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QUEST FOR A HEALTHY BANGLADESH

A Vision for the Twenty-First Century

Henry B. Perry

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Acronyms and Abbreviations

AIDS  Acquired Immunodeficiency Syndrome
ARI  Acute Respiratory Infection
BASICS  Basic Support for Institutionalizing Child Survival
BPHC  Bangladesh Population and Health Consortium
BRAC  Bangladesh Rural Advancement Committee
EPI  Expanded Program for Immunization
ESP  Essential Services Package
FP  Family Planning
GTZ  Deutsche Gesellschaft für Technische Zusammenarbeit
HPSS  Health and Population Sector Strategy
HIV  Human Immunodeficiency Virus
ICDDR,B  International Centre for Diarrhoeal Disease Research, Bangladesh
IEC  Information, Education, and Communication
LIP  Local Initiatives Program
LQAS  Lot Quality Assurance Sampling
MCH  Maternal and Child Health
MOHFW  Ministry of Health and Family Welfare
NGO  Non-Governmental Organization
NIPHP  National Integrated Population and Health Programme
STD  Sexually Transmitted Disease
TB  Tuberculosis
TBA  Traditional Birth Attendant
USAID  United States Agency for International Development
WHO  World Health Organisation
Foreword

This paper has been developed as an extension of an earlier consultation which Henry Perry carried out for the World Bank which was entitled *Innovative Approaches to Delivering the Essential Package of Health and Family Planning Services at the Outreach/Community Level: Experiences, Lessons, and Recommendations* (Perry, 1997). As Bangladesh enters the new millennium, now seems to be an appropriate moment to review activities which are emerging in the quest to achieve “health for all” and the challenges which lie ahead. This paper is adapted from Perry’s book entitled *Health for All in Bangladesh: Lessons in Primary Health Care for the Twenty First Century*, published by University Press, Ltd., of Dhaka. The book provides an in-depth assessment of numerous health and family planning activities underway in Bangladesh. This working paper highlights some of the emerging activities and challenges which lie ahead and which are discussed more fully in the book.

The author expresses his thanks to the many people who encouraged and assisted him in this task. He is grateful to Ms. Petra Osinski, Mr. Tom Merrick, Mr. J. S. Kang, and Ms. Frances Plunkett who assisted him during his World Bank consultation in 1997. He is also indebted to his friends and colleagues at ICDDR,B and at BASICS for their support and assistance.

The comments of many people about various drafts of this manuscript have helped to make this final version one which will hopefully be useful in the pursuit of improving the health and welfare of the people of Bangladesh. The author would like to express, in particular, his appreciation to Ms. Petra Osinski, Dr. Zakir Hussain and Dr. Bill Aldis who provided extensive comments on earlier drafts.
INTRODUCTION

Compared to many developing countries, Bangladesh has a dynamic and innovative health sector, and the country's experience with operations research concerning health and family planning services is one of the most extensive in the world. There has been little effort so far, however, to review and synthesize the lessons learned from these experiences or to assess their implications for the further development of primary health care services at the local level.

Primary health care services can be characterized by their availability, accessibility, utilization, coverage, quality, and impact. Of particular concern in a country like Bangladesh is ensuring that quality primary health care services reach those most in need, namely the poorest, least educated, and geographically most isolated members of Bangladeshi society. As Gwatkin, Wray, and Wilcox pointed out two decades ago (1980):

Unless the services reach those in need, even the best-conceived primary health and nutrition programs can obviously have little impact on mortality [or fertility]. Thus ... the development of plans for getting services to the people [in real need] is as important as are decisions concerning which services should be offered.

The purposes of this working paper are therefore:

- To review some of the major initiatives in health, population and nutrition which are emerging; and
- To consider how primary health care services can be strengthened in Bangladesh so that "health for all" can become a reality in Bangladesh sooner rather than later.

Hopefully, this work will serve to broaden the understanding about the exciting large-scale initiatives which are underway in Bangladesh and about the challenges which must be overcome in order for Bangladesh’s citizens to benefit as much as possible from the fruits of modern biomedical science, public health and nutrition. How Bangladesh succeeds over the next decade in implementing the major initiatives in health, population, and nutrition which are now beginning and how Bangladesh succeeds in addressing the longer-term challenges facing the country will be of great interest to those who will formulate and guide policy deliberations for primary health care programs in developing countries during the first quarter of the twenty-first century. Perhaps this paper will serve a useful purpose by focussing strategic thinking on important health policy issues facing Bangladesh and other developing countries.
Chapter 1

THE GRIM REALITY OF "DIS-EASE" IN BANGLADESH

One quarter of the world’s half-billion people living in countries with a per capita gross national product of US$ 250 or less live in Bangladesh (Population Reference Bureau, 1997). Sixty-five percent of the adult population of Bangladesh is illiterate, including 78 percent of the adult women (World Bank, 1993). Eighty percent of the population is still living in rural areas, but only 31 percent of the rural households own more than one acre of land, and 28 percent of households have no land at all which can be cultivated (BBS, 1998b).

Unfortunately, Bangladesh is one of the many countries in which Health for All by the Year 2000 will not be achieved. There are few countries in the world where the challenge of strengthening primary health care is greater.

Bangladesh is divided into six major divisions (Rajshahi, Khulna, Barisal, Dhaka, Sylhet, and Chittagong), 64 districts, and 460 thanas, or sub-districts and has a land mass of only 144,000 square kilometers, making it only one-twentieth the size of India and about the same size as the state of Georgia or Illinois in the United States. Bangladesh is the most densely populated country in the world (World Bank, 1993), with 820 persons per square kilometer at present (BBS, 1996a). Moreover, it is known for its susceptibility to floods and cyclones. Most of the land mass consists of a river delta which is flooded each year by the monsoon rains and the melting of the snows from the Himalayas which eventually make their way into the Padma, Jamuna, Brahmaputra, and Meghna rivers, and then into the Bay of Bengal. The flooding produces some of the richest farmland in the world, and conditions are optimal for growing rice.

Less than 40 percent of the population has access to modern primary health care services beyond immunizations and family planning (Abedin, 1997). Only 25 percent of pregnant women receive antenatal care, and only 14 percent of births are attended by someone with formal training. Although 97 percent of the population now obtains drinking
water from a safe source, only 44 percent of the population uses a sanitary method of excreta disposal (BBS, 1997c).

Bangladesh is one of the few countries in the world (along with India and Pakistan) where the life expectancy at birth is lower for females than for males (BBS, 1996d; MOHFW, 1998a). Studies have reported discrimination against female children in the provision of food (Chen et al., 1981) and in health care seeking behaviors (Hossain and Glass, 1988). There is a strong preference for sons in both early and later stages of family formation in Bangladesh (Rahman and DaVanzo, 1993). These findings are but a few of many which document the effects of the discrimination that females face which arise to a large degree from their inferior social status compared to that of males and to their socially and religiously proscribed isolation from activities outside of the home. One knowledgeable observer has noted:

Life for a Bangladeshi woman is, more than anything else, one of isolation. In certain parts of the country, it is common to find women who have not strayed from an area smaller than two hundred square yards for decades at a time; who have never held currency in their hand or seen a market; who have no friends; who have never played any meaningful role in the politics of their family, their village, or their country (Counts, 1996).

This observation may not apply to a majority of women in Bangladesh today, but it is certainly not uncommon.

**MATERNAL AND CHILD HEALTH ISSUES**

Rates of malnutrition in Bangladesh are among the highest in the world. More than one-third of the 3.33 million infants born annually in Bangladesh weigh less than 2.5 kg (5.5 pounds) at birth and are classified as having low birth weight. Two-thirds of children under five years of age are malnourished: the national child nutrition survey conducted in 1995-96 demonstrated that 60 percent of children 6-71 months of age are either stunted or wasted, meaning that their height-for-weight scores or their weight-for-height scores are more than two standard deviations below the international standard (BBS, 1997a; World Bank, 1998). The average height and weight of Bangladesh mothers is only 40 kg (88 pounds) and 147 cm (4 feet 10 inches), respectively, and 70 percent of mothers and children suffer from nutritional anemia.

Until recently, 30,000 Bangladeshi children were going completely blind (in both eyes) each year from vitamin A deficiency. Iodine deficiency disorders (causing goiter and mental retardation in the more severe cases) have until recently affected 10 percent of the population, particularly in the hyper-endemic northern region of the country. Recent surveys indicate that 47 percent of the population have goiters, 69 percent have biochemical iodine deficiency, and 0.5 percent have severe mental retardation attributable to iodine deficiency (cretinism) (Yusuf et al., 1993). The average daily caloric intake nationally is only 88 percent of the recommended level of 2,120 calories, and in 27 percent of rural households, the average daily consumption is still less than 1,800 calories (BBS, 1998c).

Bangladesh’s maternal mortality rate of 4.5 deaths per 1,000 live births is one of the highest in the world (MOHFW, 1997). Ninety-five percent of all deliveries still take place
in the home (Mitra et al., 1997), and almost a third of Bangladeshi women report chronic or residual morbidities associated with childbirth (MotherCare et al., 1997).

Current estimates of the infant mortality rate are in the range of 71 to 82 deaths per 1,000 live births, depending on the study, and one in nine children die before reaching the age of five (BBS, 1997b; Mitra et al., 1997). Among the poorest segments of the population, one in six children die before reaching the age of five (Mitra et al., 1997). Most deaths among children under five years of age are from readily preventable or treatable causes such as pneumonia, diarrhea, malnutrition, measles, and neonatal tetanus (Abedin, 1997; Baqui et al., 1998). The incidence of low birth weight in Bangladesh is one of the highest in the world, and low birth weight is a major contributing factor to early infant mortality.

Of the approximately 20 million children under five years of age, approximately 380,000 are dying each year. Most of these deaths are from readily preventable or treatable conditions: 120,000 deaths are associated with symptoms of pneumonia, 95,000 with symptoms of diarrhea, 19,000 from neonatal tetanus measles, and 15,000 from measles (Baqui et al., 1998). Nationwide, one-third of deaths in children under five years of age occur during the first month of life (Mostafa et al., 1996; Perry et al., 1997). Low birth weight, which in Bangladesh is primarily due to maternal malnutrition, is a major contributing factor to infant mortality. Malnutrition is also a strong underlying cause of death from infectious disease among children in developing countries: 66 percent of childhood deaths in Bangladesh are currently attributable to malnutrition even though the immediate cause of death may have been due to pneumonia, diarrhea, or a less common infectious disease (Schroeder and Brown, 1994; Pelletier et al., 1995). Thus, each year approximately 250,000 deaths among children under five years of age in Bangladesh can be attributed to malnutrition (more than 600 per day).

Official estimates indicate that approximately 15,000 pregnancy-related deaths are also occurring in Bangladesh annually (MOHFW, 1997; BBS, 1997c), although some estimates are as high as 28,000 deaths per year and even higher (de Francisco, 1997; WHO/UNICEF, 1996). Approximately one in every 40 women dies of maternal-related causes (de Francisco, 1997). Seventy percent of pregnant women are anemic, making them more vulnerable to the effects of hemorrhage (MOHFW, 1998b).

In 1992, Bangladesh had an estimated 136,000 persons with leprosy and only about 15 percent were undergoing multi-drug treatment (Noordeen, 1994; Lobo, 1998). There are

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1 This number was derived in the following manner: There are 3.33 million births in Bangladesh each year at present (BBS, 1998). The probability of death between birth and age 5 is at present 0.1155 (Mitra et al., 1997). If we assume this cohort of children live their first 5 years of life during the year of birth, and the birth cohort for the next year live their first five years during the next calendar year, and so forth, then the number of children dying each year can be estimated by simply multiplying 3.33 million x 0.1155 = 384,615.

2 These actual numbers were obtained by multiplying the estimated numbers of deaths in children under 5 years of age (380,000) by the proportion of deaths for each cause, as calculated by Baqui et al. 1998. The Expanded Programme on Immunizations in Bangladesh has estimated independently that the number of deaths due to neonatal tetanus and measles is similar to that which has been estimated with the methodology described here (Sniadack, 1999).

3 India, Bangladesh and Nepal have by far the highest total population-attributable risk for child deaths due to the potentiating effects of malnutrition on mortality. Sixty-seven percent of childhood deaths in India are attributable to malnutrition. This figure is 65 percent for Nepal. The country with the next worst overall childhood nutritional status is Vietnam, where "only" 56 percent of all childhood mortality is attributable to malnutrition (Pelletier et al., 1994).
currently an estimated 133,000 cases of active pulmonary tuberculosis and a similar number of extra-pulmonary tuberculosis in Bangladesh (Lobo, 1998).

As of the end of 1996, only 76 cases of HIV infection and 10 cases of AIDS had been documented in Bangladesh, although unofficial estimates of HIV infection are as high as 20,000 cases (Choudhury et al., 1997). As of the end of 1998, 102 cases of HIV infection have been documented and 48 cases of AIDS have been formally diagnosed. However, given the explosive growth of HIV infection in India (including nearby Calcutta) as well as in Myanmar and Thailand, and also given the high rates of sexually transmitted diseases and the presence of 100,000 commercial sex workers in the country, most experts feel that Bangladesh is a highly vulnerable country and that the potential of a “severe epidemic outburst” is very high (Choudhury et al., 1997).

THE CHALLENGE OF POPULATION GROWTH, ESPECIALLY IN URBAN AREAS

At the beginning of the twentieth century, Bangladesh had a population of 29 million persons, growing to 42 million in 1941 and increasing to 76 million in 1976 (BBS, 1993). If the total fertility rate had remained unchanged during the past two decades, the current population of Bangladesh would be 142 instead of 122 million people (Baqui, 1998).

The country’s population, nevertheless, is expected to double to 250 million persons by the year 2035 even if fertility declines to a level of replacement by the year 2005. In order to reach replacement fertility by this time, the number of contraceptive users will need to increase to 21 million persons, twice the current number of 10.6 million (Barkat-e-Khuda, 1997). A delay of 10 years in reaching replacement-level fertility will result in Bangladesh’s population increasing by an additional 40 million persons before stabilizing (Baqui, 1998).

Associated with the country’s dramatic increase in population has been an even more dramatic increase in the urban population, especially among those living in slums. Until 1961, less than five percent of the population of Bangladesh was living in urban areas (BBS, 1984). During the past two decades, however, the urban population of Bangladesh has grown from six million in 1974 (BBS, 1984) to 21 million in 1994 (BBS, 1995), and it is expected to grow to 50 million by the year 2014 (UNICEF, 1993; BBS, 1991). The current annual growth rate of the urban population is 6.1 percent compared to an overall national population growth rate of 1.9 percent (GOB and ADB, 1994). Dhaka City is currently one of the fastest growing cities in the world. Between 1961 and 1997, its population increased from 0.5 million to 9 million people, and its population is projected to increase to 18.5 million in 2014, which would make it the ninth largest city in the world (UNFPA, 1996). However, international aid to directly address the needs of the urban poor has accounted for only a modest portion of the overall support for the country (UNICEF.

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5 Replacement fertility is usually considered to be obtained when the total fertility rate reaches 2.2. Continued population growth will occur after replacement fertility has been reached because of the phenomenon known as "population momentum." Population momentum occurs when the number of women of childbearing age is growing rapidly, as it presently is and will continue to be for the next several decades in Bangladesh.
The Grim Reality of "Dis-ease" in Bangladesh

Urban population growth in Bangladesh is fuelled by the shortage of land and other means of earning a livelihood in the rural areas, particularly during periods of impoverishment and landlessness brought about by natural calamities. Forty to 70 percent of urban population growth in Bangladesh has been attributed to rural-to-urban migration, while the remainder is due to the natural increases in the urban population and the territorial expansion of urban areas into contiguous areas that were previously considered rural (Islam et al., 1997). Sixty-one percent of the urban population in Bangladesh are living in households in which the monthly household income is less than the minimum required for food and essential non-food items (defined as less than Tk. 3,500, or about US$ 88). Forty percent of the urban population are classified as living below the level for "hard core" poverty, meaning that their monthly household income is only Tk. 2,500 (about US$ 63) (Islam et al., 1997).

Three-fourths of these urban poor live in flimsy shacks, usually in slum neighborhoods characterized by extremely high population densities and absence of sanitary latrines, municipal garbage disposal and electricity. Moreover, water sources are often distant, and access to them is only possible by waiting in line for hours and by paying informal private sources or intermediary brokers for access, even though the water sources themselves are usually public (Islam et al., 1997; Baqui, 1998). Slums are generally located in low-lying areas that are otherwise unsuitable for housing. Most are flooded each year during the rainy season, forcing their inhabitants to live on the streets for a month or more. By far, the most common cause of a "crisis event" of a slum household (in which a major unanticipated expense occurs or a loss occurs such as loss of employment, theft, or damage to the home due to a disaster) is illness within the household. Two-thirds of the crisis events in slum households are caused by illness (HKI, 1997).

Although large slum neighborhoods are well-known as housing sites for the urban poor, it is important to point out that approximately half of the urban poor do not live in large slums, but live at other sites throughout urban Bangladesh, including on the sidewalks (ADB, 1998). The poor who do not live in large slums are usually living in clusters of 3-10 families on a small patch of land which has been deemed suitable for "squatting," but their individual dwellings are no better than those situated in large slum neighborhoods.

The contraceptive prevalence rate (for modern methods) in the slums is only 38-40 percent compared to 51 percent in the non-slum urban areas (Arifeen and Mookherji, 1995; GOB and ADB, 1998), and the percentage of children in slum households with completed immunizations is only half that for children in non-slum households (Perry et al., 1998a). The mortality rate of under-five-year-old children in the poorest slum households is three times that of children in better-off urban households (Perry et al., 1997). The nutritional status of children in urban slum households is even worse than that of children in rural areas with a similar socioeconomic status (HKI, 1997; BBS, 1997a). Even so, there is still considerable variation from one urban to slum to another in terms of childhood malnutrition (HKI, 1998).

6 Unless otherwise specified an exchange rate of Tk. 40 per US$ 1.00 is used.
THE IMMEDIATE AGENDA

Bangladesh is now entering a period of major reform in the provision of its health and family planning services. Changes are occurring in response to the widespread need within Bangladesh to strengthen the link between health and family planning services and also in response to the global trend toward the development and delivery of a basic “package” of services.

Other important issues now facing the country include how to strengthen the coverage and quality of local health and family planning services and how to modify services so that they can respond to a rapidly growing demand and at the same time ensure the sustainability of these services in the face of expectations that external donor support may not increase and, in fact, may diminish in the future. Significant progress has been achieved in addressing these issues, but formidable challenges lie ahead.

There is now a consensus that further reductions in fertility, further reductions in maternal and child mortality, and further reductions of endemic and infectious diseases among the general population will depend upon the effective provision, at the local level, of a “package” of “essential” services to the entire population. This consensus is reflected in the Government’s Health and Population Sector Strategy (MOHFW, 1997) which emphasizes the provision of an Essential Services Package (ESP) to the entire population. The ESP is a set of services in child health, reproductive health, communicable disease control, and limited curative care.7

There is increasing acceptance of the idea that further reductions in the infant mortality rate will be necessary in order for the fertility rate to continue to decline. This is because parents may feel less need to bear an additional child if the fear of an infant death and the actual likelihood of infant death is reduced. An analysis of fertility and mortality data in Bangladesh suggests that the occurrence of an infant death greatly increases the risk of a subsequent pregnancy (Rahman and DaVanzo, 1993), and “the general fear of a child-loss appears to have a strong impact on subsequent fertility” (Islam et al., 1996). Thus, the Ministry of Health and Family Welfare (MOHFW) and external donor agencies are envisioning a more balanced approach to health and family planning service provision in which other elements of the ESP in addition to family planning will begin to receive greater attention and support than they have in the past.

CONCLUSION

As Bangladesh embarks on these major reforms, now is an opportune time to take stock of some of the challenges that will have to be overcome so that the burden of readily preventable and treatable conditions and the burden of unwanted fertility can be reduced to the greatest extent possible with the limited resources available.

7 The ESP outlined in the Government’s new Health and Population Sector Strategy specifies services at four different levels of service delivery: (1) Outreach/Community, (2) Health and Family Welfare Centres, Rural Dispensaries, (3) Thana Health Complexes (first referral level), and (4) District Hospitals (second referral level).
MAJOR NEW INITIATIVES

As the end of the twentieth century nears, it becomes increasingly obvious that Bangladesh will need to find new solutions to its health and population problems, that the successful approaches of the past may no longer be appropriate for tomorrow, and that intensified efforts will be needed to address the unfinished health and population agenda. Policy makers also realize that donor support, which formerly provided the lion’s share of support for key health and population activities, will play a reduced role in the future, relative to overall expenditures, in supporting national programs. Furthermore, in Bangladesh, as in virtually all developing countries around the world, the private sector is playing an increasingly important role in the provision of health services. The hegemony of Government health and family planning services in rural areas will not likely persist indefinitely.


NEW NATIONAL POLICIES OF THE GOVERNMENT OF THE PEOPLE’S REPUBLIC OF BANGLADESH FOR HEALTH, POPULATION, AND NUTRITION

The New National Health Policy

In July 1998, a policy formulated by a blue-ribbon panel composed of elected Government officials, health professionals, NGO leaders, professional experts and others was presented
to Prime Minister Sheikh Hasina for her approval (GOB, 1998). Although still not yet formally adopted by the Parliament as official Government policy, it is expected by informed observers to be formally adopted with only minor changes.

The policy calls for continued efforts to achieve “health for all” by the year 2000 and for equity of access for all Bangladeshi citizens, especially the rural population and the urban poor. In it, primary health care is declared to be the principle vehicle for providing essential services to the population.

The policy calls for a full-time doctor and nurse at each of the 3,275 Health and Family Welfare Centres currently in existence throughout the country and for an adequate supply of essential medicines and equipment at these centers. In addition, one community clinic for each local population of 6,000 persons is to be established, requiring the construction of 13,000 additional new facilities. At each of these sites, all elements of the ESP should be available. The policy also calls for improvements in reproductive health services and safe delivery services, including the development of strong referral systems for emergencies (including those involving emergencies arising during pregnancy and delivery), so that levels of maternal mortality can be reduced to acceptable levels. Continued emphasis on the delivery of family planning services is also called for so that replacement fertility can be achieved by the year 2005. Improvements in primary health care and family planning services are envisioned to come about as a result of better training, supervision, and remuneration of health staff. Such improvements will make services more “transparent” and more cost effective. The need for strengthening the career opportunities for lower-level staff, especially grassroots-level workers, on the basis of job performance and seniority is affirmed by the policy.

The policy calls for decentralization of services and for increasing the awareness of the local population regarding their legal rights to health services, their responsibilities, and their role with respect to local health services. Participation of the local population and local Government institutions in policy development, financing, and monitoring of health services is also called for. The policy recognizes the need for an integrated effort between the Government and NGOs in carrying out the health policy and the need to create opportunities for coordination. Under the policy, NGOs and other private voluntary organizations are encouraged to work as “complementary forces” to the Government’s efforts.

The policy promotes the development of efforts to improve the quality of care at Government health centers through the development of standards and monitoring of service quality. Moreover, a need for strengthened epidemiological surveillance, coordinated among all of the partners of the health care sector, has been identified. The policy further calls for the establishment of a nutrition and health education unit in all thanas and the development of activities by these units which involve the local people and reach all the villages of a thana.

In order to carry out these directives, the policy document calls for the creation of a National Health Policy Council which will support the implementation of the health policy by providing advice and guidelines and by ensuring “transparency” in all health activities. Similar councils are to be formed at the local level, as well, for planning, supervising and monitoring purposes. A Health Services Reform body will be responsible for suggesting specific reforms in the infrastructure, in the appointment of health personnel, in the
training and promotion of health staff, and in the improvement of management activities within the MOHFW.

In order to restore credibility to the Government's health system, the policy stipulates that physicians responsible for providing emergency services and services during the night and weekend periods should receive a "non-practising" allowance so that they will not need to engage in private practice activities. The policy also calls for clarifying the arrangements by which Government physicians can conduct private practices. Finally, the policy calls for dealing firmly with those who do not perform their professional duties adequately or appropriately.

The policy calls for the involvement of all types of practitioners (both modern and traditional) and their professional associations in strengthening the availability and the quality of services. It further stipulates that the Government should assist traditional practitioners in improving the quality of their services.

At the present time, Bangladesh has no Bill of Rights for consumers of health care nor does the country have any mechanism for lodging complaints or obtaining compensation for damages resulting from the negligence of providers. The adoption of a Client Bill of Rights is called for in the proposed new National Health Policy. The aim of the Client Bill of Rights will be to raise the awareness of clients regarding their rights to high-quality health care which ensures privacy, informed choice, safety and efficacy of care, and adherence to approved fee schedules (MOHFW, 1998a).

The National Population Policy

The Government has made a commitment to work toward the achievement of replacement fertility by the year 2005 (MOHFW, 1998a). In order to achieve this goal, increasing reliance on clinical family planning methods (that is, IUDs, injectable contraception, Norplant® female tubal ligation and male vasectomy) will be necessary. Thus, improvements in the quality of reproductive health services in general and in the quality of family planning services in particular will be needed. The Government is also supporting the integration of family planning and reproductive health services with other health services at the local level and the merging of the two "wings" of the MOHFW, the Directorate of Health Services and the Directorate of Family Planning.

In recognition of the need for a renewed national focus on population issues, a National Population Council was established in Bangladesh in 1997. This group will be serving as the coordinating body for the development of a new comprehensive population policy which is scheduled to be finalized in 1999.

The National Drug Policy

The Health and Population Sector Program (1998-2003) calls for the establishment of a committee that would review, revise and update the National Drug Policy, particularly for the purpose of increasing the availability and affordability of essential drugs and promoting the rational use of drugs (World Bank, 1998b). The National Health Policy calls for modifications and improvements in the existing National Drug Policy that support efforts to ensure that medicines of appropriate quality are readily affordable and available to the
population and that practitioners promote the appropriate use of these drugs (GOB, 1998). The National Health Policy also calls for the national production of family planning commodities rather than continued reliance on imports. How these goals will be met in the face of growing pressure for deregulation and opening of markets to international firms remains to be seen.

The degree to which the Drug Control Committee, in charge of proposing changes to the National Drug Policy, responds to the interests of the pharmaceutical industry and the degree to which it responds to the public interest in reformulating the National Drug Policy also remains to be seen. The challenges of accommodating the interests of both is a daunting one.

A recent national household survey of the treatment of children with symptoms of acute respiratory infection and diarrhea revealed that over 360 different drug products were used, including many drugs which are either harmful or of no proven symptomatic or therapeutic benefit. Many of the products are not in the approved national formulary and have been illegally imported or produced locally by unregistered producers (MOHFW and PIACT, 1998).

**The National Food and Nutrition Policy**

The Government is one of the signatories of the Declaration of Child Rights, a product of the 1990 World Summit for Children, which established good nutrition as a basic right of all children. The National Food and Nutrition Policy was completed in 1997 (BNNC, 1997). The policy notes that the constitution of the Government of the People's Republic of Bangladesh states that one of the primary duties of the Government is to raise the level of nutrition in the population. The policy set forth a number of goals to be achieved by the year 2000: (1) the institutionalization of growth monitoring for children in all thanas, (2) the identification and treatment of all cases of acute childhood malnutrition, (3) the reduction of the prevalence of moderate and severe childhood malnutrition by 50 percent, (4) the reduction in low birth weight to 10 percent of all births, (5) the universal iodization of salt and the universal distribution of vitamin A capsules to children, and (6) the reduction of 1990 levels of anemia in children and women by one-third. The policy also sets as its goal that by the year 2000 the national daily average per capita intake of 2,279 calories, which is the minimum daily adult requirement established by nutritionists.

The policy seeks to promote the diversification of the diet with increased production and consumption of maize, sorghum, millet, wheat, potato, sweet potato, pulse, oilseeds (mustard, sesame, soybean, groundnut, and cottonseed), colored fruits and vegetables, fish, meat, and poultry products. According to the policy, a child nutrition unit staffed by a qualified nutritionist will be established in every Thana Health Complex. The policy recommends that exclusive breast feeding be promoted during the first five months of life and that continued breast feeding with complementary foods be promoted for children 5-23 months of age. Education is to be provided to the general public about the nutritional needs of vulnerable groups, namely adolescent girls, women, young children, and the elderly.

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1 A thana corresponds to a district in the World Health Organization classification of health systems. A Thana Health Complex is a hospital, outpatient diagnostic and treatment centre, training centre, and office complex where thana-level health activities of the MOHFW are based.
The policy also calls for the updating of food laws to prevent adulteration and to ensure that foods sold in commercial markets are safe. The policy recommends that an "independent and efficient" mechanism be developed for enforcing the food laws.

Finally, the policy recommends a stronger role for the Bangladesh National Nutrition Council in national and regional policy formulation, in nutritional surveillance, and to promote the inclusion of nutritional components in all development programs (Bangladesh National Nutrition Council, 1997).

The National Policy on HIV/AIDS and STD-related Issues

The National Policy on HIV/AIDS and STD-Related Issues was completed in 1996 and affirms the full human rights of persons with HIV and AIDS and calls for the development of a strong and comprehensive national AIDS/STD prevention and control program. Among other things, this policy calls for the establishment of a National AIDS/STD Control Program and the creation of a separate directorate of the MOHFW for AIDS/STD. Improving awareness about sexually transmitted diseases and access to facilities with high-quality STD services is a key component of the national policy as is widespread promotion of condom use, establishment of an HIV/AIDS surveillance program, and improvement in the safety of transfusion of blood and blood products (Choudhury et al., 1997). The policy document points out that there is now a widespread consensus that a "window of opportunity" now exists in Bangladesh during which time AIDS-awareness and AIDS-prevention measures, if instituted now, can blunt the impact of the epidemic which is almost certain to arrive in the near future.

THE HEALTH AND POPULATION SECTOR PROGRAM, 1998-2003

Since 1975, an international consortium of government development agencies in coordination with the World Bank have provided financial and technical assistance to the Government for the implementation of successive projects, each five to six years in length. The initial project, called the First Population Project (1975-80), provided support for re-establishing a physical infrastructure for family planning service delivery which had been greatly damaged during the war for independence in 1971. The Second Population and Family Health Project (1980-86) provided funds for the further development of the national family planning program. The Third Population and Family Welfare Project (1986-91) began to provide some support for the reduction of infant mortality along with support for family planning services. The Fourth Population and Health Project (1992-98) provided further support for MCH and disease control activities along with family planning services (World Bank, 1998). A review of the Fourth Population and Health Project (which ended in mid-1998) led to concerns about the lack of progress in reducing maternal mortality and morbidity, the low utilization of Government health services, and their cost effectiveness, sustainability, and quality (MOHFW, 1998).

In the past, investments from this consortium have focussed on expenses for infrastructure (buildings, supplies, equipment, and staff salaries). During the recent past, however, the need for systemic reforms in the Government’s health service system moved to the

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2 This proposal was not accepted by the Government.
top of the donor consortium's agenda—so much so that the consortium indicated in 1996 that it would not proceed with the development of further financing until the Government produced a strategy which outlined an agenda for substantive reforms (Buse and Gwin, 1998).

The overall goal of the program is to ensure universal access to essential health care services of acceptable quality which will contribute to further reductions in infant mortality and morbidity, reductions in maternal mortality and morbidity, improvements in nutritional status, and reductions in fertility so that replacement-level fertility will be reached by the year 2005. Approximately US$ 522 million will be provided by the World Bank, the governments of Canada, Germany, Great Britain, The Netherlands, Sweden, along with the European Commission, over this five-year period.

It is also anticipated that an additional amount of approximately US$ 172 million will be provided by other bilateral and multilateral donors including the governments of Japan, the United States of America, Saudi Arabia, Kuwait, Qatar, France, Denmark, Norway, and Korea, the Asian Development Bank, the Islamic Development Bank, OPEC, the United Nations Development Program, the United Nations Fund for Population Activities, UNICEF, the World Health Organization, and UNAIDS. Thus, the implementation of this Health and Population Sector Program, 1988-2003, will involve the utilization of some US$ 705 million in external donor support. The Government has pledged US$ 2.2 billion of its own funds for support of project activities and has agreed that 60 percent of public expenditure for the Health and Population Sector Program will be used in the support of the ESP (World Bank, 1998).

The specific objectives outlined in the plan to achieve this goal are:

• To provide an essential package of child health care, reproductive health care (including family planning), communicable disease control and limited curative care services with acceptable quality and equity for the people of Bangladesh at one-stop service points;
• To provide adequate basic health and family planning services through comprehensive reforms of the health and population sector;
• To provide information, education and communication services through behavior change communications which motivate clients to seek services included in the ESP;
• To facilitate the provision of the ESP, both in quantity and quality, within the context of a realistic and appropriate human resource development program;
• To determine the current status of the program, including future need in a changed situation, by ensuring regular monitoring, evaluation and research; and
• To ensure the quality of services through a client-centered approach (MOHFW, 1998a).

This program, in contrast to previous ones, explicitly aims to improve the performance and efficiency of the overall health and population sector, not just the services that are administered by the Government, and it includes family planning activities along with health activities in an integrated way.

One of the key features of this new initiative is the consolidation of 105 semi-independent projects (most of which were funded with external donor support) into 15 programs that
receive funding from the Revenue Budget of the MOHFW along with funds from external donors. While the “project approach” used in the past (whereby externally funded projects operated outside of other activities funded from the Revenue Budget) encouraged the use of donor funds in a more clearly focussed and more readily accountable fashion, the approach led to the creation of separate management structures for these activities and, as a consequence, the isolation of the project’s activities from the “mainstream” management of MOHFW activities as well as a duplication of efforts. Furthermore, the recurrent expenditures incurred by these projects have rarely been absorbed into the Government’s Revenue Budget, and the project personnel supported by the Development Budget have not enjoyed the security and benefits of regular MOHFW employees. As a result, tensions and conflicts have developed in the MOHFW.

Under the Health and Population Sector Program, the line managers in charge of the separate programs have overall responsibility for all the activities in the health sector, both Government and private, which pertain to that specific program, and activities are designed for the annual monitoring of performance across the sector. Such an approach, it is hoped, will enable the Government to play a stronger role in policy formulation, program implementation, and effective use of scarce resources.

The separate structures in the two directorates have been responsible for the establishment of separate cadres of staff all the way down to the field level which has eventually led to inefficiencies as a result of duplication of efforts and internal conflicts and to fragmentation of services. As a result, the Health and Population Sector Program proposes to eliminate the duplicative organizational structures which have arisen separately in the Directorate of Health Services and the Directorate of Family Planning and which at present are considered to be a major cause of “waste and inefficiency” (MOHFW, 1998a).

Low staff morale has been identified as one of the underlying causes of the poor quality that characterizes services provided by MOHFW staff. Staff morale has deteriorated partly because many employees who are paid from the Development Budget have no job security despite long years of service and because of a lack of support within the MOHFW for staff efforts to improve the quality of services and to respond more effectively to client needs.

The MOHFW plans to unify the health and the family planning activities at the thana level and below during the first phase of the Health and Population Sector Program. During the second phase, the activities at the district level and above will be unified. As part of this process, a decentralized service delivery system will be implemented which involves giving the thana more authority than it currently has. The development of client-centered services will also require that local people, including representatives of the local communities, have authority for decision-making, including authority for local financing and financial decision-making. Government hospitals will have greater autonomy and more opportunities to retain the fees generated by their services.

The current designations, job descriptions and job allocations of the existing Health Assistants and Family Welfare Assistants will be replaced by a single comprehensive job designation and description. Satellite Clinics and EPI (Expanded Program of Immunization) Outreach Sites will be merged. As Community Clinics are developed, they will replace Satellite Clinics (World Bank, 1998a). All fixed sites at the union level will be designated as Union Health and Family Welfare Centres and will provide the entire scope of ESP
services rather than the current emphasis on either health or family planning services. Another key outcome of the new program will be the merger of the revenue and development budgets of the MOHFW. This should make the use of the Government’s own resources for health more transparent since the Government will be accountable to the donors for the use of the external funds which have been provided.

The ESP was developed giving greatest priority to interventions that have a public-good character (such as EPI and family planning) and to interventions which strengthen high-impact maternal and child health services. More specifically, a series of workshops were held in which potential elements of the ESP were ranked in terms of potential health impact, cost (unit cost per capita), feasibility of provision, public need/public health importance, scope for private provision and financing, and economic criteria (externalities and economies of scale). A prioritization exercise was carried out in a series of exercises. The categories of activities include child health, reproductive health, communicable disease control, and limited curative care. Behavior change communication is a high priority for activities in all of these categories.

The main emphases of behavioral change communication will be:

- To change attitudes and behaviors so that people will attempt to improve their own health status;
- To build effective community support for health-seeking behavior;
- To change attitudes and behaviors of service providers so that services are more client-centered; and
- To promote men’s understanding of and respect for the special situation of women and girl children.

Doorstep delivery of pills and condoms will be gradually discontinued. The ESP will be provided at Community Clinics for populations of 6,000 persons. This will require the construction of 13,000 new clinics by the MOHFW.

Great care will be taken, however, to ensure that clients who do not utilize the Community Clinics will continue to receive domiciliary services. Moreover, Family Welfare Visitors will continue to provide services at Satellite Clinics for some time. The Community Clinics will be established in collaboration with the local community, which will have responsibility for initiating and maintaining the facility.

Community involvement will be encouraged during this program through local-level planning and participation in the implementation and monitoring of ESP delivery at the local level. Local communities will also become involved in the management of Government hospitals in their area. A National Steering Committee for Community and Stakeholder Participation in the Health and Population Sector Program is envisioned. This committee will consist of clients, legal experts, academics, and representatives from community-based organizations, women’s organizations, and professional associations along with representatives from the MOHFW (MOHFW, 1998a). This National Steering Committee will facilitate the development of local-level structures for involving local Government and NGO leaders in policy and strategy development, planning, monitoring, regulatory activities, and client advocacy.
Finally, efforts will be undertaken during this project to strengthen the private sector regulatory framework. Pilot efforts will be undertaken to promote links between the public and private sectors (World Bank, 1998).

The Government recognizes the obvious fact that, as the population of the country continues to grow, the proportion of health sector expenses that will be met by external donor support will decline since, under the most optimistic of scenarios, the absolute amount of donor support is not likely to increase beyond its current level. Therefore, according to the Health and Population Sector Program, the needed additional revenues will necessarily have to be obtained by expanding the Government’s tax base and reducing tax evasion and/or increasing the relative allocation of revenue to Government health and population programs from its current level of three percent to five percent of the Government’s overall budget. Other revenues will need to be generated locally through cost-recovery activities which could possibly include health insurance schemes (MOHFW, 1998a).

THE USAID-SUPPORTED NATIONAL INTEGRATED POPULATION AND HEALTH PROGRAM, 1997-2004

Between 1987 and 1997, USAID supported the national Family Planning and Health Services Project. That project provided support to 115 NGOs working throughout the country to provide family planning services through field workers who visited the homes of married couples of reproductive age every two months. In mid-1997, USAID initiated the National Integrated Population and Health Program (NIPHP), a seven-year, US$ 230 million effort to support continued reductions in fertility and continued improvements in family health (USAID, 1997). The project is currently working with 45 NGOs throughout Bangladesh who are providing basic maternal and child health and family planning services to approximately 20 million people.

While the previous USAID-supported project emphasized community-based distribution of family planning commodities by field workers at the doorstep, the current program emphasizes the provision of high-quality MCH-FP services at Static Clinics and at Satellite Clinics. In the case of the Satellite Clinic, a paramedic provides services from a fixed site (often a home, school, or community center) once or twice a month. The Static and Satellite Clinics are intended to make services more accessible to the poorer and socially disadvantaged segments of the population, particularly in the under-served and low-performing areas of the country, namely the Chittagong and Sylhet divisions and the urban slums.

The NIPHP is a partnership involving USAID, the Government and its MOHFW, two service delivery entities (the Rural Service Delivery Partnership and the Urban Family Health Partnership), and five other supporting entities.

The Rural Service Delivery Partnership is directed by Pathfinder International. BRAC is a collaborating organization.

The Urban Family Health Partnership is directed by John Snow, Inc. The Population Services Training Centre and Concerned Women for Family Planning are collaborating organizations.
The Bangladesh Center for Communication Programs is contributing to the efforts of both the urban and rural service delivery partnerships. The supporting entities include the Quality Improvement Partnership (directed by AVSC in collaboration with World Vision/Bangladesh and Concerned Women for Family Planning), an Operations Research Project (directed by ICDDR,B), commercial distribution of MCH and family planning commodities (directed by the Social Marketing Company), contraceptive logistic support services (directed by Family Planning Logistics Management), and technical support for child survival and urban immunizations (directed by Basic Support for Institutionalizing Child Survival, also referred to as the BASICS Project).

The Rural Service Delivery Partnership supports 20 NGOs working in 171 of the 460 thanas of rural Bangladesh. There are 159 Static Clinics and 595 Satellite Clinic teams functioning in these locations. The urban service delivery partnership (Urban Family Health Partnership) supports 25 NGOs in the four city corporations of Bangladesh (Dhaka City, Chittagong City, Khulna City, and Rajshahi City) and in 67 other smaller municipalities. There are now a total of 117 Static Clinics and 244 Satellite Clinic teams functioning in these locations.

The need to improve the quality and reduce the fragmentation of local services were prominent findings of a national customer appraisal survey carried out by USAID in 1995 (USAID, 1995). The NIPHP is attempting to respond to the needs expressed by clients in this survey. Consequently, the focus of activities has shifted from the household delivery of pills and condoms by field workers to the provision of most of the elements of the ESP from fixed sites--both Static Clinics and Satellite Clinics. The highest priority is being given to contraceptive services, management of contraceptive side effects and complications, antenatal care, management of reproductive tract infection, prevention and treatment of sexually transmitted diseases (including AIDS), EPI services, vitamin A supplementation, and management of serious childhood illness. The NIPHP does not intend to provide any significant support for the detection and treatment of tuberculosis and malaria or for the detection and treatment of locally endemic diseases (leprosy and kalaazar) unless these diseases prove to be serious problems at specific NGO program sites.

The NIPHP has a much stronger focus on child survival activities and on maternal and reproductive health activities than did the earlier Family Planning and Health Services Project supported by USAID. The NIPHP emphasizes the provision of high quality clinic services, "one-stop shopping," and local cost recovery through fees for services.

The number of NGOs supported by USAID funds has been reduced from 115 in the previous AID-supported project to the current 45, although the overall service population has remained roughly the same. USAID is implementing a predetermined policy of gradually shifting its support to a smaller number of NGOs over the course of the program without reducing the number of beneficiaries. There are no field workers currently supported by these NGOs in contrast to the 7,000 field workers supported in the previous project. The currently funded NGOs do employ community outreach workers (called community mobilizers) and also work with approximately 10,000 depot-holders who promote the utilization of clinic services and who maintain stocks of family planning commodities and oral rehydration packets for use by nearby community members if their own supplies should run out.
NIPHP intends to build a base of customers among the poorer and socially disadvantaged segments of the population, particularly in the Chittagong and Sylhet divisions of the country and in the urban slums where family planning and EPI services are less utilized, and to motivate clients to seek out quality information, services, and products related to family planning as well as maternal and child health.

THE URBAN PRIMARY HEALTH CARE PROJECT, 1998-2002

In recognition of the fact that there have not been any major Government or private programs aimed specifically at the primary health care needs of the urban poor, the Urban Primary Health Care Project, financed by the Asian Development Bank through the Ministry of Local Government, Rural Development and Cooperatives, has designed an initiative which targets the four city corporations in Bangladesh (Dhaka City, Chittagong, Rajshahi, and Khulna). This five-year, US$ 60 million project will attempt to develop basic primary health care services to 9.5 million urban poor, representing 41 percent of Bangladesh’s urban population (ADB, 1998; GOB and ADB, 1998). The project’s goal is to reduce preventable mortality and morbidity, especially among women and children, by increasing access to primary health care services. A secondary goal of the project is to strengthen the capacity of local Governments to manage, finance, plan, evaluate, and coordinate primary health care services. This project is one of the first in Asia in which there will be large-scale contracting out of primary health care services by the Government to NGOs.

The Urban Primary Health Care Project will provide a package of services which includes immunizations; micronutrient support (particularly vitamin A); family planning services; antenatal, obstetrical, and postnatal care; case management of pneumonia and diarrhea in children; case management of tuberculosis and reproductive tract infection in adults; first-level first aid and psychological support for women who have been victims of violence, and health education.

The project will construct 190 new primary health care centers near slums and other densely populated areas, each having a catchment area of approximately 50,000 persons. The ground floor of these two-story facilities will be rented out as commercial space. Rent will be applied to ongoing project costs. Outreach services will be provided at sub-centres established in the general vicinity of the primary health care centre. The operation of local primary health care programs will be contracted out to NGOs, private sector groups, or provider associations through the use of partnership agreements based on competitive bidding. There will be partnership agreements for populations of 500,000 persons, each with a primary health care center. There will be 10 partnership agreements in Dhaka City, two in Chittagong City, two in Khulna City, and one in Rajshahi City. At seven of the 10 locations where partnership agreements will be implemented, a maternity health center will be constructed to provide normal deliveries and emergency obstetric care (but not Cesarean sections).

The project will assess its impact on under-five and infant mortality rates and monitor population-based indicators (such as percentage of the catchment population obtaining immunizations, antenatal care, “safe delivery” care, family planning services, and use of iodized salt), health-related knowledge among mothers in the population (about signs and symptoms of acute respiratory infection, about how to prepare oral rehydration solution,
and about family planning methods), and quality of case management (of childhood acute respiratory infection, diarrhea, and fever as well as adult reproductive tract infection). Independent evaluation and monitoring firms will be contracted to monitor project activities and carry out population-based surveys.

THE NATIONAL NUTRITION PROGRAM, 2000-2010

As the National Food and Nutrition Policy suggests, the Government has made improving the nutrition of its people one of its development priorities. Economic analyses have indicated that without improvements in the nutritional status of the population, US$ 22.9 billion in productivity will be lost to the country between the years 2000 and 2010 (MOHFW, 1998b).

Early results of the “pilot” Bangladesh Integrated Nutrition Project indicate that a community-based nutrition program is feasible, and that such a program can make a rapid and significant impact on severe malnutrition. These findings suggest that the previously-held belief among many development experts that nutrition status cannot improve without prior poverty alleviation has been misplaced (MOHFW, 1998b). Consequently, plans are now underway to scale-up this project on a national basis. Beginning in the year 2000 and continuing for 10 years, this project is expected to apply the methodology developed in the Bangladesh Integrated Nutrition Project which is currently underway. Based on the current costs of the Bangladesh Integrated Nutrition Project, tentative estimates are that the cost of the project could be approximately US$ 1 billion over this 10-year period. One hundred thanas will be added to the project each year until, after five years, all 460 thanas will be covered. Local capacity limitations, however, may require a slower rate of program expansion. Each thana will receive services through the project for a minimum of five years (MOHFW, 1998b).

The project will be managed by the MOHFW as part of the Health and Population Sector Program, but with the involvement of multiple other Government ministries. Its goals will be to reduce levels of protein-calorie malnutrition in children under two years of age, to reduce maternal malnutrition and low birth weight, and to reduce levels of micronutrient deficiency (vitamin A, iron, and iodine), thereby contributing to the Government’s National Plan of Action for Nutrition to eliminate protein-energy and micro-nutrient malnutrition as public health problems in Bangladesh. The empowerment of communities and local Governments to manage and finance their own nutrition activities is an additional goal of the program. The proposal observes that, since the nutritional status of children in urban slums is even worse than that of children in rural areas, possibilities for adopting a similar approach for urban slums will also be considered, possibly in coordination with the Asian Development Bank-supported Urban Primary Health Care Project (World Bank, 1998b).

As is being implemented in the Bangladesh Integrated Nutrition Project (currently underway), Government-NGO partnerships are envisioned in the National Nutrition Program, 2000-2010, to carry out the program at the community level. Interestingly, the project plans call for giving serious consideration to the possibility of contracting with a small number of experienced NGOs who would then contract with smaller ones to assist the Government in the implementation of the project.
CONCLUSION

The changes now underway in the Government's policies for health care in Bangladesh and in the primary health care service delivery system are among the most extensive of any country in the developing world at this time. The degree to which these policies and programs promote "health for all" will be of great interest to the international public health community over the next decade.
Chapter 3

LOOKING TO THE FUTURE

What lessons can be learned from Bangladesh's successful experience with strengthening primary care services? What additional issues need to be addressed if primary care services are to continue to improve and to keep pace with the growing demand? What processes need to be strengthened in order to promote and accelerate continued improvements in primary care services as Bangladesh faces the daunting reality that its population will double by the middle of the next century while expectations for the scope and quality of services continue to increase as well?

THE SUCCESS OF COLLABORATIONS BETWEEN GOVERNMENT, NGOs AND THE COMMUNITY IN PROVIDING A BROAD PACKAGE OF PRIMARY HEALTH CARE SERVICES

The most promising approach to delivering the ESP at the local level consists of combining maternal and child health services with family planning services, developing firm partnerships between MOHFW staff, NGO staff and community members, and strengthening the quality of care at peripheral fixed sites of service delivery while simultaneously maintaining periodic contact with every family member in the community. BRAC health programs, the UNICEF Combined Service Delivery Project, the ICDDR,B Matlab MCH-FP Project, the GTZ Integrated Community Family Health Development Program, the Local Initiatives Program, the Thana Functional Improvement Pilot Project, the WHO Primary Health Care Intensification Project, and World Vision health programs, and the CARE health programs all affirm the feasibility and positive results achieved with this approach.\(^1\) The Government and NGO community need to establish a set of specific guiding principles which will support the further strengthening of mutually supportive and complementary relationships between the community, the Government, and the private sector.

\(^1\) These activities as well as other field activities mentioned here are all reviewed in greater detail elsewhere (Perry, 1999).
Evidence from multiple sources strongly suggests that Health Assistants and Family Welfare Assistants (Government field workers from the two “wings” of the MOHFW) can work well together at the local level if external facilitation is present. Evidence also suggests that these service providers can work in partnership with local communities and NGOs if the local “environment” (as created by the attitudes of MOHFW supervisory staff, local Government leaders and local political leaders) is supportive. And when this partnership is developed, the effectiveness of services is enhanced.

New approaches that can foster closer partnerships between Government providers, NGOs, and communities need to be developed. One recent review has called for a stronger role for NGOs in local-level planning of health and family planning services and also a stronger role for local Government in these activities as well (BPHC NGO Project, 1998).

The collaboration between the MOHFW and NGOs in strengthening family planning, EPI, tuberculosis and leprosy activities have been efficient and effective. The CARE TICA Project is a particularly important example of a successful innovative approach to strengthening MOHFW services at the local level without the usual incentives and costs associated with other pilot implementation projects (such as salary supplements for Government staff, involvement of expatriate technical and administrative staff, or purchase of additional supplies, equipment, and drugs).

The partnerships should be based on the principle that the health of the local population can benefit most if all partners can work together. Strong political and program leadership will be required in order to develop an environment conducive to such collaborations. Effective collaboration will also require the relaxation of rigid Government rules and regulations. The designation of certain thanas as “pilot” thanas which have greater flexibility in the application of Government rules and regulations would help to encourage the emergence of stronger MOHFW-NGO-community partnerships.

DEVELOPING A MORE BALANCED PERSPECTIVE ON THE STRENGTHS AND WEAKNESSES OF THE GOVERNMENT AND NGOS IN SERVICE DELIVERY

A widespread tendency exists to focus on the weaknesses and shortcomings of Government health programs and to focus also on the strengths and achievements of the NGO sector. There is also a countervailing point of view which has not been adequately promoted, however, particularly among those with a strong commitment to the Government system of health care, that the NGO sector is not quite as “stellar” as many make it out to be and that many Government health programs are quite remarkable in light of the difficulties they face.

The immense scale of activities which are often required of Government services, the limited resources available, and the political and bureaucratic constraints under which Government services operate are noteworthy, while NGOs are usually able to attract high-quality staff because of better salaries and better working conditions, usually have considerably more resources per beneficiary for their operations, and normally operate on a much smaller scale. Furthermore, NGOs often have the resources to conduct in-depth evaluations of their projects, to strengthen their activities as a result of these evaluations,
and to publicize the positive findings arising from them. Many Government health services, on the other hand, do not have the staff or the resources needed to evaluate their activities (although Government projects that are funded with external donor support usually do), thereby leaving many success stories undocumented and unpublicized.

CONTINUING MODIFICATIONS OF SERVICES AT THE PERIPHERY

There has been considerable progress over the past decade in unifying the program implementation strategies used at the local level by Government and NGO programs. This process of consolidation and coordination needs to continue. Methods need to be established for the formation of local health and family planning teams composed of Government field staff, NGO field staff, and community members in which all work together to identify and address the priority health and family planning needs in the community and to ensure that available program resources are allocated in an equitable manner. This includes ensuring access to health and family planning services by the poorest and most marginalized persons in the local population.

In view of the growing population and the unlikely prospects for expanding the numbers of paid Government field staff, Health Assistants and Family Welfare Assistants will need to develop collaborative relationships with indigenous community health workers and with NGOs in order to provide every family with the priority elements of the ESP. The experience of BRAC with their unsalaried community health workers (called Shastho Shebikas), the experience of the ICDDR,B Matlab MCH-FP Project with community health workers, the experience of World Vision/Bangladesh with community partners, the experience of the Local Initiatives Program and the Jiggasha approach with community collaborators are all promising and should be more fully assessed. The training, supervision, and support that will be needed in order for Government field workers (Health Assistants and Family Welfare Assistants) and community health workers to function effectively together to provide the ESP at the local level needs to be further specified. Where collaborations between Government field workers and community volunteers are established, mechanisms will need to be developed to ensure that Government field workers do not slacken their own work pace and, conversely, to ensure that the volunteers do not generate more work for the Government field workers than they can manage.

The BRAC experience with Shastho Shebikas and the ICDDR,B Matlab MCH-FP Project experience with local community health workers provides compelling evidence that local-level community health workers can effectively provide to the entire local population many of the elements of the ESP if training, supervision, and support are adequate and if referral sites are available where they can refer clients in need of higher levels of care. The breadth of the health activities of Shastho Shebikas in community-based health care is quite extensive, especially considering that the Shastho Shebikas are illiterate (or, at best, semi-literate) and unsalaried. Their effectiveness has been possible because BRAC has provided strong technical, managerial, and logistic support to these workers. Such support may be more difficult to achieve within the Government system of health care services. Since in the BRAC program the community health workers do not require a salary from an external resource, a similar national program can be readily sustainable in the longer run if adequate technical, managerial, and logistic support can be developed similar to BRAC’s
and if the training, role responsibilities and incentives are similar to those of the *Shastho Shebikas*.

There is general agreement that expanding the number of Family Welfare Assistants and Health Assistants is not a feasible option for Bangladesh in the near future. With the help of community health workers similar to the BRAC *Shastho Shebikas*, the population of Bangladesh could receive a broader range of services than is possible with the current cadre of Family Welfare Assistants and Health Assistants. Thus, community health workers could provide a key resource for expanding the coverage of a broader set of services in the rapidly growing national population without expanding the number of salaried Government Family Welfare Assistants and Health Assistants. As the number of Community Nutrition Promoters throughout Bangladesh increases over the next decade with the support of the Bangladesh Integrated Nutrition Project and the National Nutrition Program, 2000-2010, these workers could possibly gradually take on a broader set of skills to enable some of the local unmet needs for the provision of the ESP to be met.

Community health workers could, in addition to actually providing services, motivate communities to make better use of under-utilized Government health resources and strengthen the community's role as a partner in health and family planning activities at the local level. As the role of paid Government or NGO workers visiting the homes of clients on a regular basis to promote basic MCH-FP services gradually diminishes, indigenous community health workers could make a major contribution by maintaining contact with all women of reproductive age. Such contact has been a key element of Bangladesh's success in reducing its fertility as well as its infant and child mortality.

Family Welfare Assistants and Health Assistants are already providing several elements of the ESP at the community/outreach level. With appropriate training and supportive supervision, these Government field workers could deliver a broader range of ESP services. The potential for expanding the role of Family Welfare Assistants beyond family planning to other MCH activities appears to be strong, partly because of the greater role satisfaction which this will bring to them as a result of being able to respond more appropriately to the needs of their clients.

Family Welfare Assistants and Health Assistants should continue to focus their efforts on promoting the utilization of Joint EPI Outreach Sites/Satellite Clinics by referral of clients who need services and by providing assistance to the paramedics treating patients at these clinics. Supervision of indigenous community health workers, promotion of healthy behaviors, promotion of family planning, and referral for services should continue to constitute the core function of Family Welfare Assistants and Health Assistants.

Despite current fiscal constraints, the number of paid MOHFW staff working at the periphery should not be reduced. A common job description, a common role, and a single supervisor should be designated for the Family Welfare Assistants and Health Assistants who will be working side by side. This concept has been endorsed by the MOHFW and is currently in the process of being implemented.

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2 Experiences in other countries have shown that unless there is a strong programme of supervision for community health workers, their effectiveness and enthusiasm will wane quickly (see Heggenhougen et al., 1987).
When new lower-level field staff are required by the MOHFW to maintain the current level of workers, they should be recruited from the thana (and preferably from the union) in which they will be deployed. The value of local-level health workers serving their own people cannot be over-emphasized. When these workers are bona fide members of the communities they serve, their commitment to their work is necessarily greater.

All homes should be visited periodically, perhaps every 12-18 months, to identify the health and family planning needs of each household within a specified catchment area. These visits would provide the opportunity for clarifying the needs in each household for EPI and family planning services, for assessing infant feeding practices and basic maternal knowledge about the preparation of oral rehydration solution for treatment of diarrhea, and for assessing maternal knowledge about the warning signs of pneumonia and pregnancy for which medical attention should be sought. Such visits are also opportunities for detecting persons with early signs of leprosy and tuberculosis and for identifying cases of acute flaccid paralysis, measles, and neonatal tetanus as part of the national epidemiological surveillance system for vaccine-preventable diseases. Households with special health and family planning needs should be targeted for more frequent visitation. Community health workers similar to the BRAC, Shastho Shebikas could visit these household routinely and also visit priority clients more frequently.

Local, full-time paid health workers (both those employed by the Government as well as those employed by NGOs) should report on their work to local village committees. The local village committees should provide assessments of the quality of work carried out by these workers to the employing organization and supervisor. Local health committees should be able to participate in the decision regarding who these workers will be and whether the existing workers will continue in their current roles. The Bangladesh Integrated Nutrition Program offers one example of this type of local community involvement in Bangladesh. During the coming decade, there will be a need to gradually increase the geographic area operating under this kind of local community partnership so that the entire country can eventually benefit.

There is extensive evidence in Bangladesh as well as in other developing countries that those in greatest need of basic preventive and curative services are least likely to seek them out. Those women at greatest risk of unplanned pregnancy and those infants and children at greatest risk of death are most likely to be found in the most impoverished households, to be the least educated and consequently the least motivated to seek health and family planning services, to be further away from fixed sites of service delivery, and to lack the time and money required to seek services from fixed service delivery sites. In spite of the vigorous efforts underway in Bangladesh to reach out into the community with basic health and family planning services, major barriers still must be overcome if priority clients are to actually obtain them. Therefore, if Bangladesh is to continue to make progress toward “health for all,” efforts that attempt to ensure the provision of services to priority clients will need to receive strong support.

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3 A union is a geographic area corresponding to a population of approximately 25,000 persons.
4 I and my colleagues working in Bolivia, South America, have provided elsewhere (Perry et al., 1999) a detailed discussion of a similar approach to the provision of local primary health care services which has worked well there. We refer to this as the “census-based, impact-oriented,” or CBIO, approach.
The effectiveness and credibility of health workers is, in part, dependent on the effectiveness of the referral system and the quality of care provided at higher levels in the system. Criteria for referral (especially in the case of emergencies) need to be developed and applied on a national basis, and mechanisms need to be developed to ensure that those who need referral are actually obtaining the services they need at affordable cost. Each union should have a Health and Family Welfare Centre where services are available 24 hours a day and where referrals to higher levels of care can be assured regardless of the client's ability to pay.

If field workers and community health workers promote referral to clinics that are not functioning, that are understaffed or working inefficiently, that have inadequately trained staff, or that provide poor-quality services, then the credibility of the referring health worker and the local primary health care system will suffer. This is only one of many reasons why an acceptable quality of care at primary health centers needs to be ensured.

Although the average population of a union is 25,000 persons, there is in fact considerable variation in the populations of individual unions. In some unions the population may be as high as 50,000 persons. Thus, some unions need more clinics than the standard eight Satellite Clinics established by the Government. The need for population-based health planning and allocation of resources is obvious. NGOs and other private providers should be invited to assist in the development of new clinics in areas where Government resources are unable to meet the current need. In areas where Government resources are available but not functioning effectively, the possibility of an NGO managing these Government resources on a contractual basis with the MOHFW should be considered.

The mobility of women in Bangladesh has increased considerably during the past several decades. Even so, social constraints still impede the free flow of many women some distance from their homes. Fifty-eight percent of the rural population lives more than two miles from a Health and Family Welfare Centre. Since many women still are not comfortable in travelling very far from home and also find the expense of a rickshaw fare a major burden, there will be a continuing need, for the foreseeable future, for women to be able to walk to a health care delivery site. The Government's plan to establish 13,000 new Community Clinics will be one important step in maintaining readily accessible services. The quality of care provided at these peripheral delivery sites will need to be maintained to ensure that the Satellite Clinics are held as scheduled and that basic medicines and supplies are available.

Joint EPI Outreach Sites/Satellite Clinics should provide a broader scope of ESP services than at present until fixed-site Community Clinics obtain the capability of providing the entire scope of ESP services which are readily accessible to the entire local population. Careful thought will need to be given to the issues associated with "gender space," however, at both Joint EPI Outreach Sites/Satellite Clinics as well as at fixed-site clinics. Strategies will be needed to ensure that men feel comfortable in obtaining services at these sites, just as strategies have been developed in the past to ensure that women and children feel comfortable in obtaining services. In Bangladesh, areas outside of the home where people congregate tend to be either exclusively for males or exclusively for females. So far, most NGO and Government clinics have become "female spaces."

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5 Plans for new Community Clinics include separate rooms for male and female clients.
MOVING BEYOND TRADITIONAL GENDER ROLES IN SERVICE PROVISION AND SUPERVISION

For reproductive health and family planning services, the gender of a health worker has a major influence on the acceptability and therefore the effectiveness of the individual. Women will rarely invite male workers into their homes. Women will rarely talk to men, particularly about issues pertaining to their own health or their use of contraception. Similarly, men are unlikely to talk comfortably with a female worker about issues pertaining to their own health and their own use of contraception. Because of the central role of women in MCH-FP activities, women should be preferentially recruited into job openings for Health Assistants and Family Welfare Assistants (or whatever they may be called in the future). There will still be a need, however, for male field workers who can promote health and family planning among men.

In Bangladesh, men traditionally supervise women. There is growing evidence, however, that such a supervisory pattern is dysfunctional. It restricts the capacity of women to advance in their careers and leads to the recruitment of male supervisors who have not had the first-hand experience necessary to carry out their jobs effectively. Moreover, male supervisors are not actually able to understand or even discuss the work carried on by female workers with female clients (for the reasons mentioned above) when sensitive sexual and reproductive issues are involved. At the same time, the experience of some NGOs has shown that it is possible for females to work effectively in supervisory roles, to travel about at night, and to stand up in public meetings and address higher-level authorities (Wirzba, 1997).

The Health and Population Sector Program, 1998-2003, has recognized the importance of gender issues for health services and for health service providers. Several specific activities are planned as part of the Program. Among these are the following:

- Addressing issues of gender in the human resource development activities of the MOHFW;
- Enhancing opportunities for women at the policy and planning level;
- Establishing policies and procedures to improve working conditions and to guarantee career advancement opportunities for women; and
- Raising awareness with all staff on gender issues related to the interactions they have with their clients and on gender issues related to general personnel matters (MOHFW, 1998a).

While NGOs in Bangladesh have made strong progress in building stronger roles for female staff in the delivery, supervision, and management of health and family planning services, similar progress is now needed in Government programs.

In particular, opportunities need to be created to enable the most experienced female Family Welfare Assistants and Health Assistants to move into supervisory roles. Men who are functioning as Health Assistants and Assistant Health Inspectors (that is, supervisors of Health Assistants) need to gradually devote their attention to the health and family needs of men in the local population.
IDENTIFYING HIGH-QUALITY COMMUNITY-BASED PRIMARY HEALTH CARE PROGRAMMES AND PROVIDING SUPPORT FOR TRAINING AND OPERATIONS RESEARCH

There is a need to identify high-quality community health programs currently in place in Bangladesh where training for local health care providers (such as Family Welfare Assistants and Health Assistants and community health workers) can be offered. Moreover, training should be need-based and linked to the particular circumstances of the site where the worker will be working after the training is completed. High-quality programs in both the Governmental and NGO sectors should be identified to provide training.

The Grameen Health Programme is using this principle for its own staff development. The program sends its health assistants to the strongest health centers in the Grameen Health Programme for on-the-job training. The concept of exposing health workers to the best of their colleagues carrying out similar activities so that they can learn from them has great promise in bringing a renewed vitality to local health services, as has been shown in Indonesia (Robinson et al., 1998).

Thanas should be identified which have high-quality Government service delivery activities underway and which can become “model” thanas where new policies and procedures for improving quality, promoting community involvement, and fostering sustainability can be implemented and closely monitored. Such thanas would have the potential for becoming training sites where field staff could be trained by persons working with programs currently engaged in the effective provision of the ESP.

These same program sites offer strong potential for carrying out local operations research activities to strengthen service delivery. The program sites which are identified should have defined geographic areas for which they are responsible. In these areas, methodologies could be periodically updated for enabling local community leaders and local health and family planning staff to identify the most frequent readily preventable causes of serious illness, disability, and death in the local population, the most common reasons for unintended fertility, and those at greatest risk of these unfavorable outcomes.

Moreover, local community leaders and health staff need to have the capacity to monitor changes over time in the rates of serious illness, disability, death, and unintended fertility in their populations. Therefore, methods for accomplishing this also need to be gradually strengthened. Major progress has been made in comprehensive community-based surveillance activities in Bangladesh by the Matlab MCH-FP Project, World Vision/Bangladesh, BRAC, and Save the Children/USA, but this progress needs to continue and be applied on a broader scale in Bangladesh at a cost that is sustainable.6

The need for documentation and evaluation of local service delivery activities will continue, and future progress in reaching “health for all” will depend in part on scaling up activities that have been proven to be successful on a smaller scale and which are carefully monitored and adjusted during the scaling up process. Thus, there will need to be strong financial support for these operations research activities and also for the nurturing of individuals and organizations with interest and expertise in such research.

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6 For recent descriptions of similar approaches used in other countries, see Perry et al. (1998b, 1999b), Das Gupta et al. (1997), and Scrimshaw (1995).
IMPROVING THE TRAINING OF SERVICE PROVIDERS

There is a general perception among persons knowledgeable about the Government health and family planning program that the quality of training for lower-level Government health and family planning workers needs to be improved. A common concern voiced by these persons is that the training is too theoretical and includes too little practical experience at the field level with actual patients. Furthermore, the training often does not prepare the workers for the realities in which they later find themselves.

Another problem with training of lower-level staff in Bangladesh is that NGO health personnel often receive training based on a different curriculum from that received by Government health personnel (BPHC NGO Project, 1998). Government and NGO workers should be trained together at high-quality delivery sites (see above). Moreover, they should be taught by staff who are engaged on a day-to-day basis with service delivery. Training of Government and NGO workers together at these same high-quality delivery sites would also foster stronger collaborations and shared values between Government and NGO health staff members.

The USAID-supported National Integrated Population and Health Program has had recent success in providing updated child survival training to NGO Paramedics and Medical Officers using a Government-approved curriculum which incorporates all of the current child survival guidelines and policies. This training is provided by other NGOs with special expertise in training, but these NGOs are also providing primary health care services. A major portion of the training is devoted to practice with actual patients in the assessment and management of childhood illness. In a number of instances, Government facilities and staff provide clinical training. The training approach is, in fact, an NGO-Government collaboration, and the approach could be readily adapted for the training of Government workers using the same curriculum (Perry and Sarker, 1999).

REFORMING THE GOVERNMENT'S HEALTH AND FAMILY PLANNING SERVICES AND REASSESSING THE GOVERNMENT'S FUTURE ROLE

There is widespread agreement that MOHFW service providers and thana-level management staff (with the exception of Government field workers) have learned how to serve the "system" better than they have learned how to serve their clients. In preparation for the Government's Health and Population Sector Program, 1998-2003, the Government's Task Force on Community and Stakeholder Participation carried out an assessment of the local perception about Government health and family planning services in five villages scattered around Bangladesh using a participatory rural appraisal methodology. The assessment showed that, according to the villagers, even though Government health services are officially free, poor people are commonly charged fees (without receipt) by the staff. Even gatekeepers and peons were reportedly requesting small, unofficial payments from clients. Thus, although the "official" cost of the service is zero, the "hidden" cost is substantial and beyond the reach of the poor. Village practitioners, in contrast, charge fees which are transparent, well-known in the community, and affordable (Task Force 8, 1997a,b,c).

Furthermore, the poor villagers who participated in these discussions with the Task Force maintained that Government service providers treat them with disrespect, and the providers give priority to the better-off clients. The villagers stated that the Government
health care facilities are dirty and lack waiting rooms, toilet facilities, and privacy. Finally, they complained that the providers (and particularly the doctors) were rarely there, the facilities were often closed, and that the facilities more often than not lacked drugs. The facilities were also frequently inconveniently located, often at some distance from the markets where they are accustomed to consulting private local practitioners (Task Force 8, 1997a,b,c). Not surprisingly, villagers view Government health services only as a provider of last resort, when local village practitioners have failed in their attempt to resolve the problem and the family is becoming desperate.7

Given this local perception of Government health services, one must ask if the Government health service system is viable in the long-term. Thorough, systemic changes will be required in the MOHFW which promote accountability to the community, improve productivity and performance of health staff, encourage decentralization, improve quality of care, increase the responsiveness of the providers to the needs of clients, promote community and NGO involvement, and provide local monitoring based on accurate information. Without these changes, the effects of other improvements will be short-lived. Although the need for these changes is obvious, the capacity of the Government system to reform itself is a major question in the minds of many.

Systemic changes in the MOHFW should be seen as equal in importance to technical and financial support for improving service delivery at the local level. High-level political support along with strong managerial and technical support will be needed to carry out these proposed changes. Fostering competition between the Government health service system and the private sector will promote change within the Government system, as will the concept of “contracting out” basic Government services to private organizations— including NGOs—that has been gathering momentum in other developing countries (Roth, 1987).

Strengthening independent monitoring of health status and utilization of services at the thana level would make it possible for the MOHFW to more rationally direct its limited resources to those areas with the greatest need. Funds could be directed to those thanas and urban neighborhoods with the highest child and maternal mortality and with the highest levels of unmet need for family planning services. One possible mechanism would be through contracts which are awarded to private bidders and monitored by independent firms. Such an approach is currently being implemented in the metropolitan areas of Bangladesh by the Ministry of Local Government, Rural Development and Cooperatives through a project for urban primary health care funded by the Asian Development Bank.

Services which make the greatest contribution to the public’s health and well-being should be subsidized and made available to every person regardless of the person’s financial capacity. Such services include family planning, immunization promotion and provision, maternity care, nutrition education and provision of micronutrients, and prevention or treatment of common life-threatening infant and childhood disorders such as pneumonia, severe diarrhea, malnutrition, tuberculosis, malaria, and HIV/AIDS. It is these services

7 Complaints of this sort were not made against the Government Family Welfare Assistants, who are women visiting the homes of couples of reproductive age. Instead, the villagers considered them to be friendly and found them not to be engaging in these kinds of practices (Task Force 8, 1997a). These Family Welfare Assistants are almost all life-long local residents of the communities where they work, while other service providers tend to come from other locations just for the purpose of work and do not become integral members of the community.
which deserve priority attention from the MOHFW and financial support from the international donor community.\(^8\)

Finally, as rural-to-urban migration continues on a massive scale in Bangladesh during the next several decades, Governmental policies and programs will need to respond better to the enormous needs of the urban poor, particularly those living in slum households. In the urban areas of Bangladesh, there is great vitality and innovation underway in the private sector and in the NGO community. Thus, it will be incumbent on the national and municipal Governments to identify the most successful NGO programs currently serving the urban poor and to support their expansion.

As the private sector becomes stronger in Bangladesh, the need for stronger Government regulation will grow. At present, existing regulations related to health care services in Bangladesh are not enforced. Nevertheless, their very existence serves as a basis to extract “unofficial payments” to Government officials.

Thus, an unenforced regulation may be worse than no regulation at all (M. M. Khan, 1998). The development of a transparent and effective regulatory framework for health services in Bangladesh will also require general improvements in the nation’s legal system, as well so that the interests and property of private providers as well as the rights of patients improperly treated by health care providers can be protected (M. M. Khan, 1998). Governments of developing countries such as Bangladesh will be gradually shifting their role over the next decade from providing health services to financing and regulating them (World Bank, 1998). Therefore, the effectiveness of the skills and techniques which are employed for this purpose will have a great influence on when “health for all” will eventually be realized in Bangladesh (Brugha and Zwi, 1998).

**EXPANDING THE ROLE OF NGOS IN PRIMARY HEALTH CARE**

The current Health and Population Sector Program document calls for continued collaboration between the Government and the NGO sector for health and population activities and indicates that there is a need to further specify NGO roles and responsibilities and to further develop a set of principles that would result in expanded GOB and NGO collaboration. The document calls for a revised legal and regulatory framework which will provide for a greater transparency and accountability of NGO activities (MOHFW, 1998a).

The Health and Population Sector Program envisions the following activities as particularly appropriate for NGOs:

- Social mobilization for routine services as well as for national and international days and events;
- Fostering awareness among clients about their rights, the types of services they are entitled to, and the minimum level of quality of services they are entitled to;
- Creating and fostering community linkages, including strengthening the participation of local Governments and local leaders in the delivery of services;

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\(^8\) The 1993 World Development Report, *Investing in Health*, presents a well-thought-out approach to this issue for developing countries in general and concludes that such a package could be provided in low-income countries at a cost of only $12 per person per year (World Bank, 1993).
• Targeting the poor;
• Delivering the ESP;
• Fostering behavioral change communication activities at the local level;
• Continuing outreach services to targeted households as Government providers begin to provide more services from fixed sites and move away from doorstep delivery of services;
• Managing clinical services (including hospital services) on a competitive contractual basis with the Government;
• Training service providers;
• Conducting operations research; and
• Assisting in the formulation of national policies and strategies (MOHFW, 1998a).

NGOs frequently participate as members of thana-level and union-level health and family planning committees, although Government representatives usually play the dominant role at these levels. Perhaps the Health and Population Sector Program could also promote a stronger role for the NGOs on these committees.

The stronger role envisioned for NGOs by the Government's Health and Population Sector Program encompasses a number of facets. First, the NGO role will be strengthened by the Government enabling NGOs to bid on Government-funded activities in the health and population sector. NGOs have been able to do this for some years now in the Education Ministry and in the Agricultural Ministry of the Government, using a predetermined system that includes open bidding. It appears that these contractual agreements will be one of the mechanisms for utilizing support from external donors. Moreover, donor agencies will participate in the process of selecting the NGO that will be awarded the bid.

Secondly, more streamlined mechanisms for Government contracts with NGOs will be developed. And finally, NGOs will be asked to provide assistance to the Government in the formulation and implementation of a Bill of Rights for clients at hospitals and clinics and in enforcing the current Code of Conduct for medical practitioners and making this code more widely known among clients (MOHFW, 1998a).

STRENGTHENING THE QUALITY OF CARE PROVIDED BY LOCAL PRIVATE PRACTITIONERS

Local private practitioners will continue to play a key role in providing first-contact care for patients with life-threatening conditions such as diarrhoea, acute respiratory infection, and complications of pregnancy and childbirth. They will also continue to come in contact with patients having other illnesses of public health importance such as sexually transmitted diseases or symptoms of suspected tuberculosis or leprosy. Local private practitioners will also play an increasingly important role in the provision of family planning services (including the provision of menstrual regulation and abortion). There has been limited experience to date in Bangladesh with regard to including these practitioners as formal members of the health care system or in fostering a greater awareness among them regarding the importance of identifying clients at greatest risk of death who consequently urgently need high-quality, scientifically validated treatments. Moreover, there has been
only limited experience so far in providing these practitioners with the skills and resources they need to provide effective treatments or in encouraging them to refer cases that they themselves cannot manage effectively.

A review of the current role of private practitioners (including traditional healers, *kabiraj,* “quacks,” *palli chikitshak,* and traditional birth attendants as well as allopathic physicians in private practice) and the quality of care provided by them should be undertaken. Following this, policies and activities should be established which encourage these practitioners to improve the quality of the services they provide, to encourage healthy lifestyles and healthy behaviors in their clients, and to refer clients with life-threatening conditions to appropriate treatment centers. This could then be complemented by a more robust Governmental regulatory framework for services provided by private practitioners.

**INCREASING LOCAL-LEVEL AUTHORITY AND ACCOUNTABILITY FOR THE PROVISION OF HEALTH AND FAMILY PLANNING SERVICES**

A number of projects reviewed here focused their activities of local community participation around the local union *parishad* chairman or the local member of parliament by designating this person as the chairperson of a committee for local participation at the thana or the union level. The experience has been that, more often than not, the local politician is either too preoccupied with other activities to be effective in this type of role or more interested in personal political gain than in improvements in the local health service system. The challenge is, therefore, to identify a proper and legitimate role for local political leaders but at the same time to enable *bona fide* local leadership to emerge which has a strong commitment to (and therefore time and energy for) strengthening local health and family planning services. The Local Initiatives Program has gained valuable experience in this regard which needs to be more widely shared. The broader challenge as well, which goes far beyond the process of strengthening local health services, is to strengthen local participatory democracy and, consequently, local Government at the union level and to enable it to be responsive to the needs and interests of the local population.

The Government plans to construct, in the near future, 13,000 community health centers that will provide primary health care services, including family planning. These centers will be constructed in part with community support and they will be accountable to the community. Ideally, these centers will have a clearly defined responsibility for the entire population of approximately 6,000 persons around it. If so, these centers will need to develop and maintain a close tie to the community and, as has been mentioned before, with every household in the community to ensure that everyone in the community obtains needed basic services. The health staff at these centers will need to send patients along a clear and effective path of referral when necessary.

How local primary health care systems in Bangladesh can involve the MOHFW, the municipal Governments, the NGOs, and the private practitioners in a way that makes the system function in an optimal manner under severe resource constraints remains to be seen, but a strong beginning point would be the continued strengthening of the various local

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9 The *union parishad* is the locally elected body which is involved with all aspects of government activities at the local level.
coordination committees currently in existence. These committees are responsible for specific geographic areas and for all of the primary health care activities that take place within that area. Through such coordination mechanisms, the resources of both Government and private providers can better respond to local needs. The community can be involved in monitoring the quality and the coverage of services, thereby promoting accountability to the community for the quality of services. Such a system will be necessary to provide not only a "safety net" for the poorest segments of society but also care of appropriate quality for those who can afford to pay.

MONITORING AND EVALUATING LOCAL HEALTH AND FAMILY PLANNING SERVICES AT THE LOCAL, REGIONAL AND NATIONAL LEVELS

There has been extensive experience in Bangladesh with various innovative approaches to providing basic health and family planning services at the local level. Much of this is poorly documented or, if documented, not widely circulated or known about. Moreover, information about the cost of many of these approaches is unavailable. Furthermore, there has been little independent assessment of the effectiveness of many of the approaches. There is a need, therefore, for independent assessments of progress in strengthening local health and family planning services. Such assessments need to be carried out in an independent and objective manner, and they should be carried out for both Governmental as well as NGO health services. That is to say, such assessments need to be independent of the specific projects which are being assessed, and they should be based on carefully considered, objective criteria. Finally, there is a need for operations research which is population-based and focused on health and demographic outcomes as well as on the process of service delivery itself.

Taking these concerns into account, some of the major questions that should be addressed by monitoring and evaluation at the local as well as at the regional and national levels include the following:

• What are the most frequent causes of preventable or treatable morbidity and disability, and what are the most frequent causes of preventable mortality? Which persons within the population are at greatest risk of serious illness, disability, and death, and what are their demographic and socioeconomic characteristics (such as age, socioeconomic status, marital status, history of previous child death in the household, and so forth)\(^\text{10}\)?

• Are there appropriate preventive and curative services of reasonable quality available to those at greatest risk of serious morbidity, disability, and mortality?

• Are those at greatest risk of illness, disability, and mortality actually receiving appropriate preventive services? Are those who develop an illness which could lead to disability or death receiving appropriate and timely curative services? Are the curative services that are being provided of reasonable quality?

\(^{10}\) These questions in the strict sense of the term are addressed by epidemiological research, and some may consider the actual conduct of such research to be beyond the purview of operations research. Even if this is the case, it is nonetheless necessary for those involved in operations research to synthesize the available answers to these questions for the population of interest. This is, in itself, a demanding task.
• Are the services being provided producing the expected/potential benefit for the population?
• Are the costs of the services affordable in the long-run to the client/patient, the community, the NGO, and/or the Government?
• Is the community involved to the maximum extent possible in the planning, implementation, monitoring, and evaluation of local health and family planning services?
• Which strategies for service provision are the most cost effective, what types of service providers are the most effective, and what are the organizational influences that promote or hinder effective service provision?

Careful attention to these questions, which can be answered through operations research, and gradual change in program operations on the basis of answers to the questions should lead to a gradual improvement in the effectiveness of local health and family planning services. Although some operations research activities in Bangladesh address these questions, much more remains to be done.

Surprisingly, there is little reliable population-based data at the thana level on coverage of EPI services, coverage of family planning services, or utilization of health services. A promising approach to obtaining information of this sort has been developed which uses the standard household survey for 30 clusters of married women of reproductive age from each of 20 villages which were randomly chosen from within a thana (600 respondents in all). The survey can be carried out by six staff members in a two-week period (Rahman and Barkat-e-Khuda, 1997). The procedure provides accurate information on the contraceptive prevalence rate, maternal tetanus toxoid immunization coverage, childhood immunization coverage, recency and frequency of contact with a Family Welfare Assistant and with a Health Assistant, and utilization at EPI Outreach Sites, Satellite Clinics, Health and Family Welfare Centres, and Thana Health Complexes.

The procedure provides an independent assessment of key program performance indicators at the thana level and a means of accurately and independently monitoring performance on an annual basis. Thana-level information of this breadth and quality is not currently available. Nonetheless, such information has potential for motivating field staff to improve their performance provided that local staff are involved in the process of using the information to plan their activities and — if the information is not used to apportion blame for low levels of performance — the approach makes it possible to determine which thanas may need additional assistance in improving their performance since performance from one thana to another can vary widely.

Lot Quality Assurance Sampling (LQAS) also holds great promise for identifying low-performing thanas and urban neighborhoods using household surveys requiring small sample sizes (Lanata and Black, 1991; Reinke, 1991; Valadez, 1991; WHO, 1996). The USAID-supported BASICS Project (Basic Support for Institutionalizing Child Survival) has had experience with LQAS to identify urban slum neighborhoods with low immunization coverage levels (Tawfik and Millsap, 1998).

The reality of the situation is that our actual knowledge about the relative strengths and weaknesses of Government, NGO, and private-for-profit health services is still limited. Much of what we know about NGO services comes from evaluations which
are paid for by the NGOs themselves or their donors, and these evaluations more often
that not tend to place the results of the evaluation in as positive a light as possible.
Notably absent from many program assessments are careful analyses of the total costs
involved. For this reason, objective assessments by evaluators that have no “vested”
interest in the program or the organization associated with the program are needed
in order to obtain a more accurate picture of the strengths and weaknesses of the
service.11

The Bangladesh Demographic and Health Surveys and Helen Keller International’s
Nutrition Surveillance Project are good examples of assessments of the overall health,
family planning, and nutrition processes and outcomes in Bangladesh carried out by
independent organizations with a reputation for the collection and dissemination of
high-quality information.12 Similar population-based assessments are needed of the quality
and effectiveness of health services at the national, division, district, thana, and municipal
levels. Furthermore, similar types of independent analyses of service delivery processes
within specific organizations are also needed to enable identification of strengths and
weaknesses and the formulation of strategies to improve service delivery.

It is no secret that socioeconomic development programs, particularly those which are
supported with international development funds, can often give the appearance of being
successful when, in reality, a closer examination of them would lead to precisely the
opposite conclusion (Paddock and Paddock, 1973). There is no substitute for high-quality
information about the strengths and weaknesses of primary health care programs,
particularly information which is gleaned from the clients of the service providers as well
as from population-based assessments of program outcomes. Therefore, independent audits
and the capacity to fund, carry out, and disseminate the findings of such audits, are very
much needed in Bangladesh if solid progress in the improvement of primary health care
services is to continue.

There is a particular need to obtain information from the local people about the primary
health care services in the community. One colleague with extensive experience has urged
those with responsibilities for health programs to:

Go to the field! I have learned through bitter experience that project descriptions and
evaluations sometimes have little relationship with field realities. Talk with clients. If they
haven’t heard about the projects or benefited from them, the projects are no good. Too

11 Even though many evaluations are carried out by “independent” evaluators for both Government and NGO
programmes, in fact these persons or their firms are often eager to maintain an ongoing relationship of work with
the entity engaging them. Thus, the evaluators may not be as critical or objective as they might otherwise be since,
the evaluators may be influenced by the biases of the funding organisation.

12 The Demographic and Health Surveys are carried out in many developing countries by national firms working in
coordination with Macro, International. In Bangladesh, these surveys have been carried out by Mitra and
Associates. The DHS surveys provide information every three years from a national representative sample
regarding utilisation of maternal and child health and family planning services. The survey also provides accurate
estimates of childhood mortality rates, contraceptive prevalence, and fertility. The National Surveillance Project
is a quarterly surveillance system of health and nutrition indicators (including height and weight of children and
information about household food consumption and prices of common agricultural commodities). This surveillance
system is operated by Helen Keller International in cooperation with local NGO partners who actually collect the
data while Helen Keller International provides technical support and quality monitoring (including repeat data
collection from 10 percent of households by a quality monitoring team) as well as data analysis and report writing.
USAID provides financial support for both the Demographic and Health Surveys and the National Surveillance
Project in Bangladesh.
many people have fallen sick or died because of misrepresentations. I think the time has come to throw aside some of our cool professionalism—to gird up our loins—and to make sure that the poor, weak, sick and oppressed receive the services due them. Nothing else is acceptable.

Fortunately, this message is increasingly being heard and those responsible for the monitoring and evaluation of programs are getting out to the field to see what is actually going on. A promising approach is being envisioned as part of the Health and Population Sector Program to provide stronger local input into the monitoring and evaluation process is a series of sentinel community surveillance surveys (Gerein, 1998; CIET, 1997). These surveys will involve communities in gathering and analyzing quantitative and qualitative information about utilization, coverage and impact, with the aim of using this information to foster community-led solutions to problems which have been identified by the evaluation. Through the inclusion of the community’s "voice" in the evaluation, the proposed solutions are more likely to be appropriate and sustainable.

**SCALING UP GRADUALLY**

Because Bangladesh is a country which is small in size and also relatively uniform both in terms of culture and geography, and because the MOHFW is highly centralized, the temptation exists to assume that major initiatives can be implemented quickly and effectively if the proper bureaucratic and political support is available. Common sense, tempered with experience, however, would tell us that the greatest prospects for long-term success rest with the gradual scaling up of small and carefully thought out projects which prove to be successful and which are continuously monitored, evaluated, and adapted during the scaling up process.

There are a number of successful large-scale projects in Bangladesh that developed in this manner: the national program of Family Welfare Assistants and NGO family planning field workers visiting the homes of clients; the National EPI Program, the Primary Health Care Intensification Project, the Thana Functional Improvement Pilot Project, the BRAC National Oral Rehydration Therapy Program, the BRAC community-based tuberculosis and ARI programs, the Jiggasha approach, and the Local Initiatives Program, and the Bangladesh Integrated Nutrition Project. Additional examples include the UNICEF Combined Service Delivery Project, the BRAC *Shastho Shebika* program, and the World Vision/Bangladesh projects. These activities generally started on a small scale and gradually expanded, with "mid-course" corrections being made on the basis of experience, monitoring, and evaluation. Gradual changes based on careful evaluation of a few carefully thought out small-scale implementation projects with scaling up based on lessons learned will have more lasting effects than a widely-applied approach which was later found to be defective because of rapid scaling up and inadequate monitoring and evaluation.

Each phase of implementation should begin on a smaller scale and then progress to a larger scale of operations. Moreover, results from objective monitoring and evaluation should be incorporated into the planning of each subsequent phase. The schedule for phased implementation should be relatively inflexible, but it should allow adequate time for each phase, before progressing to the next one.
BRAC AND THE ICDDR,B/CENTRE FOR HEALTH AND POPULATION RESEARCH AS NATIONAL ASSETS

Few, if any, developing countries have organizations such as BRAC and the Centre for Health and Population Research of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), whose experience in and capacity for strengthening local health and family planning services is renowned around the world. Although there are many other organizations in the developing world with experience and capacity in community-based health and family planning services, few have the breadth and depth of experience or the technical expertise as do these two.

BRAC has extensive experience in developing community-based health and family planning services, in monitoring, evaluation and operations research, and in training. BRAC is internationally known for its success in working with communities to promote health and development. BRAC has the most extensive (both in terms of numbers of persons reached with services as well as in terms of breadth of services provided) and the most promising NGO experience in Bangladesh in the provision of a basic package of primary health care services at the local level.

BRAC's training of *Shastho Shebikas* and its formation of community partnerships through the formation of village committees provides the potential for extending all elements of the ESP to every household in a systematic, affordable, and sustainable way. The BRAC approach provides a mechanism for integrating all of the elements of the ESP at the community level. There is, however, a need for further documentation and evaluation of the BRAC experience, the costs involved, and the results achieved.

The ICDDR,B/Centre for Health and Population Research has extensive experience in operating a high-quality, comprehensive package of MCH-FP services at the local level (in Matlab), in monitoring, evaluation and operations research, in improving the treatment of diarrheal disease, in nutrition research, in training, and in contributing to the formulation of national and international health policy. The scientific basis of oral rehydration solution for diarrhea, generally credited with saving the lives of 1.5 million children around the world each year (UNICEF, 1998), was developed at ICDDR,B. The scientific research and publications from ICDDR,B have been and continue to be used throughout the world for teaching in schools of public health and for the formulation of policies and programs in maternal and child health in developing countries.

ICDDR,B has extensive experience with operations research and with the implementation of innovative approaches to providing MCH-FP services. The Operations Research Project at ICDDR,B is one of the largest in the world and has a proud history of close involvement with the MOHFW in promoting improvements in the national service delivery system. The ICDDR,B Matlab MCH-FP Project has one of the longest and most thoroughly documented experiences in Bangladesh with the provision of most of the elements of the ESP at the local level.

Two decades ago, the family planning component of the Matlab MCH-FP Project served as the model for the highly successful national program for providing family planning services. The Matlab MCH-FP Project, furthermore, has achieved international recognition as having one of the highest quality field sites for MCH-FP service delivery in
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the developing world. Almost all of the field leadership staff as well as the service providers at Matlab have been working with the program there for more than two decades and have extensive experience with the practical issues involved in providing high-quality MCH-FP services at the local level. Finally, the Matlab MCH-FP Project has valuable recent experience in the development of reproductive health interventions (including the promotion of Safe Motherhood and the detection and treatment of reproductive tract infection).

Both BRAC and the ICDDR,B/Centre for Health and Population Research can continue to make major contributions to the national program of local health and family planning services by developing and managing model projects involving collaborations among communities, NGOs and the MOHFW which can then be scaled up. Both organizations also have the capacity to offer technical assistance to national and local Government programs as well as to smaller NGOs involved in the provision of local health and family planning services.

EMPOWERING LOCAL PEOPLE FOR THEIR OWN SOCIAL DEVELOPMENT

The health, nutrition and population problems in Bangladesh remain daunting. There are millions and millions of persons needing care; many types of services are needed; financial resources are extremely limited; and the socio-political impediments are formidable. However, if the considerable human “person power” which exists in Bangladesh can be harnessed to implement effective community-based approaches to primary health care that address the most common proximate and underlying causes of serious illness, disability, and death, then formidable progress toward “health for all” will be achievable at a cost readily affordable to the country.

The experience of the past decade in social mobilization and in grassroots participation in primary health care services (especially family planning and EPI services) has been extraordinary. The challenge is now to build on this experience and to move to the next level — the formation of bona fide partnerships with the community as a part “owner” of the program and the services.

F. H. Abed, Founder and Executive Director of BRAC, has observed that Bangladesh, like most other developing countries, began after World War II to pattern their health programs after those which were in existence at that time in developed countries. He writes:

Priority was given to construction of hospitals, to the training of physicians in curative medicine, and the development of health-care systems which supported a network of curative facilities. In brief, the development stage of community-based programming was essentially bypassed. Preventive medicine and epidemiology are poorly taught, if taught at all in our medical schools. The present infrastructure of preventive services is vestigial at best, and there is little knowledge of the value of community-based services. Surveillance systems, which document disease occurrence, and vital registration systems, are all but unknown. It is clear that we tried to copy the industrialized world in designing our health system, but ignored the very framework which the industrialized world had completed during the first half of the century (Abed, 1966).
This “Western” curative model also displaces local traditions based on self-help and makes people dependent on highly specialized (and expensive) professionals and equipment (Der Geest, 1990). Bangladesh is, as has been argued elsewhere (Perry, 1996), on the verge of a “paradigm shift” in which local people will be directing a program for improved health and development, but with partners who are committed to social development and who also have technical, political, or financial resources that are needed to strengthen program activities. This emerging paradigm of partnerships for social development contrasts with the current one in which local communities are essentially recipients of and participants in social development activities (including health activities), but without any real control over decision-making or any real responsibility for maintenance of the program.

Where such paradigm shifts have taken place, the resulting impact on health improvements have been remarkable. In Jamkhed, India, for instance, an area socio-economically similar to much of rural Bangladesh, local people were able to employ simple low-cost strategies for promoting health, nutrition, and family planning and were able to reduce their infant mortality to only 18 births per 1,000 live births (Arole and Arole, 1994), a level which is also possible in Bangladesh using similar community-based principles of empowerment of local illiterate and semi-literate people. The BRAC Shastho Shiksha model of village-based health care shares many similarities to the Jamkhed approach and holds promise for moving Bangladesh into this new paradigm during the early twenty-first century at a cost which is readily affordable for the country.

Local primary health care programs that are based upon knowledge of the most frequent serious preventable or treatable conditions in the population, which have surveillance systems capable of identifying those at greatest risk of developing these conditions, and which ensure that those in need of basic services obtain them, have enormous potential for accelerating progress toward achieving “health for all” (Perry et al., 1998b; Perry et al., 1999). Developing systems that give local populations control over their own social development activities and that cannot be readily manipulated by the local elite for their own interests will, however, be required in order to bring about this paradigm shift.

NEW THREATS TO HEALTH ON THE HORIZON

Over the next two decades, childhood infectious diseases, malnutrition, and obstetrical complications will almost certainly gradually decline in importance as causes of readily preventable or treatable mortality and morbidity. Improvements in socioeconomic conditions and in the overall quality of services will, presumably, continue. The decline in fertility will also presumably continue, thereby further reducing maternal and child mortality by virtue of the simple facts that (1) a smaller percentage of women will be becoming pregnant and therefore will be at risk of a pregnancy-related complication, and (2) siblings who are born at greater birth intervals have a greater probability of survival (as a result of better care provided by the mother and the prevention of the “maternal depletion syndrome” associated with frequent childbearing and poor maternal nutrition).

Even so, other causes of ill health will become more important and will have to be overcome in order to achieve “health for all.” Some of these are known and can be anticipated. Others are not.
Seventeen thousand persons are now dying annually in Bangladesh from injuries and accidents, and Bangladesh has one of the highest fatality rates per vehicle due to road accidents in the world (BBS, 1996c; M. A. Khan, 1998). While in Western European countries, approximately two road accident fatalities occur every year per 10,000 vehicles, in Bangladesh there are 47 deaths per 10,000 vehicles, a rate 23 times higher. As the number of deaths from infectious diseases among children in Bangladesh has declined, drowning has become the leading cause of death among children 12-59 months of age (Baqui et al., 1998). One percent of the population currently has a serious impairment or disability, which in most cases could have been prevented and/or can be rehabilitated (BBS, 1998). Many of the accidents and injuries in Bangladesh are preventable, and many of the deaths can be averted if appropriate medical treatment can be provided.

Almost half of the men of Bangladesh now smoke at least an occasional cigarette (BBS, 1996b). If rates of smoking continue at this level or increase over the next several decades, the percentage of adult deaths for which smoking was an underlying cause will be substantial.

The specter of AIDS as a coming plague cannot be dismissed, and the need to strengthen the diagnosis and effective treatment of sexually transmitted diseases as well as to promote condom use for extra-marital sexual contacts is an urgent and compelling one. In view of the likely resurgence of tuberculosis as the AIDS epidemic accelerates (as has occurred in a number of other countries), there is an urgent and compelling need for quickly strengthening the national tuberculosis program so the devastating effects of these two diseases in combination can be minimized.

Finally, the longer-term effects of naturally occurring toxic levels of arsenic in the groundwater are raising major concerns because of the potential for greatly increasing the risk of cancer in a substantial proportion of Bangladesh’s population (Bearak, 1998).

Thus, while strategies for achieving “health for all” can benefit from reviewing the lessons of the past, as we have done here, strategies for achieving “health for all” will also require addressing health problems which, to date, have received limited attention in Bangladesh. Vigilance, commitment, creativity, leadership, and technical expertise will be required to overcome the seemingly never-ending constraints to extending the benefits of modern biomedical science, public health and nutrition to all of the people of Bangladesh.

CONCLUSION

The International Declaration of Health Rights proclaims that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” and that health “is not a privilege reserved for those with power, money or social standing.” Taking into account its limited financial resources, the persistence of its traditional cultural values, and its high levels of illiteracy, Bangladesh has made remarkable progress during the past three decades in slowing population growth, in improving the health of the population, and in strengthening primary health care services. But the highest

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13 This document was created in 1992 for the occasion of the 75th anniversary of the founding of the Johns Hopkins University School of Hygiene and Public Health.
attainable standard of health will remain, for the foreseeable future, beyond the grasp of millions of Bangladeshi people, especially the poorest of the poor.

“Health for all” will be achieved in Bangladesh when every person in the population has attained the highest level of health which can reasonably be expected given its available resources. Actual achievement of this vision will require continued efforts from local communities, from the private sector, from NGOs, and from the Government. It will require professional, technical, political, and financial support — both from within Bangladesh and from the international community.

The experiences of Bangladesh’s recent past bode well for her future. “Health for all” will be achieved sooner rather than later if a new common vision can be forged and if the commitment and dedication which sustained the activities since Bangladesh’s independence in 1971 can be carried forward into the twenty-first century.
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