BACKGROUND PAPER

for

WHO COUNTRY COOPERATION STRATEGY, BANGLADESH

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1. BACKGROUND

Bangladesh, a small country with a large population of about 130 million is contained in 147,570 square kilometres (56977 sqr. miles) gained independence on March 26, 1971 after about 9 months struggle (war of liberation) for separation from Pakistan, is almost entirely surround by India (North, West, East) except for a short frontier with Myanmar at south-east, and a southern coast line on the Bay of Bengal. The country is low-lying mostly alluvial plain embeded with large and small rivers lies within the deltas formed by the Ganges and Brahmaputra-Jamuna, subjected to frequent flooding, devastating cyclones, tidal bore and even drought. Hot and humid seasonal monsoons dominate the climate with cool and dry winter from November to February. The country has agro-based economy with GPD growing at a rate of 4.0-4.5%

The country for administrative purpose is divided into 6 Divisions, 64 Districts (Zilas), 507 Thanas/Upazila (sub-districts) and 4,484 Unions, 87319 villages[1]. The country has a unitary form of government run by democratically elected representatives of the people. The President is the Head of the State and the Prime Minister is the Head of the government. The State language of Republic (People's Republic of Bangladesh) is Bangla.

2. POPULATION CHARACTERISTICS

While the enumerated population of Bangladesh is 12,31,51,246, the adjusted population (adjusting persons missed) is 12,92,47,233 as on January (22nd night) of 2001.[2] The density of population (of adjusted population) per sq. km. 876, sex ratio, 103.8 males per 100 females, number of households 254 million with average households size 4.8 person (as against 5.5 persons in 1991), the annual compound growth rate in 2001 (129.3 million population) is 1.48%. The percentage of urban population is about 23.39 and rural population is 76.61% (Census 2001, BBS).

The life expectancy at birth (year) for both sex was 61 year (M-61, F-61:) in 1998.[3] The population by age groups (percent) is:

Year	Percent
0 — 4	11.86
5 — 14	28.76
15 — 49	45.92
50 — 59	6.45
60 +	7.02

3. VISION

Over the years through the process of trial and error, the National Health Programme has been following the path towards quality care, greater decentralization, increased community participation, accountability with client's and providers' rights established. In addition, a trend has been set towards privatization of facilities and private initiatives for establishing clinical as well as field services in the health sector. Based on past experiences, the health programme

[1] BBS-Statistical Pocket Book, Bangladesh, 2000, P-3, 81.
[2] Census-2001, Preliminary Report, August 2001, BBS.
[3] BBS-2000, Statistical Pocket Book.

will have multi-dimensional facets with multi-sectoral approach to meet cross-cutting and overarching issues effectively. To meet Constitutional obligation to provide services to the people to ensure their basic needs (Health), devolution of power, authority, responsibility, decentralization of fund-management, local level participatory planning, local generation of fund are but essential. The service-delivery culture is envisioned to be gender-sensitive, pro-poor and client-focussed. A vision for an efficient Health-Management Cadre pooled from various disciplines on the basis of merit and quality selected through open competition has emerged. A good health-manager who may hail from any discipline is the `best actor' to sustain an integrated health service delivery system. The vision, a dream of today, is a reality of tomorrow.

"The government's policy of providing health care is based on the principles of universal coverage and accessibility; optimum utilization and development of human resources for health; appropriate use of technology; gender equity; improvement of the quality of life; priority service for the most vulnerable groups including women, children, and the poor; and promotion of health as an integral part of overall socio-economic development"[4]. The Above statement contains a vision and reality for a developing country like Bangladesh.

4. CHALLENGES

Bangladesh is relatively a young and unstable democracy beset with deficiencies in areas of law and order, human rights, besides low status of women, low level of literacy, low income and investments. Corruption is rampant. Public administration lack efficiency, is reluctant to structural changes, basic reforms, and liberalization. Tolerance is lacking in the existing political culture. The mind-set for enhanced investment in health for overall development is still to grow. Since Health is not merely the absence of disease and debility, it is a state of physical, mental and social well-being of each member of the society. As health and health-related problems are widespread and deep rooted sustained, efforts and cost-effective interventions will be required by the sector with strong multi-sectoral approach to improving the community health and health conditions of the poorer segment of people at large. Adequate flow of resource will be a pre-condition to placing the health sector into the broader context of health promotion initiatives.

Finally, Bangladesh Health-Population Programme design in terms of **unification, reorganization** and **restructuring** is a challenging task that need to be carefully proceeded with. The organization and management dynamics of **two vertical structures** (Health and Population Programmes) call for strong knowledge-base, clear understanding and skillful handling by concerned experts and authorities.

Since challenges for development are many such as – poverty, gender equality, ill-health, lack of housing, illiteracy and environmental degradation, pollution, a new direction in development thinking with globalization and localization (with a balanced approach) might offer exceptional opportunities for optimum utilization scarce resources nationally.

5. OPPORTUNITIES

The Bangladesh Health Prorammes is well-established with a vast network of infrastructures spread down to union and village level. The Union Health and Family Welfare Centres, Community Clinics at village/ward level, beside 87 Maternal Child Welfare Centres (MCWCs) at different locations, Upazila level Health Complex, District Hospitals are altogether several thousands in number. The Health and Family Planning Programme also have field workers

[4] Bangladesh Demographic and Health Survey, 1999-2000.

upto union and ward level and they constitute a vast army of personnel for promotive and curative care. Over a hundred thousands field staff of Health-FP programme are more or less trained and are being re-oriented/retrained through decentralized In Service Training (IST) programme under HPSP. With good management of health sector activities, they as field force can bring about desired changes in health-delivery system. Another opportunity that could be seized is the services of a large number of NGOs working in social sector including health-population. There are a good number of big, medium and small NGOs capable of rendering health services at the community level and to the poorest of the poor. Bangladesh could be proud of these resources (human, infrastructural and non-government agencies). With a good health management system in place, these resources are opportunities to open up new frontiers of fortune for the people deprived of due health services.

6. HEALTH STATUS-MAJOR HEALTH PROBLEMS AND ISSUES

6.1 Major Health Problems

Bangladesh is one of the least developed countries of the world where sustainable reduction in fertility has taken place and demographic transition is underway. Because of high fertility in the past, still 39 percent of this population is below 15 years of age, and only 5 percent of the population is 65 years or older[5].

There has been a great improvement in child health status with success in immunization programme, and sixty percent of the Bangladeshi children have been vaccinated against six diseases (tuberculosis, diphtheria, pertusis, tetanus, polio and measles), in place of 54 percent in 1996-1997. However, only 53 percent had been fully vaccinated before their first birthday. For births occurring in 1992-1996, 75 percent of the mothers received at least one tetanus toxoid (TT) injection during pregnancy, while by 1995-1999, the proportion had increased to 81 percent[6].

The number of urban poor has increased from 7 million in 1985 to 12 million in 1999 and their health indicators are the worse than the rural poor[7]. According to the census – 2001 the urban population in Bangladesh is 29 million and has increased at the rate of 38.02 percent during the last 10 years, which is about 4 times the rural rate[8].

Although breast-feeding is universal in Bangladesh, 45 percent of the children under 5 are stunted, 10 percent wasted, and 48 percent are underweight (low weight for age)[9].

The contraceptive prevalence rate (CPR) has increased at the level of 53.8 percent and the fertility rate (TFR) has declined to 3.3 percent[10]. As a cumulative effect of all these factors it has resulted in higher life expectancy at 68 years, with higher in females (HDS 2000). As fertility started to decline, the growth rate has come down to 1.48 percent at the end of Fifth Five Year Plan through decline in crude birth rate (CBR) as well as crude death rate (CDR)[11]. It has been

[5] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[6] Bangladesh Demographic and Health Survey 1999-2000.
[7] Ministry of Health and Family Welfare (2001), Expanded Programme of Immunization, National Plan of Action, 2001-2005, Revised Draft
[8] Population Census, 2001, Preliminary Report, Bangladesh Bureau of Statistics.
[9] Bangladesh Demographic and Health Survey 1999-2000.
[10] Bangladesh Demographic and Health Survey 1999-2000.
[11] Population Census, 2001, Preliminary Report, Bangladesh Bureau of Statistics.

forecasted that, the population of Bangladesh will be doubled in the next 47 years. It is projected that the population will reach 167 million in 2020, even under every optimistic assumptions[12].

Bangladesh has one of the worst scenario in terms of nutrition, and 45 percent of children under 5 are stunted. The women have a low Body Mass Index (BMI) and a low height, both of which are considered as nutritional risk[13].

Only 48 percent of pregnant women receive antenatal care during pregnancy, and almost all births (91 percent) in Bangladesh occur at home…Assistance from a trained attendant at the time of birth is only 12 percent[14].

STD/AIDS related knowledge although increased is not so much encouraging to combat the upcoming threat of AIDS in the region. According to BDHS-2000, percentage who were unaware of the process of avoiding AIDS has declined since 1996-1997, from 41 to 12 percent in women and from 27 to 11 percent in men, which in fact is a positive development. Seven percent of the women reported genital sores or ulcers, and 5 percent of men reported having had an STD in the six months preceding the survey[15].

At present, the main cause of death remains poverty-mediated infectious diseases, exacerbated by malnutrition. Iron deficiency anaemia is common among mothers and children. About half (48 percent) of the women and 78 percent of the children are anaemic[16]. As gender differential persists in the society other problems including violence against women also appears to be a major public health problem.

Utilization of services from the health facilities is one of the greatest concerns since long. Although there has been a good amount of success in health services, still more than 60 of the population has very little access to basic health care. Other issues are overall poor utilization of government facilities, as well as cost effectiveness, sustainability and quality of public sector services. The rates of seeking care from health facilities are consistently low (Ahmed, et. al 2001, SDS, 1999)... In addition, gender discrimination regulated by lower value of women in the society, and other social and cultural determinants play important role in underutilization.

The maternal mortality ratio has reduced to 320 (per 100,000 live births) during the period of 1998 to 2000 (based on verbal autopsy identification of maternal deaths)[17].

The under-five mortality rate has also declined from 116 per 1000 live-births in 1992-1996 and reached at the level of 94 per 1000 live-births. The infant mortality rate has also declined from 87 per 1000 live-births in 1989-1993 to the level of 66.3 per 1000 live-births during the period of 1995-1999, with wide acceptance of oral rehydration therapy and reduction in ARI death. The infant mortality among the children of mothers having secondary education is 55 per 1000 live births, and those of mothers having no education (most probably the poors) is 92 per 1000[18], which is nearly double of the former group.

[12] Strategic Directions for the Bangladesh National Family Planning Program 1995-2000, MOHFW (1996)
[13] Bangladesh Demographic and Health Survey 1999-2000.
[14] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[15] Bangladesh Demographic and Health Survey 1999-2000.
[16] The Nutrition Surveillance in Bangladesh in 1999 (2001), HKI and IPHN
[17] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[18] Bangladesh Demographic and Health Survey 1999-2000.

Neonatal mortality rate has also declined from 63.3 deaths per thousand live births during the 1985-1989 period to 42 per 1000 live births during the 1995-1999 period. Overall, the infant, child, and under five mortality in 1999-2000 show uniform decline by 18-19 percent since the period of 1996-1997[19].

Crude birth rate has come down at 20, and CDR to 5.2 per 1000 live births during the same period[20]. Among the general causes of morbidity and mortality in population the top ten causes remained almost the same as were a decade ago. One of the rising concern is that, the incidence of accidents and injuries including violence against women, and non-communicable diseases like hypertension, diabetes, cancer, mental health etc. are rising faster than the communicable ones. HIV-AIDS poses a new threat on the population. In addition, the emerging (arsenicosis and dengue) and re-emerging (tuberculosis, malaria and kala-azar) diseases are the areas of serious concern.

Although there has been a rise in life expectancy to 61 years[21], it is still 17 years less than that of the developed countries, on an average. The persistent high rate of child and neonatal mortality is one of the prime causes of this low level of life expectancy in the country. Since the age structure has been changed and the absolute number of aged population in the society has been increased, there is a need for special care of the elderly people to ensure their health including nutrition.

6.2 Specific Health Issues

Child Health

In Bangladesh, compared to the past, although the IMR has reduced to 62 to 66 per 1000 live births[22] it is still very high compared to those of the developing countries. Despite the overall decline in infant and child mortality in the last 15 years, 1 in every 15 children born dies within the first year of life, and 1 in every 11 children dies before reaching age 5.

The neonatal mortality quoted for the period of 1995-2000 was 42 per 1000 live births, and post-neonatal mortality quoted for this period was 24.3 per 1000 live births. The post-neonatal mortality is higher for girls than in boys (31 vs 27.5). The main feature of the IMR in Bangladesh is persistent high rate of neonatal mortality which is directly related to persistent high rate of maternal mortality and morbidity, lower maternal age and lower use of antenatal, delivery and postnatal care provided through trained providers. Children born to younger mothers are more likely to be of low birth weight, which is probably an important factor contributing to their higher neonatal mortality. The infant mortality rate among children of mothers under age 20 is 103 deaths per 1000 birth and it declines steadily with age to 66 deaths per 1000 live birth for women aged 30-39 years[23].

Acute Respiratory Infection (ARI) is one of the major causes of morbidity and mortality among children in Bangladesh. According to BDHS 1999-2000, 18 percent of the children were reported to have respiratory illness in the two weeks before the survey. When compared with

[19] Bangladesh Demographic and Health Survey 1999-2000.
[20] Bangladesh Demographic and Health Survey 1999-2000.
[21] Pocket Book of the Year, 2000, Bangladesh Bureau of Statistics
[22] Ministry of Health and Family Welfare (2001), Expanded Programme of Immunization, National Plan of Action, 2001-2005, Revised Draft
[23] Bangladesh Demographic and Health Survey 1999-2000.

the findings of 1996-97 BDHS survey, it is observed that, prevalence of ARI has increased from 13 to 28 percent and the proportion taken to a health facility decreased from 33 percent to 27 percent[24]. In Bangladesh, approximately 172,000 children do not survive their first year. Among these deaths, 18-25 percent are due to ARI, which is the number one killer disease of children in Bangladesh. An estimated number of ARI deaths reduced from 145,000 per year in 1990 to the level of 100,000 in 1997, whereas the goal to be achieved by the year was 48,000 cases per year[25]. In 1993, the case fatality rate of the under-five ARI cases treated by ARI programme was 0.44 percent, which reduced to 0.32 percent in 1999 (ARI Programme, DGHS). Poverty and low birth weight were identified as major causes behind vulnerability of these children. Almost all ARI deaths in children are due to pneumonia particularly when associated with delay in treatment. Only 20 percent of children are taken to the qualified service providers[26].

Dehydartion from diarrhoea is a major contributing factor of childhood mortality in Bangladesh. In seventies and eighties, diarrhoeal disease was the number one killer of children under-five. Due to the concerted effort of the government through Control of Diarrhoeal Diseases Programmes, NGO interventions, and ICDDR'B it has come down. Still is the second major killer disease of children. Oral rehydration therapy was developed in Bangladesh more than 30 years ago. ORS packets are currently available in health facilities, shops and pharmacies. Diarrhoea prevalence was highest among children aged 6-23 months. Overall, 6 percent of children under age five were reported to have suffering from diarrhoea. Among the children under five more than 60 percent reported of giving a solution made from ORS packets, and 25 percent were given home-made saline solution. The data also indicate that, although the benefit of increasing fluid intake during a diarrhoeal episode is widely understood, about one in four mothers still engages in the dangerous practice of curtailing fluid intake when their children have diarrhoea…A decline in diarrhoeal prevalence (from 8 percent in 1996-1997 to 6 percent in 1999-2000) and increase in use ORS (from 49 percent in 1996-1997 to 61 percent in 1999-2000) has been reported[27].

Reproductive Health

In Bangladesh, the situation of reproductive health is a matter of concern both in terms of quantity and quality. The estimates of maternal mortality ratio shows a slow decline to 320 per 100,000 live birth during the period of 1998 to 2000 (based on verbal autopsy identification of maternal deaths)[28].

The major causes of maternal death are postpartum haemorrhage, eclampsia, complications of abortion, obstructed labour, postpartum sepsis, concomitant medical causes, and violence and injuries. It is very important to note that 9 percent of the households are female headed, and 14 percent of the pregnant women's death are associated with violence and injury[29].

The major objectives of antenatal care (ANC) is to identify and treat problems such as anaemia, pre-eclampsia and infections during pregnancy. Screening for complications and its advice including place of delivery and referral of mothers are also the major objectives of antenatal

[24] Bangladesh Demographic and Health Survey 1999-2000.
[25] Barkat A and M. Majid (2001), Overview of Diseases of Poverty, Paper presented at BRACE Centre, Mohakhali for South South Centre
[26] ARI Program, DGHS, (2000).
[27] Bangladesh Demographic and Health Survey 1999-2000.
[28] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[29] Ministry of Health and Family Welfare, Programme Implementation Plan,Part II, HPSP, April 1998.

care. Although Bangladesh has a comprehensive infrastructure of facilities through-out the country for provision of maternal care, most of these are underutilized. The BMMS Survey 2001 indicate that, more than half the mothers do not receive any antenatal care. The use of antenatal care is also strongly associated with education and economic status. Mothers with some education as well as mothers from the welthiest household are twice as likely to receive antenatal care than the mothers with no education and the poors. In Bangladesh almost all deliveries (91 percent) occur at home, and only 12 percent of these deliveries are attended by trained birth attendants (doctor, nurse/midwife, FWV etc.). Use of health facilities is much more common in urban areas (21 percent). But post-delivery care is a rare event. According to the recent BMMS survey, in only 16 percent of the deliveries, mothers saw someone for a check-up during two months after delivery. It is very important to note that, in case of 52 percent of births mothers received neither ANC nor DC nor PDC, and in 4.7 cases they received all the cares (ANC, DC and PDC). The EOC report estimates that 15 percent of the 25,09,988 (estimated) annual births would have complications. This counts to 376,498 complicated births. The National Maternal Mortality Survey 2001 reported that in 56 percent pregnancies with complications women sought care[30].

The global estimate is that, around 5 percent of the deliveries would be complicated to need a Cesarean Section. The proportion of births by Cesarean Section has been tripled from 0.7 percent in 1994 to 2.6 percent in 2001[31].

Knowledge of life-threatening conditions of pregnancy is a precursor to treatment seeking behavior and thus reductions in maternal mortality and morbidity. While 56 percent of women cited tetanus as life threatening, only a minority of women identified retained placenta (38 percent), obstructed labor (37 percent), convulsions (26 percent), bad fetal position (25 percent), and excessive bleeding (18 percent) as potentially life threatening[32].

According to the official statistics, adolescents are defined as those who fall in the age group 10-19 years. Bangladesh has a total adolescent population of about 29.5 million, who constitute about 23 percent of the population. The issues needing immediate attention, especially for the female adolescents are gender discrimination, education, employment, marriage and dowry, and nutrition. Early marriage is customary for the female adolescents in Bangladesh. Dowry still remains at the core of marriage negotiations and a major cause of violence. The prevalence of malnutrition is found to be markedly higher among female children than male children. Over half of the adolescent girls are stunted and more than one third of adolescent girls in rural areas are wasted. Adolescent girls suffer from iron, iodine and vitamin A deficiencies. The Anemia Survey Conducted by HKI, Bangladesh in rural areas reported that 43 per cent of adolescent girls were anemic in 11-16 years age (HKI/Bangladesh, 1999). A most recent study on Adolescent Reproductive Health in Bangladesh indicated that, a substantial proportion of the adolescents and youths are not aware about the following: causes of menstruation, consequences of unprotected sexual act, Gonorrhoea, Syphilis, how a person can be infected with HIV/AIDS, menstrual regulation, and availability of treatment facilities for STDs. Experience of premarital sex was reported by around 7 percent of the adolescents (both unmarried and married) and 21 percent of the unmarried youth; and over 50 percent of unmarried adolescent and youth did not use condom during first pre-marital intercourse[33]. In almost all circumstances of unwanted

[30] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[31] Draft of Sixth Five Year Plan, Health and Population Sector
[32] Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001
[33] Barkat A, SH Khan, M Majid, N Sabina (2000). Adolescent Sexual and Reproductive Health in Bangladesh: A Needs Assessment, Conducted for International Planned Parenthood Federation (IPPF) and Family Planning Association of Bangladesh (FPAB)

pregnancy, the adolescents choice the path of clandestine abortion induced by self or untrained peoples, resulting in sepsis of the uterus and birth canal. Out of the total obstetric deaths, 14 percent are due to abortion[34].

Immunization of Children and Women

In Bangladesh, the Expanded Programme of Immunization (EPI) follows the international guidelines recommended by the World Health Organization. According to BDHS 1999-2000, only 60 percent of the Bangladeshi children 12-23 months can be considered fully immunized[3]. While almost all parents (96%) understood that child should be fully immunized, far fewer (55%) realized that, they must bring their child at least 4 times in the first year to be immunized (CES, 2000). Neonatal tetanus is a fatal disease and Tetanus Toxoid (TT) injections are given during pregnancy for its prevention. Overall, 64 percent of births in the five years before the survey were to mothers who received two or more TT during pregnancy, and 18 percent received one injection. About one-fifth of the mothers did not have any TT vaccination during pregnancy. Besides more pregnant mothers now have blood pressure checked and urine taken for analysis than in 1992-1996[35].

Communicable Disease Control

Tuberculosis is one of the major public health concerns in Bangladesh. WHO estimated the Annual Risk of TB infection (ARTI) in Bangladesh to be of 2.24 percent in 1997 with a natural decrease of 1 percent per year. More than 300,000 new cases and 60,000 deaths due to tuberculosis are estimated to have occurred in Bangladesh in 1999, which ranks fourth among the TB high-burden countries of the world[36]. It is forecasted that TB cases will significantly increase in case of HIV epidemic.

Leprosy is a public health concern especially in northern part of Bangladesh. It is very difficult to eradicate since it is difficult to diagnose, and require long-term treatment with multi-drugs, which is costly for most people. The indicator for elimination of leprosy is achieving fewer than 1.0 cases per 10,000 population. It is very encouraging that, elimination has been achieved, as the rate for second quarter 2000 is 0.76 per 10,000.

Malaria kills more than 1 million people worldwide each year. The majority of those who die are children under 5 years. They die because they are poor, unprotected from mosquito bites and are not treated quickly enough with effective antimalarial drugs to prevent the disease[37]. Malaria is a major public health problem in Bangladesh and situation is worsening in recent years. The epidemiological data of 1982-1997 shows that, the number of malaria cases has increased over time. A total of 115,660 cases were diagnosed in 1992, which registered more than 100 percent increase over 1982.The highest number of malaria case was found in 1994 with 166,563. In 2000, malaria cases reported were 383,615 clinical cases, 41502 laboratory confirmed cases and 448 deaths[38]. Approximately 88 percent of the 130 million peoples in the country are at risk of malaria.

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[34] Government of Bangladesh and UNICEF (2000). Situation Assessment and Analysis of Children and Women in Bangladesh.
[35] Bangladesh Demographic and Health Survey 1999-2000.
[36] Bangladesh Health Bulletin 1997, MOHFW 1999
[37] Massive Effort Against Diseases of Poverty, WHO (2001)
[38] Malaria & Parasitic Disease Control Unit (M&PDC), Bangladesh Country Report, Presented in ACT Malaria Executive Board and Partner's Meeting, Kuala Lampur, Malaysia, 30th April- 3rd May, (2001)

Bangladesh is situated in the center of South Asia surrounded by growing regional HIV/AIDS epidemic prone countries. In 2001, about 3 million people died of AIDS and 14,000 are people are getting infected with HIV everyday. In countries like Thailand and Burundi, HIV- positive patients are occupying 40-70 percent of the beds in big city hospitals. Although Bangladesh is geographically located in close neighborhood of two highly endemic countries for HIV, fortunately it is still a low prevalent country as revealed in three consecutive sentinel zero-surveillances conducted in the year 1999, 2000 and 2001. The Institute of Epidemiology, Diseases Control and Research (IEDCR) with the National AIDS Committee, tested 70,676 persons belonging to a variety of occupational groups. Till date 188 were found to be HIV positive of which majority were males. So far 19 HIV infected persons developed AIDS of which 13 already died[39]. Studies of the sex industry identify large number (100,000) of generally illiterate commercial sex workers (CSWs) whose customers represent all segments of the society. Female CSWs have an average of 2-5 clients a day, making the number – half a million men a day[40].

In Bangladesh, despite the successful eradication of smallpox and the control of several infectious diseases, there remain some significant threats that are particularly challenging because of the changing nature of the disease pattern and the ways it manifests itself in the population. At present dengue and arsenicosis are the major emerging diseases and posing major threat to the population. During the recent years tuberculosis, malaria and kalazar has also re-emerged. The multi-drug resistance tuberculosis (MDT) is 100 times costly to treat.

Malnutrition and Poverty

Malnutrition has been identified as the one of the direct effects of poverty prevailing in the form of economic, social, and psychological deprivation among the people lacking sufficient ownership, control or access to resources for minimum required level of living. Chronic energy deficiency, protein energy malnutrition, low birth weight, micronutrient deficiency are all serious problems in Bangladesh. Although it affects people of all ages, the children, women and the female adolescents are most badly affected. The deprivation is so severe that more than around 50 percent of the children born to these women are underweight (below 2500 gm.)[41]. These low birth weight babies are also deprived of the minimum required food during their infancy, childhood and adolescence. Again, due to low intake of calorie, proteins and minerals during pregnancy, they even lose their weight (instead of gaining) in many occasions and are severely demineralised especially of iron and calcium. The profile of human deprivation reveals that about 46 percent of the people of Bangladesh are income-poor (head count index) while 77 percent of people lack basic or minimally essential human capabilities – capacity to be well nourished and healthy, capacity for healthy reproduction, and capacity to be educated and knowledgeable. BIDS Human Development Report (2000) posited that 53 percent of people lack adequate access to health services, access of the poorest groups to effective medical care poses one of the most pressing institutional challenges in the health sector.

Anaemia following iron deficiency among the women and adolescent girls is one of the growing concern of the government of Bangladesh. Almost half (49 percent) of the women are suffering from anaemia (Hb <11.0 gm/dl). But among children aged 6-11 months, this is alarmingly high at 78 percent[42]. However, among adolescent girls aged 11-16 years the situation was a bit

[39] ASM Matiur Rahman (2001), An overview of HIV/AIDS in Bangladesh.
[40] Working Paper for Log-frame Workshop of Next HPSP of Government of Bangladesh.
[41] National Nutrition Project (2001), Project Description Paper
[42] Bangladesh Bureau of Statistics (1999), Pocket Book of the Year .

better and 43 percent of them were anaemic (Hb <12.0 gm/dl), and about 4.6 percent were below 10.0 gm/dl. Rural women and the poors were the worst sufferers[43].

Vitamin A deficiency is one of the leading causes of preventable childhood blindness, as well as a major contributing factor to the severity of several causes of childhood mortality and morbidity. Currently the prevalence of night-blindness in children is around 0.3 percent, which was 3.6 percent in 1983. A recent survey shows that, only 14 percent of pre-school aged children meet their daily requirement of Vitamin A through the diet. Prevalence of night-blindness among women is very high at 2.2 percent, and pregnant and breast-feeding women it is even higher at 2.7 percent and 2.4 percent respectively. Although there is a provision for giving a high potency Vitamin A capsule following delivery, the coverage is less than 6 percent[24].

Deficiency of iodine salts in the food with or without goiter was one of the most common events in Bangladesh. Iodine deficiency results in goiter in adults, and cretinism and mental retardation in children. The first survey on iodine deficiency in Bangladesh revealed that 69 percent of the population is affected with deficiency of iodine. The recent survey has shown that iodine deficiency has declined from 69 percent to 43 percent. The prevalence of goiter has also dropped from 47 to 18 percent.

Helminthiasis

Bad hyegenic practices and improper disposal of human excreta has resulted in a high prevalence of parasitic infection in the population. The helminthic infestation results in poor nutritional status in children and women. This also contributes to loss of appetite and malabsorbtion which lead to anaemia and undernutrition. In one study conducted by BRAC, it was revealed that, among the healthy adult and adolescent population of the rural community the prevalence of parasitic infestation was 33.3 percent of which 35.8 percentage was in females and 27.9 percentage in males. Only 30 percent of the people who washed their hands with soap and water after defecation suffered from parasitism as against 77 percent, who did not use soap and water[45].

7. FUTURE PATTERNS OF DISEASE[46]

The WHO-GBD report project likely patterns of cause of death for the year 2010. This twenty-year projection is based on patterns of cause of death in 1990, using known data for that year. The projections do not focus on all of the 200 of more potential causes of death. Rather they project the broad groupings of communicable, injuries, and non-communicable causes. This table summarises these trends as shown below.

[43] National Vitamin A Survey (1998), Helen Keller International and Institute of Public Health and Nutrition

[44] SMZ Hyder (1999), BRAC, Research and Evaluation Division, August 1997, Published in Research Compandium on Maternal and Adolescent Nutrition in Bangladesh, Bangladesh, Bangladesh Breast Feeding Foundation and Bangladesh National Nutrition Council, 1999.

[45] Drawn from Barkat, Abul and Murtaza Majid, 2002, *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh

Table 3: Projections of major causes of mortality in Bangladesh [26]

Major cause of Death category	Total				Males				Females			
	1990	%	2010	%	1990	%	2010	%	1990	%	2010	%
Communicable	4775	51.0	3058	29.8	2418	49.6	1713	30.0	2356	52.4	1345	29.5
Injuries	808	8.6	1142	11.1	456	9.35	674	11.8	352	7.8	468	10.3
Non-communicable	3788	40.4	6065	59.1	2001	41.0	3322	58.2	1788	39.8	2743	60.2
Total	9371	100	10264	100	4875	100	5709	100	4496	100	4556	100

(Source: Streatfield INDIA 1990-2010SEX1)

Over the two decades, these projections suggest a 9.5 percent increase in total deaths, nine tenths of which occur among males. The total population will increase by almost 40 percent. (to 153 million in 2010). However, age-specific death rates are expected to decline.

The important change in the causes of mortality is that communicable, perinatal and maternal diseases are projected to decline from about half of deaths to less than one third of all deaths, both for males and females. Deaths due to unintentional and intentional injuries will increase slightly, both in absolute numbers and in percentage terms, and for both males and females. But the most significant change will be that non-communicable diseases will account for well over half of all deaths. However, there are selected conditions or diseases that have the potential to increase rapidly, exerting a major impact on demand for health services. One obvious case is HIV/AIDS and another is tuberculosis. However, existing diseases may re-emerge or increase to epidemic levels periodically. These include certain diarrhoeal diseases, malaria and dengue.

The policy implications of the changing patterns of disease

The burden of disease at any one point in time represents the outcome of epidemiological processes, on the one hand, and, on the other, investments by households and the government in better health. Many of these investments need to be sustained in order to maintain low disease incidence rates. For example, the relatively low prevalence of immunisable disease in Bangladesh is a tribute to the EPI programme but might not be maintained if resources were shifted away from immunization. Second, a prominent, even rising, source of disease burden does not translate automatically into a public finance priority. Finally, the costs of prevention and the costs of cure for different diseases vary greatly in relation to a given health gain. As a result, the public priority may be to subsidese promotion and prevention, rather than cure, if affordable treatments are available from other sources.

In principle there are two reason for a government to intervene in health (or other) markets. The first is to compensate for market failures. There are three typical failures in health and related markets that justify a public subsidy to health service costs. Consumers tend to neglect prevention and private providers have (i) little incentive to offer health promotion and preventive services (ii) They may be reluctant to pay the full costs of damage done to the health of others (externalities) if they suffer from communicable diseases or behave dangerously. (iii) They may

[26] Health Futures in Bangladesh: Strategic Options, Synthesis Report, Second Draft

be unable to insure against the costs of catastrophic illness and accidents. The public intervention to compensate for these market failures may be in the form of state-owned production (such as a national health service); by way of administrative regulation or by taxing or subsidising the production or consumption of selected services.

The second justification for public intervention in health markets is to improve the equity of health service consumption. This requires a subsidy on services consumed by poor people.

The current focus of health policy in Bangladesh is on an Essential Package of Services (ESP) delivered largely at upzilla level facilities and below. The ESP targets the prevention and treatment of communicable diseases, the morbidity and mortality associated with childbirth and population growth control.

Some 48 percent of DALYs are associated with diseases that are relatively cheap to prevent. Of these, some are amenable to low-cost defensive measures individuals can take themselves, such as using a condom or a bed-net. However, in some cases, more expensive collective action is required, such as improving the quality of water supply. In many cases, effective prevention requires still more expensive economic improvements: better food and a reduction in domestic over-crowding. Related issues concern public responsibility for education in domestic over-crowding. Related issues concern public responsibility for education, for pollution control, for road system development and for better industrial regulation to reduce the risks of accidents at work.

However, there is a fair degree of agreement between the main diseases according to DALY ranking and the health services supplied by the ESP and about 75 percent of public allocations at upzilla level and below go to subsidising preventive health services

All the recent data indicate that nearly half of the disease burden in Bangladesh imposes some degree of spill-over cost on society, a cost which is unlikely to be paid for by individual health service consumers, and justifies some degree of public subsidy. It is to be noted that diarrhoeal and respiratory diseases contribute around 30 percent of the total. About 9 percent of government allocations at upzilla level and below subsidise the control of communicable diseases.

Household may have difficulty in insuring against catasrophic treatment costs. The conditions that impose the greatest burden of years of life lost and are also likely to impose the greatest treatment costs on either households or the state. It would be imprudent to suggest that these automatically qualify for publicly-financed insurance. However, some might, such as those imposing the greatest cost in terms of years of life lost in the two most expensive treatment categories: cardio-vascular conditions, trauma and child-birth related conditions. There is growing evidence that catastrophic health costs have a much greater and permanent effect on poverty than the costs of preventative measures such as immunisation. Illness-related expenditures and income loss due to disease are thought to be the second most common source of income crisis on rural Bangladeshi households, after natural disasters, resulting in an income erosion of 27 percent of annual income from the extreme poor, compared with 13 percent for the non-poor [27].

It is not only the costs of treatments that may be 'catastrophic' but also the costs of lost earnings, estimated to be about five times treatment costs, and the direct costs of care for the

[27] Binayak (2001) (ibid)

disabled. In terms of their overall contribution to disease burden, the top ten are nutritional and endocrinological conditions, the results of unintentional injuries, neuro-psychotic diseases, conditions related to childbirth, respiratory diseases, cardio-vascular diseases, sensory impairments, the results of congenital diseases and digestive tract disorders. In some richer countries, the state provides disability allowances for such conditions.

The ESP make less provision for financial protection from the costs of catastrophic illness and accident than other causes of market failure. However, whether this is a priority in Bangladesh is a matter for discussion. A focus on ensuring that more people change their behaviours and have access to effective treatments that save lives or defer the disabilities from degenerative diseases might be a more effective use of limited resources.

The second main reason for public intervention in health markets is to redistribute the consumption of health services in comparison with the ability to pay. Because poor people suffer more ill-health than rich people, the greatest gains to society would come if they had at least equal, if not preferential, access to health services: each individual with equal health needs would be treated equally. In practice the extent to which this is thought to be desirable depends on public choice. The extent to which it is possible not only depends on political decisions but also on the way finance for healthcare is mobilised and pooled. A number of distributions exist which fulfil equity criteria. The only condition that is inequitable by any measure is if the poor subsidise the health service consumption of the rich.

In Bangladesh, 35 percent of the population are thought to be poor. This proportion has fallen over the last decade so that more people now can afford to pay something for healthcare, and do, mostly unwisely. There is no explicit mechanism to subsidise the consumption of health services by poor people. Rather public subsidies are directed to a set of primary care services (the ESP) that have a preventative bias, have high externalities and are mainly delivered at the lower levels in the health service structure. It is intended that this would place them close to where poor people live. This subsidy is therefore directed partly to a set of services and partly, but only by implication, to a set of people (the poor). It is notable that the urban poor have not received as much policy attention as the rural poor in this respect. In addition, the poor face both social and economic differential barriers to accessing the health services they need and desire most. In particular, there is no explicit instrument available to exempt them from catastrophic treatment costs, although they do have access to subsidesed services in public facilities. Finally, the resulting distribution of health service subsidies is not strikingly progressive. There are major challenges to be faced in targeting public subsidies more precisely to poor people that are discussed later in the report.

In Bangladesh, the contribution of communicable diseases to the burden of diseases is likely to fall over the next 20 years, a benefit of the sustained public health efforts that have been made earlier. At the same time, some existing and new communicable diseases remain a threat, none more than an increasing prevalence of AIDS-HIV. Nevertheless, there is likely to be an increase in the contribution of non-communicable disease and trauma to the overall disease burden in the future and relative decline in the contribution of communicable diseases. Although this does not automatically imply that there should be major shift in resources away from communicable disease prevention and treatment, the mortality and, more particularly and absolutely. Moreover, the incidence of these diseases may already be greater amongst poor people than the rich. Additional policy attention should be paid to ensuring that they are prevented, that mortality and disability from them is delayed and that, at least, the poor are protected from the costs associated with their treatment.

8. HEALTH POLICY

8.1 Policies Undertaken before Fifth Five Year Plan Period

Bangladesh inherited the pre-independence policies of health services with priority assigned to the development of hospital service care particularly in urban areas. The first five-year plan (1973-78) envisaged the need for expanding the health care coverage in the rural areas through the establishment of a 31-bed hospital with other preventive care (specially Smallpox Eradication, TB Control and Malaria Control) at the Thana level under a scheme called Integrated Thana Health Complex (ITHC).
During the Second Five Year Plan (1980-85), Bangladesh being a signatory to the Alma Ata Declaration, adopted the Primary Health Care concept. During the same period family planning activities was integrated with MCH services and initiated implementation through integrated programme. Multi-sectoral population control activities was also launched through involvement of nine different ministries (other than Health and Family Welfare).

During the Third Five-year Plan (1985-90) focus was on primary health care services including the immunization and nutrition education programme under "Health for all Programme by the Year 2000". The main strategies taken were to pursue the delivery of immunizations to rural areas, to ensure the awareness of environmental health, and nutrition education to the rural households in order to make the delivery of primary health care successful.

In the Health and Population sectors, the objectives of the Fourth Five Year Plan were to enhance the physical infrastructure network upto union levels through construction of more Upzilla Health Complexes, Union Health and Family Welfare Centres, and enhancing number of beds at secondary and tertiary level hospitals. In addition to the infrastructure development, during this period, emphases were given to Primary Health Care with specific programmes on MCH-based Family Planning and expanded programme on Immunization, communicable disease control. The plan also had objectives to improvement of the human resources and through functional improvement of basic medical, nursing, para-medical education and in-service training. During the Fourth Five Year Plan period (1990-1995) various programmes were undertaken. Much of these programmes/projects were under the Fourth Population and Health Project (FPHP) with financial assistance from The World Bank and other consortium of donors. Main objectives of the plan was to continue the efforts for reduction of infant and maternal mortality, and thus increase the life-expectancy and improve the quality of life through increase in immunization coverage, control of communicable diseases, increase in contraceptive prevalence, and decrease in diarrhoeal and ARI deaths in children. Special emphasis have also been given to improve the nutritional status of the population, specially the vulnerable children and the mothers through the Bangladesh Integrated Nutrition Project (BINP). During this period some other new projects on reduction of maternal mortality encompassing Emergency Obstetric Care (EOC) also came into action through bilateral donations. Diseases like polio, neonatal tetanus and leprosy were targeted for eradication or elimination, and some others were envisaged to put under control depending on the nature of public health problem[47].

[47] Barkat, Abul and Murtaza Majid, 2002, *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh

8.2 Policy Perspective of the Fifth Five Year Plan (1997-2002)

The Ministry of Health and Family Welfare (MOHFW) realized that the existing structure of the Directorates of Health and Family Planning with separate cadres at all levels could not adequately respond to the needs of child and maternal health including contraception, and limits the potential for increasing the range, quality and effectiveness of services. This dual mechanism of service delivery leads to situation where the mother goes to one service provider for family planning services, and for other ailments for herself or her child goes to another. The structure was not also considered to be cost effective. The inter-project linkages and institutional co-ordination and support within the sector was also poor. The separate structures impeded referrals, generated internal conflicts, and contributed to the low utilization of public facilities. Moreover, field functionaries did not put up their best efforts owing to job insecurity despite having long years of service. The management systems provided few incentives to improve quality of care, and respond to clients' needs. The service system did not allow clients to obtain health, reproductive health, and other services from a particular service point. At the same time, due to existing resource constraints, it was not possible to provide all the required services needed by all segments of peoples[48].

8.3. Policies and Strategies Pursued during the Fifth Five Year Plan

During the Fifth Five Year Plan[49] period government has adopted the **National Health Policy**. The main aim of the National Health Policy is in pursuance of the Article 15(A) of the Constitution-"Supply of basic medical requirements to all levels of the people of the society", in pursuance of the Article 18(A) of the Constitution- "Improvement of nutrition of the people and public health".

The draft **National Population Policy** is under discussion with different stakeholders for its finalization. Bangladesh is now moving into the phase of demographic transition in which actions are required to reduce unwanted fertility and counteract the effect of population momentum. Where the desired TFR is 2.5, it is still plateuing at 3.3…In Bangladesh, 15 percent of the currently married women have unmet need of contraception[3].

Government has approved the **National Policy for HIV/AIDS and STD** related issues, which aims to reduce transmission of STD/HIV through- reducing risk-generating environment, reducing personal, economic and social impact of STD/HIV/AIDS, and mobilizing national and regional/ international response to the threat of STD/HIV/AIDS.

Bangladesh developed and adopted a **National Drug Policy** in the Year 1982. A number of programme relating to the rational use of drugs, manufacturing, quality control and distribution of essential drugs are being implemented. One of the main thrusts of the drug policy is to control the quality and price of drug so as to keep within the purchasing power of the poor. Although it has to be revised within 1992 but the drug policy has not yet revised.

Government of Bangladesh has formulated and approved the **National Food and Nutrition Policy** in an attempt to improve the nutritional status of the people, particularly the women,

[48] Barkat, Abul and Murtaza Majid, 2002, *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh
[49] Fifth Five Year Plan 1997-2002, Planning Commission, Government of Bangladesh, March, 1998.

children and other vulnerable groups and thereby contribute to the improvement in the quality of life. Based on the policy, the MOHFW in collaboration with the Bangladesh National Nutrition Council (BNCC), developed the National Plan of Action for Nutrition (NPLAN).

A comprehensive **Bangladesh National Strategy for Maternal Health** has been developed reflecting the convergence of ideas and views from different segments of society in a consensual framework. The relevant Line Directors, participants from the development partners, NGOs and private sectors contributed in developing strategy.

9. THE HPSS AND HPSP

9.1 HPSS (Health and Population Sector Strategy)

During the early Fifth Five Year Plan period the Government drafted a Health and Population Sector Strategy (HPSS) in collaboration with the development partners and NGOs. The main sectoral objectives of the HPSS were (a) maintenance of the momentum of efforts in Bangladesh to lower fertility and mortality; (b) reduction of maternal mortality and morbidity; and (c) reduction in the burden of communicable diseases.

The Essential Services Package (ESP) identified in the HPSS consists of basic reproductive and child health services, including family planning, maternal care and immunization as well as control of selected communicable diseases, limited curative care and behavioral change communication. The ESP has been planned to be delivered through different levels of primary health care systems (Community, Unions and Upzilla levels).

9.2 Health and Population Sector Programme (HPSP)

In July 1998, the government has formulated a five year Programme Implementation Plan (PIP) for the **Health and Population Sector Programme (HPSP)**, based on the principles of HPSS. During the preparation of HPSP a logical frame work (Log Frame) approach was used to strengthen the design process. The major components of the programme are: (i) essential services package; (ii) service wide management system; (iii) integrated support service system; (iv) improved hospital management; (v) sector wide management system; (vi) policy and regulatory framework; and (vii) other health and nutritional services.

HPSP has already completed about three years of its implementation and has achieved limited success in term of (i) shift to a single programme; (ii) improved planning and review process and financial management; (iii) increased focus on sub-sectoral policy development; (iv) increased spending on essential package (about 65 percent); and (v) shift to provision of integrated services through unification at upazila level and below.

On **restructuring and reform**, the progress is somewhat mixed though the intention has remained constant. The **unification** locally is a near reality and the next steps required are unification at both District and National levels.

The process of **decentralization**, by contrast, has hardly moved. The annual planning process has been plagued by its historical legacy of separating development from regular budget formats, of being largely uniformed by what has been happening locally, and of failing to recognise the resource constraints so that the planning and budgetary process could be underpinned by realism.

In fifth five year plan, initiative has been taken in the development of a **local level planning**; in the partial delegation of budgetary power; in the (partial) process of unification of development and revenue budgets; and in launching pilot schemes on hospital improvement/autonomy.

Although decentralization cannot occur simply through the issue of government orders, as it is an integral part of the culture, nonetheless, government can play an enabling role. The **involvement of communities** in local level planning is spelt out clearly in the ESP service delivery, so that it is both staff and community interests that are at stake if the process of decentralization is not accelerated.

9.3 Sector-wide Management

The government has introduced Sector-Wide Management (SWM) approach in managing the health and family welfare sector, rather than maintaining a series of projects with separate funding, management, implementation and reporting arrangements. Key features of sector-wide management are:

- A clear sector policy and strategic framework;
- Clear links between the sector policies and the expenditure plans for the sector;
- Integrated management of activities under line managers rather than separate project offices/project directors;
- Separate annual operational plans to be carried out under each line manager;
- Efficient use of resources to implement the plans, with pooling of resources from various sources to fund the plan;
- Reporting of activities and results against the plan, with common reporting and performance monitoring arrangements.

Monthly performance monitoring by the Directorates and MOHFW are being conducted using standardized formats. A set of milestones of indicators that have been developed in consultation with the line directors (LDs) and development partners (DPs) are the main basis for quarterly and yearly monitoring (APR).

In addition to these monitoring mechanisms, the unified MIS provides necessary information to the LDs as well as Planning Unit responsible for monthly and quarterly monitoring. The operational plan prepared by the LDs also indicated benchmarks for completion of activities for monitoring on quarterly basis.

10. HEALTH FINANCING

Governments have the responsibility to ensure that drug financing mechanisms are managed in such a way as to achieve equity of access to essential drugs. Financing mechanisms include public financing, health insurance, user fees, donor financing, and development loans.

Some public spending will always be needed to ensure access to drugs by the poorest in society; to ensure provision of drugs for tuberculosis, sexually transmitted diseases, and other communicable diseases. Health financing reform should improve the use of public resources, but it should not be aimed to further reduce public spending on health.

Allocation of financial resources is a major issue in a country with limited resources. Country's expenditure on drug includes expenditure on imports, state expenditure, and expenditure on national consumption.

The World Bank also calculates that total annual spending of eight dollars per person in more than enough to provide acceptable standards of clinical care[50]. As envisaged in the " Macroeconomics and Health-Investing in Health for Economic Development" -- Report of the Commissions on the Macroeconomics and Health, December 2001, WHO, the level of the health-spending in the low-income countries is insufficient to address the health challenges they face. According to that report, estimated minimum financing needs is around $30 to $40 per person per year to cover essential interventions, including those needed to fight the AIDS pandemic, with much of that sum requiring budgetary rather than private-sector financing. Actual health spending is much lower than that of the required.

In revenue and development budgets of 2002-2003 the allocations for health are 5.53 percent and 9.44 percent respectively, which were 5.42 percent and 9.02 percent respectively for 2001-2002. So, health budget has increased slightly but it is inadequate comparing to the needs. In the budget (both revenue and development) of 2002-2003 the total allocation for health sector is Tk.31368.60 million which is 7.27 percent of the total amount i.e. Tk.431.72 billion.

According to the recent estimate by the WHO commission on Macroeconomics and Health 2001 the set of essential interventions costs, on average, about $34 per person per year, which is much higher than the current level of public spending of around $5 recorded for Bangladesh. The huge resource gap in financing the health needs of the poor cannot be met without additional resource mobilization from external resources[51].

The sources of drug financing in Bangladesh include government allocation, loan from World Bank and other financial institutions, International Development Agencies, financial assistance from NGOs, community participation in cost-sharing, health insurance system, health cooperative systems, private investment by business entrepreneurs, income-generating mechanisms, bank loan, joint ventures etc.

The main source of drug financing in the public sector is government revenue. The public sector provides the budget for medical care through government health facilities, which includes drug expenses for the poor, the disadvantaged, the elderly, government officials, and public enterprise employees and their families. Only a very few people are covered by health insurance.

In Bangladesh private sector drug financing includes household expenditures, private nursing home investments and drug funds from nongernmental organizations (NGOs). Most Bangladeshi usually obtain majority of their drugs from the private sector. Private nursing homes, doctors in private clinics and other health practitioners prescribe medicines to patients who must buy them at full price. Private expenditures for pharmaceuticals in developing countries typically account for 50 to 90% of all spend on drugs. Even for rural populations and the urban poor, the most common source of drugs is direct out-pocket purchase from the private market[52].

The main problems in drug financing include: public sector budget limitations, perception of health services as the Government's responsibility, lack of buying capacity in low-income and underprivileged groups, slow progress in decentralizing drug financing, the increasing price of

[50] World Health Organization, *Access to Drugs and Finance,* Geneva, 1991. p.1
[51] Economic Relations Division, Ministry of Finance, Government of the People's Republic of Bangladesh, 2002, *A National Strategy for Economic Growth and Poverty Reduction.* p.35.
[52] World Health Organization, *Health Reform and Drug Financing*, 1998, p.iii

drugs, the limited budget allocation for drugs, the slow progress in decentralizing the drug financing system, inadequate skills and motivation of the health professionals at village level and vested interested of the health professionals.

Possible options of drug financing include public financing, health insurance, user charges, non-state collective non-profit-making financing, donors and international loans. In some countries the option is a pluralistic approach in which different financing mechanisms are used to serve different groups of the population.

Total health spending depends not only on economic output and GNP, but also on political will and government commitment to protect the health of the population. The percentage of GNP spent on health in countries with similar levels of development can vary from 2 to 8%[53]. Lower public health spending in developing countries is not always the result of a lack of political will. In many cases, the low level of the health budget is the result of the drastic cuts in public expenditure imposed by structural adjustment programmes.

11. HEALTH AND POVERTY REDUCTION

The development of human capital has strong poverty reducing effects in Bangladesh. Several aspects of human development will be given priority…Within the health sector, although some success has been achieved in preventive health care, a small proportion of poor people has access to public health care services. In short, addressing the pro-poor concerns in health remains an unfinished task and the sector needs to be given the priority it deserves. Developing a pro-poor agenda within the rubric of a sector-wise approach to health represents the biggest institutional challenge in this regard[54].

Health issues are not just medical problems. They are related to the developmental problems of our country. Today's development model is pro-rich. The new economic policy encourages free market and it emphasizes privatization and globalization. The gap between the affluent and the poor are becoming wider day by day leading to the rich becoming richer and the poor poorer.

For decades it has been generally assumed that good health is a direct outcome of strong economic development. However, evidence has suggested that the opposite is true: strong economic development is an important outcome of improved health[55]…Improvements in health would translate into higher incomes, higher economic growth, and reduced production growth[56].

Health, development and empowerment are linked to each other inseparably, with empowerment here representing a state of 'understanding that one has power'-and the broader that power base, the more sustainable health will be.

Although there are many factors like education, water, housing etc. that affect the people's health status, they are in turn dependent on income and wealth. It is the poor that have less

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53 World Health Organization. *Financing Drugs in South-East Asia. Report of the second meeting of the WTO/SEARO working Group on Drug Financing,* Indonesia, 1997, p.32

54 Economic Relations Division, Ministry of Finance, Government of the People's Republic of Bangladesh, 2002, *A National Strategy for Economic Growth and Poverty Reduction.* p.34.

55 World Health Organization. 2001. *Macroeconomics and Health: Investing in Health for Economic Development.* Report of the Commission on Macroeconomics and Health. p.1

56 World Health Organization. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Report of the Commission on Macroeconomics and Health. p.3

access to safe water are less educated, cannot afford adequate nutrition and for whom health facilities are least accessible[57].

Poor health retains the poor in poverty, and poverty retains them in poor health. Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty wields its destructive influence at every stage of human life – from the womb to the tomb.

However, to recognize that poverty is multidimensional in character, including deprivation in a variety of forms such as inadequate income, lack of education, knowledge and skill, poor health status and lack of access to health care, poor housing, lack of access to safe water and sanitation, insufficient food and nutrition and lack of control over the reproductive process.

The linkage between poverty and health is complex. A better understanding of the linkages between poverty and health is essential for knowing where to initiate interventions. An important aspect of poverty is that it is both a determinant of ill health and an obstacle to solutions to health problems. For example, poverty puts children at risk for morbidity and mortality, and then obstructs efforts to counter those risks through such factors as maternal illiteracy and lack of understanding of preventive or promotive measures that are needed. Alleviating these destructive aspects of poverty requires more than medical technology- it require intersectional action that targets communities and households that are at greatest risk, and builds community's capacity to help one another to move beyond the development paralysis brought on by poverty.

In Bangladesh, poverty is widely recognized as a multi-dimensional problem involving income, consumption, nutrition, health, education, housing, crisis-coping capacity, insecurity, etc. Poverty refers to all forms of economic, social, and psychological deprivation occurring among people lacking sufficient resources for minimum required level of living. Whatever the dimension is, we know for sure that abject poverty among mass people is the hard reality, and that is the central reason to put this agenda in the centre. The profile of human deprivation reveals that about 50 percent of the people of Bangladesh are income-poor (head count index) while 77 percent of people lack basic or minimally essential human capabilities-capacity to be well nourished and healthy, capacity for healthy reproduction, and capacity to be educated and knowledgeable. UNDP's Human Development report posited that 53 percent of people lack adequate access to health services, 63 percent are without sanitation and 26 percent of children are not attending primary school.[58]

The number of urban poor has also increased from 7 million in 1985 to 12 million in 1999 and their health indicators are the worse than the rural poor[59]. The population living in urban slums are also at the level of extreme poverty. Although, the poverty eradication agenda tops the list of the commitment of government, it is so huge in magnitude that without an integrated approach and greater political commitment it has become quite an impossible task to make a break through. These along with other factors like inadequate information leading to poor healthy behaviour is responsible for an increasing trend of diseases burden like tuberculosis, malaria, HIV/AIDS, diarrhoea, complications associated with pregnancy and delivery, and childhood illness that include acute respiratory infections, measles, and diarrhoeal diseases. According to

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[57] Globalisation and *'Coping Strategies' for the Poor,* published in LINK, Bulletin of Asian Community Health Action Network, Vol.16 No.2 June, 1999

[58] Ministry of Health and Family Welfare, (1999), *Population and Development Post-ICPD Achievements and Challenges in Bangladesh*, Government of Bangladesh, June 1999, Dhaka

[59] Ministry of Health and Family Welfare (2001*), Expanded Programme of Immunization, National Plan of Action, 2001-2005*, Revised Draft

WHO these seven conditions are responsible for two-thirds of the deaths among children and young adults living in Asia and Africa.[60]

The impact of these seven conditions are far beyond the suffering of those who are affected directly, evidence shows that they threaten economic growth and are an enormous hurdle to achieving national growth and prosperity. Life saving medicines and tools to treat or prevent these conditions are available and relative low cost[61].

Cost of Prevention and Treatment of Most Serious Diseases of Poverty [7]

- US $ 10 - For a 6 month DOTS treatment (for tuberculosis)
- US$ 0.27- For 5 days of paediatric antibiotic treatment of ARI
- US$ 0.26- For administration of 1 dose of measles vaccine for immunization
- US$ 0.33- For rehydration salt use in integrated management of childhood illness
- US$ 11- For treatment of Sexually Transmitted Infections
- US$ 0.12-For one course of first-line drug treatment of malaria
- US$ 3 - For an Insecticide Treated Net for prevention of malaria
- US$ 1 - For a disposable home delivery kit for mother and baby

Global inequalities in wealth are today widening at an unprecedented rate. According to the World Bank's World Development Report, in 2000 an estimated 1.5 billion people subsist on the equivalent of one US dollar a day. According to the tenth annual UNDP's human Development Report, the richest 20% of the world now account for 86% of world Gross Domestic Product (GDP), while the poorest 20% have just 1%.[63] Dr. Gro Harlem Brundtland, Director- General WHO Stated that people in the developing world carry over 90 per cent of the disease burden – with access to only 10 per cent of the resources for health[64]. The inequities between the developed and developing countries are striking. In developed countries, a course of antibiotics to cure pneumonia can be bought for the equivalent of two or three hours wages. One-year treatment for HIV infection costs the equivalent of four to six months salary. And the majority of drug costs are reimbursed. On the other hand, in developing countries, there may be only one pharmacist for one million people. A full course of antibiotics to cure a common pneumonia may cost one month's wages. In many countries, one year of HIV treatment - if it were purchased - would consume the equivalent of 30 years income. And the majority of household must buy their medicines with money from their own pockets.

The power of our state to determine its national development strategy independently has been curbed a lot due to unequal rules of globalization as well as various aid conditionalities laid down and imposed often unilaterally by the WTO and its associated organizations. This is actually one of the fundamental obstacles against a proper reflection of people's will on the process of determining priorities and strategies of poverty reduction. Under the given unequal global and national power structure the whole process of poverty reduction strategy ultimately turns out to be a personal matter of some local and foreign bureaucrat, (wherever they may live i.e. in Dhaka, Paris, Washington or Geneva!), some special vested interest groups and a few academic policy makers! The people from bottom actually have no voice and also little

[60] World Health Organization, *Massive Effort against Diseases of Poverty*

[61] Barkat A, and M Majid, "*Overview of Diseases of Poverty in Bangladesh",* research paper presented at national seminar organized by Partners in Population and Development (PPD) and South-South Centre at BRAC Centre, Dhaka on 25th May, 2001

[63] Ritchie, Mark *et. al.*, *WTO and the Globalization of Food Security*, 1999, p.18.

[64] International Medical Parliamentarians Organizations, House of Representatives (Republic of Indonesia, Jakarta) and World Health Organization, *Economic Crisis and Its Impact on Health*, 1998, p.6

opportunity to participate in these debates and therefore often fails to reach a consensus with their counterparts[65]. So it can be assumed that the effects of formulation and implementation of Poverty Reduction Strategy Paper of Bangladesh would not be better than the effects of Structural Adjustment Programme which was introduced in 1980s.

12. CONSTRAINTS IN HEALTH SERVICE DELIVERY

HPSP faced some operational problems and delays such as: (a) absence of a clear transition plan caused confusion and delay in the first years; (b) procurement was bundled mechanically and this caused delay and disruption in project delivery; (c) coordination was insufficient in orienting GOB staff to work within the framework of a sector-wide approach; (d) financial management, accounting and adult systems could not be designed in-time causing functional problems; (e) politicization of site-selection of community-clinics, a large and basic component of the programme, making such facilities functionally ineffective in many cases[66].

On the whole, the programme confronted serious procurement-related problems; past trend of improvement of CPR and, as a consequence, decline of TFR could not be sustained; past attempts on two different occasions for the merger of the two departments of Health and Family Planning respectively did not succeed; and similar attempt without adequate preparations under this programme led to loss of momentum in the family planning services.

The MOHFW is spending an average of 85 percent of its yearly allocation, for many years. The issue of this weak absorbtive capacity of MOHFW needs to be examined for reasons and institutionalizing corrective measures for full utilization of available resource.

The major **constraints and system inefficiencies** identified are:

- Partial unification (only upto Upazilla level) has resulted in management and administrative problem;
- Revised job distribution, and delegation of drawing and disbursement authorities (DDO) have resulted in dissatisfaction among a group of personnel affecting delivery of services;
- Earmarking specific department with no in-built capacity resulted in low quality construction;
- Uncoordinated interventions between different departments with tasks;
- Pursing World Bank procurement guideline sometime caused delay;
- Poor capacity of procurement management in CMSD with long multi-step system of procurement of the World Bank;
- Development of large sized packages affected the total package and resulted in delay in procurement of some minor items;
- Low level of supervision and monitoring has resulted in delivery of poor quality services;
- Unification of support services (BCC, Logistics and MIS) has not proceeded as planned;
- Establishment of reward or punishment based on performance not in place;
- Accurate total expenditure status under each operation plan cannot be ascertained fully due to non-integration of revenue and development budgets;

[65] Akash, MM, *Poverty Reduction Strategy: What, Why and for Whom*, key note paper presented in the national convention on Poverty Reduction Strategy organized by People's Empowerment Trust and ActionAid Bangladesh, IDB Bhaban Auditorium, Dhaka, March 09, 2002.

[66] Barkat, Abul and Murtaza Majid, 2002, *Position Paper on Health, Population and Family Welfare Sector*, paper prepared for Planning Commission, Ministry of Planning of the Government of the People's Republic of Bangladesh

- Reimbursements of expenditure particularly of GOB source could not be claimed and made on time;
- Capacity of Cost Centres for development of statement of expenditure has not been built effectively;
- Limited progress with hospital autonomy;
- Effective local level planning yet to take place;
- Decentralization of financial powers under revenue allocation not yet substantial and satisfactory;
- Decentralization of administrative authority at cost centres yet to take place;
- Absence of clear cut career path for service providers;
- Still existence of separate development and non-development (revenue) budgetary and planning system with no linkage or coordination with each other;
- Non-development of single sector investment plan due to existence of vertical tied-up projectised support by some development partners;
- Lack of adequate capacity building in preparation of operational plan (OP) at the management level; and
- Inadequate monitoring of implementation of OPs based on performance indicators at all levels.

13. EXTERNAL ASSISTANCE AND THE ROLE OF DEVELOPMENT PARTNERS

"External assistance is considered a critical item for economic development of Bangladesh inorder to bridge the gap between savings and investments and balance of payment. Upto june 30, 2001 (1971-72 to June 2001) a total of $ 46,072.1 million of external assistance was committed. Total foreign aid disbursement as of June 30, 2001 was $ 37,713.5 million of which 47.7% was grants and 52.3 % was loans, the per capita debt obligation of the country has increased from $ 6.59 in 1973-74 to $ 114.6 in 2000-01. Since the share of grant in the external aid package is shrinking the volume of external borrowings is increasing every year which resulted in a progressive increase of per capita debt obligation[67].

Development Partners (DPs) have been playing a major role in Health sector development for over a decade or so. DPs interest in health sector intensified since 1996 when Health Population Sector programme (HPSP) design process was started. Donor consortium lead by World Bank/IDA assured support for sector-wide approach to integrated Health-Population Programme. A 2.895 million (say 2.9 billion) five-year sector programme was appraised by the Bank with GoB contribution of 2.191 billion (75.7%). Development partners were Canada (CIDA), EC, Germany (Gtz, KFW), the Netherlands, Sweden (SIDA), UK (DFID), UN Agencies and others sources including UNICEF, UNFPA, ADAB, USAID, Japan and WHO (Project Appraisal Document – Report No.17684-BD, World Bank, June 1, 1998, SASHP, Bangladesh, South Asia – Health and Population Program Project). See also HPSP External Financing Commitments (Annex1).

GoB's commitment to Health and Population Sector in Annual Development Programme (ADP) has increased from US$ 147 million in FY 1995-96 to US$ 275 million in FY97-98 (11% increase), to $ 312.38 million in 2002-2003 which is 12% increase over FY97-98 allocation.[68] We are strongly inclined to believe, "that it is feasible, on average, for low-and middle-income

[67] Flow of External Resources into Bangladesh – Economic Relationship Division, Ministry of Finance, Govt. of Bangladesh, 10, march 2002, pages XXI, XXV.

countries to increase budgetary outlays for health by 1 percent of GNP by 2007 and 2 percent of GNP by 2015 compared with current levels, though this may be optimistic given intense competing demands for scarce public resources" (Macro-economics and Health: Investing in Health For Economic Development; WHO; December 2001).

HPSP is a massive and ambitious health programme without which or beyond which the health activities were very modest and on a low profile. Nevertheless, the importance of UN agencies – inter-governmental agencies, and their role can hardly be under-estimated. WHO will continue to play a major role as technical agency in all matters relating to health which encompasses life in its totality. Any cause and consequence that affect health and healthy living of human being will call for technical intervention by WHO. **WHO is the lead agency in coordinating health sectoral** development not necessarily from financial stand point, but as the technical agency. It has been supporting various health related projects and initiatives in many ways though modestly. In Health, Nutrition, Food, Drugs, Environment, Disease Control and Prevention, Sanitation, Water and in many other related areas WHO's role will continue to be useful. **The stark reality is that Bangladesh in no way can loose any opportunity to harness its internal resources for development.**

14. NGOs IN HEALTH DEVELOPMENT

It is widely known that NGOs in Bangladesh have a wealth of experience and proven ability in service delivery, targeting the poor, mobilizing the community for development. Their potential to contribute to health development is quite substantial. NGOs have comparative advantage in reaching the poor and vulnerable populations. Strong GoB-NGO **collaboration** and stronger sense of **partnership** would be to key success in health development initiative.

In Bangladesh nearly 25000 NGOs are registered (24,000 in 2000), but only 1500 (1300 in 2000) are registered with NGO Affairs Bureau, and only 500 NGOs work in the Health, Nutrition, Population (HNP) sectors. NGOs are working in Nutrition, FP, Reproductive health care, Arsenic, HIV/AIDS, Immunization Programmes, Sanitation, Communicable disease control, ESP delivery programme, Health-manpower training, and in several other areas of Health – FP programme. The ADB-supported Urban health Project rely almost entirely on NGOs for service delivery. NGO collaboration will include both local (action-level) and central levels (decision-making level) involving –

- Principles of collaboration
- Scope of NGO roles and responsibility/accountability;
- Process of involvement at both national and local level – policy, planning, implementation and monitoring,
- Fund disbursement mechanism and reporting;

Communication gaps sometimes lead to strained relationships between GoB and NGOs but once the cost-efficiency of NGO administered health programmes are well established there will remain hardly any room for misunderstanding.

15. PROFESSIONAL ASSOCIATIONS AND COMMUNITY BASED ORGANIZATIONS WORKING FOR HEALTH

It is public opinion expressed through organized civil society that holds a government accountable. People depend on networks, associations and other social organizations to reduce life's risks, access services and resources, and protect themselves against the depredations of the fellow human beings. It is this 'social capital' which must serve ultimately to hold governments accountable and thereby enhance their performance. Consequently, improving governance depends on progressively building the networks of civic organizations and other positive forms of social capital, which extend people's range of institutional choices in accessing public services, and strengthen their ability to influence policy formulation and implementation.

Increasing poor people's social capital must be a key component of an effective strategy to reduce poverty in Bangladesh. Typically the poor have weak social networks – they lack social capital – and therefore tend to be excluded from mechanisms that would allow their voices to be heard. Mobilization and involvement of the general population, their voice against misgovernance, is also very important. Pro-poor policies and programmes promote better governance. Efforts at strengthening the voice of the general public in determining better governance have thus best chances at the local community level.

To ensure health there is a need to further democratize and strengthen the organizations for the poor (such as NGOs and CSOs) as well as the organizations of the poor (such as CBOs). This will create an environment whereby social entrepreneurs can play a role. Social entrepreneurs may include different actors including NGOs/CBOs, corporate bodies, social charities and trusts initiatives, and individuals with philanthropic motives. All pro-poor agencies including large and small NGOs and CBOs must be encouraged to remain accountable to the poor.

To improve health situation, in the rural and urban areas, interventions might be designed in the following areas e.g. income growth, improvement in the coping capacity of the poor, and access to public service and goods for the poor. This sort of interventions could be highly successful if the health department can successfully involve the "Best Actors" of human governance. Main actors for human governance include individuals, the community, civil society organizations, media, private sector, state and international organizations.

Since health has an impact on individuals, families and specific local communities, the culture, social policies, economic conditions and health needs are important elements of the efforts to improve the health situation in our country. Thus a decentralized approach that understands nation and is different regions health situation has become a must. Centralized top-down setup does not seem like a method that responds to the needs of the people and is run by the people themselves with the government giving necessary directions. Such a decentralized model would led to promotion of health through inexpensive, participatory approaches at the village, union, upazila and district levels To run such programmes efficiently, administrative and financial powers need to be given to the local government institutions. The Kerala Government's democratic planing scheme is a model for this. Since the *Panchayat* gives the salary to the village health workers, their direct responsibility to the people can be guaranteed. It is the responsibility of the people to protect those who fulfil their health needs.

We must pave the way toward a universal health democracy in which all people are informed, their voices are heard, and they are able to participate in decisions affecting their own health. The democratization of health will require strong political will, for no longer is it acceptable in a modern age to tolerate unnecessary illness and death in a world with abundant knowledge and

resources to prevent such suffering, Good health is the cornerstone of economic progress, a multiplier of a society's human resources, and, indeed, the primary objective of development. Ultimately, we must strengthen the moral or ethical basis of health equity.

WHO should be a global institution for global health governance and it must strengthen its recognized normative role for supporting equity-oriented health policies, operating as the "world conscience" of health[69].

[69] Godlee F. 1997. WHO reform and global health. *British Medical Journal* 314: 1359-1360

Annex-1

HPSP External Financing Commitments

Source of Finance	**PAD 1998**	**PCC 10/2000**	**Revised PIP 03/2001**	**%Change 10/00 to 03/01**
IDA (HPSP)	250.0	250.0	250.0	-
Canada	14.5	14.5	13.5	-6.9
European Commission (HPSP)	88.1	88.1	61.0	-30.8
Germany (KfW)	25.5	25.5	20.0	-21.6
Germany (GTZ)	5.4	5.4	4.5	-16.7
Netherlands	24.4	24.4	23.0	-5.7
Sweden (SIDA)	32.5	32.5	28.0	-13.8
United Kingdom (DFID)	81.8	81.8	86.5	5.7
Donor Consortium	**522.2**	**522.2**	**486.5**	**-6.8**
United Nations Organizations	-	100.0	58.0	-42.0
UNDP	-	-	8.0	-
UNICEF, UNFPA and WHO	-	-	50.0	-
European commission (Balance of FPHP)	-	10.5	7.5	-28.6
ADB, JICA and IDA (BINP)	-	100.0	83.4	-16.6
ADB (2nd health and Family Planning (Survey)	-	-	9.9	-
IDA (BINP)	-	-	43.5	-
JICA	-	-	30.0	-
IDA (HIV/ AIDS)	-	-	20.0	-
Islamic Development Bank	-	9.9	9.0	-9.1
SFD	-	-	3.5	-
USAID (NIPHP)	-	210.0	150.0	-28.6
Other Development Partners	**-**	**430.4**	**311.4**	**-27.6**
National Nutrition Program	**-**	**106.2**	**-**	**-**
IDA	-	92.6	-	-100.0
Netherlands	-	13.7	-	-100
Committed External Resources	**522.2**	**1,058.8**	**797.9**	**-24.6**
Additional Assistance to be Mobilized	**182.5**	**-**	**188.2**	**-**
External Resources	**704.7**	**1,058.8**	**986.2**	**-6.9**

Notes: Project Appraisal Document 1998 Status of External Financing Commitments provided by PCC October 2000, Revised Program Implementation Plan, March 2001.

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