

Basic Services Delivery in Underdeveloped Countries

— the Bangladesh experience

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The FAO's Freedom From Hunger Campaign/Action for Development unit organised a programme for "Change Agents" in the south-east Asian region over an eight week period from March this year where together they discussed and analysed informally the major issues and problems faced by rural change agents and learnt of social and human skills necessary for initiating a participatory development process. Mr. Siriwardena, a Research Officer from the People's Bank, who participated in this programme gives his impressions here of a case of participatory development in action. He acknowledges the assistance of Dr. Zafrullah Chowdhury and Mrs. Geetha Chakrawarthi who provided him with much of this information and assisted him during his field visits to this project in Bangladesh.

Development cannot be brought to a people, it must come from within them, if we accept that development is basically a process of liberating people — liberating them from paralyzing tradition and exploitative systems, from want and deprivation. The development referred to here is what is known as "participatory development" — a development that will involve men and women directly in the process of change, that will give them the opportunity to participate in those decisions that affect their lives and also in the implementation of these decisions. Many developing countries have made genuine attempts at this type of development but several more have only paid lip service to it.

Development in the country's of the Third World, which are largely agricultural, must actively involve the rural people. But even in development of these rural areas basically two different types of approach have been observed. One is the "participatory" approach and

the other a "directive" approach.

The *participatory approach*, as we have seen, follows from the broad objective of the over-all development of people and their potential. It should be what is called a "bottom-up" approach; particularly in our Asian countries where people are the biggest resource. It is clear that if their tremendous potential can be released, and their energies and motivations realised the pace of development can then also be well accelerated. Though centralised planning cannot be done away with the participatory development approach demands a great deal of decentralisation.

In the more *directive approach* the rationale is to get on with the job; to get it done as soon as possible to beat the clock. The assumption is that if the 'goods are delivered', the conditions of people will automatically improve. So, ready-made plans are sought to be somehow implemented. Attempts are made to involve people, but not as an intrinsic objective of the programme. People's participation is merely looked upon as a means to get 'sanction' for a pre-cooked, pre-packaged plan of action.

Both these approaches to development are in use in different parts of Asia. Some organisations function in a 'directive' way while others prefer a more 'participatory' approach, and some fall in between these two categories.

A recent regional training programme for "Change Agents", organised by the FAO's Action For Development, for participants from Bangladesh, India, Nepal, and Sri Lanka gave us the opportunity of observing both types of development in action. A good example of the participatory approach being adopted in Bangladesh is that of the *Gonoshasthaya Kendra*. The impressions set out below are intended to give an idea of how effectively the concept is being put into practice.

The morbidity rate among the under privileged sections of our developing countries is so high that the curative aspect of medical care is naturally demanding greater attention. Most of these rural people who live in remote villages are cut off from the towns and cities where modern health facilities are available. Among such communities even a very basic health service could bring about a vast improvement. The extension of urban patterns of health services, however, will not solve these rural problems; and ideas derived from curative medicine in the context of developed countries are unlikely to be appropriate for preventive work in the rural villages, for most of their health problems have got aggravated due to a lack of attention and do not require the services of highly trained physicians or facilities of modern hospitals. Hospitals and doctor oriented "developed country" type curative medical care systems have helped to foster a strongly urban-biased medical education and health service. Such training has also been found to be not quite relevant to health care needs of rural communities. Bangladesh is a clear case in point.

In Bangladesh a group of its own people and some of their own young Bengali doctors came to realise that an integrated approach to the development of the community was the best means of providing a basic health care service in an under developed country such as theirs. The idea of *Gonoshasthaya Kendra* or people's health centre was thus born. These doctors had worked with the Bangladesh hospital during their "war of liberation" in 1971 when it served refugees and liberation forces on the Indian front. At the end of the War they moved back to Bangladesh and into a rural area, covering nearly 300 villages, with a population of about 200,000, where they found that there wasn't even a health centre. In this area, called the *thana* or administrative unit, they found that the practice from British times had been to appoint one Sanitary Inspector and a few assistants to provide the entire health education and immunisation services of such a vast area.

A significant finding they made was that these Central government employees were given no supervision, were poorly paid to operate their programme and had no ideas or intention for community involvement. The result was that most of what they put forth was ineffective. These doctors, led by Zafrullah Chowdhury, coming into this *thana* (Savar) in 1972 started by holding meetings with villagers and students in the area in order to find out how they could best bring health services to the people of the area. Initially they recruited over 100 part-time volunteers from amongst the students who were to carry out vaccination and health education programmes. They needed a base from which to organise their activities and land was donated for setting up their main centre at Savar. Then their programme moved into operation.

In their early meetings with the villagers these doctors found that the allied groups in the field who were the more vocal members often dominated and tried to impose their ideas of health servicing on the entire project. Thus at the start a decision was taken to charge a flat fee for all families of two taka, which is the equivalent of about two Sri Lanka rupees. It was later realised that the poorer sections of the population were unable to pay even this and so fees had to be modified making a differentiation between the rich and poor villagers. After nearly one year's operation it was realised that part time volunteer workers could not fulfil the demands this project's work was making on them. It was therefore decided that a full-time paid worker was necessary and here came into being the concept of their paramedic which has continued to evolve while retaining the basic characteristic of a worker who brings community development services to his village.

An Integrated Approach

The Gonoshasthaya Kendra team now realised that a strict medical approach would not produce a healthy community. Moreover, without the involvement of the community anything that was produced may have questionable value. What started as a health centre in the village therefore came to include community development as well, and also family planning, vocational guidance, agricultural extension and human development

programmes. The health services could be considered an "entry point" to these rural areas, but to lift the conditions of living in the villages health services alone would not suffice. They realised that the villagers had many interconnected social and economic problems and it would serve no purpose dealing with only one aspect of their problem. Thus the paramedics were trained not only in areas of health education, nutrition and hygiene, curative care, immunisation programmes, pre and post-natal care, family planning and delivery services and follow up; but also basic pharmacology, record keeping, elementary pathology and minor surgical procedures to be capable of performing female sterilisations. In addition they were trained to give advice in regard to agricultural and livestock problems and offer basic veterinary services. Most important, they developed an understanding and sensitivity to the life of the village.

They did not preach Vitamin A capsules, but rather local green vegetables. Unlike the doctor who doled out two to six large *piperazin* tablets (a child's dose for intestinal infestation with round worm) to be taken at home, the paramedic had the child take the required treatment in front of her, being aware that a mother would be hesitant to give such a large dose of medicine to a child at one time.

It was also the paramedic who questioned the wisdom of the ante-natal clinics. For the population being served in one sub-centre area (15,000 to 20,000), there would be approximately 800 pregnancies in a year. Out of this number no more than 15 to 20 per cent would be "at risk" pregnancies, that is, women requiring special attention. Gathering all of the women and having them sit unnecessarily was neither an efficient use of their time nor of the clinic's. An alternative was to have the paramedics pay regular visits to these 'at risk' pregnant women most likely to have difficult labour or other pregnancy problems and give them the necessary instruction and observation. The result was generally no maternal death in the area.

Further, effectiveness of the work of the paramedics in health education was seen when an evaluation team recently visited the



Village women learning carpentry from a Gonoshasthaya Kendra worker.

area and found virtually no skin disease, nor did they come across any diarrhoea. This did not mean that there is no longer any incidence of diarrhoea, rather now the mothers know how to mix the dehydration fluid, and will use it when diarrhoea occurs.

The selection of the paramedics involves the villagers. This leads to a greater responsibility for the programme, on both sides. Members of the community chosen to interview the new recruits are older villagers, but from among the wider mass of the poorer class.

The Subcentre: a Community Centre

At communicating distance from the main or referral centre, the subcentre serves as a grass roots, community-centered, base, which generally renders all those services available at the main centre: curative medicine, pathology, minor surgery, including tubal ligations and facilities for obstructed labour. The subcentre also serves as a storage place for poultry vaccine as well as general drugs, and vaccine for immunization of the general population. It is a centre for vital statistics, information, records, the place of payment for services and women's vocational training. A gathering place for the local community it would eventually become a general educational resource.

The subcentre is meant to serve an area of 10 to 15 villagers, with a population of from 15,000 to 20,000. There would be an average of 3,000 population per paramedic at the subcentre, and one *dai* (traditional village midwife) per 1,000. Also one female village worker, per 1,000 population. The village worker and the *dai* toge-

ther would cover the following areas of activity: Deliveries, basic child care, family planning (service and follow-up), tubewell maintenance, directing children to school, livestock immunization, vocational training of women, food and seed processing and storage, preservation of surplus fruits and vegetables, and the planting of fast-growing trees for firewood and compost. Each subcentre would also have one supervisor for the overall community programme. They have six sub-centres beside the main centre. Every week there is a clinic. For the rest of the week, the paramedics go to the villages. One paramedic stays at the subcentre all the time.

Paramedic's Perception

A qualified doctor might well know to treat a patient. He will diagnose the disease and duly administer treatment, but the ill health of the villagers is of a different type which medicine alone will not cure. It is necessary to know not only what disease they suffer from, but also what causes their ill health; their lack of food and sanitary conditions and their generally grinding deprivation. In many cases, parents in these villages gave up all hopes for their children in case of any serious illness. They did not have the money to see a doctor and to seek treatment. The gap is indeed great between urban dwellers and the people of these villages; it appeared to be even greater between the educated and qualified doctors and the poor illiterate villagers. To many villagers the paramedics still appeared to be these same doctors from the city, who, in the words of one poor villager "has come like God to save our lives". The paramedics themselves realised that many mistakes had been made initially. According to one "perhaps the greatest initial weakness of the *Gonoshasthaya Kendra* was that its leaders came from the city and many mistakes were made from doing things through an urban resident's point of view. To many of them, at the start a big imposing building, a beautiful modern hospital seemed to be the best. But it was realised that such buildings would only alienate the leaders. Since then, we have built our own sub-centres out of mud and thatched roofs like the village houses", said one paramedic.

The Doctor Myth

"For better treatment consult a qualified doctor and go to a good hospital" — these are the myths formally embedded in the minds of the average villager in these regions, according to the experience of the paramedics in the *Gonoshasthaya Kendra*.

One paramedic explained this idea to us in the following words: "for a basic essential health care service no formal education seems necessary". One female paramedic in the *Gonoshasthaya Kendra* who could barely write her name, performed tubal ligations as well as simple surgery for four years. Another educated paramedic told us that her education created a gap between her and the villagers. They did not always understand what she said, because the villagers had a different kind of life and way of looking at things.

One of the main sicknesses children die of in Bangladesh is diarrhoea. There is a simple solution which can be made in any house, that can save almost all patients. Paramedics teach the mothers how to make this mixture — one glass of water to two teaspoonfuls of sugar or molasses and half a teaspoon of salt.



A paramedic teaching the mother of a sick baby how to prepare oral diarrhoea mixture during a home visit.

The *Gonoshasthaya Kendra* also showed concern for the education of children in these villages. To them education was not instruction which would equip them to do impossible or useless things. It was something which the villagers would feel they have a need of and know to be possible in their situation. Their education was thus practically attached to the needs of the immediate environment; for the children of the

very poor (landless) a "functional school" was begun. The need for education to cater to their practical needs was emphasised by one paramedic with the following statistics.

"Bangladesh government statistics indicate that 56 per cent of the nation's school-age children do not attend school. Surveys show that only 14 per cent of those attending continue after five years and only one per cent go on to college or university studies. On completion of the 'higher education' students generally remain jobless. In the case of girls, 14 per cent complete 5 years of schooling and boys 33 per cent, according to a survey conducted in Savar."

Initially the school at the *Gonoshasthaya Kendra* was limited to an enrolment of 50, but expanded to 100 after the first year. Students accepted are between the ages of 4 to 10. As the paramedics who surveyed the villages have access to them, a careful study was possible, and only the very poorest were chosen to attend. The site of the school is at the project's land in Savar. A mud building has been erected, along with bamboo, swings, slides, see-saws, etc. The areas of health, hygiene, physical education, carpentry, machine shop-work, agriculture, music, arts and crafts are included in the curriculum.

Indebtedness

Indebtedness among these villagers is no different from that in many Asian rural communities. In these areas of Bangladesh particularly the farmers find themselves often short of money for food and other basic necessities and are forced to borrow. The money lenders charge them exorbitant rates of interest — for each 100 taka they must pay back an interest of 30 to 40 kilograms of paddy, in a three to four month period; an equivalent of 250 per cent interest. The *Gonoshasthaya Kendra* has initiated action to relieve what seems an insurmountable problem. They started the following small project to see more clearly what the difficulties were and how they could be overcome. Sharecroppers and poor farmers living in villages surrounding the project who had relatively close ties with the *Gonoshasthaya Kendra* were given loans upto 200 taka each, during the difficult

period when food is particularly scarce, at half the regular interest rate. The interest is used for creating revolving capital. The reaction of the village money-lenders was not hard to predict.

A further attempt to assist the farmers of the area has been with the experimenting in the line of agriculture on the project site. In 1974 an attempt was made to find someone who could head this agricultural work. But to get someone with the knowledge and willingness to integrate with the villagers seemed impossible.

Family Planning

The demand for family planning services always existed in these villages, and almost from the beginning of the programme the *Gonoshasthaya Kendra* began offering family planning service, but always within an integrated programme. Without real efforts at assuring parents that their children would reach adulthood it was felt they could not be denied the right to sons and daughters of their own. The programme, therefore, has directed its efforts into providing the needed health care, educating parents in birth control methods and family planning in order to properly motivate them, and, once the method was chosen, to carefully follow up each client with house to house visits on a regular basis.

The traditional birth control attendant, or 'dai', has also been successfully incorporated into the programme. Remaining in the village she works on a part-time basis, distributing pills, checking for side-effects, assisting where possible and referring to the centre or sub-centre where needed. She is also taught to spot pre-eclamptic patients and other possible labour and birth difficulties, and to instruct the mothers in regard to child care. Because she is village based, her drop-out rate in regard to family planning acceptors is lower than that of the paramedic.

Since the beginning of the programme in 1972, a steady pattern was noticed of clients moving towards a more permanent method of contraception, once family planning has been accepted. In 1974 the *Gonoshasthaya Kendra* began to offer female sterilization performed by the paramedics, and found that a relatively large demand existed for this method.



A paramedic arriving on the scene of emergency on her bicycle.

The sterilizations are performed under local anaesthesia, both at sub-centres and the main centre. Paramedics, trained to perform these operations have proved themselves to be quite skilled. The villagers prefer the female paramedic to the male physician, and it had been noted that the infection rate for the paramedics is lower than that of the doctors. The reason for this may be that the doctor is generally an occasional operator, and there is doubtless a tendency for him to assume the task of the more difficult cases for himself. The paramedics, too, may be more prone to pass over to the doctor what might promise to be a more complicated operation.

Another Reality

"Health education alone can only go so far. You cannot teach them about good nutrition (except for breast feeding) when food is not available" said one paramedic. It is merely another form of inappropriate education. "Why are you telling me to do something, when, as good as it is, I know it is impossible"? asked a villager. Face to face with the village the *Gonoshasthaya Kendra* has come to realise more and more what is possible and what is not.

The director of the project, Dr. Chowdhury drew attention to the innumerable obstacles these paramedics have to encounter in breaking through the traditional and exploitative systems. He recounts a particular case thus:

"Nizam was 25 years old. He had been with the project as a paramedic since its inception, and when a paramedic subcentre was to be set up at Shimulia he was the one arranging the final details of the land. It was felt that the

coming of the centre to Shimulia would threaten the fraudulent practices of a good many people, including illegal possession of government lands, smuggling, and selling health centre drugs. Among those involved in the illegal activities was a qualified physician in the area, who was making a handsome profit. Nizam did not realise just how great a threat the new centre was. In collaboration with local officials, i.e. the union chairman and a union member, the physician is said to have hired a group of thugs to have Nizam murdered, confident that he could make the necessary payments to the proper people, allowing him to continue his illegal work, along with his cohorts, and ensuring that the centre would not become a permanent fixture in Shimulia. Nizam lost his life, and now an almost incredible struggle for simple justice seems to be availing nothing. We have come face to face with the village. We have reached, it seems, our limit. Do we carry on with our small struggle or are we sustaining a system that would (and should) crumble sooner without our gallant efforts. And even if we choose to work on, can *Gonoshasthaya Kendra* last in its present form? How viable can a body remain when it is alien to this system in which it operates? These are questions may be others can help us answer. An example which proves very strongly that preaching 'people's participation' and their involvement in development is quite easy, but for those personnel who help to put it into practice the task is almost impossible".

An Assessment

The *Gonoshasthaya Kendra* project has received funds from outside sponsors, but depends partly on local financial support, and it hopes to ultimately become totally dependent on local income.

Some funds have been spent on unnecessarily grandiose buildings (at the wish of the sponsors). The funds received from outside have mainly been used for setting up the centre; while the actual village community development work being undertaken is largely self funded.

Intended initially to be only a health care service in a typical rural area, it was soon realised that in response to the real needs encountered in the course of medical work that the project must

supplement its health work with programmes in family planning, agriculture, nutrition and education and vocational training. More important is that the original team that came into Savar to set up the project in 1972 found the need to absorb into the staff of the project (especially as paramedics) the people from this area; and therefore, co-operation has been sought and received readily from people of all levels in the local community. As a result of this close relationship between the project and the local community there has been all along an interchange of ideas; the project staff listen as well as speak. Thus, the aims and methods of the project are subject to constant revision.

A final judgement of this project cannot be made at this stage as it is still in the process of creation. But it has evoked a favourable response among other projects in various other parts of the country. The mere fact that local women, locally trained, are successfully performing tubal ligations and other skilled work, indicates clearly the potential of ordinary local people as opposed to "qualified specialists", for solving local problems, if only they are given the opportunity to be active participants in the development process.

The entire programme has brought into focus one definite lesson and that is before one can find and prescribe a solution to a problem one should understand the problem fully; if not one might find oneself fighting the symptoms rather than the causes of a problem. People involved in rural development work should not only try to understand the local situation with its economic, political and social structures (the micro situation) but also the connections of this situation with the macro situation, the power structures at the national and international level. The micro and the macro situation, one would find are intricately bound together. One must be able to see and comprehend these links and connections for in such links may also be found the causes of as well as the solutions to poverty. Those behind the *Gonoshasthaya Kendra* project of Bangladesh have shown a keen awareness of these links and it is perhaps this which accounts a great deal for their achievement.