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Health Predicament of Dhaka during Pakistan Period

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ABSTRACT

This paper documents the health system of Dhaka during the Pakistan period. In this tenure, the total public sector of East Pakistan was fragile. Despite being endowed with limited privilege, Karachi surpassed Dhaka in the total number of health institutions and in doctor-patient ratios. This evident health disparity, we argue, cannot be attributed to regional differences in several age populations, health infrastructure types, the quality, and unit cost of treatment. The city experienced significant political and socio-economic transformations that adversely affected public health. The study aims to identify the main health challenges, including the prevalence of infectious diseases, malnutrition, and inadequate sanitation, which contributed to a deteriorating health landscape. Furthermore, it explores the healthcare infrastructure and services available during this period, assessing the capabilities of hospitals, clinics, and public health initiatives in addressing these challenges. By examining the interplay between socio-political dynamics and healthcare delivery, this research seeks to provide a comprehensive understanding of the health predicament in Dhaka during the Pakistan period, shedding light on the historical context that shaped public health in the region.

KEYWORDS: Dhaka, Health Management, Pakistan, Discrimination, Challenges

1. INTRODUCTION

A health system represents how a society reacts to the factors influencing health. Each society has its own beliefs about what influences health, and these beliefs don't always align with scientific evidence or rational thinking. At its core, a health system is based on the principle of valuing human life. The extent to which a society values human life largely dictates how much human, material, and financial resources it dedicates to its health system. The success of a health system hinges on the extent to which services are made available and accessible in ways that people can understand, accept, and use effectively (Anwar Islam, 2014). Dhaka was the capital of East Pakistan (now Bangladesh), which was the main center of all kinds of developments from the Mughal period. In 1947, following the independence of the British colony, Dhaka was also designated as the provincial capital of East Pakistan. The city became one of the most populous towns regarding all sectors, including financial, socio-cultural activities, educational progress, healthcare services, etc. Amidst the incessant political turmoil of that time, it was very hard for a new Dhaka to be stable. After the partition of Bengal in 1947, the health management of East Pakistan was fragile. In addition to administrative, economic, and political disparity, the health sector was extremely neglected during this epoch. The root of the disparity in Pakistan, based on the two-nation theory, was the lack of equitable distribution of resources between the two provinces. During the regime of Pakistan, five-year plans were adopted three times, but most of the fund allocation was spent on the development of West Pakistan. Due to the need for egalitarian policies from the ruling party of Pakistan, there was a dearth of medical institutions in the country. There were only two medical institutions in Dhaka during this regime. There was a great disparity between the two provinces of Pakistan, and the first instance of disparity was through the language movement, in which medical students became advocates for the protection of the country, demanding Bengali as the state language of Pakistan alongside Urdu. The first rise of discrimination was during the language movement, where medical students became advocates for the protection of the country and the demand for the Bengali language. There was a shortage of equipment in hospitals, a lack of enough doctors, and low salaries for officials. Such a crisis in the health system motivated those concerned with it during the freedom struggle of Bangladesh. Many of them played a role in the formation of a free country by serving the freedom fighters or by participating

in the liberation war of Bangladesh alongside the fighting masses. That is why the history of the health system of Dhaka during the Pakistan period has become an important part of the national history of Bangladesh. While past literature has focused on the health environment of Dhaka in the pre-Pakistan period, earlier studies, such as Dr. Sharif Uddin Ahmed (2010), focused on a health institution in Dhaka from 1858 to 1947, not exactly covering the Pakistan period. Another contemporary research highlights Dhaka Medical College. Existing health research on this topic is not exhaustive. From this consideration, the present study has been conducted. The objective of this study is to analyze the nature of the health predicament of Dhaka. The paper is divided into four parts. Chapter one provides a historical context of Dhaka as a capital and the background of the health environment of this city. The second chapter discusses the main health challenges of Dhaka, and the third chapter covers the healthcare infrastructure and services during this period. The final chapter addresses the impact of socio-political factors on public health and the government-public response to these challenges.

2. METHODOLOGY

This study adopts a qualitative and historical research methodology to explore the health predicament of Dhaka during the Pakistani period (1947–1971). The focus is on understanding the meanings, contexts, and interpretations of historical events and personal experiences as they relate to the health facilities of Pakistan. The conclusions are based on information from primary and secondary sources. I used a variety of sources to learn about the health environment and management of Dhaka. These sources included autobiographies, official documents such as letters, diaries, archival sources, newspapers, and historical records made by the governments of Pakistan. In addition, sources from the internet, books, journals, research reports, seminar reports, reviewing reports, and editorials were used for the study. In order to draw a conclusion from this study, I state my positions as follows: I look into the things that are creating disparity between the two wings of Pakistan that affected the health system of Dhaka, which was another factor operating in East Pakistan to become Independent Bangladesh.

1. Historical overview

Dhaka City, located in the heart of Bangladesh, lies in the southern region of Dhaka district. It spans between latitudes 24°40' N to 24°54' N and longitudes 90°20' E to 90°30' E. The city is bordered by the Buriganga River to the south, the Balu and Shitalakhya Rivers to the east, Tongi Khal to the north, and the Turag River to the west (Hossain, Rapid Urban Growth and Poverty in Dhaka City n.d.). Dhaka gained some distinction in the seventeenth century during the Mughal era when it became the capital of Subah-e-Bangla, the province of Bengal, around 1610 (some say 1608) (Kamol 2008). As late as the nineteenth century, James Taylor, a British officer stationed in Bengal, found Dhaka “with its minarets and spacious buildings, the appearance, like that of Venice in the west, of a city rising from the surface of the water” (Taylor 1840). The birth of Dhaka is inextricable from various parts of Bangladesh and beyond; over the past decades, people of different races, religions, and languages have arrived, including Afghans, Greeks, Portuguese, Dutch, French, and English, mostly for reasons of trade and commerce. After the partition of Bengal, Dhaka found itself flooded with people from all over the country, mostly seeking shelter and employment. The population of the city increased from a meager 69,000 when the first census was conducted in 1872 to nearly 240,000 in 1941 (Hossain, Rapid Urban Growth and Poverty in Dhaka City, 2008). The exploration of Dhaka's healthcare system dates to the city's origins. During the Mughal era, traditional Ayurvedic or Kabiraji medicine was widely practiced in the region (D. S. Ali, Bangladesh District Gazetteer Larger Dhaka 1993). Western medicine arrived in the Indian subcontinent through European trading companies. Initially, the medicine was used among the soldiers living in this country. Later, in 1764, when the Indian Medical Service was formed for doctors and related personnel, the foundation of Western medicine was strengthened (D.

S. Ahmed 2007). In 1803, a hospital for the local population was established in Dhaka as a branch of the Calcutta Native Hospital. However, it provided care to only 40% of its patients and struggled to offer adequate medical services due to poor ventilation and limited space. In 1839, a government charitable dispensary with 100 beds was set up through Taylor’s efforts, but both institutions lacked proper equipment and sufficient medical staff to meet the needs. Throughout the 19th century, Dhaka had a limited healthcare infrastructure, consisting of a Native Hospital, a Military Hospital, a lunatic asylum, and a prison hospital, all of which were inaccessible to the public (Mamun 2015). Mitford, the Collector of Dhaka, donated a portion of his property for the welfare of the city's residents before his death. Using these funds along with local zamindars' donations, Mitford Hospital was established in 1858. The hospital's head was always a European, serving as the civil surgeon of Dhaka. Dr. Alex Simpson, the first European doctor, was appointed as its supervisor. In response to local needs, Dhaka Medical School was founded in the 1870s (Report on the Vernacular Medical Schools of Patna 1880). The government decided to transfer the management of Mitford Hospital to the Dhaka Municipality. From 1883 to 1920, the hospital operated under municipal control. However, due to its high operational costs, the services remained accessible only to the upper class. That hospital was nationalized in 1920. In the 1930s, the Western medical system in Bengal expanded with the addition of personnel such as doctors, nurses, and staff, along with the

introduction of several departments. However, the infrastructure remained limited, comprising facilities like a dental clinic and departments for ear, nose, and throat care. Although many students graduated from Dhaka Medical School since its establishment, adequate job opportunities were lacking for them. Recognizing the need for MBBS doctors, the people of Bengal had long been urging the government to establish a medical college in Dhaka. In the 1944–45 session, Dhaka University established a multipurpose medical faculty in response to the growing need for a medical college. On August 14, 1945, shortly before the end of World War II, the people of East Bengal voiced a strong demand for its establishment. As a result, following the end of World War II, Dhaka Medical College was established in 1946, with W.J. Virgin serving as its first principal (Lieu 2012). The healthcare facilities of Dhaka during the pre-Pakistan period were not good at all.

Partition of Bengal in 1947: Health System of Dhaka

The population growth significantly altered the city's composition, with Dhaka's population increasing from 343,740 in 1951 to 543,565 in 1961 and reaching 1,522,776 by 1971 (Statistics n.d.). A major factor behind this surge was rural-to-urban migration, which contributed to 60% of the city's population growth during the 1960s and 1970s (Dhaka, Bangladesh Population 2024). World Population Review. Retrieved September 28, 2024, from https://worldpopulationreview.com/cities/bangladesh/dhaka n.d. In addition to becoming a megacity and experiencing all related ills, particularly against the backdrop of inadequate infrastructure, the city has continued to grow.

Since becoming the capital of East Pakistan in 1947, the landscape of Dhaka city has been undergoing rapid change. The city expanded northward, and the high-class residential areas were constantly endeavoring to keep themselves at the northern periphery of the city by creating “New Dhaka,” mainly because higher lands were available in the north and lowlands in the east and west were vulnerable to annual floods. The Motijheel area, once desolate and lying on the fringe of marshes and swamps, was earmarked as a commercial area in 1954. To cater to the ever-increasing residential needs of the new capital, the Dhanmondi area, which was adorned with paddy fields, came to be developed as a residential area after 1955. Urban areas are key contributors to climate change on multiple levels, yet they are also highly vulnerable to its effects. This vulnerability is due to their dense populations, environmentally risky conditions, and lower socioeconomic standards. Climate change can significantly affect human health, leading to increased illness and mortality, as well as altering the patterns and distribution of diseases. While the connection between temperature and health has been explored in developed nations, there is limited understanding of how atmospheric conditions impact disease burden in developing countries, particularly those with tropical climates. The rapid pace of urbanization, often called the 'urban turn,' is giving rise to megacities, with more than 75% of them located in the developing world. Dhaka, currently the eleventh-largest city globally and one of the fastest-growing, is expected to face many of these public health challenges (Burkart 2009).

Public Health Challenges of Dhaka

The poor living conditions in Dhaka, such as overcrowding, lack of clean water, and inadequate sanitation, made it easy for diseases like cholera, tuberculosis, and malaria to spread.

Most of the drains in Dhaka city were broken, and the covers over the manholes were shot and destroyed. It was not possible to clean the drains without repairing and improving them. In most places, the water from above-ground drains could not meet with the underground drains. So, the water would accumulate. As a result, mosquitoes could lay eggs and spread diseases. The lack of a drainage system and the inability to easily carry away black feces at night were the main reasons for the spread of epidemics. Apart from this, the main sources of water supply in rural areas were reservoirs and ponds. All these ponds were not hygienically maintained and contributed to the spread of diseases and the emergence of epidemics. Food items were kept open in the old Dhaka city market. Edible oil, ghee, and milk were also adulterated in food and sweets.

Due to the discriminatory policies of the government of Pakistan, medical scientists in medical colleges did not make much progress. The rich could go to the city to get medical treatment, but the common people couldn’t afford it. As a result of this poor state of the health system, the number of child deaths and premature deaths of mothers increased in the city.

Malnutrition made people even more susceptible to these diseases because it weakened their immune systems. Since people didn't have access to clean drinking water, they often got sick with diseases like diarrhea, cholera, and dysentery, especially in poorer areas.

Health Challenges in East Bengal (1950s-1960s)

In the 1950s, East Bengal (later East Pakistan) faced several public health crises due to widespread communicable diseases, including cholera, malaria, kala-azar, dysentery, tuberculosis, smallpox, and leprosy. The inadequate response from the government exacerbated these issues, leading to a significant loss of life and suffering, especially among vulnerable populations.

Leprosy, also known as Hansen's disease, was prevalent in East Bengal, driven by poverty, overcrowding, and poor medical infrastructure. The disease carried a heavy social stigma, causing patients to be ostracized from society. In 1950 alone, 70 people in Dhaka died from leprosy. Although there were a few missionary and charity-run hospitals offering treatment, specialized care remained limited. Mohakhali in urban Dhaka housed a leprosy care hospital that treated 564 patients, but rural areas had no dedicated clinics. Efforts to control the disease increased in the 1950s and 1960s, supported by WHO and NGOs. These initiatives included public awareness campaigns and treatment centers; yet, progress was hampered by political instability and limited resources.

Tuberculosis (TB) was another severe health challenge, spreading rapidly due to overcrowded living conditions. With the expansion of factories in Dhaka city, people from rural areas flocked to the city in search of employment. They lived day after day in unsanitary conditions in overcrowded slums. The economic lifestyle in both urban and rural areas, characterized by low mobility, malnutrition, lack of health education, and unsanitary living arrangements, contributed to the spread of this disease. It primarily affected the lungs and spread through airborne droplets from infected individuals. People usually wanted to hide their TB disease and hesitated to report it to the concerned authorities. As tuberculosis is a contagious disease, people were very afraid of it. When the disease occurred in a family, other family members tried to avoid them at weddings and other social functions. Thus, the number of deaths reported due to the disease is probably much lower than the actual death toll. In 1952, acute TB infections led to the deaths of 7,533 people in West Pakistan and 3,723 in East Pakistan. After partition until 1959, the average annual death rate from this disease was 486.07 per thousand in Dhaka.

Cholera was even more devastating, with outbreaks peaking during monsoons when floodwaters contaminated drinking supplies. Cholera outbreaks occurred twice a year, once from September to December and once from February to April. Since it was a waterborne disease, cholera epidemics occurred at the beginning of the season when the water began to recede and before it finally settled. In rural areas, raw latrines were often built on the banks of rivers or on the surface of ponds and drains, and cholera epidemics spread due to villagers drinking and using contaminated water from the same water bodies. The bacterium Vibrio cholerae spread quickly through unsafe water and food, resulting in 18,361 deaths in East Bengal in 1952 alone. Cholera's impact was felt across Dhaka and other parts of East Pakistan, with little preventive action from the central government. Smallpox also remained a significant threat, causing 7,158 deaths in East Bengal in 1952. Although the disease would eventually be eradicated globally in the late 1970s, it caused widespread mortality and left survivors with disfiguring scars. The main reasons for the spread of smallpox among women were veil practices and the lack of female immunizers.

Recognizing the seriousness of the TB epidemic, the Pakistani government, with support from WHO and UNICEF, established a Tuberculosis Hospital in Dhaka in 1953. Due to a shortage of hospital beds across the region, this facility treated not only TB patients but also those suffering from other illnesses. However, the disparity in care between the two wings of Pakistan was evident—West Pakistan had 1,128 hospital beds for TB patients, while East Bengal had only 284. A close relationship is usually observed between water and drainage systems, with malaria incidence increasing in autumn when water levels are low. The number of deaths due to malaria usually increased from September and reached its peak in December. Malaria was rampant, particularly in the rural areas of East Bengal, where stagnant water created breeding grounds for Anopheles mosquitoes, which transmit the disease. Children were particularly vulnerable, with high morbidity and mortality rates. Although quinine was available as a preventive treatment, the government failed to distribute it effectively. Instead, they profited by selling the drug, earning approximately 100,000 rupees. Kala-azar, though less prevalent than other diseases, was present in Dhaka during this period. The death toll from the disease dropped from 601 in 1948 to 149 by 1958, indicating some progress in controlling the outbreak. In 1963, 1,024 kala-azar patients were treated in Dhaka, showing continued efforts to manage the disease. In the late 1960s, there was a greater focus on leprosy control, with international organizations like WHO and NGOs introducing multi-drug therapy and public awareness campaigns. However, political instability, insufficient funding, and a lack of public awareness limited the effectiveness of these initiatives. Social stigma persisted, complicating efforts to treat and reintegrate leprosy patients into society. The health crises in Dhaka and East Bengal during the 1950s and 1960s highlight the region's vulnerability due to poor healthcare infrastructure, neglect by the central government, and socio-economic challenges. Diseases like cholera, TB, and malaria caused widespread suffering, while efforts to manage chronic illnesses like leprosy faced significant social and institutional barriers. Non-communicable diseases (NCDs) gradually emerged as a significant public health challenge in Dhaka during the Pakistan period. These chronic

conditions, influenced by a combination of genetic, physiological, environmental, and behavioral factors, started to affect urban populations as lifestyle changes became more prominent. Although infectious diseases dominated the public health discourse, NCDs such as heart disease, diabetes, cancer, and high child and maternal mortality rates became growing concerns over time. Cancer began to appear as a notable health issue, although it received limited attention during the early Pakistan period. In 1950, the disease had a reported death rate of 14 per thousand people, according to data from the Bangladesh District Gazetteer (1993). Specialized cancer care was virtually nonexistent, and early detection was rare. While cancer was not a major focus in public health before the separation of Bengal, it gradually became a recognized threat as cases increased. The Bangladesh Bureau of Statistics (BBS) later identified cancer as the sixth leading cause of death in the country. Lung and oral cancers were prevalent among men, while breast and cervical cancers affected many women. High child mortality rates posed a major health challenge during the Pakistan period. Between 1948 and 1958, the average number of child deaths was 7,787 annually. These deaths were often attributed to malnutrition, infectious diseases, and congenital conditions, with limited healthcare services to manage these issues effectively. Maternal mortality was also alarmingly high during this period. From 1947 to 1958, the district recorded 8,787 maternal deaths, reflecting the inadequacies of maternal care. Poor nutrition, lack of access to skilled healthcare providers, and insufficient medical infrastructure contributed to these high mortality rates. Heart disease began to become more common in Dhaka as urbanization accelerated and nutritional habits deteriorated. However, specialized cardiac care was scarce, leaving many cases undiagnosed or untreated.

The absence of diagnostic tools and trained cardiologists significantly impacted the population's health. Similarly, diabetes emerged as a growing but underrecognized health issue during this period. The lack of healthcare infrastructure, particularly in rural areas, meant that many individuals went undiagnosed and untreated. Public health efforts at the time remained primarily focused on combating infectious diseases, which diverted attention away from these emerging chronic conditions. By the 1960s and beyond, NCDs like heart disease, diabetes, and cancer became more prevalent in Dhaka and other parts of Bangladesh. However, several barriers hindered effective prevention and treatment. Limited awareness among the public, coupled with a lack of specialized doctors and medical equipment, meant that many cases were diagnosed at late stages, especially in Dhaka. Poor dietary habits, smoking, and sedentary lifestyles further contributed to the rising prevalence of NCDs. These factors became particularly concerning in urban areas, where rapid urbanization brought significant lifestyle changes. The healthcare system, however, remained underdeveloped and ill-prepared to address these chronic conditions. In addition, public health policies remained heavily focused on infectious diseases, leaving NCD prevention largely neglected during the Pakistan period. In the decades following independence, NCDs became a global health priority. By 2018, according to the World Health Organization (WHO), NCDs accounted for 41 million deaths annually, or 71% of global mortality. These diseases—mainly heart disease, diabetes, chronic respiratory diseases, cancer, and mental health disorders—caused 80% of premature deaths worldwide, with 85% of these deaths occurring in low- and middle-income countries like Bangladesh. The healthcare system in Bangladesh continues to struggle with the rising burden of NCDs. Dhaka, in particular, faces challenges due to shortages of specialized medical staff and equipment, leading to delays in diagnosis and treatment. Public health efforts now recognize the importance of tackling NCDs, but progress remains limited due to a lack of awareness and resources, especially in rural areas.

3. Development of Healthcare and Medical Education in Dhaka: 194 7 –1971

Dhaka Medical College (DMC) was established on July 10, 1946, initially as a 200-bed field hospital for the British Indian armed forces. Its first superintendent was Major W.J.N. Virgin, followed by Colonel E.G. Montgomery. However, the hospital's medical infrastructure was underdeveloped, lacking essential equipment and specialized doctors. Despite having buildings, it faced shortages of teachers and operational resources, limiting its ability to function as a full-fledged medical college. After the partition of India in 1947, Dhaka Medical College struggled with faculty shortages. Critical subjects like anatomy and physiology could not initially be taught. Students attended temporary classes at Mitford School until Pashupati Bose and Dr. Hiralal Saha were recruited to teach these subjects. Psychology, once taught by Major Virgin, was excluded from the curriculum due to the lack of qualified teachers, despite its importance in medical training. During this period, there were only three local professors at DMC, and many teaching posts were filled by visiting faculty members from Calcutta Medical College. On July 20, 1948, Dr. T. Ahmed, an ophthalmologist from Calcutta, became the principal of the college. Due to limited facilities, the first two student batches lived in Palashi Barracks and other Dhaka University dormitories, while female students stayed in the nursing hostel. In response to student demands, the construction of temporary bamboo barracks began between 1948 and 1950, providing minimal dormitory facilities. Dr. Sayed Haider recalled that the barracks were basic structures with brick walls and bamboo ceilings fenced with barbed wire and plagued by unsanitary conditions. Following partition, medical students and young doctors faced difficulties gaining recognition from the Pakistan Medical Council. This lack of accreditation

hindered their professional advancement. Finally, in April 1953, Dhaka Medical College received formal recognition from the council.

During this period, Dhaka saw significant growth in healthcare services:

- Mohakhali Thoracic Hospital, established in 1955 with 200 beds, expanded to 330 beds by 1960 and was renamed the Chest Diseases Institute in 1962.
- Sir Sal mullah Medical College (SSMC) was formed by upgrading Dhaka Medical School in 1962, with 13 teachers, including 8 foreign diploma holders.
- Dhaka Dental College, the first dental institution in the region, was established in 1961.
- The Institute of Postgraduate Medicine and Research (IPGMR) was inaugurated in 1965 in Shahab to produce specialist doctors and foster medical research.

During 1962–63, Dhaka Medical College's student population grew to 657, including 12 international students. Four doctors from the surgical unit passed preliminary FRCS exams in London, with 13 more preparing for the examination that year.

- Mitford Hospital, originally founded in 1858, was integrated into SSMC in 1962, becoming a teaching hospital with 439 beds. It was essential in treating public health emergencies, such as cholera outbreaks.
- The Police Hospital, established in 1954, had 70 beds and provided medical care for police officers, treating over 17,000 patients by 1964.
- The Railway Hospital catered to railway workers with 48 beds and treated about 1,187 patients annually by 1964, though it relied on specialists from DMC for complex cases.
- The prison hospital managed healthcare for inmates with 100 beds and limited medical personnel, consisting of only four doctors and convict-trained staff.

Private healthcare began to develop gradually:

- Holy Family Hospital, founded in 1956, started with 146 beds and became a critical facility for maternal care.
- It also housed the Holy Family Nursing School and Midwifery School, both recognized by the Pakistan Nursing Council. Islamia Eye Hospital, established in 1960 by Dr. M.A. Ispahani became a prominent center for eye care and charity services, offering free treatment to underserved communities.

Nursing and Midwifery Development: 1947–1970

- In 1947, a professional senior nursing school was launched at DMC Hospital, managed by tutors and staff from Madras and India.
- The East Pakistan Nursing Council was established in 1952 to regulate nursing education and services.
- By 1970, the number of nurses in East Pakistan grew from 50 to 600, despite challenges.
- That same year, the College of Nursing was opened in Mohakhali, offering diplomas in nursing administration and education.

Cholera Research and Public Health Progress: 1960–1970

The Mohakhali Cholera Research Hospital, now known as the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR, B), was founded in 1960. It played a pioneering role in the development of oral rehydration therapy (ORT), a breakthrough in the treatment of diarrheal diseases that saved countless lives. During the Pakistan period, healthcare services were concentrated in urban centers like Dhaka, leaving rural areas underserved. This disparity had severe consequences for maternal and infant health. Pregnant women in rural regions lacked access to prenatal and postnatal care, leading to high maternal and infant mortality rates. Many births took place at home without trained medical professionals, increasing risks for both mothers and newborns. Role of Hospitals in Political Movements: 1952–1971 Both DMCH and Mitford Hospital played significant roles in key political events, such as the 1952 Language Movement and the 1971 Liberation War. They provided essential medical care to injured protesters and freedom fighters during these critical moments in Bangladesh's history. This chronological narrative highlights the evolution of Dhaka's healthcare system from 1947 to 1971. It underscores the establishment and expansion of medical institutions, the development of nursing education, the rise of private healthcare, and the public health challenges faced during this period. Despite limited resources, these institutions laid the foundation for the modern healthcare infrastructure of Bangladesh. Government and Public Response: In the 1940s, post-partition Pakistani public health and medical affairs were subject to budget debates. At one stage of the budget debate, the problems of medical education in East Bengal were highlighted. East Bengal had a government medical college and a private medical college, which were not sufficient for this purpose. In this debate, it was proposed to increase the number of colleges, establish TB hospitals, import good doctors to medical schools and colleges, make skilled nurses, and increase the allocation of money in the medical

budget. Additionally, making the public health department more efficient and dynamic, increasing public awareness, setting up clean water in rural areas, and taking necessary measures to eradicate malaria to reduce its prevalence were highlighted. Between 1947 and 1948, the Mitford Medical School in Dhaka was the first to train girls in midwifery with scholarships. The budget of 1948-49 initially allocated 18 lakh 50 thousand rupees for the medical sector, but the government of Pakistan reduced the allocation to 10 lakh rupees. Bad governance and mismanagement were major problems in the medical colleges; inexperienced and incompetent principals were appointed without public service recommendations. Additionally, most of the doctors in charge of the hospitals were neglecting their duties and regularly engaging in private practice. Due to the non-availability of necessary hospitals, abandonment of village hospitals, low allocation of hospital budgets, and lack of prescriptions, the hospitals became non-functional. Political social unrest and anarchy, along with ruling class incompetence, blind conservatism, and a sectarian spirit, made the social and non-political environment corrupt and intolerable. On the other hand, communal riots, refugee marches, smuggling, food shortages, and abnormally high prices of daily essentials created great anger in the minds of the people. The state language question of Urdu or Bangla awakened the East Bengal student society. From accommodation problems of students to the work on college buildings, development of various departments of the college, medical services in hospitals, and various problems of young doctors, including the internships of newly graduated doctors and their salary allowances, the authorities were very reluctant. Likewise, there was neglect and indifference towards a considerable number of talented doctors going abroad for higher education. Inadequacy and disparity in hospital services rendered the entire medical community helpless. Besides, the government of Pakistan used to receive a lot of financial assistance from various international organizations for the treatment and prevention of diseases, most of which was spent on West Pakistan. There was a hospital in West Pakistan but no such hospital in East Bengal. Due to the lack of female doctors, many women did not go to hospitals even when they were seriously ill because of the practice of veiling. Despite the shortage of doctors, the doctors who graduated from private medical colleges were not employed in the health sector; instead, the Dhaka National Hospital Medical Institute building was closed. Also, no budget allocation was made for Ayurvedic, Unani, or Homeopathy treatment. Dhaka Medical College and Mitford School faced a housing crisis, an examination hall shortage, and the State Medical Faculty had no permanent office. The medical department was lagging behind due to unskilled officers being equipped with extra machines. The medical college had no proper food facilities, including no common room for girls. Due to inadequate bathroom facilities in the college, patients, including medical students, had to suffer a lot. At that time, the students at Dhaka Medical College drew the attention of the authorities to the problems in the college and hospital. The relationship between the students and the authorities deteriorated due to these demands. Although there is no specific data documented on the health sector in Dhaka, the extent to which the people of East Bengal were discriminated against can be estimated from the data on the health systems of East Pakistan and West Pakistan.

	West Pakistan	East Pakistan
Population	55 million	75 million
Number of doctors	12,400	7,600
Number of Hospitals	26000	6000
Rural Health Centre	325	88
Urban development centre	81	52
Recruitment of private labour force	Rural-59% Urban-41%	Rural-86% Urban-14%
Per Capita Income (Rupees)	1960-335 1970-492 Growth Rate-46.9%	1960-269 1970-303 Growth Rate-12.60%

Source: Bangladesh Documents Ministry of External Affairs, Government of India, New Delhi,1971, Chapter 1, pp-21-22

The Ayub Khan government of Pakistan militarized other sectors of the economy as well as exploited the medical sector in the process. In terms of allocation of funds by the central government in various development schemes, West Pakistan used to get more money than East Pakistan.

In millions of rupees and as a percentage		
Plan	First Plan (1955-1960)	Second Plan (1960-1970)
East Pakistan 188 million (31.3%)	394 million (29.8%)	1251 million (44.4%)
West Pakistan 413 million (68.7%)	926 million (70.2%)	1532 million (55.2%)
Total – 601 million (100%)	1320 million (100%)	2790 million (100%)

Source: Mahmudul Haq., The strategy of Economic Planning: Second Five Year Plan, Government of Pakistan

In the 1960s and 1970s, the difference in per capita income rose to 184 points between the two provinces. Although women's interest in institutional delivery increased, proper health care facilities were not developed. The Pakistan period did not bring happiness at all for East Bengal. East Bengal, originally centered on Dhaka, was transformed from one British colony to a Pakistan colony. The hope that the people formed the state of Pakistan never brought prosperity. Differences in per capita income between the two provinces and disparity in food imports had not resulted in the necessary changes in health infrastructure to meet the needs of the population. There was huge discrimination between Pakistan's healthcare system centered in Karachi and the healthcare system centered in Dhaka. Reluctance to develop the infrastructure of the medical sector, inadequacy of development allocation, and misuse of what was allocated, along with not appointing skilled doctors compared to the population, made the common people of the region angry. These disparities served as one of the factors in the formation of independent Bangladesh in East Bengal. The government and the people of East Pakistan, particularly in Dhaka, made efforts to address the ongoing health crisis. However, political and economic challenges limited their success. The government launched health campaigns, expanded healthcare facilities, established local health committees, and attempted to improve urban sanitation. Despite these efforts, limited resources and inadequate infrastructure restricted their effectiveness. Communities often relied on traditional healthcare practices and informal care networks, especially in rural areas. NGOs and international organizations stepped in to assist with vaccination campaigns, maternal and child healthcare, and crisis relief. Civil society in Dhaka became increasingly vocal, demanding better healthcare services. International organizations such as WHO and UNICEF provided vital support for vaccination programs, disease control efforts, and emergency relief. However, the overall response to Dhaka's health crisis remained inadequate due to the political and economic marginalization of East Pakistan.

3. CONCLUSION

During the Pakistan period (1947–1971), Dhaka faced severe health challenges exacerbated by political instability, socio-economic disparities, and inadequate healthcare infrastructure. Key health issues included high rates of communicable diseases like cholera and tuberculosis, widespread malnutrition, and poor maternal and infant health outcomes due to insufficient prenatal and postnatal care. Political marginalization by the central government led to underfunding and neglect of East Pakistan's healthcare needs, resulting in limited healthcare facilities, a shortage of trained medical personnel, and poorly implemented health policies. Civil unrest and economic exploitation further disrupted healthcare services and exacerbated regional disparities. The combination of these factors created a public health crisis in Dhaka, with inadequate responses to health crises and a healthcare system ill-prepared to meet the needs of its growing population. The period highlighted the critical impact of political and socio-economic conditions on public health and the importance of equitable healthcare infrastructure and policies.

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