

BANGLADESH

HEALTH BRIEFING PAPER

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Bangladesh is a South East Asian republic bordering India, Myanmar and the Bay of Bengal. It has nearly 600km of coast and is low-lying with many rivers, forming a fertile delta which experiences frequent and severe flooding. A tropical monsoon climate generates frequent cyclones (in 1970 1/2m people were killed in one of worst ever recorded natural disasters). Rivers and flooding inhibit the development of road and rail transport; waterways are therefore significant.

Bangladesh has few natural resources; its manufacturing base is small although it is now beginning to exploit natural gas. GNP per capita is around \$US 230 of which 40% is generated by agriculture. Fishing, tea, and jute are important products.

Initially a part of Pakistan, following partition from India in 1947, Bangladesh achieved full independence in 1971. In 1991 a parliamentary democracy replaced the military regime. Six divisions of local government are broken down into 64 districts, subdivided into 460 Thanas, thence into unions and villages. Rigid central government structures and lack of agreement between main parties about key social problems have inhibited effective response to local need, although a wide programme of decentralisation is planned. A strategic aim of the state is to reduce the fiscal burden of state subsidised services in order to improve economic growth but government employees are highly sensitive to changes which may affect their rights.

Bangladesh has a population of 123m; density is very high (824 per sq. km) and is evenly distributed. The population is largely Bengali and there are small numbers of ethnic minorities. 85% are Sunni Muslim, others are mostly Hindu.

Life expectancy is 56 years and the population is young, with few over 65s (only 3% of the population). Illiteracy is widespread, gender inequality is pervasive at all levels and many children work and therefore receive little education.

Health Status

Poor hygiene and sanitation cause up to 80% of disease. High levels of maternal and infant mortality are experienced and adherence to traditional practices is strong in some areas. There is a history of external aid to promote family planning although high levels of unsafe abortions continue. Diet and nutrition are generally poor. Bangladesh is one of the few countries where life expectancy at birth is lower for females than for males. There are significant geographical variations in the incidence and prevalence of disease.

Health Service Delivery In The Public Sector

Less than 40% of the population has access to basic health care. At the same time government services are poorly utilised. Expenditure on health in 1996/7 amounted to \$10.5 per head, some

3.9% of GDP. Households accounted for 64% of total spend, the majority of it on drugs. Public sources (including external assistance accounted for a further 34%).

An informal system of user charges often runs alongside official user fees and services which should be free at the point of use.

Bangladesh has a central “command and control” management system, oriented towards inputs rather than outputs, outcomes or value for money. Significant levels of foreign aid have been granted on an individual project basis. Prior to the new programme, some 120 separate projects were being funded and co-ordination was not always achieved.

Services are provider-oriented rather than client oriented. The exception is the family planning service which is delivered in the main by locally-recruited women.

The magnet effect of urban centres, which attract staff and resources, has led to unsustainable inequities in resource distribution and access to services (reinforced by poor transport networks). Many trained staff are unwilling to work in rural areas; Bangladesh has a very hierarchical society and most professionals are from upper class urban backgrounds. Cultural traditions of patronage mean that many service providers have little knowledge of the needs of the urban and rural poor and conversely clients may not know of their rights and entitlements; “public service is not understood as an accountable duty”. There is little professional regulation in medicine, nursing and dentistry. NGOs are active, and there is potential for greater integration with the state sector. There is wide use within families of traditional and homeopathic remedies. Traditions, beliefs and culture exert a strong influence in access to and use of care, with gender roles a particular issue in both the provision and receipt of care.

Primary care

Thana health centres (THCs) were established some 20 years ago as the cornerstones of primary care. Over 400 were created to a standard design, including theatres, X-ray, pharmacy, basic laboratories, dental suites and delivery suites and each has a 31 bedded ward. Physical facilities have deteriorated in most THCs and poor staff practices exist in many (e.g. high levels of absenteeism, informal user-charging).

Skilled doctors are unwilling to work there, regarding postings as ‘punishment’. As a result THCs no longer enjoy public confidence and are underused. The low state salaries earned by doctors have led to growth in private practice. Doctors are thereby diverted from their THC duties and a vicious circle has evolved whereby their vested interests may wish to keep public sector service quality relatively low.

The concept of an essential package of services (ESP) to be delivered in THCs is well grounded, although delivery is patchy.

The ESP consists broadly of:

- ◆ reproductive health care
- ◆ child health care
- ◆ communicable disease control
- ◆ limited curative care.

Health services and family planning services are run as two entirely separate arms of the Ministry of Health and Family Welfare (MOHFW) and duplication runs throughout the management hierarchy, reflecting this split. This is recognised to be an inefficient way to run modern services and reorganisation has started.

Below Thana level, Union health posts are equally poorly used and currently function only for family planning and the periodic supply of drugs. There are somewhat controversial plans to have a 'community clinic' in every village where former health and family planning workers will both be based.

Gender issues complicate the bifurcation of health and family planning services. Family planning workers are mainly female and are on short-term contracts from project funding. In contrast, health workers are largely male and on permanent contracts with greater job security.

Hospital sector

The hospital system is overused, with high rates of self-referral, by-passing the THCs. There is a high ratio of doctors to nurses in hospitals and potential to improve skill mix.

Background to, and rationale for reform

A five year plan (the fourth in Bangladesh) ran from 1990/91 to 1994/95, incorporating various programmes and projects, many of which were financially supported by the World Bank and other donor consortia. The objectives of the fourth plan were to further reduce both infant and maternal mortality, including major drives in immunisation, the control of communicable diseases, attention to diarrhoeal and respiratory diseases in children, and contraceptive services. The fourth plan was reviewed in the last year of its implementation. Lessons learned were factored in to the planning of further health sector reform. A national strategy was formulated in 1996/97 – the Health and Population Sector Strategy – in consultation with development partners.

The aims of the strategy are to provide a sustainable universal package of essential health care services (EPS) for the people of Bangladesh, and to slow population growth, with an emphasis on client- centred, accessible services, particularly for children, women and the poor. The EPS has grown out of recognition that it is not possible to provide all of the services needed by all segments of the population. A feature of the strategy was the decision to move from a project-driven approach (as under the fourth five-year plan) to a sector- wide approach (SWAp), now known also as sector-wide management, where development partners work with the government in the implementation of a comprehensive and integrated programme. The fifth plan is now known as the Health and Population Sector Programme (HPSP). It is led by the Government of Bangladesh in the implementation of the strategy and funded by GoB and donors both through pooled support as part of a consortium led by the World Bank and through earmarked support.

The thrust of the HPSP is implementation of the EPS through decentralised delivery on one-stop service models, and with increased involvement of the private sector and NGOs. The EPS concept has been developed, and will include a prioritised list of interventions to be delivered at Thana level and below, with referrals to secondary and tertiary levels also identified.

A wide range of activities is planned in pursuit of strategy implementation, and the following eight component outputs of the HPSP have been identified:

- ◆ the EPS defined, funded, promoted and implemented
- ◆ service delivery mechanisms unified, restructured and decentralised
- ◆ integrated support systems strengthened
- ◆ hospital level services focused and improved
- ◆ sector-wide programme management system established and operational policy and regulatory framework strengthened
- ◆ other services of public health importance strengthened
- ◆ other health and nutrition services strengthened.

The SWAp experience is discussed in more detail in an IHSD briefing paper.

The Contribution of DFID

DFID is working in partnership with the Government of Bangladesh in the improvement of the structure and operation of the health sector, with the overall purpose of maximising the health and well-being of the poorer sections of the population. In addition to some £30m in the Sector Wide Management pool, the specific initiatives which DFID is supporting are;

- ◆ organisation and management, in particular the capacity within the Ministry to implement major change including wide scale decentralisation, supported by a Management Change Unit
- ◆ strengthening hospital management
- ◆ changes to the management of human resources
- ◆ exploring the benefits of closer public/private sector co-operation.
- ◆ support for NGO activities
- ◆ developing capacity in health economics
- ◆ strengthening medical education
- ◆ strengthening nurse education

Mark Pearson, September 1999



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