Despite constitutional guarantees, Bangladesh is failing to deliver adequate healthcare to rural citizens

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Bangladesh's Constitution indicates that health is a basic right, and that the government is responsible for ensuring citizens' access to healthcare. Yet the current system is failing those living in rural areas, even though they make up the majority of the population. ***Mohammad Tarikul Islam*** *discusses the structure of health services in rural areas and where main challenges lie.*

National economic and social development depends to a degree on the status of a country's health facilities. The healthcare system reflects the socio-economic and technological development of a country and is also a measure of the responsibilities a community or government assumes for its people's well being.

The Constitution of the People's Republic of Bangladesh guarantees that 'health is the basic right of every citizen of the Republic'. The Ministry of Health and Family Welfare leads on policy formulation, planning and enforcement. Within this, there are five Directorates: health Services, family planning, nursing services, drug administration and health engineering. In recent years, health policy has focused on sustaining provision of basic services to the entire population, particularly to under-served rural communities.

The Union Parishad is the lowest tier of the local government of Bangladesh and plays an important role in rural development. One of its responsibilities involves providing health security to the rural population, which is a challenging task given that only 30% of Bangladeshis live in cities and there is limited infrastructure and a lack of health professionals in rural areas. A standard upazila (district sub-unit) in Bangladesh will have a Health & Family Welfare Center at Union Parishad level and Community Clinics at village level. The Welfare Centre offers general health services, and basic reproductive, maternal, and child health care services for local people free of charge, and each one has a Medical Assistant trained for three years in disease prevention, health education and basic first aid, and a Family Welfare Visitor who receives 18 months of training in family planning, reproductive health, and pre- and post-natal care.

Community Clinics are government run (having taken the place of local clinics which were established as part of a donor driven mega programme initiated on pilot basis from 1996-2000). They are mostly used by people living within a half-mile radius, but around 50 percent of rural women are not aware of their existence and many rural people prefer to consult with a *palli chikitshak*, a local village doctor without any formal healthcare training. This is perhaps unsurprising given that clinics are ill managed and understaffed and therefore associated with poor quality care and attention to patients.

Maternal and child health training funded by AusAid. Credit: Department of Foreign Affairs & Trade, Australia CC BY 2.0

Public healthcare is supplemented by efforts led by local entrepreneurs, NGOs and international organisations. A number of local NGOs like BRAC have special reproductive health care programs and facilities for providing antenatal and safe delivery care. There are also numerous private clinics throughout the country and many doctors from the public hospitals deliver services part-time in these clinics to supplement their incomes. The clinics operate on a fully commercial basis and are therefore costly, but those who have the resources prefer them because they are seen as offering better quality than public hospitals. However, private clinics lack accountability because they cannot be regulated by the government.

Despite the facilities and support provided by both the government and private/NGO providers, rural healthcare in Bangladesh is therefore inadequate. For every one million people there are just 241 physicians, 136 registered nurses and 10 hospitals (making the availability of hospital beds 1 for every 4000 people). The available literature suggests that health security for rural people is undermined by the lack of physicians, employees and nurses', misdiagnosis, negligence towards patients, irresponsibility, absenteeism and a lack of professional ethics. Furthermore, although the bulk of the population of Bangladesh lives in rural areas, most doctors are based in cities and towns. Doctors are deterred from serving in the villages due to the absence of proper capacity development, accommodation, quality education, transportation facilities, and the lack of career prospects. The Union Parishad also struggles to push for improvements due to the scarcity of resources and dynamic leadership.

A comprehensive National Health Policy was introduced in 2011 and re-emphasised every citizen's basic right to adequate health care and the state and the government constitutional obligation to provide the necessary infrastructure. Its stated objectives were to strengthen primary health and emergency care for all, expand the availability of client-centred, equity-focused and high quality health care services, and encourage people to seek care based on rights for health. However, this has not been effectively enforced over the last five years, and as a result health provisions are unevenly distributed across the country and access to the best care will be prohibitively expensive for the majority of rural Bangladeshis.

It is obvious from the above discussion that the Union Parishad is one of the most important units of government in overseeing the health security for rural population but it is confronted with chronic problems which it does not have the resources to address on its own. Central government support and enforcement of existing legislation alongside greater cooperation with civil society organisations, the media, academics and the donors is needed to enable local government to ensure a higher standard of basic healthcare in rural areas.

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