

Empowering Rural Healthcare: The Origins, Growth, and Present Status of Bangladesh's Community Paramedics Program

Bangladesh has long faced a critical shortage of formally trained health human resources, historically operating with a sharp deficit in its physician-to-population ratio. While urban centers house the vast majority of qualified doctors, nearly 70% of the population resides in rural areas where access to formal primary healthcare remains heavily restricted. Compounding this issue, most private clinics and hospitals in urban and semi-urban areas are heavily dependent on unqualified clinical support staff who lack formal training or certification.

To bridge this healthcare divide, a unique and highly structured healthcare cadre emerged: the **Community Paramedic (CP)**. Distinct from traditional community health workers, traditional birth attendants (TBAs), or informal "village doctors," Bangladesh's Community Paramedics are formally educated, certified professionals trained to provide essential maternal, neonatal, child health, and primary curative services directly to underserved rural communities.

1. History and Genesis: From FWV to the CP Cadre

The blueprint for utilizing mid-level healthcare providers in Bangladesh traces back to pioneering non-governmental organizations (NGOs) in the early post-independence era. In 1972, organizations like *Gonoshasthaya Kendra (GK)* began training local para-professionals to deliver unsupervised primary care across rural villages, proving that heavily supervised local workers could drastically cut maternal and infant mortality rates (Bhuiyan & Haque, 2024; Ellangovin, 2009).

Over the decades, organizations expanded these methodologies to address acute humanitarian crises and systemic gaps. For instance, Research, Training, and Management International (RTMI) developed and implemented a model of training Community Trained Birth Attendants (CTBAs) in 2008—a one-year, mentoring-based course that included two months of clinical skill training involving Rohingya youth in the Cox's Bazar refugee camps. RTMI also initiated a one-year Community Health Worker (CHW) course with the approval of the Ministry of Health and Family Welfare (MOHFW) through the State Medical Faculty (SMF), though the SMF discontinued the program after a few years of operation. Concurrently, larger NGOs like BRAC scaled up vast networks of traditional CHWs (Bhuiyan & Haque, 2024).

However, as the rural disease burden shifted and the demand for more advanced, clinical, and standardized healthcare grew, a clear structural gap became evident. The informal health sector, composed of traditional healers and untrained village doctors, vastly outnumbered formal providers yet lacked regulated clinical knowledge (Khan et al., 2015).

The Generational Vacuum

The conceptual foundation of the modern CP program is deeply rooted in the history of Bangladesh's highly successful Family Planning and Maternal and Child Health (FP-MCH)

programs of the 1980s and 1990s. The technical backbone of this historic success was the **Family Welfare Visitor (FWV)** cadre.

Unfortunately, due to severe funding shortages, the government's 18-month FWV training program was completely halted for over 11 years. As the first generation of government-recruited FWVs retired, a critical generational vacuum emerged in rural maternal and infant care, making a second generation of mid-level clinicians essential.

The Advocacy and Policy Dialogue

Recognizing the impending crisis, Dr. Ahmed Al Kabir, the former President of RTMI, spearheaded an intensive advocacy campaign to establish a sustainable, private-sector alternative to the state-funded FWV training program. RTMI organized a series of high-level policy dialogues and consultations, notably partnering with the **American International University-Bangladesh (AIUB)** and national media outlets like *The Daily Prothom Alo* and *The Daily Star*, to build public and political consensus on the urgency of reviving this healthcare tier.

Following these consultations, Dr. Ahmed Al Kabir initiated formal dialogues with the MOHFW. It has resulted in the formation of an official ministry-level committee:

- **Chairperson:** Additional Secretary of the Ministry of Health and Family Welfare.
- **Private Sector/NGO Representation:** Dr. Ahmed Al Kabir served as the sole private sector and NGO representative on this strategic committee.

The committee ultimately agreed to anchor the new course within the **National Institute of Population Research and Training (NIPORT)** and the **State Medical Faculty of Bangladesh**.

The NIPORT Era: Formalizing the Curriculum

To institutionalize the reliable tier of rural health clinicians, the MOHFW designated NIPORT to design and spearhead the formal curriculum for Community Paramedics. In the late 2000s, NIPORT, acting as the state's apex training and research institute for population health, meticulously formulated the framework for a two-year technical program.

To build the curriculum, the committee decided to adopt **90% of the original FWV content** and expand it into a comprehensive two-year program. NIPORT formed a dedicated working group to develop the curriculum and teaching materials, introducing two crucial components to the core framework:

1. **An additional six months of intensive skill development training** focusing explicitly on Basic Safe Delivery.
2. **Language training (English or Arabic)** to enhance functional communication and open pathways for international professional mobility.

Upon finalizing this exhaustive curriculum development process, NIPORT approved the first pioneering cohort of **12+ institutions and organizations (all NGOs)** to officially impart the two-year Community Paramedic training. To guide and support these newly minted centers, a

private-sector *Association of Private Training Institutes and Organizations* was established, with Dr. Kabir serving as the foundational nucleus of the association.

The Regulatory Shift to BNMC

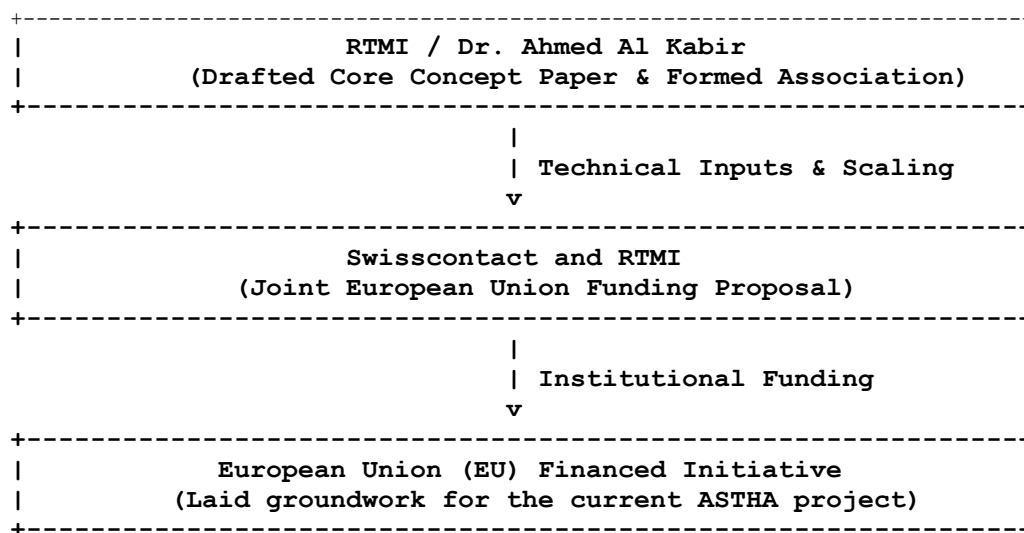
As the program matured and the number of private and NGO-led Community Paramedic Training Institutes (CPTIs) scaled across the country, the need for a strict, long-term clinical regulatory body became apparent. To ensure continuous professional standards, formal licensing, and institutionalized examinations, the regulatory oversight of the program was structurally transferred from NIPORT and the State Medical Faculty over to the **Bangladesh Nursing and Midwifery Council (BNMC)**. Under the BNMC's contemporary jurisdiction, the curriculum became strictly regulated, legally binding the CP cadre to formalized national nursing, midwifery, and mid-level clinician standards.

2. Evolution, Swisscontact and RTMI Partnership, and Growth Drivers

As the foundational framework of the CP program solidified, the strategic focus shifted toward long-term sustainability and systemic capacity building.

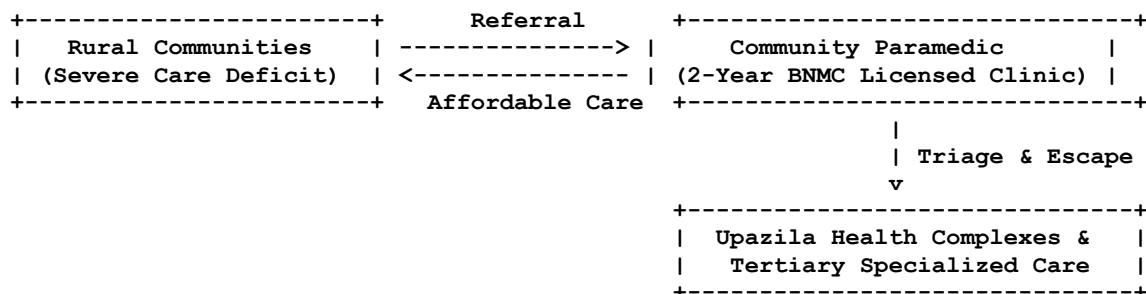
To scale the initiative, Dr. Ahmed Al Kabir, on behalf of RTMI, drafted a pivotal **Concept Paper** aimed at strengthening the institutional capacity of the CP program. The document was technically refined and finalized in partnership with **Swisscontact**. RTMI and Swisscontact jointly submitted this proposal to the **European Union (EU)**, successfully securing the vital international funding required to institutionalize private-sector community paramedicine across Bangladesh.

The contemporary **ASTHA** (*Achieving Sustainability Towards Healthcare Access*) project, currently implemented by Swisscontact, is the direct, evolved follow-up of this historic RTMI-Swisscontact partnership.



3. Present Status

Today, the modern CP curriculum remains structurally anchored to that first foundational blueprint, though it has undergone iterative developments to adapt to modern medical practices. Community Paramedics serve as an indispensable, frontline tier within Bangladesh’s pluralistic healthcare ecosystem.



Scope of Modern Practice

Licensed CPs balance clinical employment within established health facilities alongside a highly successful **Micro-Enterprise Model**, operating independent rural health posts or clinics. Their current clinical responsibilities are diverse:

- **Maternal & Neonatal Care:** Assisting doctors, nurses, and midwives in conducting antenatal and postnatal checkups, tracking high-risk pregnancies, and facilitating safe, hygienic institutional deliveries or timely referrals. They also establish and run specialized breastfeeding corners within clinics.
- **Primary Care, Diagnostics, and Triage:** Assisting medical staff in diagnosing and managing common childhood illnesses (such as pneumonia and diarrhea), managing acute infectious diseases, and treating basic skin conditions.
- **Chronic Disease Monitoring:** Partnering with primary care physicians to facilitate home visits, routine assessments, and evidence-based tracking for chronic conditions like Chronic Obstructive Pulmonary Disease (COPD), hypertension, and diabetes.
- **Family Planning & Nutrition:** Providing critical contraceptive counseling and addressing nutritional gaps in young children. They provide clinical contraceptive services, including intrauterine device (IUD) insertions and injectable services, matching the capabilities historically held by FWVs.
- **Clinic Aides and Vaccinators:** CPs are increasingly employed in both NGO and private sector clinics as formally trained Clinic Aides and Vaccinators, successfully replacing unqualified, untrained staff.
- **Infection Prevention:** Supporting institutional quality assurance activities, including autoclaving, medical storage maintenance, and strict infection prevention (IP) protocols.

mHealth and Digital Health Integration

A significant modern milestone is the convergence of community paramedicine with mHealth and telemedicine frameworks. Utilizing mobile health applications, smartphones, and portable diagnostic tools, contemporary CPs regularly bridge the geographical gap by

consulting urban-based medical specialists via digital video links. This ensures that isolated rural populations receive accurate, evidence-based, expert assessment right from the village clinic.

4. Key Challenges and the Path Forward

Despite its undeniable success in making healthcare accessible, the Community Paramedics program faces ongoing institutional and market hurdles:

| Challenge Area | Current Impact |
|---------------------|--|
| Market Competition | CPs frequently compete with entrenched, unlicensed "village doctors" who often prescribe unnecessary antibiotics or cheap, unregulated over-the-counter medications. |
| Gender Barriers | A large percentage of CPs are women. Operating independent night clinics or traveling solo to remote villages occasionally clashes with traditional social dynamics, requiring continuous local community and structural backing. |
| Career Architecture | There remains a strong push for the government to structurally absorb more licensed CPs directly into public rural community clinics to provide them with a predictable, long-term career path. Advocates argue the government should systematically employ CPs in the vacant positions historically reserved for FWVs, thereby removing the need to train new FWVs using limited government funds. |

The Community Paramedics program of Bangladesh has successfully transitioned from a critical, crisis-driven advocacy campaign led by private sector visionaries like Dr. Ahmed Al Kabir and RTMI into an internationally funded, state-regulated healthcare paradigm. By fusing the historical strengths of the FWV framework with advanced clinical training, language skills, and private-sector adaptability, the program provides a scalable, resilient blueprint for resource-limited nations worldwide striving to achieve universal healthcare coverage.

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