HCI Policy Note 2: Why Community Clinics Need Strengthening, not to be Abolished

Revitalizing Bangladesh's Community Clinics: A Strategic Imperative for Universal Health Coverage

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Summary: This note argues against the recent proposal to phase out Bangladesh's community clinics, highlighting them as essential for achieving Universal Health Coverage (UHC). Established in 1998, these clinics provide low-cost, vital primary healthcare to rural populations, albeit some shortcomings. Their abolition will undermine major health gains, deepen inequities, and contradict Bangladesh's development goals.

Drawing lessons from Thailand, Brazil, and Rwanda—countries that strengthened community-based healthcare as pillars of their UHC success—the paper advocates for revitalizing, not abolishing, community clinics. Key reforms proposed include increasing primary healthcare financing, professionalizing and incentivizing health workers, integrating digital health systems, upgrading infrastructure, and enhancing community ownership.

While rejecting the abolition idea, this note recommends reforming governance through the Community Clinic Health Support Trust (CCHST), mobilizing international support, and piloting a revitalization model to strengthen Bangladesh's rural healthcare system.

The conclusion emphasizes that community clinics are a strategic asset, not a failure, and with investment and reform, they can be a global model for efficient and equitable healthcare delivery.

2. Background and Context

2.1 Community Clinics in Bangladesh

Established in 1998, community clinics represent a decentralized approach to primary healthcare delivery. Each clinic caters to 6,000 people and is staffed by three key health workers, offering

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preventive, promotive, and basic curative services. Over 13,000 such clinics are operational across Bangladesh today.

2.2 Policy Reform Threat

A reform proposal has suggested the abolition of community clinics, citing inefficiencies and duplication. However, the proposal fails to recognize:

- Their **critical role in rural health service delivery**
- Their **low operating costs**
- The **absence of viable alternatives** in many remote regions

3. The Strategic Value of Community Clinics

3.1 Achievements to Date

- Significant increase in **antenatal care, immunization, and contraceptive use**
- Reduction in **maternal and infant mortality rates**
- Improved **health-seeking behavior** in rural populations
- Crucial role during **COVID-19** for awareness and referrals

3.2 Role in Equity and Accessibility

- Community clinics bring healthcare to **last-mile populations**, especially women and children
- Reduce **financial and geographic barriers**
- Enhance **trust in public health systems**

4. International Evidence: Strengthening, Not Abolishing

4.1 Thailand's Tambon Health Promoting Hospitals

- Anchors of Thailand's successful UHC journey
- Embedded in communities, well-staffed, linked to referral networks
- Fully government-funded with digital health integration

4.2 Brazil's Family Health Strategy

- Teams include doctors, nurses, and community health agents
- Cover over 120 million people with strong preventive focus
- Linked to reduced hospitalizations and better chronic disease management

4.3 Rwanda's Community Health Worker System

- 45,000 trained volunteers integrated into national health strategy
- Instrumental in achieving high maternal care and immunization rates
- Supported by mobile health tools and performance-based incentives

5. Why Abolishing Community Clinics is Counterproductive

- **Loss of service coverage** for roughly 85 million rural residents
- **Undermines past gains** in maternal and child health
- **Increases health disparities** in underserved regions
- **Contradicts SDG and Vision 2041 commitments**

6. A Roadmap for Revitalization

6.1 Governance and Financing

- Increase allocation from <3% of health budget to at least 10% for primary care
- Integrate community clinics into local government health planning

6.2 Human Resources

- Upgrade skill sets through **continuous professional development**
- Ensure retention through incentives and career pathways

6.3 Technology and Data Systems

- Introduce **electronic health records and telemedicine**
- Real-time data collection for **monitoring and accountability**

6.4 Supply Chain and Infrastructure

- Ensure consistent supply of **essential medicines**
- Upgrade infrastructure to support safe deliveries and diagnostics

6.5 Community Ownership

- Strengthen community groups and health management committees
- Incorporate **social accountability tools** (e.g., scorecards, feedback loops)

7. Strategic Recommendations

1. **Rejecting abolition proposal** and, instead, adopting a **reform and investment** strategy
2. Aligning community clinics with a **national UHC strategy**
3. **Strengthening capacity of CCHST** and enabling its autonomous governance structure
4. Mobilizing **development partners** (multi-lateral development banks (e.g., World Bank), United Nations (e.g., World Health Organization – WHO) and bilateral partners (e.g., JICA) for support
5. Creating **interoperable digital systems** to link clinics with higher care levels
6. Launching a **pilot revitalization initiative** in 2–3 divisions to model scalable success

8. Conclusion

Community clinics are not a policy failure—they are an **underutilized and underfunded success story** waiting to be scaled. The way forward is not in dismantling the system, but in **strengthening its foundation, rethinking its design, and reinvesting in its mission**. With political will, innovation, and community ownership, Bangladesh can turn its community clinic network into a global model for inclusive and equitable health care.