesh, particularly with respect to creating increased access for the poor, ultrarpoor and marginalized population groups. The process of study, by means of PRA method, was also supposed to initiate an effort to strengthen social capital among them, that is, to increase the sense of health ownership among poor people, increase access to CPHC for the poor, increase community understanding of the importance of PHC and community-level determinants of health. The study was also supposed to make a review of existing tools and recommend new tools/modification of tools that would better inform GK, other NGOs and government-provided PHC services of the extent and effectiveness of their programme,

Both secondary and primary information were collected to implement the study. Through desk research and field level participatory action research that included courtyard meetings, participatory rural workshop and focus group discussions, it based its analysis mostly on qualitative data while some relevant quantitative information was also utilized. As a means of data validation data collected from various sources were compared with each other. Structured one-on-one interview and semi-structured in-depth individual interviews worked as an important source of data against which beneficiary level data were validated.

Review of documents and existing literature indicate that the GK model of CPHC for the rural poor, ultrarpoor and destitute could be a model for any development agency concerned for promoting HFA in Bangladesh.

GK divided the rural population into five socio-economic categories though implementing a census in its intervention locations. One objective of this classification was to introduce a card system where poor and destitute would be entitled to free services. Village committees were developed and rural communities were mobilized with the objective of resource mobilization. In most of the cases the rich and influential rural elite eventually extended friendly hands and the community donated land for developing infrastructure. Money raised by GK from service charges provided to mid and high income groups (and other fund raising initiatives) was spent to meet the cost of free service for the poor. The health workers were recruited and posted to health centres on a regional basis to increase their acceptability. These workers played a pivotal role in disseminating health messages and information through courtyard meetings and one-on-one sharing leading to positive health behavioural changes observed today in GK intervention locations. GK developed networks with government service providers and played an important role in various sectors like family welfare, immunization, water and sanitation. The linkage developed by GK with government health service networks has proved helpful in escalating programme outcomes for both government and GK. In some cases GK implemented community clinics successfully. Its role in HRD for rural health development is pioneering and unique. Community based medical education and an elaborate scheme of paramedic training established by GK also benefits government, private sector and other NGOs. GK has an elaborate system of programme evaluation, monitoring and research through its RMED.

The field level findings of the present study indicate GK's contribution in reproductive health, child health, family planning, immunization; nutrition, water and sanitation, limited curative care, and referral have been significant.

However, despite various strengths and positive achievements GK programmes have been found to be in need for further development in various fronts. Participation of the rural poor in planning, implementing and monitoring programmes needs to be increased. It was reported (during the present study) that the village committees are not functional. A top down approach still seems to dominate programme implementation. Local resource mobilization is another area where GK programme remains weak. As economic poverty is improving rural community members attain more capacity, be it small in scale, to contribute, funding/financial support to programmes. It is interesting to note that at an organizational level *Gonoshashthay Kendra* now has reached a greater level of self-funding (about 70 per cent of GK programme funding is now from its own source). Local resource mobilization should increase community ownership of GK programmes. The participatory rural workshop implemented during the present research indicates the potential of utilizing non-financial resources from the poor to increase and ensure access for poor to the public health system. GK alone can't meet all the health needs of poor section of the population. It is neither practicable nor it is desirable given the presence of a large public health system. But this public health system is not yet functioning in a way that benefits the poor. The workshop participants, through formation of committee, showed their interest in working for utilizing social capital to their advantage for promoting their health rights and improving the public health system. To sustain this process GK needs to adopt it as a part of its programme implementing strategy.

The following section provides some recommendations and the rationale for them.

6.2 Recommendations

6.2.1 Revisiting the classification/Re-confirming the distribution in the two studied villages

Either the current structure of classification of villagers into 5 categories needs to be revisited or the correctness of census data crosschecked. As shown in Table 4.1 in two programme villages *Hatiagla* and *Kazirchar* the percentage of poor households is 92.38 and 85.10 respectively. These figures do not tally with national estimates and may reflect an error that many mid income households have been labelled as poor. On the other hand, the percentage of ultrapoor in these villages is very low which also does not tally with national estimates. According to various sources (i.e. BBS, UN organizations) about half of the rural population in Bangladesh lie below the poverty line and about one-third of them are hardcore poor.

6.2.2 Prioritizing ultrapoor/destitute during field visit

Once ultrapoor/destitute are identified properly, the field visits by paramedics should be designed to give more emphasis to these households to increase their access to health care.

6.2.3 Activate village committees and utilize social capital

The revival of village committees is needed to let the community express their demands, plan actions and participate in implementation processes. A functioning village level community platform such as a "village committee" decreases the risk of top down approach in the

programme⁴⁰. The village committees could play an important role in utilizing social capital for promoting access to PHC for the poor/ultrapoor.

6.2.4 Advocacy/campaign and linkage/network building

GK has been previously viewed as a service delivery institution by villagers. Although this image had its own historical necessity, it is time that GK comes out of this image. GK alone can't ensure access for all the poor and destitute households to its own services. Advocacy and campaigns are needed to increase access to public health provisions. Service providers need to be motivated/sensitized and service recipients need to be aware of their rights. Linkages and networks need to be developed not only with government but also with other NGOs, civil society, local/national media for this.

6.2.5 Emphasize local resource mobilization

Resource contribution by the community remains limited to land donation only. The community has no contribution to infrastructure/building, equipments and other amenities. To create local ownership and ensure local participation into the programme local resource raising should be systematically introduced in these areas (for example community members could be encouraged to donate stethoscopes, BP machines, scales, other useful equipment, bed/cot, fans, lights, bicycles; a list of such donations may be kept in the health centre for visitors to create a demonstration effect) .

6.2.6 Integration with livelihood support

For poor households there is little room for considering health as an isolated entity from their struggles for livelihood. Knowledge of nutrition is important, but to create an effective impact on the nutrition level of the household its income must be increased or ensured in a sustainable way. PHC programmes need to be integrated with livelihood support services, directly by GK or through linkages with other organizations.

6.2.7 Centre based health education programmes

Health workers presently disseminate health information through courtyard meetings and individual communications. The health centre infrastructure is used to provide health services only. But it may also be developed as a centre for disseminating health information and education on a periodic basis. Sharing sessions, workshops, and audio-video shows could be arranged to turn GK health centres into vibrant locales for health education for community members.

6.2.8 Introduce dental and mental health services

As part of primary healthcare dental and mental health components should be introduced to GK health centres. The community based Ganoshasthya Dental College could be integrated with this initiative. For mental health at the moment GK can emphasize creating awareness on how to provide special care to people facing mental health challenges at family and community levels.

6.2.9 Modification of monitoring system to review access situation

The present monitoring system addresses more the need for reviewing pre-set project/programme activities. A participatory monitoring system needs to be introduced that

⁴⁰ Findings from the field survey during this study (please see information provided by the Health Assistant under section 4.3 above) indicate that presently the village committees are not functioning actively.

includes indicators to assess the levels of community participation and access to health care services by the poor, ultrapoor and destitute. It is recommended that some indicators/cross checks/comparisons be included in the present monitoring such as:

- Random cross checks of the reported socio-economic status of outpatients (it is observed that the OPT registrar assigned “Ka” or Poor to all patients who visited the GK health centre during the week prior to the field visit by this researcher)
- Check what percentage of households visited by health workers in the field are from poor, ultra-poor and destitute groups
- Do village committees remain active? If not, why not, and if yes, how well have they been promoting health access for poor, ultrapoor and destitute (qualitative information)
- Number of advocacy meetings/workshops held and its impact in promoting access for poor (qualitative information)
- Local resources raised during the last quarter (quantitative information)

6.2.10 Other issues that need to be addressed

Availability of a full time doctor from community based *Ganoshasthya* Medical College or others sources doctor should be ensured. Although there are provisions for posting an interneer doctor from *Ganoshasthya* Medical College, he or she is not always available. Three junior and one senior paramedic are presently available at the health centre. This appears to be inadequate given the population size covered by the programme. Presently only two days are allocated as outpatient days due to the shortage of paramedics (the paramedics need to make home visits on other week days). Low and irregular payment works as a disincentive for health workers who are supposed to be the key health providers in a CPHC scheme. It is reported that turnover rates are high and after completion of mandatory training periods many health workers move to the private sector without making any significant return for the investment GK made for their skill development.

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CPHC Research Instrument for KII at field level
Checklist for UP member

[Note for the interviewer:

Please build rapport with the interviewee before starting the interview. Inform the interviewee regarding objectives of the present research and take his/her consent for using information/opinion provided by him/her before you start the actual interview. If he/she does not provide consent abandon interview. During interview, carefully listen and take note. PLEASE DO NOT TRY TO INFLUENCE HIS/HER OPINION WITH ANY OF YOUR WORDS. BE CAREFUL EVEN NOT TO INFLUENCE BY YOUR BODY LANGUAGE. Follow all instructions you have been given during the trainings session]

1. Please tell something PHC program at your locality
2. During early years of programme inception at your locality what types of health services were provided by Gonoshasthaya Kendra (GK)
3. Who were target group of these services? Any special group or all?
4. Please tell us about special features of this program at that time
5. At your locality who other than GK (both government/NGO) provides health services? What types of health services do they provide?
6. Currently how many doctors/paramedics of GK have been working at your locality
7. What types of Government health services provided in your locality without GK and others?
8. How many doctors and paramedics provide PHC in your community? Please tell us how do they provide the PHC services?
9. How community participates in GK programme?
10. Please tell us about the strength of Primary health program of GK
11. What are the weaknesses of PHC program of GK?
12. How effective do you think GK health programme is?
13. Please tell us the changes that have been brought forth by GK intervention at your locality
14. How poor, ultrapoor, and destitute populations of your community have been benefited from GK intervention?
15. According to your opinion what steps should be taken to make GK PHC a more effective one?
16. (Please ask if anything more the interviewee is willing to tell about GK programme from herself/himself in addition to his/her responses to above questions. If so please record it here)

CPHC Research Instrument for KII at field level
Checklist for GK Health Service Provider

[Note for the interviewer:

Please build rapport with the interviewee before starting the interview. Inform the interviewee regarding objectives of the present research and take his/her consent for using information/opinion provided by him/her before you start the actual interview. If he/she does not provide consent abandon interview. During interview, carefully listen and take note. PLEASE DO NOT TRY TO INFLUENCE HIS/HER OPINION WITH ANY OF YOUR WORDS. BE CAREFUL EVEN NOT TO INFLUENCE BY YOUR BODY LANGUAGE. Follow all instructions you have been given during the training session]

1. What type of health services do you provide in this locality?
2. Please tell something PHC program at your locality
3. At your locality what other individuals/organizations (other than government) provides health services? What types of health services do they provide?
4. What are the major health problems in this locality? Please elaborate particularly with respect to following:
 - Health care for pregnant mothers
 - Safe delivery
 - Maternal and infant mortality
 - Mother and Child health care
 - Family planning
 - General health care
 - Emergency health care
 - Water and sanitation
 - Other (please mention)
5. Please tell us what health services does GK provide in your locality? With respect to health problems, particularly just mentioned above, what type of contribution GK has been making?
6. According to your opinion what are the major achievements/success of GK programme? What factors or features (of their programme) have made this success possible?
7. Particularly how GK has done with respect to following:
 - With respect to mother and child health and care
 - Ensuring safe delivery
 - Reducing maternal and infant /child mortality
 - Providing child health care
 - Immunization
 - Family planning
 - General health care
 - Emergency health care
 - Water and sanitation
 - Birth and death registration
 - Other (please mention if any)
8. How GK works in collaboration with you? How it adds to programme benefits?
9. What role GK plays to create health awareness in the locality?

10. What changes have been brought forth among the members of the local community due to intervention by GK? Particularly how their behavior/attitude has been changed?
11. Please tell us how GK involves community members with their programme?
12. Please tell us how GK is doing particularly to meet the health service needs of poor, ultrapoor, destitute/ and marginalized population in the community?
13. How GK programme has contributed to bring I changes or to affect health programmes of other providers in your locality
14. According to your opinion what are the major strengths of GK programme? What are the weaknesses? What are their failures and limitations?
15. According to your opinion what measures are needed to be taken to improve /make more effective GK programme?
16. What measures, in general should be taken to reduce maternal and infant mortality at your location? How GK should contribute towards this end? More specifically to achieve MDGs?
17. (Please ask if anything more the interviewee is willing to tell about GK programme from herself/himself in addition to his/her responses to above questions. If so please record it here)

**Study on CPHC of programme
Checklist for Family welfare officer**

1. How many day you are working here?
2. What types of PHC you provide in the community?
3. What are the processes of PHC?
4. What types of Government health services provided in your locality without GK and others?
5. What are the major health problems of your locality? There are health problem are given below? Please tell on the priority basis?
 - a. Pregnant women care
 - b. Sate delivery
 - c. Mother and child care
 - d. Child health care
 - e. Family planning
 - f. General health care
 - g. Emergency health care
 - h. Water and sanitation
 - i. Others (mentions)
6. What type of health service GK provide in your community? What are the contributions of GK in case of health problem? What are the effective positive results of them? How these results have possible?
 - a. Pregnant women health service and care
 - b. Sate delivery
 - c. To reduce maternal and child care
 - d. Child health care
 - e. Immunization
 - f. Family planning
 - g. General health care
 - h. Emergency health care
 - i. Water and sanitation
 - j. Birth and death registration
 - k. Other(mentions)
7. What type of coordination conducting GK and others (Public and private) and what type of advantages of conducting coordination?
8. What types of role play GK for the awareness of the community people? What type of change happened among the community? In case of special health, what types of change in belief and behavior?
9. What types of role of the community involvement in the PHC programme of GK?
10. What types of role played the GK's PHC for marginalized people? How the marginalized people becoming beneficiary the health insurance card?
11. What types of change happened in all others health services, in your community for the PHC of GK?
12. What are the strength and weakness of PHC of GK?
13. According to your accord, what step can be taken for making more effective the PHC of GK.?
14. What steps are needed to reduce the maternal mortality and infant mortality in your community? For this reason what step should take by GK as your opinion? What are the more steps should be taken by GK for achieving the MDG within 2015 AD

15. What are the excess information without the above information which is provided by GK PHC program?

Study on CPHC Program of GK Focus Group Discussion with Beneficiaries

1. What types of health service you get from Gonoshasthaya Kendra, tell in briefly (There are some problems here say according to priority)
 - Get at home
 - GK sub center
 - Drugs
 - Advices
 - Referrals
 - Minor operations
 - Orthopedics
 - Camp
 - Others (Mother and child)
2. What types of change has happened in your community for the GK PHC program?
 - Pregnant mother care
 - Safe delivery
 - Reduce maternal mortality and infant mortality
 - Child health care
 - Family planning
 - General health care
 - Emergency health care
 - Water and sanitation
 - Birth and death registration
 - Others
3. Usually by seeing which disease problem / symptoms you go to GK?
4. How the GK health workers provide the PHC? What are the relationship among GK's worker and community people?
5. What are the roles of community people play in the PHC?
6. When and How GK establish in your community?
7. What types of relationship changed at the pioneer and presents time of GK with community people?
8. What are the contributions of GK from beginning to till now? As a result what health condition changed? At that time what were the major health problems? What was the MMR and IMR rate?
9. What types of role played GK for health awareness in the community people? What type PHC programs do awareness of community?
10. What types of modification occur for PHC program of GK in case of belief, behavior?
11. What types of role played the GK's PHC for marginalized people?
12. How the marginalized people becoming beneficiary the health insurance card?
13. Where do you go for health card without GK? Explain about those health centers? What are the differences between GK and others health centers?
14. If, in case of acquiring PHC of GK, there are some changes ? What about you think?
15. Explain about the quality of health services of GK and expenses of health services of GK.
16. What types of advantages you get from GK PHC?
17. What types of PHC did they (GK) do at the beginning period?
18. Tell those health centers name and activities provided health service in your locality?
19. Tell those health centers infrastructure provided health service in your locality?
20. What are the extra activities of GK which may be more effective?

21. Who come at the beginning period of your health problems?
22. When you fell any symptoms of health problem, you go any health centers, have you seen any doctor, if there is their behavior?
23. What are the infant mortality and MMR in your locality?
24. i) When you need any health problem then where go for treatment?
- 24 ii) Who provide the health service? Generally what types of health service you get from them?
24. iii) How much money you have to spend for that treatment?
- 24 iiiii) How far away you have to go for health service and what is the vehicles?
- 24 iiiii) How many times you go to whose for the purpose of health service and priority?

Service provider	order	problems	fees	distance	Transport	Waiting	Quality of health services	Number of beneficiaries
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25. What step should be taken for the participation of community in the GK's PHC?
26. What are the barriers GK's PHC? How can it overcome?

Study on CPHC of GK Checklist for Union health assistant

1. How many days you are working here?
2. What types of PHC you provide in the community?
3. What are the processes of PHC?
4. What types of Government health services provided in your locality without GK and others?
- 5 What are the major health problems of your locality? There are health problem are given below? Please tell on the priority basis?
 - j. Pregnant women care
 - k. Sate delivery
 - l. Mother and child care
 - m. Child health care
 - n. Family planning
 - o. General health care
 - p. Emergency health care
 - q. Water and sanitation
 - r. Others (mentions)
- 6 What type of health service GK provide in your community? What are the contributions of GK in case of health problem? What are the effective positive results of them? How these results have possible?
 - s. Pregnant women health service and care
 - t. Sate delivery
 - u. To reduce maternal and child care
 - v. Child health care
 - w. Immunization
 - x. Family planning
 - y. General health care
 - z. Emergency health care
 - aa. Water and sanitation
 - bb. Birth and death registration
 - cc. Other(mentions)
- 7 What types of activities conducting according to coordination with other health service provider? What types of benefited according to coordination?
- 8 What types of role play GK for the awareness of the community people? What type of change happened among the community? In case of special health, what types of change in belief and behavior?
- 9 What types of role of the community involvement in the PHC programme of GK?
- 10 What types of role played the GK's PHC for marginalized people? How the marginalized people becoming beneficiary the health insurance card?
- 11 How much differences have occurred in your community to get health services by the GK's PHC programme?
- 12 What are the strength, weakness and limitations of PHC of GK?
- 13 According to your accord, what step can be make more effective the GK's activities?
- 14 What steps are needed to reduce the maternal mortality and infant mortality in your community? For this reason what step should take by GK as your opinion? What are the more steps should be taken by GK for achieving the MDG within 2015 AD
- 15 What are the excess information without the above information which is provided by GK PHC program?

Historical review of GK Intervention in PHC

Checklist for Main respondent (project manager, Project director, senior director)

1. When and how the GK's PHC program started?
2. What was the background of PHC? What was the philosophy, ideology of PHC?
3. Beginning stage (during established period) within this PHC?
4. i) What types of service delivery provided?
ii) Who were the target group?
iii) What are the strategies of PHC implementation?
iv) What was the special character ties of PHC?
5. What is the experience of PHC of GK from beginning to till now?
6. What are the interventions of PHC according to NHP?
7. What type of health service provides GK for achieving the MDG?
8. What types of contribution of local community in the PHC of GK?
9. Tell about the PHC of sherpur sub center? Why health center first started in sherpur?
10. What was IMR, MMR, safe delivery, birth rate before established GK health center in sherpur? What types change has become of IMR, MMR, safe delivery, birth rate after establishing center in sherpur?
11. How the community person is working with GK? What is role of community of it selves?
12. At present, what special features we can address in this PHC?
13. Comparatively, What are the prime special features of PHC of GK? What special probable held for the health demand of marginalized people of Bangladesh?
14. What are the barriers / obstacle and challenge of project implementation?
15. How does cope with this barriers /obstacle and challenge of project implementation?
16. How much the expected result achieves to PHC and way it possible?
17. Why the actual expectation could not achieve?
18. What are the strength of PHC of GK?
19. What are the weaknesses of PHC of GK?
20. According to your accord, what step can be taken for making more effective the PHC of GK.?
21. What is the future plan of GK in the PHC?
22. What are the excess information without the above information which is provided by GK PHC program?

Study on CPHC Program of GK
Interview checklist for Person in charge GK Health Center Losmonpur Bhatchhala,
Sherpur

1. When and how the GK's PHC program started? What was the background of PHC? What was the philosophy and ideology of PHC?
2. Did any special reason for selecting GK's activities in this area? At that time what was the condition of PHC in this area?
3. How many doctors and paramedics involve with it, how many sub centers here? How do you conduct the health care activities details?
4. What types of use method and instrument for PHC implementation?
5. Tell the specific method and instrument which are used for the outcome of CPHC at losmonpur project?
6. What are the experiences of PHC of GK's from begging to till now?
7. What are the major health problems of your locality? There are some health problem are given below? Please tell priority basis on the health problem?
 - a. Pregnant women care
 - b. Sate delivery
 - c. Mother and child care
 - d. Child health care
 - e. Family planning
 - f. General health care
 - g. Emergency health care
 - h. Water and sanitation
 - i. Others (mentions)
8. What types of method are used for achieving the expected result? By using which methods you evaluate the activities? How you measurement the program of activities? For monitoring which methods are used?
9. What types of role of the community involvement in the PHC programme of GK?
10. How, you and your workers provide the PHC in the community? How they help you for implementing their PHC?
11. Comparatively, what type of changing relationship before and after between GK and other NGO or Government?
12. What types of role play GK for the awareness of the community people? What types of change happened among the community?
13. What types of change in belief, behavior and practice?
14. What types of role played the GK's PHC for marginalized people?
15. How the marginalized people becoming beneficiary the health insurance card?
16. What are the differences between GK and other health service provide the health care?
17. How much differences have occurred in your community to get health services by the GK's activities?
18. How the other NGO and Government conduct with GK (linkage, network and advocacy) in a result, what types of advantage and disadvantages in the PHC?
19. What are the problems to implement the health activities in your locality?
20. What are the strength and weakness of PHC?
21. How you solved the problem of those activities?
22. Did your past and present health activities are evaluated? If yes would say the evaluation methods and achieving result?
23. What steps should be taken for creating the expected MMR, IMR, safe delivery rate and birth rate?

24. What are the more activities you expect from GK for the development of the locality?
25. How much expected result has gained from your activities and how you have acquired it? In which case it fail to acquire and why?
26. Comparatively, what is the specialty of GK from other in the field of health services activities? What is the role of your organization for the demand of health services for the marginalized people?
27. What are the excess information without the above information which is provided by GK PHC program?

Study on CPHC of GK
Checklist for Upazila Health In charge

1. How many days you are working here?
2. What types of PHC you provide in the community?
3. What types of Government health services provided in your locality without GK and others?
4. What are the major health problems of your locality? There are health problem are given below? Please tell on the priority basis?
 - i) Pregnant women care
 - ii) Safe delivery
 - iii) Mother and child care
 - iv) Child health care
 - v) Family planning
 - vi) General health care
 - vii) Emergency health care
 - viii) Water and sanitation
 - ix) Others (mentions)
5. What type of health service GK provide in your community? What are the contributions of GK in case of health problem? What are the effective positive results of them? How these results have possible?
 - a. Pregnant women health service and care
 - b. Sate delivery
 - c. To reduce maternal and child care
 - d. Child health care
 - e. Immunization
 - f. Family planning
 - g. General health care
 - h. Emergency health care
 - i. Water and sanitation
 - j. Birth and death registration
 - k. Others (mentions)
6. What types of activities conducting according to coordination with other health service provider? What types of benefited according to coordination?
7. What types of role play GK for the awareness of the community people? What type of change happened among the community? In case of special health, what types of change in belief and behavior?
8. .What types of role of the community involvement in the PHC programme of GK?
9. What types of role played the GK's PHC for marginalized people? How the marginalized people becoming beneficiary the health insurance card?
10. How much differences have occurred in your community to get health services by the GK's PHC programme?
11. What are the strength, weakness and limitations of PHC of GK?
12. According to your accord, what step can be taken for making more effective the PHC of GK.?
13. What steps are needed to reduce the maternal mortality and infant mortality in your community? For this reason what step should take by GK as your opinion? What are the more steps should be taken by GK for achieving the MDG within 2015 AD
- 14What are the excess information without the above information which is provided by GK PHC program?

Study on CPHC of GK
Checklist for Upazila Family planning officer

1. How many days you are working here?
2. What types of PHC you provide in the community?
3. What are the processes of PHC?
4. What types of Government health services provided in your locality without GK and others?
5. What are the major health problems of your locality? There are health problem are given below? Please tell on the priority basis?
 - i) Pregnant women care
 - ii) Safe delivery
 - iii) Mother and child care
 - iv) Child health care
 - v) Family planning
 - vi) General health care
 - vii) Emergency health care
 - viii) Water and sanitation
 - ix) Others (mentions)
6. What type of health service GK provide in your community? What are the contributions of GK in case of health problem? What are the effective positive results of them? How these results have possible?
 - i) Pregnant women health service and care
 - ii) Safe delivery
 - iii) To reduce maternal and child care
 - iiii) Child health care
 - v) Immunization
 - vi) Family planning
 - vii) General health care
 - viii) Emergency health care
 - ix) Water and sanitation
 - x) Birth and death registration
 - xi) Others (mentions)
7. What types of activities conducting according to coordination with other health service provider? What types of benefited according to coordination?
8. What types of role play GK for the awareness of the community people? What type of change happened among the community? In case of special health, what types of change in belief and behavior?
9. What types of role of the community involvement in the PHC programme of GK?
10. What types of role played the GK's PHC for marginalized people? How the marginalized people becoming beneficiary the health insurance card?
11. How much differences have occurred in your community to get health services by the GK's PHC programme?
12. What are the strength, weakness and limitations of PHC of GK?
13. According to your accord, what step can be taken for making more effective the PHC of GK.?
14. What steps are needed to reduce the maternal mortality and infant mortality in your community? For this reason what step should take by GK as your opinion? What are the more steps should be taken by GK for achieving the MDG within 2015 AD

15. What are the excess information without the above information which is provided by GK PHC program?

Checklist for (VOSD) NGO at losmonpur Sherpur

1. How many day you are working here?
2. What types of PHC you provide in the community?
3. What are the processes of PHC?
4. What types of Government health services provided in your locality without GK and others?
5. What types of GK provide PHC?
6. How much effective of GK PHC programme?
7. What are the strength and weakness of GK PHC programme?
8. What are the excess information without the above information which is provided by GK PHC program?



GK Sign board beside road



Paramedic provide health education through yard meeting



Doctor checking the patient at community level



Doctor checking the patient at community level



FGD session (Researcher and community members)



GK health center at Losmonpur (study village)



Paramedic carrying the pregnant women from community level to health center



Paramedic sharing with elderly person at the community level



Paramedic providing health education among pregnant women through yard meeting