

Health Governance in Bangladesh: An Assessment of the Millennium Development Goals

**A Dissertation
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MAGD, Batch III**

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**INSTITUTE OF GOVERNANCE STUDIES
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October, 2009**



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Statement of the Candidate

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The main objective of this thesis is to appraise the performance of Bangladesh towards achieving health-related MDGs and fulfilling the overall health mission, then put forward some logical solutions to the problems that might impede this mission. To say very frankly, this thesis paper is an outcome of the ample supports and co-operations from different corners. At first, I would like to pay my heart-felt gratitude to my honorable and revered supervisor, Professor M. Emdadul Haq, PhD without whose valuable guidance and directions it would have been impossible for me to gain insight into the study and complete this paper. In fact, his relentless inspirations and personal care for me has made this thesis work possible. My indebtedness to him is just inexpressible in words.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
BDHS	Bangladesh Demographic and Health Survey
BINP	Bangladesh Integrated Nutrition Project
BMA	Bangladesh Medical Association
BNHA	Bangladesh National Health Account
CMR	Child Mortality Rate
CBR	Crude Birth Rate
CDR	Crude Death Rate
DOTS	Directly Observed Treatment Short Course
DMCH	Dhaka Medical College Hospital
ENT	Ear, Nose and Throat
EPI	Expanded Program for Immunization
FWC	Family Welfare Center
FY	Financial Year
GOB	Government of Bangladesh
HDI	Human Development Index
HFA	Health for All
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Virus
HNPSP	Health, Nutrition and Population Sector Program
HRD	Human Resources Development
IMF	International Monetary Fund

LDC	Least Developed Country
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MHS	Maternal Health Services
MMR	Maternal Mortally Ratio
MoHFW	Ministry of Health and Family Welfare
MO	Medical Officer
MOMCH	Medical Officer Maternal and Child Health
NDP	National Drug Policy
NGO	Non-Governmental Organization
NHP	National Health Policy
NNP	National Nutrition Program
NSAPR	National Strategy for Accelerated Poverty Reduction
ORS	Oral Rehydration Saline
PHC	Primary Health Care
RMO	Residential Medical Officer
RMP	Rural Medical Practitioner
TB	Tuberculosis
UFPO	Upazila Family Planning Officer
UHFPO	Upazila Health and Family Planning Officer
UHFWC	Upazila Health and Family Welfare Centre
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
U5	Under five
WHO	World Health Organization

Abstract

Bangladesh is one of the least health access countries of the world. After thirty eight years of independence it could not yet achieve the desired development in health arena; as still around forty percent of the population is living below the poverty line. Though some improvements have taken place in health indices, overall health condition of the population is far from satisfactory; especially women and children have been victims of various health hazards. Child and maternal mortality rate are quite high. Along with the constitutional obligation for providing medical care, Bangladesh was committed to ensure primary health care (PHC) to its citizens by the year 2000 as per *Alma Ata Declaration 1978*. It has already failed to keep up this vow. In the mean time, the era of new global challenges has commenced with the introduction of eight new challenges for the global community including Bangladesh. Amongst these eight goals which are to be achieved by 2015 three are directly health-related, namely as reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

In fact, the health-related challenges are never-ending. New problems and hazards are keeping on emerging from time to time. Health governance is a crucial factor in fulfilling those challenges. In this arena, the government is the protagonist followed by private sector run by local entrepreneurs, NGOs and international organizations. In fact, experience shows that health governance is a complicated one and fulfilling the health related challenges of this sizable population is not possible for the government alone. So far, in the case of MDGs nine years have already elapsed and available time ahead is only six years. It is now necessary to analyze the performance of Bangladesh towards attaining the health-related MDGs and fulfilling the overall Mission of Health, detect if there is any loophole in the goals and what the inherent problems are and finally find out requirements for achieving the said mission, so as to help proper policy-formulation for this purpose.

Chapter 1

Orientation to the Thesis

1.1 Prelude

'Heath is wealth'- is a very old and popular saying, and it becomes more true when health is well-maintained. Health is related to life and there is nothing which is more precious than life. It can be well expressed by an Arabian proverb which says 'He who has health has hope and he who has hope has everything'. Good health is the source of all energy, not only physical, but mental as well. Health is a gift from the Almighty Allah as Prophet Mohammad (PBUH) clearly said that 'There are two blessings that many people are about to lose: health and free time' (*Sahih Al Bukhari*). Furthermore, the Prophet had always encouraged Muslims to work, to be energetic and to start their day early; all of which requires a healthy body. The importance of health has been revealed in other religious scriptures as well. Lord Buddha said 'Health is the greatest gift, contentment the greatest wealth, faithfulness the best relationship'.

WHO defined health as a state of complete physical, mental and social well being and merely not an absence of disease or infirmity (Wikipedia, 2009a). Sound health is also a prerequisite of sound thinking and actions. However, health depends on a number of things namely as, nutritious food, health care, sound environment. They again depend on many other things like economic condition of people, food security, health care facilities, proper policy and legal framework and so on. In a nutshell, it can be said that health condition of the population greatly depends on how the health-related things are governed, that is, health governance. As per the World Bank's definition 'Governance is the exercise of political authority and the use of institutional resources to manage society's problems and affairs' (Wikipedia, 2009b).

In view of the above discussion health governance can be defined as the exercise of political authority and the use of institutional resources to manage health-related affairs and problems. It follows that good and sound health all along the life of human being is not depending on just on his or her own will and ability to maintain, a number of other external factors are also there to affect public health condition. There is no doubt that healthy population would bring in momentum in the developmental process of the country, as good health is the basis of desired level of functioning by human beings.

1.2 Background

Constitutionally the Government of Bangladesh has the responsibility to ensure provision of basic necessities of life including medical care to its citizens. Nevertheless, the state could not ensure primary health care facilities for all of its citizens as yet. Health is universally regarded as a cornerstone of human development and also a fundamental right of people. In deed, development in any sector is not possible without healthy population and workforce. On the global scale, provision of primary health care was also agreed upon by the nations in Alma Ata Declaration of the International Conference on Primary Health Care 1978 held in Alma Ata of the former Soviet Union. In the conference the countries vowed to ensure primary health care by the year 2000.

The primary health care approach has since then been accepted by members countries of WHO as the key to achieving the goal of 'Health for All' (HFA). The above two obligations pose the fundamental challenge for the Government of Bangladesh and new challenges also have been adding to older ones. At the United Nations Millennium Summit in 2000, together with other countries, Bangladesh renewed its commitment to development by adopting Millennium Development Goals (MDGs) which set eight clear targets, or challenges if termed otherwise. Millennium Development Goals (MDGs) amongst which

three are health-related set out new challenges. The health-related MDGs, that is, reducing child mortality rate, improving maternal health; and combat HIV/AIDS and other diseases are obviously of immense importance towards the mission of health.

It follows that no sooner had the domestically set out challenges been fulfilled, global challenges have come into existence. The fulfillment of health-related MDGs would certainly be great achievement towards human development. But it will not suffice to achieve the desired level of capability for desired level of functioning by the population. Throughout the life health condition of individuals is subject to many other parameters. Besides new health hazards posed by environment, harmful human actions and practices are emerging from time to time and adding to existing hazards. The pollution of air, water, soil and sound has been having subtle effects on human health. Their effects on human body can go unnoticed and years or decade may pass before symptoms appear. A single exposure or a single chemical may not trigger an illness, but an accumulation of exposure over time can take its tolls. Many hazards may influence the appearance of one disease, while a single hazard may influence many outcomes (OREGON, 2009). Furthermore, adulterated food items are having bad impacts on human health by slow poisoning the concern over which coupled with environmental hazards is growing over time.

As a whole health governance as become more complicated than ever before. The initiatives for mitigation of these hazards are not upto mark. So far, there have been no organized efforts to diagnose why the state has failed to ensure basic healthcare for its citizens, what are the impediments within and beyond the set-up for ongoing and future challenges. So far there have been a number of writings on the overall governance of Bangladesh but, nonetheless, no writings have given focus particularly on health governance. In this backdrop, as the topic of this thesis health governance of Bangladesh has been adopted in order to have an examination thereof in the light of previous, on-going and future challenges.

1.3 Rationale

Hardly any nations in the world would be found to have been developed without good health condition of the population. In this regard, a quotation of former British Prime Minister Benjamin Disraeli (1804-1881) is worth mentioning; he said 'The health of the people is really the foundation upon which all their happiness and all their powers as a state depend' (Futurehealth, 2009). In Bangladesh, however, the health condition of the population is far from satisfactory. Though few indicators such as life expectancy at birth, child mortality rate, and maternal mortal rate have improved in Bangladesh; but they do not portray the whole picture, rather they are just a tiny part of the whole scenario. As said earlier, it is crucial point that the health condition depends not only on the individual capability of people, there are other factors as well, the people's right to health is largely shaped by these factors which to a large extent fall under the purview of health governance. Health governance is however interrelated with governance in other arenas which as a whole make it a complicated issue.

The development is an outcome of the level of human functioning. The more a nation works the more it develops; Japan could be the best example in this regard- as the Japanese are very hardworking nation. Their war-wrecked economy had not taken much time to revive and turn into economic superpower just because they have been very hard-working which implies their high level of functioning. Eminent economist Amartya Sen in his book titled *Development as Freedom* has said human functioning depends on capability and capability depends on other determinants. He has emphasized human freedom and has also said that growth of GNP or individual incomes can, of course, be very important as means to expanding the freedom enjoyed by the members of the society and freedom depends on other determinants, such as social and economic arrangements (for example, facilitates for education and health care)

as well as political and civil rights (Sen, 1999:3). As meant by him human capability depends on various factors including health care which cannot be harnessed by individuals. In the health sector, the government has an important role in promoting equitable access to services, assuring sustainable financing for health objectives, and preventing the spread of disease. But too often, governments fail to perform these functions, leading to inadequate and unequal access, poor quality of care and inefficient services and in many cases government failure is linked to corruption (Vian, 2002:1).

Here comes the question of health governance which is broadly the action and means adopted by a society to organize itself in the promotion and protection of health of its population. Like most other traditional societies, the simultaneous existence of different system of medicine or *medical pluralism* is common in Bangladesh. It also reveals the disparities of the quality of health services received by Bangladeshi people. The weak governance in health sector has caused the poor and vulnerable members of the society to suffer the most in terms of costs and deficient service delivery. The average quality of health services is substandard as generally perceived by the people; there are spatial differences also in the quality and availability of services. Some of these inequities are stark and persistent and are holding the country back from making further gains at aggregate level. Besides, malnutrition is widespread among the poor people. In fact, the overall governance scenario in Bangladesh is unpleasant or far from satisfactory; the health governance in particular is in miserable state. Hence the reality is that governance failure in health sector perhaps has far higher social cost than those in other sectors; corruption for example has enormous social costs.

In addition, the harshest truth about human health is that the health-related problems are never-ending. New problems and hazards are keeping on emerging from time to time. HIV and arsenicosis, for example, are new types of threats to public health in Bangladesh; so the overall mission of health comes across newer dimensions from

time to time, posing newer challenges for the health governance. Bangladesh has already failed to fulfill the first commitment manifested in Alma Ata Declaration-the year 2000 has come and gone. For MDGs the available time ahead is only six years; for Goal 6b (achieve, by 2010, universal access to the treatment for HIV/AIDS all those who need it) the time is even shorter. So, there is a fair degree of doubt about achieving those goals in time. The health mission comprises of primary health care, public health care, and the goals embedded in the MDGs. Hence it is now worth tracking why Bangladesh failed to ensure 'Health for All' by the deadline, analyzing the performance of Bangladesh towards achieving health-related MDGs and fulfilling the overall mission of health, and detecting what are the inherent problems and identifying the requirements of achieving the said mission.

Bangladesh is one the least developed countries of the world. After thirty eight years of its independence it could not made expected level of development, one of the causes of which might have been less level of functioning of the population due to poor health condition. In this backdrop, overall development is a far cry, if health of the population is not properly taken care of. As the developmental challenges in the twenty first century are far harder than ever before, whether or not we are ready to face these challenges needs to be examined. The appraisal of the performance in health issues, knowing the inherent problems and then recommendations put forward in this thesis would hopefully help the policy makers to redesign the policy for fulfilling the said mission by which the whole nation would be benefited and the process of development would be easier.

1.4 Objectives

The basic objectives of this study are the following:

- i. To examine whether Bangladesh is on the right track of attaining the health-related MDGs

- ii. To analyze the difficulties of Bangladesh in keeping up Alma Ata Declaration
- iii. To identify the setbacks or barriers to the governance in health sector from the wider socio-economic perspectives

1.5 Methodology

This is an analytical and exploratory type of research which strives to explore the answers to the research questions based on secondary data. Various statistical periodicals published by divergent institutions, both government and non-government, previous thesis works on health have been consulted. Domestic and international journals and books, newspapers and websites have been used as the source of data. For collecting data literature review technique has been opted. The evaluation reports of both the Government of Bangladesh and some international agencies have been used extensively, and data from both types of sources have been cross-checked. For portraying the overall picture of health governance, that is, health system profile and addressing setbacks of health governance, a number of local and international publications have been consulted. Furthermore, the researcher's own observation and experience have also been applied and various websites have been visited to collect information. Some publications have been consulted to look into the history of health governance in Bangladesh and find out the root of the problems.

The study has been carried out within a stipulated short time which might have limited the scope of going further in-depth of the concerned issues. As we can see that sometimes there are inconsistencies among the data published by different institutions, both in the government and outside the government, it is hard to decide which one is close to reality; so this study cannot guarantee the authenticity of the data to be used.

1.6 Literature Review

This research is based on an extensive review of available books, publications, reports, newspapers and relevant websites. In order to conduct this research a good number of publications have been consulted for conceptualizing the idea about 'Health for All', health-related MDGs, and policies and programs. The evaluation reports of both the Government of Bangladesh and some international agencies have been used extensively. Books and journals on the relation of health condition to developmental process, study reports on health governance issues, papers on health service generating system, history of the legal framework, gender and environmental issues in health, and MDGs country progress reports have given general ideas and conceptual basis of this research.

Development as Freedom—the renowned book of the eminent economist Amartya Sen coined the thought about people's right to freedom and entitlement of various civil rights such as the right to education, health etc. as means for development (Sen, 1999:3-4). The author stressed that human capability and human development depends on freedom and rights they enjoy. This book has been consulted to have some new philosophy about the importance to the developmental process of a country of human functioning which is an outcome of good health condition.

Prepared by the Government of Bangladesh *Millennium Development Goals: Mid Term Bangladesh Progress Report 2007* reflects the trends of all MDG indicators and highlights various programs taken up to attain MDGs. It is a kind of official poster of the GOB about the MDGs' progress. It does not give any references to the micro and macro factors affecting the attainment of MDGs. The same is true about the report titled *Millennium Development Goals: Bangladesh Progress Report 2008* prepared jointly by the GOB and UNDP, *Millennium Development Goals: Bangladesh Progress Report 2005* prepared jointly by the GOB and United Nations, and *UNGASS Indicators Country Report*, prepared by United Nations. And 'The

Compilation of MDGs Case Studies: Reflecting Progress and Challenges in Asia', published by UNDP Regional Centre, Colombo and *Reaching the Millennium Development Goals in South Asia* published by Centre on Globalization and Sustainable Development, the Earth Institute of Columbia University, USA are a kind of some general picture of Asia and South Asia respectively and hence they lack sufficient references to Bangladesh context. Besides, these writings do not give any indications as to why Bangladesh could not ensure PHC for its citizens.

In 2005, the World Bank published a report titled *Attaining the Millennium Goals in Bangladesh* which focuses on the five major human development related MDGs in Bangladesh-consumption poverty, infant and under-five mortality, child malnutrition, schooling enrollment and completion, and gender disparities in schooling. The analyses of this report suggest that attainment of under-five mortality is feasible with a combination of interventions, including sector-specific interventions, for example expanding immunization coverage (The World Bank, 2005: i). However, it will be challenging for Bangladesh for attaining child mal-nutrition related MDG. The role of NGOs has been emphasized in the report which mentioned that a factor that is likely to be important in Bangladesh's relative success in attaining positive social outcome is the work of its non- governmental organizations (The World Bank, 2005: ii).

Derick W. Brinkerhoff wrote a paper 'The Enabling Environment for Implementing the Millennium Development Goals: Government Actions to Support NGOs' which was presented in 2004 at George Washington University Conference on *The Role of NGOs in meeting the Millennium Development Goals*. In the paper the writer addressed the voice raised by various actors about the need to create an enabling environment to put in place the conditions that will facilitate the efforts of actors in the public, private, NGOs or civil society sectors to take the various steps needed to reach the targets of MDGs .The paper sought to clarify what government can and should do to support

societal partners to pursue actions related to MDGs (Brinkehoff, 2004:1). This paper was written on global perspective without focusing on any particular country; however, just a single reference to Bangladeshi NGOs like BRAC and Grameen Bank came quite relevantly.

The paper published in 2004 by Millennium Project of United Nations Development Group titled *Millennium Development Needs Assessments* aims at quantifying the 'needs' for meeting the MDGs in terms of human resources, financial resources and infrastructure. For the health-related MDGs, a health sector need assessment in terms of estimation of the number of doctors, nurses, lab technicians and other health professionals has been done. It has also quantified the country's needs in terms of health infrastructure such as health posts and clinics, and assessed the cost of meeting the MDGs. For the purpose of the report Millennium Project worked with local partners of five countries including Bangladesh where MDG evaluations were done. This report has helped this research in deed a lot for getting general ideas about the 'needs' for attaining health-related MDGs.

Multiple Indicator Custer Survey Bangladesh: Key Findings: Progotir Pothey 2006 prepared by GOB with the help of UNICEF and the GOB's report *Bangladesh Demographic and Health Survey 2007*, UNICEF's report *The State of the World's Children 2009: Maternal and Newborn Health* have also helped for collection of data on MDGs despite there was no special focus on MDGs in the said reports. Public Health Watch of Open Society Institute, USA in 2006 in its report *TB//HIV Policy in Bangladesh: A Civil Society Perspective* analyzed the TB and HIV policy of Bangladesh along with four other countries from the perspective of civil society. This report that resulted from monitoring effects reveals a number of overarching themes regarding HIV and TB. Researchers all found low levels of awareness of the basic facts about TB and HIV/AIDS co-infection among political officials and the general population including within high-risk group such as people living with HIV/AIDS (Open Society Institue,2006:13).

It also put forward some recommendations for the GOB to fight TB and HIV/AIDS

Adolescent Reproductive Health in Bangladesh: Status, Policies, Programs, and Issues was prepared in 2003 by Policy Project, USAID, as a part of the series of assessment in 13-countries in Asia and Near East made an assessment of adolescent reproductive health (ARH) issues, policies and programs of Bangladesh. The paper began with social issues- the issues that need to be addressed to meet the reproductive health needs of adolescents. It also outlined specific ARH issues; legal, political and policy issues related to ARH, current in-country programs on ARH, its operational barriers and concluded with recommendations to improve the situation in Bangladesh. Though in the paper the focus was not on MDGs, it has been helpful for the current research as MDG 5 (improve maternal health) has a direct relation with ARH issues such as early marriage which is customary among the female adolescents in Bangladesh is one of the causes behind high maternal mortality ratio.

A number of publications on HNP sector have been consulted for this research. The report *HNP Strategic Investment Plan* published in 2004 by the Ministry of Health and Family Welfare of the GOB identified the key investments required to modernize the HNP sector. The report *Health, Nutrition, and Population Sector (HNPS) Program Implementation Plan, 2nd Revised: 2003-2011 (RPIP)* jointly prepared by the GOB and United Nations in 2006 outlines the program implementation plan of HNPS. In the current year, the GOB has conducted annual program review and prepared a report into two parts of which volume-I was the main consolidated report on key findings, conclusion and recommendations and volume-II contains the technical report on stewardship, service delivery and support systems; both parts have the general heading *as Health, Nutrition and Population Sector Program (HNPS): Annual Program Implementation Report (APIR) 2009*. All these reports have helped a lot have knowledge about the government's plan about HNP and have a critical look over

the HNPSR as most importantly review report mentioned in the end was done by an independent team.

The World Bank published an unique report in 2007 titled *Strengthening Management and Governance in Health, Nutrition and Population Sector of Bangladesh: Bangladesh Development Series* which addressed many of the governance and management issues like absenteeism, private practice by doctors, corruption etc. in Bangladesh's HNP sector that hinder the efficiency and effectiveness of service delivery. Basically, it was the outcome of a study which was intended as a first step in gaining a better understanding of how to improve governance and service management in the HNP sector. However, the report had no focus on the health-related MDGs; in fact, it addressed the general issues of the HNP sector. Another paper which was exclusive on a particular governance issue is Taryn Vian's 'Sectoral Perspectives on Corruption: Corruption and the Health Sector'. The title of the book is self-explanatory about its area of concern, that is, corruption in health sector. This paper describes important areas of vulnerability to corruption within health sector and identifies approaches for prevention (Vian, 2002: 1). Two areas of special focus include the supply of drugs and medical equipment, and informal economic activities of health providers (Vian, 2002: iii). In fact, the paper was written in the context of developing and transitional economies where government resources are already scarce and the issues discussed in the paper are all common in Bangladesh, and it also has given a number of references to Bangladesh quite reasonably (Vian, 2002:19, 22).

Another paper that has been consulted for the purpose of this research is 'Governance and Corruption in Public Health Care Systems', written by Maureen Lewis published in 2006 as an working paper of the Center for Global Development of the World Bank. The paper focused on what factors affect health care delivery in the developing world. This working paper looks at factual evidence to describe the main challenges facing health care delivery in developing

countries including absenteeism, corruption, informal payments, and mismanagement. The author concludes that good governance is important in ensuring effective health care delivery and that returns to investments in health sector are low where governance issues are not addressed (Lewis, 2006:44-45).

Henry Perry wrote a book *Quest for a Healthy Bangladesh: a Vision for the Twenty First Century* which was published in 1999 just before the last year of deadline of Alma Ata Declaration and the starting year of MDGs. As it was written before the MDGs were coined, there was no scope of saying anything on health issues in light of MDGs, yet in the book the author gave some general recommendations on what to do in quest for a healthy Bangladesh, but the issues have not been analyzed in light of the governance parameters; moreover, no specific reasons behind the failure to keep up the vow of Alma Ata Declaration could not be found in the book. John Rohde in his book *Learning to Reach Health for All: Thirty Years of Instructive Experience at BRAC* reviewed the history of his activities in BRAC over thirty years and sought to analyze how BRAC performs its activities related to health and how they contribute to reach 'Health for All'. Again, the governance issues affecting health condition have not been well focused. In the book written by M. Ahmed *Bangladesh towards Twenty First Century* published in 1999, the author outlined general roadmap of Bangladesh towards the twenty first century; here he pointed out the sector-wise requirements including health sector to face the challenges of the twenty first century.

However, on literature review some notable limitations have been commonly traced out in the previous studies, in that, they never specifically tracked why the country failed to keep up Alma Ata declaration. The evaluation reports merely focused on the track records of MDG performance, but have not addressed why the performance have not been being satisfactory. Furthermore, all they have done is just narrowly focusing within health sector and have either failed to address the problems through wider view from socio-

economic perspectives or have done it poorly, and even the legal framework for health governance has not been appraised as yet. All that means as far as insight into health governance is concerned, there have been gaps from both micro and macro perspectives. In the present context, things are more interrelated than they have been ever before; a problem of a particular sector may well be implicated with factors beyond its domain. Any failure to trace out the factors beyond as well within the concerned set-up might cause adoption of inappropriate policy instruments that would eventually aggravate governance failure. Hence the present study is an attempt to bridge the said gaps.

1.7 Organization of the Report

The thesis has been organized into six chapters. Chapter 1 is the introductory part that sets the background, rationale, objectives, and methodology of the thesis and embeds the critical examination of the related research works or write-ups, and finally briefly outlines the organization of the report. Chapter 2 outlines the theoretical perspective of the thesis and focuses on previous and on-going challenges. It critically discusses the health service system in Bangladesh, the available infrastructure thereof, instruments for health governance, that is, policy and legal frameworks, and pinpoints their weaknesses and loopholes. Chapter 3 focuses on the track records of performance in terms of defined goals and obligations and then also the challenges ahead and forecast about the likelihood their attainment in light of the performance track. Chapter 4 pinpoints the socio-economic and other macro-environmental factors inhibiting the governance arena of health sector. Chapter 5 accentuates the findings of the research. The final chapter puts forward the concluding remarks and recommends the means of good governance in health sector, better health service for citizens and thus fulfilling the mission of health.

Chapter 2

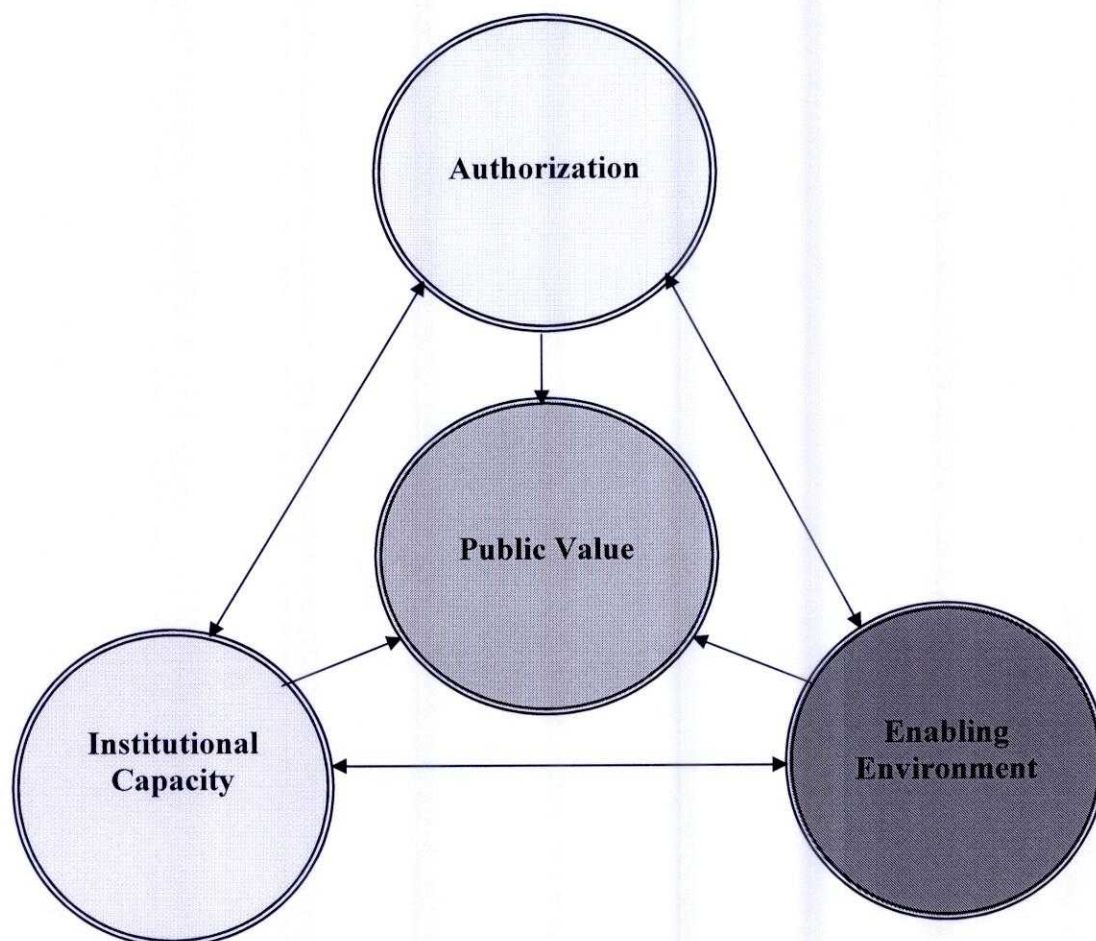
Framework and Mechanism

2.1 Prelude

As said earlier, health governance is the exercise of political authority and the use of institutional resources to manage society's health affairs and health-related problems; these are basically performed through some appropriate actions with a view to creating public value. Health sector is there for creating public value by providing necessary medical care and health-related services. Public value can never be made arbitrarily; there has to be some mechanism. Since health is integrally related to one's life, the services ought not to be given arbitrarily. As public value remains at the centre of the service process, in order to make sure that public value is created through proper health services, first of all, one needs to have authorization from the competent authority on behalf of the government or any entity entitled by the government to give authorization. The parties which seek to provide these services must have the institutional capacity to provide services, in the form of proper degree, fund, manpower, medical equipments and physical facilities. In health service, there must be competent doctors, nurses and technicians, and alongside an enabling environment, that is, a set of interrelated conditions such as legal, bureaucratic, fiscal, informational, political, cultural etc. congenial for providing health services.

The above process has been portrayed in the following diagram which also tells theoretically what fundamental things health governance entail for creating public value or preliminarily what things should be considered for establishing mechanism for health service. And later in the subsequent two chapters what practically happens in the health sector of Bangladesh, that is, what are gaps between theory and practices in the mechanism of creating public value would be addressed.

Figure 1: Process of Creating Public Value in Health Sector



(Source: Dr. Gowher Rizvi)

In the subsequent sections the existing institutional capacity and environment which constitute the base for health governance in Bangladesh will be examined. Prior to this, let us have some theoretical background of the health-related challenges which in this study will serve as the standard for examining the performance in health governance.

2.2 Components of Primary Health Care

Traditionally primary health care used to be narrowly viewed as the medical care a patient receives upon first contact with health care system, before referral elsewhere within the system. As per Mosby's medical dictionary, it is a basic level of health care that includes programs directed at the promotion of health, early diagnosis of

disease or disability, and prevention of diseases (Mosby's Medical Dictionary, 2009). These definitions have been mere technical, whereas Alma Ata Conference in 1978 incorporated socio-economic dimension into its definition. Alma Ata International Conference provided for new dimensions on primary health care that focuses on essential health care based on methods and technology that are:

- practical
- scientifically sound
- socially acceptable

It stressed health care to be universally accessible to individuals and families in the community through their full participation, and also affordable at the cost that the community and country can maintain at every stage of their development in the spirit of self-determination.

As a whole, Alma Ata Conference brought in a new approach incorporating four essential components of primary health care which are:

- i. Universal coverage by ensuring sufficient supply of medicines and services; removing financial barriers to access and ensuring social health protection
- ii. People-centered care by transforming traditional healthcare delivery models (specialist, procedure or hospital-based) into people-centered primary health care network
- iii. Inclusive leadership by shifting from conventional "command-and-control" approaches to increasing participation of all stakeholders and moving from supply-led to demand-led policies and programs
- iv. Ensuring health in all policies so that all relevant sectors (e.g. labor, environment, education) incorporate health issue in their agendas (Wikipedia, 2009c)

2.3 Public Health

Public health is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as small as a handful of people or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health is typically divided into epidemiology, biostatistics and health services. Environmental, social, behavioral, and occupational health are also important subfields. There are two distinct characteristics of public health:

- i. it deals with preventive rather than curative aspects of health
- ii. it deals with population-level, rather individual-level health issues

The focus of public health intervention is to prevent rather than treat a disease through surveillance of cases and the promotion of healthy behaviors. In addition to these activities, in many cases treating a disease may be vital to preventing it in others, such as during an outbreak of an infectious disease. Hand washing, vaccination programs and distribution of condoms are examples of public health measures (Wikipedia,2009d) .

The mission of public health is to fulfill society's interest in assuring conditions in which people can be healthy. The well-known comment about public health of former Surgeon General of the United States Charles Everett Koop can be mentioned in this regard- *'Health care is vital to all of us some of the time, but public health is vital to all of us all of the time'* (Novik and Mayes, 2005:457). Public health is basically community health. The three core public health functions are:

- the assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;

- the formulation of public policies designed to solve identified local and national health problems and priorities;
- to assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care (Dee and Kathleen, 2009:252).

The above two areas of challenges, that is, PHC and public health fall under some general category whereas the challenges revealed by the following goals are specific.

2.4 MDGs: the New Health Mission

In 2000, in the UN Millennium Summit the global community comprising of 192 United Nations member states and at least 23 international organizations agreed upon eight new international developmental challenges amongst which three are directly health-related. These goals along with defined targets and indicators include:

GOAL 4: REDUCE CHILD MORTALITY

Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicator 13: Under-five mortality rate

Indicator 14: Infant mortality rate

Indicator 15: Proportion of 1-year-old children immunized against measles

Under-five mortality rate is the number of children who die by the age of five, per thousand live births. According to UNICEF, most of the child deaths (seventy percent in developing countries) results from one of the following five causes or combination (Wikipedia, 2009e):

- acute respiratory infection
- diarrhea
- measles
- malaria
- malnutrition

Infant mortality rate is defined as the number of deaths of infants (one year of age or younger) per thousand live births). The most common cause of infant mortality worldwide has traditionally been dehydration from diarrhea (Wikipedia, 2009f).

GOAL 5: IMPROVE MATERNAL HEALTH

Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 16: Maternal mortality ratio

Indicator 17: Proportion of births attended by skilled health personnel

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Indicator 19: Condom use rate

Indicator 21: Prevalence and death rates associated with malaria

Indicator 22: Proportion of population in malaria risk areas using effective malaria prevention and treatment measures

Indicator 23: Prevalence and death rates associated with tuberculosis

Indicator 24: Tuberculosis detection and treatment success

2.5 Policy and Strategy in Bangladesh

For any national goals to be achieved, there must be appropriate policies and workable implementation plans. In Bangladesh, a number of health-related policies, so far, have been adopted by the successive governments. It is mention worthy that the last decade has brought about significant changes in the policy environment of health and population sector of Bangladesh and there have also been many

developments in the policy arena. Sector-wide approach evolved from project-based approach. This brought many aspects of health and population sector under a coordinated mechanism for funding, service delivery and monitoring. The current sector-wide program Health, Nutrition and Population Sector Program (HNPS 2005-2010) has brought nutrition, HIV/AIDS and urban health under the same broad mechanism. Nonetheless, it does not necessarily mean that each policy or program has been a success all the time, there are some dark sides of the story also which will be critically discussed in the concluding part of this section. Now let us have a critical look over the predominant health-related policies of Bangladesh.

National Health Policy:

It is very unfortunate that after thirty eight years of independence Bangladesh has not yet been able to introduce a fully-fledged National Health Policy (NHP). Several attempts so far have been made. During the Ershad regime a draft policy was made which was amended in 2000, and again during the last care-taker government another attempt was made. Now the present government has formulated a draft policy 2009 after reviewing two previous drafts. The goal of this draft NHP sounds good as it aims at sustainable improvement in health, nutrition and family welfare status of the people, particularly of the poor and vulnerable groups, including women, children and elderly with ultimate aim of their economic and social emancipation and physical and mental well-being. Nonetheless, this draft policy has triggered a big question about the people's right to health as it has suggested 'user fee' to be given by the patients for getting health services from the public hospitals. If implemented this suggestion would go against the poor as it would make health services costlier for the poor.

National Population Policy:

Bangladesh, being a country with high population density, has been focusing on the control of rapid growth of population since independence. The population policy of Bangladesh was formulated in

1976. From then to the present, this policy has evolved in two distinct phases; first phase continued upto 1997 and since 1998 the second phase has been continuing. This stage is strongly influenced by United Nations Conference on Population and Development, Cairo, 1994. One of the major constraints of the population policy pursued by successive governments over the years in Bangladesh had been a narrow focus given to the subject and predominance of short-term perspective.

Drug Policy:

Bangladesh endeavored to establish a National Drug Policy (NDP) back in 1972, and after a decade disquiet pushed by academics, regulatory experts and health activists, the government implemented the policy in 1982 with an aim to ensure quality of drugs by removing those considered harmful, useless and unnecessary from the market and importantly to promote local drug industry. This policy, however, encountered negative reactions from the domestic and multinational pharmaceutical companies and certain foreign governments. Though under the patronage of this policy the domestic pharmaceutical industry flourished since 1982 and but the objective of providing medicines of standard quality could not yet been fully attained. The national drug testing authority in its round of drug evaluation in 2004 identified counterfeit drugs making up some six percent of the market. It does not necessarily mean that the NDP failed to bring in some quality in the drugs; in fact, compared to pre-NDP period during when the proportion of sub-standard drug were thirty six percent, there has been some notable advancements, as a 2005 government report reveals that the quality of drugs has improved and that the proportion of sub-standard drugs has fallen to just to two percent (Islam, 2009). The NDP was amended lastly in 2005.

National Policy on HIV/AIDS and STD-related issue:

Though Bangladesh is still a low HIV/AIDS prevalence country, threat of it cannot be ruled out because of the existence of all predisposing

factors. Bangladesh formed a national AIDS committee in 1985 and took up a national policy on HIV/AIDS and STD-related issues in 1996. Because, no drugs to cure HIV/AIDS have so far been invented, the only way to fight it is the prevention which requires public consciousness. But the awareness regarding HIV/AIDS in the Bangladeshi population remains quite low. One recent survey has found that 'Only 19 percent of the ever-married women and 33 percent of the currently married men had heard of AIDS' (WHO, 2009) The national policy regarding HIV/AIDS has rightly addressed this point; the slogan *Bachte hole jante hobe* is being given wide-spread publicity to make the general population knowledgeable enough to be able to successfully combat this diseases and also eradicate the misconceptions about the disease.

In order to achieve the health mission the Government of Bangladesh has undertaken a number of programs which embedded strategies also. Of them the predominant ones have been highlighted below:

National Strategy for Accelerated Poverty Reduction (II):

After the completion of PRSP which was the 'road map' for overcoming the poverty situation or an anti-poverty framework announced late in 1999 by the World Bank and IMF, new NSAPR was initiated. It has undergone two phases and as a sequel to the first NSAPR, the Government has introduced NSAPR (II) for FY2009-11 which will guide the Government's efforts in redressing poverty during budget preparation and implementation in the next three years.

National Strategy for Maternal Health:

The process of developing the National Maternal Health Strategy started in December, 2000 and it was published and operationalized in October, 2001. It has a ten-year perspective and the objectives are strengthening the provision of essential (including emergency) obstetrical care and improving referral and utilization of services; improving the nutritional status of women and adolescent girls,

ensuring that right people with the right skills are trained to provide quality maternal health services (MHS) at all levels of the health system and lastly promoting women friendly health services

Health, Nutrition and Population Sector Program (HNPS):

The program started in July 2003; it was aimed to be completed by June, 2006. Later on it was revised twice, firstly extended to June, 2010 and second time, extended to June, 2011. During the program preparation and in the first year of execution, several development partners decided to pool their funds and entrusted their administration to the World Bank. Overall, the HNPS is worth US \$ 4 billion with government's funds making up 66 percent of the total and the pooled fund contains approximately US\$750 million, and parallel funds administered directly by development partners total approximately US \$649 million (HLSP Institute, 2008). Within the overall development policy framework of the GOB, the goal of HNPS is to achieve sustainable improvement in health, nutrition, and reproductive health, including family planning and status of the poor. As per the government statement, basically this program is going on for providing health care services to the people from the grass root to central level.

National Nutrition Program (NNP):

It is the largest nutrition initiative to reduce malnutrition in children, adolescent girls, and women. The earlier nutrition intervention of the Bangladesh Integrated Nutrition Project (BINP) was completed during 1995-2002, and the experiences gained now being used for the NNP.

It follows from the comprehensive list of policies and programs that in Bangladesh there is no dearth of policies and programs for health sector. The problem is that health-related policies and programs are formulated by a too centralized administrative set-up, with zero participation by the elected representatives of the people. Furthermore, donors' influence has become very common in development activities in the underdeveloped countries like

Bangladesh. On many occasions, the donors insist on employment of their consultants to draft the policy and action plan. These consultants, most of whom are foreigners are unable to go in-depth of the problem as they are not associated with the local population; they lack in knowledge of the strengths and weaknesses of the local people and system. And the responsible persons from part of the government also have shortage of knowledge in the concerned field. As a result, the policies and programs have not been sustainable. How the zero participation of people's representatives and national experts on health causes to happen miserable fate to a program can be well exemplified by the HPSP (Health and Population Sector Program), the previous phase of HNPS. This program was formulated by some inexpert persons from the government and donor appointed consultants. This mammoth program was never discussed in the parliament nor was placed before the parliamentary standing committee for scrutiny. As a result, the \$ 3 billion HPSP had a very miserable fate and is stumbling along under a new name-HNPS (Rahman, 2009).

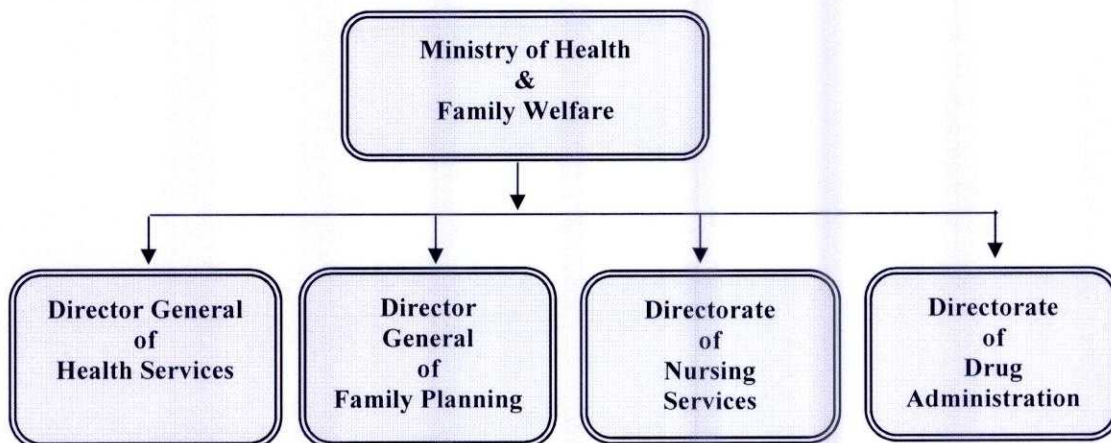
Hence policies and programs in health sector should not be arbitrarily formulated; there must have be participation by the people's representatives and genuine experts on health, not rookie experts. In order to be a success a policy or program must have to be pro-people and it is very possible that if these are formulated without zero participation by people's representatives and genuine experts, these policies and programs would not be truly public and pro-people, and would fail to fulfill the broader goals of the policy. This is surely a governance issue as it involves public policy the ultimate goal of which is creating public value. Unfortunately, as said above, the public policies of Bangladesh are not always truly public in nature; and this shortcoming coupled with other stumbling factors which will be discussed in the upcoming chapter as a whole put health governance in a mess.

2.6 Main Actors: Actions and Interplay

Health governance in Bangladesh is dominated by the public sector institutions followed by private sector run by local entrepreneurs, NGOs and international organizations. The health sector of Bangladesh is governed by the 'Ministry of Health and Family Welfare (MoHFW)' on behalf of the government. In this regard, the ministry is the protagonist in the health governance arena through policy formulation and planning and decision making at micro and macro level. The ministry conducts and manages health affairs through four of its directorates namely as:

- i. Director General of Health Services
- ii. Director General of Family Planning
- iii. Directorate of Nursing Services
- iv. Directorate of Drug Administration

Figure 2: Main Actors in Health Governance in Bangladesh



Four directorates are implementation wings staffed by professionals and technicians. At the divisional level, there are divisional directors' offices of health and family planning responsible for support and HRD functions. At the district level, the Civil Surgeon heads the health management and Deputy Director (family planning) is responsible for maternal and child health care and reproductive health services. At the upazila level, Upazila Health and Family Planning Officer (UHFPO) looks after the preventive and clinical health

services and Upazila Family Planning Officer (UFPO) manages the family planning and reproductive health services.

In the service arena the government is responsible to ensure basic health care to the people of the country. It provides the most of the HNP services as the protagonist in this arena and also manages and coordinates the services of private sector and non-governmental organizations (NGOs). Thus, the government is playing both the role of rowing and steering, in that, it provides health services as essential need to the citizens as well as governs the health sector. The co-actors of health governance comprise of the 'Ministry of Finance', the 'Ministry of Planning', private sector and NGOs playing the role locally and the World Health Organization, UNICEF, and UNDP playing the role internationally. They basically participate in health governance indirectly. Their relationships with MoHFW can be categorized into the following areas or dimensions:

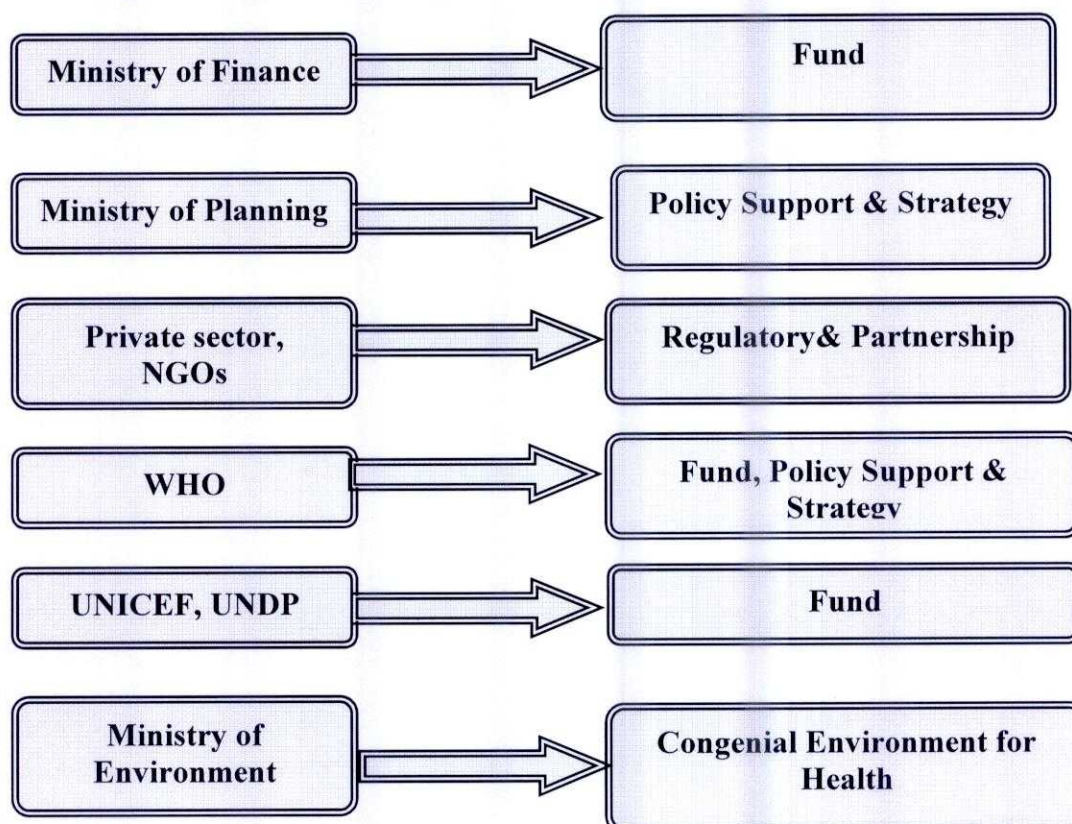
- Regulatory
- Supportive
- Partnership

Regulatory: private sector and NGOs fall under the purview of this category, that is, the government directly regulates these two players with the help of the existing regulatory framework which includes laws, rules and regulations.

Supportive: all the co-actors' roles are somehow supportive directly or indirectly. The local co-actors are the 'Ministry of Finance', the 'Ministry of Planning', private sector and NGOs, and international co-actors are WHO, UNICEF, and UNDP. The 'Ministry of Finance', WHO, UNDP and UNICEF are the sources of funds, whereas the 'Ministry of Planning' and WHO are giving policy support. The 'Ministry of Environment' is playing the role as the conservator of the congenial environment for good public health and hence the role of this ministry is purely indirect. The private sector and NGOs,

independently or through partnership with the government, are providing health services for the citizens.

Figure 3: Relationships of MoHFW with Co-Actors



(Self-compiled)

Partnership: As said earlier the private sector and NGOs are related with the government not for regulatory purpose only, they also have some partnership relations in providing health services. BRAC Health Program, for example, is conducting the Tuberculosis Treatment Program with the fund of the government

2.7 Health Manpower and Development Facilities

As health service is a very technical one, health professionals and technicians have to have required skills, otherwise the health of the service seekers may be endangered, even loss of life may take place. As per latest available data, the manpower for health service in government sector is shown below:

• Doctor: registered: 50,004 • Nurses: registered: 23,732 • Dental Surgeon: 3,484 • Medical Assistant: 5,598	• Pharmacist: 7,622 • Radiographer: 1,054 • Lab Technician: 2,220 • Health Assistant: 21,016
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(Source: HRD Data Sheet 2009- MoHFW)

In Bangladesh, there are several institutes for health manpower development; at the peak there is a medical university and among the other institutions there are 17 medical colleges, 8 post graduate institutions, 2 institutes of health technology, 8 medical assistant training schools, 1 nursing college and 38 nursing institutes.

2.8 Pertinent Laws and Conventions

For governing any particular area there must be a pertinent legal framework, that is, a set of laws, rules and regulations. As health is a sensitive issue and any arbitrary actions can cause enormous damage to human beings and may even lead death, in any civilized society the purview of health-related laws is usually wide. Bangladesh is no exception, for the purpose of health governance in Bangladesh there are apparently a wide range of laws, rules and regulations which derive both from domestic and international sources, but the question as to whether they all work in practice and if there are any shortcomings will be discussed later on. First, let us have a focus on the legal framework for health governance.

2.8.1 Domestic Laws

The domestic laws however can be divided into three categories based on chronologically starting from British colonial period, then Pakistan regime and lastly after independence of Bangladesh. All the laws that had been promulgated in British and Pakistan period were assumed soon after the independence of Bangladesh.

a. British Colonial Period

In this period there had been a few health-related laws of which one, that is, *The Indian Penal code, 1860* is of general and substantive nature and rest two, that is, *The Medical Degrees Act, 1916* and *The Drug Act, 1940* are exclusively for health governance. The British contributed to public health by introducing smallpox vaccination, establishing Western medicine and training modern doctors, by killing rats, and establishing quarantine procedures (Maddison 1971:12).

In British India the first ever criminal law introduced by colonial power was *The Indian Penal Code, 1860*. Almost every aspect of criminal activities prevailing in the contemporary India was covered by this law and thus, it was introduced as a general law. There had been ten sections (from section 269-278) related to the offences affecting public health, describing the form of offences and punitive measures against them. The sections cover the penal provisions for the offences due to the health hazards created by spreading of infectious diseases, adulteration of food, drinks or medical preparation, any noxious articles; selling, or offering or exposing for sale, or issuing any drug or medicinal preparation, as a different drug or medical preparation other than for medicinal purposes. It also addressed a number of environmental issues like offences related to fouling public water bodies and vitiating atmosphere. The first ever law that was promulgated exclusively for health governance in this region was *The Medical Degrees Act, 1916* particularly for regulating the grant of titles implying qualifications in Western medical science, and the assumption and use by unqualified persons of such titles. And the second special law was *The Drug Act, 1940* for regulating the import into, export from and the manufacture, distribution and sale in this region of drugs.

b. Pakistan Period

The only two health-related laws that had been promulgated in this period over the span of twenty four years are *The Pure Food Ordinance, 1959* and *The Medical Colleges (Governing Bodies) Ordinance, 1961*.

The first one is one of the most key laws that have been so far promulgated in the arena of health governance because in the present context also this law bears immense importance. The latter provides the constitution for governing bodies of medical colleges for the efficient administration and management of the affairs of such colleges and thus less related with the direct health governance.

c. Bangladesh Period

In the independent Bangladesh as many as five directly health-related laws have been promulgated so far. Nevertheless, as the supreme law of the land the constitution of the country in 1972 may be termed the first law for health governance, because it addressed health issues also, that is, medical care and public health. 'Health for People' is a constitutional obligation. Three articles of the Constitution of Bangladesh refer to the state's vow for people's medical care and public health such as Article 15(a) has said about the provision of basic necessities of life including medical care, Article 16 has said about the improvement of public health along with education and communications progressively to remove the disparity in the standards of living between the urban and the rural areas and finally Article 18(1) has asserted that the State shall regard the raising of the level of nutrition and the improvement of public health as moving its primary duties. However, the five laws that had been promulgated exclusively for health governance are *The Pharmacy Ordinance, 1976*, *The Medical and Dental Council Act, 1980*, *The Drugs (Control) Ordinance, 1982*, *The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982*, and *The Smoking and Tobacco Usage (Control) Act, 2005*.

In addition to the above, the domestic laws which are indirectly concerned with health are *The Bangladesh Standards and Testing Institution Ordinance, 1985* and *The Environmental Conservation Act, 1995*.

2.8.2 International laws

Bangladesh being a member of the global community is more or less affected by the international conventions. International law in the history of health governance first came into being with the inception of the World Health Organization (WHO). The most influential international laws for global health governance are the *Constitution of the World Health Organization, 1946*, and the *International Health Regulations, 2005*. The International Health Regulations were first adopted by the Health Assembly in 1969, and with the emergence or re-emergence of international disease, threats and other public health risks, it underwent several revisions with the latest revision taking place in 2005. The other two laws for global health governance are the *Protocol concerning the Office International, d'hygiène publique, 1946* and the *Agreement on the establishment of the International Vaccine Institute, 1996*. There are yet other international conventions which are not directly for health governance, but are concerned with health; they are the *Kyoto Protocol to the United Nations Framework Convention on Climate Change, 1997* and the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979*.

2.9 Service Generation System

The present health service delivery system and administrative set up is mostly a legacy of British *Raj*. Over the years, successive regimes tried to make some changes in order to establish better service delivery system but with little success, as the policies and programs have not been sustainable. Furthermore, the population of Bangladesh has also increased that has brought in new demands and aspirations in the health care services (Rahman, 2009). These have been amongst the causes of health governance being complex in Bangladesh. Now, the picture of the institutional capacities, as referred in section 2.1, of health sector of Bangladesh will be

provided by the government sector. Private sector is also playing role in providing health services and the role of NGOs is also becoming significant. Their roles have also been discussed in this section.

2.9.1 Health Service System in Bangladesh

The successive health plans of the country emphasize Primary Health Care (PHC) as the key approach for improving health status of the people. The public sector health system is structured as hierarchical pyramid divided into three levels with five layers; three at primary, one at secondary and one at tertiary. The primary level means the level existing at union and upazilas, secondary level lies at districts, and finally tertiary level is there at the capital or national or divisional level. At all divisions, specialized hospitals are available while in some areas there are postgraduate hospitals. All districts have various types of hospitals and types are depending on facilities and number of beds availability. At upazila level, upazila health complexes provide health care services. At union level, there are Union Health and Family Welfare Centers (UHFWCs) whereas community clinics are there at village level. The facilities and services at different layers are shown in the following table.

Table 1: Levels of Health Service in Government Sector

Facilities	Services
Primary Level	
Community clinic and home visitation	Family planning, immunization, communicable diseases control, treatment of common problems and referral
Union Health and Family Welfare Centre(4300)	Out patient service: Family planning, maternal and child health care, communicable disease control, clinical care, normal delivery and adolescent health care

Facilities	Services
Primary level	
Upazila Health Complex (414)	Out patient services, inpatient services(31-50beds) with diagnostic and operative treatments
Facilities	Services
Secondary level	
District Hospital(55)*	Outdoor and indoor services (50-250 beds) with laboratory, radio graphic and ambulance services
Maternal and Child Welfare Centre (55)	EOC and other related service
Facilities	Services
Tertiary level	
17 medical colleges hospitals**	
10 post graduate institute and hospitals	
1 dental college hospital	
20 specialized hospitals	
1 homeopathic medical college hospital	
1 ayurvedic degree college hospital	

(Source: MoHFW 2009: * and ** after recent up-gradation of 3 district hospitals to medical college hospital)

Government documents in Bangladesh show that physical facilities for provision of health care services have been improving throughout the country. As a result, population per bed doctor ratio has been improving gradually, but compared to the need it still remains unsatisfactory. Over the last two decades, 1980s and 1990s, the number of hospital beds almost doubled and consequently the per capita availability of these facilities has also been improved. The availability of hospital beds improved from one bed for about 4000 people to one bed for 3000 people between 1980 and 2000. Though very recent data are not available, another source shows that from 2005 to 2006 health facilities in terms of number of hospitals, number of beds, persons per hospital bed, registered physicians, persons per

physician and households per physician improved, but the improvement in the availability of hospital beds relative to the population is very insignificant as shown in the following table.

Table 2: Health Facilities in Government Sector

Health Facilities	2005	2006
Hospitals	1676	1683
Hospital Beds	50827	51044
Persons per Hospital Bed	2736	2732
Registered Physician	41933	44632
Persons per Physician	3317	3125
Households per Physician	691	655

(Source: Statistical Pocket Book of Bangladesh 2008, BBS)

Though in terms of infrastructural health facilities, Bangladesh is said as one of the well-resourced countries (CPD, 2001 cited in Ara, 2008:5), the doctor-population, doctor-nurse, nurse-population ratios remain far below the standard level.

As per very recent data published by the MoHFW, some of the key health manpower-related information has been given below:

- Doctor- Density per one thousand Population : 0.26
- Nurse- Density per one thousand Population : 0.14
- Doctor- Nurse ratio:1: 0.54
- Medical Assistant- Density per one thousand Population : 0.06

(Source: HRD Data Sheet 2009- MoHFW)

Just a single example might suffice that the number of health professionals are not enough for such a huge population. In order to examine the trend of availability of doctors with respect to the population, if doctor-density per one thousand population over the year is calculated it can be seen that the situation has even deteriorated; as found on calculation from the table: 2 in 2005 and 2006 it was 0.30 and 0.32 respectively, but after 3 year currently the

ratio is 0.26. It implies the number of health professionals is not compatible with the growing needs of the population.

2.9.2 Private Sector

It is extremely difficult to collect data on the involvement of the private sector in health services, because many of the doctors and specialists working in private health institutions and medical colleges are on part-time basis. Moreover, many of the same doctors and specialists are enrolled or working in a number of institutions at the same time. So, the actual number of doctors or specialists employed in private medical colleges is very difficult to ascertain. Yet, the data collected by a study conducted back in 1999 have been given in the following table which shows that private medical colleges or institutions had a total of 1606 doctor in the concerned time:

Table 3: Health Facilities in Private Sector

Category	No. of Medical Professionals		
	Male	Female	Total
Private Medical Colleges	732	201	933
Other private institutions	464	209	673
Total	1196	410	1606

[Source: Kasem K. Human Resources Status of the Country, 1999, WHO, Dhaka (as cited in webpage of MoHFW)]

This is a rapidly growing sector, which already provides most health services (according to BNHA-2, some 55 percent by value). It includes:

- fully qualified commercial providers of services (private medical practice, diagnostic centres and clinics) based predominantly in the cities and larger municipalities,
- semi-qualified or unqualified allopathic practitioners, and
- alternative medical practitioners (ayurvedic, homeopathic, unani or kabiraj and others.

Some kinds of practice, such as ayurveda, are on declining trend, but others, such as semi-qualified Rural Medical Practitioners (RMPs) flourish, particularly in rural areas. While reliable figures on the numbers of these different types of informal practitioners are lacking, the Bangladesh Health Labour Market Study has estimated the total number of private practitioners in Bangladesh to be around 0.45 million, or 3.6 per 1000 population. The ratio of the traditional and unqualified providers with formally qualified providers stands at twelve to one (GOB, 2004:11). It points at the existence of pluralistic medical system in Bangladesh. Another report titled '*The State of Health in Bangladesh 2007*' published by a civil society group reveals that roughly 80 percent of the country's population still seek their first line of healthcare from those informal healthcare providers (Shakeel, 2008: ii). That most of the services are being provided by the informal sector does not necessarily mean their services are all satisfactory and upto quality; in fact, a substantial portion of them are unskilled and quacks and providing services without authorization. They are very often causing hazards to the service seekers and even causing loss of lives.

2.9.3 NGO HNP Services

Though most of the Non-governmental organisations (NGOs) focus on socio-economic sector and their work include income generation, education and social development, yet health promotion and service also are key part of their services. NGOs, amongst whom BRAC is playing the lead role, are a significant and growing source of HNP services in both rural and urban Bangladesh. Their services have mainly been in the areas of family planning and maternal and child health care. More recently, NGOs have extended their range of services and are now the major providers of urban primary health care. NGOs have been commissioned by the MoHFW to provide the community nutrition services under BINP and NNP. Besides, NGOs are also providing services for HIV/AIDS prevention and for the

national tuberculosis and leprosy control programs. BNHA-2 data suggest that total volume of expenditures on HNP services by NGO facilities and other non-profit institutions increased more than threefold in real terms over the five years since 1996/97, accounting for over nine percent of total sectoral expenditures in 2001/02. Bilateral donors channel many of their programs in the health sector through NGOs. There is a general acknowledgment that the NGOs provide quality services which are well accepted by consumers. Moreover, NGOs in general have more flexible management system, enabling them to practise greater flexibility in decision making which facilitates effective program implementation, especially in the areas of social mobilization, community linkage and targeting the poor.

A truth comes out of the above discussion that with the given health manpower-cohort at present it is very difficult for the government alone to reach every citizen, hence formal and informal collaborations with NGOs are very commendable. This is why joined-up governance in the health sector, especially for PHC and services for three health-related MDGs is an urge of time; what the government needs to do is making the enabling environment so that other players can render better services.

Chapter 3

Performance Appraisal

3.1 Prelude

Millennium Development Goals (MDGs) are the new eight development challenges for the global community including Bangladesh. As stated in section 2.4 of chapter 2, MDGs cover eight challenges under mainly six broad areas of development namely as poverty eradication, primary education, women empowerment, health, environment and global partnership. The goals include the following:

- Goal 1:** Eradicate extreme poverty and hunger
- Goal 2:** Achieve universal primary education
- Goal 3:** Promote gender equality and empower women
- Goal 4:** Reduce child mortality
- Goal 5:** Improve maternal health
- Goal 6:** Combat HIV/AIDS, malaria and other diseases
- Goal 7:** Ensure environmental sustainability
- Goal 8:** Development a Global Partnership for development

It is necessary to appraise the performance of Bangladesh so far in fulfilling MDG challenges and also the feasibility of achieving the goal in time. Though concern of this chapter is health-related MDGs, nonetheless how they are compatible with other MDGs will be seen later on.

3.2. Millennium Development Goal 4

Child mortality rate is a reflection of the care, health and nutrition status of children below the age of five years and also indicates the social, cultural, and economic progress in the country. MDG 4 indicates that under-five mortality rate must be reduced from 151 deaths per thousand live births in 1990 to 50 by 2015. Bangladesh's performance in reducing child mortality has been good, particularly during the 1990s the decline has been the most rapid, even better than India a country which has two times the per capita income of

Bangladesh. Now, let us see whether this decline is well enough to achieve MDG target.

i. Under-five Mortality Rate

The most recent data published in '*Millennium Development Goals: Mid Term Bangladesh Progress Report 2007*' prepared by the Planning Commission of the GOB and '*Millennium Development Goals: Bangladesh Progress Report 2008*' jointly prepared by the Planning Commission of the GOB and UNDP show that the under-five mortality rate in Bangladesh declined from 151 deaths per thousand live births in 1991 to 62 deaths in 2006—an encouraging 24 per cent ahead of the target for that year. The actual annual progress between 1991 and 2006 also surpassed the targeted annual rate by 0.65 per cent. In 2007, the rate further declined to 60 deaths. The said reports hope that if Bangladesh can maintain this trend, it would meet the final target before 2015.

ii. Infant Mortality Rate

In the first report mentioned above it is said –'*Latest reports show that the infant mortality rate fell from 94 per thousand live births in 1990 to 45 in 2006. Reductions in the infant mortality rate by 2006 were almost 9 per cent ahead of schedule for that year. The average annual reduction between 1991 and 2006 was 3.07 per cent - against a target of 2.52 per cent. If this trend continues, Bangladesh will meet the MDG target of 31 per thousand live births before 2015*' (GOB, 2007:18). As per the second report mentioned above, the infant mortality in 2007 was 43 which again shows the declining trend. Both the reports hope of attaining the target by 2015. But another report says that if the rate of infant mortality decline experienced between 1979-83 and 1995-99 continues into the future, infant mortality rate in Bangladesh expected to reach a level 34 in 2015 just slightly above the MDG level of 31. If future rate of decline remains at the (as high as 4.7%) rate experienced in the 1990s, the infant mortality rate could decline to 29 by 2015. Thus what Bangladeshi needs to do in order to attain or

come very close to infant mortality MDGS is just to maintain the trend it has been in the recent past.

Table 4 (1): MDG 4: Target and Achievements

Goal	Target	Indicator	Base year (1991)	Current	Target 2015
GOAL 4: REDUCE CHILD MORTALITY	Target 5: Reduce by two thirds, between 1990 and 2015, the under- five mortality rate.	13. Under five mortality rate (per 1,000 live births)	151	62 (2006)	50
		14. Infant mortality rate (0-1 year per 1,000 live births)	94	45 (2006)	31
		15. Proportion of 1 year old children immunized against measles	54%	87% (2006)	100%

(Source: Millennium Development Goals: Mid Term Bangladesh Progress Report 2007)

Table 4 (2): MDG 4: Trends of Attainment

Goal	Base year	Mid-term Report 2007	Current Status
Under five mortality rate	146	62	60 (2007)
Infant mortality rate	92	45	43 (2007)
Proportion of 1 year old children immunized	54%	87.2% (2006)	88 (2006)

(Source: Millennium Development Goals: Bangladesh Progress Report 2008)

iii. Immunization against Measles

Immunization plays a critical role in reducing infant and child morbidity. The government's Expanded Program for Immunization (EPI) is able to record considerable success in combating infant and child morbidity. As per the afore-mentioned reports, the program has extended its reach from less than 1 per cent of the population in 1981 to 54 per cent in 1991, increasing further to 88 per cent at the end of 2006. Its positive impact is evident in the significant reduction in child mortality. Bangladesh is often cited as one of the countries to have made the best progress in immunization. The average increase in the coverage of child immunization between 1991 and 2006 was 3.25 per cent: 0.65 per cent above the targeted annual rate of 2.6 per cent. The first report hopes that the country is likely to reach 100 per cent immunization by 2012, three years ahead of 2015.

The estimated figures in 2015 mentioned in the second report are 28, 17 and 100 % for U-5 mortality, infant mortality and immunization respectively (GOB and UNDP, 2008:40). And about the first two rates it has been said in the report that the target will be achieved five years ahead of the deadlines (GOB and UNDP, 2008:36). However, the estimates of the report seem somewhat exaggerated. Though Bangladesh's progress in MDG 4 indicators is encouraging, the government report admits to some dark sides of the scenario, which are about the spatial and gender differences. Urban slums, the Chittagong Hill Tracts, coastal belt regions and other ecologically vulnerable areas are falling behind. There is urban-rural difference in under-five mortality rates. In 2001, the rate in urban areas was 52 percent while in rural areas it was 89 percent. Similarly, there is also difference in under-five mortality rate between boys and girls. In 2001, the under-five mortality rate for boys was 84 percent and for girls 81 percent. Over the years, appropriate interventions have helped to reduce the proportion of underweight children from 66.5 percent in 1990 to 51.1 percent in girls and mothers, because if mothers are

malnourished, their children are much more likely to have low birth weight, and to remain malnourished throughout their lives.

The government, with the support of its development partners, must ensure that its efforts reach all Bangladeshi people, and that progress to date is sustained

3.3 Millennium Development Goal 5

i. Maternal Mortality Ratio

In Bangladesh from the health perspective, the women's condition is worse than that of the men. Although the life expectancy gap between men and women has narrowed over the last decade, Bangladesh continues to be one of the world's fewest countries where the women's life expectancy is lower than that of the men (GOB and UN, 2005:34). High rate of maternal mortality is one of the causes behind it. Under the MDG 5 Bangladesh needs to reduce its maternal mortality ratio by three quarters from 574 per 100,000 live births in 1991 to 147, if it is to meet this target by 2015. Until 2006 there has been adequate success in reducing maternal mortality ratio (MMR).

According to the first report mentioned above, it declined from 574 deaths per 100,000 live births in 1991 to 290 against the target of 298 in 2006. As said in the first report, if this current rate continues, the country will be able to meet the target by 2015. But according to the second report, in 2007 Bangladesh's performance in MDG 5 has been alarmingly poor as the MMR has jumped to 351 marking a 61-unit increase in the rate.

It means that despite significant improvement in the previous years, the performance has started to deteriorate very recently. Unfortunately, Bangladesh's maternal mortality rate is still one of the highest incidences of the world (The New Age, 2007a). Though in view of the improvement made in the near past some health experts are hopeful about attainment of the target about maternal mortality (The New Nation, 2007a and 2008b), but if before the deadline the trend

encompasses a few such degradations as happened in 2007 there will be no hope of attaining MDG 5.

ii. Births Attended by Skilled Health Personnel

In 1990, almost all births took place at home. Only 5 per cent occurred in health centers. Traditional birth attendants assisted around two-thirds of deliveries, with the rest attended by relatives and friends. However, most obstetric complications cannot be prevented by either antenatal care or trained birth-attendants during delivery. Though deliveries attended by skilled health personnel increased from 5 per cent in 1990 to 20 per cent in 2006, but it has declined to 18% in 2007. So far, the progress rate of the indicator 17 is poor; hence there is a fair degree of doubt about achieving the target in time. To meet MDG 5, Bangladesh must increase the proportion of births attended by skilled health personnel to 50 per cent by 2015.

Table 5(1): MDG 5: Target and Achievements

Goal	Target	Indicator	Base year (1991)	Current	Target
GOAL 5: Improve maternal health	6. Reduce by the three quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio (per 100,000 live births)	574	290 (2006)	147
		17. Proportion of births attended by skilled health personnel	5%	20% (2006)	50%

(Source: Millennium Development Goals: Mid Term Bangladesh Progress Report 2007)

Table 5 (2): MDG 5: Trends of Attainment

Goal	Base year	Mid-term Report 2007	Current Status
Maternal mortality ratio	574	290 (2006)	351 (2007)
Proportion of births attended by skilled health personnel	5%	20% (2006)	18% (2007)

(Source: Millennium Development Goals: Bangladesh Progress Report 2008)

In the second report dire skepticism has been expressed about the attaining targets of MDG 5 as it estimates the probable figure of MMR and proportion of births attended by skilled health personnel in 2015 as 317 and 26.90 per cent respectively which are far below the actual targets (GOB and UNDP, 2008:50). So, Bangladesh needs to accelerate the rate of progress to reach at least near the 2015 targets..

Bangladesh should quickly catch up with respect to indicator 16 and 17 in MDG 5. This goal, in general, has thrown up some steep hurdles, because it is inextricably linked with complex social and economic factors related to health beliefs and practices, education and poverty. This makes the challenge of maintaining the maternal mortality reduction rate harder, particularly given the widespread practice of early marriage and reluctance to go for birth-attendance by skilled personnel. Bangladesh should establish proper institutional arrangements, improve effective service delivery, effective management (especially in primary and maternal health services) and needs an extensive training program to increase the number of skilled birth attendants, and last but not the least, enhance the awareness of people.

3.4 Millennium Development Goal 6

i. HIV/AIDS Prevalence Rate

There is a dearth of data on HIV/AIDS in Bangladesh. Though some sources suggest that the HIV/AIDS prevalence rate is insignificant

and detection is very low, the number of HIV positive persons in Bangladesh was around 12,000 up to 2007 (HIVinsite, 2009). However, risky behavior is very common among some vulnerable groups, since sex workers in Bangladesh have more partners than anywhere in Asia and almost everyone buying sex in Bangladesh is having unprotected sex (Begum and Salimullah, 2004:99). In addition, because of the increasing numbers of workers migrated abroad, and the increased numbers of people traveling to the neighboring country where the HIV/AIDS prevalence rate is reportedly higher, the number mentioned above is expected to rise sharply since insufficient attention is given to prevention. Although the prevalence of HIV/AIDS in Bangladesh is very low, effective surveillance of the potential sources is essential.

Table 6(1): MDG 6: Targets and Achievements

Goal	Target	Indicators	Base year (1991)	Current status	Target 2015
GOAL 6: Combat HIV/AIDS, malaria and other diseases	7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.	N/A	N/A	
		19. Condom use rate of the contraceptive prevalence rate (among currently married women 15-49 years old)	2.5%	5.5% (2004)	
		19a. Condom use at the last high-risk sex	N/A	N/A	
		19b. Per cent of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	N/A	38(2004)	

Goal	Target	Indicators	Base year (1991)	Current status	Target 2015
	8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.	19c. Contraceptive prevalence rate	40%	58%	
		20. Ratio of school attendance of orphans to school attendance of non-orphans	N/A	N/A	
		21a. Notified cases of malaria per 100,000 population	42	34(2005)	
		21b. Malaria death rate per 100,000 population, all ages		0.35(2005)	
		22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	N/A	N/A	
		23a. Tuberculosis prevalence rate per 100,000 population	N/A	406(2005)	
		23b. Tuberculosis death rate per 100,000 population	N/A	47(2005)	
		24a. Tuberculosis detection rate under DOTS	34%	71%(2005)	100%
		24b. Tuberculosis treatment success rate under DOTS	84%	91%(2005)	100%

(Source: Millennium Development Goals: Mid Term Bangladesh Progress Report 2007)

Table 6 (2): MDG 6: Trends of Attainment (HIV/AIDS)

Goal	Base year	Mid-term Report 2007	Current Status
HIV prevalence among population	0.005	-	0.319 (2007)
Condom use rate		-	4.5 (2007)
Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV		-	15.8 (2006)

(Source: Millennium Development Goals: Bangladesh Progress Report 2008)

Table 6 (3): MDG 6: Trends of Attainment (Malaria and TB)

Goal	Base year	Mid-term Report 2007	Current Status	Target by 2015
Prevalence of malaria per 100,000 population	43(2000)	34(2005)	59(2008)	Halting
Death rate associated with malaria per 100,000 population	0.37(2000)	0.35(2005)	0.11(2008)	Halting
Proportion of children under-five sleeping under insecticide treated bed nets (13 malaria prone districts)	-	-	89(2008)	-
Prevalence of TB per 100,000 population	264(1990)	406(2005)	225(2007)	Halting
Death rate associated with TB 100,000 population	76(1990)	47(2005)	45(2007)	Halving

Goal	Base year	Mid-term Report 2007	Current Status	Target by 2015
Detection rate of TB under DOTS	21(1994)	71.1(2005)	73(2007)	Sustain
Cure rate of TB under DOTS	73(1994)	91.5 (2005)	91(2006)	Sustain

(Source: Millennium Development Goals: Bangladesh Progress Report 2008)

ii. Condom Use Rate and Contraceptive Prevalence Rate

As mentioned in the first government report, surveys suggest that a government advocacy campaign has led to 38.4 per cent of the population professing a comprehensive knowledge of HIV/AIDS. The contraceptive prevalence rate has risen from 40 per cent in 1991 to 58 per cent in 2004, an average annual increase of 1.4 per cent. Use of condoms among married women in the 15-49 age group increased from 2.5 per cent in 1990 to 5.5 per cent in 2004, but has decline to 4.5 percent in 2007 as found in the second report. Data for condom use among high-risk groups are not available. As per the second report still a huge proportion of the population have lack of knowledge about HIV/AIDS as the proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS has been found to only 15.8 per cent.

It follows that there is no hope of achieving the targets in this regard. The second report is also skeptical about the targets related to HIV/AIDS whereas hopeful of the attainment of malaria and TB related targets (GOB and UNDP: 60). It means that the GOB has lot more things to do about HIV/AIDS.

iii. Malaria

Though aggregately Bangladesh has made some progress in combating the spread of malaria, threat is deepening in some parts of the country. As per government reports mentioned above, the disease's prevalence dropped from 42 cases per 100,000 in 2001 to 34

in 2005, but there has been a sharp increase to 59 cases in 2008. Though death rate associated with it has declined in 2008, but prevalence could not be halted. While malaria is endemic in 13 of the country's 64 districts, the impoverished people living in the remote hill tracts and adjacent districts of East and Northeast border of the country are most the affected (Mahmood et al 2000). Over 98 per cent of all malaria cases are concentrated in these areas. In total, those 13 districts accounted for 48,121 laboratory confirmed cases and 501 deaths in 2005-against 48,647 cases and 502 deaths nationally. This is down from the previous year's figures of 58,894 cases in those 13 districts (59,853 nationally) and 535 deaths (538 nationally).

However, the story is not all pleasant-as national mechanism to combat malaria has become weak due to insufficient resources, poor surveillance, rising drug resistance, prohibitive costs of insecticides and poor community mobilization (Begum and Salimullah, 2004:99). It follows from the above trend and facts that though there have been progress in curbing spreading of malaria, the rate of progress is not sufficient to achieve target by 2015. The country also needs to develop strong mechanisms to monitor outbreaks of malaria in high-risk districts and to develop effective treatments for drug resistant malaria strains. Simultaneous increases in detection and cure rates, along with improvements in the quality of diagnostic services, will continue to pose a major challenge for the country.

iv. Tuberculosis

Tuberculosis (TB) is a leading cause of adult mortality and preventable death in Bangladesh. An estimated seventy thousand individuals die from TB each year in Bangladesh-one death every ten minutes (Open Society Institute, 2006: 7). TB hits the poor and most economically productive age group. However, Bangladesh has also achieved significant success in halting and reversing the spread of tuberculosis (TB). The year 2007 has been marked with huge decline in the prevalence of TB, as it has fallen to 225 cases from 406 cases in 2005.

Deaths associated with TB have also decreased in 2007. Detection of tuberculosis by the Directly Observed Treatment System (DOTS) more than doubled between 2002 and 2005, rising from 34 per cent to 71 per cent in those three years. And also in 2007 there has been a slight increase as it has reached 73 percent. There has been moderate progress in the successful treatment of TB; though recently a very slight decline in the success rate has taken place, it has remained almost steady in 2007 compared to 2005.

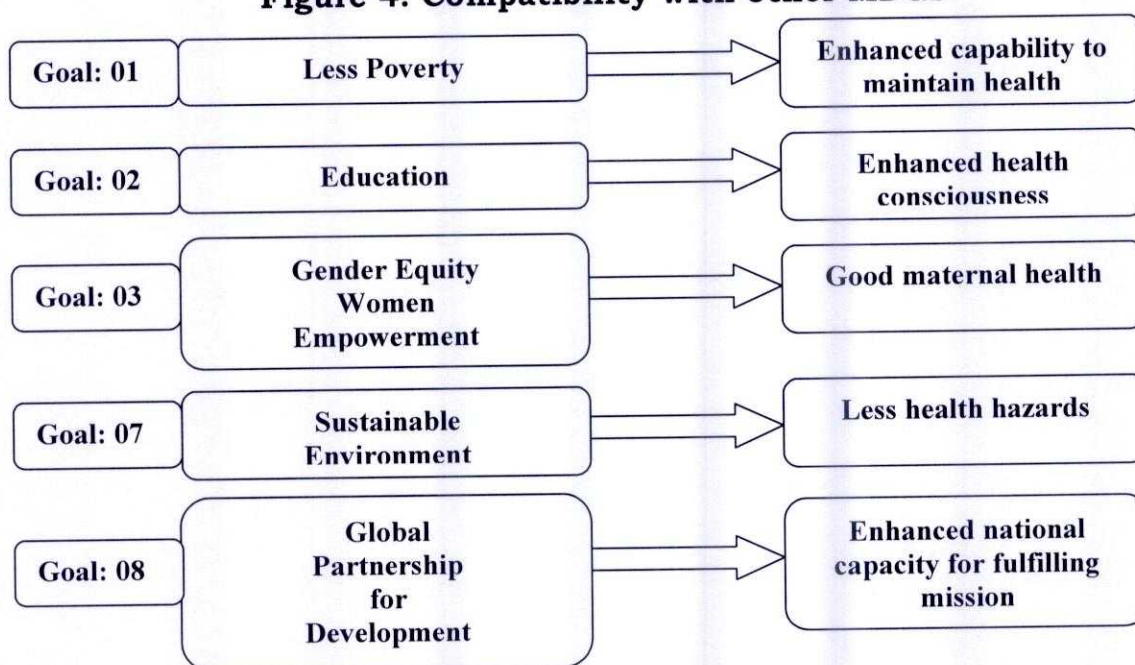
Though in respect of TB the performance has been fairly impressive Bangladesh still has a long way before 100 per cent detection and successfully treating TB is achieved. In practice, 100 per cent success in any treatment is not always the case as cure depends on many external factors also. However, if the external factors remain favorable Bangladesh could surely go near 100 percent success in curing TB. Detection is a very important factor; the success in treatment in a particular case could easily be achieved, provided that a case is detected for treatment to be done. But if a significant number of TB cases goes unnoticed, true success in curbing TB would never be achieved. The data published by the government also indicate that the rate of progress in regards of detecting TB is not enough to achieve the target by the deadline.

In the second report halving has been mentioned as the target for deaths associated with TB (GOB and UNDO, 2008: XVII); whereas in all other documents on MDGs 'halting and reversing' has been mentioned as the target related to it. Now, if only the target of halving is concerned it is quite possible to be achieved by 2015 because already it has approached almost half (45) of the base year's figure i.e. 75. But if the halting and reversing is concerned the target would become very tough to be achieved.

3.5 Compatibility with other MDGs

As said earlier that MDGs covers six fields of socio-economic arena, it is very interesting to look at the fact at all the health-related MDGs are somehow compatible with five MDGs of other fields. How the other MDGs affect health-related MDGs has been shown in the following diagram:

Figure 4: Compatibility with other MDGs



(Self-compiled)

In Bangladesh, the economic condition of a large proportion of the population is far from satisfactory and poverty is widespread; forty percent of the population is living below poverty-line. This is the main causes as to why they cannot afford to maintain good health. Another prime cause is the lack of education. The uneducated people, in general, are not aware of demerits of having many children and also unaware of health-maintaining measures. In the patriarchal society, women have minimal right to decide even about their own health, in that, the pain of more child-bearing which hampers health condition is imposed upon the women. So, if women get education and are given empowerment they would be more conscious about maternal health as well as child's health. Good environment for living means less

health hazards for the population and when global partnership for development is strong, the capacity of the poor countries like Bangladesh for fulfilling the human developmental challenges would be easier.

The compatible relationships among MDGs give some important indication, that is, if the progress rates of other five MDGs are sound they would help accelerate the attainment of health-related MDGs. Hence there has to be a strong nexus amongst all the efforts of the attaining of MDGs, and the attainment of the health-related MDGs will be easier if other MDGs are on the track. It is a very important point to be noted by both policy makers and policy implementers.

Chapter 4

Setbacks and Difficulties

4.1 Prelude

In general, every sector of Bangladesh is prone to manifold problems, both from micro and macro-environment; health sector is no exception. In this chapter in the subsequent sections, common problems and hazards faced by the people of Bangladesh, socio-economic perspectives aggravating the poor health condition of the population, particularly its relation with poverty, and lastly some practical difficulties found particularly in the health sector which as a whole could be seen as setbacks for fulfilling the challenges for mission of health of Bangladesh will be analyzed.

4.2 Problems and Hazards Faced by People

The quality of the health services in Bangladesh, be it provided by government or private sector, is not good as generally perceived by the people. The condition of the public sector is more severe. The following are the problems seen in general in the health sector of Bangladesh:

- lack of proper service delivery
- medicines are not available in the government hospitals as stolen therefrom and trafficked to private dispensaries
- patients in the government hospitals do not get food as per allotment due to pilferage or misappropriation of fund
- faulty treatment by quacks or fake doctors and technicians causing health hazards or even loss of life
- loss of money of the service seekers

The above problems have been persisting in the health sector of Bangladesh for long. Of them the first three ones are commonly seen in the government hospital and health centers. Evidences reveal that it is the poor and rural people who are mostly subject to these

problems, because most of the time they find no other options but going to the government hospitals or health centers and unqualified service providers or quacks simply because of the inability to bear the cost of quality private services.

The people of Bangladesh have been facing a number of public health hazards from time to time. Some of these hazards are persistent and the others are seasonal in nature. Environmental pollution, arsenic contamination, avian influenza and AIDS are sources of these public health hazards.

i. Environmental Pollution

Environmental pollution is perhaps the most rampant problem causing the public health hazards of the highest order. These hazards are widening day by day. Air, water, soil, and sound are all contaminated due to human actions. Amongst them, the exposure to air pollution is the main environmental threat to human health in many towns and cities. Smoke-emission is mainly responsible for increased death rate and respiratory problems for the urban population. This problem is acute in Dhaka, the capital of the country and also the hub of commercial activity. Around 1,000 metric tons of pollutants are pumped into the air of Dhaka city alone every day of which seventy percent emanates from vehicles. Dhaka accounts for 15,000 deaths due to air pollution annually. About 6.5 million people of four major cities of Bangladesh annually suffer from respiratory infection due to air pollution only (sos-arsenic.net, 2002).

Toxic industrial wastes are causing water pollution and making water unsafe for human use. The people living beside the industries are mostly affected by the industrial toxics. Consumption or use of this water poses threat of long term harms for various internal organs of the human body and may even cause cancer. Moreover, a large proportion of Bangladeshi people still do not have access to safe drinking water. It causes diarrheal diseases mainly in slum areas of the cities. Soil is also getting contaminated by industrial toxic

chemicals drained out to the farm lands. So, the workers in agricultural land and the consumers of agro-products are having the hazards. Yet another problem is becoming alarming, that is, pesticides used in agricultural purposes. Some of them are sprayed directly to the fruits and vegetables; people are directly consuming these toxic pesticides which might even cause immediate damage to public health. Excessive use of pesticides on farmlands in two villages of Dhamrai upazila of Dhaka district caused death of at least three children a few months ago (BangladeshNews, 2009).

Sound pollution or noise pollution is increasing to an alarming extent. In this regard, the condition of Dhaka city where more than 10% of the country's entire population resides is just more than severe. The noise levels measured in different areas of Dhaka city are substantially higher than the acceptable level. The intolerable level of sound all around Dhaka city is resulting in sharp increase of the number of patients to the ENT doctors, especially with hearing impediment (Arzu, 2006). In addition, it may also lead to cardiovascular problem.

ii. Arsenic Contamination

Arsenic contamination has already been posing its threats to public health in Bangladesh. Under ground water of more or less 53 Districts of Bangladesh are found contaminated with arsenic. Meanwhile, the 8 to 12 million contaminated wells across the country continue to be the main source of water for most Bangladeshis, presenting a growing danger to their lives. The scope of the calamity has drawn worldwide concern and triggered a broad effort to remedy of the problem.

Today, more than 30 million people in Bangladesh are affected by contaminated water. In West Bengal, the area across the border with India, a minimum of 6 million people, including 2 million children belonging to 9 out of the total 18 districts were drinking arsenic contaminated water, which contained arsenic of more than 50 ug/L. The victims show a number of symptoms, ranging from

blackened fingernails, hair follicles, and white or black patches on the skin. Arsenic also inflicts serious damage to the lungs, liver, and kidneys while arsenic-related cancer causes nearly three thousand deaths a year. Since the symptoms may appear as long as ten years after someone starts drinking contaminated water, and because the arsenic does not affect everyone the same way, many cases of poisoning have gone unreported. Proper reporting is also hindered by the fact that the arsenic does not come only through the water, but through the food chain as well. Even those who manage to avoid contaminated water can be exposed to poisoning through ingesting rice, peas, wheat, and meat. However, the extent of arsenic contamination of food is still unknown.

Although the WHO's recommended maximum limit for arsenic in drinking water is 0.01 mg/L, the Bangladesh government's standard is at a slightly higher rate, at 0.05 mg/L being considered safe. The arsenic levels in Bangladesh, in some cases, exceed 5.00 mg/L. Forty thousand people in Bangladesh are already showing signs of arsenic poisoning, what may be rightly termed as the largest case of mass poisoning in history. Arsenic poisoning will cause about ten percent of future adult deaths in Bangladesh (population ~150 million) unless something is done. Some research concludes that even at the lower concentrations, there is still a risk of arsenic contamination leading to major causes of death.

iii. Avian Influenza

Avian influenza, commonly known as bird flu is mostly a seasonal problem-it haunts Bangladesh almost every year. It poses threat mainly to those who deal in poultry business. The 'Ministry of Fisheries and Livestock' has recently reported two fresh outbreak of H5 poultry A1 outbreaks in two district namely as Chittagong and Rajshai on August 29, 2009. Previous outbreaks have been in thirteen districts during the period of January to June' 2009 (WHO, 2009).

Though so far only one human case of H5N1 (the technical name of the virus) infection occurred in January 2008, it does not mean that no threats are prevailing, in fact Bangladesh is a high-risk country in this regard.

iv. HIV/AIDS

Though so far it has not yet broken out in a large scale in Bangladesh, but it may someday emerge as a threat to the population since the country is surrounded by India a HIV-prone country and a huge of Bangladeshis are working abroad some of whom might possess HIV clandestinely and spread it in Bangladesh. It is evident from the fact that HIV positive Bangladeshis are concentrated in the expatriate dominated districts. The number of HIV Positive persons in Bangladesh was 12,000 up to 2007. In 2008, at least 42 people in Bangladesh died of it, 111 got infected and 288 found HIV positive, whereas in 2007, 123 people died of AIDS, 365 others got infected and 1,207 were found HIV positive. These are not negligible figures, so if the issue is not properly taken care of it may sometime turn into disastrous one.

4.3 Socio-Economic Perspectives: Macro-Environment

The government data showing that the health condition of population is improving may mislead someone about the true picture of the overall health governance of Bangladesh. Although since 1990s some indicators like life expectancy, material mortality, child and infant mortality have improved significantly, but the overall health condition of the population is far from satisfactory and vulnerable to health hazards as well-the socio-economic factors from the macro-environment behind which are the following:

i. Poverty

Poverty means less capacity to have access to basic necessities of life like food, health care, education, clothes, and housing. Poverty is

perhaps singly the largest factor behind poor health condition. Poverty is one which does have multifaceted effects on people's life. As the poor people cannot have access to nutritious food, it primarily causes their inability to maintain good health; it leads them to vulnerability to health hazards and furthermore, they cannot spend required money for health care when they fall sick. Some diseases such as TB, malaria etc. are termed as the diseases of the poor. Poverty also causes urban-rural differentials in health service.

ii. Less Education

The average level of education of the people is low; moreover a large proportion of population is still illiterate (the literacy rate was 56.10 percent in 2007) (BBS, 2007). These people are plausibly less aware of health or less health conscious. This might have also contributed to the on-going poor health condition and vulnerability to health hazards. For example, people are having food items sold in open space without hygiene and falling victim of bacterial diseases, and also consuming fruits ripened by toxic chemicals like calcium carbide. Some producers are mixing artificial chemicals to ripen fruits without knowledge about how harmful they can be to human health. So, less awareness has impact in both ways; from the consumers' side and also from the producers' side.

iii. Material Pursuit

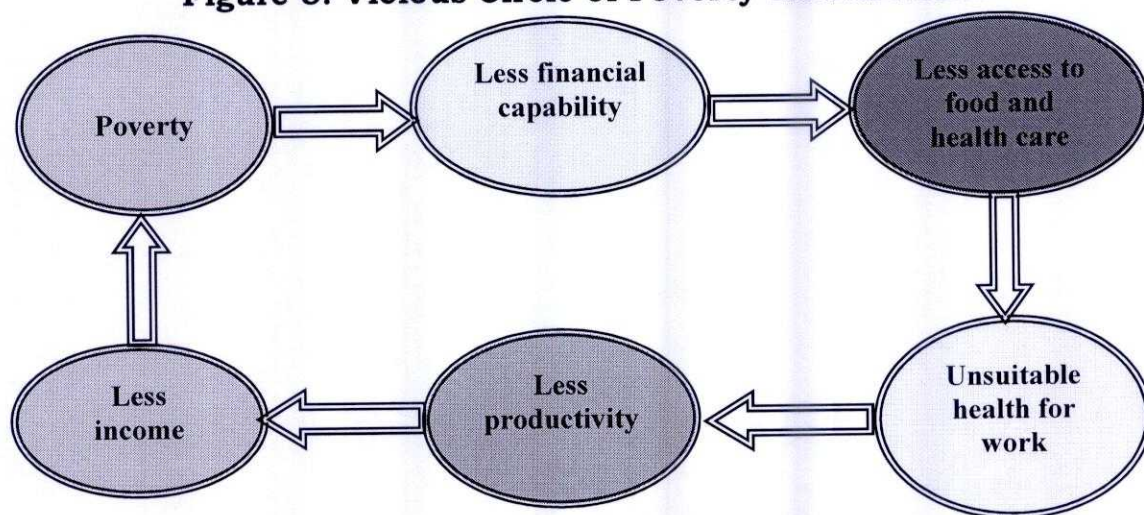
Our whole society is suffering from erosion of moral values and idealism. Some of our businessmen are so callous about the consumers' right to safe products that they do not hesitate to sell adulterated products. Some food traders adulterate the food items and some others ripen fruits using toxic chemicals, even knowing the magnitude of hazards to public health. These unscrupulous businessmen hanker after profit only. They do not mind to make profit even at the cost of causing harm to consumers.

4.4 Poverty-Health Nexus and Inequalities

As said earlier, health has a direct and conspicuous relation with poverty. It is observed that the health condition of the poor is also poor. They do not have access to proper food and medical care, and their children are most vulnerable. It can be said that that poverty is a major cause of under nutrition and ill health; it contributes to the spread of disease, undermines the effectiveness of health services and slows population control. Morbidity and disability among the poor and disadvantaged groups lead to a vicious spiral of marginalization, to their remaining in poverty, and in turn, to increased ill health. So, the relation between poverty and health needs to be discussed separately and it has been done here in this section.

In Bangladesh, the profile of human deprivation is revealed in the incidence of poverty that about 40 percent of the people of Bangladesh are income-poor in terms of head count index (HIES, 2005). These people lack basic or minimally essential human capabilities: capacity to be well-nourished and healthy, capacity for healthy reproduction, and capacity to be educated and knowledgeable. There is a large income inequality and this inequality is increasing alarmingly. Poverty and unsound health keep a very strong nexus and involve in a vicious circle that can be logically delineated by the following diagram. Poverty leaves an individual with less financial capability which hinders necessary access to health care and food. Healthier people can transform their energy into productivity, both mental and physical, more efficiently than ill-healthy and undernourished people can do. An efficient use of people's productivity turns into more economic output, higher income and economic development (Akter and Wohab, 2006:125). On the other hand, lack of proper food and health care leads to unsuitable health which reduces the productivity and then earning scope of the individual. And finally less income leads again to poverty and thus fulfills the vicious circle.

Figure 5: Vicious Circle of Poverty-Health Nexus



(Self-compiled)

Poverty is a major contributory factor to poor health. Poverty and the associated characteristics are overcrowded housing, limited assets, inadequate nutrition, and low levels of education and poor environment, which inevitably increase susceptibility to ill health. For these reasons, diseases such as tuberculosis, malnutrition, diarrhea and malaria are often termed as the 'diseases of the poor'. Similarly, poor health often leads to and reinforces poverty, both through the high costs of health care, and the effects of ill health on household income and productivity. Ill health and its consequences can drive the nearly poor into poverty, or the moderately poor into more severe poverty.

In Bangladesh poverty is a widespread phenomenon. Despite relentless efforts by the government and non-governmental developmental agencies reduction of poverty is slow or negligible. As delineated in the above diagram, the persisting poverty of a significant proportion of the population has been one of the major causes of unsatisfactory health condition. Health condition of an individual depends on both on health care and nutrition, and as matter of fact it is far from possible for the government alone to provide all forms of medical care and food items free of cost; hence an underlying fact come out in front, that is, unless and until poverty is reduced to a

significant extent, the health condition of the population would remain as usually far from satisfactory.

4.5 Difficulties and Malpractices: Micro-Environment

There are reasons to believe that the path of MDGs along with health-related other challenges is not smooth for a number of factors from within the health sector which, directly or indirectly, impede the achievement thereof. As a whole, the health sector of Bangladesh encounters a number of inherent and persisting difficulties and malpractices. The government itself, the service providers, the pharmaceutical companies are liable for their part in the problems and malpractices stated below:

i. Lack of Adequate Manpower and Facilities

Albeit significant progress has taken place in expanding the physical and human facilities, the total availability has still been woefully inadequate in relation to the needs of the people of Bangladesh. The state-run facilities, especially in rural areas, are facing acute shortage of health professionals. '*State of Health in Bangladesh 2007*' a report published by the civil society group reveals the story in this regard; it shows that Bangladesh is still running a staggering shortage of over 60,000 doctors, 2.8 *lakh* nurses and 4.83 *lakh* health technologists. And from the perspective of availability of health professionals, it has been found that there are roughly five physicians and two nurses per 10,000 people, the report also reveals another striking fact, that is, the country currently has two doctors for every nurse – a scenario inverse of the World Health Organization's recommendation of having three nurses per doctor in a well-functioning healthcare system (Shakeel, 2008: ii).

According to 'Health Ministry', of the 90,000 public health care personnel position in the country, 18,000 are currently vacant, including the post of about 5,500 doctors (AlertNet, 2009). Nationwide the average number of vacancies over all types of providers in rural

health centers is 26 percent. Regionally, vacancy rates (unfilled posts) are generally higher in the poorer parts of the country (Chaudhury and Hammaer, 2003: Abstract). Hence rural Bangladesh is facing health care crisis. Better service from any institution requires that it is adequately manned, but the rate of recruiting fresh health professionals in government health centers is not keeping pace with the sizeable population of Bangladesh.

ii. Partisan Associations of Doctors

Despite under Government Service Rules the government employees' involvement in politics is strictly prohibited, the government doctors of Bangladesh perhaps are the only government professionals who involve in active politics of the two major political parties though under disguised banner. They politically pursue in posting of doctors. The doctors once posted in rural or peripheral areas try to get posting by using political persuasion through their association. It creates a situation in which the health centers of the city areas are overmanned and to the extreme health professionals, in some cases, outnumber patients whereas the health centers of rural areas are undermanned. For example, in gynecology and obstetrics department at Bangabandhu Sheikh Mujib Medical University (BSMMU), the prime medical institute of Dhaka, one hundred and six physicians are on duty for a department which has the capacity to house only eighty patients (IRIN, 2009). But the exact opposite situation is prevailing rural areas where shortage of health professionals almost plagues the service system (AlertNet, 2009).

iii. Absenteeism of Doctors

This is one the most acute problems of the government health centers in rural areas. The union health sub-centers are simply bogged down by this problem and upazila health complexes are also facing it which affects the rural people the most. The doctors who are posed at the rural stations do not like to stay there and their accountability mechanism is also poor. Besides, they sometimes go for persuasion for

posting in the urban or at least semi urban areas. This is why the union sub-centers most of the time remain undermanned. When separated into level of facility, the absentee rate for doctors at the larger clinics is 40 percent, but at the smaller sub-centers with a single doctor, the rate is 74 percent (Chaudhury and Hammaer, 2003: Abstract). Absenteeism is not a fact that is found in the case of doctors only, in fact the whole health workforce in the upazila level is prone to this malpractice. A study report by the World Bank in 2007 reveals that as a whole approximately 16 percent employees were found absent from the upazila health complexes studied. Although 16 percent of the employees were found fully absent, there are a large number of employees who remain absent for a few hours. It was frequently observed by this study that the employees arrive late, and some employees leave office at any time once or twice during office hours. Often, they remain outside the office for up to a few hours (World Bank, 2007:7-8). How severe the situation is can be portrayed by the figure given in the following table.

Table 7: Absenteeism of Health Workforce

Designation	Number of Employees Observed		
	Expected as per Record/List	Found Present	% of Absenteeism
UHFPO	15	14	7
RMO	13	10	23
UFPO	13	7	46
MOMCH	15	10	33
MO	43	32	26
3rd class and 4th class employees	297	259	13

(Source: Health Risk Area Validation Survey 2004 as cited in the World Bank, Bangladesh Development Series, Paper No.15, March 2007)

It happens because of the lack of supervision by the authority and weak accountability mechanism of the doctors. This might cause yet another problem, that is, the few doctors who actually remain present in the rural hospitals are likely to be overburdened with patients and demoralized by the poor facilities and equipment.

Absenteeism of staff and health professionals has a direct influence on the availability of healthcare for the poor. Poor people have to pay extra payments to health staff to access services. These payments mean a substantial burden to them. The massive cost associated with absenteeism, especially for the poor, justifies immediate action first to ensure that the system uses resources more efficiently and second begin to build client's confidence in the delivery of health services (World Bank, 2007: 10)

iv. Private Practice of Doctors

In Bangladesh, an estimated 80% of government doctors engage (legally) in private practice as well, and most at least double their government salary this way (Vian, 2002:22). In another study by the World Bank in 2007, sixty percent of doctors in the hospitals were found engaged in private practice during office hour. Some doctors have private offices outside the health complex. Doctors also leave the public facility early to work his or her private office (World Bank, 2007: 13, 47). In this study about one-fifth of the patients (as the respondents) reported that the doctor was absent (World Bank, 2007: 55). In response to a question about directing patients to the doctor's private office, about one-fifth of the patients responded positively that doctors had in fact steered them toward their private practice (World Bank, 2007: 47).

Hence it is evident that most of the practitioners give more time and efforts to their private practice than to their official duties in hospitals. This is one of the major causes of absenteeism of doctors and unsatisfactory service in government hospitals. Though private practice is not illegal, nonetheless the on-going kind of practice

indicates utter violation of professional ethics. Unfortunately, there is no effective mechanism to hold them accountable for this unethical practice. It is also widely perceived that the doctors have implied contract with the pathological or diagnostic centers to steer the patients for test into those centers even if it is sometimes unnecessary. In return, these doctors receive certain commission from those centers. As there is rural-urban difference in availability of healthcare services, the said problems and malpractices may be attributed to this difference.

v. Syndicate of ‘Dalals’ (Brokers) and Private Clinics

Some private clinics recruit brokers locally known as ‘*Dalals*’ who are out there to collect patients for the profit seeking clinic owners. The rural innocent people who come to the city areas for treatment in the public hospital are the main target of these brokers. These patients are steered or even sometimes forced by these brokers to visit private clinics they are working for.

vi. Rampant Employees’ Unions

This is one of the common problems in the service sectors run by the government. The employees’ unions of the public hospitals are the source of power of some unruly employees. The staff misbehavior is a very common phenomenon in government hospitals. These unruly employees not only misbehave with the patients and their attendants, they sometimes get into conflict also with the doctors. This misbehavior is just an expression of their power. Besides, sometimes their conflict with the doctors disrupts the normalcy in the hospital. For example, on 03 May, 2007, a trivial matter triggered a clash between doctors and employees at Dhaka Medical College Hospital (DMCH) disrupting services at the country’s largest public hospital for about two hours (The Prothom Alo, 2007a). An investigation report by TIB cited the areas of mismanagement in DMCH particularly demanding bribes for seat allocation, medicine, extra care, and appointment of food suppliers. A mafia gang comprising of third grade

employees are engaged in massive corruption, mismanagement, harassment and negligence to the patients in the country's premier hospital, and often the doctors and nurses become hostage to the gang as employees' jobs are not transferable. The corrupt employees are also involved with the pilferage of medicine medical equipment from the hospital (The Daily Star, 2006a). This type of practices surely impedes the quality service to be given in the government hospitals.

vii. Lack of Effective Law

News regarding clashes between the relatives and hospital personnel following the death of the patients due to alleged faulty treatment or negligence of the hospital personnel is very often found in the newspapers of Bangladesh. Health is a very sensitive matter, so any negligence of health professionals may cause serious damage to the patients' health which may even lead to loss of life. But unfortunately there is no effective legal measure to hold those defaulters guilty for their misdeeds and for reparation for the patients due to damage done by negligence or faulty treatment.

viii. Corruption

Health sector is one of the leading corrupt sectors of Bangladesh. According to a report published by TIB in 2003, health sector ranked fourth in terms of incidence of corruption. In the government hospitals medicine are not available, because a huge number of medicines are stolen. Some employees of government hospitals are allegedly selling medicines to the markets and depriving the patients especially the poor ones. Not only medicines, but other medical supplies are also being stolen. The hospital authorities, from top to bottom, know well that the drugs, meant for treatment of the patients, are available at drug shops, not in the hospital pharmacy or drug store room; nonetheless, so far there has been no visibly strong attempt to stop this stealing. Another form of corruption is food related. Patients in the government hospital do not get food as per allotment because of pilferage or misappropriation of fund.

ix. Unethical Promotion of Drug

In fact, this is a significant problem not only in the developing countries, but also throughout the world (Vian, 2002:9). The pharmaceutical industry in Bangladesh is also engaged in unethical promotion of medicines. The pharmaceutical companies are always pursuing for selling their medicines and offer free samples and lucrative gifts to bias the doctors to prescribe the medicines of particular companies, even if the quality of their medicines might not be upto mark. By this way, the doctors get into a kind of understanding with particular pharmaceutical companies to help sell their products. This is a kind of violation of the professional ethics. The government has almost nothing to do in this regard, that is, it can neither intervene in the prescriptions the doctors give as they are free in giving their prescriptions, nor can it stop the pharmaceutical companies from giving lucrative gifts to doctors as it is almost impossible to monitor. In fact, this is more an ethical issue than governance issue.

x. Lack of Supervision

There is lack of supervision over the fake doctors and technicians, quacks, and practices of private clinics that do not have competent and trained manpower and also doing business without authorization and those who are selling adulterated, expired and sub-standard medicines. Besides, the doctors who do not stay at their stations at rural areas are perhaps beyond the supervision of their controlling authority. In fact, lack of supervision is the root of many other problems such as absenteeism of doctors, corruption, rural-urban difference etc.

xi. Lack of Coordination

Coordination is very necessary for better health governance, but the 'Ministry of Health' does not seem to have any formal coordination with other ministries and offices such as the 'Ministry of Environment' and 'Ministry of Women and Children Affairs' and BSTI etc.

Partisan associations of doctors, absenteeism of doctors, their inclination to private practice, syndicate of brokers and private clinics, rampant employees' unions, and corruption associated with health sector discussed above have all the indications of lack of rule of law. This is a sign of governance failure; in fact, the general picture of the rule of law in Bangladesh is far from satisfactory as the laws are not implemented properly. It is also true to a large extent in regards of the health-related laws.

The worst-rated governance indicator in health sector is the lack of accountability of health manpower. The other indicators such as equity, effectiveness, efficiency etc. are not also satisfactory in health sector, be it public or private. There is lack of equity between the service for rich and poor people. Both the government sector and a large proportion of private sector are lacking effectiveness and efficiency. The governance scenario of Bangladesh, in general, is not satisfactory. Bangladesh shows all the symptoms of an underdeveloped polity. The governance in one sector is not independent of other sectors, because all the sectors run under the purview of some general set-up. In Bangladesh, laws are abundant in number, but the question is as to whether they are all implemented well or whether they are all effective enough to create public value-the answer is very sure "no". A number of laws are outdated, poorly formulated and poorly enforced, especially in the health sector and so the malpractices mentioned above have been persisting for years together. For example, '*The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982*' is a law which is hardly found to be satisfactorily complied with by the private clinics and diagnostic centers outside the city areas.

The above discussion proves the fact that health governance in Bangladesh is very complex as it has to encounter manifold problems and difficulties. Along side, all the problems stated in this section could be seen as the indicators of governance failure since they are exclusively under the domain of health governance.

Chapter 5

Findings of the Study

5.1 Viability of Attaining MDGs

Based on the analysis and discussion made so far in this study, the findings are the following:

Though according to government reports as well as some other reports, Bangladesh's progress towards MDG 4 indicators is encouraging, the contention of this study is that the progress rates are not enough, so the possibility of Bangladesh of attaining Goal 4: (Reduce Child Mortality) is partial, that is, if the current trend continues it could achieve the indicator 13 (U5 mortality rate), but there is fair degree of doubt of achieving indicator 14 (infant mortality rate). The possibility of achieving indicator 15 (immunization) is also less.

The very recent trend in the indicators of MDG 5 has come as a terrible blow to its attainment. Until 2006, the trend of indicator 16 (maternal motility ratio) had been fairly impressive, but very recently there has been a sharp turning-around; if a few such degradations take place ahead which is not very unusual in a country like Bangladesh there is no hope of attaining target in this respect by the deadline. Indicator the 17 (the proportion of births attended by the skilled health personnel) also has no possibility to reach the target by 2015 due to some social constraints which will be elaborated below. Independent report also supports that though Bangladesh is on the track to meet most of the MDGs, but those which may not be achieved include poverty reduction, and maternal and under-five mortality (RIU, 2007). And there is no hope of achieving MDG 6 in respect HIV/AIDS and malaria, because of the performance so far in regards of target 7 (HIV/AIDS) is far behind the target of 2015 and recently the prevalence of malaria has experienced a sharp increase, and moreover it is almost impossible to entirely halt malaria prevalence in the

Chittagong Hill Tracts which is an ideal habitat of the mosquitoes acting as the vector of malaria. Nonetheless, the part of MDG 6 that has a fair degree of possibility of reaching the target is TB related. If halving of deaths is the target, based on the present trend it could be possible to be achieved, but if 'halting and reversing' is concerned the target would become very tough to be achieved. Besides, if the present trend continues target of 'halting and reversing' the prevalence of TB would not be possible to be achieved. Although not impractical or impossible, but reaching 100 percent of detection and cure of TB is not always easy, because they sometimes depends on the individuals' awareness and also the preference to be subject to detection and treatment, and besides, treatment success not only depends on the treatment itself, a number of other factors such regularity of treatment, fate of the patients etc. comes up. However, if not 100 percent due to the aforesaid causes, reaching near 100 percent in detection and treatment success could be feasible by 2015.

Besides, the recent global economic crisis has bred further degree of doubt over MDG attainment of Bangladesh. In this regard, a quotation by the eminent economist Dr. Hossain Zillur Rahman is worth mention here- he said *'The MDG has lost focus due to the global crisis that threatened the entire financial system. We should try to keep the MDG issue on table, making our argument ready on how the fuel, food, and financial crisis will eventually affect Bangladesh's MDG attainment move'* (Bangladesh Budget Watch, 2009). Moreover, the erosion of real income due to rampant price hikes is also threatening the people's individual attempts in the areas of human development like health and education. Though apparently the global crisis has not loomed large in Bangladesh, but as it requires supports from the donors in attaining MDGs, it could miss some of the crucial targets of MDGs. However, other significant findings which along with the factors discussed in section 4.3 and 4.5 could hold back the attainment of the MDGs are the following:

i. Under-utilization of Health Facilities: Though, as said earlier in chapter 2, the availability of health facilities in Bangladesh is not sufficient to meet the growing demand of the population but, there is also some striking feature of the case which is under-utilization of these facilities. According to some government as well private sources primary health care facilities are greatly underutilized, despite the tremendous health needs and repeated efforts by the government to improve these services (PRICOR, 1987; FPHP, 1999 cited in Islam M., 2000:2). Under-utilization means less productivity of the health facilities. In an underdeveloped country like Bangladesh where resources are scarce, under-utilization of facilities is in deed regrettable. Health centers have been established in three layers, even in union level. These facilities are underutilized mainly because of three reasons, namely as, lack of adequate health manpower, absenteeism (discussed earlier) and lack of awareness of the people.

ii. Lack of Awareness: What achievements have been attained so far in child and maternal health condition in Bangladesh could have been further higher, if the awareness regarding them were higher. For example, antenatal care and safe delivery is an acknowledged requirement not only for mothers' health, but also for new-born babies; a study shows that only a negligible proportion of women use Family Welfare Center (FWC) or Satellite Clinics (SC) for antenatal care (Khanum, 1996 cited in Islam, 2000:2). It is one of the causes of the low proportion of births attended by the skilled health personnel as well as the under-utilization of health facilities mentioned above.

Unlike the situation for general health, the decision about maternal health is based on preference. There has always been an expressed preferences by the rural and poor women for home deliveries as it is familiar, reassuring and supportive, and going to a health facility suggests there is something wrong and it is more frightening, unfamiliar and costly (Sida,2008:32). It means a

availing of the opportunity of the maternity-related services, even having those at their door-steps, as they are unaware or less aware of the hazards of home delivery. The patriarchal society, where status of women is low, is also liable for this problem. Neglectful and harmful practices during pregnancy and childbirth are quite common. It indicates that mere taking the facilities to the door-steps of the people is not enough, if the people are reluctant to avail those facilities. As long as people remain unaware about the demerits of home delivery there is no hope of achieving MDG 5 fully, not even within a short period beyond the deadline. Home delivery not only puts the maternal health at risks, but neonates also remain under risks.

So, mere making the services available is not enough to achieve broad national goals like MDGs, the people have to be made aware of what benefits they would get by taking those services. In this regard, the men of the families who remain consciously unconscious have the greater responsibility as the decisions regarding the maternal health care are still dominated by the husbands or the family-chief who is also inevitably a man. Their decisions regarding maternal health are predominantly based on prejudice and traditions. Sometimes, despite having the knowledge about the risks of home deliveries, they do not like to take the pregnant women to the health center. As long as they remain consciously unconscious as such the MDG indicator the 17 (the proportion of births attended by the skilled health personnel) will never be achieved. So, first the men have to be actively conscious about the care of the women during maternity and the concerned department of the GOB has to conduct huge campaign for raising the awareness amongst the people.

iii. Unequal Contest: Millennium Development Goals, as said earlier, have been adopted by 192 UN member countries. The goals, targets and indicators are general across nations, in that, all countries have to follow the same scale in respect of goals, targets and indicators. The areas such as poverty, education, health condition etc. which the

MDGs had addressed were not surely in the same scale for the member states in 2000. Thus, the member countries are on an unequal contest, as a particular country regardless of its position in the starting year had to start the race towards the goals to achieve by the same calendar year, that is, 2015. The contextual factor of the countries was overlooked while setting out MDGs. Now, there arises a big question as to if a backward country like Bangladesh fails to achieve the targets by the deadline—who is going to be responsible? - is it the country itself or the United Nations who imposed the targets?. The global policy makers did not pay attention to this issue.

5.2 Kept Failing Alma Ata Declaration

The causes as to why the country failed to keep up the Alma Ata Declaration can be traced out by examining the requirement stated in the essential components of primary health care in section 2.2. The question arises as to whether Bangladesh could maintain those conditions:

- i. Is there the universal coverage by ensuring sufficient supply of medicines and services?
- ii. Is people-centered primary health care network established?
- iii. Is people's participation ensured and are demand-led instead of supply-led policies and programs being pursued?
- iv. Has health in all policies been incorporated?

There have been mixed answers of the above questions. As discussed in section 4.2 and 4.5, in the public sector hospitals medicines are not available; the medicines are stolen and trafficked to the nearby drug shops. Very often poor people have to pay extra payments to health staff to access services. Hence the answer of the first question is very sure 'no'. The answer of the second question is fairly positive- evidences show the primary health care network is fairly strong in Bangladesh; PHC service network spreads even to

union level, but this network is not performing to its full potential due to either of lack of health professionals or their absenteeism. About the third question it can be said that people's participation in the policy-making is yet to be ensured. A policy is demand-led when actual participation of people takes place in the process of policy formulation, but the policies of Bangladesh are supply-driven as they are formulated by the individuals who do not have actual understanding of the problems. The policies do not involve people's representatives and genuine experts; for example, HPSP the first ever huge program in health sector of Bangladesh was not placed in the parliament for discussion by the people's representatives. And the answer to the fourth question is partially positive as in some of the other policies such as environment; education and labor etc. health issue has been addressed to some extent. As a whole, the essential components of PHC could not be maintained in Bangladesh and thus the vow for 'Health for All' is stumbling out on the way of its fulfillment.

Keeping the primary health care (PHC) in mind as a strategy for achieving the goal of Alma Ata declaration, Bangladesh started a pilot project in six upazilas in the year 1989-80. Subsequently PHC Program started in 1980 in light of the pilot project. The first evaluation for HFA strategy in 1986 revealed that due to various constraints PHC could not be translated into action. The constraints were inadequacy in the managerial process, lack of adequate resources, bias towards curative medicines and lack of coordination and community involvement.

Now, let us have an elaborate discussion on the other side of the story of health-related MDGs in the context of Bangladesh. This attempt has been made in the subsequent sections.

5.3 Shortcomings of MDGs

Since the base year of 1991, the mortality rate in Bangladesh has been declining in terms of both under-five mortality and infant mortality rate. It is good, no doubt; every human being who takes birth has the right to live which is a universal human right. It is very logical and rational to take care of this right. However, one thing is clear, that is, in Bangladesh child mortality mostly prevails in the lower stratum of the society and along side high birth rate is also a fact mostly found in the same stratum in comparison with the upper stratum of the society. The urban affluent and educated families have been tending to have few children. Historically the demographical pattern of Bangladesh has observed high fertility rate among women and side by side death rate was also high due to some killer diseases such as malaria, smallpox and cholera, famine, and poor health condition.

The demographic pattern of Bangladesh is immensely influenced by this lower stratum of the society because it is larger than upper stratum. The people of the lower stratum tend to have more children as a source of inexpensive labor. In a country where agriculture predominate and subsistence farming takes place, families tend to have larger families as larger family means more workers to the agricultural production and besides, lack of social securities for the elderly people also make them think that more children would secure their life in elderly age (Husain, 2004). However, in the earlier days the co-existence of both high birth rate and high death rate meant high birth rates were somewhat offset by high death rates; hence as a whole there had been somewhat natural balance in the population, which could have been even higher if the gaps between the two rates were wider. This is why until eighteenth century the population of Bangladesh remained almost stationery. Since the beginning of the nineteenth century the gaps began to become wider as the death rate had begun to diminish. In the following table the

Crude Birth Rate (CBR) and Crude Death Rate (CDR) in the beginning of the decades (except a few of the early decades) of the last century have been given for further understanding.

Table 8: CBR and CDR of Bangladesh in 20th Century

Year	CBR	CDR	Gap
1881	..	41.0	
1901	..	44.4	
1921	52.9	47.3	5.60
1941	54.7	37.8	16.90
1951	49.4	40.7	8.70
1961	48.1	29.7	18.40
1971	51.7	35.0	16.70
1981	42.0	14.0	28.00
1991	32.0	11.0	21.00

(Source: Banglapedia, 2006)

In 1901, Bangladesh had a population of 28.9 million. It increased by 9.1 percent by 1911. In the period 1911-21, the rate of increase was very slow at 5.4 percent due to high mortality from the influenza epidemic of 1918-19. In the above table, it can be seen that in 1921 the CBR and CDR were very close; henceforth the both rates have declined though there have been some ups and downs within this span of the period due to some socio-economic, political and natural events such as Bengal famine, Indo-Pak partition, cyclone, genocide in liberation war and famine again in 1974.

During the first half of the last century the population increased by 45 percent. This slow increase resulted from a combination of high birth rate and high death rate. In the second half of the twentieth century population growth was rapid, and the population tripled during this period. In the independent Bangladesh the first census took place in 1974 and found the population of the country to be 71.40 million. The incidents just stated above also depressed the CBR to some extent although the overall trend in the fertility pattern was not affected. During 1974 to 1991, a downward trend in CBR has been observed with a marked decline in the CDR. The decline in CBR

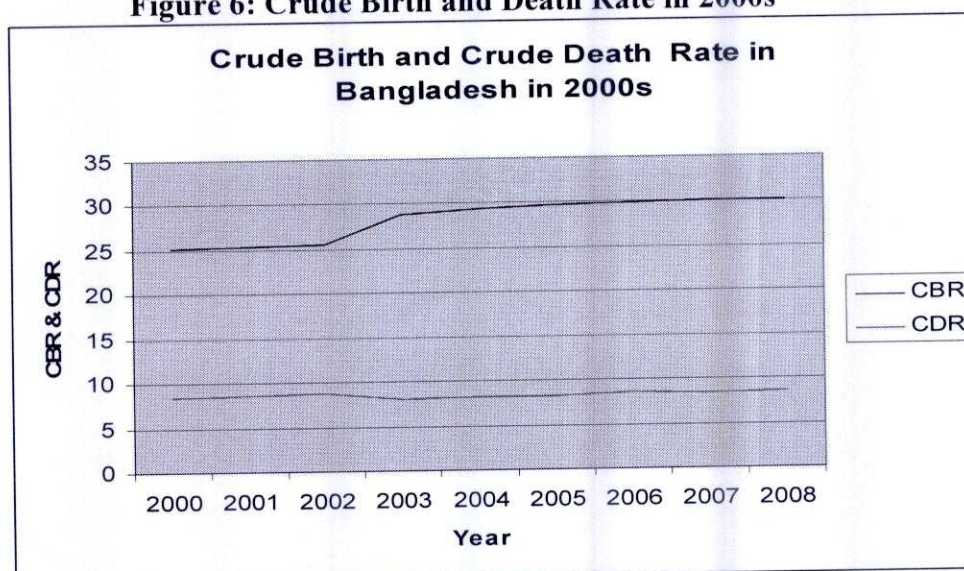
and CDR was the result of the successful control of communicable diseases and food shortages or famines, improvement of medical facilities, and to some extent, the impact of the family planning activities (Banglapedia, 2006). The CBR still remains high and well above the world average. According to the recent estimate of CIA World Factbook Bangladesh is holding the 71th position in the world in terms of CBR as arranged in descending order (CIA World Factbook, 2009).

Table 9: Crude Birth and Death Rate in 2000s

Year	CBR (Births/ 1000 population)	CDR (Deaths/ 1000 population)
2000	25.44	8.73
2001	25.30	8.60
2002	25.12	8.47
2003	29.90	8.63
2004	30.03	8.52
2005	30.01	8.40
2006	29.80	8.27
2007	29.36	8.13
2008	28.86	8.00

(Source: CIA World Factbook)

Figure 6: Crude Birth and Death Rate in 2000s



If the data of CBR and CDR of the present decade (given in the above table) are focused it is observed that upto 2002 there had been

a downward trend in birth rate, then right in the next year there was sharp rise which continued upto 2004. Though from 2005 it began to decline, it is still well above the starting year of Millennium Development Goals. On the other hand, death rates have been keeping on almost steady trend.

Bangladesh is one of the least developed countries of the world, where still forty percent of the population live below the poverty line, and on the other hand the economically solvent and educated section account for a less proportion of the population. In Bangladesh, the people of lower stratum of the population, who are economically incapable of rearing more children, tend to breed more children whereas those of the up-scale society, who are capable of rearing more children, have been having fewer children. As a result, the average family-size of the low-scale society is larger, whereas that of the up-scale society is smaller. And that is the crucial point of the demography of Bangladesh. Naturally the demographic pattern of the larger part of the society affects the whole. It is nowadays said that the rate of decrease in birth rate has become slower due to the sluggishness of family planning department. The people of upper stratum of the society themselves are conscious about controlling birth and are keeping the family-size small on their own accord, so family planning department has little to do with them. On the contrary, the poor and uneducated people are not aware of the demerits of having more children and the benefit of family planning; besides, increasing cost of contraceptives does also impede their family planning. It means that family planning department has more things to do with the lower stratum.

The children who are taking birth in these poor and uneducated families in whatever number are now surviving due to reduction in child mortality rate through huge immunization. The imbalance between birth and birth control is aggravating the population of Bangladesh. Another noteworthy point is the relatively young age structure of the population of Bangladesh. According to CIA Factbook

2008 one-third of the population of Bangladesh is under 15 years of age, 63 percent belongs to age-group of 15-64 years, and 4 percent are of 65 years of age or older. The relatively young age structure indicates continued rapid population growth in the future. This young age structure creates built-in population momentum, which will continue to generate population increases well into the future, even in the face of rapid fertility decline. Projections indicate that the population will increase rapidly even after attaining replacement-level fertility because of the echo effect of the high fertility experienced in the past (BDHS, 2007:2). In a country like Bangladesh, birth control measures in family planning programs should be given utmost importance, otherwise it would turn into a land of plethora of human beings only and nothing would suffice to cater to the needs of the people.

Birth involves 'child' and 'mother', and giving birth to many children hampers maternal health and may even cause fatality thereto and thus aggravates maternal mortality rate. So, without considerably reducing birth rate as a whole by family planning, improving maternal health is not possible. Here is the important point to be noted; the proponent of MDGs, advertently or inadvertently not sure, ignored 'Reduce Birth Rate' to include as one of the MDGs. For the countries like Bangladesh which has been bearing a sizeable population, "Reduce Birth Rate" should have been set out as an MDG. This is a notable shortcoming of the present set-up of MDGs. Here the earlier contention of this paper can be again referred, that is, MDGs ignored country-context. All the efforts of the government have focused on 'Reduce Child Mortality Rate' and 'Improve Maternal Health' and are diverting the effort from controlling birth. It is logically true that birth-control not only reduces population-growth, but also helps reduce CMR and MMR since the less the number of child born, the less rate of CMR, and the less the occasion the women conceive and bear children, the less the rate of MMR.

Bangladesh is the most densely-populated country of the world; except for a few city-states nowhere in the world there lives so huge population in such a small territory. So, population control is not just important here, rather it should be a far more important part of the agenda in national development scheme. The present initiatives of family planning program have to be much more rigid, in that, there should be a kind of 'command and control' policy in this regard so that people are somehow compelled to follow family planning. The policy could be like this: not to give certain social security privileges to those who have more than one child. Along side, the contraceptives should be made available at minimum cost.

It follows from the above discussion that, for Bangladesh as far as health-related MDGs are concerned there is a big question as to what is the use of achieving them while population is increasing in a land-scarce and resource-scarce country which would be in deep trouble in accommodating and feeding them all. As it has been shown earlier that all other MDGs, directly or indirectly, have some compatible relationship with health-related MDGs, hence without considering 'Reduce Birth Rate' it would certainly have some negative impacts on almost all MDGs related to the fields other than health. As said earlier, if population increases mainly because of the increase taking place in lower stratum represented by the poor or extremely poor, their poverty could be aggravated by the greater costs of living to be borne. Thus, Goal 1 of MDGs could be hampered. Secondly, about universal primary education, that is, Goal 2: if more children are to be given primary education, it will require more resources, which would be a burdensome task for the state as well as their parents. Goal 3, that is, 'Promote gender equality and empower women' has three indicators under target 3a: Eliminate gender disparity in primary and secondary education preferably by 2005, and all levels by 2015, and the indicators are:

- Ratios of girls to boys in primary, secondary and tertiary education

- Share of women in wage employment and in the non-agriculture sector
- Proportion of seats held by women in national parliament

Amongst the above three indicators for the women bearing more children it would be tougher to be engaged in employment. So, the achievement of Goal 3 in case of women giving birth to more children is being hindered. Women empowerment has a profound relationship with maternal health. In Bangladesh women have less say in deciding giving birth to children, that is, even though giving birth to many children is not good for their own health. So, as long as women are not getting the right in deciding about giving birth to children or planning their own family, the government's programs of family planning would not be a success. Women's education is also very important in building up their consciousness about maternal health. Goal 7 (sustainability of environment) will also be affected by the burden of a sizeable population as the overabundance of population is one of the major causes of environmental pollution and hinders to achieving sustainability thereof; so in Bangladesh as long as population size remains so huge, sustainability of environment is a far cry.

There is another shortcoming of present structure of MDGs. Goal 6 about combating HIV/AIDS and other diseases is a commendable one in the present context; nonetheless, there is something which, by no means, is less fatal than HIV and which is dormantly or clandestinely posing fatality in Bangladesh-this is Hepatitis C virus. But in Goal 6, the context of Bangladesh was overlooked as combating this fatal threat to human liver was not included in MDGs. Vaccine for Hepatitis B is already included in the national immunization program in Bangladesh. About one hundred and seventy million people around the world are infected with the

infection. In Bangladesh, the number of the people affected by Hepatitis C virus is over four million which is about four percent of the total population (The Khaleez Times, 2005a). So, the number of Hepatitis C affected people is far higher than that of HIV positive people. This is why the government should be careful in this regard and include the vaccination against Hepatitis C virus in the national immunization program.

5.4 Can MDGs Ensure Health Mission?

The children who survive build up the population. They through some stages such as childhood and adolescence reach the age of youth and join the workforce. It has been said in the chapter 2 that capability of an individual to work, both physical and mental, depends on many things. Proper nutrition is the prime factor affecting the capability of working; other factors for good health are accessibility to health facilities, affordability to have good health etc. as stated in Chapter 2 while discussing primary health care. If the children who survive beyond five years of age do not get proper food or remain underfed their functioning ability would not grow. Food security is still a major problem for a large section of the people of Bangladesh where decisive progress in health standards is held back by the prevailing degree of malnutrition as poor households are obliged to spend large proportion of their income on food. In 2005, almost forty percent of children under five were underweight. Bangladesh is able to grow only about ninety percent of its needs for rice in a typical year, making the country the fourth largest importer of the grain (Oneworld.Net, 2008). A particular part of the northern region is prone to food insecurity during a particular season of the year, commonly known as '*Monga*'. As long as food insecurity persists, only health-related MDGs would not suffice to contribute to improving health condition of the population.

Along side, there is nothing about primary health care in Millennium Development Goals. One may argue that it was there in

Alma Ata Declaration where the countries vowed to achieve 'Health for All' by 2000, but Bangladesh already failed to achieve that goal. Here also comes the question of country-context. The government should look into as to why the vow to ensure 'Health for All' could not be materialized by the deadline, and take up and implement necessary and workable plans and make enabling environment for the other player of the health sector so that they can also play necessary roles in providing PHC services. In fact, without ensuring primary health care for the citizens only health-related MDGs will not be enough for mission of health.

It is well and good if Bangladesh fulfills its challenges of health-related MDGs, but if through growing stages children do not have proper nutrition and primary health care, and remain exposed to health hazards, they would not be able to contribute the developmental process of Bangladesh, since human development would not be there in true sense. So, mere attaining of the health-related MDGs would not be enough for overall health mission.

In this regard, Eminent economist Amartya Sen in his book '*Development as Freedom*' has said that many people of the world suffer from unfreedom. Even in the countries where famines no longer sporadically strike the population, malnutrition may still affect very large number of vulnerable people. Along side, a large number of people have little access to health care, to sanitary arrangement or to clean water and spend their life fighting unnecessary morbidity and often succumbing to premature mortality (Sen, 1999: 15). This is very true in the case of Bangladesh where the people are still captive to the said menaces and thus they are also unfreedom. Under these circumstances, true development would not take place as long as their captivity persists and they remain unfreedom as such. Not only that, the people of Bangladesh are captive to the global policy makers too, as said earlier, the global policy-makers many a time ignore the country-context as what has happened in the case of imposing MDGs.

It follows from the above discussion that Bangladesh as a member of the global forum has a very weak negotiating power. But, it should not be the case always; the representatives of the state in the global forum should speak out against the policies which are arbitrarily imposed by any global organizations. However, it is not meant to say that the globally imposed challenges are all incompatible with Bangladesh and all are outright resistible; now, what should be ensured is that the country-context should be considered in setting national goals, for example the deadlines of the goals could be different for the countries based on their given macro environment in order to make sure that they are not on unequal competition. In addition, some adjustments should be made in the areas of goals based again on the country-context, such as for a country like Bangladesh, 'Reduce Birth Rate' should have been one of the MDG targets.

Chapter 6

Conclusion and Recommendations

Nine years have already elapsed and the available time ahead is only six years for attaining MDGs; Bangladesh should endeavor in some new scheme along with older ones if the attainment is to be meaningful and helpful for facing overall developmental challenges. Health governance should be performed in such a manner that the stumbling factors discussed in previous two chapters do not persist and the achievement of health-related MDGs is accelerated. As shown in chapter 3, MDG 4 and MDG 5 may be partially attained by the deadline; in order to accelerate the attainment reaching the community and strengthening the public health care system are essential. Here are some general recommendations for achieving better health governance in Bangladesh in order to achieve the health-related MDGs and then fulfill the health mission.

- i. A pro-people National Health Policy with workable implementation plan should soon be introduced
- ii. Health-related policies must be formulated with participation by the people's representatives ; each policies should be placed in the parliament for necessary discussion and debate
- iii. Population growth has to be restrained through comprehensive 'Family Planning Program' by the government. Birth control drive has to be given utmost priority
- iv. Social security measures should be confined only to the people having less than two children as a disincentive for having more children
- v. Contraceptives should be subsidized so that poor people do not loose interest in family planning

- vi. People's awareness should be enhanced through comprehensive media coverage regarding the bad effect of early marriage of girls and benefits of maternal health care by the qualified formal and skilled health personnel. The local government authorities can do a great deal in this regard. The members themselves should always speak up for it and besides, the revered persons in the community such as 'Imams' of the mosques can also play role as they can have a regular congregation during prayer. The media also should always be very vocal about it.
- vii. People awareness about HIV/AIDS and STD should be enhanced through comprehensive media coverage; as raising awareness is the only means to fight against HIV/AIDS because no medicine for the cure HIV/AIDS has yet been invented. Again here the same approach can be applied by the members of the local government and revered person of the community.
- viii. The stakeholders' participation, that is, community participation needs to be increased for achievement of health-related MDGs
- ix. Vaccine for Hepatitis C virus has to be included in the national immunization program
- x. Food security has to be ensured to avoid malnutrition
- xi. People have to have access to safe drinking water and proper sanitation
- xii. Health-related laws and policies have to be implemented properly
- xiii. Laws, like 'Tort', regarding reparation for damage due to faulty or maltreatment needs to be introduced
- xiv. Separate Court, like Labor Court, can be established to try the violations of health-related laws

- xv. Strong administrative measures have to be adopted to reduce absenteeism and private practice of the health personnel during office hours
- xvi. Bangladesh Medical Association (BMA) and all the associations of government doctors should be kept free of partisan politics
- xvii. The MoHFW needs to have formal close and effective coordination with related ministries
- xviii. Allocation in national budget for health sector needs to be reviewed; this allocation should be increased
- xix. Allocation for health sector needs to focus more on primary health care, nutrition and family planning
- xx. Public-private partnership in health services needs to be enhanced to ensure more joined-up governance
- xxi. A 'National MDG Monitoring Committee' needs to be established to oversee the progress of attaining MDGs and for suggesting correctives measures
- xxii. Economic growth needs be enhanced and growth should be pro-poor so that income inequality between the rich and poor does not persist
- xxiii. Economic growth needs be sustainable, that is, it should not be attained at a high cost of environmental pollution which poses health hazards to the people
- xxiv. The policy of E-governance in health sector should be adopted and implemented
- xxv. The management of health sector should be decentralized to a sustainable stage

The authority however has to look into the other sides of the story also, for example, what is the background of high rate of absenteeism amongst the doctors in the rural areas. The doctors are the key actors in health service; if their problems are not attended it would diminish their motivation towards duty. It is not very wise to expect better and target-oriented performance from the demotivated

workforce. Hence no actions should be arbitrarily taken up, since a arbitrary action might bring in desired outcome in the short-run, but in the long run it might not work.

Bangladesh is one of the least developed countries of the world. After thirty eight years of independence it has not yet been able to make desired level of development and basic necessities of life including health care for a large proportion of the population are yet to be met satisfactorily. It is also one of the backward countries in UNDP's Human Development Index (HDI) where its latest position is 138 among the member states. It implies that Bangladesh should be more serious about the investment in human capital. It is true that population-growth cannot be stopped overnight; in fact, it takes time. However, what Bangladesh needs to do right now is to be serious about population control and along side, turn the population into human capital as well. Here comes the question regarding investment in social sector, especially in health and education; it is now widely recognized that investment in social sector has positive impact on the performance of the population which ultimately has positive impact on national economy.

The government always has to learn from the past mistakes, such as it should meticulously analyze the causes behind the failure to keep up Alma Ata Declaration as detected in this study. It will help the country face the future challenges. Notwithstanding the government has the primary and fundamental responsibility to ensure universal access to quality health care according to people's needs, not according to their ability to pay, it is worth recognizing that given the present economic situation Bangladesh government cannot sustain free primary health care service to every citizen. Nonetheless, fees for health services should not be burdensome for the poor. The proposed 'user fee' in the recent draft NHP has already evoked criticism amongst the health experts (The Daily Star, 2009b). In this backdrop, if the government wants to achieve the health-related MDGs, the services related to them have to be given almost free of

cost. This is why more subsidies are needed in the health services which require added budgetary allocation and it will largely depend on the receipt of more donor support. The GOB has to be very tactful in negotiation with donors in order to make sure no cutbacks take place in donors' allocation for Bangladesh and MDGs do not lose their focus; rather it has to try hard so that allocation increases. Thus, for achieving the MDGs joined-up efforts by the government, donors and NGOs are essential. Though NGOs are reputed for their management system there is however a great deal that could be done to improve the coordination and synchronization of the works of the NGOs and work of the government to reduce overlap and duplication. As health-related problems are never-ending and new challenges keep on emerging from time to time, the joined-up efforts would need to be further enhanced in future.

The global policy makers should look to the context of the countries; they should not arbitrarily impose challenges on the countries. The policy makers of Bangladesh also should bring the issue of the country's context to the notice of the global policy-makers and convince them to incorporate necessary adjustments in the national goals set out by any global organizations. Everyone involved in the policy formulation should bear in mind that 'one size does not fit all'. Last but not the least, good governance is a must. It will hopefully bring the things in order and fulfill the health mission and other developmental challenges as well. The Millennium Declaration also recognizes good governance of which public administration is a central part, as means for achieving the goals of the declaration. And support to modernize state institutions is linked to achieving the MDGs in several ways.

One thing needs to be kept in mind that health-related MDGs are not an end, it is rather a journey towards health mission-this mission is never-ending. The state machinery always needs to keep on track for the betterment and welfare of the people and be aware of the fact that the right to live is a universal human right; this right can

never be pleasantly materialized unless and until the right to good health is ensured.

References

- Ahmed M. (1999) *Bangladesh towards Twenty First Century*
Community Development Library, Dhaka
- Alert Net (2009) "Health manpower in Bangladesh", Internet
- Ara F. (2008) 'Key Issues to Health Governance in Bangladesh' Paper
presented in the International Conference on *Challenges of
Governance in South Asia* in Kathmandu, Nepal, December 2008,
Internet
- Bajpai N. (2004) 'Reaching the Millennium Development Goal in South
Asia', *Working Paper No.17*, Centre on Globalization and
Sustainable Development, The Earth Institute of Columbia
University, USA
- Bangladesh Budget Watch (2009) 'Bangladesh could miss crucial
MDG targets', Internet
- Bangladesh Bureau of Statistics (2008) *Household Income and
Expenditure Survey 2005*, Government of Bangladesh: Dhaka
- Bangladesh Bureau of Statistics (2008) *Monthly Statistical Bulletin
October 2008*, Dhaka
- Bangladesh Bureau of Statistics (2008) *Statistical Pocket Book of
Bangladesh 2008* Dhaka
- Bangladesh National AIDS Committee (2005) *UNGASS Indicators
Country Report January 2003- December 2005*, Dhaka
- BangladeshNews (2009) 'Killer pesticides', Internet
- Banglapedia (2006) 'Fertility in Bangladesh', Internet
- Barakat A. and Murtaza M. (2003) *Adolescent Reproductive Health in
Bangladesh: Status, Policies, Programs, and Issues*, Policy Project,
USAID, (Internet)
- Brinkerhoff D. W. (2004) 'The Enabling Environment for Implementing
the Millennium Development Goals: Government Actions to

- Support NGOs', International Public Management Research Triangle Institute, Washington DC, USA
- Chaudhury N. and Hammer J. (2003) 'Ghost Doctors: Absenteeism in Bangladeshi Health Centers' *World Bank Policy Research Working Paper 3065*, World Bank, Washington DC
- CIA World Factbook (2009) 'Birth rate in Bangladesh', Internet
- CPD (1997), 'Crisis in Governance: An Independent Review of Bangladesh's Development (IRBD), *Annual Volume 1997*, Centre for Policy Dialogue, Dhaka
- Dee A. and Kathleen M. (2009), *Nursing Informatics and the Foundation of knowledge*, Jones and Berlett Publishers Inc. Sudbury, MA, United States
- Futurehealth.org, (2009) 'Health Quotation', Internet
- Garnham N. (1997) 'Amartya Sen's "Capability" Approach to the Evaluation of Welfare : Its Application to the Communications', Centre for Communication and Information Studies, University of Westminster, London, UK, Internet
- Government of Bangladesh (2002) *Bangladesh: A National Strategy for Economic Growth, Poverty Reduction and Social Development*, Economic Relations Division, Ministry of Finance, Dhaka
- Government of Bangladesh (2004) *HNP Strategic Investment Plan*, Ministry of Health and Family Welfare, Dhaka
- Government of Bangladesh (2007) *Health Bulletin*, Management Information System (MIS), Directorate General of Health System, Dhaka
- Government of Bangladesh (2007) *Millennium Development Goals: Mid Term Bangladesh Progress Report 2007*, General Economics Division, Planning Commission, Dhaka
- Government of Bangladesh (2008) *UNGASS Country Progress Report*, National AIDS/STD Programme (NASP), Ministry of Health and Family Welfare, Dhaka, Internet

- Government of Bangladesh (2009) *Health, Nutrition and Population Sector Program (HNPS): Annual Program Implementation Report (APIR) 2009*, Vol. I and II, Ministry of Health and Family Welfare, Dhaka
- Government of Bangladesh and UNDP (2008) *Millennium Development Goals: Bangladesh Progress Report 2008* General Economics Division, Planning Commission, Dhaka
- Government of Bangladesh and UNICEF (2007) *Multiple Indicator Custer Survey Bangladesh 2006 Key Findings: Progotir Pothey 2006*, Dhaka.
- Government of Bangladesh and United Nations (2005) *Millennium Development Goals: Bangladesh Progress Report 2005*, Dhaka.
- Government of Bangladesh and United Nations (2006) *Health, Nutrition, and Population Sector (HNPS) Program Implementation Plan, 2nd Revised: 2003-2011 (RPIP)* Ministry of Health and Family Welfare, Dhaka.
- Government of Bangladesh and WHO (2000) 'Parliamentarians' Call for Action' *Report of the Regional Conference of Parliamentarians on Impact of Tuberculosis and Malaria on Poverty*, Dhaka, Bangladesh, November, 2000
- Halder A. and Kabir M. (2008) 'Child Mortality Inequalities and Linkage with Sanitation Facilities in Bangladesh', ICDDR, Dhaka
- HIVinsite, (2009) 'AIDS/HIV in Bangladesh', Internet
- HLSP Institute (2008), 'Performance Monitoring Frameworks in the Health sector: Country Notes', Internet
- IMF (2006) 'Bangladesh: Joint Staff Advisory Note on Poverty Reduction Strategy Paper' *Country Paper no. 06/5*, International Monetary Fund, Washington, D.C.
- IRIN (2009) 'Bangladesh: Rural health care in the spot light', Internet
- Islam M. (2000) 'Under-utilization of Health Care Services in Bangladesh: An Emerging Issue' Paper 9, Center for Policy Dialogue, Dhaka

- Islam S. (2009) 'Drugs for People' HIMAL South Asian, Internet
- Kickbush I. and Payne L. (2004) 'Constructing Global Public Health in the 21st Century' Paper presented in the Meeting on the Global Health Governance and Accountability, June 2004, Harvard University, and Cambridge, MA
- Lenne J. at el (2007) 'Bangladesh Country Assessment: Executive Summary' *Research into Use Programme* (RIU), DFID, UK
- Lewis M. (2006) 'Governance and Corruption in Public Health Care Systems', *Working Paper Number 7*, Centre for Global Development
- Mahmud S. (2008) 'Public Health Care System in Bangladesh: The Role of Public Administration', Internet
- Mathew D. (2004) 'Information Technology and Public Health Management of Diseases-A Model for South Asian Countries', School of Social Sciences, Indira Gandhi National Open University, New Delhi, India
- Millennium Project (2004) 'Millennium Development Needs Assessments', United Nations Development Group, New York, USA
- Ministry of Law (2008) 'Laws of Bangladesh', Internet
- MoHFW (2009) 'Human Resources Status of the Country, 1999', Internet
- Mosby's Medical Dictionary (2009) 'Definition of Primary Health Care', Internet
- Mozumder A. at el (1998) 'Determinants of Child and Infant Mortality in rural Bangladesh', *ICDDR Working Paper No 115*, Centre for Health and Population Research, ICDDR, Dhaka
- Mridha M. at el (2009) 'Public-sector Maternal Health Programmes and Services for Rural Bangladesh' *Public Health Services Division, ICDDR, Dhaka*
- National Institute of Population Research and Training (2007) *Bangladesh Demographic and Health Survey*, Dhaka
- Novik L. and Mayes G. (2005) *Public Health Administration: Principles for Population-based Management*, Jones and Berlett Publishers Inc. Sudbury, MA, United States

- OGERON.gov (2009), 'Environmental Public Health Tracking Program'
Internet
- Osmani et Al (2006) 'The Macroeconomics of Poverty Reduction: The
Case Study of Bangladesh', UNDP Regional Centre, Colombo
- Palit S. (2006) 'The Impact of Socio-Economic Reforms on Governance:
The Bangladesh Experience' *JOAG*, Vol.1, No.1
- Perry H. (1999) *Quest for A Healthy Bangladesh: A Vision for the
Twenty First Century*, The University Press Limited, Dhaka
- Philip A. (Undated) 'A Human Rights Perspective on Millennium
Development Goals', Internet
- Public Health Watch (2006), 'TB//HIV Policy in Bangladesh: A Civil
Society Perspective' Open Society Institute, New York, USA
- Rahman M. (2009) 'Affordable health policy, sustainable programme:
an overview' *The New Age*, the sixth anniversary special, Internet
- Richard D. et al (2002) 'Global Health Governance: A Conceptual
Review' *Discussion Paper No.1*, Centre on Global Change & Health,
London School of Hygiene & Tropical Medicine, and Dept of
Health & Development, WHO
- Rohde J. (2005) *Learning to Reach Health for All: Thirty Years of
Instructive Experience at BRAC*, The University Press Limited, Dhaka
- Save the Children (2005) 'Consultative Feedback on PRSP in
Bangladesh: Making the PRSP Child-Sensitive' United Kingdom,
Internet
- Sen A. (1999) *Development as Freedom*, Anchor Books, New York,
United States
- Sida (2008) 'Listening to Poor: People's Realities about Primary
Healthcare and Primary Education', *Bangladesh Reality Check
Annual Report 2007*, Sida, Bangladesh
- Siddiqui A. (2003) 'Searching Micro Situation' *Development
Organization of the Rural Poor (DORP)*, Bangladesh and WEMOS,
the Netherlands
- sos-arsenic.net (2002) 'Environmental Pollution in Bangladesh',
Internet

- The Daily Star (2006a) 'Tk 40 lakh changes hands at DMCH for seats' October 20, 2006
- The Daily Star (2009b) 'Draft health policy draws criticism' October 05, 2009
- The Khaleez Times (2005) 'Hepatitis C virus stalks Bangladesh' October 31, 2005
- The New Age (2007a) 'Slow and Unsteady on MDG Path' Editorial, April 14, 2007
- The New Nation (2007a) 'Bangladesh can achieve MDG target in health sector', June 18, 2007
- The New Nation (2008b) 'MDG 4, 5 achievable in child and mother survival', November 24, 2008
- The Prothom Alo (2007a) 'Clash between the doctors and the employees in DMCH', May 04, 2007
- The World Bank (2007) 'Strengthening Management and Governance in Health, Nutrition and Population Sector of Bangladesh' *Bangladesh Development Series Paper No.15*, South Asia Human Development Unit, the World Bank Office, Dhaka
- U4 Utstein Anti Corruption Resource Centre (2006) 'Corruption in the Health Sector', Bergen, Norway
- UN Millennium Campaign (2008) *The Compilation of MDGs Case Studies: Reflecting Progress and Challenges in Asia*, United Nations
- UNICEF (2008) 'Child Survival in Bangladesh', Internet
- UNICEF (2008) 'Maternal Health in Bangladesh', Internet
- UNICEF (2009) 'Maternal and Neonatal Health in Bangladesh', Internet
- United Nations (2007) 'UN in Bangladesh Makes 'Tiger' its Mascot to Localize MDGs' *Media Release*, 06 April 2007
- United Nations Children's Fund (UNICEF) (2009) *The State of the World's Children 2009: Maternal and Newborn Health*, UNICEF, New York, USA

- Vian T. (2002) '*Sectoral Perspectives on Corruption: Corruption and the Health Sector*', USAID & MSI, Internet
- WHO (2000) 'Decentralization of Health Service' World Health Organization, Regional Office for South-East Asia, New Delhi, Internet
- WHO (2004) 'Improving Maternal, New Born and Child Health in South East Asia Region', Internet
- WHO (2009) 'Avian Influenza Situation in Bangladesh', Internet
- WHO (2009) 'HIV/AIDS Awareness Bangladesh', Internet
- Wikipedia (2009a) 'Definition of Health', Internet
- Wikipedia (2009b) 'Definition of Governance', Internet
- Wikipedia (2009c) 'Components of Primary Health Care', Internet
- Wikipedia (2009d) 'Public Health"', Internet
- Wikipedia (2009e) 'Child Mortality', Internet
- Wikipedia (2009f) 'Infant Mortality', Internet
- World Bank (2005) 'Attaining the Millennium Goals in Bangladesh' *Report No.31846-BD*, Human Development Unit, South Asia Region
- World Bank and ADB (2003) *Bangladesh: Public Expenditure Review*, Document of the World Bank and Asian Development Bank, Dhaka, Internet