

Gonoshasthaya Kendra: From the right to health to integral community development in Bangladesh



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Colophon

Gonoshasthaya Kendra: from the right to health to integral community development in Bangladesh

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FOREWORD

GK started off as a field hospital during the independence war in 1971. GK, which means “the People’s Health Centre”, set out with the key objective of “health care for all”. Concentrating on the poor, GK began by providing preventive and primary health care in the surrounding rural areas where access to health services was almost non-existent. Over the years, GK has developed a whole range of social protection services, since good health does not only depend on good health services. GK now runs programmes in many different fields such as education, vocational training, nutrition, agriculture, income gen-

eration and vaccine and drug research. Key to the success of this integrated approach is the empowerment of the poor, in particular women and children. The organisation currently employs 5.450 persons.

World Solidarity has been a longstanding and very proud partner of GK because we share the same vision on sustainable development. With the present thematic report, World Solidarity would like to show its recognition



1

INTRODUCTION TO BANGLADESH

Bangladesh, officially the **People's Republic of Bangladesh**, is a sovereign state located in South Asia. It is bordered by India on all sides except for a small border with Myanmar (Burma) to the far southeast and by the Bay of Bengal to the south. The capital is Dhaka, the hub of all cultural, political and social affairs.



The total area of Bangladesh is 147,570 km². In that area, over 150 million people live together, making it one of the world's most densely populated countries with approximately 1019 people per square kilometer (km²). About 48% of the population is female. The people from Bangladesh are called Bangladeshi and they grow every year with 1.34%.

A high poverty rate prevails, with 40% of the population living below the poverty line, although the United Nations have acclaimed Bangladesh for achieving progress in human development over the last decades with improvements in a range of social indicators such as education and the health of mothers and children.

Bangladesh faces a number of other major challenges, including widespread political and bureaucratic corruption as well as ever recurring natural calamities. Natural calamities, such as floods, tropical cyclones and tornadoes occur almost every year making Bangladesh one of the countries most vulnerable to climate change. These calamities seriously affect agriculture, water & food security, human health and shelter, making the fight against poverty even more difficult.

1.1. Politics

Bangladesh is a unitary state and parliamentary democracy. Direct elections in which all citizens, aged 18 or over, can vote are held every five years for the unicameral parliament known as Jatiya Sangsad. Currently the parliament has 350 members including 50 reserved seats for women, elected from single-member constituencies. The Prime Minister, as the head of government, forms the cabinet and runs the day-to-day affairs of state. The President is the head of state.

The Constitution of Bangladesh was drafted in 1972 and has undergone 15 amendments. The highest judicial body is the Supreme Court. Justices are appointed by the President.

Major parties in Bangladesh are the Bangladesh Awami League, the Bangladesh Nationalist Party (BNP) and Jamaat Islami Bangladesh, Jatiya Party (National Party). Student politics is particularly strong in Bangladesh, a legacy from the liberation movement era. Almost all parties have highly active student wings.

A large alliance led by the Bangladesh Awami League won the December 29, 2008 poll, in a landslide victory. They won 230 of the 300 seats in the parliament.

1.2. Social

The majority of Bangladeshis are Bengali, comprising 98% of the population. The remainder are mostly Biharis and indigenous tribal groups. The indigenous tribal peoples are concentrated in the Chittagong Hill Tracts in the southeast. There are 13 tribal groups located in this region, the largest being the Chakma. Outside the Hill Tracts, the largest tribal groups are the Santhals and Garos (Achiks), while smaller groups include the Kaibartta, Meitei, Munda, Oraons, and Zomi.

Nearly all Bangladeshis speak Bangla as their mother tongue and it is the official language. English is used as a second language among the middle and upper classes. English is also widely used in higher education and the legal system.

The main religion practiced in Bangladesh is Islam (89.6%), but a significant percentage of the population adheres to Hinduism (9.3%). Other religious groups include Buddhists (0.7%, mostly Theravada), Christians (0.3%, mostly of the Roman Catholic denomination), and Animists (0.1%). Bangladesh was founded as a secular state.

1.3. Economy

Despite continuous domestic and international efforts to improve economic prospects, Bangladesh remains a developing nation. However, Bangladesh gradually decreased its dependency on foreign grant and loan from 85% (in 1988) to 2% (in 2010) for its annual development budget. Its per capita income in 2010 was US\$ 641 compared to the world average of US\$ 8,985. The country has achieved an average annual growth rate of 5% since 1990, according to the World Bank.

Bangladesh grows very significant quantities of rice, tea, potato, mango, onion and mustard. According to FAOSTAT, Bangladesh is one of the world's largest producers of: Rice (4th), Potato (11th), Mango (9th), Pineapple (16th), Tropical Fruit (5th), Onion (16th), Banana (17th) and Tea (11th). However, Bangladesh still needs to import rice (from Thailand, India, Burma and Vietnam) since it doesn't produce enough to feed all.

Although two-thirds of Bangladeshis are farmers, more than three quarters of Bangladesh's export earnings come from the garment industry, which began attracting foreign investors in the 1980s due to cheap labour and low conversion cost. In 2009-2010, the industry exported US\$ 12.6 billion worth of products, whereas in 2002 the exports amounted to US\$ 5 billion. Recently Bangladesh has been ranked as the 4th largest clothing exporter by the World Trade Organisation (WTO). The industry now employs more than 3 million workers, 90% of whom are women. A large part of foreign currency earnings also comes from the remittances sent by Bangladeshi living in abroad.

In order to enhance economic growth, the government set up several export processing zones to attract foreign investment. These are managed by the Bangladesh Export Processing Zone Authority.

1.4. Culture

Reflecting the long history of the region, Bangladesh has a culture that encompasses both traditional and contemporary elements. The Bengali language boasts a rich literary heritage, which Bangladesh shares with the Indian state of West Bengal. The earliest literary text in Bengali is the 8th century Charyapada. Medieval Bengali literature was often either religious or adapted from other languages. Bengali literature reached its full expression in the 19th century, with its greatest icons being poets Rabindranath Tagore, Michael Madhusudan Dutt and Kazi Nazrul Islam.

The musical tradition of Bangladesh is lyrics-based (Baniprodhan), with limited instrumental arrangements. Folk music is often accompanied by the ektara, an instrument with only one string. Bangladesh also has an active heritage in North Indian classical music. Similarly, Bangladeshi dance forms draw from folk traditions, especially those of the tribal groups, as well as the broader Indian dance tradition.

Bangladesh produces about 80 films a year. Mainstream Hindi films are also quite popular. Around 200 daily newspapers are published in Bangladesh, along with more than 500 periodicals. However, regular readership is low at just under 15% of the population.

The culinary tradition of Bangladesh has close relations to nearby North-East Indian and Middle Eastern cuisine as well as having its own unique traits. Rice, and fish are traditional favorites. Biryani is a favourite dish of Bangladesh and this includes egg biryani, mutton biryani and beef biryani.

The sari (shaṛī) is by far the most widely worn dress by Bangladeshi women. A guild of weavers in Dhaka is renowned for producing saris from exquisite Jamdani muslin. The salwar kameez (shaloar kamiz) is also quite popular, and in urban areas some women wear



western attire. Among men, western attire is more widely adopted. Men also wear the kurta-paejama combination, often on religious occasions, and the lungi, a kind of long skirt for men.

Eid ul-Fitr and Eid ul-Adha, being the most important holidays in the Islamic calendar, are the subject of major festivals. The day before Eid ul-Fitr is called Chād Rat (the night of the moon) and is often celebrated with firecrackers. Eid ul-Adha is celebrated in the memory of great sacrifice of Prophet Abraham. Major Hindu festivals are Durga Puja, Kali Puja and Saraswati Puja. Buddha Purnima, which marks the birth of Gautama Buddha, and Christmas, called Bôrodin (X mas), are both national holidays. The most important secular festival is Pohela Baishakh or Bengali New Year, the beginning of the Bengali calendar. Other festivities include Nobanno, Poush parbon (festival of Poush) and observance of national days like Shohid Dibosh and Victory Day.

1.5. Education

Article 17 of the Bangladesh Constitution provides that all children between the ages of six and ten years receive a basic education free of charge. The literacy rate in Bangladesh stands at 56.5% in 2009. There is a clear gender disparity though, as literacy rates are 62% among men and 51% among women, according to a 2008 UNICEF estimate.

The educational system in Bangladesh is three-tiered and highly subsidized. The government of Bangladesh operates schools in

the primary (from grades 1 to 5), secondary (from grades 6 to 10), and higher secondary (from grades 11 to 12) levels. However, there are many areas where there are no schools. Education is mainly offered in Bangla, but English is also commonly taught and used.

Universities in Bangladesh are mainly categorized into three different types: public university (government owned and subsidized), private university (private sector owned universities), and international university (operated and funded by international organizations). There are 34 public universities and 34 private universities in Bangladesh.

1.6. Health

Public health is a constitutional obligation for the government, according to Article 18 of the Constitution which reads as follows: "The State shall regard the raising of the level of nutrition and the improvement of public health as moving its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and drugs which are injurious to health"¹.

Over the last few decades, Bangladesh has made significant progress in health outcomes. According to the World Health Organisation (WHO), most of the health indicators show steady gains and the health status of the population has improved².

Health indicators	1990	2007
Under five mortality rate (per 1.000 live births)	144	65
Infant mortality rate (per 1.000 live births)	94	52
Maternal mortality (per 1.000 live births)	4,8	3,2
Proportion of births attended by skilled personnel	7	17,8%
Life expectancy at birth (both sexes)	N/A	66,6 years



¹ See 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.
² Country Health Profile, WHO Country Office in Bangladesh: <http://www.whoan.org/EN/Section28.htm>.

An important factor in improving health is of course a **functional health system**: such a system consists of all the facilities (health care centres), the people (medical staff) and actions (all kinds of health care services) whose primary objective is to deliver accessible, affordable and good quality health care services. Health services are provided both through public and private sectors, with the latter becoming more important every day.

FACILITIES AND HEALTH CARE SERVICES

Bangladesh is divided into seven administrative divisions. Divisions are subdivided into districts or zila. There are 64 districts in Bangladesh, each further subdivided into upazila (subdistricts) or thana. These are subdivided into several unions, with each union consisting of multiple villages. The health care pyramid follows this administrative division.

- **Level 1 – services at community level:** health care workers, from the public sector but often from NGO's, bring health care to the doorstep by visiting homes at specified intervals. They provide limited curative care, contraceptive services as well as health education.
- **Level 2 - services at union level:** the union is the first administrative unit which disposes of a health facility, the union health center (UHC). Approximately 1.312 such union health centers are operating in Bangladesh³. The average population of each union is 2000. They provide limited curative care, contraceptive services, health education as well as post conception contraceptives.
- **Level 3 – services at upazila level:** each upazila or subdistrict consists of 8 to 12 unions. The “upazila health complex” (UHC) delivers primary health care (preventive and curative services) and emergency care. It often has an ambulance and patients can stay overnight. In principle, the UHC has a staff of 14 doctors, but only 4 doctors are available on any given day. Overall, 421 UHC operate throughout the country with about 16.000 beds available⁴.
- **Level 4 – services at district level:** at this level, people can access secondary health care services in the district hospitals. Preventive, promotive and curative care are available at this level in one of the 62 district hospitals around the country⁵.
- **Level 5 – services at divisional and national level:** tertiary-level curative care is mostly provided at divisional and national levels through large hospitals affiliated with medical teaching institutions.

MEDICAL STAFF⁶

Bangladesh has managed to develop a nation-wide network of medical colleges, nursing and paramedical institutes. There are 59 medical colleges (41 of them are private), 13 nursing colleges (7 of them are private), 69 nursing institutes (22 of them are private), 17 medical assistant training schools (10 of them are private), and 16 institutes of health technology (13 of them are private). Despite all this, the country still faces an important shortage of health workers (doctors, paramedics, nurses and midwives). The nurse–doctor ratio is among the lowest in the world. While the majority of people live in rural areas, the majority of health professionals work in urban areas. Vacancy rates in government health services in remote subdistricts (upazilas) are much higher than those near major cities.

Number of registered doctors	49,994
Doctors at work in public sector	12,382
Number of registered nurses	23,729
Nurses at work in public sector	14,377
Doctor – nurse ratio	2/1
Number of registered midwives	22,253

PRIVATE SECTOR

The private sector has become an important player in the health sector in recent years. There are now private, and thus for-profit facilities at all levels delivering mainly curative services. These services are obviously unaffordable for the poor. The private sector is also very active in medical education (see above under “medical staff”). Since health is a fundamental right, the Government has the obligation to regulate and control the private sector with a view to ensuring that the health workers are properly qualified and that the services meet quality standards. For the moment, though, such regulation and supervision of the private sector has not yet been put in place.

NON-GOVERNMENTAL INITIATIVES (NGOS)

NGO's are complementing the public health system. As mentioned above, the public system is very much present in the cities. As a result, NGO's, like GK, have focused primarily on the rural areas where the majority of people live and work. An exact number of the NGO's active in the health sector is not available. Gonoshasthaya Kendra (GK) is one of the pioneers and still one of the most recognized social organizations active in the area of health care. In the next chapter, an overview will be given of the comprehensive social protection services they offer, based on their integrated approach to health care.

³ Directorate-General of Health Services: data available at http://dghs.gov.bd/inst_info/other/usc.php.

⁴ Directorate-General of Health Services: data available at http://dghs.gov.bd/inst_info/other/uhc.php.

⁵ Directorate-General of Health Services: data available at http://dghs.gov.bd/inst_info/other/dlh.php.

⁶ Country Health Profile, WHO Country Office in Bangladesh: <http://www.whoban.org/EN/Section28.htm>.



Conclusion

With regards to the public sector, one has to acknowledge that health facilities are available, but that they are most concentrated in urban and peri-urban areas. In spite of all those services being available at different levels, **utilisation of the services by the population is comparatively low**, according to the WHO. If people do not attend the public health care services, they often take recourse traditional and/or spiritual leaders.

The low utilization rate has to do with the **difficult accessibility in geographical** (no or very few health facilities in remote rural areas) **and financial** (cost of the services) **terms**. Moreover, the poor quality of the services keeps people away from the public health care facilities. This **poor quality** is due to lack of funding, weak infrastructure, shortages of or lack of adequately educated medical staff. Indeed, the **shortage of qualified health workers** remains an important challenge.

Even though the private for-profit sector is also delivers services, it has to be emphasized that the Government bears the human

rights obligation⁷ to improve the access of whole the population, including those living in very remote areas, to quality services and to increase the responsiveness of the service delivery system to the needs and demands of the population (people-centred care).

Dr Kadir on the health care services in Bangladesh

“A lot more health care services are needed. The government services are insufficient and often function badly. They fulfil the needs of only 30% of the entire population. Moreover, there is a lack of personnel, medicines and hospital beds. Another large problem in Bangladesh is the way people are informed about diseases and health care in general. In some villages, people are told that they should not give water to their child if it suffers from diarrhoea, but not giving water is very dangerous. Privatization of the sector is another big problem. For many companies it is easy to use the lack of health care services to establish private hospitals and institutions, to which only the rich have access⁸.”

⁷ Based on Article 18(1) of the Constitution as well as Article 12 of the International Covenant on Economic, Social and Cultural Rights, ratified by the Government of Bangladesh on 5 October 1998.

⁸ Lieven Van Den Bulck, Interview with Dr Kadir, in *Visie*, 8 april 2011.

2

GONOSHASTHAYA KENDRA

2.1. The origins of GK

Gonoshasthaya Kendra (hereafter GK) started off as a field hospital with 480 beds for the wounded freedom fighters and Bangladeshi refugees during the liberation war in 1971. The **Bangladesh Field Hospital** was established at Melaghar in Tripura state of India, with the help of the Provisional Bangladesh Government. A few doctors from Bangladesh, some medical students and university and college girls joined as volunteers.

Following independence, the **Bangladesh Field Hospital** was relocated to Dhaka. At the same time, many of the volunteers and doctors linked to the hospital, realized that millions of people in the rural areas had no access at all to any kind of health care facilities.

On 27th April 1972, 22 volunteers and doctors moved to the village Bais Mile in Savar, 40km north of the capital Dhaka. Their objective: **"Grame Cholo Gram Goro"** which means "let us go to the village and build the village". The organisation was re-named as **Gonoshasthaya Kendra (GK)**, which means the "People's Health Centre"; it was registered as a Public Charitable Trust in 1972.

Very soon, the workers began to realize that it would not be possible to provide the villagers with good health care services without involving the community as a whole. This **transformative approach** of GK translated itself into 2 key visions of the GK movement:

- Firstly, **the fate of the poor decides the fate of the country;**
- Secondly, **development of the country depends on the development of women.**

The doctors and the volunteers resided in 6 tents at Savar. Improving the health care services for the rural population, especially women and children, became the entry point for what was, and still is, in reality a vast programme of community development. Indeed, GK did not limit its interventions to health care but, looking at the context in which the rural population lived and in close consultation with them, they developed other services which would improve the living and working conditions of the villagers. This integrated or holistic approach is a key feature of GK's policy. As a result, GK is not just an NGO active in health care, it is a community development organization.

Very soon GK's holistic or integrated approach gained recognition, in Bangladesh and beyond. GK was awarded the highest national award, the **"Independence Day Award"** in 1977 for its contribution to integrated community health and family planning services. The GK programme was then accepted as one of the three main background papers for the **International Conference on Primary Health Care**, which was convened in Alma-Ata in September 1978. The innovation of the programme was regarded as a turning point for health care services in developing countries.

During the last four decades, GK has increased its coverage from 50,000 people in 50 villages in 1972 to almost 1.2 million people in the rural areas of Bangladesh through a network of 39 primary health care centres, 5 referral hospitals and 2 tertiary-care hospitals. GK is present in 608 villages across 38 unions in 40 sub-districts in 17 districts across the country, making GK the largest health care service provider apart from the government of Bangladesh.



2.2. Vision, objectives and strategies of GK

The liberation war in 1971 was a turning point in the history of Bangladesh. The country gained independence for a start. But more importantly, the post-liberation period was a time of euphoria for many young people who were thinking with vision and excitement about the possible future of their communities. Among those young people was also Dr Zafrullah Chowdhury, one of the doctors who established the Bangladesh Field Hospital and, as such, one of the founders of GK.

2.2.1. THE VISION: BUILDING THE NATION WITH THE POOR AND WITH WOMEN

The fate of the poor decides the fate of the country

In a recent interview, he stressed yet again, 40 years after the foundation of GK how important the poor are in building up the nation after the devastation wrought by the war: "When independency was a fact in 1971, I told everyone that poor people were also needed to rebuild the country. The belief of the poor is the country's belief. If they have faith in the future, their country has a future. If they haven't got the faith, the country doesn't have a future"⁹. Through discussions with villagers and observation of local lifestyles as well as by involving the communities in their work, GK can constantly adapt its interventions and programmes to the realities of the people in the villages. People in the villages are not the mere beneficiaries of GK's programmes: they are the agents, taking responsibility of their health, education etc.

Development of the country depends on the development of women

At the same time, he was convinced that no development would be possible without the full and effective participation of women. In their first proper base, those 6 tents in Savar, Dr Chowdhury trained 600 girls to become nurses. It was a revolutionary thing to do.

Ms Maya Altafunessa, current coordinator of GK, on women empowerment

"Most of these girls that were trained in those days by Dr Chowdhury, you have to understand, could not read or write, would never even obtain a degree. All of a sudden, they received a proper education. In return, though, GK expects them to work for the movement as paramedics for a couple of years. This means they take the bike, go the furthest corners of the country and provide basic health care on the doorstep"¹⁰.

When asked whether people liked their approach to women emancipation, Ms Altafunessa wholeheartedly admits that many people were totally against: "Especially the religious fundamentalists were outraged. One thing was that we provided young girls with education. But then we also sent these girls on bikes without a veil (burka) to the villages to work as paramedics. They found that unacceptable in Bangladesh at the time. In the beginning, some of our paramedics were physically attacked. Fortunately, we were able to turn the tide by explaining to the men that their work had many advantages. For example, their wives did not need to make long and costly trips to the city to see a doctor as medical care came right to the doorstep"¹¹. Dr Chowdhury adds: "In our education programmes, we do not allow women to wear burkas. Sometimes, Muslims accuse us of renouncing and violating our culture. I always ask myself the same question: "What does our culture mean"? What does law and abiding by the law mean? I always compare the idea with eating. Muslims do not eat certain things. It's impossible to say that the things you don't eat are bad, isn't it? How can you know if you have never eaten it? The same goes for culture. How can you know if something you do is good or bad if you have never done it?"¹².

2.2.2. THE OBJECTIVES

As explained above, GK's overall objective is to use primary health care as an entry point to work with the people for the people to develop a equitable, self-reliant and socially just society. To achieve this, GK pursues the following specific objectives:

- Develop a people-oriented health-care system which provides comprehensive health care and makes people aware of their health issues;
- Promote education among the poor, particularly poor women and children;
- Respect women's rights and change their status in society;
- Work with people on their economic emancipation by organizing income-generating activities;
- Advocate to influence policy at the national and international level which will directly and indirectly benefit the poor;
- Raise awareness about fundamentalism and communal violence and protect the interests of minority groups;
- Undertake disaster relief and rehabilitation programmes; and, finally
- Promote self-reliance by engaging in more commercial activities to become less dependent on donors.

⁹ Katrien Vandeevegaete, interview with Dr Zafrullah Chowdhury, OKRA Magazine, February 2012.

¹⁰ Katrien Vandeevegaete, interview with Maya Altafunessa, OKRA Magazine, February 2012. Alma Dewalsche en Sara Cools, interview with Maya Altafunessa, MO*, 28 May 2011.

¹¹ Katrien Vandeevegaete, interview with Maya Altafunessa, OKRA Magazine, February 2012. Alma Dewalsche en Sara Cools, interview with Maya Altafunessa, MO*, 28 May 2011.

¹² Katrien Vandeevegaete, interview with Dr Zafrullah Chowdhury, OKRA Magazine, February 2012.

2.2.3. THE STRATEGIES

To achieve all these objectives, GK developed a whole range of innovative strategies. Furthermore, these strategies explain the success of GK over the last 40 years.

a. Understanding rural reality

GK staff constantly travels to the rural areas because there is no better way to really understand the living and working conditions in these areas. Through discussions with villagers and observation of local lifestyles, GK has learned to design its development activities to fit rural people's needs. Moreover, even in the GK headquarters in Savar, all GK staff, including the senior directors, have to take part in the agricultural morning work: this raises their awareness of agricultural concerns and the villagers' life, fosters community ties and solidarity among the GK staff and ensures an efficient use of GK's land. As a consequence of this approach, GK paramedics visit people in their villages rather than expecting them to travel to the medical centre. GK also uses the Bengali calendar instead of the European one when dealing with villagers.

b. Grassroots leadership

GK places a strong emphasis on employing people from the grassroots into leadership positions. Staff who are firmly rooted in the villages serve as role models for their communities and earn GK a lot of credibility within these communities. This also explains why GK has invested a lot in training and working with the village women who traditionally assisted deliveries in their villages, the so-called traditional birth attendants (TBAs). These TBAs are culturally accepted by the people in the village, so just replacing them by a doctor was not an option for GK. Instead, GK chose to medically train these TBAs.

c. Gender equality and equity

GK's approach towards gender equality and equity combines the improvement of women's material well-being with strategies for empowerment. GK offers so many women the chance to study and work. In that process, GK seeks to demonstrate to the trainees themselves and to the society at large that women can perform roles other than those traditionally ascribed to them. A day care centre (crèche) at the GK headquarters enables women to work and study despite the demands of motherhood. GK women are entitled to six months maternity leave, four months with full pay. They are paid through a bank rather than in cash, to encourage to save and make use of bank facilities. It helps them to have some degree of autonomy within their families, in which traditionally male members have control of the family purse, including the women's earnings.

As many women commute between their homes and the GK headquarters, they have become an active link between the organisation and its communities. Most women have gained new status in their villages where they are no longer perceived merely as wives, sisters or daughters: for the first time in their life, they are recognised for their own merits as villagers come to them to seek advice in matters such as family planning, health and nutrition.

d. Community-based

GK firmly believes that decentralization, community participation and involvement of local government are key to the success of their programmes. GK ensures community participation in health service delivery by establishing a Gonoshasthaya Health Committee at union level. All strands of society are represented: the local authorities, the TBA, the local imam/priest and the villagers. GK also involves elected representatives of local government in the joint management and monitoring of GK's programme. The local authorities means the members of the "union parishad" or community council: every "union parishad" can elect 3 members for the committee and one of the female members holds the chairmanship of the committee. Considering that the Chairperson of the Committee is one of three signatories of all local accounts of GK, then there is no doubt as to whether GK involves the community effectively.

e. Social inclusion

An important aspect of GK's overall policy is its secularism. Muslims and non-Muslims work, eat and live together at GK. They are treated equally and their respective religious festivities are acknowledged and celebrated. As a result, the organisation is actively involved in campaigning against fundamentalism and communal violence. GK has also shown a strong commitment to the rights of indigenous peoples in the country. In order to promote the language and culture of indigenous people, teaching in the Chittagong Hill Tracts is taking place in their languages. Local teachers are recruited from the indigenous population and a curriculum is designed that relates to their culture, traditions, language and history.

Other very vulnerable people have found a new sense of dignity at GK. Destitute women who have been abandoned by their husbands, for example, can join communal life in the GK headquarters, where they receive education and vocational training. People with physical disabilities, often left to their own device by the State as well as their families since disability is considered a curse, also find refuge at GK: they receive shelter and a job just like all the others.

f. Communal lifestyle

Another important aspect of GK's overall policy is its communal lifestyle. In fact, the 6 tents once set up in Savar in the early 1970s have evolved into a real community, the GK community. Here, the GK headquarters are established providing accommodation, catering, educational facilities, a school and a day care centre for the students' and workers' children, a hospital offering health and family planning services, various workshops, a bank etc. And of course land on which the community works and grows its own food. Directors, doctors, staff and students all live and work together. The fact that non-family related men and women work, eat and live together on a daily basis is highly unusual but it strengthens collective relationships, solidarity networks and group consciousness.

2.3. GK in the field

A strong vision, a clear set of objectives and innovative strategies to go about it: on such a solid foundation, GK was able to develop its activities in the field. In what follows, an overview is given of the most important actions of GK in the field.

2.3.1. DEVELOP A PEOPLE-ORIENTED HEALTH-CARE SYSTEM WHICH PROVIDES COMPREHENSIVE HEALTH CARE AND MAKES PEOPLE AWARE OF THEIR HEALTH ISSUES

a. Medical staff: central role for the paramedics

Central to GK's primary health care model are its paramedics, who are predominantly young women from rural areas. The training of these women to become community health workers is one of GK's most innovative programmes. In the early days, these women could not read or write. Nowadays, many of them have enjoyed some schooling. At the same time, GK continues to recruit girls from poor families in which no one has a stable income. By giving the opportunity to one family member, the young girl, to become a paramedic, the family gains an income which is crucial in the poverty-stricken rural areas of Bangladesh.

In the early 70's, the female paramedics were also trained to ride a bicycle which was contrary to the village customs at the time. The bike, however, remains a key tool for GK in bringing health care services to the most remote areas of the country. It was a significant challenge for GK to convince the women in the villages, where traditions are strong, to become a health worker. Once trained, the challenge shifted to the other villagers: convincing them of accepting these paramedics in their communities. As explained above, the female paramedics faced abuse and intimidation by the traditional village leaders in the beginning. Following dialogue and a great deal of perseverance, the GK paramedics are now well respected.

b. Comprehensive package of medical services

The female paramedics carry out most of the health activities in the villages. **They go from door to door, visit everyone in the community** - women, children, the elderly, people with disabilities - and treat them in their houses. The paramedics keep records of all information including vital events (birth, death or migration of community members) and report these on a monthly basis. Usually one paramedic looks after 900-1000 families in 1-4 villages.

The paramedics provide **primary health care, both preventive and basic curative services**, such as:

- vaccinations;
- treatment of common diseases;
- antenatal and postnatal check up;
- child care;
- nutritional and family planning advice;
- physiotherapy and ayurveda;
- regular checks of blood pressure; etc.

The GK paramedics also discuss personal hygiene with the people they visit, and as a consequence, they help with cutting people's nails if needed and treat scabies and lice. For all maternal health care, the paramedics have joined forces with the traditional birth attendants (see below).

When a paramedic is faced with a problem she or he cannot deal with, they can call upon a doctor for support. There is in principle 1 supervisor per 6 paramedics. Paramedics serve as the front-line workers and refer complicated cases to a hospital for secondary or tertiary health care.

In 1993, GK initiated its urban health programme with the aim of improving health care services for the urban poor. For this group, the services are provided in "satellite clinics" in key areas. These are run in collaboration with community leaders, factory owners, schools and mosques: they provide a venue (a school, factory,...) where the GK medical team can receive and treat the people.

c. Reproductive health care: paramedics joining forces with the traditional birth attendants

The "traditional birth attendant" (hereafter referred to as TBA) is an integral part of the social fabric in rural Bangladesh. They are usually middle aged (45+) village women, respected members of the community, who have inherited ancient indigenous medical skills. Because of their status, these women have a confidential relationship with the young women in the village. Since time immemorial, the TBA's assist women during delivery of their children. Estimates indicate that **around 80% of all deliveries in Bangladesh take place in the household, in the presence of a traditional birth attendant.**

Very soon GK realized it should work with these TBA's in order to improve the health status of mothers and their newborn babies. For all deliveries, the TBA remains the reference, but **they are assisted by a paramedic and a doctor.** Moreover, TBA's are now **continuously trained** for 5 to 7 days per year to reduce maternal and infant mortality rates.

The paramedics visit every newborn at least twice within the neonatal period. About 35% of the newborns are visited within the first 48 hours, while 80% babies are visited within 7 days following birth. 20% of the newborns are usually checked by a doctor. Every infant and maternal death is thoroughly investigated and discussed in the next village meeting. Things that went wrong are noted and measures undertaken to prevent this from happening in the future.

Another very innovative initiative in the field of antenatal health care deals with the relation between the daughter-in-law and her mother-in-law (Bou-Shshuri Mela). In communities, GK paramedics seek to convince mothers-in-law to adopt their daughters-in-laws as their own daughters and treat them better by allowing them to eat first and have 3 to 4 hours of midday rest. Many pregnant women need balanced food and rest to allow the foetus to gain sufficient weight.



GK and MDG 5

DG 5 has two targets: to reduce the maternal mortality ratio by three quarters by 2015 and to achieve universal access to reproductive health care. The approach of GK towards reproductive health is based on the firm conviction that **maternal mortality is not merely an abstract statistic. It is the reminder of a face, a person lost in the prime of her life**¹³. From the strategies described above, it is clear that the Government of Bangladesh could achieve universal access to reproductive health if it replicates GK's model of a real "health team" (which consists of well-trained TBA's, the paramedics and doctors) which links up with the "village development committee", where local government officials, members of the community as well as GK staff discuss the death of babies and mothers. Even the World Bank acknowledges the merits of GK's approach: "On maternal mortality, GK has achieved a rate of 186 deaths per 100,000 live births, which is 42% lower than the national average. **GK is likely to attain the MDG 5 target in its areas of intervention.**"¹⁴

d. Health care financing: the health insurance scheme of GK

In Bangladesh, health care services are free of charge in the facilities (centers, clinics, hospitals, etc) **run by the Government**. In practice, however, public health care facilities are concentrated in the urban centers and not widely available in rural areas where the majority of the population lives. Where facilities exist, there is a lack of qualified staff and poor equipment.

In such circumstances, the wealthy Bangladeshi have themselves treated in private for-profit health care clinics. **The poor Bangladeshi have the option of inadequate** (if they still can reach a facility) **or no care at all**. At least, these were the options until GK started its operations.

In order to finance its curative health services, GK put in place a health insurance scheme in 1975, the oldest of its kind in Bangladesh. The preventive and promotive services are still free of charge. The purpose of this social insurance is to pool the risks among all members of the community, and as a result the costs of the services drop significantly for all. At the point of service delivery, **GK works with co-payment**: those who are insured, will pay only a small percentage of the total cost of the services and medicines given.

The most striking feature of GK's health insurance is its progressive nature: **the level of the premiums and co-payments, which people pay, vary according to their income**. To that

end, GK undertook a vast socio-economic survey to classify households in its intervention areas in 1974. In the beginning there were only three groups: poor, middle class and rich. But nowadays GK has five socio-economic groups to take better account of the conditions in which especially the poor live. In what follows, an overview is given of some of the key indicators GK staff look at while assessing someone's socio-economic status.

- Land ownership: landless or landowner
- Assets: utensils, furniture, electronic goods, domestic animals, etc;
- Job: regular or irregular income, formal or informal economy, etc;
- Housing: roof, walls, door, windows, veranda, ...;
- Water and sanitation: source of water, type of latrines, tube well, ...;
- Food intake: number of meals and type of food;
- Gender;
- Support from the local administration;
- Connections to roads;
- Access to credit;
- Access to education and health.

The indicators for this classification exercise are constantly assessed by GK¹⁵, explaining the evolution of 3 socio-economic groups in the early 70's to 4 groups mid-90's and finally 5 groups since 2003. These groups are the following:

- **Destitute**: neglected widow or widow from landless family,

¹³ These words are taken from Ms. Nasreen Pervin Huq, a Bangladeshi activist for women's right to live. The following book of GK was dedicated to her: R. Chaudhury and Z. Chowdhury, "Achieving the Millennium Development Goals on Maternal Mortality – Gonoshasthaya Kendra's experience in rural Bangladesh", Gono Prokashani, January 2008, pp. 188.

¹⁴ To the MDGs and Beyond: Accountability and Institutional Innovation in Bangladesh, World Bank Office Dhaka, January 2007, p. 53 and following; R. Chaudhury and Z. Chowdhury, "Achieving the Millennium Development Goals on Maternal Mortality – Gonoshasthaya Kendra's experience in rural Bangladesh", Gono Prokashani, January 2008, p. 78-81.

¹⁵ The socio-economic survey is primarily conducted by the paramedics who go from house to house to collect basic demographic, economic and social data.

women abandoned by their husband, beggars, physically and mentally disabled;

- **Ultra Poor:** landless farmers, door-to-door vendors, daily wage workers and all other households with no regular income source. Those families who cannot afford two meals a day regularly. They do not have any fixed assets.
- **Poor:** small farmers (less than one acre of land), small shops, small business, and low paid job. They have some sort of regular income. Those families who can somehow afford two meals a day. Have some assets.
- **Middle class:** farmers with 2 to 3 acres of land, keepers of permanent small stalls in the market place, have formal jobs,

owners of rickshaws or boats. They have a fixed income. With their income, they can afford all expenditures of the family including the education of the children. Have various assets. They can save money at the end of the year after all expenditures.

- **Rich:** farmers holding more than 3 acres of land, owners of bigger shops and businesses, middle and upper class officers and professionals in the private sector. With their income they can afford all expenditures of the family including the higher education of the children. Have various luxurious assets. They save money at the end of the year after all expenditure.

Table 1 Social class based health insurance scheme

Social class	Annual premium per family for non-smokers	Annual premium per family for smokers
Destitute	Taka 5.00	Taka 7.00
Ultra poor	Taka 6.00	Taka 8.00
Poor	Taka 10.00	Taka 12.00
Middle class	Taka 50.00	Taka 60.00
Rich	Taka 80.00	Taka 100.00

The health insurance system of GK requires a family to pay a fixed premium per year (see table 1). For curative services, the insured family then pays for consultation services and certain percentage of the drug and other costs (co-payment) (see table 2).

Table 2 Charges for consultations and medication scheme

Social class	Consultation	Medication	1st specialist consultation	Subsequent specialist consultation
Destitute	Taka 2.00	Free	Free	Free
Ultra poor	Taka 3.00	Free	Free	Free
Poor	Taka 5.00	75%	Taka 20.00	Taka 15.00
Middle class	Taka 10.00	100%	Taka 75.00	Taka 50.00
Rich	Taka 12.00	100%	Taka 100.00	Taka 75.00
Without health insurance	Taka 15.00	100%	Taka 125.00	Taka 100.00

This progressive health insurance scheme is very successful: the fact that over 1 million people are covered by it demonstrates that such a system, if intelligently conceived and adapted to the local context, is viable. Fully in line with the basic ideas of social justice and fairness, **the stronger shoulders are requested to bear a larger part of the burden.** As a result, the destitute, ultra poor and poor pay very small premiums and the first two groups do not pay anything at all for their medication and specialist consultations. The system builds and fosters **solidarity between the members of the same community** and strengthens social inclusion. Moreover, GK has noted that for many of the communities it serves, paying a small amount towards their services is also a matter of dignity: they deserve quality services! In Bangladesh, people often regard free services as bad services, which is all too often true in the public health system.



Dr Zafrullah Chowdhury on GK's health insurance scheme

"Everyone, including the poor, has to pay for GK's health care services. Their contribution is determined by their income. The more money they earn, the more they pay. When you pay for something, you can better estimate its value. If you can get it for free, you are more indifferent. Moreover, dignity is also something that is important.

"I'm extremely disappointed, though, that we still don't have a generalised health insurance in Bangladesh. Despite the fact that we have strived for obtaining the insurance, we haven't succeeded. The rich and middle class are not willing to cooperate. They prefer to pay for private health care. But by doing so, they forget their responsibility. They don't have sleepless nights over their health condition."

For transparency, GK displays all the premiums and service fees under the co-payment system outside their health care centers or referral hospitals, so that the people can take their own decision. Thanks to the premiums and service charges, GK is able to finance just over 50% of its health care interventions. The remainder of the funding it draws from its more commercial activities which will be dealt with later.

GK and MDG 4

MDG 4 targets the reduction of the mortality rate of children under 5 years by two-thirds, between 1990 and 2015. According to the earlier report of the World Bank, GK has already exceeded the MDG 4 target for infant mortality in 2004. In concrete numbers: in GK intervention areas, the infant mortality rate has dropped below 32 deaths per 1,000 live births. In the rest of the country, this number is still a lot higher, sometimes twice as high¹⁶.

e. Access to essential drugs: GK and the National Drug Policy

Access to essential drugs is very important. Although the percentage of the world's population without access to essential medicines has fallen from an estimated 37% in 1987 to around 30% in 1999, the total number of people without access remains between 1.3 and 2.1 billion. In the same line, the WHO estimates that by improving access to existing essential medicines¹⁷ and vaccines, about 10 million lives per year could be saved. Even though access to essential medicines is most restricted in low income countries, Bangladesh is a notable exception, thanks to GK.

GK played a leading role in the formulation of the National Drugs Policy in 1982. This policy aimed at ensuring that common people can get the essential and necessary drugs easily and to ensure the quality and safety of these essential drugs. Already in 1981, GK established a "Pharmaceuticals Laboratory" for the production of essential drugs. It also set up a factory to produce the raw materials needed for antibiotics. These two practical measures are instrumental in supporting the effective implementation of the national drug policy since they ensure that these essential drugs can be produced in Bangladesh and that the country does not depend on others. To lower the prices of the medicines, GK also produces bigger packages.

Once the drugs are available, GK had to ensure they are properly prescribed and used. Therefore, paramedics and TBA's receive training on these drugs; paramedics can now prescribe 23 types of medicines, the TBA's 5 different types. All these essential drugs are available at discount rates for the people, for some (the destitute and ultra poor) even for free. GK also raised awareness on the use of drugs in the communities by means of posters and leaflets, as it is important for people to know when and how to use certain drugs.

The key challenge ahead is the TRIPS agreement. Thanks to its National Drug Policy of 1982, Bangladesh did not have to adhere to this international agreement until 2016. The "Agreement on Trade-Related Aspects of Intellectual Property Rights" sets minimum standards in the international rules governing patents, including on medicines. It came into force on 1 January 1995 and is binding on all members of the World Trade Organization (WTO), currently more than 150. For many civil society organizations, TRIPS threatens access to essential medicines since it strengthens patent rules for these in the same way as for mere consumer goods. Stricter patent rules limit competition and local production. GK is very

¹⁶ *To the MDGs and Beyond: Accountability and Institutional Innovation in Bangladesh*, World Bank Office Dhaka, January 2007, p. 53 and following.

¹⁷ WHO definition of essential medicines: "Essential medicines are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford. The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations; exactly which medicines are regarded as essential remains a national responsibility." See: http://whqlibdoc.who.int/hq/2004/WHO_EDM_2004.4.pdf.



concerned about this and keeps on working with the government to find ways to mitigate the impact of TRIPS on the provision of essential, life-saving drugs in the country.

f. The elderly

Another group of vulnerable people that has drawn a lot of attention from GK in recent years are the elderly. People live longer, also in Bangladesh and in the villages. Moreover, young generations leave their villages to try their luck somewhere else. Children are looking for a job in the capital city or abroad. They send their parents money to survive, but the amount of money is not enough. In addition, **older people end up very lonely**. That is why GK organises activities for elderly people, to keep them busy. Paramedics often visit them to give them some attention and to take care of them. They go swimming together to fight arthritis, for example, or they go for a walk together. In some villages, GK organised social gatherings for the older inhabitants, where they can meet each other and chat over a cup of tea and a bowl of rice. GK students are also requested to “adopt” an older person in the communities where they work, which means they spend more time with that person because **social contact is so important to fight loneliness**.

2.3.2. PROMOTE EDUCATION AND TRAINING AMONG THE POOR, PARTICULARLY POOR WOMEN AND CHILDREN

GK’s initial focus on purely curative services to the poor soon evolved thanks to the understanding that a person’s overall health is conditioned by the circumstances in which people grow, live, work and age. GK’s focus shifted to the well-being of a person, not just the absence of disease. One area in which GK started investing very early was education.

a. Primary education

GK has started its primary basic education programme, the Gono Pathshala or the “People’s School”, for children of destitute and landless families in 1976. The overall aim of the education programme is to enable children from underserved communities and indigenous minorities, living often in remote areas which are hard to reach, to receive participatory, quality primary education coupled with basic life skills to improve their living standards. Education, therefore, also addresses issues such as primary health care, hygiene, sanitation, care for the environment, the rights of people etc.

The People’s School was developed in response to inadequate national educational facilities, low school attendance and high drop-out rates. The latter two factors are related to unmotivated teachers and lack of understanding of the needs of the poor.

GK’s schools offer an alternative approach: they allow for a flexible time table adjusted to the rhythm of agricultural work and children are allowed to bring their animals to the school. This enables children to go to school as well as carrying out work for their families. The schools make no demands in terms of uniforms and provide the children with a slate and pencil. Even with this degree of flexibility, it is important to note that GK offers formal education so

that students have an opportunity to go for further education.

Again, the community is a key stakeholder in this programme. The community provides land, locally available construction material and the manpower to build a school. GK invests in appropriate teacher training for local women. A “School Management Committee” is established: all major decisions are taken by these committees, which consist of members of the “union parishad” (union council), village leaders, teachers, parents and pupils.

At present, 17,810 children are currently enrolled in 181 People’s Schools. 50.65% of those children are girls. The attendance rate is on average 83%. All the teachers in these schools, approximately 390, are women. In the Chittagong Hill Tracts, where the indigenous minorities live, around 90 schools are operational: teaching takes place in the indigenous language.

GK has also established schools on the “chars”, the so-called “small islands” that emerge within the river channel or attached to the riverbanks due to the dynamics of erosion and accretion. Although these chars offer significant amounts of land for settlement and cultivation, living and working conditions are very harsh due to the elements (drought, flood and occasional river erosion) and the lack of infrastructure (roads, electricity, sanitation, drinking water, schools and health facilities). Still, GK has now 68 schools running in these chars.

b. Higher education: Gono Bishwabidyalay

Gono Bishwabidyalay (GB), GK’s university, was established in 1998 and is accredited by the University Grants Commission (UGC) and approved by the Ministry of Education, Government of Bangladesh. It particularly encourages women, students from low-income groups and from ethnic minorities to enroll. A major objective of the university is to act as a link between established scientific knowledge and people’s knowledge, which is based on their experiences and socio-economic conditions.

All students have to take a number of general courses, such as: history of the liberation war of Bangladesh, gender, ethics, equity, environmental sciences, English and Bangla. The university has three faculties: medicine and health sciences, basic and social studies and postgraduate studies.

c. Paramedical training

When it all started, GK had 6 tents where it had to train young girls to become nurses. Nowadays, GK has 3 professional training centers and each of these centers can train and accommodate 150 students at a time. These training centers have lecture rooms, canteens and boarding facilities.

The standard training programme for paramedics takes 6 years, with at least 6 months of in-service training as medical auxiliaries. Training includes classes in anatomy, selected topics in physiology, pathology and common drugs. An advanced paramedic training is also available with classes in microbiology, X-ray and midwifery. Over the last 40 years, GK has trained more than 6,000 paramedics.



The training programme of GK for paramedics is recognized since GK also trains paramedics of other local and international NGO's in Bangladesh.

2.3.3. WORK WITH PEOPLE ON THEIR ECONOMIC EMANCIPATION BY ORGANIZING INCOME-GENERATING ACTIVITIES

Nari Kendra: the vocational training center for women

Women empowerment is not merely an 'issue' related to women. It is an essential part of the development of the society as a whole. Women's education, health and their ability to work and earn an income are important for society. With "Nari Kendra", a vocational training centre for rural landless women, GK is able to act on these 3 elements at the same time.

In 1973, GK founded "Nari Kendra". The aim was **to provide women with basic education (ability to read and write) as well as technical skills which improve their chances on the local labour market**, such as metalwork (welding and sheet-bending), carpentry, shoe-making, construction work, driving, electrical work, plumbing, printing etc.

In the early days, GK had real difficulties in recruiting women as cultural norms and values did not allow for women to work outside the household. But once again, GK managed to change the attitudes of people and many women have now found their way to Nari Kendra. The training period usually lasts 2 years.

2.3.4. RESPECT WOMEN'S RIGHTS AND CHANGE THEIR STATUS IN SOCIETY

The impact of Nari Kendra goes far beyond the fact that women know how to read and write, plumb and wire a house or drive a car. The most significant impact is that **women have become more conscious of their own capacities**, which make them **more autonomous** as they earn money and they can decide what to do with it. They become more **self-confident** and assert

themselves. More and more, women take up leadership roles in their communities, which builds further awareness about women's rights and their management capacities.

The same can be said for the central role women play in GK's health delivery system as paramedics and in its primary education programme as teachers: women take important positions in the communities where they work and this raises their status. Community members respect them and turn them for advice on all kinds of issues.

GK and MDG 3

MDG 3 aims at promoting gender equality and empowering women. More specifically, it seeks to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The "People's Schools" of GK, established in areas which are difficult to reach, are attended by girls and boys alike in nearly equal proportions. And not just in terms of education, also by means of vocational training, awareness raising and advocacy, GK really encourages women to take their place and play their role in their communities, as skilled workers, paramedics, teachers, TBA's, etc. Some of the more striking results are the following:

- On May 1st 1977, 40 women of GK covered 40 km on bike from Nabinagar to Dhaka to draw the government's attention to women's empowerment.
- GK already disposed of a day care centre for young children in 1983, which allowed their mothers to continue their studies at GK's university or their job within the GK movement.
- With regards to maternity leave, GK provides 6 months of leave with full pay and 6 months with 50% of the salary.

2.3.5. ADVOCACY TO INFLUENCE POLICY AT THE NATIONAL AND INTERNATIONAL LEVEL WHICH WILL DIRECTLY AND INDIRECTLY BENEFIT THE POOR

a. Advocacy by GK

Through its vast and integrated development programme, GK has acquired a wealth of experience in many different fields. In Bangladesh, it is a very respected organization which can weigh on policy-making.

GK played a vital role in the promulgation of the **National Drug Policy (NDP)** in 1982. Especially Dr. Zafrullah has played an important part in drafting this important national policy instrument, which made Bangladesh the first country in the world to have a drug policy based on the WHO's list of essential medicines. The NDP effectively improved the availability of quality medicines at affordable prices. It remains to be seen what the effect will be of the entry into force of the TRIPS agreement in Bangladesh in 2016.

Another success story was the adoption of the **Women Development Policy (WDP)**: much of GK's experience with the empowerment of women directly influenced the contents of this policy. With regards to health workers, the Government copied the example of GK and started recruiting many women as health care workers.

GK also advocated for a people-centred **National Health Policy (NHP)**, starting in 1987. Main features of the policy were the establishment of an efficient referral system and access to health care irrespective of residence. The whole health care system was to be decentralized and devolved with the creation of sub-district, district and regional authorities. Moreover, the NHP provided that investment in health was to be increased from 2,5% to 10% of the national budget in phases over five years. The Parliament adopted the NHP but the President later annulled the policy.

The longstanding campaigns of GK **to ban smoking in public spaces** has not yet resulted in such a ban, but GK is committed to continue its lobby in this respect.

GK has also engaged itself in the international "Health for All" campaign which seeks the effective implementation of the commitments made by the international community during the Alma Ata International Conference on Primary Health Care in 1978. In reality, however, the decades following the Alma Ata Conference were marked by intense economic liberalization, including in the health sector, which led to privatization and commercialization of services. It became clear that the Alma Ata Declaration, which promised "Health for All by the year 2000" would remain just another declaration. Several international organizations and civil society movements decided to organize a **"People's Health Assembly"**, which was **hosted by GK in its headquarters in Savar** from 4 until 8 December 2000. Nearly 1.500 delegates from 92 countries participated and discussed basic issues of people's health. The "People's Charter for Health" was the outcome of their discussions and has become a valuable advocacy tool worldwide.

b. Advocacy by the people: the integrated "char" survival programme

Another interesting example of people's empowerment is the "integrated char survival programme". As explained above, these "chars" are in fact "small islands" that emerge within the river channel or attached to the riverbanks due to the dynamics of erosion and accretion. Although these chars offer significant amounts of land for settlement and cultivation, living and working conditions are very harsh due to the elements (drought, flood and occasional river erosion) and the lack of infrastructure (roads, electricity, sanitation, drinking water, schools and health facilities).

GK, in partnership with local NGO's, started a programme **to organize and empower local communities to improve good governance** in these areas. People living in rural areas hardly ever enjoy the benefits of the existing legal and regulatory framework because they do not know their rights, let alone how to enforce them. In the "chars" this problem is very acute.

As a result, GK has started to establish "Social Development Councils": the members of these SDC's are the char dwellers but they receive a lot of counseling from technical specialists on issues such as health, education, livestock, agriculture, women's development, children's rights etc. Within the SDC, **the char dwellers discuss and define their local development plan**, in which they identify their priorities in terms of basic primary education, primary health care, seasonal loans for agriculture and cattle rearing, etc. The SDC also acts as a "pressure" or lobby group which has **to influence the local authorities** to effectively implement or change existing laws and regulations.

A very concrete result of this programme are the 68 schools that are now operational in a number of chars. As always, the char dwellers have appointed the local women who are the teachers in these schools; GK provided the necessary training for these women.

2.3.6. UNDERTAKE DISASTER RELIEF AND REHABILITATION PROGRAMMES

Natural calamities, such as floods, tropical cyclones and tornadoes occur almost every year, so GK has gained enormous experience in conducting relief and rehabilitation programmes. These calamities seriously affect agriculture, water & food security, human health and shelter.

GK has a three-pronged strategy which aims at helping people from the very beginning, when disaster has struck, right to the point where they can start their normal activities again. At first, GK undertakes **immediate relief activities** which include basic health care services as well as food supplies. Different foods are distributed among men and women, according to nutritional need. GK also introduced special types of survival food such as handmade "chapattis" which are high in calories. At a second stage, GK helps with **post relief interventions**: the installation of sanitary latrines as well as tube wells for the provision of safe drinking water, the construction of temporary shelter for the people and the provision of a balanced food mix (based on the local

traditions, the nutritional value as well as the hygienic conditions). Thirdly, GK undertakes **rehabilitation work** by reconstructing schools and houses, repairing the damage to agricultural fields, social forestry, repairing dams and embankments, etc. GK also provides micro-credits and seasonal loans to further kick-start economic activity in the affected areas.

Sometimes disaster is man-made, like the occasional waves of communal and ethnic violence which hit communities. GK is one of the very few NGO's that deploys its relief and rehabilitation work even in these difficult circumstances. In the aftermath of such dreadful eruptions of fundamentalism and communal tensions, GK invests in a lot of awareness raising to foster mutual understanding and respect.

2.3.7. PROMOTE SELF-RELIANCE BY ENGAGING IN MORE COMMERCIAL ACTIVITIES TO BECOME LESS DEPENDENT ON DONORS

This is also one of the major objectives of GK. For 40 years, GK has made large-scale investments in different fields such as health care, education and vocational training, income-generating activities, disaster relief and rehabilitation awareness raising and advocacy. All that work requires funding. Therefore, **GK has set up several commercial activities to raise the necessary funding for its work.**

GK's first such venture was **a cafeteria** along the Dhaka-Jessore highway in 1975, entirely managed by women.

In 1976, GK started **Gono Prakshani**, a publishing company which publishes important books as well as GK's monthly magazine (since 1982).

Gono Mudran Ltd, also known as the Printing Press, started operating in April 1987. It produces modern off-set printing materials such as posters, leaflets, brochures, magazines, official forms and all kinds of packaging materials. Some posters are designed

to disseminate health messages on HIV/AIDS, pregnancy, plastic surgery etc.

In 1981, **Gonoshasthaya Pharmaceuticals Limited** (GPL) and in 1984, **Gonoshasthaya Antibiotics Limited** (GAL) were established to produce high quality, essential drugs which are available for the local market at very affordable prices and thus within the reach of poor people as well. GPL is one of the largest pharmaceutical production units in Bangladesh. GAL was the first antibiotic plant in Bangladesh. Both companies have set an example worldwide of how developing countries can guarantee the rights of its people to essential, live-saving drugs if technology is transferred. The profits of GPL and GAL are allocated as follows: 50% is invested in the further development of the company, 20% is for the workers (mostly local women) and the remaining 30% is used to finance GK's health care and basic education programme.

Gonoshasthaya Foods Ltd started in 1991 and has developed protein-rich nutritious supplementary foods using soybean as one of the major ingredients. The supplementary foods provide adequate amounts of proteins and calories and most of the necessary vitamins and minerals. Gonoshasthaya Foods has developed these supplementary foods in reaction to severe malnutrition of children which affects their intellectual and productive capacities during adulthood. Since soybeans are high in proteins (twice as much as meat and fish, four times as much as eggs and wheat flour, six times as much as rice) and a lot cheaper in terms of production, it is an essential ingredient for the supplementary foods produced by Gonoshasthaya Foods.

Other examples of commercial ventures of GK are Gono Bakery (1975), Gonoshasthaya Grameen Textile Mills Ltd (1998) and Gonoshasthaya Basic Chemicals (1997). All of these enterprises follow the same principles: they employ poor people, in particular women from rural areas and their profits are invested in the company, its workers and the social programmes of GK.



3

LESSONS LEARNT AND FUTURE PERSPECTIVES

3.1. Lessons learnt

From the Bangladesh Field Hospital during the Liberation War in 1971 to meeting MDGs 3, 4 and 5: Gonoshasthaya Kendra or the People's Health Centre has gone a long way. A very long way, indeed! Improving the health care services for the rural population, especially women and children, became the entry point for what was, and still is, in reality a vast programme of community development.

It all started with **health care** on the doorstep. Staff visits people at home and treats them there, to ensure that women and children see a paramedic or doctor from time to time. Secondary and tertiary health services are also offered by GK in its clinics and hospitals.

Over the years, GK then started developing several **different interventions in various fields** such as education, vocational training, nutrition, agriculture, income generation and vaccine and drug research, because health is not only a matter of preventing or treating illness. The circumstances in which people grow, live, work and age strongly influence how people's health. GK started acting on these so-called social determinants of health very quickly. By doing so, one could say **GK offers a whole range of social protection services to ensure not only people's good health but also their overall well-being.**

As a result, GK is not just an NGO active in health care, it is **a community development organization with an integrated or holistic approach.** Developing the community is not the task of an outsider, rather the drive for change has to come from within: the members of the community, in particular the poor and the women, the village leaders, the imams and priests, their elected local government officials etc. GK brought these together in "village development committees" (or in "social development councils" in the chars) and it limits its own role to providing technical expertise and support. The community is the agent, GK is the facilitator.

This recipe for community development works very well. It has been applied for 40 years now and is therefore time-tested. GK's work at the grassroots level has been the basis for a genuine transformation of communities. People have changed their attitudes with regards to their health care, the schooling of their children, the status of women in their communities. This is also the best guarantee that **changes at the grassroots level – changes of social inclusion, equality, resilience – are sustainable.**

Despite all these remarkable results, one should not forget that the development of GK was not a bed of roses. Several paramedics have suffered attacks when they entered the villages on their bikes and without burkas. One paramedic, Nizam, was even killed. GK properties have also been the object of attacks. Gonoshasthaya Pharmaceuticals Ltd was attacked in 1984, leaving 84 workers injured. Support from local villagers was essential: for two months, they guarded the factory during the night allowing it to continue its operations. United, GK stood!

3.2. Future perspectives

GK can be considered as a dynamic social organization, constantly responding to new challenges, always exploring new opportunities but without losing sight of its vision, objectives and strategies as the principal guidelines for all its activities.

For the coming years, GK sees the following challenges:

- Health services become commodities, they are no longer seen as a service to the people;
- More and well-trained health service providers are needed to serve the poor;
- Privatization puts profits before health; poor people are again the losers.
- Higher education remains a distant dream for the poor and lower middle class;
- Employment and income opportunities for the poor are very scarce;
- Demographic development in the country: life expectancy increases but the services for the elderly are not in place;
- Climate change influences the health condition of people, especially the poor.
- In 2016, the TRIPS will entry into force in Bangladesh, which will affect access to essential medicines of the poor.

Responding to these challenges, GK will focus its efforts on:

- More vocational training for and boys from the poorest families;
- An expansion of its service delivery in education, health care, income-generating activities, nutrition etc;
- Lobby and advocacy to maintain a continuous dialogue with government and other stakeholders;
- Consolidating its work as a genuine social movement, based on the involvement of local people and trained leaders, with the objective of improving the well-being of all.

“ Bangladesh has achieved success in preventive and curative care, in particular where NGO’s in the health sector are using clear lines of downward and upward accountability. One of these NGO’s is Gonoshasthaya Kendar (GK), now the second largest health service provider in Bangladesh after the Government. In its areas of activity, GK has reduced maternal mortality by 42% below the country average by using such checks and balances, thereby putting these areas well on track to meet the MDG target.

In rural areas, **GK’s downward accountability is assured by Village Development Committees**, consisting of one women member from the Union Parishad (directly elected local government), one NGO member active in the region and other members elected from the village. They oversee and evaluate GK’s activities and staff performance. On the other hand, **upward accountability mechanisms involve senior government official**. Each time there is a death in the village, a post mortem investigation is done in presence of these officials, whereby mistakes are analyzed and unveiled to the community. Such engagement is part of a larger strategy to involve all levels of government and the community in solving problems relating to health service delivery and making the necessary institutional changes. It is this linkage that allows it to be expanded by the public sector in both the rural and urban context¹⁸.”

The model that GK proposes is people-centred and time-tested. Moreover, it is affordable considering its health care delivery costs, for example, are 4 times lower than in the public health sector. It is efficient and effective because it involves the community and the public authorities at all levels.

All these considerations suggest that the model could be replicated at the national level by the Government of Bangladesh. If the government would decide to do so, GK is certainly prepared to play its role.

18 *To the MDGs and Beyond: Accountability and Institutional Innovation in Bangladesh*, World Bank Office Dhaka, January 2007, p. 53 and following.





OVERVIEW OF THE MAIN ACTIVITIES OF GK

All Projects undertaken can be broadly divided into two distinct groups: **(i) Projects relating to direct service to the community and social developments and (ii) Commercial and indirect service to the community.** But in all activities, the interest of the poor people is carefully guarded and women's participation is ensured.

1. PROJECTS DIRECTLY RELATED TO COMMUNITY SERVICE AND SOCIAL DEVELOPMENTS:

A. Health care

- a. Primary Health Care
- b. Secondary Health care
- c. Tertiary health care through Referral hospital
- d. Provision of essential drugs

B. Education and Training

- a. Primary education for the poor
- b. Secondary education for the poor
- c. GK University, Medical College and Dental College
- d. Vocational training center for women
- e. Paramedical training

C. Vaccine Research Laboratory

D. Research and Publication

E. Advocacy

F. Disaster management

G. Agriculture, Seasonal crops credit, agriculture cooperative

2. COMMERCIAL VENTURE AND INDIRECT SERVICE

A. Health Related

- a. Gonoshasthaya Pharmaceuticals Ltd..
- b. Gonoshasthaya Antibiotic Ltd.
- c. Pharmachemy (Bangladesh) Ltd.

B. Nutrition related

- a. Gonoshasthaya Bekary and Foods Ltd.
- b. Gonoshasthaya Vita minerals (Iodized Salt)
- c. Cow farming for the poor.
- d. Tulip Dairy and foods Ltd.
- e. Gonoshasthaya Foods Ltd.

C. Education Related

- a. Gono prokashoni (Gonoshasthaya Publication)
- b. Gono Mudran Ltd. (Printing Press)

D. Others

- a. Gonoshasthaya Grameen Textile.
- b. Gono Tat Ltd (Handloom)
- c. Progressive Credit Co-operative Society Ltd.
- d. Micro-credit for poverty elevation

