

**James P. Grant School of Public Health
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**Bangladesh Health System in Transition:
Selected Articles**

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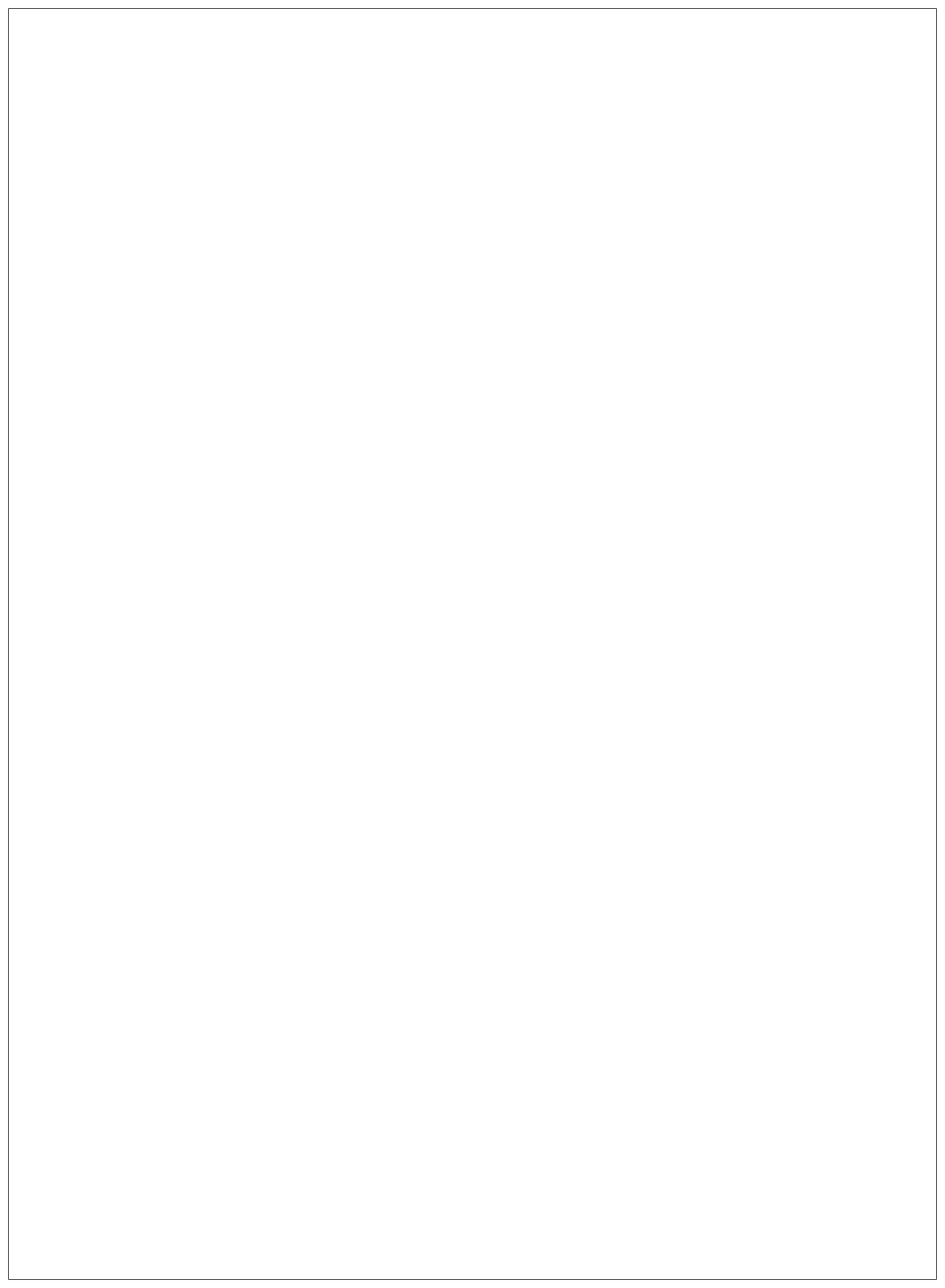
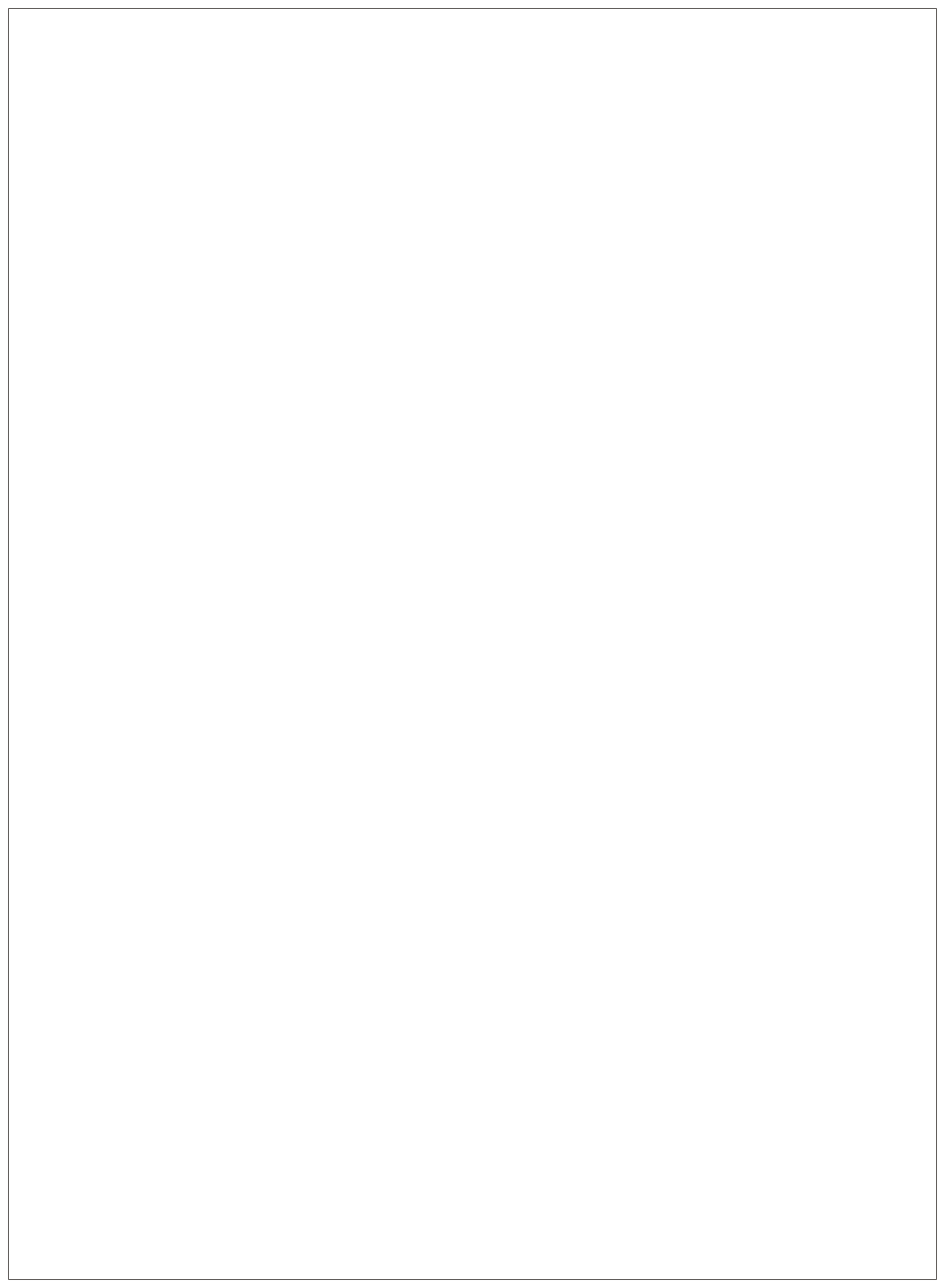


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PREFACE

The articles published here appeared in the daily New Age over the last one and a half years from early 2008 to mid 2009. They covered various issues related to the problems, constraints and challenges faced by the broader health system in Bangladesh- from gender-based violence, overarching policy void to human and financial resource scarcity and to road traffic fatalities. Although each article was written in the context of prevailing issues confronting the health system, it is strongly felt that are still relevant and remain to be fully addressed. It is in this context that the James P Grant School of Public Health, BRAC University thought of combining the articles in a single booklet or monograph so that they are available to interested students, faculty, researchers and public health professionals and advocacy groups for reference.

Some of the articles are very much at the core of challenges faced by the health system in Bangladesh. The policy void is of particular importance. In 1988, during the autocratic rule of President Ershad, Bangladesh had its first health policy. However, the first overarching health policy by a democratically elected government did not see the light of the day before August 2000 too far into the mandate of the then ruling party (see the article entitled “National Health Policy: No Scope for a Piecemeal Approach”). Unfortunately, much of the initiatives promised by the Health Policy 2000 were quietly abandoned by the newly elected government in 2001. However, it never bothered to come up with a comprehensive health policy of its own. The current elected government seems to be serious in presenting a new national health policy consistent with the letter and spirit of its election manifesto. As these articles are being published, we are still awaiting such a comprehensive national health policy, although some planned programs/initiatives have already become apparent through various piecemeal announcements of the Honourable Minister of Health and some of his high-level officials. As the new national health policy takes shape debates and dialogues among the stakeholders, I intend to participate in this debate through newspaper articles and other means. I hope that we shall be able to present another monograph next year bringing together some of these anticipated publications.

I hope that students, faculty, researchers and the wider public health professionals find these articles interesting, informative and useful. Please feel free to share any comments or suggestions that you might have. Your comments will make us further improve the Monograph series regularly published by the School.

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CHALLENGES FOR THE HEALTH SYSTEM IN BANGLADESH

Bangladesh, along with the rest of the world, will observe the 2008 World Health Day today. Perhaps, we should use this occasion to take stock of what we have achieved in health over the last few decades and at the same time better understand the challenges faced by the health system in Bangladesh.

SINCE independence, Bangladesh has made tremendous progress in health and development. In some cases, we have made more impressive gains than most of our neighbours. We now live longer – the average life expectancy at birth increased from 40 years in 1960 to 64 years in 2005. At the time of independence, our gross national income was hardly \$100 per capita. In 2006 our GNI per capita was \$480. Our adult literacy rate increased from 24 in 1970 to 47 in 2006. Enrolment in primary education (6 to 10 years old) in Bangladesh increased from 54 per cent in 1970 to almost 110 per cent by 2006, as an increasing number of children less than 6 years old and over 10-years old are also joining the pool. Most importantly, at the primary and secondary levels of education, Bangladesh has been successful in abolishing gender inequality. Now we have more girls than boys in our schools. The infant mortality rate (number of infants aged 12 months or less dying per 1,000 live births) in Bangladesh declined dramatically – from 145 in 1970 to 52 in 2007. Similarly, the under-5 mortality rate (children aged 5 years or less dying per 1,000 live births) declined from 239 in 1970 to 65 in 2007.

Our success in expanding immunization – the percentage of fully vaccinated children increased from less than 10 per cent in 1980s to more than 80 per cent by the turn of the twenty-first century contributed immensely to these impressive gains in child health. As more children started to survive the first year and then the first five years of life, women in Bangladesh started to have fewer and fewer babies. Our total fertility rate (number of children born to women aged between 15 and 49 years) declined from 6.3 during 1971-75 to 2.7 by 2007. Needless to say, our contraceptive prevalence rate also registered impressive growth – from a low of 7 per cent (percentage of married couples using modern methods of contraception) in 1975 to more than 47 per cent in 2007.

However, we have our failures too. We have made little progress in reducing malnutrition among children. The percentage of underweight children aged 6-59 months remained more than 45 per cent since mid-1990s. Moreover, 30 per cent of our population suffer from malnutrition. At 320 per 100,000 live births, the maternal mortality ratio also remains stubbornly high in Bangladesh. A precondition for reducing maternal mortality is to ensure skilled birth attendants during delivery. Sadly, we have achieved precious little in this respect. In 1995, only 10 per cent of deliveries were done by skilled birth attendants. The figure increased to 12 per cent in 2000 and to 17.8 per cent in 2007. In other words, unskilled health workers are handling more than 80 per cent of childbirths. Not surprisingly, a high 85 per cent of births in Bangladesh continue to take place at home, attended by unskilled individuals who can neither recognize pregnancy-related complications nor provide effective interventions.

Income inequity and disparities in access to health and other services continue to persist in Bangladesh. More than 40 per cent of our population live on an income of less than a \$1 a day. Almost 50 per cent of our population live below the national poverty line. More importantly, income inequity seems to be rising in Bangladesh. Income share held by the lowest 20 per cent of the population declined from 9.5 per cent in 1990 to 8.6 per cent in 2000 and to 7.3 per cent in 2005. Clearly, more and more wealth is being concentrated in fewer and fewer hands. As the poor has less access to health care services, they share a disproportionate burden of disease and deprivation. According to the 2007 Bangladesh Demographic and Health Survey, among the lowest wealth quintile (the poorest segment of the population), skilled personnel attended only 4.5 per cent of deliveries. The corresponding figure for the highest wealth quintile (the richest segment of the population) was 60.1 per cent. Likewise, while only 28.3 per cent of women from the lowest wealth quintile received antenatal care, 91 per cent of women from the highest wealth quintile did so. The survey also shows that only 20.3 per cent of children from the lowest wealth quintile received treatment for Acute Respiratory Infection, while the corresponding figure for the highest wealth quintile was 58.1 per cent. Disparities between the rich and poor continue to persist in other areas too including malnutrition, anaemia during pregnancy among women, and the percentage of fully vaccinated children.

The status of maternal health often acts as a litmus test for a health system. Since science, religion, culture and social values intersect so profoundly on issues related to sex, pregnancy and childbirth – in short, on maternal health the strengths and weaknesses of a health system also most often become evident in this sphere. Clearly, these discomfoting figures underscore some serious weaknesses of the health system in Bangladesh. On the occasion of the World Health Day, we should reflect on the challenges faced by our health system so that effective policies and plans can be initiated to further strengthen it.

Perhaps the most critical challenge faced by the health system in Bangladesh is in the arena of human resources for health. Bangladesh is one of the few countries in the world where there are more physicians than nurses and trained midwives who are so vital for effective primary health care services, including maternal, newborn and child health services. We have around 15,500 nurses and 39,000 physicians, according to a soon-to-be published report of the Bangladesh Health Watch. Based on low-income countries' average, as the Watch points out, Bangladesh currently has a shortfall of 60,000 physicians. The shortfall is going to increase further as the population increases. The nursing shortage is so catastrophic that we require urgent action in addressing the issue. At the same time, human resource is unevenly distributed across the country with little resources in rural areas. Most upazila health complexes suffer from inadequate human resources, especially physicians and nurses. Absenteeism of key health human resources (“ghost” physicians) often make matters much worse. Lack of drugs, supplies and other facilities also plague the health complexes. As a result, our publicly funded health care system is used by only 25 per cent of the population.

Bangladesh has a burgeoning private sector providing health services. Pharmacies, clinics, diagnostic centres and modern tertiary care hospitals constitute the landscape for

a robust for-profit private sector in health. It is growing at a rate of 15 per cent each year. On the other hand, our informal health care providers – from Hakims and Ayurveds to pharmacists and various kinds of unqualified “village doctors” – outnumber the “formal” qualified service providers by 12 to 1. From time to time, newspapers flash horror stories about some of these for-profit clinics – from unnecessary surgeries to unqualified surgeons. Stories of re-use of used syringes, using unsafe blood for transfusion and almost total negligence to medical waste management by some of these clinics and diagnostic centres often make the news. Despite these periodic horror stories, most of the people regularly use these private sector institutions for their health care.

Our not-for-profit private sector is also a large and growing phenomenon. It is composed of the non-government organizations that are involved in diverse activities – from health and education to providing micro-credit and agricultural training. Along with the big three - BRAC, Gonoshasthya Kendra and Grameen Bank – the NGO sector includes thousands of other smaller ones. BRAC and Gonoshasthya not only provide health care services, but are also involved in creating health resources. BRAC runs the internationally acclaimed James P Grant School of Public Health that produces 25-30 Masters in Public Health each year (graduates are almost evenly divided between Bangladeshis and non-Bangladeshis), while Gonoshasthya runs a full-fledged medical university as well as a world-class drug and other healthcare supplies factory. The NGO sector is also growing fast in its reach and depth and diversity of services, often in contract with the government.

In spite of such a fast growing private sector, Bangladesh does not have a comprehensive health policy with a vision for the totality of the health sector. As a steward for the health system, the Ministry of Health and Family Welfare is yet to come up with an overarching strategic direction for the health sector as a whole encompassing both the public and the private sector. Lack of progress in maternal health underscores lack of such an overarching strategic framework. Instead of looking at women's health from a life-cycle perspective, our maternal health interventions, mostly part of the publicly run Health, Nutrition and Population Sector Programme, are primarily clinical in nature emphasizing availability of and access to emergency obstetric services. A life-cycle approach, on the other hand, would have focused on various social, cultural and structural factors that impede women's access to health, education, nutrition and other services from birth through adolescence, adulthood and old age. Such a comprehensive approach to women's health could revolutionize our health system in providing better and more appropriate interventions encompassing all aspects of a woman's life. In such an approach, violence against women – so pervasive in Bangladesh also becomes a public health issue to be addressed by the health system. Ensuring appropriate sexual and reproductive health services for our adolescents thus becomes an integral part of the health systems' mandate. Such a holistic approach could also be instrumental in shifting the emphasis of our population program from family planning to improving maternal, newborn and child health through the promotion of healthy timing (no pregnancy before age 18) and spacing (more than two years of gap between pregnancies) of pregnancy.

Moreover, as we move through a demographic and epidemiological transition, the health system in Bangladesh is faced with the dual burden of communicable diseases and emerging non-communicable diseases like diabetes, hypertension and cardiovascular ailments. Effectively addressing these dual challenges also requires a strong proactive steward.

Clearly, our health system is faced with the challenge of a dynamic, proactive stewardship – leadership at the highest level with a vision for the entire health system. Such leadership would bring the public and the private sectors together for the common good. Such leadership will bring meaningful health sector reform involving community participation to make the health system accountable to the people that it intends to serve. Above all, such a dynamic steward will make fulfilling the non-medical expectations of the consumers (the respect and dignity that they receive and the confidentiality granted to the information that they provide) and the fairness of the system (ensuring financial protection to all segments of the population) as the penultimate objectives of the health system. On the occasion of the World Health Day, let us pledge to work together to build the capacity of the health ministry so that it can emerge as the steward providing most dynamic and evidence-based leadership to the health system in Bangladesh with a strategic vision that encompasses the public as well as the private sector. .

COMBATING VIOLENCE AGAINST WOMEN: Need For A Radical New Perspective

ON MARCH 8, Bangladesh joined the rest of the world in celebrating International Women's Day. Along with talk-shows, seminars and workshops, a rally was organised where men pledged to fight violence against women. Following these celebrations, life seemed to have returned to 'normal'. News media continues to inform us of yet another incident of acid violence and, with alarming regularity, of dowry-related deaths. Are we, at the societal level, making progress in combating such violence? Do we fully understand the enormity and complexity of the task? Let us look at some of the facts, trends and manifestations of violence against women so that we are better prepared to respond to the challenges.

Bangladesh is not unique in beating and killing its female citizens. It is a widespread and a growing problem in practically all societies. Due to unequal power relationships between men and women, in all societies and in all phases of their lifecycle, women face discrimination and violence at the hand of the state, the community and the family. The violence that they face varies in form – from low-level physical, sexual and psychological abuse to trafficking to forced prostitution, infanticide, genital mutilation and brutal murder. Bangladesh, however, has a distinctive brutality against women – acid violence. Nowhere in the world men are able to inflict so much pain and sufferings to women with such ease and utter disregard to human life. Perhaps the most distinctive characteristic of gender-based violence is its origin and legitimisation within the family as a social institution. Consequently, as we witness in Bangladesh, in most cases, other women mothers-in-law and sisters-in-law, for example – act as accomplices in such gender-based violence within the family.

Family/domestic violence cuts across all religions, cultures and countries. It is estimated that in Canada more than 1.5 million women are living in a battered relationship and that about a million Canadian women are physically abused by their spouses or partners every year. The situation is much worse in the United States. According to a Commonwealth Fund Survey (1998), nearly one-third of American women (31 per cent) report being physically or sexually abused by husband or boyfriend at some point in their lives. In India, one study suggests that between 18 and 45 per cent of married men admit to abusing their wives and in Southern India, 34 per cent of women reported being abused by their husbands so severely as to require medical attention. In both India and Bangladesh violence against women often remains unreported. One recent report suggests that only 10 per cent of rapes get reported in India and out of every 100 reported cases only 5 offenders are ever convicted. A multi-site study in rural Bangladesh reports that the most common and frequently repeated forms of violence against women in marital relationships are verbal abuse, slapping, severe beating and forced sex. Acid violence and dowry-related deaths by burning or severe beatings are also on the rise in Bangladesh as evident from daily newspaper reports and studies.

Domestic violence is a major cause of injury and death. In its pioneering World Report on Violence and Health (2002), the World Health Organisation estimates that globally at least one in every three women has been beaten, coerced into sex, or otherwise abused by a man in her lifetime. According to the report, domestic violence accounts for more deaths and disability among women aged 15-44 years than the combined effects of cancer, malaria, traffic injuries and war. Apart from health related sufferings, the battered women suffer from low self-esteem; they feel isolated and powerless; they often suffer from a sense of guilt, somehow blaming themselves for the abuse and violence. As a result, as the WHO report points out, women who are victims of domestic violence are 12 times more likely to attempt suicide than those who do not experience such violence. Not surprisingly, women in different cultures learn to blame themselves for such violence. More than 90 per cent women in Egypt and Zambia and 70 per cent of women in India, according to a 2004 study, believe that wife beating is justifiable.

Although our religion prohibits it, dowry – a payment to be made by the bride's family to the groom's family at marriage – continues to be a leading cause for violence against women in Bangladesh. It is also prevalent in India and Pakistan. A 1999 UNICEF study reported that over a dozen women a day die in India as a result of dowry-related disputes often in kitchen fires designed to look like accidents while 'cooking'. A 2002 report puts the figure to as high as 18 per day.

Trafficking of women for the purpose of prostitution is another form of violence against women widespread in Thailand, Philippines, India, Nepal, Sri Lanka, Bangladesh, and parts of Africa. According to a UNFPA report, two million girls between the ages of five and 15 are introduced into the commercial sex market each year. More than 200,000 women from Bangladesh have been trafficked to Pakistan over the past decade and thousands more to India – more than 200,000 between 1990 and 1997 alone. Some 5,000-7,000 Nepali women and girls are illegally traded to India each year. Trafficking of women also takes place internally within the borders in many countries, often from rural areas to cities. Recent reports and studies have produced convincing evidence that globalisation and feminisation of labour have transformed trafficking in women into a 'big business' in Asia and in other parts of the world.

How to explain such widespread and multifarious forms of violence against women across cultures? This is because the social structural factors underlying such violence against women are pervasive and universal. A male-centred ideology that perpetuates gender-based social inequality is common in countries across continents – from Bangladesh to Burundi, India to Indonesia and Cambodia to Canada and the United States. Enmeshed in our culture and constantly reinforced by our language and the mass media, patriarchy as an ideology becomes part of us – our personality. Being born and raised in a particular culture and language it is difficult to come out of this male-centred ideology. We become prisoners of our own social world and accept the culturally prescribed path as the only route to knowledge. Truth cannot be discovered if one fails to question the path itself as a Sufi notes: 'none may arrive at the truth until he is able to think that the path itself may be wrong. This is because those who can only believe that it must be right are not believers, but people who are incapable of thinking otherwise than they already think.'

Language, as an essential social construct, is often a barrier in this regard. The words we use to identify the social world and define our experience also reflect our deep-seated societal values, the prevailing gender perspective being one of them. Thus when we acquire language, we acquire at the same time, a way of organising our experience. Therefore, it is not an accident that there are far more words to describe women than men and many of these have negative connotations. We often use different words to describe work of men and women even when the work is the same. Likewise, describing independent women as unmarried or women who are not mothers as childless 'reinforces the social expectation of marriage and motherhood'. Needless to say, independent or unmarried men do not receive the same treatment. Treating women as the 'weaker' or the 'abnormal' sex pervades all other spheres of our lives. Men and women are not simply considered different from one another, but in every domain of life, men are considered the normal human being, and women as somehow abnormal and/or deficient. Women, therefore, constantly worry about measuring up, doing the right thing, being the right way. This cultural perception of female otherness occurs in every field – in science, law, medicine, history, economics, social science, and in literature and art.

Many social scientists cite examples of this 'maleness' of our social world. In politics, for example, trade and commerce, crime, and war are considered to be 'important issues' by governments and the media, while such issues as day care, reproductive health, and family planning are labelled as 'women's issues'. Likewise, while debating international human rights issues, the Security Council of the United Nations is hardly interested in things like wife-beating, female genital mutilation, or forced prostitution. Again, they are treated as 'women's issues'. In history books Greece is immortalised as the 'cradle of democracy' – the intellectual springboard of Western civilisation – although there was no democracy or human rights for women and slaves. In medicine, whether in Bangladesh or Burkina Faso, students learn anatomy and physiology and separately, female anatomy and physiology as if the male body is anatomy itself. The other day, Dhaka had an exhibition of works by female artists; we do not advertise exhibitions of works by male artists. The assumption seems to be that male painters represent art itself, while works by women artists are different and lesser. Even a scientist like Sigmund Freud in his theory of psychoanalysis, assumed the male as the developmental norm for humanity and female development as a pale and puny deviation from it. In short, 'we are born into a society structured on male privilege. Our own observations and experiences, the reactions of others, and the language we learn to categorise experience all reinforce cultural definitions of masculinity and femininity. These cultural definitions, coupled with a tradition of male authority, interact with economic controls to maintain gender distinctions. Gender distinctions are established at the institutional level and reinforced through socialisation, custom, and where these fail, intimidation and force.'

It is difficult to come out of this pervasive 'male-centred' philosophy so enmeshed in our culture and daily living experience. Nevertheless, it must be realised that a gender perspective demands nothing less. Clearly a new paradigm is needed that looks at violence against women as the ultimate form of social control reinforcing the dehumanisation of women. Without such an understanding how can one describe the trauma, pain and agony experienced by the victim of a dowry murder from the day of her

marriage to the day of her being burned alive? How can one capture the shame, pain and helplessness of a rape victim abandoned by the family because of a sense of 'dishonour'?

Public policy can hardly be influenced without capturing and describing the human dimension of the problem of violence against women. Statistics may highlight the problem; but it is through powerful description of the human suffering; the experience of fear, powerlessness, alienation and guilt that public policy can be moulded. In other words, the inner knowledge and intuition must lead to concerted, determined efforts to change our social world. Knowledge must lead to action, to policy development and implementation. It is time that we make a fundamental paradigm shift in understanding violence against women and follow up with concrete action. This will require nothing less than changing ourselves, unlearning most of the things that we have learned since childhood and changing our views about ourselves.

It is important to realise the enormity of the task. A gender perspective implies fully understanding and appreciating the structural factors – power relationships, culture and ideology – underlying gender-based violence. Most importantly, this implies 'thinking outside' the socio-cultural milieu – the 'social box' in which we are born. Although the task is immensely difficult and challenging, it can be done as so many scholars and gender advocates have demonstrated across cultures and religions. The central question is: are we willing to come out of prevailing pervasive 'male-centred', patriarchy-conditioned theoretical framework and philosophy? Do we have the intellectual integrity to accomplish such a paradigm shift? As we confront dowry-related deaths almost each day, this is perhaps the greatest challenge for Bangladeshi men and women and our policymakers.

A MORE HOLISTIC APPROACH TO WOMEN'S HEALTH ISSUES

...in dealing with women's health, our health system adopts a parochial gender perspective treating women primarily as tools for reproduction. How to make pregnancy and motherhood safer, therefore, is the rallying cry of the health system. We forget that the seeds of malnutrition that a pregnant woman suffers from were sown much earlier perhaps in her infancy when gender (always favouring the boy child) largely dictated food allocation and intake pattern within the family.

BANGLADESH has made significant gains in many areas of health and social development since independence. Our life expectancy at birth not only increased from 45 years at the time of independence to 65 years by 2005, the male-female disparity in this respect also disappeared. Our infant mortality rate declined from 153 per 1,000 live births to 52 per 1,000 live births by 2006. So is the case with under-5 mortality rate it declined from over 100 per 1,000 live births during the 1970s to 65 per 1,000 live births by 2007. Nevertheless, recent reports seem to conclusively show that we have made little progress in reducing the maternal mortality ratio (number of pregnant women dying because of pregnancy complications or during childbirth per 100,000 live births) – perhaps the most important test for any health system. Alas, we don't even seem to agree on the precise number of pregnant women dying during pregnancy or childbirth. For quite sometime it was generally agreed the maternal mortality ratio stands at 320 per 100,000 live births. A recent report by UNICEF puts the figure at 570, while a few weeks ago in a seminar attended by none other than the director general of health services the ratio was put at 264 per 100,000 live births (Prothom Alo, May 29). Since it is quite difficult to accurately measure maternal mortality ratio, it seems that our confusion in this regard will not go away soon. However, it is important to note that in order to achieve the relevant Millennium Development Goal, our maternal mortality ratio must be reduced to 120 within the next seven years. A challenging task indeed, especially if the figure is closer to what UNICEF wants us to believe.

Bangladesh has good infrastructure for maternal and child health. Across rural Bangladesh, there are more than 3,600 health and family welfare centres, more than 400 thana/upazila health complexes, 64 district hospitals, 14 government medical college hospitals, 10 postgraduate institutes/hospitals and 20 specialised hospitals. In addition, there are 64 maternal and child welfare centres at the district level – covering a population of one to two million – to provide health services to women and children, including assisted delivery and emergency obstetric care. These are all part of the publicly funded health system.

In rural areas, the health complexes function as the core of the public healthcare system serving a population of around 200,000 to 300,000 at the sub-district level. Each complex has a 31-bed functional hospital with physicians, nurses, paramedics, lab technicians and

female field workers designed to provide an array of in-patient and out-patient services, including family planning and maternal and child health services. On the other hand, we have male and female family welfare assistants and health assistants to provide family planning and some maternal health services. Male health assistants are also responsible for distribution of vitamin A capsules, immunisation, detection of malaria and prevention and treatment of diarrhoeal diseases. The district hospitals with 50 to 200 beds serve a larger population and provide limited specialist services as secondary level health facilities. They act as referral centres for the upazila health complexes. On the other hand, the medical college hospitals – teaching hospitals with a wider range of specialist resources and laboratory and other facilities – are our tertiary healthcare centres for treatment of more complicated and difficult cases. They act as referral centres for the districts. Mostly located in Dhaka, we also boast of a number of specialised national health institutes that are known to provide the highest level of medical care available in the country.

It is evident that this seemingly good network of healthcare infrastructure has largely failed to significantly improve maternal health if maternal mortality ratio is taken as the major indicator. Why? The most common reasons cited are: a large number of pregnant women in Bangladesh (almost half) do not receive any antenatal care; home is the site of almost 90 per cent of deliveries; traditional birth attendants with little knowledge/skills are the primary resource (in almost 65 per cent of cases) available at the time of delivery; only 12 per cent of deliveries are attended by medically trained individuals; and pregnant women have little access to emergency obstetric services. Often it is pointed out that quick access to emergency obstetric services could substantially reduce maternal mortality in Bangladesh by alleviating the immediate causes of such deaths (obstructed labour, excessive bleeding, eclampsia, etc.).

Is there anything wrong with these conclusions? From a clinical point of view, it is difficult to ignore these issues. Like anyone else in the world, our pregnant women have the right to antenatal care, safe delivery and emergency obstetric services. Our health system must ensure these basic rights to all pregnant women irrespective of their place of residence, socio-economic status, ethnicity or level of education. However, when dealing with women's health, we make two fundamental mistakes: (a) we assume that women's health issues start with pregnancy and end with delivery; and (b) we believe health challenges faced by women (in our case, pregnant women) can be addressed clinically through ensuring skilled birth attendants at the time of delivery and access to emergency obstetric services. Consequently, our health system is preoccupied with reproductive health and safe motherhood. In other words, the health system views women primarily as reproductive agents ignoring other roles of women in our society – as a girl child growing up, as an adolescent faced with all the challenges of impending puberty and adulthood, as an adult trying to juggle work-life and a career with the competing demands of the family and motherhood, and as an aging matriarch forced to contemplate the perils of retirement and a not-so-exciting old age. At the same time, health is viewed from a narrow medical/clinical perspective ignoring the role of culture and societal factors and forces in shaping and influencing our – men, women, and children – health and health seeking behaviour.

In other words, in dealing with women's health, our health system adopts a parochial gender perspective treating women primarily as tools for reproduction. How to make pregnancy and motherhood safer, therefore, is the rallying cry of the health system. We forget that the seeds of malnutrition that a pregnant woman suffers from were sown much earlier – perhaps in her infancy when gender (always favouring the boy child) largely dictated food allocation and intake pattern within the family. Iron supplementation during pregnancy could be a good clinical intervention; however, such an approach would hardly remove the socio-cultural condition that generates such iron deficiency in the first place. For example, during pregnancy a large number of women in the sub-continent suffer from bacterial vaginosis (various forms of infection of the reproductive tract) that can be treated with antibiotics (often vaginal wash could be used during delivery so as to protect the baby from any harm from such bacterial vaginosis). Such clinical intervention is not only costly but would be completely ineffective in tackling the root cause of bacterial vaginosis – menstruation management or mismanagement that prevails among our growing adolescents and young girls. Most of our young girls, especially in rural areas, use and re-use the same cotton patch during menstruation. Since there is a cultural taboo against these cotton patches to be seen by men, young girls are likely to put them in the remote, often dark, corners of the house to dry them. Needless to say, they are seldom dried completely before being re-used making these clothes fertile ground for bacteria to grow. Can we take care of bacterial vaginosis through antibiotics for pregnant women without addressing the critical cultural, social and financial issues related to menstruation management for young girls?

Similarly, is it possible to separate family/domestic violence and women's health irrespective of their age group? What could one expect from a pregnant woman in terms of health issues if she had been subjected to domestic violence since her marriage? Many women continue to suffer from domestic violence during pregnancy further complicating normal childbirth. Should the health system ignore domestic violence and its impact on women's health and simply concentrate on 'safe' delivery? Will such a clinical approach improve women's health in the broadest sense of the term? Will such an approach alone help substantially reduce maternal mortality/morbidity? Such a clinical approach will surely help save the lives of some pregnant women; however it will not put a serious dent on the number of new cases of pregnant women requiring such clinical intervention. In short, such a clinical approach alone is unlikely to improve women's health in the long run.

There is overwhelming evidence that anaemic pregnant women are more likely to give birth to babies with low-birth weight who are, in turn, more likely to succumb to pneumonia or other diseases and die prematurely. Clinical interventions to reduce anaemia among pregnant women (for example, iron supplementation) will surely work if implemented rigorously. However, that will not address the critical factor that anaemia among adult women is the result of decades of gender-based discrimination in terms of food intake and/or quality food at the family level. Why a girl child is still likely to receive less calorie intake in our intra-household distribution of food? Why an adolescent girl is less likely to receive medical care as quickly as her brother when both are sick? Why a newly married young woman is more likely to 'sacrifice' her education or career

than her newly married husband? Sacrificing education or career is likely to result in a demand to produce a child as soon as possible. Not surprisingly, more than a quarter of our married girls end up being pregnant before they reach 18 year of age – a sure precursor to complications during pregnancy. And yet, our family planning program puts little emphasis on 'healthy timing and spacing of pregnancy' – raising awareness in the critical need of not getting pregnant before the age of 18 and ensuring a gap of 3 to 4 years between pregnancies in order to protect and promote the health and well-being of the pregnant women as well as that of the newborn. Our family planning programme is still primarily aimed at increasing contraceptive use and reducing the total fertility rate and, thereby, the population growth rate. It is not, unfortunately, predicated on promoting and protecting the health of women and the newborn.

Clearly it is time that we take a more holistic approach in addressing women's health issues. The health system must get away from treating women as tools for reproduction and, consequently, concentrating resources on reproductive health and safe motherhood. A life cycle approach is needed that addresses health issues confronted by girl child, adolescent girls, married and pregnant women and the elderly women. At the same time, along with clinical interventions, our health system must also better understand and address the cultural, religious and social values, beliefs and practices that greatly affect the health and health-seeking behaviour – and well-being – of our girls, mothers and the elderly women. Without adopting such a holistic perspective, Bangladesh can hardly make progress in improving women's health and, thereby, substantially reducing the maternal mortality ratio often regarded as the litmus test of the efficacy and efficiency of a health system as a whole.

OUR POPULATION PROGRAMME NEEDS RADICAL REALIGNMENT

Greater emphasis on expanding women's education (especially higher education) and their employment opportunities could have had a positive impact on our population programme, particularly in further lowering the total fertility rate.

Bangladesh, unlike many other developing countries, observed the 2008 World Population Day on July 11 on a rather sombre note – if the total fertility rate or TFR (2.7 in 2006) does not decline further and soon – our population is going to double by 2050 reaching a staggering 280 million. There is no doubt that our population has been increasing since the beginning of the 20th century, particularly during the 1960's and through the 1990s. There were 41.9 million of us in 1951 according to the first census conducted after the break up of India. During the following decade (1951-61) we grew at a rate of 1.91 per cent, reaching a total of 50.8 million in 1961 – the last such census carried out in the then Pakistan. Our population growth rate increased sharply to 2.61 per cent during the next decade (1961-71) and we estimated ourselves to be 71.3 million strong in 1974 as we emerged as an independent nation.

The first census conducted in independent Bangladesh (1981), put the figure at 89.9 million. However, the population growth rate declined somewhat to 2.35 per cent during the decade following our independence. It declined further to 2.17 per cent during 1981-91 and to 1.51 per cent during 1991-2001. At the turn of the 21st century (2001), we numbered 130 million. In 2005, the World Health Organisation estimated us to be 141.8 million strong and growing. If the TFR does not come down to the replacement level by 2010, as was hoped for by our ever-optimistic population policy, we will continue to add more than 10 million people every five years. Even if we achieve a replacement-level fertility by 2015 or so – as it is currently believed by most population experts – our population will continue to increase till about 2025 before it starts on a declining mode.

Although this is truly alarming, we should place this in the larger context. According to the United Nations Population Division, the world population is expected to increase by 2.6 billion by 2050 - from the current 6.5 billion to 9.1 billion. Almost all of this population growth will be in developing countries where the total population will increase from 5.3 billion in 2005 to 7.8 billion by 2050. The developed countries as a whole will remain largely stagnant – at about 1.2 billion people. Between now and 2050, the populations of some poor developing countries are projected to more than triple. These include the strife torn Afghanistan (29.9 million in 2005), Congo (3.9 million/2005), Liberia (3.3 million/2005), and Uganda (28.8 million/2005). We can take some solace in the fact that our population is not projected to triple by 2050. At the same time, it is clear that Bangladesh is not alone in this dangerous boat.

On the other hand, it is important to note that despite declining fertility rates, six 'big' developing countries – and, unfortunately, Bangladesh is one of them, will continue to be

responsible for most of the world's population growth through the next 50 years. India's population of 1.2 billion (2005) is projected to reach almost 1.9 billion by 2050 if the present trend continues. Pakistan's population of 157.9 million in 2005 is expected to surpass 390 million by 2050. Nigeria's (131 million in 2005) and Egypt's (74 million in 2005) population will reach 268 million and 135.7 million respectively by 2050. And, of course, the population of Bangladesh, already one of the poorest and most densely populated countries, will double by 2050.

Why this continuing population growth? It is the result of, on the one hand, declining mortality and increasing life expectancy and, on the other, declining but not yet replacement-level fertility. Why would our population programme, often credited with so much success, fail to achieve replacement-level fertility rate by its target date of 2010? There are several factors and perhaps the most important factor was and is our blind adherence to the principle of fertility control. Over the years, our target-oriented population programme distributed more condoms and pills than what the results show. Family planning workers also had targets – how many condoms and pills to be distributed in a given month in a given village or upazilla – with little regard for the health of the target population, women in reproductive age – 15 to 49 year olds. Historically, the population programme put little emphasis on addressing health concerns of women, including tackling side-effects of contraceptive use. More importantly, as it remained exclusively focused on fertility control, the programme failed to promote the critically important idea of 'healthy timing and spacing of pregnancy' – not to get pregnant before reaching the age of 18 and to keep a gap of at least two to three years between pregnancies. Why was it critical? There is concluding evidence that 'healthy timing and spacing of pregnancy' is essential to protect and promote the health of the pregnant women as well as that of the newborn. Scientific studies from across countries and cultures have proved this so conclusively that in 2005, the World Health Organisation came out with a policy statement urging population programmes around the world to re-focus on healthy timing and spacing of pregnancy. In short, the WHO called for a fundamental shift in population programmes – from fertility control to protecting and promoting the health of women and that of the newborn. Alas, despite failures our population programme remains squarely focused on fertility control, currently on reaching the target in 'hard-to-reach' areas.

Our population programme is hardly concerned with the fact that more than 52 per cent of Bangladeshi girls get married by the time they are 16 years old and that deteriorating law and order situation prompts parents to marry off their daughters at an increasingly early age. For example, CCD Bangladesh, a communication and journalism based NGO working among the indigenous populations in northern Bangladesh, have recently warned that 'early marriage is rising alarmingly among the indigenous communities' (CCD, October 2007).

Why is this trend of marrying the girls early? Again, 'due to lack of security, they are compelled to marry their daughters at the age of 13 to 16', CCD notes. In other words, ensuring security of young girls – protecting them from sexual harassment, domestic

violence and acid throwing – is critically important in promoting our population programme. Our population programme must be more holistic in better understanding and accommodating such inter-connectedness of social, cultural, economic and demographic factors. Sadly, that is not the case. Our population programme remains largely oblivious to this interdependent and interconnected nature of reality.

The singular focus on fertility control also makes our population programme ignore the fundamental fact that fertility is a function of two factors – the infant mortality rate and the opportunity cost of raising a child. It is completely rational to expect women to have more children if their chances of survival are lower. In other words, the higher the infant mortality rate, the higher would be the fertility rate. In short, if we fail to ensure quality healthcare for the mother and the newborn, we cannot expect women to restrict their pregnancy. The infant mortality rate (IMR) in Bangladesh declined quite dramatically over the last two decades – from over 150 per 100,000 live births during the 1970's to 52 per 100,000 live births by 2006. As the IMR declined or, in other words, more newborns began surviving the fertility rate also declined. Should our health system improve resulting in further decline of the IMR, the TFR is also likely to go down further. Unfortunately, our population programme planners seldom recognise this dynamic relationship between the quality of health system as reflected in the IMR and the TFR. Consequently, over the years we paid more attention to the population programme than in strengthening the overall health system. Not surprisingly, more than 60 per cent of our infant deaths occur during the first 30 days of birth – called neonatal mortality. Despite significant reduction in the IMR over the last decades, the proportion of neonatal mortality within the IMR remained almost unchanged – it actually increased between 2004 and 2007 (Bangladesh Demographic and Health Survey 2007). Needless to say, neonatal mortality is one of the critical signs of a weak health system.

At the same time, the higher the opportunity cost of raising a child, the lower is likely to be the fertility rate. A woman in the paid labour force, for example, is likely to have fewer children than her non-working (i.e. not in the paid labour force) counterpart. Why is it that educated women (likely to be engaged in gainful employment) the world over have fewer children than their less educated counterparts? We must not think that highly educated women think or behave more rationally than less educated or un-educated women. The simple fact is that the opportunity cost of having and raising a baby is much higher for an educated woman than that for a less educated woman. Similar is the case between the rich and poor women. In short, women everywhere – from all social strata – behave rationally. We have traditionally paid little attention to this factor of opportunity cost. Greater emphasis on expanding women's education (especially higher education) and their employment opportunities could have had a positive impact on our population programme, particularly in further lowering the total fertility rate. In this respect, opening the door of credit facilities for women and making it easier for women to enter the business world of small and medium enterprises (SMEs) are all potential contributors to our population programme. In other words, without overall economic development and more equitable distribution of the fruits of such development no country can aspire to lower its population growth. Over the last few decades, Bangladesh has made good progress in terms of economic development – our per capita income rose from about

\$100 per capita during early 1970s to more than \$480 by 2006. However, the fruits of our economic development remain dangerously concentrated in fewer hands. With almost 50 per cent of the population living under officially declared level of poverty, Bangladesh can hardly claim to have achieved much success in promoting distributive justice.

Conversely, so long as we remain a nation sharply divided into the rich and the poor, we cannot expect to get much success in achieving the goals of our population programme.

It is clear that for the foreseeable future we will continue to experience robust population growth. We are already the mostly densely populated country in the world and we are likely to remain so. The increasing population will place increased demand on the ecosystem resulting in environmental degradation and increased poverty. This will also put more demand on health systems. In the short term, Bangladesh will strain its capacity to satisfy the basic human needs of the growing population, alleviate poverty, provide adequate and effective healthcare services, establish good governance, and safeguard the environment. In short, it will have an adverse impact on our economic and social development. Current and projected population trends in Bangladesh make it unlikely that some of the Millennium Development Goals – primarily those related to reducing poverty and ensuring environmental sustainability – can be achieved without effectively addressing population issues more aggressively and more holistically.

It is time we recognised the interrelationship between population growth, socio-economic development, individual safety and security, environmental sustainability and health. This will prompt us to reorganise our population programme and make it more focused on improving women's health through the promotion of healthy timing and spacing of pregnancy. It is imperative that we make our population programme an integral part of our overall integrated health and development effort.

URBANISATION AND URBAN HEALTH: A Crisis Unfolding

Population increase and unplanned urbanisation, in the short term, will strain the capacity of a country like Bangladesh to satisfy the basic human needs of their populations, alleviate poverty, provide adequate and effective health care services, establish good governance, and safeguard the environment. In the longer term, severe resource scarcity and environmental degradation could give rise to violent conflict and migration pressure threatening social cohesion, stability and global security.

BY 2050, as I have noted in my previous article (Our population programme needs radical realignment; *New Age*, September 21), the world population is expected to increase by 2.6 billion – from the current 6.5 billion to 9.1 billion. It is important to highlight two defining characteristics of this population growth. First, almost all of this additional population will be in developing countries, including Bangladesh, India and Pakistan. Second, and this is alarming for people living in cities like Dhaka, a significant proportion of this additional population will settle in cities – mega cities that already have a population of 10 million or more. Needless to say, such rapid population growth in the developing world will further worsen poverty over the next few decades. Currently, more than a billion people in poorer countries live in poverty – struggling to survive on \$1 a day or less. This number is likely to double by 2050 unless the developed as well developing countries redouble their efforts to alleviate poverty and reduce inequity within and among countries.

Before we discuss the nature and consequences of urbanisation in the developing world, let me briefly note two demographic trends that would also have great significance for poorer countries. One is the increase in the elderly population and the other is the 'bulge' in the adolescent population. Globally, between 2005 and 2050, the 60-plus age-group will almost triple from 672 million to 1.9 billion. At the same time, the number of 'old-old' people aged 80 years or more – will increase from 86 million to 394 million. Alarming, most of these increases will also take place in developing countries that are most ill-equipped to effectively respond to the health and social needs of the elderly population. While we are faced with a growing elderly population, the largest ever generation of adolescents – 1.2 billion people between the ages of 10 and 19 – is about to enter their childbearing years, mostly in developing countries. To a large degree, the world's ability to meet the sexual and reproductive health needs of this generation will determine the future population growth of the developing world. There are profound policy implications of these two demographic phenomena for health and social and economic development.

For the first time in human history, according to the United Nations Population Division (2002), a majority of the world's population currently (as of late 2007) lives in cities.

Urban population is increasing by almost 70 million a year and by 2030, 60 per cent of the world's population – more than four billion people – will live in urban areas. In other words, almost all the expected population increase between now and 2050 will be absorbed by the urban areas of the developing world. Where exactly are these people heading?

According to the UN Population Division, more and more people are going to call a mega city – a city with a population of 10 million or more – or smaller cities with a population of 1 million or more their home. By 2015, according to UN projection, there will be as many as 21 'mega cities' of at least 10 million people. Almost 40 per cent of the population in mega cities will be living in slums characterised by environmental degradation, poverty, disease, deprivation, scarcity of resources and infrastructure. Where are these mega cities? In 1950, there was only one mega city and that was New York – the commercial/business capital of the richest and the most powerful country in the world, the United States. By 1975, the number increased to six and for the first time three mega cities emerged in developing countries (China, Mexico and Brazil). The number of mega cities increased almost threefold between 1975 and 2001 to 17 and thirteen of them were in developing countries. For the first time, Dhaka along with four other cities from the subcontinent (Mumbai, Kolkata, Delhi and Karachi) achieved the title of a mega city. The UN Population Division projects that by 2015 there will be 21 mega cities and only 4 of them will be in developed countries (Tokyo, New York, Los Angeles and Osaka).

In short, the mega cities are expanding in number and in population – their combined population will increase from 68 million in 1975 to more than 340 million by 2015 (projected). Moreover, they are increasingly becoming a developing country phenomenon. In a recent projection, the UN Population Division (2008) has come up with a more alarming scenario – by 2025 the number of mega cities will increase to more than 40, an overwhelming majority of them in poorer developing countries. According to this projection, although Tokyo remains the largest city in 2025 with a population of 36.4 million, Mumbai becomes the second biggest city with a population of 26.4 million, followed by Delhi (22.5 million). Perhaps most alarmingly, by 2025, Dhaka is likely to emerge as the fourth largest city in the world with a staggering population of 22 million. Kolkata is projected to have a population of 20.5 million by 2025. Not surprisingly, by 2025, five (Mumbai, Delhi, Dhaka, Kolkata and Karachi) of the top ten mega cities will be in the Indian subcontinent with a combined population of more than 110 million.

Along with these mega cities, the fastest growing smaller cities (with a population of 750,000 or more) are also increasingly becoming a developing country phenomenon. According to the latest UN Population Division projection, all the ten fastest growing smaller cities are in poorer African and Asian countries. These are Abuja (Nigeria), Luanda (Angola), Sana'a (Yemen), Kinshasa (Congo), Lome (Togo), Ouagadougou (Burkina Faso), Kathmandu (Nepal), Mbuji-Mayi (Democratic Republic of Congo), Kabul (Afghanistan), and N'Djamebam (Chad). The annual growth rates of these cities vary from a high of 8.3 per cent (Abuja) to a relatively low of 4.5 per cent

(N'Djamebam). Even war-torn Kabul is growing at a rate of 4.6 per cent.

What are the implications of urbanisation for developing countries in general and for Bangladesh in particular? For most developing countries, including Bangladesh, urbanisation is not a planned process or the result of industrialisation and economic development. Urbanisation in this case is unplanned – more a consequence of 'push' factors that force people in rural areas to flee and seek a living in big cities. In Bangladesh, for example, every natural disaster like a flood or a cyclone forces hundreds of thousands of rural people, mostly poor, to flee to Dhaka or Chittagong in search of a 'living'. Most end up in slums that are already overcrowded and underserved. In short, for developing countries like Bangladesh increased population as well as unplanned urbanisation place increased demand on the ecosystem resulting in environmental degradation and increased poverty. This will also put more demand on health systems. In the short term, such population increase and unplanned urbanisation will strain the capacity of developing countries like Bangladesh to satisfy the basic human needs of their populations, alleviate poverty, provide adequate and effective health care services, establish good governance, and safeguard the environment. In the longer term, severe resource scarcity and environmental degradation could give rise to violent conflict and migration pressure threatening social cohesion, stability and global security.

What do all these mean for us – thirteen million-plus souls living in Dhaka? It means overcrowding and further environmental degradation. It also means an ever-growing slum population and increasing poverty. In the early 1990s, a study conducted by UNICEF concluded that 28 per cent of the people of Dhaka live in slums. The percentage – and the numbers – must have increased over the years as an estimated 300,000 to 400,000 migrants from rural areas come to Dhaka city each year swelling the ranks of the poor. If we say, conservatively, that 30 per cent of the people live in slums the total number would be a staggering 4 million today. According to the UNICEF study, 90 per cent the houses in slums are made of bamboo, bags and scrap papers and that only 10 per cent are concrete. Sixty-five per cent of the heads of households in the slums are illiterate and only 18 per cent of children attend school. Only about one-third of slum dwellers have access to safe drinking water while 90 per cent of them have no sanitation facilities. Most of the slum dwellers work in the informal sector and 92 per cent of them do not earn enough to meet most basic needs. The UNICEF survey also showed that 60 per cent of children in the slums are chronically malnourished and that 30 to 45 per cent of slum dwellers are ill at any given time. It seems that the slums are breeding grounds for numerous social problems including smuggling, prostitution and crime. Moreover, the study also found widespread abuse of girls/women in the slums.

In other words, the slums epitomise the public health crisis faced by the country at large. However, it would be wrong to point out to the slums only as pockets public health challenges. Dhaka as a whole suffers from similar problems. These are compounded by the scarce and increasingly diminishing resources – from piped water and electricity to education and healthcare services. Due to rapid rise in the population, access to WASA-supplied piped water in Dhaka declined almost 10 per cent over the last twenty years. Because of overuse, our groundwater level is rapidly declining – it dropped 20 metres in

the last decade. Future development of surface water sources are also faced with the danger of increasing industrial pollution. We produce more than 3,500 metric tonnes of solid waste each day – and it is increasing rapidly as the population rises. Most of this solid waste never gets collected by any the city corporation or any other authority. They simply add to our public health crisis.

As the population of Dhaka is still increasing and the city could become the fourth largest in the world by 2025 with a population of 22 million, it is imperative that we put serious emphasis on better understanding and addressing the health and social challenges we are faced with. It is a crisis that will surely compound and further aggravate unless addressed urgently.

NEED FOR MULTI-SECTORAL APPROACH TO URBAN HEALTH IN BANGLADESH

We must move away from a regime of sound health policy to that of healthy public policies where all public policies – irrespective of the ministry – become accountable for their potential implications for human health. Promoting healthy public policy is essential in addressing the myriad public health problems faced by the mega city of Dhaka in particular and by Bangladesh in general.

DHAKA is the most densely populated city in the world with almost 30,000 people per square kilometre. It is also the fastest growing city. While the population of Bangladesh doubled since independence, the population of Dhaka registered a fourfold increase over the last twenty-five years. It had a population of slightly more than three million in 1980; by 2005 the population of Dhaka reached almost 13 million. According to the United Nations Population Division, Dhaka will have a population of 17 million by 2015 and, ten year later, by 2025, it will have the distinction of being the fourth largest city in the world with a population of 22 million. Needless to say, neither the infrastructure (roads and highways, sewage, electricity, water supply) nor health, education and social service sectors are keeping pace with this enormous population growth.

As we create more demand on the environment more we pollute it and destroy the ecological balance. Our industrial waste is regularly discharged into rivers and canals around Dhaka. The result is predictable. Slowly but surely rivers and canals like the Buriganga, Turag and Tongi Khal are being depleted of their fish and other aquatic species that will, in the long run, seriously affect the broader ecology. We are, on the one hand, polluting our surface water and, on the other, making our groundwater level recede faster as we try to extract more and more of it.

Dhaka, like Mexico City in the 1970s and 1980s, is fast becoming one of most polluted city in the world. The quantity of floating particles in our air, according to the Air Quality Monitoring Project, is several times higher than the standard set by the United States Environmental Protection Agency. According to the Bangladesh Road Transport Authority, Dhaka has one of the highest traffic densities in the world with more than 1.1 million vehicles crowding a little more than 220 kilometres of roads. And yet the city adds more than 3,000 vehicles to its overcrowded streets every month creating not only further traffic jams but also pollution to its air. Add to these the facts that a good portion of the solid waste that the city population produce – almost 4,000 tonnes each day – seldom gets further than the streets, lanes and by-lanes of Dhaka, polluting the environment.

From health perspective, perhaps the most dangerous is the volume of medical waste that our growing number of clinics and hospitals leave on the streets or seldom emptied garbage dumps each day. If the city as a whole is faced with such acute environmental problems, the slums of Dhaka – home to almost four million people and growing – epitomise the extent of our environmental degradation. Lack of access to potable water and sanitation by these slum-dwellers further adds to our environmental woes.

The situation in other cities in Bangladesh is not much different. Pollution, lack of safe drinking water and sanitation for a large section of the population, scandalous absence of solid waste management, most hazardous medical waste being thrown out with garbage, and above all, a deafening silence about all these from relevant authorities pervade the lives of all city dwellers across Bangladesh. The profound implications of all these factors for our health and well-being are well documented and widely known.

Some of our behaviour, often mistakenly attributed to our culture, significantly add to our health hazards. Bangladeshis, it seems, are prone to frequent spitting and/or violently clearing their nose in public. It does not matter whether a Bangladeshi is riding in a car, bus or rickshaw, the urge of spitting or sneezing seems to be overwhelming. The fact that it can often land on the head or shoulder of an unsuspecting pedestrian does not seem to prevent a bus rider to spit through the window. More ominous is the scene of people – all males – relieving themselves on the sides of crowded streets in full view of others. To pee in public seems to have become a right of some classes of males – rickshaw-pullers, day-labourers and other downtrodden masses.

Are these – spitting, peeing in public, etc – part of our culture? Obviously they are not part of our culture or any other culture. Bangladeshis living in New York, London or Toronto would not dare to pee in public. Some spitting might happen in the confines of the ghettos where expatriate Bangladeshis, along with Indians and Pakistanis, predominantly live. In other words, these are not part of our culture but that of our 'tradition' – behavioural patterns that have enslaved us so much that we can hardly abandon them even when we migrate to other countries and cultures.

Some might argue that these are physiological necessities or urges that are hard to resist. This argument also falls flat when one considers that other human beings – the Americans, the British or the French – do not engage in spitting or otherwise relieving themselves in public. We tend to have a similar behavioural proclivity when dealing with our household garbage. We do not mind to either throw them through the window or to dispose them raw onto the street knowing fully well that these will not be collected by the city or municipality within a reasonable time. In other words, the garbage will rot on the street endangering public health.

The city of Dhaka, like other cities and towns in Bangladesh, also faces a unique public health hazard annually – during the ritual sacrifice of cows and goats on the occasion of Eid ul-Adha. Hundreds of thousands of cows, goats and other animals are slaughtered in Dhaka every year in a span of three days during this Eid. However, neither in slaughtering nor in disposing of the discarded remains of the sacrificed animals do we consider the implications for public health. They rot within the precincts of our houses as well as on the streets creating havoc for public health.

These behaviours are extremely detrimental to public health, especially in an urban setting, where the population density is high. High population density coupled with a high level of interaction among people in cities make it so much easier to transmit a virus

carried by sputum or other bodily discharges to a large number of people. Similarly, wastes of various kinds rotting on the roadside also create a greater public health hazard in a densely-populated mega city where millions are exposed to them.

Traditionally, in response to any health-related problem, we tend to focus on healthcare services – how many hospitals or clinics and beds we have, how many physicians, nurses and allied health professionals are there, and how well is the primary healthcare system organised. These are critical issues. However, it is time that we focus more on the environment and try to make it a health-producing one rather than an illness-generating one.

Creating and sustaining a health-producing environment being the ultimate objective, the critical question remains: how to effectively address these environmental and other public health problems besetting Dhaka? The problems are diverse – polluted rivers and canals, polluted air, crowded city streets with human and solid wastes and, above all, ever-growing slums with dwindling resources and infrastructure. It is the most densely-populated city in the world that is growing rapidly outstripping its available resources. Moreover, some of our behaviours are adding to the problem – from spitting in public to leaving household waste on the street.

It is apparent that these are not purely health issues within the purview of the health and family welfare ministry. They cut across different ministries and different sectors. For example, river pollution cannot be addressed without close collaboration between a number of ministries – the Ministry of the Environment, the ministry that oversees inland water transport, the Ministry of Industry and, obviously, the city corporation. Similarly, we require a number of ministries including the transport ministry to work together to address the air pollution problem. Improving the slums – better infrastructure, water and sanitation, and educational facilities – would need massive efforts from almost all ministries of the government as well as the non-governmental organisations and the private sector.

Perhaps, the big issue is how to change our behaviour. It would take a concerted effort involving at least three ministries (health, education, and mass communication) as well as the mass media, and socio-cultural, political, religious and opinion leaders. In short, it is apparent that without a truly multi-sectoral approach we would not be able to address these diverse issues. Sadly, we hardly recognise the need for such a multi-sectoral approach nor do we have the institutional framework for undertaking efforts that cut across ministries and sectors – from industry, education, and health to transportation to environment.

Such a multi-sectoral approach also means that human health is the common denominator cutting across all sectors and ministries. Prior to instituting a policy each ministry must first assess its possible impact on human health. In setting its policy on fertiliser use, for example, the agriculture ministry must first assess its possible implications for human health. So is the case for the communications ministry prior to setting its policy on

transporting hazardous goods or on speed limits on the highway. Likewise, implications for human health must remain central to the industry ministry in setting policies on industrial waste disposal. In setting the curricula for primary or secondary education, the education ministry must think about human health too – how to promote healthy lifestyle among students or how to make them better aware of personal hygiene and public health issues. In short, we must move away from a regime of sound health policy to that of healthy public policies where all public policies – irrespective of the ministry – become accountable for their potential implications for human health. Promoting healthy public policy is essential in addressing the myriad public health problems faced by the mega city of Dhaka in particular and by Bangladesh in general.

Unfortunately, promoting healthy public policy would require a paradigm shift – a profound change in the way we think, analyse and understand a problem and the way we employ our resources. It would also require acting collectively and working together across ministries and sectors – a rare cultural quality indeed for Bangladeshis. Nevertheless, there is no substitute for such a paradigm shift. The health and well-being of Bangladeshis in general and that of the citizens of Dhaka depends on such a radical paradigm shift.

EXPANDING FRONTIERS OF OUR FREEDOM

So long as our political culture remains feudal in character, we will fail to create a modern political system dominated by political parties geared towards debating and addressing issues of public good.

Following a long two-year wait the nation is eagerly looking forward to the stalled general elections to the ninth parliament. As the political parties are busy in selecting their candidates and declaring their election manifesto, it is time to ask the most critical of questions – where are we heading? Will it bring improved health and social development for the people of Bangladesh? These questions take greater significance when we consider the fact that political parties in Bangladesh seldom talk with clarity about socio-economic development and much less put any credible plan for sustainable development. Why is that so? Why do our political parties differ so fundamentally from their counterparts in developed as well as in many developing countries? To explain this anomaly we have to better understand the nature of our political system and its social structural foundations.

In a democracy a political party is supposed to be based on a particular ideology that shapes its views on government and its role and the relationship between the government and the governed. In the United States, for example, the Republican Party traditionally stands for 'small' or 'less' government and a 'restricted' role for the government in the social and economic affairs of the nation. The Republican Party believes socio-economic development should largely be left to the market and the government's role should be restricted to facilitating the market to function optimally. The invisible hand of the market forces, as Adam Smith noted in his classical *Wealth of Nations* in 1798, is best to ensure economic growth and development, they say. Our interdependence on each other, according to this philosophy, ensures the efficiency of the market in promoting economic development. To emphasise this point Adam Smith observed 'it is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest.' Although the economic meltdown currently sweeping the US and much of Europe has seriously dented the belief in the efficiency of the markets, in recent decades it received much enthusiastic support from numerous political leaders. Vaclav Havel, the highly respected President of the post-Soviet Czech Republic once commented: 'A market economy ... is the only natural economy, the only kind that makes sense, the only one that can lead to prosperity, because it is the only one that reflects life itself. The essence of life is infinitely and mysteriously multiform, and therefore it cannot be contained or planned for, in its fullness and variability, by any central intelligence.' A political party with such a philosophical bent would prefer governments not to interfere in the workings of the market.

The Democratic Party, on the other hand, believes in big government and relies less on the market forces to ensure socio-economic development. The Canadian-born, Berkeley-trained John Kenneth Galbraith and a host of other economists and philosophers, believed

in an 'interventionist' government – a government that is willing to intervene forcefully in the economy when the national interest needs it. During the Second World War, US president Roosevelt put Galbraith in charge of price controls in the United States. His price control measures, introduced in early 1942, achieved astonishing success – keeping the inflation rate at about two per cent a year in spite of a rise in output by one-third and keeping unemployment virtually nonexistent throughout the war. In following such an interventionist approach, Galbraith followed the teachings of the nineteenth-century British economist John Maynard Keynes who transformed the dismal science of economics into a revolutionary engine of social progress, credited with the quote: 'the important thing for government is not to do things which individuals are doing already and to do them a little better or a little worse; but to do those things which at present are not being done at all'. In his *The Affluent Society* (1958) and *The New Industrial State* (1967) and other books, Galbraith analysed the paradox of private affluence amid public squalor, unprecedented wealth along with poverty and inequity that pervade in the United States and other industrialised countries and saw a critical role for the State in overseeing the economy in order to ensure more even distribution of the fruits of development. Fiscal and monetary policies are tools that governments might use in making society more equitable.

A progressive taxation system – taxing the rich more than the poorer segments of the population is, therefore, a major tool to ensure greater socio-economic equity. Throughout the history of the United States, Democrats have often resorted to such measures to promote equitable socio-economic development. The recent global economic collapse, first started in the United States, and the quick interventions of governments in almost all affected countries – from the United States to Germany, United Kingdom, Iceland and to Japan reinforce the Keynesian philosophy of active government.

In most countries major political parties differ in terms of their philosophical stances. In almost all industrialised countries in Europe as well as in Canada, Australia and New Zealand major political parties are fundamentally divided along these lines. This is more so in two-party dominated states. In some countries, as in Canada – and increasingly so in the United Kingdom – a strong third party often exists that is ideologically more left-leaning or socialist. However, the two major parties dominate the political scene liberal or labour being the interventionist ones and the conservative or republican being the followers of the philosophy of the primacy of markets. Although the global economic crisis now devastating the lives of millions is seriously denting the free-market philosophy, major political parties nevertheless continue to largely maintain this philosophical divide.

Unfortunately in most developing countries political parties are often individual-centric and not ideology driven. Consequently, these political parties seldom articulate any vision for socio-economic development. In some cases, religion-based parties demonstrate strong ideological bent, but those relate to religious values rather than modern statecraft. Bangladesh, unfortunately, is no exception. Although one of our major parties has a long rich history of progressive policies and philosophy, it became increasingly leader-centric and lost some of its historical charm. The other parties are either creations of military

dictatorships, religion-based preachers of theocracy or ego-centric individual dominated pseudo parties masquerading as political parties. These parties, therefore, have little passion to debate socio-economic development. They seldom devote much intellectual or financial resource to develop comprehensive plans for national development. It is likely that most of these parties do not think of development beyond economic growth - an increase in the Gross Domestic Product (GDP). Changes in the domains of health, education, housing, or accessibility to safe drinking water or sanitation do not receive much attention from our political parties without the compulsion that incumbency vests in them. Power and its use remain restricted to gaining more power rather than changing the lives of the governed for better.

The concept of development, as we are aware, has changed radically over the years. During the 1950's and 1960's, economic growth measured in terms of GDP or GNP (Gross National Product) was equated with development. As such economists were more concerned with the 'stages of development' taking the Western economic model as the 'ideal' to be followed by all developing countries. Slowly the concept started to change as social scientists began to emphasise economic growth as well as its distributional aspect. Growing disparity between the rich and the poor in many developing countries that experienced rapid economic growth during the 1970's prompted this change in the concept of development. By the early 1980's the concept evolved further to include health, education and housing. The concept transformed into Human Development Index (HDI) endorsed and aggressively promoted by the United Nations Development Program (UNDP) and other UN agencies. By mid-1990s environmental sustainability became part of the development lexicon – as we pursue development we must not leave a poorer environment for our next generation. In his *Development as Freedom* (1999), Nobel Laureate Amartya Sen further enriched the concept of development and equated it with freedom – freedom from hunger, freedom from preventable disease and death, freedom from illiteracy, and freedom from a preventable polluted environment. Development, in this sense, is 'a momentous engagement with freedom's possibilities.' For Amartya Sen, education and health are the two fundamental human capabilities that are essential to enjoy freedom. Public investment in health and education is, therefore, essential to promote and sustain development.

The concept of development, thus, radically changed over time – from purely economic growth to the HDI and finally to embrace the idea of freedom. Perhaps the following definition, first articulated by United Nations Children's Fund under the dynamic leadership of James P Grant, profoundly brings home this holistic concept of development: 'the day will come when the progress of nations will be judged not by their military or economic growth, nor by the splendor of their capital cities and public buildings, but by the well-being of their peoples; by their levels of health, nutrition, and education; by their opportunities to earn a fair reward for their labors; by their ability to participate in the decisions that affect their lives; by the respect that is shown for their civil and political liberties; by the provision that is made for those who are vulnerable and disadvantaged; and by the protection that is afforded to the growing minds and bodies of their children'.

Political parties in Bangladesh, like in many other developing countries, seldom find the time to debate the concept of development or the role of the government in fostering development. Does this mean that our political parties are 'underdeveloped'? Two interdependent factors might help explain this paradox – the feudal character of our political parties built on a patron-client relationship; and the absolute nature of power in the hands of the ruling party that precludes the coexistence of other centres of lesser power in a decentralised or diffused system. The feudal character and the absolute nature of power reinforce each other. In Bangladesh to be a politician one must have 'control' over scarce resources, be it land, wealth, jobs, or access to people with power. With such control over scarce resources a politician is able to 'distribute' or provide access to these resources to the select few who would act as the politician's 'inner' circle. The inner circle gets the reward of having a job, a bank loan, or a tender without going through competition. Sadly, protection from the arm of the law has also emerged as a 'reward' a politician could provide. This patron-client relationship between the politician and his/her inner circle is extended to the population at large. We expect that our politicians would not only look after the public good but also our personal good. In return for our support, we expect our politicians to deliver jobs, or bank loans, or ensure access to other scarce resources. Obviously all supporters do not get their personal needs fulfilled. However, once the personal needs of the inner circle are ensured, coercive power can be used with the help of mastans to keep the larger population subdued. On the other hand, to be able to maintain control over the scarce resources, politicians in our country must ensure that power is concentrated in few hands not diffused along other competing centres or pressure groups so common in mature democracies. The patron-client relationship, thus, is reinforced by the centralisation of power.

So long as our political culture remains feudal in character, we will fail to create a modern political system dominated by political parties geared towards debating and addressing issues of public good. And only political parties rooted in democracy – decentralization of power and multiplicity of power centres along diverse pressure groups – could engage them and the nation in confronting the challenges of sustainable development. For now, overcoming the feudal character of our political system remains the most critical stumbling block in pursuing development and expanding the frontiers of freedom in Bangladesh.

WHERE IS THE VISION FOR 21ST CENTURY?

Unlike the Awami League, the BNP does not generally identify any specific target to be achieved nor does it provide any strict timeframe in achieving them. However, like Awami League, it also fails to provide any credible strategy to achieve the targets.

THE political parties – at least the major ones – have declared their election manifestos. While most of them made fighting corruption as one of their major election promises, none of them had the courage to acknowledge their role over the years in making corruption synonymous with our beloved Bangladesh. Why and how we topped the list of the Corruption Perception Index compiled by the Transparency International Bangladesh year after year as we entered the 21st century? None of them dared to either diagnose the problem or discuss their contribution to this disease. Needless to say, apart from a generalised pledge to 'fight' the disease, none of them came up with a credible strategic plan to tackle corruption. It must be clearly and unambiguously recognised that there are three critical pre-conditions in fighting corruption: a thorough de-politicisation of the bureaucracy and academia (public universities and colleges to the national institutes of higher learning and/or research); reforming, modernising and completely freeing the law enforcing agencies (the police, the Rapid Action Battalion and the Anti-Corruption Commission, in particular); and complete freedom for the print and electronic media. Unfortunately, none of the party election manifesto talks about these three critical pre-conditions and ways of fulfilling them.

The Awami League, for example, would like to increase our average life expectancy by five years, reduce infant mortality rate from the current 54 per 1,000 live births to 15, and the maternal mortality ratio from 380 per 100,000 live births to 150 – and all of these by 2021, barely 12 years from now. By 2021 it would also like to eliminate all kinds of communicable diseases from Bangladesh including diarrhoea, tuberculosis and malaria. Moreover, the Awami League will re-start 18,000 village-based community health clinics that were established earlier.

Are these feasible to achieve within the next decade or even within the next 25 years? Let me give an example. The World Health Organisation, as part of the Alma Ata Declaration of 1978, solemnly pledged 'Health for All' by the year 2000 through a comprehensive thoroughly community-based, community-owned and community-directed primary healthcare system. Although the target was 22 years away and WHO had substantial resources at its disposal, it failed to ensure HFA by the year 2000. Fortunately, WHO never declared what it would do if it failed to achieve the HFA target. The Awami League has also remained silent in this respect – no discussion on what to expect should it fail to achieve these wonderful targets by 2021.

Let's take another election promise of the Awami League. It pledged to re-start 18,000 village-based community health clinics. How will these function? Where will we get doctors, nurses, medical technicians, physiotherapists and allied health professionals to

effectively run these clinics? Bangladesh Health Watch, a civil society advocacy group representing a number of stakeholders in health and headquartered in the James P Grant School of Public Health, BRAC University, each year publishes a research-based report on a significant health systems issue in the country. The 2007 report, released in May 2008, was on human resources for health or health workforce. According to this report, Bangladesh seriously lacks appropriately trained adequate number of human resources for health. We have only about 31,000 physicians, while we require an additional 60,000 physicians to ensure a minimal level of basic healthcare services. Our nursing resource is scarcer still. To conform to the WHO established nurse-population ratio, we currently have a deficit of almost 140,000 nurses. Moreover, Bangladesh has one of the worst nurse-physician ratios. We have only one nurse per three physicians while the ratio should have been the other way around – three nurses for one physician. We have an acute shortage of medical technologists and allied health professionals – physiotherapists, laboratory assistants, x-ray technicians, etc. Human resources for health cannot be produced quickly. It would require long-term planning and massive investment in resources and infrastructural development. Unfortunately, the AL manifesto does not present any coherent plan for the development of human resources for health.

Although there is no concrete plan on how to translate these grandiose ideas with specific target dates, the AL manifesto cannot be accused of shyness in covering a wide range of areas – from poverty, housing, agriculture, industry, environment, to education, local government, labour, communication and information technology, and to good governance. However, most of these pledges defy all logical explanation and contradict expert opinion. To make Bangladesh arsenic-free and ensuring the supply of potable drinking water to all within the next three years – by 2011 – could be a dream. But it is an illogical, irrational, clearly unachievable and deliberately misleading pledge and so is the pledge of ensuring proper sanitation across Bangladesh covering all households within five years. The pledge of ensuring 'housing for all' by 2015 is similarly misleading. Perhaps, the most mysterious aspect of the manifesto is its complete silence on two absolutely critical and interdependent issues: how much will it cost to implement all these pledges? And where the money is coming from? Is the Awami League planning to raise taxes or the VAT to generate additional revenue? Is it expecting and depending on more foreign assistance?

The most disappointing part of the Awami League's manifesto is its scandalous neglect of the most critical issue faced by Bangladesh – population growth. Despite our recent success in reducing the total fertility rate to 2.7, the population as a whole is increasing quite rapidly. By 2050, our population could reach 280 million unless we make strenuous efforts in further reducing the TFR quickly to achieve a replacement level fertility. That would require a complete overhaul of our population programme and redirect its focus from fertility control to improving the health and wellbeing of pregnant women and the newborn. The emphasis must shift from family planning to promoting healthy timing (no pregnancy before age 18) and spacing of pregnancy (at least 2-4 years gap between pregnancies) that underscore the health of the pregnant women and the newborn. The AL manifesto is completely oblivious to this most critical challenge faced by the country and, consequently, totally ignores the issue of re-focusing/re-structuring our population

programme. It only talks about increasing the contraceptive prevalence rate to 80 per cent by 2021 from the current 57 per cent. Such a singular emphasis on CPR demonstrates the Awami League's callous neglect of the population problem faced by Bangladesh. It is also questionable how far the party is prepared to seriously address the complex issue of population where religion, social values, science and culture so forcefully intersect.

Not surprisingly, the Awami League's naiveté regarding the population problem permeates its prescription for the burgeoning metropolis Dhaka. The mega city of Dhaka currently has a population of 13 million and, according to the United Nations Population Division, it will reach a staggering 22 million by 2025. Already, the most densely populated city in the world, Dhaka will become increasingly environmentally unsustainable especially when we consider the fact that more than 30 per cent of its population live in slums – the big and growing pockets of poverty, disease, deprivation and environmental degradation. Construction of underground and/or elevated railways will not solve the problem of this mega city; it would require much more serious thoughts and comprehensive planning. Effectively addressing Dhaka's problem would require massive decentralisation of power along with making other cities equally attractive for people to live in. The history of Bengal demonstrates that a city seldom develops unless it is also a political centre – home to a government. Dividing Bangladesh into several provinces with powerful provincial governments could decentralise power, make development more evenly distributed across the country and, in the process, help shift (and sustain) population from Dhaka to other provincial capitals. In other words, decentralisation of power and development is the key to relieving Dhaka of its massive population pressure. This will also make the fruits of development being more evenly distributed across the country. It seems that in this respect, the Jatiya Party has some brilliant ideas that other parties should seriously look at.

Although with specific targets and target dates, the AL manifesto comes across more as a five-year plan developed by respective ministries, credit must be given to the AL for articulating, however imperfectly, the vision of a democratic, secular, progressive Bangladesh anchored in social justice, rule of law and human rights.

The election manifesto of the Bangladesh Nationalist Party is a massive document covering almost every conceivable issue. Interspersed with stories of its past success during 1991-96 and 2001-2006 (and often referring to General Zia's achievements), the BNP pledged to eliminate illiteracy within five years, introduce health insurance with a view to ensuring access to healthcare services of the poor, improving nursing education, exporting trained nurses to Britain and the Middle East, and introducing appropriate language training (English, Arabic, Italian, Malay, Korean, Japanese, etc.) for people willing to work in Europe, North America, the Middle East, South Korea and Japan. It also pledged underground or elevated trains for Dhaka and making Bangladesh arsenic free. The BNP manifesto covers all segments of the population – women, the youth and the elderly, the poor and the expatriates. It has specific pledges on industry, agriculture, communication and information technology, health, education, land and forestry, roads and highways, ports, and foreign policy.

Two pledges stand out: forming national committees of experts in different areas education, health, agriculture, industry, trade, investment, electricity, mining, water resources, law national security, local government, environment, science and technology, sports and culture, human resources and disaster management, etc – in order to ensure expert input in shaping public policy in these areas; and making available collateral-free loan of up to one million taka to young scientists and entrepreneurs to encourage innovation in science, technology and business. These are noteworthy efforts and could contribute immensely in developing coherent policies based on evidence if the committees are given freedom. Collateral-free loan is also a good idea to encourage innovation in science, technology and business. However, introducing health insurance for the poor is rather misleading. We are aware that in the United States, the richest and the most powerful country in the world, more than 46 million people – almost 15 per cent of the population – cannot afford to buy health insurance. Will our poor be able to buy health insurance? Clearly, the issue requires much more in-depth review.

Unlike the Awami League, the BNP does not generally identify any specific target to be achieved nor does it provide any strict timeframe in achieving them. However, like Awami League, it also fails to provide any credible strategy to achieve the targets. Most importantly, there is absolutely no information on the cost of implementing the promises made or about the source of such funds.

Most importantly both these major parties seem to have equated development with economic growth without regard to the distributive aspect of economic growth. During the 1960s and early 1970, a number of developing countries including Ayub Khan's Pakistan (remember Field Marshall Ayub Khan's Decade of Development spanning 1958 to 1968?) achieved considerable economic growth measured in terms of the increase in the gross domestic product. Despite such rapid economic growth, poverty intensified as the 'trickle-down' approach failed to distribute the fruits of such economic growth more equitably. That resulted in the emergence of the legendary 22 families in the then Pakistan – rich, powerful and oblivious to the plight of the poor. What happened to Pakistan as a consequence is history. Do we want 'development' without distributive justice? That would be a tragedy for Bangladesh. It would violently contradict one of the most fundamental founding principles of Bangladesh – socialism.

With the demise of the Soviet Union, the concept of socialism may have lost some attraction. However, as globalisation produces greater inequity across and within countries, social justice must become the guiding principle of development. Bangladesh must continue to uphold its fundamental principles and actively promote and safeguard the ideal of more equitable distribution of the fruits of economic growth. The 21st century belongs to the dreamers of social justice epitomised by the increasingly assertive leaders of a resurgent Latin America. Let's not allow our political parties to ignore or lose that vision.

PLEDGES, PLATITUDES, PITFALLS AND POSSIBILITIES

Only an inclusive government aware of its time-limited mandate and heavy responsibility to produce results would be able to surmount these challenges. Five years are too short a time and the people – as jury and judge – are ready to replace one party with another if its expectations are not fulfilled.

Although the scale of the victory of the Awami League-led alliance united under a secular and progressive banner, was not predicted by anyone, it was not unthinkable either. A number of factors were converging to produce an electoral revolution: the unprecedented corruption and misrule perpetrated by the previous government; the pervasive politicisation of the bureaucracy and every other instrument of the government as well as the institutions of higher learning; increasing inequity and poverty amidst greater wealth; state-sponsored rise of the religious right; and a sense of utter helplessness of the governed. The fact that this religious right not only stood against all the fundamental principles underpinning the independence movement but denied the very liberation war itself was proving to be too much to stomach.

These factors, nonetheless, were only necessary conditions for such a revolution; they were not sufficient. A few other factors, largely oblivious to the media, the pundits and even to the political parties until very late in the election process, provided the sufficient conditions for the revolution: the more than 10-million strong new young voters exposed to and increasingly shaped by the forces of globalisation; the information-communication revolution that, on the one hand, brought the world to our living rooms making us better aware of the economic, political, and social systems elsewhere – making us smarter as well as raising our expectations of our leaders – and, on the other, giving the new generation the tools – from e-mails to SMS - to carry out the revolution; and the spectre of food insecurity that galvanised the womenfolk fed up with spiralling cost of essential commodities. We heard of the feminisation of poverty, but could hardly fathom the prospect of the feminisation of electoral revolution. Who could imagine that women from all walks of life – from little educated women in villages to those who are enriching the garment manufacturers, to the educated housewives in cities and students across the country – would come out to vote in droves with the determination to change the political landscape of Bangladesh? Following the collapse of the Soviet Union, a number of ex-Soviet states experienced velvet revolution or orange revolution to usher in greater representative democracy. Our women in droves wouldn't have come out to vote unless they were confident of security and peace in the voting stations. The Election Commission and the-then interim government must be commended for that.

Clearly the election manifesto of the AL – its bold overarching pledge for change – attracted the attention of the young who are already hooked to the world through the web and popular media and would like to see the full realisation of the potential of

Bangladesh as a democratic, secular, peaceful, modern, progressive and economically independent country based on social justice and rule of law. It is unlikely that they paid much attention to the details of the AL manifesto that pledged to achieve numerous targets within a specific time period. For the younger generation there is absolutely no excuse for Bangladesh to miss the 'development train' while situated in the proximity of the two fastest growing economies of the world – China and India. At the same time, the children of the information-communication revolution sweeping the world see no reason for Bangladesh not to be a digitalised country open to ideas as well as for business. These two pledges economic/social development and a digitalised Bangladesh – were enough to bring the younger generation closer to the AL. As for our brave womenfolk, they crave not only for food security but also for peace, personal security and justice. Expectations, indeed, are high.

The AL has received platitudes from far and abroad for its overwhelming election victory. The prime minister and her cabinet assumed power amid unprecedented popular goodwill and support. Will the electorate get its expectations fulfilled? Will the AL government be able to implement its election manifesto? Will we see a digital Bangladesh within the next decade? Will we see secularism take root so deeply that it would be synonymous with Bangladesh? Even if the numerical target-specific pledges of the election manifesto are ignored for now, the new government has to work extremely hard to achieve its overall objectives – ensuring rapid economic growth, controlling and lowering prices of essentials, curbing corruption, upholding law and order and give us a transparent, accountable government. Good governance is perhaps the overarching concept that defines and encompasses all our expectations. Nevertheless, the question remains - as the euphoria over a massive election victory subsides, what can we realistically expect in the short- and long-run?

Perhaps the composition of the cabinet could provide us with some ideas about what to expect. It is promised as a cabinet with integrity, character and considerable political, legal and social sector experience. Most importantly, it is a cabinet where, for the first time in the history of Bangladesh (and of South Asia), women hold key portfolios. Their relative lack of experience in respective areas could be compensated by their personal integrity and political maturity. Unfortunately, lack of experience was quite evident when the new home minister referred to the sporadic post-election violence as a manifestation of the rival political party's 'internal divisions'. Post-election vengeance in 2001 saw many killed, raped, houses gutted and businesses looted and burned. Based on evidence perpetrators of that mayhem should be brought to justice. However, in 2008 the electorate did not expect any post-election violence. Nevertheless, violence and reprisals seem to have happened. Even if only one person died in such violence, we must consider that as one person too many. Such incidences of violence should have been seriously investigated, brought under control and law and order restored. On the part of the home minister, blaming the internal divisions of the rival political party for such violence does not bode well for law and justice. We can only hope that this will serve as a learning experience.

In an age of globalisation, the ministry of foreign affairs is not limited to external relations in the traditional sense of the term. It is much more complex and involves international trade, migration, development assistance as well as humanitarian concerns. The garment industry, for example, could be a natural domain for the ministry of industry. However, insofar as it relies on exports to North America, Europe, Australia and other industrialised countries to bring in billions of dollars for Bangladesh, the garment industry becomes a critical issue for the ministry of foreign Affairs. To open up new markets for our products and maintain such markets with appropriate diplomatic support are also critical functions for the foreign ministry. International trade is so tied up with diplomacy that in many developed countries they have been lumped together. In Canada, for example, foreign affairs and international trade were merged as long ago as in the 1980's to form the department of foreign affairs and international trade (DFAIT). Similarly, migrant labour – at present mostly unskilled labour to the markets in the Middle East and East Asia – is a subject for the ministry of labour, however, it is the foreign ministry that must make it possible to open up (and sustain) such markets for our labour and identify new markets.

Bangladesh is still dependent on foreign aid for much of its health and development efforts. Two ministries – the Ministry of Foreign Affairs and the Ministry of Finance – must work in concert to ensure adequate external assistance and its effective use. Likewise, in modern times, the foreign ministry must also be involved in a wide range of issues related to human rights – from violence against women to child rights and child labour to trafficking of women and children across borders. In short, diplomacy in the traditional sense of the term is not the only business of foreign affairs. The minister for foreign affairs, therefore, must have knowledge, skills and expertise in diverse areas from diplomacy to international trade and human rights to gender issues. Did we get a foreign minister with such a diverse expertise? Perhaps not; however, her youth, and her diversity of knowledge (pursuing law after a medical degree amply demonstrates such diversity), political acumen and ideological orientation may largely compensate the lack of experience. Nevertheless, it would be immensely helpful if a committee well represented by experts from these diverse areas is there to advise the minister of foreign affairs.

It is also important to note that we also have a woman as the minister of agriculture, perhaps the most important ministry for Bangladesh where agriculture still dominates the economy with an overwhelming majority of the population living in rural areas. However, the minister of agriculture is not only an experienced one, but also possesses the qualities of a charismatic leader with honesty, integrity and an uncanny ability to inspire people around her with her energy and ideological commitment to serve the poor and the dispossessed. Few would ever question her integrity, commitment, willingness and ability to reform the agricultural sector and thereby improve the living conditions of the farmers across Bangladesh.

However, challenges and pitfalls remain. One of the most significant pitfalls is indeed the scale of the election victory. Too much control over the parliament could make the ruling

party ignore or stifle any opposition and establish a de facto parliamentary 'dictatorship'. In such a context the media and civil society must play a more critical role as the defender of the freedom of expression of opinion, human rights and of dissent. Weakness of our public institutions and of political parties at large is another obstacle that the ruling party must overcome. Without a strong political culture of tolerance and democratic values, it would be difficult for the ruling party to always practice, in spirit and in practice, the higher values of democracy. Lack of reciprocity from other political parties could be a not-so-negligible obstacle.

The possibilities are truly enormous and profound. The incoming government could usher in an era of democracy, tolerance and human rights and social justice. It could lay the foundation of a truly democratic, secular, progressive Bangladesh where the fruits of economic growth are more equitably distributed across all segments of the population. It could restore our pride and take Bangladesh off the list of one of the most corrupt countries in the world. It could make us a powerful member of the global village at the cutting edge of the information-communication revolution. However, it all depends on how successful the ruling party is in rising above its party identity and becoming a truly national government embracing all other parties and pressure groups. Only an inclusive government aware of its time-limited mandate and heavy responsibility to produce results would be able to surmount these challenges. Five years are too short a time and the people – as jury and judge – are ready to replace one party with another if its expectations are not fulfilled. Let's hope that the AL is aware of this most fundamental principle of democracy.

THE ODA HOOPLA

Foreign aid has slowly but surely transformed into a business – an 'industry' with its beneficiaries concentrated mostly in developed countries but with an increasingly powerful, rich and vocal cohort in the developing world. Looking at this transformation of foreign aid, some could legitimately argue that it is nothing but a massive transfer of poor taxpayers' money from the rich countries to the rich non-taxpayers in poor countries.

OVERSEAS development assistance or foreign aid started after the Second World War following the successful example of the Marshall Plan of the United States that poured billions in rebuilding the war-devastated Europe. The war saw the demise of the League of Nations and the rise of the new United Nations with New York as its headquarters. The aftermath of the war also saw the emergence of the World Bank and the International Monetary Fund as two of the most powerful Breton Woods institutions to regulate and oversee the emerging global financial system soon to be dominated by the United States. The post-war years also witnessed the growth of a number of UN agencies with macro-level regulatory responsibilities such as the World Health Organisation, the UN Fund for Population Activities, the International Labour Organisation, the United Nations International Children's Emergency Fund, the Food and Agriculture Organisation and the United Nations Development Programme. In other words, the devastation and human suffering brought on by the war also produced an unprecedented spirit of, and opportunity for, cooperation and collaboration for international development. The concept of overseas development assistance – transfer of financial resources from the rich countries to the poorer ones to help them develop – seemed to be a natural outgrowth in this environment.

Initially, ODA was meant to reduce or eliminate hunger, improve health and promote universal education in developing countries. The emphasis, therefore, was on agriculture, strengthening primary health care, and promoting primary education. In this early phase, governments were considered to be the primary vehicle through which development work must proceed. ODA consequently, provided much emphasis on strengthening the public sector through capacity building. The Green Revolution of the 1950s and 1960s that saw food production increasing rapidly across most of the developing world owes much to this early phase of ODA. Similarly, the Alma Ata Declaration of 1978 that pledged 'Health for All' by the year 2000 through an integrated community-based primary healthcare system also can largely be attributed to this early phase of ODA. By the late 1950s almost all the industrialised rich countries established their own foreign aid agencies to disburse funds. The US got its Agency for International Development while Britain established the Department for International Development. Soon the Canadians, Norwegians and Australians as well as the re-built and re-invigorated Germans and Japanese also joined in along with the Belgians, Swedish, Italians and Dutch. The world saw the emergence of such development agencies as the Canadian International Development Agency, Norwegians Agency for Development, Australian Agency for

International Development and Japanese International Cooperation Authority. By the 1960s the Germans came out big with their technical assistance arm GTZ. All these rich donor countries, mostly of western in origin, formed the Organisation for Economic Cooperation and Development headquartered in Paris. Even the tiny Luxembourg joined in. A development assistance committee was constituted to coordinate development policies of these 22 industrialised donor countries in Europe and Australia, Canada, Japan, New Zealand and the United States. More recently, a few other newly emerging rich countries such as South Korea, Taipei (Taiwan), the Czech Republic, Iceland, Latvia, Lithuania and the Slovak Republic started their own development assistance programmes. However, they provide little ODA in comparison with the DAC members. In 2006 these seven non-DAC countries provided a total of \$1.2 billion in ODA. Taipei and South Korea are the biggest non-DAC ODA providers. In 2006, for example, these two countries provided a total of \$960 million in ODA – more than 77 per cent of the non-DAC total.

The DAC members are the primary source of ODA. In 2006 ODA from the 22 DAC countries totalled \$104.4 billion. Within DAC, G-7 countries (the United States, Japan, the United Kingdom, France, Germany, Canada and Italy) provide the most ODA. In 2006, their combined ODA amounted to more than \$75 billion or 72 per cent of the DAC total. On the other hand, non-G7 countries contributed about \$29 billion or 28 per cent of the DAC total. In absolute terms, the five big ODA contributors are the US (\$22.7 billion in 2006), the United Kingdom (\$12.6 billion), Japan (\$11.6 billion), France (\$10.4 billion) and Germany (\$10.3 billion). Three questions seem to dominate the discussion on ODA: Do these rich countries contribute enough to international development? How much of these funds really find their way to the poor recipient countries? And perhaps the biggest question of all is the age-old controversy regarding the very role of ODA in international development – does ODA really foster development or does it create dependency that poor countries find hard to overcome?

In 2005, according to the OECD, ODA from the 22 DAC countries totalled \$107.1 billion or 0.33 per cent of their total gross national income. This was far short of the 0.7 percent of the GNI that the UN recommended in 1975. Moreover, by 2006, ODA from the DAC countries fell to \$104.4 billion or 0.31 per cent of their GNI. In 2007 ODA from the DAC countries dropped further to \$103.5 billion or 0.28 per cent of their GNI. However, it should be noted that all DAC countries are not equally responsible for such GNI shortfall. Some of the small Scandinavian countries (Norway, Sweden) as well Luxembourg and the Netherlands have surpassed the UN mandated 0.7 per cent of GNI threshold by the end of the twentieth century. In 2006, for example, Sweden contributed more than one per cent of its GNI to overseas development. In 2006 Norway and Luxembourg contributed 0.89 per cent of their GNI to ODA, while Denmark and Netherlands contributed 0.8 per cent and 0.81 per cent of their GNI respectively. On the other hand, Canada, France, Germany and Japan contributed only 0.3 per cent, 0.47 per cent, 0.36 per cent and 0.25 per cent of their GNI respectively to ODA in 2006. In that year, among the G7 countries only Britain contributed more than 0.5 per cent of its GNI for overseas development. In 2006 the biggest individual donor and the leader of the G7 – the United

States of America – contributed only 0.17 per cent of its GNI for international development. Clearly, unless the G7 countries – the biggest block of donors – collectively increase their ODA significantly the UN target (0.7 per cent of GNI) set back in 1975 will not be reached. Despite repeated pledges, the G7 is yet to act decisively in this regard. The current global economic recession is likely to further erode ODA and push back reaching the UN mandated target.

The answer to the first question is clear: rich countries do not dedicate enough resources to ODA. Nevertheless, how much of this money really reaches the poor? It is an intriguing and complex question. Not much analytical research has been done to answer this question fully and definitively. In 2004 the UK-based non-governmental organisation ActionAid International launched a pioneering study to measure how much foreign aid truly reaches the intended beneficiaries. It was completed and widely disseminated just before the G7 leaders had their annual gathering in Gleneagles. The idea was to inform as well as to 'shame' the G7 leaders in making aid more 'untied'. Dividing foreign aid into two – the 'real' aid that reaches the poor and the 'phantom' aid that is consumed by consultants, administrative and others costs – the ActionAid study ranked all donor countries in terms of the nature of its aid. According to the study, for all the 22 DAC countries, 53 per cent of the total aid was 'phantom' in 2003. For the G7 countries, the biggest bloc of donors, a whopping 68 per cent of the aid was phantom in 2003. In other words, only about 32 per cent of the G7 aid ever reached the intended beneficiaries. What about the United States – the biggest donor? According to the ActionAid study, 72 per cent of the US aid was phantom in 2003. In 'phantom' aid, the French topped the list in 2003 78 per cent of its aid was phantom, so was 58 per cent of German aid. The 'best' G7 country was the United Kingdom – only 27 per cent of its aid was phantom in 2003.

What makes aid 'phantom'? Often ODA comes with 'technical assistance' – consultants to be hired from the donor country. Consultants from donor countries are expensive; they are often paid 200 to 800 per cent more than a local expert. Based on an outdated development model, overseas consultants seldom understand/comprehend the cultural aspects of development in developing countries and, therefore, could hardly play an effective role. At the same time, this practice of reliance on foreign consultants fails to build long-term capacity in developing countries. Some ODA is 'tied' – the recipient country is required to buy goods and services earmarked in the aid project(s) from the donor country irrespective of the cost. In some cases, organisations based in donor countries are hired to act as 'executing agencies' for donor-funded projects. More than 87 per cent of USAID contracts are awarded to US-based firms such as Pathfinder, the Management Sciences for Health, and John Snow Incorporated. These executing agencies have elaborate head offices in the US and often maintain country and/or regional offices in many cities across the developing world. Many of these agencies almost exclusively rely on the USAID for their survival that account for more than 95 per cent of their annual revenue. Needless to say, all costs associated with managing and maintaining these organisations, their headquarters and sub-offices form part of ODA. The DfID is not an exception in this regard. At least 80 per cent of contracts awarded by DfID in 2005-06 went to British firms and most of the rest to firms from OECD countries.

TA (consultants along with training and research) and executing agencies thus form the most noticeable part of the phantom aid. TA alone continues to eat up almost one-quarter to one-half (30 to 50 per cent) of donor budgets. Consultants from abroad are often placed in key positions to advise recipient countries on development policy. As foreign consultants, they often exert considerable power in deciding how aid funds are used. It is clear that once the TAs and the executing agencies are paid for, there is precious little left for the poor recipient countries. In other words, foreign aid, in most part, remains in the foreign country that provides the funds rather than coming to work for the poor in developing countries. Despite the Paris Declaration of 2004, donor countries are yet to substantially 'untie' their aid and recipient countries are far away from significantly improving their governance structure dealing with ODA.

So, why is there so much hoopla about foreign aid? Perhaps because foreign aid has slowly but surely transformed into a business – an 'industry' with its beneficiaries concentrated mostly in developed countries but with an increasingly powerful, rich and vocal cohort in the developing world. Looking at this transformation of foreign aid, some could legitimately argue that it is nothing but a massive transfer of poor taxpayers' money from the rich countries to the rich non-taxpayers in poor countries. This brings us to the last question – does ODA really work in fostering development? As the debate rages on personified by William Easterly on the one end (ODA does not work) and Jeffrey Sachs on the other (we need more ODA), the question demands most careful examination.

FOREIGN AID AND END OF POVERTY: Mutually Exclusive

...foreign experts cannot solve our poverty. The solution must come from within by unleashing the ingenious agency of our people, giving them the freedom to err, learn from their mistakes and ultimately find the solution that works. No 'standard' so-called scientific solution can be transported and implemented across countries.

FOREIGN aid started as an act of altruism whereby the rich countries set aside a portion of their gross national income for the poorer countries in order to help them develop – reduce poverty, increase productivity, avoid disease and disability, and enhance education. However, the spirit of altruism did not last long. Soon foreign aid transformed into a business and an enterprise with powerful interest groups on both sides of the isle – in the rich as well as in the poor countries – vying for an ever-increasing slice of the pie. Who are these vested interests? How do they work? Bureaucrats, the powerful ones – who form the 'management' part of the development agencies in the western countries, constitute the first group of vested interests so far as foreign aid is concerned. It should be made clear that, unfortunately, my direct experience with the development bureaucracy is restricted to that of the west. I am quite unsure about the nature of such bureaucracy in the east, for example in Japan or in South Korea. However, the fact that, in Japan, high-level managers often commit suicide when faced with terrible moral quagmires is an indication of the 'moral/ethical' nature of that bureaucracy. In the west, on the other hand, managers have no such moral compunction. Unless pursued in the courts and found guilty – a rarity – they seem to be above normal rules of organisational behaviour. Although there are legions of technocrats in these development agencies to provide 'technical' advice on the basis of extensive analytical exercise, the managers (the 'management' category within the bureaucracy is composed of a select few chosen through special examinations often not open to all) are more likely to either ignore or bypass such technical advice.

Managers – from the junior to the most senior one – love to hire outside consultants for any issue they are faced with. Should aid to Africa be increased? How should the increased funds be channelled? What do we mean by 'fragile states'? How to provide development assistance to fragile states? What is 'health systems'? How do we strengthen health systems in developing countries? All these issues can be researched, analysed and appropriate responses/strategies identified by in-house technical experts. Nevertheless, in all these cases the managers are more likely to hire a short-time consultant from 'outside' and paid a hefty fee. In a given year, some of these external consultants may earn three or four times of their 'salary' providing advice to the development agency. Millions of dollars are spent by the development agency each year generating innumerable consultants' reports. Quite often two or three managers in several departments or divisions may hire separate external consultants to research/report on essentially same or similar issues. On the other hand, if there is a new manager following the submission of a

consultant's report, it is likely that he or she would hire another consultant to initiate another study on the issue and submit a report. These consultants also often act as 'experts' on different projects/programmes financed by the development agency. They also serve as monitoring and evaluation experts on behalf of the development agency for projects/programmes in developing countries. All these expenses are part of the official development assistance.

Then there is the practice of 'reorganisation' – a sacred prerogative of the management kind. Each new situation or crisis – whether real or perceived – is answered with some sort of reorganisation, primarily consisting of changing titles in the organisational boxes or 'rediscovering' and refining the vision and mission of the division or branch. Needless to say, an external consultant is always hired to suggest how to reorganise. Although each reorganisation is supposed to enhance organisational efficiency and/or effectiveness which requires time, managers can hardly wait for another round of reorganisation. Obviously, there is no dearth of consultants to suggest reorganisation of the same division or branch year after year as demanded by the management. It is wise to note the observation of Petronius Arbiter, a Greek philosopher in 210 BC, on the subject of reorganisation: 'We trained hard...but it seemed that every time we were beginning to form up into teams, we would be reorganised... I was to learn later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress, while producing confusion, inefficiency, and demoralisation.' Alas, these modern day managers seem to have never heard of this advice from an ancient master of organisational science.

These external consultants constitute the second group of vested interests. Since they collectively consume a substantial portion of the foreign aid, it is logical to identify and understand the nature of these so-called external consultants. They are mostly members of consulting firms established by experts often working in universities, research organisations and/or think-tanks in developed countries. Most importantly, there is a symbiotic relationship between these experts and the development agency managers. They (the managers and the external consultants) are often linked in terms of being 'friends' attending the same school or university, or belonging to the same golf club or to the same socio-cultural organisation. In short, they form a close-knit network of like-minded 'buddies'. Although there is no financial exchange involved, one must be a part of this network to be considered or hired as a consultant by the development agency. Consequently, the constituents of this network resemble the members of the development agency management structure in terms of ethnicity/race and social background. They are overwhelmingly white, educated middle class. It is extremely difficult for an ethnic minority (for example, an East Indian, an Arab or a Black) to become part of such a network irrespective of his/her level of education or expertise. It is this exclusiveness of the network that makes it so distasteful. Nevertheless, in the name of 'objective external studies' and 'technical assistance', this network of managers and experts is claiming an increasingly greater portion of the development pie. A group of local consultants in developing countries has also emerged to complement their developed country counterparts.

Nevertheless, the biggest demand on the foreign aid pie is made by the 'executing agencies' – non-governmental consulting firms based in developed countries that receive funds to implement projects/programmes in developing countries on behalf of various development agencies. With elaborate bureaucratic structure, head offices as well as country-level field presence, each of these firms is a multi-million dollar annual business enterprise. Totally dependent on foreign aid funds, these agencies compete against each other for grants. A few of them often form a 'consortium' to collectively compete for a large grant. Although there are many such firms in the United States, Canada and the United Kingdom, in each country a few large firms tend to dominate the foreign aid business. Each of these firms has annual revenue of a couple of hundred million dollars. For these firms their own survival is the primary goal rather than development in poor countries. They are, therefore, more eager to keep the funding agency satisfied even if such actions compromise development efforts in poor countries. It is debatable how far these firms are dedicated to development in the real sense of the term. Survival being the primary goal, they have to look after their own interests first.

With all these diverse interest groups claiming a portion of the foreign aid pie, does it really work? Does foreign aid really promote development? This ultimate debate is epitomised by two contemporary scholars from opposite sides of the spectrum – William Easterly and Jeffrey Sachs.

Professor Jeffrey Sachs chaired the World Health Organisation's Commission on Macroeconomics and Health and is a firm believer in foreign aid and more of it. In the commission's report submitted in December 2001, Sachs forcefully argued that with a substantial increase in foreign aid poverty and disease in the developing countries can be eradicated. According to the commission's 2001 report, eradication of such devastating communicable diseases like malaria and tuberculosis would require an increase in foreign aid for health to \$17 billion a year by 2007 and to \$38 billion a year by 2015. For Sachs, the proven solutions/interventions are there, we only need adequate aid dollars to introduce and/or scale them up in poorer countries. It should be noted that about 10 per cent of foreign aid (a little more than \$10 billion in 2005) is earmarked for health. It is unrealistic to expect foreign aid for health to increase anywhere near \$38 billion a year by 2015. Nevertheless, as chair of the United Nation's Millennium Development Project, Sachs passionately argues for more generosity and increased foreign aid from the rich countries to solve the problem of disease, deprivation and poverty in the Third World. In his *End of Poverty* (2005), Sachs emphatically made the same argument and called on the donors to be more generous.

Professor William Easterly, on the other hand, took a diametrically opposite position. An economist by profession, Easterly worked at the World Bank for a long time before joining the New York University following the publication of his iconoclastic 2001 book *The Elusive Quest for Growth* that mercilessly criticised, with convincing empirical evidence, prevailing international efforts in promoting Third World development as ill-conceived and largely ineffective. He is also a senior fellow at the Centre for Global Development. His new book entitled *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good* (2006), proved to be more

provocative as it termed foreign aid projects as 'failures'. For Easterly it is a tragedy that despite spending \$2.3 trillion on foreign aid over the last five decades, the west 'still had not managed to get 12-cent medicines to children to half of all malaria deaths...or to get \$4 bed nets to poor families. The West spent \$2.3 trillion and still had not managed to get \$3 to each new mother to prevent five million child deaths.' Why such failure? It is not because the west is stingy, but because the western experts and planners think that they have all the answers to solve the Third World's problems. In response to Sachs's *How Aid Can Work* (New York Review of Books, December 21, 2006), Easterly presented his argument most succinctly: 'Poverty never has been ended and never will be ended by foreign experts or foreign aid. Poverty will end as it has ended everywhere else, by home-grown political, economic, and social reformers and entrepreneurs that unleash the power of democracy and free markets. Yes, some specific problems are fixable by aid and there has been progress on some already in health and education...But the answers were never so obvious in advance to the "experts". Future solutions will be found by trial-and-error search for what works on the ground (e.g. how to motivate delivery of bed nets to those who need them? how to convince the poor to use them?). Productive searchers will come from actors who each take responsibility for one step at a time and get held accountable for success or failure. The unaccountable foreign experts who promise to comprehensively end poverty "at an amazingly low cost" a claim that bears stronger intellectual kinship to late-night TV commercials than African reality will accomplish very little' (New York Review of Books, January 11, 2007).

Whichever side of this debate one belongs, it is apparent that foreign experts cannot solve our poverty. The solution must come from within by unleashing the ingenious agency of our people, giving them the freedom to err, learn from their mistakes and ultimately find the solution that works. No 'standard' so-called scientific solution can be transported and implemented across countries. As countries differ in history, culture, socioeconomic structure and political organisation, each country must find its own solution to overcome poverty, disease and deprivation. In other words, our paths out of poverty could be as diverse as our culture and history. The art and science of development, in this sense, is indeed 'a tumultuous engagement with the possibilities of freedom,' as Nobel laureate Amartya Sen argues in his *Development as Freedom* (1999). Democracy and freedom are, therefore, the preconditions as well as the products of development.

WOMEN'S EMPOWERMENT AND DEVELOPMENT: What Progress Have We Made?

ON MARCH 8 we celebrated yet another International Women's Day. On this occasion last year while talking about gender-based violence in Bangladesh, I emphasised the critical need for a gender perspective in fully understanding and, effectively responding to, gender-based violence. A gender-based perspective, it was noted, 'implies fully understanding and appreciating the structural factors – power relationships, culture and ideology – underlying gender-based violence. Mastering what C Wright Mills termed as 'sociological imagination', we have to unlearn some of the cultural values and beliefs that we take for granted from our childhood. Most importantly, this implies 'thinking outside' the socio-cultural milieu – the 'social box' in which we are born. Clearly as a society we have made little progress in either mastering a gender-based perspective or in socially tackling the disease of violence against women.

Even the days before the International Women's Day, our newspapers reported several murders of women due to dowry and domestic violence. How many women were killed by their partners or near and dear ones during last year? Our home-grown human rights organisation Ain O Shalish Kendra puts the figure at 518 – almost half of them, 246, were victims of domestic violence, while conflict over dowry claimed the lives of another 33 per cent, 172. Moreover, according to ASK, 367 women in Bangladesh – a little over 1 a day – were raped in 2007. Needless to say, these numbers constitute the 'reported' or 'known' cases. There could be three times more victims who never had the opportunity or the social backup to either raise their voice (in case of rape, for example) or get included in this sad statistics as 'victims' – their deaths being explained away by the powerful as 'accidents'. Moreover, it is easy to count deaths due to domestic violence or dowry-related conflicts. How to count the number of women who are, at any given point, subjected to domestic violence and/or dowry-related torture? Some studies from India, Pakistan and Bangladesh suggest that 40 to 60 per cent of women in these countries experience physical and/or sexual abuse during their adult life. Translated in Bangladesh context, the numbers are simply staggering. Violence or abuse is only one dimension of the social deprivation faced by women. There are innumerable others – discrimination at work, denial of property rights, sexual harassment in place of work and even in universities, unwanted propositions and subsequent harassment and violence from area mastaans that often lead to either withdrawing from schools/colleges or forced emigration from her own village or town. Most importantly, they face an uphill battle in registering a case with the law enforcement agencies, let alone in seeking justice. The police in Bangladesh, as in many other male dominated countries, are not only insensitive to gender-based violence, it often acts as the bastion of male chauvinism and the worst features of patriarchy. Although some attempts are being made, with support from the United Nations Development Programme and other UN agencies and donors, to provide gender-sensitivity training to our police force, it is having little real impact.

Gender equity in any society is profoundly dependent on the fundamental ideological and structural orientation of four key societal institutions: the legislature and the legislators – those who make laws that form the overarching policies and strategic directions for the state at large; the administration/bureaucracy who are there to implement the laws and policies; the judiciary with the responsibility of interpreting and applying the laws; and the police who form the first point of contact with the state for people seeking justice. Although all these four institutions are important, perhaps the most fundamental institutions are the legislature and the police. In crafting and promulgating laws the legislature, represented by various segments of the population, mirrors the society at large and in the ultimate sense reflects the overall societal values and beliefs. The more democratic a society is the more likely that the legislature would reflect the broader society in terms of classes, parties and status groups. Alas, democracy hardly guarantees the representation of the poor and the disadvantaged, including women and ethnic minorities, in the legislature. Neither does democracy guarantee the representation of people from the ideological extremes (as well from various counter-cultures) in the legislature.

Insofar as we have an elected legislature we can say it reflects the larger societal values and the social compact on women's rights. From a global perspective, it can be said the Convention for the Elimination of All Forms of Discrimination against Women that was adopted by the United Nations on December 18, 1976 and entered as an international treaty on September 3, 1981 represents the global compact on women and their rights. Although Bangladesh ratified CEDAW as early as in 1984, it expressed serious reservations on some of the more progressive provisions of the convention. Through much efforts and social mobilisation by women's organisations and civil rights groups spearheaded by the Bangladesh National Women Lawyers Association, Mahila Parishad, and Nari Pokkho, the government in mid-1990s finally relented and withdrew its objections to the so-called controversial parts of CEDAW.

In 1997 the then government led by the Awami League also pronounced a new national women's development policy. The policy promised not only 'equal opportunity' for women in national development but also to promote 'economic empowerment of women' and to ensure their 'equal rights over controlling property'. The government of the day recognised the need for modernising existing laws and/or to enact new laws to put these policies into action. Alas, with the change in the government in 2001, the policy also got revised. In the process, the women of Bangladesh lost a good number of rights that was promised by the previous government. Our commitment to CEDAW and its full implementation also waned seriously during the reign of the BNP-led government.

It is in this context that the caretaker government, with much hoopla, 'introduced' its own national women's development policy in 2008. Before the contents and the finer details of this policy could be debated and carefully reviewed by the civil rights groups and women's organisations, it prompted violent protests from the religious right. The caretaker government, rather unexpectedly, capitulated and gave the policy to a group of religious scholars for feedback. Sadly, the policy, thereafter, never saw the light of the day and died prematurely without much fanfare. With the Awami League government in

power again, expectations are again high that there will be a new national women's development policy soon, similar in spirit and content with that of the 1997. On International Women's Day, the Awami League and its leaders, including the prime minister, promised no less. With powerful women ministers in key ministries under the overall leadership of a woman prime minister, this government has all it takes to introduce a radically new and progressive policy. Nevertheless, some fundamental questions need to be probed and fully understood.

We must realise that having women as powerful ministers alone will not change our women's status or empower them. Since 1991 the politics and the government in Bangladesh were dominated by two powerful women each having absolute control over her party. Bangladesh is the only country in the world to have two powerful women dominating politics and the state machinery for so long. For almost two decades, power, in an absolute sense, revolved around these two women. To this day, they not only remain unchallenged within their parties but also indispensable to the polity of the country as a whole. Alternately they ruled and continue to rule the country with such concentration of power that all decisions from the mundane to the most critical – seem to be either made by them directly or at least need their explicit approval. Given the nature of our political culture, they are more powerful than Indira Gandhi at her prime at the helms of the state structure in India.

How much have we gained from this dominance of two powerful women in our politics and statecraft? All the key indicators of women's empowerment and/or gender equality – from the incidence of acid burning to dowry-related deaths – seem to have deteriorated over the years. The incidence of 'domestic' violence, rape and sexual harassment in workplace continues to rise. The facts that our women are more educated, participate in gainful employment in ever greater numbers, and make their presence felt in all occupations do not seem to change the reality of day-to-day life experience of an overwhelming majority of our women. How to explain this seemingly contradictory anomaly? On the one hand, women ruling the country and dominating the political discourse at the top and, on the other, gender-based violence and discrimination shaping the lives of women at large, particularly that of the poor? Bangladesh is not an exception in this regard either. It is stated that New Delhi and its surrounding areas had more than one dowry-related death (all women, of course) while Indira Gandhi was ruling India as one of its most powerful prime ministers in recent memory.

The underlying reason is our failure to distinguish between the gender identity of an individual and his/her gender perspective, on the one hand, and between policy and its practical implementation at the grassroots level. Being a female member of parliament or of the cabinet has little to do with her gender perspective or ideology. It would be good to remember that in most dowry-related deaths, the mother-in-law seems to play an important and often the most vital role in murdering her daughter-in-law. The sex of the perpetrator is quite irrelevant here. What is relevant is the broader culture and societal values that shape the ideological bent of the individual. In other words, so long as we fail to radically change our cultural/societal values related to gender, simply having women ministers and/or politicians would not do. At the same time, we must work harder to get

the policies implemented. So far as gender equality is concerned, we need a profound change in two state institutions that are critical in interpreting policies/laws and in applying those laws – the judiciary and the police. Our judiciary is not only dominated by men, but they have little exposure to gender issues. It is imperative that a massive re-education programme for our judiciary is launched to make them internalise and apply a gender perspective while rendering justice.

Our police force – the frontline state officials to uphold and apply policies and laws – remains overwhelmingly a male preserve and devoid of much modern discourse on gender. At about 2,000 women constitute a little more than one per cent of our police force. However, more important is the fact that in spite of some recent efforts, our police force has had little concerted and continuous training programme on gender and gender issues. Because of their background, level of education and socio-cultural orientation, perhaps our police force is most in need of massive gender-sensitivity training. Radical re-orientation of their gender perspective is a prerequisite for promoting greater gender equality in Bangladesh.

Nonetheless, our first task is to admit that we are all born in and products of a patriarchal culture. Patriarchy is part of our personality. Equality for women and their equal participation in development cannot be achieved unless we, collectively, make an effort to change our patriarchal ideology. Perhaps, the concept of a 'national policy on women's development' also reflects our patriarchal ideology. The title reinforces the complacent patriarchal idea that our women are somehow 'under-developed' or 'undeveloped' and that they need development. Our women do not need development; they demand, deserve and have the right to equally participate in and enjoy the fruits of national development.

As a nation, we must ensure space, resources and time for women to forcefully articulate their own interests and goals rather than anticipate and enshrine them in policies on their behalf. In other words, women need enfranchisement and freedom to use their own agency to participate equally in national development. As eminent gender specialist Naila Kabeer once said 'planners can be valuable and powerful allies in this process of enfranchisement, but in the final analysis the main actors must be those whose voices have been suppressed for so long within the different arenas of development.' Guaranteeing freedom for women to re-fashion their lives so as to achieve self-actualisation would require an ideological as well as institutional revolution in Bangladesh. Men and women – at all levels and segments of society – must work together to bring about such a social revolution one step at a time.

CHRONIC DISEASES AND OUR HEALTHCARE SYSTEM: The Emerging Challenge

It is deplorable that the Millennium Development Goals, set around the turn of the century by the United Nations, failed to explicitly acknowledge and address the emerging challenges of chronic diseases. Perhaps, this failure by the world body made us ignore the threat of chronic diseases. However, the threat is too catastrophic to be ignored anymore.

IN THE early 1990s public health experts Dean T Jamison, W Henry Mosley, Anthony R Measham and Jose Luis Bobadilla, in their pioneering work entitled *Disease Control Priorities in Developing Countries*, predicted that by the turn of the twenty-first century, developing countries would undergo a demographic and epidemiological transition and that chronic non-communicable diseases would emerge as major challenges for the health care system. According to the prediction of these scholars, communicable disease will account for only about 20 per cent of deaths in developing countries by 2015 as chronic diseases like cancer, cardiovascular complications, hypertension and diabetes start to take an increasing toll. Due to numerous intervening factors, including the devastating effect of HIV/AIDS in most developing countries that was difficult to visualise even in early 1990s, that prediction did not fully come true. However, it is undeniable that slowly but surely chronic diseases are emerging as the most critical challenges to the health systems in developing countries, especially in countries that did not experience the full brunt of HIV/AIDS. Bangladesh is no exception in this epidemiological transition.

According to the World Health Organisation, three of the deadliest communicable diseases – HIV/AIDS, tuberculosis and malaria – together claimed the lives of slightly more than 5.3 million people globally in 2005. On the other hand, cardiovascular diseases alone accounted for an estimated 17.5 million deaths in 2005 around the world. In 2005 globally cancer and chronic respiratory diseases claimed the lives of an estimated 7.6 million and 4.1 million people respectively. In short, out of a projected total of 58 million deaths from all causes in 2005, chronic diseases accounted for an estimated 35 million deaths or 60 per cent of the total. This is more than double the number of deaths from all communicable diseases (including HIV/AIDS, tuberculosis and malaria) as well as maternal and perinatal conditions and nutritional deficiencies combined. Unfortunately, we often tend to equate chronic diseases with the rich developed countries and infectious diseases with the poor developing world. The truth is quite different.

Low- and middle-income countries, according to WHO, account for 80 per cent of chronic disease deaths where an overwhelming majority of the world population lives. Developed industrialised countries, home to about one-sixth of the global population, account for only 20 per cent of chronic disease deaths. A World Bank study more precisely demonstrated the distribution of chronic disease deaths in 2005. According to this study, 35 per cent of chronic disease deaths occurred in low-income countries and another 37 per cent deaths in lower middle-income countries. Upper middle-income countries accounted for a projected 8 per cent of chronic disease deaths, while high-

income countries accounted for only 20 per cent of chronic disease deaths in 2005. In other words, four out of five chronic disease deaths occur in low- and middle-income countries. In cases of some selected chronic diseases, the ratio of deaths in developing and developed countries is more uneven. For example, according to some renowned researchers, between 1901 and 2000, a total of 100 million people died of tobacco-related diseases, mostly in developed countries. However, between the year 2001 and 2100 – over the next hundred years – almost 1,000 million people are likely to die from tobacco-related diseases and almost all of these will occur in developing countries. While high-income countries are almost eliminating deaths attributable to tobacco use, poorer countries are assuming an increasingly greater burden to tobacco-related deaths. It is projected that currently about 4.9 million people die as a consequence of tobacco use – more than 90 per cent of them in low-income countries. If this trend continues, by the middle of the present century, tobacco deaths would be almost an exclusive feature of developing countries.

Moreover, according to WHO, while mortality from infectious diseases, maternal and perinatal conditions, and nutritional deficiencies combined are expected to decline by 3 per cent over the next 10 years, mortality from chronic diseases are projected to increase by 17 per cent during the same period. Most importantly, this is a global phenomenon. In all countries – rich and poor – mortality from infectious diseases are declining while that from chronic diseases are on the rise. This epidemiological transition – from infectious to chronic diseases – is becoming more and more evident in developing countries, Bangladesh included. Globalisation and the resultant changes in some of our behavioural patterns are making the process of this epidemiological transition faster.

It is important to note that chronic diseases cause a far greater number of people to suffer from debilitating physical, psychological and emotional problems than they kill. In other words, morbidity resulting from chronic diseases is much higher than mortality. Chronic diseases make a large number of people either partially or fully disabled. Often a chronic disease profoundly reduces the quality of life of an individual or makes him/her incapable of contributing as a full productive member of the society. For example, while diabetes kills an estimated 1.2 million annually worldwide, it makes more than 25 million people suffer from a range of debilitating effects – from partial or full blindness to restricted physical mobility. Similarly, cardiovascular diseases kill more than 17 million people annually, while affects five times more people globally with various debilitating conditions including paralysis. Economic impact of chronic diseases is enormous not only in terms of healthcare costs, but also in terms of lost productivity and income. For example, it is estimated that the amount China 'will forego in national income over the next 10 years as a result of premature deaths caused by heart disease, stroke and diabetes' is a staggering \$558 billion – more than \$55 billion a year. Likewise, it would suffer a projected national income loss of almost \$250 billion between 2005 and 2015 due to heart disease, stroke and diabetes.

What are the factors responsible for such rise in mortality and morbidity from chronic diseases? Although the complexity of causes for chronic diseases is well-recognised, a few powerful yet modifiable risk factors common across cultures and countries can easily

be identified. These are: unhealthy diet, lack of physical activity, and tobacco use. Unfortunately, these factors are all somehow tied up with the process of globalisation. The forces of globalisation over the last three decades not only made our markets and economies more interdependent they also created a tremendous amount of wealth across countries. A rich (and increasingly richer) class of entrepreneurs emerged in developing countries. Globalisation also helped the educated middle class in the developing countries grow in numbers as well as in wealth. As the class structure changed, so did our food habits. With the advent of such fast-food giants as McDonald's, Kentucky Fried Chicken, A&W and Pizza Hut in poorer countries to cater to the taste of the rising upper and middle classes, we are increasingly consuming hitherto unavailable western fast food. On the other hand, large department stores (another offshoot of the process of globalisation) are also importing and selling an increasing variety of western food items (from frozen pizza to a wide variety of ice creams) that tend to add to our waistlines. This nutritional transition is a significant contributory factor to the increasing incidence of chronic diseases among the urban elite and the middle class in developing countries. For the poor, on the other hand, a balanced healthy diet is increasingly becoming a rarity as the forces of globalisation further worsen their poverty. Chronic malnutrition makes them increasingly vulnerable to chronic diseases. Illiteracy and lack of access to information on chronic diseases and their risk factors add to their vulnerability. On the other hand, as globalisation tends to feed the urge of getting richer faster for all entrepreneurial classes in developing countries (and corruption help them fulfill this dream), we are all faced with the daily danger of consuming contaminated food. Needless to say, as we consume more and more adulterated food we become more and more vulnerable to all types of diseases including chronic diseases.

At the same time, due to globalisation and the proliferation of computers, televisions, video games and other forms of electronic entertainment, we are becoming more sedentary devoid of strenuous physical activity. These days, physical activity remains largely confined to the nutrition-deficient poor and the disadvantaged. The rich and the growing middle class seldom engage in physical activity except a few of them flocking to the urban parks and/or the ever proliferating fitness centres (another offshoot of globalisation). Moreover, an increasing number of children and adolescents are spending more and more of their time in front of the TV or video games rather than in more taxing physical activities. The consequence is increasing obesity and various types of chronic diseases. It is estimated that more than a billion people are overweight and that an increasing proportion of them are children and adolescents.

Tobacco use is another contributory factor. As tobacco use is declining in most developed countries, tobacco companies are increasingly targeting the developing world for their products. Laws in developing countries are lagging behind in terms of discouraging tobacco use through restrictive advertisement and/or greater taxes. Enforcement of such laws is also sluggish in most developing countries. Consequently, tobacco use is not only high in developing countries an increasing number of adolescents in these countries are picking up the practice. It seems that the WHO Framework Convention on Tobacco Control adopted in 2003 with much fanfare has so far failed to get much attention or strict application in many developing countries.

Although these three risk factors contribute to the vast majority of chronic disease mortality and morbidity in all parts of the world and among all age groups and in men and women alike, in most developing countries there is little concerted efforts in addressing them. For example, the facts that more than 2.6 million people die as a results of being overweight or obese and another 7.1 million as a result of elevated blood pressure seldom make the discourse on health and health care in most developing countries. Similarly, the fact that 1 in 12 people in India or 1 in 11 people in Pakistan or Bangladesh, according some studies, are suffering from diabetes largely remain ignored while planning for healthcare services at either the national or district/sub-district level. It is estimated that in Bangladesh 1 in 10 people, particularly among the poorer segments of the society, suffer from various forms of liver disease due to adulterated food. In a report published recently, WHO estimated that in Bangladesh chronic diseases accounted for 44 per cent of all deaths in 2002. As the prevalence of overweight among adults and adolescents in Bangladesh increases, chronic diseases will also take a greater toll. According to a recent study, by 2010, chronic diseases in Bangladesh 'will be responsible for 59% of deaths compared to 40% in 1990'. A survey conducted by ICDDR,B in two rural settings in Bangladesh in 2002-05 among the elderly (60 years old and above) found a very high prevalence of chronic diseases 73 per cent in one area and 44 per cent in the other.

In other words, chronic diseases are emerging as key health hazards for the people of Bangladesh. And yet our health system rarely takes this into account while planning for service delivery. While a massive information, education and communication drive is needed to make our people aware of the dangers of chronic diseases and how to prevent them, it is sad to note that at the upazila level there is hardly any information or health education programme addressing chronic diseases. It is deplorable that the Millennium Development Goals, set around the turn of the century by the United Nations, failed to explicitly acknowledge and address the emerging challenges of chronic diseases. Perhaps, this failure by the world body made us ignore the threat of chronic diseases. However, the threat is too catastrophic to be ignored anymore. Our health system must be prepared to face the challenges of chronic diseases. As 80 per cent of chronic diseases can be avoided through proper diet, physical exercise and cessation of tobacco use, our health system must focus on prevention through behaviour change. At the same time, a wide spectrum of services must be made available at all levels. Most importantly, health policy makers and planners must fully acknowledge and address the challenges of chronic diseases while developing the new national health policy.

TOWARDS A PARADIGM SHIFT IN DISASTER MANAGEMENT

Indeed, as noted by the Ministry of Food and Disaster Management, we need a paradigm shift in our thinking about disasters... Such a paradigm shift would also require decentralisation of healthcare services and empowerment of local level governments, communities and facilities so that disaster planning and management can take place at the local level.

WE observed another World Health Day on April 7, 2009. This year's World Health Day, as noted on the web page of the World Health Organisation, 'focuses on the safety of health facilities and the readiness of health workers who treat those affected by emergencies. Health centres and staff are critical lifelines for vulnerable people in disasters – treating injuries, preventing illnesses and caring for people's health needs.' In other words, the day is concerned with disaster preparedness of the health system in a comprehensive sense. Disasters could be man-made (riots, conflict, war) or natural (earthquake, flood, cyclones, and the slow process of climate change). Although Bangladesh has been immune from experiencing any large-scale man-made disaster since the war of liberation in 1971, we are prone to natural disasters with almost predictable regularity. Floods and cyclones are our almost yearly rituals often with devastating effects. World Health Day encourages us to reflect on whether our health system is prepared and, if so, to what degree, to face such natural disasters.

Bangladesh, it should be noted with pride, has a comprehensive disaster management programme under the leadership of the Ministry of Food and Disaster Management. Approved by the government in 2003, the programme is meant to provide a 'whole-of-government' approach 'designed to optimise the reduction of long-term risk and to strengthen the operational capabilities for responding to emergencies and disaster situations including actions to improve recovery from these events.' The overall vision of the programme is 'to reduce the vulnerability of the poor to the effects of natural, environmental and human induced hazards to a manageable and acceptable humanitarian level.' With this broad mandate, the food and disaster management ministry has boldly announced that its mission is 'to achieve a paradigm shift in disaster management from conventional response and relief to a more comprehensive risk reduction culture.' This recognition by the ministry of a need for paradigm shift in our disaster management culture is truly commendable. Why do we need a paradigm shift?

Our disaster management is archaic and primarily reactive in nature rather than proactive. Moreover, in assessing the needs of the affected people following a disaster, our focus is primarily on food, clothing and shelter – in that order. Perhaps, this focus on food and shelter has brought the disaster management efforts within the purview of the food ministry. Disasters – whether floods, cyclones or earthquakes – create a wide range of

crises, from immediate physical survival that involves food as well as health care to shelter and to the long-term challenge of rebuilding the shattered habitat, the economy and the ecosystem. Our usual practice is to respond forcefully to the immediate crisis, flooding the affected areas with officials, volunteers and with journalists. Politicians and dignitaries also visit the affected sites and distribute food and other essential items in selected settings largely to publicly demonstrate their concern for, and commitment to, citizens' welfare.

At the same time, our attention span to disasters seems to be utterly short – not more than the so-called media attention to such crisis. We tend to descend in an affected area in large numbers often adding to the pain and sufferings of the already struggling people. Once the media attention fades, much of the relief and rehabilitation work also slows down. It is not unlikely that a visit to the affected areas six months or a year after the disaster would find destroyed houses still standing unattended or hungry families still looking for relief and rehabilitation.

On the other hand, we hardly plan in advance to face a disaster. Even in case of floods that can be predicted with almost total certainty months ahead of time we tend not to prepare ourselves. We can predict whether there will be a flood in a given year; with almost total certainty we can predict its path and the extent of damage it would cause. Scientifically speaking, we know what sort of ecological damage a flood would cause and, consequently, what type of diseases it would bring. Floods inundate ponds, wells and other forms of water reservoirs creating a crisis for potable water. Presence of carcasses and dead bodies could add to this crisis. Following the flood, therefore, the primary task would be to ensure adequate distribution of safe drinking water. This should be followed by cleaning and decontaminating the water reservoirs – ponds and wells – so that the affected people can get back to their usual practice. Diseases to be expected after a flood are also scientifically predictable – mostly waterborne diseases like diarrhoea, cholera and other digestive system-related ailments. Sadly, despite such precise knowledge, neither the health system nor the disaster management system prepares itself for floods or other disasters.

This un-preparedness is reflected in the influx of thousands of diarrhoea afflicted people to the International Centre for Diarrhoeal Disease Research, Bangladesh in the capital Dhaka. The ICDDR,B responds to such influx of diarrhoeal patients with erecting tents on its premises to accommodate them. The ICDDR,B successfully treats thousands of additional children, women and elderly people and deservedly receives laurels from the government and the donor agencies. Who does not like to see the ICDDR,B dedicate itself to the suffering humanity? However, we tend to forget that these tents and the influx of diarrhoeal patients from around Bangladesh to the ICDDR,B is symptomatic of a massive failure of the health system – its failure to prepare for a disaster, be proactive rather than reactive to a natural calamity.

How else can we explain the tremendous loss of life and property – and large-scale destruction of the ecosystem – year after year from floods or cyclones? Can we not get

prepared for floods a year before they are likely to hit us? Why do we allow our schools or healthcare centres in rural areas to get destroyed every time there is a flood or cyclone? We cannot pretend that floods are not a regular natural calamity in Bangladesh. We must also be fully aware that cyclones are also almost regular visitors to impoverished Bangladesh. If so, can we not take precautions against floods and cyclones while designing our houses or schools or health centres? We hardly think about building buildings that would not submerge in floods or could withstand at least medium-force cyclones.

Indeed, as noted by the Ministry of Food and Disaster Management, we need a paradigm shift in our thinking about disasters. While we tend to respond to or confront disasters, it is time to think about planning for a disaster – planning ahead of time so that, on the one hand, we can minimise the loss of lives and property and, on the other, recover from such loss within the shortest possible time. Such a paradigm shift would also require decentralisation of healthcare services and empowerment of local level governments, communities and facilities so that disaster planning and management can take place at the local level. Unfortunately, we have decentralised our health care services, but never thought of devolving power to the local level. In the absence of devolution, local level governments are absolutely dependent on the higher level federal government for all decisions. Local level facilities, therefore, can hardly stock emergency supplies or drugs and mobilise communities for preparedness against an impending flood or cyclone. The recent Bashundhara shopping mall fire, needless to say, nakedly exposed our unpreparedness for such fire in a high-rise building. Subsequently, occupants/managers of most high-rise buildings in the capital tried to organise mock fire drills in their buildings and, to their utter shock, discovered how un-prepared they are! Even the Bangladesh Secretariat, the citadel of power, was not immune from such lack of preparedness. To our horror, we, the citizens of Bangladesh, also discovered that our fire service department does not possess enough equipment, including proper mechanical ladder, to respond to high-rise fire in an appropriate and timely manner.

Hospitals in Bangladesh, especially the public hospitals that cater to needs of the poor, are overcrowded, unhygienic and more often than not devoid of appropriately trained adequate number of human resources for health. From the Dhaka Medical College Hospital to the district hospitals and the upazila health complexes are ill-equipped to handle emergencies because of lack of beds, space, equipments and, above all, trained human resources. Most hospitals have too few physicians, nurses, and medical technologists than they require. In many cases, we have the undue distinction of having 'ghost' doctors – doctors who are there on paper, but not in reality. Most hospitals have outdated x-ray machines and other equipment; they often lack trained technologists to run these high-tech equipments. And yet, on World Health Day, we heard the pledge from the government to introduce digital health care across Bangladesh. We have also been told that the government will introduce – and in some case, increase – user fees across the healthcare system. The user fees will be collected at the local level and will be distributed among many partners – from the central exchequer to the upazila-level healthcare

workers. The differential formula for distributing the user fee is interesting. However, nowhere it said how much new revenue do we expect to raise through such user fees. Also, there is no announcement about the cost of introducing and administering this user fee regime. In other words, what would be the net additional revenue that user fees will generate? Is it worth it? Most importantly, there was no indication about the possible impact of such user fees on equity, on people's access to health care. Will it make it harder for the poor and the disadvantage to access healthcare services? With such a comprehensive analysis of its impact, it is ill-advised to introduce user fees at all levels.

Equity must be the central guiding principle of our health system. On the occasion of World Health Day, it would have been far desirable to hear about how we are going to protect, preserve and further enhance equitable access to our healthcare system for the poor rather than about digital health care or user fees. Perhaps it is time that we commit ourselves to modernizing our moribund national health policy. Let the new health policy guides us to greater equity and freedom – freedom from preventable diseases, death and disability.

NATIONAL HEALTH POLICY: No Scope For A Piecemeal Approach

We need a full-blown national health policy and not a piecemeal approach of coming up with bits and pieces. Let's fashion a national health policy that recognises health as a fundamental human right and ensures accessibility to and availability of basic healthcare services to all irrespective of income, gender, religion, ethnicity, and place of residence.

BEFORE leaving office, the then caretaker government was working on developing a national health policy. Based on the few elements of the health policy that were disclosed in the media, it seemed that the caretaker government was looking for a bigger role for the private sector in our healthcare system. However, the effort was aborted and the unelected government never came out with a health policy. The last fully operational national health policy was introduced in 1988 during the autocratic Ershad regime. Although the Awami League in 2000 promulgated a national health policy with 15 goals and objectives, 10 policy principles and 32 strategies, it was soon sent to the cold storage by the incoming Bangladesh Nationalist Party-led government that ruled the country for a second term (2001-2006). Consequently, it was expected that the newly crowned Awami League government will take immediate steps to update and announce a progressive national health policy. In spite of some loud noises, it seems that the government is not in a mood to design and deliver a comprehensive national health policy soon. On the other hand, some of the recent announcements by the Ministry of Health and Family Welfare seem to indicate that we are in for a piecemeal approach to national health policy receiving bits of it once at a time.

In recent months, the health ministry (and often the health minister) has announced four new programmes/initiatives that amount to elements of a broader national health policy. As soon as the new government assumed power, we heard of 'digital' health. Since creation of a digital Bangladesh by 2021 was one of the pledges made by the Awami League in its election manifesto, the health minister's call for a digital health care is understandable. Electronically connecting different levels of healthcare facilities is a positive initiative. It would be useful if physicians as well as other healthcare providers can exchange patient-related information quickly and with ease across the country. However, the ministry did not make it clear what would be the extent of such digitalisation. On the other hand, any digitalisation would require additional resources, both financial and human. Are we about to get more financial resources for health care?

Bangladesh spends less than three per cent of its gross domestic product on health care which is substantially lower than most developing countries with similar level of socioeconomic development. For example, according to the World Health Report 2005, India and Sri Lanka spend 5.0 and 4.1 per cent of their GDP respectively on health care. Nepal, on the other hand, spends 5.8 per cent of its GDP on health. It must be noted that these three South Asian countries are similar to Bangladesh in terms of their level of economic development measured by GDP per capita. It is interesting to note that between

the year 2000 and 2005 (latest year that reliable data is available) Bangladesh's spending on health as a percentage of its GDP actually declined – from 3.1 per cent in 2000 to 2.8 per cent by 2005 (World Health Report 2005). Pakistan is the only South Asian country that spends less on health (only 2.1 of its GDP in 2005) than Bangladesh. On the other hand, Tanzania (5.1 per cent of GDP), Uganda (7.0 per cent of GDP), and Vietnam (6 per cent of GDP) all spend more money as a percentage of their gross domestic product than Bangladesh. And tiny Maldives and war-torn Cambodia spend 12.4 per cent and 6.4 per cent of their GDP respectively on health. It should be noted that Maldives increased its spending on health from 6.8 per cent of its GDP in 2000 to 12.4 per cent of its GDP by 2005 (World Health Report 2005).

It is more important to look at the distribution of this healthcare expenditure. How much of it is public funding? How much of it comes from the pockets of healthcare consumers? In this case too Bangladesh does not fare well compared with many other developing countries. Out of a total per capita expenditure of about \$12 a year (2005) on health, less than a third (only 29.1 per cent to be exact) is from the public exchequer. In other words, out-of-pocket expenses on health care by individuals and households account for almost 71 per cent of the total. In Sri Lanka, on the other hand, out of the total per capita expenditure of \$61 a year on health, more than 46 per cent is from the government while out-of-pocket expenses account for about 54 per cent of the total (World Health Report 2005). The corresponding figures for Vietnam and Cambodia are exemplary. In Cambodia out-of-pocket expenses account for only about 24 per cent of its total per capita expenditure (\$29) on health per year. In Vietnam, the corresponding figure is only about 26 per cent (out-of-pocket expenses) out of its total expenditure of \$37 on health per capita per year. What is the significance of such large out-of-pocket expense? It is likely that the greater the share of out-of-pocket expenses the greater is the overall inequity in the health system. It can reasonably be concluded that in a poor country like Bangladesh, only a small minority would be able to spend so much money for healthcare services. The poor would either avoid using healthcare services (at least the 'expensive' ones) unless absolutely necessary (often too late to be of much help) or exclusively rely on the public sector.

In this respect, undoubtedly, Bangladesh is better than India or Pakistan. In India and Pakistan out-of-pocket expenses account for more than 81 per cent of the total expenditure on health. As these countries responded to the demands of globalisation and liberalised their economies (especially India), government expenditure in the social sector, including health, started to decline. In India it declined more sharply than in most other developing countries. On the other hand, Sri Lanka continues to enjoy greater public funds for the health sector than out-of-pocket expenses. In Sri Lanka, as noted earlier, out-of-pocket expenses account for only about 54 per cent of the total expenditure on health. So is the case in Tanzania, Kenya, Botswana, and a host of other African countries.

It is easy to understand that without the infusion of more public funds digitalisation of the health system cannot be achieved. So far the health ministry is rather silent on the issue. Perhaps during some of the planned pre-budget discussions we will get more information in this regard. On the other hand, a digital health system will also require appropriately

trained adequate number of human resources to sustain it. More funds will not necessarily guarantee such trained human resources. The bigger question is: Do we have such trained human resource? What will it take to attract such human resources to the health system? Again, the declaration of creating a digital health system is uncomfortably silent on these broader issues.

The second policy declaration was the government's determination to introduce user fees at all levels of the health system. In some cases, the existing user fees are going to be increased. Although the question of 'why' user fees has not been answered clearly and explicitly, the planned distribution of the revenue generated by user fees seems to indicate that the purpose is to generate funds for the healthcare workers – from physicians to nurses to health technicians of various types. Although more details are required to comment with greater confidence, it is apparent that there are some significant unanswered questions. How much money do we expect to generate through the user fees? How much will it cost to generate these funds? Do we have an effective and efficient accounting system to account for all these additional revenues? In other words, what is the net revenue that we are expecting to generate through user fees? It was not clear how much research has been done to clearly identify the net revenue.

In most developing countries that experimented with user fees, the net revenue (new funds generated minus the cost of introducing and maintaining the accounting system) turned out to be too small to be much value for the health system or the public exchequer as a whole. In most cases, user fees did not generate more than 3 to 5 per cent of the total health care costs. On the other hand, user fees created a good many problems including widespread corruption as governments tried to cushion the poor against user fees by introducing exemptions. Exemptions, however defined and implemented, provide an incentive for under-the-table exchange of part of the user fee between the bureaucrat and the consumer in a perfectly 'sensible' economic encounter. For example, for a relatively well-off consumer it makes perfect economic sense to pay Tk 2 of a Tk 5 user fee to get the exemption. It also makes perfect economic sense for the provider to accept the bribe given the minimal risk involved in getting caught for corruption. Since making a provision of exemption for the poor is always a political compulsion for all governments or ruling parties, they seldom fully explore or understand the consequences of such a policy. Corruption always seems to be a collateral damage of user fees.

The user-fee declaration also suggested a complex differential formula to distribute the generated revenue among different levels of the healthcare workers at the upazila health complex. In this formula physicians are earmarked to get a greater share of the additional revenue generated by user fees than the nurses, and the nurses more than the field-level health workers. The philosophy behind this proposed differential distribution of user-fee generated additional revenues seems to be that doctors deserve more income than other healthcare workers. Perhaps the argument is correct – our physicians deserve greater additional income. However, do we have an independent oversight body at the upazila level that would judiciously implement such a differential distribution system with a built-in accountability mechanism? In the context of Bangladesh, is it likely to generate corruption? Does the fact that upazila health complexes are administered by physicians compromise the accountability mechanism? Unfortunately, the user-fee announcement

does not provide much insight into the issue of accountability. Neither does it confront the ethical issue of making physicians responsible for the collection (as administrators of upazila health complexes) as well as the distribution of additional revenues generated by user fees (and entitled to get a greater share of it).

The third recent announcement of the health ministry confirms the government's belated realisation that the physicians need more income. The ministry has proposed to allow the physicians to engage in private practice while on 'official' duty. Will it make the physicians work harder in serving the public interest? Or will it encourage them to divert patients to their private practice? How to keep track of such dual practice? Who decides when a physician is required to work as a public servant or when to work as a private practitioner? Will it encourage them to regard 'expensive' procedures (procedures that could attract more fees, such as caesarean delivery) to be on private time? If so, will it lead to more caesarean delivery, even when they are not clinically necessary, in upazila health complexes? Moreover, diverting patients to private practice (through paid agents and/or intimidation), some argue, is already a widely practised phenomenon. Making private practice on public time 'legal' is likely to further entrench this practice. Legalising private practice on public time, therefore, might lead to greater misuse of public facilities for private gain rather than strengthening the overall health system.

The last of the four announcements was the determination to reactivate the village-based health clinics as the lowest tier of the health system. It is understandable that the AL government would like to reactivate the village health clinics as this was the model primary healthcare system visualised by the Awami League during its first term in office. The question is: Do we have the resources – human, financial, structural and logistics – to make the village health clinics truly functional? On the other hand, it could be argued that we should try to resolve myriad problems faced by the existing health system before starting a new initiative. It is not very logical to reactivate the village-level clinics without first resolving the problems faced by the upazila health complexes including that of scarcity of financial and human resources. Forcefully addressing the critical issue of scarcity of appropriately trained adequate number of human resources for health at all levels of the health system deserves especial attention. It would be a misnomer to initiate the village clinic project without addressing the human resource issue. Perhaps we should devote a full debate on the question of human resources for health in Bangladesh.

In closing, it must be emphasised that we need a full-blown national health policy and not a piecemeal approach of coming up with bits and pieces. Let's fashion a national health policy that recognises health as a fundamental human right and ensures accessibility to and availability of basic healthcare services to all irrespective of income, gender, religion, ethnicity, and place of residence. Introducing user-fees, private practice on public time, or digital health should be an integral part of such a national health policy. Most importantly, the national health policy must be discussed and reviewed by all stakeholders – in both the public and private sectors – before it is adopted by the government. At the same time, recognising health as a precondition as well as a product of socioeconomic development, Bangladesh must make a bold start in introducing and implementing the principle of health public policy – ensuring accountability of all public policy for human health.

CLIMATE CHANGE AND HEALTH: A Neglected Area For Research

Climate change and health: a neglected area for research Bangladesh is faced with diverse health consequences due to climate change. These include resurgence of some communicable diseases and a range of diseases like river blindness, schistosomiasis, cutaneous leishmaniasis, lyme disease, rift valley fever, etc. However, without further research we can hardly understand and get prepared for the health consequences of climate change.

THE average weather patterns – temperature, rainfall, wind – make up the climate. Climate change, a slow process of change in the patterns of temperature, rainfall, etc due to a variety of complex natural factors, occurred many times throughout the evolutionary history of the Earth. These long-term changes in the weather patterns often take millions of years to materialise. Since the Big Bang and the creation of our solar system, it went through a number of radical changes in its environment before the good Earth became hospitable to life and finally to human life. Since then human beings lived a life off exploiting the nature hard enough to earn a living but not hard enough to violently disturb the nature's equilibrium. This balancing act between human beings and the nature continued unabated for much of our existence on earth. It was the Industrial Revolution of the seventeenth/eighteenth century that first occurred in Western Europe and subsequently spread to the rest of the western world that, for the first time, challenged this human-nature relationship based on the principle of maintaining a balance or equilibrium. The Industrial Revolution radically changed the lives and lifestyle of human beings. The Industrial Revolution made possible the emergence of large urban settlements – cities and mega cities – that are completely divorced from production of basic life-support ingredients – food. As life became more complex and rich, human beings started to exploit the nature hard enough to disturb the equilibrium. The process of taking more from the nature than it can sustain continued in an unprecedented rate as rampant consumerism overtook the human civilization at large. While the industrialised west set the standard, the rest of the world soon followed in the same path of 'development' – consuming more and more as the standard of living improved. The climate change that threatens our lives now is the result of this rampant consumerism starting with the Industrial Revolution. It is hardly two hundred and fifty years old and yet threatens the human civilisation at least a large part of it – terribly.

This unbridled consumerism, based on extracting more and more from nature and at the same time adding a variety of harmful chemicals and pollutants in the air, produced global warming an increase in the average temperature of the Earth – resulting in changes in our climate. A warmer Earth would lead to changes in the pattern of rainfall over a large part of the globe. It will cause the sea level to rise in different regions of the world. Changing patterns of rainfall could lead to too much in some areas while drought in other areas. These changes, in turn, are likely to have a wide variety of impacts, yet to be completely understood, on our wildlife, flora and fauna and ultimately on us – the

human species. Obviously the industrialised countries contributed most to this global warming. Lately a number of emerging global economic powers – China, India, Brazil and Turkey – are also contributing to the slow process of global warming. As we all follow the same path of development – industrialisation and increased consumption of goods and services based on an ever-increasing demand on nature – the process of global warming will accelerate unless we take corrective measures on an urgent basis.

It was the World Conference on the Environment – the Earth Summit – of 1992 held in Rio de Janeiro, Brazil that for the first time convincingly argued for immediate actions on arresting global warming and saving the environment. Led by Maurice Strong, a Canadian scientist and social activist, the Earth Summit produced convincing scientific data on the vulnerability of the environment, the greenhouse gas effects and the long-term consequences of global warming on human civilisation. The concept of environmental sustainability of all our development interventions became a buzzword following the Earth Summit. 'Save the environment' became a rallying cry. The Green Movement emerged as a strong multilateral endeavour. Needless to say, the historic pictures of the earth swimming in the vast space captured from the moon and other space flights for the first time in human history demonstrated the vulnerability of the fragile Earth to climate change. These historic pictures helped move public opinion – and the attention of the governments and world leaders – to the environmental cause. Scientific evidence on climate change coupled with the pictures of the fragile Earth in the vastness of the space was too powerful factors to be ignored.

By the end of the 1990s, climate change – more precisely, the warming of the environment and its possible consequences for human civilisation – emerged as one of the most critical challenges faced by the global community. As scientists got into the act of more precisely measuring the trend of climate change and in identifying their impact, world leaders also started debating the means of combating global warming – reducing greenhouse gas emissions. In 1990 the United Nations formed the Intergovernmental Panel on Climate Change. The IPCC produced the United Nations Framework Convention on Climate Change and placed it before the Earth Summit in Rio in 1992. The UNFCCC, adopted at the Rio Summit, called on the industrialised countries to reduce their greenhouse gas emissions to the level of 1990 by the year 2000. Although the industrialised nations did take some actions to implement the UNFCCC recommendations, they had little concrete success primarily because of non-cooperation from the biggest climate change culprit – the United States. The United States government, especially under George W Bush, consistently refused to abide by the UNFCCC. Moreover, President Bush and his administration tried to undermine the scientific basis of the UNFCCC by sponsoring and/or encouraging studies that would produce so-called data 'contradicting' the established knowledge on climate change. Consequently, when the United Nations moved to provide more 'teeth' to the UN Framework Convention on Climate Change and came up with the Kyoto Protocol in 1997 urging member states to take concrete actions in combating climate change, the Bush administration refused to abide by it. Although more than 175 countries signed the Kyoto Protocol, the United States led by Bush remained a non-signatory. With the advent of the Obama administration, things are going to change. An ardent supporter of the

environmental movement, President Obama has pledged his full support to the Kyoto Protocol. It is expected that at the upcoming G-8 conference to be held next week in Italy, President Obama will take the lead in fashioning a concerted G-8 response to the Kyoto Protocol giving new life to the environmental movement.

President Obama's role at this stage is extremely critical. Following the Bali conference of the NFCCC in 2007, member states are engaged in intense negotiations in implementing what is being dubbed as the Bali Action Plan. Under this plan, member states must reach a consensus on four critical issues within the next few years so that the Kyoto Protocol can be fully realised. The four critical issues under deliberations are: mitigation (how to mitigate or reduce/eliminate climate change), adaptation (how countries affected could adapt to climate change), technology development and transfer (how to develop new technologies related to climate change and transfer these technologies to developing countries), and finance (how to finance all these climate change related activities). These negotiations are to culminate in the Copenhagen Conference of the Parties to be held in late 2009 where a consensus shall emerge. Fifteen influential member states – both from developing and developed countries – are involved in this Copenhagen Conference.

The consequences of climate change are being felt by poorer developing countries. Two of the most affected countries are in South Asia – Maldives and Bangladesh. It is likely that as the ice in the Himalayas start to melt due to global warming; Bangladesh will experience more intense flooding in the foreseeable future. Some scientific data seem to suggest that with a rising sea level about 15 to 20 per cent of the landmass along Bangladesh's coastline could be submerged resulting into a massive dislocation of people. The estimated sea level rise is between 1.5 metres to as high as 6 metres by the year 2100. With a 1.5-metre rise in the sea level, Bangladesh could find 22,000 square kilometres of its landmass inundated affecting more than 17 million people. It is important to note that the mega city of Dhaka, with a projected population of more than 20 million by 2025, is only 5 metres above the current sea level. The sea level rise, even if modest, will result into a mass migration of millions in search of higher ground. Loss of lives and livelihoods would have tremendous impact on the economic and social fabric of Bangladesh. Millions of eco-refugees would have significant regional implications for stability and security as people move across borders. In the long run, on the other hand, we are likely to face depleted water in rivers and canals resulting into a scarcity of water with a devastating impact on agriculture. It is encouraging to note that the government of Bangladesh has made some preliminary action plans in responding to the challenges of climate change. In 2004 it established a 'Climate Change Cell' within the Ministry of the Environment. By 2005, a National Adaptation Programme of Action was developed with a number of priority programs including a community-based coastal forestation project that received good funding from the UNFCCC. The government of Bangladesh also established a sizeable climate change fund.

Unfortunately, there is little focus on understanding and addressing the health impact of climate change. The problem lies with the international community too. The United Nations commissioned Intergovernmental Panel on Climate Change, for example,

engaged some 1,600 scientists and 620 reviewers since 1990 to generate scientific evidence on 'human-made climate change, its causes and effects on our physical and biological environment' as Professor Rainer Sauerborn, a German scholar, noted in a recent article. 'In contrast,' Dr Sauerborn writes, 'the health effects of climate change, which, after all, should be the primary driver of mankind's interest in the topic, have attracted only a couple of dozen scientists worldwide.' Consequently, IPCC reports remain poor and fragmentary in terms of pinpointing the health impacts of climate change. Needless to say, Bangladesh is faced with diverse health consequences due to climate change. These include resurgence of some communicable diseases and a range of diseases like river blindness, schistosomiasis, cutaneous leishmaniasis, lyme disease, rift valley fever, etc. However, without further research we can hardly understand and get prepared for the health consequences of climate change. It is important that as Bangladesh prepares for climate change, it should earmark more funds for more, diverse and interdisciplinary research on health consequences of climate change.

Moreover, despite being at the forefront of climate change and its catastrophic impact, the topic remains little emphasized in our universities and research institutions. There is hardly any attempt by either the government or research institutions to comprehensively map the coastal areas that are likely to be most affected by climate change. Which areas are precisely likely to disappear because of global warming? How many people currently live there? How many households will be affected? What will it take to rehabilitate these households? What would be the precise financial loss? How many families or households would require compensation for rebuilding their livelihoods? There is hardly any attempt to measure these dimensions of the impact of climate change in Bangladesh. In other words, we have little preparedness in better understanding and, therefore, responding to, the massive consequences of climate change. This is more so in terms of understanding the health impact of climate change. Needless to say, such lack of knowledge will make us more vulnerable to climate change and at the same time arguing for and receiving compensation for their impact from international or UN agencies. It is time that we urgently respond to this knowledge gap.

THE ROAD RAGE: Road Traffic Accidents and Our Healthcare System

ROAD traffic accidents killing and maiming people are a 'normal' everyday phenomenon in Bangladesh. Newspapers routinely report traffic accidents, mostly in the nation's highways almost each day. How many are killed in our roads and highways each year? Over a recent one-week period, various daily newspapers reported a total of 32 deaths in road accidents throughout Bangladesh. What is the impact of these accidents and fatalities on the families affected? Or their impact on our economy and the healthcare system? Recently, the World Health Organisation published a global report on road traffic accidents, deaths and injuries and their causes across the developed and developing countries. This Global Status Report on Road Safety, according to WHO, 'is the first broad assessment of the status of road safety in 178 countries, using data drawn from a standardised survey conducted in 2008.' The results are truly alarming.

Worldwide almost 1.3 million people are killed on the road every year. Another 20 to 50 million are injured. It is interesting to note that over 90 per cent of these road accident deaths occur in low- and middle-income countries which account for only 48 per cent of the world's registered vehicles. For example, Bangladesh with little more than one million registered vehicles in 2007 reported a total of 4,108 deaths on its roads in the same year. Australia, on the other hand, had more than 14.7 million registered vehicles and reported only 1,616 road traffic fatalities. Likewise, Afghanistan with only 731,607 registered vehicles reported 1,779 road traffic deaths in 2007, while Belgium with a total of more than 6.3 million registered vehicles had only 1,067 traffic deaths. Similarly, Colombia with 4.9 million registered vehicles had 5,409 traffic deaths in 2007. In the same year, with a total of more than 20 million registered vehicles, Canada reported only 2,889 road traffic fatalities. The trend is consistent across regions and continents – poorer countries have higher road accidents and reported deaths and injuries. According to the WHO study, 'low-income and middle-income countries have higher road traffic fatality rates (21.5 and 19.5 per 100,000 population respectively) than high-income countries (10.3 per 100,000 population).' It seems that roads and highways in low-income and middle-income countries are less safe or more dangerous than those in high-income countries. While in recent decades, the study reports, the road fatality rates in high-income countries have either stabilised or declined, in poorer countries they have markedly increased and are rising further. If the present trend continues, road-traffic deaths will increase to 2.4 million a year by 2030 with more than 90 per cent of them in developing countries.

Who are the victims of road traffic accidents? Here too the study revealed some troubling trend. Almost half of those who die or are injured are not in the cars or in the vehicles but are what the study defines as 'vulnerable road users' – pedestrians, cyclists, motorcyclists or users of motorised two-wheelers. Alarming, this proportion is also higher in low- and middle-income countries. For example, while in the high-income countries of the

Americas 65 per cent of road-traffic accident victims are occupants of vehicles, the corresponding figure for low- or middle-income countries is only about 30 per cent. In other words, in poorer countries more than 70 per cent of road traffic accident victims are 'vulnerable road user' and not occupants of the vehicles in question. Why is this so? Margaret Chan, the director general of the World Health Organisation, while releasing the results of the study, noted that over the last few decades much progress has been made in keeping people safe in cars (seat-belt legislation, setting highway speed limits, introduction of automatic air-bags, etc). However, not much attention has been given to the safety of pedestrians, cyclists and motor on the road. 'We must do better if we are to halt or reverse the rise in road traffic injuries, disability and deaths,' the WHO director general aptly noted.

Needless to say, she finds glaring gaps in road safety measures and their enforcement in various countries. For example, helmet laws exist in more than 90 per cent of the countries, only 40 per cent of them have laws that cover both the riders and the passengers. On the other hand, only about 35 per cent of countries have legislations that require helmets to meet certain specified standard. Globally, only 57 per cent of countries have laws that require all occupants of a car to wear seatbelts. In the developing world, only 38 per cent of countries have such seatbelt legislation. The situation is far worse in case of using child seats in cars. While 90 per cent of high-income countries have such legislation, only about 20 per cent of developing countries have any such law. In other words, an overwhelming majority of low-income and middle-income countries ignore child safety issues in cars.

Driving while drunk or under the influence of drug is a major factor for motor vehicle accident. And yet fewer than 50 per cent of the countries use the WHO-recommended blood-alcohol concentration level of 0.05 grams per decilitre as a standard measure for drunk driving. In many countries such standard blood-alcohol concentration level of 0.08 grams per decilitre or more. On the other hand, less than one-third of countries meet the basic criteria for reducing speed in urban areas another important contributory factor to road traffic accidents. Only 15 per cent of countries, according to this pioneering study, have comprehensive laws addressing the major issues related to road safety. Few developing countries have reliable and up-to-date information on traffic deaths and injuries. Dr Etienne Krug, director of the Department of Violence and Injury Prevention and Disability at WHO, highlighted the critical need for accurate and timely statistics in better understanding the state of road safety and in measuring the effects of efforts of further improving it.

It seems that developing countries in general are not only lacking in laws and regulations that could reduce road traffic accidents and fatalities but also negligent in enforcing such laws. For example, while 90 per cent of developed countries have laws that require young children in cars to be restrained with appropriate child restraints, among developing countries only 20 per cent have any such law. Globally, only one-third of countries have a national road safety strategy with specific targets that is endorsed by the national government and that has funding allocated for its implementation. Needless to say, very few low-income countries have such a national road safety strategy backed by public

funding. Sadly, Bangladesh falls into that category. We have a national road safety strategy; we also have some measurable targets. However, there is no funding for the implementation of our national road safety strategy. Moreover, in Bangladesh major new road construction projects are not subjected to any formal audit to determine whether they meet the standard road safety criteria. Nor do we have regular such audits of existing road infrastructure. Moreover, while 53.7 per cent of our road traffic accident victims are pedestrians, we make hardly any effort to reclaim footpaths from the clutches of myriad of vendors and peddlers. More than 400,000 people in Bangladesh are injured in road traffic accidents every year. And yet we do not have any formal, publicly available pre-hospital care system for the injured. Neither do we have any national universal access telephone number that can be used by road traffic accident victims to seek urgent medical assistance.

According to the WHO study, currently road traffic accident is the ninth leading cause of death worldwide. At present, road traffic accidents account for 2.2 per cent of deaths. The study projected that by the year 2030 road traffic accidents will account for 3.6 of deaths globally rising to be the fifth leading cause of death. Moreover, road traffic accident victims both the dead and the injured – are universally young people. Consequently, it is the leading cause of death for people aged 5 to 44. It is this implication for the young that prompted the Bloomberg Philanthropies, the charity arm of the New York mayor Michael Bloomberg, to fund the Global Status Report on Road Safety. In making the study report public, Michael Bloomberg rightly noted 'for the first time we have solid data to hold us accountable and to target our efforts. Road safety must be part of all transport planning efforts, particularly at this moment of focus on infrastructure improvements and road building by many countries around the globe.' As we are planning a wider highway linking the capital city of Dhaka and the port city of Chittagong and of new roads and overpasses for Dhaka, can we expect our planners and policymakers to emphasise and ensure safety for the so-called 'vulnerable road users' – pedestrians, cyclists, motorcyclists and the users of two-wheelers?

On the basis of the 'growing body of scientific evidence on the steps necessary to improve road safety', the study made some poignant recommendations to the governments of the world. First, in planning and building roads governments must take into account the safety needs of all road users. So far, the study observes, the needs of the vulnerable road users have received little attention in many countries. They should receive 'renewed emphasis, particularly when decisions are made about road infrastructure, land-use planning and transport services.' Secondly, the study made urgent plea to governments to 'enact comprehensive laws that require all road users to be protected through enforcement of speed limits that are appropriate to the type and function of the road.' Enforcement of laws, so lacking in most developing countries, has also been urged by the study. It recommends 'the enforcement of comprehensive and clear legislation with appropriate penalties and accompanied by public awareness campaigns' as critical in reducing road traffic fatalities and injuries. The study urged the governments to ensure that national agencies responsible for 'actions for road safety have appropriate allocated financial and other resources to carry on their mandate in an effective manner.' Lastly, the Global Status report urged governments around the world 'to encourage

collaboration between the different sectors involved in collecting and reporting data on road traffic injuries.' This will require close collaboration between the police, transport authorities and the health care system 'as well as increasing human capacity to undertake data collection.'

The World Health Organisation would like to see the just-released Global Status Report on Road Safety as a benchmark against which progress made in subsequent years by developed as well as developing countries can be measured and assessed with some degree of scientific validity. As the report shows, no country can assume that it has done enough in making its roads safer. To achieve significant and sustained progress in improving road safety would require 'close collaboration between relevant leaders and agencies whose policies – directly or indirectly – impact on the safety of those on the road.' It is such collaboration between different national agencies – the transportation ministry, the police and the healthcare system, for example, is most lacking in almost all developing countries, Bangladesh being no exception. In this respect, the study did not hesitate to point out the critical role of the international agencies either. 'The international community', the study notes, 'must also play its part in halting and reversing the current global trend of increasing road traffic deaths, by recognising road traffic injuries as an important health and development problem and by intensifying support for prevention.'

With more than 4,000 road traffic fatalities and almost half a million injuries a year, Bangladesh can hardly afford to ignore this pioneering WHO study and its recommendations. We must realise that road traffic accidents are killing and maiming our younger most productive segments of the population. These fatalities and injuries are devastating families and communities. Our healthcare system, overwhelmed with communicable diseases, maternal, newborn and child health issues and other more urgent priorities, is ill-equipped to effectively respond to the needs of road traffic victims. Traffic accident victims – those who survive often face debilitating injury and paralysis. Apart from the Centre for the Rehabilitation of the Paralysed, our healthcare system has hardly any other credit facility providing specialised services to such road traffic victims. I am not sure whether the health system will soon respond to the needs of such victims. Moreover, our laws regulating road safety are either non-existent or weak and, as the report points out, remain almost universally un-enforced. As the World Health Organisation suggests to make this Global Status Report on Road Safety a baseline to measure progress of countries over the years in promoting and ensuring road safety, are we listening? It would be a tragedy if Bangladesh, given the sorry state of our roads and highways and almost non-existent planning for road safety, ignores this global report.

