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**POLICY BRIEF ON “HEALTH AND
POPULATION SECTOR POLICY”
CPD TASK FORCE REPORT**



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POLICY BRIEF ON THE HEALTH AND POPULATION SECTOR

1. INTRODUCTION

The Centre for Policy Dialogue (CPD) has brought together representatives of the civil society, within a number of Task Forces, to prepare a series of Pre-Election Policy Briefs. The purpose of this exercise is to draw upon the talents and commitment of civil society to influence the formulation of policy agendas through the national political process, in the run-up to, and immediately after, the parliamentary elections to be held this year. The purpose of the Policy Briefs is to address issues of urgent public concern where concrete, doable, policy agendas can be identified for implementation within the prevailing political configurations of the country. The Policy Briefs focus on (a) issues of urgent public concern with a view to developing concrete, implementable policy agendas within the existing realities of the country and (b) translating academic and applied research and views of different stakeholders into practical policy recommendations.

CPD has constituted a Task Force on Health and Population Policy to prepare a Policy Brief on the health and population sector of the country. The Task Force held a series of meetings and a number of brainstorming sessions, in which strategic issues relating to the sector were identified and articulated. Based on these discussions, the Task Force has prepared a draft Policy Brief, which was discussed in great details in a dialogue organized in Comilla on July 21, 2001. Professionals representing different organizations and groups, involved with the population and health sector, actively participated in the dialogue. The cutting edge issues that emerged from the dialogue were taken into account while finalising this Policy Brief, which is presented below.

2. THE CURRENT SITUATION

In Bangladesh the total fertility rate (TFR) has declined from around 6 in the mid-seventies to 3.4 in 1993-94. The major share of this decline should be attributed to the increase in the level of contraceptive prevalence from 7 per cent in 1975 to 44.6 per cent in 1993-94. Such an increase in the level of the contraceptive prevalence rate (CPR) in the setting of Bangladesh has taken place without any remarkable change in the level of household income, education or health. This indicates that the population of Bangladesh has not experienced the necessary transition in the quality of life traditionally associated with a significant increase in demand for contraceptive use. The increase in CPR must thus be ascribed largely to institutional interventions in the area of family planning (FP), which may have improved the motivation for adopting contraceptive methods. However, the level of CPR has increased from 44.6 per cent in 1993-94 to 53.8 per cent in 1999-2000, but TFR remained plateaued at a level of 3.3. In other words, the increase in CPR was not translated into the expected decline in the level of fertility. This implies that the replacement level fertility will not be achieved by 2005 and the population size will continue to grow at a moderate rate and the size of the stable population will be much higher than expected.

According to the WHO composite index for overall health system attainment of 191 member states, Bangladesh is ranked 131, worse than Sri Lanka, India and the Maldives but better than Pakistan, Bhutan and Nepal (WHO, 2000). Similarly, out of 162 countries, Bangladesh

ranks 132, according to the Human Development Index, 2001, behind the Maldives, Sri Lanka, India, Pakistan, Nepal and Bhutan (UNDP, 2001).

The infant mortality and maternal mortality rates are still very high in Bangladesh, 79.6 per thousand live births and 4.3 per thousand live births respectively (BDHS Preliminary Report, 2001; BIRPERHT, 1996). The perinatal mortality rate is 57.4 per thousand pregnancies (of more than 7 months).

It is very disappointing to note that almost two-thirds of the births do not receive any antenatal care. Among those who receive antenatal care, only 16 per cent are informed of the signs of complications, and slightly more than one-third receive iron tablets. For delivery, only 6 per cent use health facilities. Trained health personnel assist deliveries of only 22 per cent of the births.

The complete coverage of immunisation is not achieved for almost 50 per cent of the children. Prevalence of acute respiratory infection (ARI) is high (18.3 per cent) but treatment is sought for only one-fourth of the ARI patients.

Malnutrition continues to be a severe health problem among both mothers and children in Bangladesh. The extent of stunting and underweight are 45 per cent and 48 per cent respectively for children under five years of age, while anaemia is prevalent among 53 per cent of pregnant women.

The major causes of death are pneumonia, respiratory failure, injuries, upper respiratory tract infection and diarrhoea, while the major causes of morbidity appear to be ulcer, diarrhoea, malaria, asthma and rheumatism/rheumatic fever.

There are only 18 doctors and 5 nurses for every 100,000 people in Bangladesh. These figures indicate that the existing health care system is very poor in the country.

3. POLICY RECOMMENDATIONS

3.1. Commitment of the Government

The Government of Bangladesh (GOB) should have a commitment to provide to its citizens quality health care service, which is affordable and accessible to all. The focus of government policy should be on the fundamental goals of improving health, enhancing responsiveness to the expectation of the population and assuring fairness of financial contribution. These fundamental goals include the following: increasing health status, reducing health inequalities, ensuring access to social support network, improving the quality of basic amenities and choice of provider, and ensuring that every household pays a fair share according to its ability. Special measures need to be adopted for meeting the needs of the poor and vulnerable groups, for whom safety nets have to be constituted.

The government needs to play a more effective regulatory role but, in view of the low economic status of the people, it will also have to continue to serve as an important provider of essential and cheap health care services. In implementing its health care programme, the government needs to forge partnership with the civil society and non-governmental organisations (NGOs) and encourage them to play a more effective and expanded role. It

should also involve the private sector in health care provision but needs to ensure quality of care in order to safeguard the interests of the people.

The government will have to provide more resources to the health and population sector. Per capita health expenditure in Bangladesh is \$13, compared to \$8 in Nepal, \$14 in Bhutan, \$17 in Pakistan, \$23 in India, \$25 in Sri Lanka and \$107 in the Maldives (WHO, 2000). Per capita out-of-pocket expenditure in Bangladesh is \$7, compared to \$6 in Nepal, \$8 in Bhutan, \$13 in Pakistan and Sri Lanka, \$19 in India, and \$39 in the Maldives.

3.2. Population

3.2.1. Population Momentum and Population Size

The size of the population of Bangladesh will grow at a faster pace during the next forty to fifty years. The total population will be doubled (or nearly doubled) during this period. This overwhelming growth in the size of the total population within a short span of time will pose formidable challenges to the policymakers. To address this issue, the government needs to give highest priority to restructuring the implementation strategies of policies in the light of sharp increase in the size of total population and its impact on health, education, agriculture, and the economy as a whole.

The number of women of reproductive age will increase sharply during the next fifty years. This will have direct and indirect impact on the costs of family planning, the standard of health services, maternal mortality and morbidity, programmes for increasing the level of education of girls, income generating activities for women, etc.

The population momentum will cause rapid increase in the number of elderly people in the country. Our existing population and health strategies are inadequate to provide necessary health and social welfare services to the increasing size of the elderly population. A specific guideline is needed to address the emerging concerns about elderly population in Bangladesh. The allocation of budget for health and population needs careful rethinking on the basis of the concerns generating from population momentum. Without a very well planned and cost-effective allocation, it will be difficult to solve the problems in the long run.

Bangladesh does not have effective manpower planning. However, it is necessary to draw a balancing line between needs and expenditures at an optimum level. Without optimum manpower planning, it would be difficult for the government to achieve targets with the limited resources at its disposal.

3.2.2. Population and Health Policies and Implementation Strategies

The Ministry of Health and Family Welfare (MOHFW) has adopted the Health and Population Sector Strategy (HPSS) in order to integrate the programmes on population and health. Some major changes have been undertaken in the light of HPSS. The cost-effectiveness and the relevance of these strategies need to be evaluated.

The integration of health and family planning and its consequences need to be examined carefully and remedial measures have to be suggested in order to make the administrative hierarchy of the ministry suitable for an optimum service delivery system in the setting of Bangladesh. In this regard the following issues need immediate attention:

- a) Decentralisation is needed at the upazila, union and community levels in order to make the HPSS activities effective. This can be achieved through active participation of the stakeholders of population and health services at the grassroots levels. The stakeholders need to be empowered so that they can participate in planning, management, resource generation, monitoring and decision-making at the community level.
- b) The Community Clinics should be transformed into community-managed clinics. The communities should be involved in managing clinics and they should monitor the services of doctors and other workers.
- c) GOB physicians are seldom present at their duty stations for the assigned working hours/days and hence the population and health sector activities suffer. This problem needs immediate attention by the policy makers.
- d) Under the current system, the workers are not seen in the field. This has serious negative impact on both family planning and health activities.
- e) For improving the primary health care situation, motivational work is important. Hence there is an important role of Behavioural Change Communication (BCC) in order to accelerate the primary health care activities in Bangladesh. Under the current programme, the BCC activities are far from the expected level of communication. The fieldworkers can be trained and assigned to share these motivational works.
- f) The attitudinal problems of the doctors in government facilities discourage the potential clients from obtaining services GOB hospitals and clinics. For a user-friendly system, doctors have to change their behaviour towards the patients.
- g) Female doctors should be employed at the health complexes/centres to take care of the female patients. This will improve the performance of female sterilisation in the long run. The female doctors should be present in their work places.
- h) Registration of couples and births should be emphasised and effectively used in health services.

3.2.3. Decline in Fertility and Family Planning

The level of fertility had declined during 1975-1993 period. However, since 1993-94 TFR has been hovering around 3.3. This issue raises concern among the policymakers regarding the impact of increase in the level of CPR on TFR in the absence of socio-economic development.

A change in the method-mix is needed to make CPR more effective. The share of longer acting and permanent methods needs to be increased. This shift, which requires a number of programmatic inputs, should be given high priority at the implementation phase.

It is unlikely that the replacement level fertility can be attained by 2005. Family Planning should be recognised as the primary national problem and a target to achieve a net reproductive rate (NRR) of 1 by 2015 should be adopted. The government should delve into the causes of the stagnating TFR and should adopt programmes to accelerate the decline in this rate.

In addition to temporary methods of family planning, clinical and permanent methods should be popularised in order to increase the contraceptive prevalence rate and ensure further decline in the total fertility rate. Women need to be empowered so as to enable them to take decisions regarding contraceptive use and family size. Also, of particular importance is the

need to adopt programmes aimed at bringing about a behavioural change in men and increase their involvement in family planning.

In order to popularise family planning, a more intensive countrywide motivational campaign under the BCC programme should be launched. The Reproductive Health and BCC programmes need to be strengthened. Also, appropriate education on reproduction and reproductive health should be introduced in schools and colleges.

The high incidence of teenage marriage and high-risk fertility should be discouraged in the society. This cannot be achieved without strong political commitment. Community participation in the population and health programmes at the local level is a precondition for bringing about such changes in the society.

Measures are to be implemented in order to increase the length of birth intervals for potential mothers of all ages to improve the health conditions of mothers and children. The high infant mortality rates favour high fertility and hence a further decline in infant mortality needs to be ensured for a subsequent decline in the level of fertility.

The service delivery system needs to improve the quality of care at all levels. The process of motivation and service delivery at doorsteps should be continued until the Health and Population Sector Programme (HPSP) is made fully operational. Service delivery in the Chittagong and Sylhet Divisions is to be strengthened considering the constraints in those regions.

The Family Planning and Health Directorates should be integrated on a functional basis keeping in view the principles of seniority. The Health cadre officials should be mainly responsible while the FP officials should have a greater role to play in terms of motivation, store management, administration, etc. A committee should be set up to identify problems relating to integration and its impact on the FP programme.

The population aspect should be considered, wherever possible, while evaluating programmes and activities.

3.2.4. Mortality

The levels of infant and child mortality rates are still very high. The infant and child mortality rates can be reduced through: (a) increasing the rate of full coverage of immunisation, (b) providing adequate reproductive health care, including antenatal care (ANC), safe delivery and postnatal care (PNC) at all levels of the service delivery system, (c) ensuring adequate service facilities through the essential services package (ESP), (d) developing an effective referral system for complications during pregnancy and delivery, and (e) ensuring the presence of health care providers in their assigned duty stations.

The high prevalence of maternal mortality and maternal morbidity rates needs to be taken into account with high priority. In order to decrease pregnancy-related mortality and morbidity: (a) health care facilities during ANC, delivery and PNC need to be strengthened, (b) efficient referral system needs to be implemented for the high risk groups, (c) knowledge about safe motherhood needs to be provided to all potential mothers, (d) iron and calcium supplements should be provided to pregnant women, and (e) life threatening and high risk complications need to be diagnosed during pregnancy.

The control of communicable diseases should be given high priority and a sustainable mechanism needs to be developed through which the diagnosis of communicable diseases can be made inexpensive and accessible to everyone.

3.3. Health Promotion

The government needs to create greater awareness of and provide services for newly emerging diseases like hypertension, asthma, HIV/AIDS, heart disease, etc. Steps need to be taken to combat common diseases, such as ARI, tuberculosis and diarrhoea, which particularly afflict the poor. Special measures need to be initiated for combating malaria, dengue and kala-azar, which have recently registered a significant increase in the country.

The issue of arsenic in drinking water needs to be taken up urgently by the health committees, hospitals and health professionals and, to the extent that treatment can be extended, this needs to be ensured. The local government needs to provide a solution to the problem and take steps to educate and sensitise the people.

The BCC unit of MOHFW should be activated and health education introduced in school curricula and their contents need to be widened. It is important to take steps to make the Upazila Health Committees play an effective role in promoting good health. These committees should be empowered to take local level decisions in terms of planning, management, resource generation and decision-making.

The morbidity pattern and regional manifestation of diseases need to be mapped in order to help focus on health care efforts and conserve resources. The regional mapping of diseases may play an important role in procurement of medicines, management of clinics, and providing cost-effective service at the local level.

3.4. Medicare

3.4.1. Government Service Providers

In order to increase the access of the people to quality health care services, 5,000 posts of doctors should be created in the next five years. There should be proper manpower planning to absorb the medical graduates into the national medical service. There should be a doctor available in every Union Health and Family Welfare Centre (UHFWC) and in Community Clinics (CC) for a fixed number of days. The health centres/clinics can be made more functional if female doctors are employed for women patients. In addition, presence of health personnel should be ensured in their work places. Community participation is essential to make the health centres/clinics functional. The communities are to be empowered with resource management and decision-making. In order to ensure commitment of the doctors, it should be made mandatory for doctors to serve in rural areas before they are allowed to practice in the cities. The government should devise a mechanism for evaluating and monitoring the professional development of doctors.

Personnel (doctors and essential complementary staff) appointed under development projects or in the revenue non-cadre positions should be integrated into the cadre service. These personnel should get the same facilities in terms of promotion etc. like the personnel under the revenue set-up. The health care personnel should be rewarded or punished on the basis of

their performance in their work places. The attitude of the health care providers needs to be changed, in order to attract the clients to the government facilities.

A committee headed by the Secretary of Establishment should frame recruitment rules, which would need to be often revised in view of creation of new specialised posts, under the overall guidance of MOHFW. The normal protracted system should be shortened.

If the situation demands, the period of current charge should be taken into consideration for the purpose of promotion. As far as possible, there should be at least a three-year tenure in posts that require specialised knowledge. Appointments as Officer on Special Duty (OSD) should be strictly limited to a fixed number linked to training and higher education. The Ministry should deal with transfers of professors while the Director General (DG) should be responsible for that of posts below professors.

3.4.2. Reform and Decentralisation

A health sector reform body should be set up to evaluate the ongoing process of transition in the health sector as well as to suggest necessary reforms to make the health services available to everyone. As part of the reform process, authority, both administrative and financial, as far as possible, should be decentralised. An inter-ministerial committee headed by the Minister for Health and Family Welfare should decide on the specifics and, where necessary, obtain approval of the Prime Minister/Cabinet. For accelerating the process of reform and decentralisation, the following issues need special attention:

- a) Purchases within certain limits should be decentralised. The DG should have the authority to approve expenditure up to Taka 50 million and consultancy up to Taka 10 million, except where loan conditionalities stipulate otherwise.
- b) MOHFW should sub-allot lump grants keeping the Ministry of Finance (MOF) informed, subject to the instructions of the latter.
- c) The units should carry out minor repairs of hospitals with the approval of the medical colleges.
- d) The Community Clinics can be made functional by involving local communities in the process of resource management and decision-making. Brahmanpara in Comilla District can be cited as a success story in this regard. They have accumulated about Taka 100,000 by realizing nominal fees of Take 1-2 from each patient. However, due to government barriers they were unable to utilise the money for improving the outstanding problems of the clinic. User fees can be utilised for procuring medicine, equipment, diesel etc. Hence, this example can be replicated in other community clinics. However, there should be an adequate system of auditing the funds and expenditures to guard against possible misappropriation of funds.
- e) It is necessary to determine the person who is in charge of a CC. It is necessary to train midwives who can sit in CCs, while the fieldworkers can serve the clients and potential clients at their doorsteps.
- f) In most of the government hospitals, the patients are referred to private clinics. In addition, attitude of doctors is one of the barriers in improving the health care system.
- g) For health personnel at the field level, an incentive scheme should be implemented to motivate them to take challenges in their work places.

The capacity of the Directorate of Health to monitor and perform its regulatory function, particularly in respect of medical colleges, hospitals, clinics and diagnostic centres should be

strengthened both in numbers and quality. The rules guiding the setting up of medical colleges and hospitals should be reviewed and only those providing adequate manpower and facilities should be approved.

3.4.3. *Provision of Health Care Services*

Unless essential, the government should set up only autonomous Medicare units, which will provide for greater flexibility regarding appointment of personnel, contracting out of services, charging of user fees, and introduction of new technology, etc. As far as possible, services necessary for the operation of Medicare facilities should be contracted out. Ambulance services should be privatised with arrangements to provide services to patients, referred by government institutions, at fixed rates particularly for the poor. As far as possible, outdoor treatment should be encouraged.

All medical colleges and hospitals should accept referred patients. It should be the responsibility of such units to arrange admission in other hospitals if necessary. A network of referral system should be developed in order to assure the patients of treatment from health facilities.

There should be an arrangement for receiving complaints in service delivery centres and the medical colleges should review such complaints and take appropriate measures to address them.

3.4.4. *Payment for Health Care Services*

To the extent possible, free treatment in government hospitals should be ensured for those who cannot pay. Necessary funds should be provided through user fees, government allotment, social organisations, etc. Fair price medicine shops should be arranged in all hospitals. Gradual coverage through affordable insurance schemes needs to be introduced. User fees may be charged but at the same time safety nets for the poor will have to be provided. The hard-core poor should be exempted from making any payment for services. Collecting institutions should be allowed to spend the funds, particularly on equipment, medicines and essential supplies.

For government doctors there should be a gradual change over to institutional practice. Funds accruing to hospitals should be spent for development purpose.

Fees for providing medical advice or diagnostic purpose should be reviewed and controlled where necessary. Private practice of the doctors can be brought under a standard set of guidelines.

In order to bring about a balance in the economic status between the genders, emphasis should be given on measures to provide better and expanded service to women and children.

The experience from Brahmanpara can be replicated in other community clinics. User fees can be collected from the clients and utilised for procuring medicines and equipments and to meet other expenses that can make the CCs functional.

3.4.5. Accountability and Stakeholder Participation

Accountability should be ensured. Service associations, management committees, and professional organisations should play a more effective role. Stakeholders should be involved in formulating policies and included in management committees of hospitals, in order to increase accountability and transparency.

The local hospital management committees and the district and upazila health committees should initiate plans. However, to the extent the expenditure is financed by funds beyond their own generated earnings, the effectiveness of such plans would be limited to basically the units generating funds. The central authority would, however, give a lot of weight to the proposals emanating from such units. Such planning should aim to ensure essential equipment and medicines.

3.4.6. Drug Issues

In order to address important issues relating to drugs and medicines, the following steps need to be taken:

- a) The drug policy should be reviewed. The objective would be to bring about a balance between the desire to support local pharmaceutical industry and that of providing the citizens with the opportunity to avail themselves of the latest development in the pharmaceutical sector.
- b) Protection should be provided to patented drugs for the legal duration.
- c) The drug administration department should be strengthened and expanded to cover all districts of the country.
- d) The central drug-testing laboratory should be strengthened and branches opened.
- e) A list of drugs to be sold across the counter should be drawn up and their sales regularised.
- f) A central reference laboratory should be set up.
- g) In order to encourage family planning, some pills and injectables should be kept out of the purview of the Drugs Act with certain stipulations.
- h) Sale of limited drugs, on the basis of prescriptions issued by recognised paramedics, should be allowed.

3.4.7. Other Issues

The proportion of elderly population will increase rapidly during the next decades. A comprehensive plan is necessary to address the emerging issues concerning health and social welfare programmes for the elderly population in Bangladesh.

Computerised and improved management information system (MIS) should be introduced. Hospital records and data should be reflected in the MIS format.

A committee, headed by the Secretary, MOHFW, and comprising related organisations and individuals, should coordinate research work. The DG (Health and FP) would also head a body that would make initial recommendations.

The Bangladesh Medical and Dental Council (BMDC) and similar organisations should be strengthened and made more effective. The Pharmacy Council and State Medical Faculty should be strengthened and empowered to play a more effective role.

3.5. Primary, Secondary and Tertiary Health Care

Primary health care (PHC) is the most important tier of the national health system. Attempts should be made to improve the quality of PHC and make it accessible to the people, especially the poor and the vulnerable. To this end, the following recommendations are made:

- a) Sixty per cent of the total expenditure in the health sector should be incurred in this area.
- b) The provision of ESP under HPSP should be strengthened.
- c) There should be a doctor in every UHFWC.
- d) The CCs should be strengthened and the services of a doctor should be provided during certain fixed days every month. The CC would be the focal point for providing ESP at the village level. Regular supply of drugs and medicines to the CCs should be ensured.
- e) Domiciliary services should continue.
- f) There should be greater involvement of the community, i.e., local government, civil society, community groups.
- g) NGOs should be encouraged to provide PHC services and should also meaningfully be involved in the functioning of CCs.
- h) Greater efforts should be given to reduce maternal mortality and child mortality. Post and antenatal care should, in particular, be stressed and doctors and paramedics dealing specifically with PHC should be proficiently trained on the subject.
- i) Training of Traditional Birth Attendants (TBA) should be initiated and should continue parallel to the policy to replace their role with that of trained paramedics and doctors.
- k) Emergency Obstetrics Care (OEC) should be provided in every Upazila Health Complex.
- l) Universal coverage of Vitamin A consumption should be ensured.

For improving *Secondary Health Care* the following recommendations are made:

- a) Hospitals should be semi-autonomous with financial empowerment.
- b) Management Committees at hospitals should be strengthened and empowered to take administrative and financial decisions.
- c) The DG Health should be able to transfer the Civil Surgeon and below in rank.

In order to improve *Tertiary Health Care*, the following steps should be taken:

- a) Existing institutions should be expanded and strengthened.
- b) Existing specialised units should be strengthened and new ones should be set up only if the need is critical.
- c) The number of health specialists needs to be increased.
- d) New branches of sub-specialisation should be created in medical colleges so that patients do not need to come to Dhaka. The set-up should be absorbed in the revenue structure.
- e) Except where it is absolutely necessary, only autonomous units should be created.

- f) Hospitals should be empowered to contract and hire specialists from abroad to provide hands-on training on new technology. The proposals should have to be approved by a body of professionals headed by the DG (Health).
- g) All referred patients should be accepted by medical colleges/hospitals, and, if necessary, they should assume the responsibility of referring them and ensuring admission elsewhere.
- i) Hospitals should have multi-disciplinary facilities for catering to the needs of the patients.

3.6. Paramedics

The position of the paramedics should be re-evaluated and they should be given a greater role to play in matters of PHC in view of the prevailing situation in the health service delivery system and socio-economic conditions. A committee should be set up to suggest policy measures.

BMDC should be empowered to enable the paramedics to treat and prescribe medicines in a limited manner. The Upazila and District Health Committees should review the activities of such paramedics.

3.7. Nursing

Given the dearth of nurses, measures should be undertaken to create posts for a maximum number of nurses over the next five years. The post should be integrated within the revenue set-up upon completion of the development project. A committee should be constituted to look into the existing management, staffing, functioning and problems facing the nursing profession.

Nursing should function in hospitals as part of a unit. There should be expanded and improved arrangements for providing higher training/degree courses to nurses and personnel policy should encourage them to opt for such training. The Nursing Council overseeing the approval of nursing institution courses and administrative matters should be reorganised to include more professionals.

3.8. Training

In order to improve the quality of health care services, regular training has to be provided to health and family planning personnel. In this regard, the following recommendations are made:

- a) A training institute should be set up. The FWVTIs and RTCs could be brought under this training institute.
- b) There should be two committees headed by the Secretary and the Director General to oversee training programmes and activities.
- c) Training should be need-based and should take into account the need and availability of different specialisations. A proper manpower survey should be conducted.
- d) The curriculum, besides focusing on professional needs, should also stress on management, attitudinal aspects, treatment and containment of common diseases.
- e) The medical colleges should conduct short-term in-service courses and the district hospitals should also provide facilities for limited training.

- f) There should be greater stress on clinical training organised both at home and abroad.
- g) Training should be provided for upgrading skills and knowledge and it should also be linked to promotion/tenure of the trainees.

3.9. Sanitation

The citizens should be educated on proper sanitation. In this regard, stress should be given on BCC activities for informing the citizens of proper sanitation. These concepts should be included in school curricula around the country.

The local government and the Public Health Engineering (PHE) department need to be linked up for supporting sanitation measures. The responsibility for supporting sanitation measures should be borne jointly by the local government, particularly municipal authorities, and PHE.

Regulation is to be implemented to solve the problem of waste disposal. Local committees need to be empowered to take decisions regarding waste disposal. Sanitary and health inspectors should be given more responsibilities. We have to ensure that laws on sanitation are implemented.

A comprehensive and doable plan regarding waste disposal needs to be formulated. Given the enormity of the problem of waste disposal, particularly in the hospitals, steps need to be taken in phases to have a central hospital waste system and appropriate legislation will need to be introduced.

3.10. Nutrition

Proper knowledge about nutrition needs to be disseminated amongst the citizens. Motivation is essential for promoting nutritional status. Knowledge about all the major components of nutrition can be disseminated to the citizens. The National Nutrition Programme needs to be expanded to cover the entire country and adjusted on the basis of the gathered experience. Committees will have to be set up at different tiers to initiate/review activities relating to nutrition. In every upazila, a nutrition and health education unit should be set up.

3.11. Immunisation

The present efforts in the field of immunisation should be evaluated and the existing programme needs to be continued with the commitment of greater resources. Government resources have to be increased in order to offset decreasing foreign support and to share the greater need for resources in order to raise coverage, which of late has been stagnating. While the National Immunisation Day (NID) activities have been successful, the normal coverage of immunisation has not been so encouraging. Other immunisation programmes covering, for instance, Hepatitis B need to be undertaken.

For reviewing the immunisation programmes, upazila and district level committees need to be formed. In the municipal areas, MOHFW, with the support of the local government and NGOs, should be responsible for immunisation activities. Greater funds have to be channelled to integrate local support.

3.12. Standardisation of Food and Drugs

The standardisation of food and drugs needs special attention. This problem has been neglected but major health hazards stem from the consumption of unhygienic food and low quality drugs. To ensure proper standardisation of food and drugs, a network of efficient Food and Drug Administration (FDA) should be developed. FDA personnel should be adequately trained and equipped with modern facilities to test for standardisation on a regular basis. The Food and Drug policies are to be reviewed and exemplary punishment needs to be meted out to persons involved in producing and marketing unhygienic food and low quality drugs. In this regard, necessary measures should be taken to bring the Food and Drug Administration under one unit and relevant laws should be amended and new laws enacted.

Table 1. Population and Health Profile of Bangladesh

Total Population,	1991	111.45 million (BBS, 2001)
	2001	133.20 million (Projected)
	2015	183.30 million (Projected)
Population <15	1999-2000	39.2 percent (BDHS, 1999-2000)
Population >60	1999-2000	6.4 percent (BDHS, 1999-2000)
Growth Rate	1991-2001	1.78 percent (Based on projected figures)
Population Density	2001	903 per sq. km. (Based on the projected population)
Crude Birth Rate	1999-2000	30.2 per 1000 population (BDHS, 1999-2000)
Total Fertility Rate	1993-94	3.4 (BDHS, 1993-94)
	1996-97	3.3 (BDHS, 1996-97)
	1999-2000	3.3 (BDHS, 1999-2000)
Mean Ideal Number of Children	1999-2000	2.5 (BDHS, 1999-2000)
Contraceptive Prevalence Rate	1993-94	44.6 percent (BDHS, 1993-94)
	1996-97	49.2 percent (BDHS, 1996-97)
	1999-2000	53.8 percent (BDHS, 1999-2000)
Adolescent Pregnancy	1999-2000	34.7 percent (BDHS, 1999-2000)
Perinatal Mortality	1999-2000	57.4 per 1000 pregnancies (7+months) (BDHS)
Neonatal Mortality	1999-2000	50.4 per 1000 live births (BDHS)
Post neonatal Mortality	1999-2000	29.2 per 1000 live births (BDHS)
IMR	1999-2000	79.6 per 1000 live births (BDHS)
Child Mortality	1999-2000	33 per 1000 live births (BDHS)
Under 5 Mortality	1999-2000	110 per 1000 live births (BDHS)
ANC Provider	1999-2000	(BDHS, 1999-2000)
Doctor/Nurse/Midwife		33.3 percent
No One		63.0 percent
ANC Component	1999-2000	(BDHS, 1999-2000)
Informed of Signs of Complications		15.9 percent
Received Iron Tablets		36.4 percent
Received TT Vaccine (2+)		63.7 percent

Table 1 (contd.) Population and Health Profile of Bangladesh

Place of Delivery	1999-2000	(BDHS, 1999-2000)
Home		91.6 percent
Health Facility		5.6 percent
Delivery Attendant	1999-2000	(BDHS, 1999-2000)
Trained		21.8 percent
Untrained		78.2 percent
Vaccination by 12 months		(BDHS, 1999-2000)
BCG		90.0 percent
DPT (3)		70.2 percent
Polio (3)		69.1 percent
Measles		62.1 percent
All		52.8 percent
Prevalence of ARI (<5 Years)		18.3 percent (BDHS, 1999-2000)
Treatment of ARI		27.2 percent (BDHS, 1999-2000)
Prevalence of Diarrhoea (<5 Years)		6.1 percent (BDHS, 1999-2000)
Received Vitamin A-capsule (<5 Years)		73.3 percent (BDHS, 1999-2000)
Maternal Mortality Rate	1993-94	4.3 per 1000 live births (BIRPERHT, 1996)
Malnutrition (Percent < -2SD) for Children < 5 Years		(BDHS, 1999-2000)
Stunting (Height-for-Age)		44.7 percent
Wasting (Wt-for-Ht)		10.3 percent
Underweight (Wt-for-Age)		47.7 percent
Pregnant Women with Anaemia		53 percent
Major Causes of Death	1997	Streatfield et al., 2001
Pneumonia		15.7 percent
Respiratory Failure		9.4 percent
Injuries (unintentional)		8.7 percent
Upper Respiratory Tract		5.9 percent
Diarrhoea		4.9 percent
Major Causes of Morbidity	1997	Streatfield et al., 2001
Ulcer		7.0 percent
Diarrhoea		5.1 percent
Malaria		3.2 percent
Asthma		2.6 percent
Rheumatism/Rheumatic Fever		1.8 percent
Doctors		18 per 100,000 population
Nurses		5 per 100,000 population
