

Bangladesh

Towards

**21st
Century**

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HEALTH SCENARIO

Syed Masud Ahmed
A Mushtaque R Chowdhury

Current scenario

Bangladesh is the most densely populated country in the world, having a land mass of 144,000 sq. km. (861 persons/sq. km. in 1997). With a population growth rate of 1.8%, Bangladesh ranks 144th out of 175 countries with an estimated GNP per capita of US\$253 (World Bank, 1996). At least 70 million people live in absolute poverty, and of these, 35 to 50 million form the extreme ultra poverty group¹ (BIDS, 1990; '92). Forty-seven percent of the adult population of Bangladesh is illiterate and two-thirds of them are women; 20% of primary school-age children (6-11 yrs) do not enroll in school at all (ADB, 1997; BBS, 1997a). The life expectancy at birth is still only 59 years; indeed, Bangladesh is one of the few countries in the world in which the life expectancy is lower for females than for males. The infant mortality remains high at 77 per thousand live births (BBS, 1996). Poverty, illiteracy, and gender discrimination combined with violence within and outside home contribute to the adverse effect on women's health. As many as six of every hundred women (28,000 women annually) die from pregnancy related causes (Kamal et al, 1993). Only 25% of pregnant women receive antenatal care, and trained midwives attend only 14% of the births. Only 39% of the district hospitals and 56% of the Thana Health Complexes (THCs) have the potential to offer adequate basic obstetric services. More than one-third of the 3.33 million infants born annually weighs less than 2.5 Kg, the threshold for low birth weight (lbw). Two-thirds of the children under six years of age are either under-weight or stunted and some 17% are moderate-to-severely wasted (BBS, 1997b). Of the approximately 20 million under-five children, an estimated 380,000 die from pneumonia, diarrhoea, measles and neonatal tetanus every year (Abedin, 1997; Baqui et al., 1998). Nationwide, one-third of the deaths in children under five years of age occurs during the first month of life (BBS, 1996; Mostafa, 1996).

The average daily calorie consumption is only 80% of the recommended level (World Bank, 1995) and in 25% of rural households, the average daily consumption is still less than 1,800 calories, the minimum for extreme poverty (World bank, 1998a). Although the use of safe sources for drinking water is almost universal, only 44% of the population uses a sanitary method of excreta disposal (BBS, 1997a).

Medical pluralism

Like most transitional societies, the simultaneous existence of different systems of medicine or medical pluralism is a fact of life in Bangladesh (Ahmed, 1993a). 'Modern' allopathic medicine generally has established itself in these societies not so much by displacing indigenous medicine as by increasing the therapeutic options available to these populations. Kabiraj, Hakim, practitioners of 'folk' medicine, and faith healers of different shades (pir, fakir etc.) fall under the broad umbrella of 'traditional' medicine (see later). Bangladesh has an extensive array of local shops and pharmacies where drugs and other health-related supplies are sold. There are an estimated 85,000 retail outlets nationwide, one for approximately 2,000 persons (POPTECH, 1995; Mookherji et al., 1996). In addition to selling medicines, these retail outlets also provide health service and treatment, though only a fraction by qualified allopathic practitioners. Recent data suggests that approximately half of all health and family planning expenditure made by individuals in Bangladesh were for over-the-counter drugs or for local "unqualified" practitioners (Data International, 1998). By far the single largest group of rural private practitioners is the 'unqualified allopaths' who are the untrained pharmacists, market sellers, and roadside "quacks" with little or no professional training who use allopathic drugs, including antibiotics (Ahmed, 1998). These practitioners rarely follow standard therapies. Rather, treatment tends to be a function of negotiation between patient and provider regarding what the patient or their families can afford. Medicines are usually sold per tablet, capsule or spoon in case of syrup on the basis of what is described by a relative, and seldom involve the direct examination of the patient (Ashraf et al., 1982). They present a formidable barrier in rational prescription of drugs for treating diseases.

¹ defined as less than 1805 kcal consumption per day

Access and utilization of public health facilities

Less than 40% of the population of Bangladesh has access to modern primary health care services beyond immunization and family planning (Abedin, 1997). Utilization of the public health care system has declined from 20% in 1981 to 12% in 1994. The large majority of the health care-seeking population go to the unqualified practitioners of various kinds for treatment that is frequently sub-standard, in-effective or harmful (Begum, 1996). Reasons cited for non-use of public facilities are: inadequate attention given by the physician (28%), non-availability of medicines (26%), distance to the nearest health facility (9%), and factors like long waiting times, absence of doctor, ineffective treatment and the charging of informal and extra fees (24%) (Khan et al., 1988). Even though the 'official' cost of the service is zero, the 'hidden' cost may be substantial and beyond the reach of the poor.

Government expenditures on health and family planning activities have never exceeded 3% of its budget including donor support (GOB, 1998a). Preventive care as part of Primary Health Care (PHC) seems to have even less priority. Two-thirds (66%) of the Ministry Of Health and Family Welfare (MOHFW)'s expenditure is for hospital services, including the THCs. One-quarter (24%) of MOHFW expenditures are for tertiary health care services at the medical college hospitals and at specialised hospitals. On the other hand, the great majority of international financial support is given for PHC including family planning. Thus, MOHFW has a very marginal position in the delivery of PHC services and in 1990-95 devoted no more than 8% of the resources to preventive care (Data International, 1998). Public health facilities are running at only 50% of capacity (IBRD, 1995) and a 1996 survey of THCs found that doctors were working as little as 15% of their designated hours (IBRD, 1996).

Current Government expenditure amounts to about \$3.50 per capita for all health and family planning purpose, while the World Bank estimates that an essential package of basic services for a country like Bangladesh would cost around \$12 (UNICEF, 1997). Of this expenditure, payment and allowances take a greater portion of the spending than health care delivery services expenses. User fees for government services amounted to less than 1% of government health

expenditures. Benefits from public health spending represents only 0.5% of rural household income. However, the incidence of such spending, as proportion of income, is the highest for the poorest decile (2.9%), declining almost secularly to 0.2% in the case of top two deciles. The relative proportion of the public and private health expenditure indicates that public expenditure only fills 15% of the health care demand (Sen, 1997).

State of urban health care services

The urban population of Bangladesh has increased rapidly from around 8% in 1971 to around 20% in 1997, following a growth rate of approximately 6% in the past two decades (MOHFW, 1996). Around 60% of this growth are due to poverty and disaster related migration from the countryside. A major consequence of the surge in urban population is the rapid growth of slums and squatter settlements. It is estimated that there will be about 16 million 'poor' and 9 million 'hard-core poor' in urban Bangladesh by the year 2000¹. About half of the population of Dhaka (amounting to about 4.5 million) can be categorized as living below the poverty line. While the urban poor population is not confined to slums, these do present an aggregation of the poorest section of the urban population and due to overcrowded, unsanitary and substandard dwellings, are thus at high risk of contracting communicable diseases.

The health and family planning status of the slum population is worse than in the rural areas (Perry H et al., 1996; URC, 1996). The IMR is 138 per thousand live births in Dhaka slums compared to national urban and rural estimates of 67 and 89 per thousand live births respectively. The mortality rate of under-five children in the poorest slum households is three times that of better-off urban households (Perry et al., 1997). The nutritional status of children in urban slum households is even worse than that of children in rural areas with a similar socioeconomic background (HKI, 1997; BBS, 1998). Again, the contraceptive prevalence rate (CPR) for modern methods in the slums is only 38-40 percent compared to 51 percent in the non-slum urban area (Arifeen and Mukharjee, 1995; GOB and ADB, 1998).

¹ The World Bank has identified two groups: the 'poor' who earn less than Taka 2600 per month for the average family of six persons, and the 'hard-core' who earn less than Taka 1724 per month (Tawfik Y et al., 1996)

In retrospect: evolution of the health services

Providing health care is the constitutional obligation of the Government: "...it shall be the responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens- a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care..." Bangladesh inherited a poor state of health and health services at independence which was the product of decades of colonialism, conflict, and neglect. With 72 million people, Bangladesh was already a densely populated country with low agricultural productivity and an annual food deficit of staggering proportions. Before independence, only one in five adults could read and write, most of whom were men. At 47 years, life expectancy was one of the lowest. More than half of all rural families and three quarters of those in cities and towns suffered from severe nutrition deficiency. At around 150 per 1,000 live births, Bangladesh had one of the highest child mortality rates in the world (GOB, 1998b).

In order to improve the health of the population, various programmes were undertaken in the country in the past decades. One of the major programmes was the development of physical infrastructures like 31-bed Thana Health Complexes (THCs) and the Union Health and Family Welfare Centres (UHFWCs) as grassroots units for delivering PHC services at the doorsteps of the rural people. These centres have been built with the assistance of a donor consortium led by the World Bank and ultimately, all 4,770 unions will be covered. The network of institutional facilities starts from the UHFWCs at the union level with THCs as the first referral centre. In each union, there are eight sites for outreach services, called satellite clinics (SCs). The Family Welfare Visitors (FWVs) conduct these SCs once every month. Family Welfare Assistants (FWAs) motivate clients and refer them to this clinic for family planning services and other services that cannot be served at home. Beside PHC and FP services at the UHFWCs, specialised services in the field of medicine, surgery, gynae, obstetrics, paediatrics and anaesthesia and dentistry are provided at each of the 374 THCs. Supply of essential drugs and vaccines has further been improved and cold chain instituted in each THC to maintain the quality and effectiveness

of drugs and vaccines. Currently, there are 3,200 operational UHFWCs of which 1,525 are staffed by an MBBS doctor. The other staff are: Medical Assistant (where there is no doctor), Family Welfare Visitor, occasionally a pharmacist and other ancillary staff. The number of hospital beds has increased significantly over the years. Currently, there are about 34,786 hospital beds giving a bed-population ratio of approximately 1:3,450 (GOB, 1998b).

From 1974 onwards, the MOHFW has had a bifurcated organisational structure from the top down to the grassroots level, with one cadre of workers in family planning activities and another cadre in health activities. Developed at the insistence of the donors for aggressively pursuing the FP activities, it led to duplication of management and service delivery staff, inefficiencies and difficulties of coordination at all levels. Also, current management systems provide few incentives to improve the quality of care and respond to the client's needs. In a study done by BRAC on the two wings of MOHFW in one thana in 1988, a dismal picture emerged (Chowdhury, 1990). The study found the large number of field staff to be spending less than half of their scheduled working time on the job. Many of the assigned duties were not done, or done only partially. A sense of mutual suspicion and mistrust seemed to exist between the workers of the health and family planning wings, which affected their performance. The findings from the study played an important role in reviewing and improving the activities of the two wings of MOHFW. Currently, attempts are being made to integrate these two services and improve management for efficient and cost-effective delivery of an essential package of health care services at the grassroots (see later).

'Indigenous' or 'traditional' medicine

Despite increasing utilization of 'modern' (allopathic) health care services in Bangladesh with consequent reduction in mortality and morbidity, 'traditional' medical systems still persist and exert a significant influence by competing with, and sometimes delaying the use of, these services. Over the last two decades, rapid population growth, the current state of public health and consequently the need for medical staff (unfulfilled by the "western" trained medical and

Progress over the years: a brief sketch

In its short history, the country has faced a daunting challenge of improving the health of its people courageously and made remarkable progress. Impressive gains have been made in reducing mortality. The infant mortality dropped from a level above 100 in late 1980s to just around 70 by 1996. Similarly, under-five mortality has decreased by almost 30% during this period to around 110 deaths per 1,000 live births. This coincided with a higher rate of immunization coverage through the EPI (launched by the GOB and its development partners) which rose from 2% in 1985 to 67% in 1997 among children 12-23 months of age and from less than 2% to 86% in women with a child under one year of age who obtained at least two tetanus toxoid immunizations (WHO, 1995; EPI, 1998). In 1996-97 an estimated 48% of children with diarrhoea were treated with pre-packed oral rehydration salts, and a further 28% treated with a homemade solution of sugar, salt and water, called 'labon-gur' solution (LGS) in Bangla. BRAC played a very important role in popularising the LGS in Bangladesh. Over a ten-year period from July 1980 to November 1990, 12 million mothers were taught to prepare and administer LGS by the Oral Therapy Extension Programme (OTEP) of BRAC (Chowdhury and Cash, 1996). Supplementation of Vitamin A is now given to all children under 12 months of age at the time of routine immunization. Currently, more than 80% of children one to five years of age receive vitamin A capsules every six months and given the known mortality reducing effects of vitamin A in undernourished children with vitamin A deficiency, an estimated 125,000 lives are being saved annually through this programme in addition to reduction in the prevalence of night blindness. Due to this dramatic improvement in child survival, parents can now afford to reduce the number of children they have. This has also contributed in motivating the parents to limit the size of their family.

The most spectacular progress has been made in the field of family planning, reproductive health care and child health services. Bangladesh is the only country among the poorest 20 countries in the world where sustained fertility reduction has taken place over the past 15 years (World Bank, 1998b). Between 1972 and 1996, the 'contraceptive prevalence rate' rose from 4% to 49%, bringing down the 'fertility rate' from 6.3 to 3.3 children per woman. These results were achieved

by the family planning programmes launched aggressively from mid-seventies with emphasis on the provision of a highly personalized community based services supported by information, education and communication, an effective FP/MCH logistics system, vibrant networks of NGOs providing services, rigorous operations research and an effective social marketing.

The role of micro-credit based development programme in empowering poor rural women and raising contraceptive use has been well-documented (Pitt et al., 1995; Schuler and Hashemi, 1994). Since independence, NGOs began to play an ever-increasing role in the field of rural development, poverty alleviation and disaster management in Bangladesh, especially during the last one and half decades. Currently, about 80% of the Thanas¹ have been brought under NGO programmes (ADAB, 1996). They have been specially effective in the provision of selected social services like health, education, credit-based income generating opportunities for poor women, and service delivery in family planning. More girls are now achieving primary education and more women are working outside the home to earn an income. Exposing women to new knowledge influences their reproductive outcome by reducing desired family size (Le Vine et al., 1991). Work outside home exposes women to new ideas, better access to family planning services and informed choice resulting in higher contraceptive use (Mahmud and Johnstone, 1994). Thus, the works of NGOs have contributed substantially in the field of fertility transition in Bangladesh.

Morbidity burden of the rural society has also declined substantially in the recent years. Point prevalence² of acute illness declined from 16.2% in 1984 to 4.3% in 1995 (BIDS, 1996). However, the major diseases are still the infections and parasitic ones while other gastrointestinal problems like acidity, ulcer etc. too are common cause of illness in rural areas. With respect to health professionals, the current doctor-population ratio is 1:4,870 and the nurse-population ratio is 1:10,714 (the doctor-nurse ratio is 2:1, totally reversed from western standard).

¹ the lowest administrative unit in Bangladesh

² defined as total number of persons with acute illness at any point in time

The National Drug Policy: a landmark

The National Drug Policy adopted by Bangladesh in 1982 was one of the firsts among developing countries that promoted the use of essential drugs and restricted the use of drugs with no scientifically proven efficacy. It limited the list of approved drugs to 150 essential drugs, restricted the manufacture and sale of most drugs to national firms and thus prohibited exorbitant profits (Chowdhury, 1996). Over the past 15 years, this policy has undergone some modifications as a result of pressure from interested quarters, the major of which was the de-regulation of the price of non-essential drugs. However, the price of essential drugs is still the lowest in Bangladesh among the countries of the region.

Health-poverty interface: a new dimension for development

Sickness through 'income erosion' is a major contributing factor to the process of impoverishment in rural Bangladesh. Acute vulnerability of the poor households to sudden and unanticipated health related shocks lead not only to the loss of income and employment (equivalent to around 10% of the ultra-poor's income), but also to increased indebtedness associated with the raising of coping costs. Health hazard-related risk events explain, on average, 16% of causes of deterioration along the poverty spiral experienced by households during the 1990-94 period. For non-poor households who slipped subsequently into 'hard core'¹ poverty, the share of health related causes are as high as 21%. (Sen, 1997). Access to high impact (essentially preventive) health services significantly reduces vulnerability of the poor households to illness-induced income erosion and expenditure crises. Thus, reductions in fertility and improved health are important for poverty alleviation as well.

NGOs: another key player in the health scenario

The dynamic NGO sector existing in Bangladesh has carved an important niche for itself in the provision of health and family planning services at the grassroots level. This has been possible due to two factors:

¹ The terms 'ultra-poor' and 'hard-core poor' have been used interchangeably to describe the bottom 10-15% in the income scale

delivery of relatively high quality services at a reasonable cost, and innovative ways to involve local community to change its own health in a sustainable manner. Many NGOs have close relationships with the communities they serve, and are therefore, in a better position to identify and reach vulnerable individuals and groups than government institutions. These NGOs range from large international organizations (e.g., CARE, Save the Children and World Vision) to large national ones like BRAC, Ganashasthya Kendro, Grameen Health Programme, FPAB etc., to hundreds of smaller local NGOs. Currently, around 4,000 NGOs are working in the health, nutrition and population sector in Bangladesh. The NGOs, due to its flexible, result oriented management style, are able to experiment with innovative ways to deal with the health and population problems of Bangladesh compared to the highly bureaucratic government structure. The Bangladesh Population and Health Consortium NGO Project funds 47 small-to medium size NGOs for provision of MCH-FP services to the poorest of the poor in the harder-to-reach areas. These smaller NGOs currently serve around 1.65 million people in 67 thanas throughout the country. These NGOs have strong outreach services and community participation, and strong integration of the family planning and MCH services (BPHC NGO Project, 1997).

Partnership between NGOs and the Government

There has been marked progress over the past decade in supportive and complementary collaboration between the MOHFW and the NGOs in delivering health and family planning services at the grassroots level. Experiences gained from BRAC health programmes (BRAC, 1995), the UNICEF Combined Service Delivery Project (Talukder, 1996), the ICDDR,B Matlab MCH-FP Project (ICDDR,B, 1997), the GTZ Integrated Community Family Health Development Programme (GTZ, 1996), the Thana Functional Improvement Project (TFIPP, 1997), the WHO PHC Intensification Project (DGHS, 1993), and the World Vision health programmes (World Vision, 1996) indicate that government Health Assistants (health cadre) and Family Welfare Assistants (FP cadre) can work well together at the local level if external facilitation from the NGOs in the form of training, management, coordination, and supervision and monitoring, is present. Evidence suggests that when

these service providers can work in partnership with local communities and the NGOs, the effectiveness of the services is greatly improved. The GO/NGO collaboration has particularly been very successful in the areas of family planning and childhood immunization, and control of tuberculosis and leprosy. Experiences with these programmes show that the GO/NGO partnership works very well only when the government is fully committed and genuinely wants NGO cooperation. Also, much can be achieved by relying on how people understand their health problems and how they want to solve it with the limited resources available. The new Health and Population Sector Programme (HPSP 1998-2003) of the government envisions a strong role for the NGOs. NGOs will be able to bid on government-funded activities in the health and population sector and mechanisms for contracting out government activities to the NGOs will be developed. It calls for providing assistance to government in the formulation and implementation of a Bill of Rights for clients in hospitals and clinics and in making the current Code of Conduct for medical practitioners widely known among clients (MOHFW, 1998).

Challenges ahead

Bangladesh continues to face a number of significant challenges in the health sector despite some progress since independence. Even after considerable decline in IMR and MMR, they continue to be unacceptably high compared to many other developing countries. The quality of life of the general population is still very low. Low calorie intake continues to result in malnutrition in a large proportion of women and children. Preventable communicable and poverty-related diseases still dominate top 10 causes of morbidity and 65% of all morbidity causes in 1996 were caused by these. Resurgence of malaria, kala-zar and other re-emerging diseases as well as emerging diseases like HIV/AIDS, substance abuse etc. are increasing the disease burden of the population. Environmental degradation due to air, water and industrial pollution, deteriorating living conditions in the urban slums, increased concentration of arsenic in subsoil water reported recently in some areas of the country etc. poses significant adverse impact on public health (GOB, 1998b).

Towards the new millenium: facing the challenges

At the turn of the millenium, the GOB, donors, and private sector have recognised that Bangladesh's health and population problems face new demographic and programme realities. Till date, donors have underwritten lion's share of the government's expenditure for health and population for more than two decades which currently accounts for roughly 35% of the ministry's budgeted expenditure (Buse and Gwin, 1998). In the coming days, the proportion of health sector expenses that will be met by external donor support will, at best, not likely to increase beyond its current level. It is projected that total available financial resources will be insufficient to keep pace with the health and family planning needs of the rapidly growing population. To achieve the demographic goals, the programmes must become significantly more cost-effective by delivering a package of basic health and family planning services in an integrated and quality manner. Customer survey and other research information confirms that the people have a strong desire for integrated family planning, reproductive health and other essential health services that are both accessible and of high quality (USAID, 1995). Also, the private sector is going to play an increasingly important role in the health and family planning sectors in the future. Thus, the health and family planning programmes are undergoing a radical overhauling to face the next millenium in an effective and efficient way. These are briefly described below.

Health and Population Sector Programme, HPSP (1998-2003)

Since 1975, a World Bank led consortium of development agencies has provided financial and technical assistance to the Government for the implementation of successive health projects. The First Population Project (1975-80) provided support for re-establishing an infrastructure for family planning service delivery. The Second Population and Family Health Project (1980-86) provided funds for further development of the national family planning programmes. The Third Population and Family Welfare Project (1986-91) began to provide some support for the reduction of infant mortality along with support for FP services. The Fourth Population and Health project (1992-98) provided further support for MCH and disease control activities along with FP services (World Bank, 1998b).

With the experiences gained from past health projects, the MOHFW has reformed its policies and approach to health by restructuring and integrating its previously divided sectors, health and family planning - maternal-child health. The reformed MOHFW presents 'HPSP 1998-2003' with the purpose to "achieve client-centred provision and client utilisation of an Essential Service Package, plus selected services" (MOHFW, 1998). The Essential Service Package (ESP) includes : prioritized reproductive and child health services, communicable disease control and limited curative care. In addition, a new component Behavioural Change Communication (BCC) has been initiated to empower people to demand services and expect quality of life and health care. Funded by the World Bank and a consortium of donors beside GOB and multilateral development partners (UNDP, UNICEF, UNFPA, WHO and UNAIDS), this large internationally financed health and population project is undertaken to reduce infant and maternal mortality and morbidity, improvements in nutritional status and reductions in fertility so that replacement-level fertility will be reached by the year 2005. To achieve these targets over the next five to seven years, the government will pursue at least five strategies: 1) design and implement the ESP; 2) reorganize public sector service provision; 3) improve financial sustainability; 4) build a greater role for the private sector and NGOs; and 5) review, revise and update the National Drug Policy, particularly for the purpose of increasing the availability and affordability of essential drugs and promoting the rational use of drugs. It calls for addressing the issues of gender in human resource development activities of the MOHFW, enhancing opportunities for women at the policy and planning level, improve working conditions and guarantee career structures for women. Also, attention is given to raise awareness of the staff on gender issues while interacting with clients and colleagues. Efforts will be undertaken during this project to strengthen the private sector regulatory framework. The implementation of this programme will involve the utilization of around US \$ 2.9 billion (with some US \$ 1 billion in external donor support).

National Integrated Population and Health Programme, NIPHP (1997-2004)

Between 1987 and 1997, USAID supported national Family Planning and Health Services Project (FPHSP) provided support to 115 NGOs

working throughout the country to provide family planning services through field workers who visited the homes of married couples of reproductive age every two months. Based upon the external evaluation of FPHSP, a USAID-funded strategic options/sector assessment, and a 1995 USAID appraisal of FP and health customers, USAID and GOB launched in July 1997, the NIPHP partnership between USAID, the GOB and its MOHFW, along with two service delivery partners, RSDP (Rural Service Delivery Partnership) and the USDP (Urban Service Delivery Partnership), and five other supporting entities. The primary purpose of the NIPHP is "to enhance the quality of life of poor and underprivileged members of the society by helping to reduce fertility and improve family health" (USAID, 1997). The partners currently operate through 45 NGOs within Bangladesh's national population and health programme and cover approximately 25 million people. It represents a radical new approach to health and population service delivery: while the previous USAID-supported project emphasized community-based distribution of family planning materials by field workers at the door-steps, the current programme emphasizes the delivery of a high quality high impact ESP (lesser version)¹ in a clinic-based one-stop setting, targeted to the whole family. The services are provided through both static clinics and satellite clinics. These clinics are supposed to be readily accessible to the poorer and socially disadvantaged segments of the population, particularly in the under-served and poor-performing areas of the country. The NIPHP has a much stronger focus on child survival activities and on maternal and reproductive health activities than did the earlier FPHSP. The RSDP supports 20 NGOs working in 171 of the 460 thanas of rural Bangladesh. There are 159 Static Clinics and 595 Satellite Clinics functioning in these locations. The USDP supports 25 NGOs in the four City Corporations of Bangladesh and in 67 other smaller municipalities. There are now a total of 117 Static Clinics and 244 Satellite Clinics functioning in these locations.

¹ aspects of the ESP which receive low levels of support through NIPHP are: "safe delivery", care of post-abortion complications, control of communicable diseases and curative care of common diseases

Bangladesh Integrated Nutrition Project, BINP (1996-2001)

Funded by the GOB/World Bank and with technical assistance from the UNICEF, this community-based nutrition project, partnered by GOB and NGOs, was launched in 40 thanas with three components: the core component of community-based nutrition activities, national-level nutrition activities and inter-sectoral nutrition programme (BRAC, 1997b). In the core component, a Community Nutrition Centre (CNC) staffed by a local woman Community Nutrition Promoter (CNP) is established at a site donated by the local community. In this site, children under two years undergo monthly weighing and pregnant women undergo height and weight measurement during their pregnancy. The severely malnourished women and children receive daily pre-cooked snacks and nutrition counseling. On a quarterly basis, a community growth chart is prepared which describes the nutritional status of all the children in a way that can be readily understood by the community members. The project is six years in length and will reach almost 10% of the population located in 40 thanas. BRAC is playing a major role, both as implementor and trainer/supervisor, in the initial phase of the programme. Analysis of project experience showed that a community-based nutrition programme like this can make rapid and significant impact on severe malnutrition. These encouraging findings paved the way for scaling up BINP and develop a 10 year national nutrition project for the entire population with WB financing and UNICEF technical assistance. The project will be managed by the MOHFW as part of the HPSP through partnership with NGOs, along with the involvement of relevant government ministries.

New Initiatives in the Urban sector

In urban areas, MOHFW has only a limited preventive and promotive health care infrastructure. A mixture of private, NGO and government hospital facilities providing mainly curative services complements this. The responsibility for providing public health services, including immunization, in urban areas lies with City Corporations and municipal authorities under the jurisdiction of the Ministry of Local Government, Rural Development and Cooperatives (MLGRDC). The MLGRDC does not have in its structure a health cell to plan, implement and monitor the health services for urban Bangladesh. The role of the municipal

and health managers is often co-ordination of the many service providers, namely, NGOs, private practitioners, traditional healers, municipal health facilities and MOHFW facilities (hospital based secondary and tertiary care). Some new initiatives have been taken in the urban health sector to improve the current state of urban health, with particular focus on the slum and non-slum poor.

Urban Family Health Partnership under NIPHP

Currently, in the urban area, the UFHP¹ under the NIPHP delivers clinic based full range of ESP through 24 NGOs (117 static clinics, 35 in City corporations and 65 in other municipalities; 2 satellite teams per static clinic). There are six areas where UFHP plans to develop direct working relationship with GOB: liaison and networking with GOB representatives at municipal level, sharing lessons learned on quality, improving municipal coordination on family health matters, helping to launch an urban TB project, franchising ICDDR,B's cholera hospital to GOB sites in Dhaka, launching 'sustainability contracting' in urban slums.

Urban Immunization by BASICS (Basic Support for Institutionalising Child Survival, one of the partners of NIPHP)

The urban EPI project, initiated in 1988 with USAID funding to reduce the gap in national and urban EPI coverage in the late 1980s, was brought under the global USAID health project BASICS in 1994. Although overall childhood immunization coverage in the cities of Bangladesh is now higher than the national coverage, several surveys have found that the coverage of children living in urban slums lags behind that of non-slum children, creating gaps of un-immunized population. In 1996, BASICS developed a coordinated strategy to meet the special needs of immunization for the urban poor, living in slum areas focussing on two specific objectives (Tawfik et al., 1998):

- to assist GOB to develop and implement strategies to extend supply and demand for EPI in selected municipalities, with special emphasis on the urban poor

¹ participants of UFHP are: John Snow Institute, Family Planning Services and Training Centre, Concerned Women for Family Planning and Behaviour Change Communication Programme (led by JSI)

- to assist GOB to achieve and sustain 85% EPI coverage with emphasis on the urban poor

Urban Primary Health Care Project (1998-2002)

There has not been any major government or private programme specifically targeted at the primary health care needs of the urban poor, especially those living in the urban slums. To cater to their needs, a five-year, US\$ 60 million Urban PHC Project was launched through the MLGRDC in four City Corporations of Bangladesh (Dhaka, Chittagong, Khulna and Rajshahi), targeting 9.5 million urban poor, representing 41% of Bangladesh's urban population (ADB, 1998; GOB and ADB, 1998). The project's goals are: reduce morbidity and mortality especially among the women and children, strengthen the capacity of the local governments to manage, finance, plan, evaluate and coordinate primary health care services. The project will construct 190 new PHC centres near slums and other densely populated areas and provide services on immunization, micronutrient support (e.g., Vitamin A), FP services, antenatal, obstetrical and postnatal care, management of diarrhoea and pneumonia in children, and TB and RTIs in adults, first-aid and psychological support for women who have been victims of violence.

Attempts to integrate 'traditional' medicine into the public health system

Currently, no measures have been undertaken to use the vast army of traditional practitioners in the public health care system. In general, the 'traditional' systems operate outside the Government health care system and are self-financing, dependent upon the financial capability of the patient. Traditional medical practitioners should be taken into account when planning PHC programmes, if for no other reason than because it is used by a significant number of people throughout the country either as the only health resource available or a substitute for, or a complement to, allopathic health care services. Practitioners now working in traditional sectors should be integrated into the official medical sector, as an inexpensive means of expanding the availability of efficacious health care services. This will lead to the development of a new culture of 'integrated' medicine by accommodating traditional

Although Bangladesh has a formidable public sector health and family planning infrastructure, it is under-utilized, inadequately managed and of poor quality. The last two and half decades have shown that a 'growth promoting' approach to development on its own will not result in sustainable health improvement for the majority of the population. A new paradigm of interventions for creating health environments for prevention and care provide a more efficient and sustainable way to deliver health services. A change in favour of the private sector is needed to play an active role in health prevention and treatment and improve their access to essential health services and quality health care for the next millennium.

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- * defined as less than 1805 kcal consumption per capita per day
- * The World Bank has identified two groups: the 'poor' who earn less than Taka 2600 per month for the average family of six persons, and the 'hard-core poor' who earn less than Taka 1724 per month (Tawfik Y et al., 1996)
- * the lowest administrative unit in Bangladesh
- * defined as total number of persons with acute illness at any point in time
- * The terms 'ultra-poor' and 'hard-core poor' have been used interchangeably to describe the bottom 10-15% in the income scale
- * poor women's group (an average of 35 members per VO) organized by BRAC through which all development inputs including credit are delivered
- * aspects of the ESP which receive low levels of support through NIPHP are: "safe delivery", care of post-abortion complications, control of communicable diseases and curative care of common diseases
- * Participants of UFHP are: John Snow Institute, Family Planning Services and Training Centre, Concerned Women for Family Planning and Behaviour Change Communication Programme (led by JSI)
- * The full range of ESP components:
 - Child Health
 - Immunization for common childhood diseases
 - Prevention and control of ARI, Diarrhoea, Measles, Malaria, Malnutrition; VAC, Iodine supplementation; integrated management of childhood illnesses
 - Reproductive Health
 - ANC, Delivery including EOC, PNC
 - MR and post-abortion complication care
 - Clinical and non-clinical contraception and management of side-effects/complications
 - Adolescent health
 - Communicable disease control
 - TB
 - RTIs/STDs
 - HIV/AIDS
 - Malaria
 - Leprosy
 - Kala-azar
 - Filaria
 - Intestinal worms
 - Limited curative care
 - Treatment of common ailments
 - First-aid treatment
 - School Health Services
 - Behaviour Change Communication