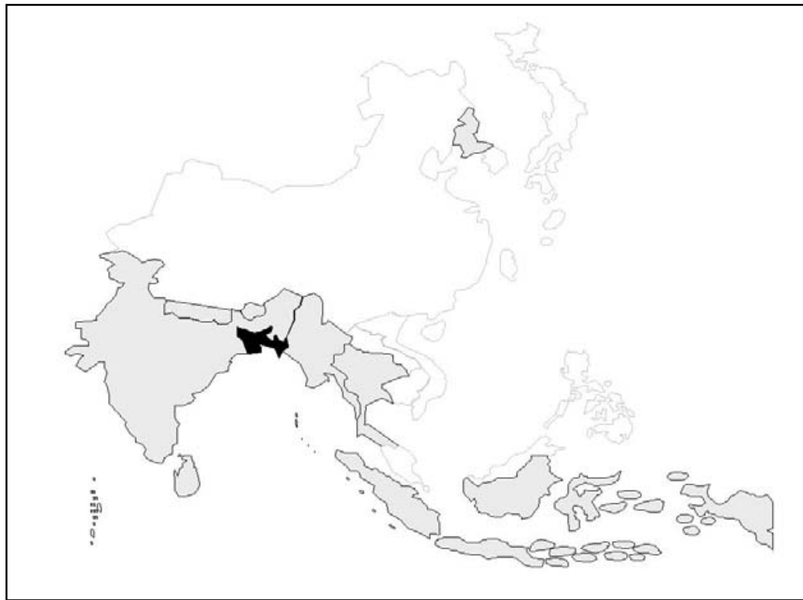
COUNTRY HEALTH PROFILE

BANGLADESH



The boundaries shown on the above map do not imply official endorsement or acceptance by the World Health Organization.

SECTION 1: TRENDS IN POLICY DEVELOPMENT

The government gives priority to health sector development as an integral part of overall socioeconomic development, and is committed to the HFA goals and the PHC approach. Towards this end, the government follows the principle of universal health coverage and accessibility, priority to the poor and the most vulnerable groups, improvement in the quality of life, and promotion of health. The Health and Population Sector Strategy (HPSS) introduced in 1998 forms the basis for national health policy in Bangladesh. It incorporates the following key principles: greater orientation to client needs, especially those of women; improved quality, efficiency and equity of government health services; provision of a package of essential health services; expanded private sector role in providing health and population services; one-stop shopping via co-location of services; and expanded cost recovery and improved efficiency of resources by the public sector. There is also an awareness that in the context of a changing health situation in the country, reforms in the health sector itself will be essential, and should include decentralized health management systems.

SECTION 2: TRENDS IN SOCIOECONOMIC DEVELOPMENT

2.1 Economic trends

There has been a slow but steady increase in GDP per capita from US $217 in 1991 to $ 373 in 2000. The annual growth rate of the GNP at constant market prices increased from 3.56% in 1991 to 4.86% in 1995. With the increase in population, the overall public financing for health remains the same.

About one-half of the total population is poor, with the same picture seen in both urban and rural areas. Income generating schemes are being financed by the Government to make the poor more self-reliant.

2.2 Demographic trends

The annual population growth rate has declined from 2.04% in 1991 to 1.51% in 1998. Similar declining trends are seen over the same period for the crude birth rate (31.6 to 19.9), crude death rate (11.2 to 4.8) and total fertility rate (4.24 to 3.3).

2.3 Social trends

The adult literacy rate in the population over 15 years has shown a gradual increase between 1981 (males 39.7% and females 18.0%) and 1999-2000 (males 71.9% and females 62.2%). Whether this increase has resulted in better utilization of health services is difficult to ascertain.

2.4 Food supply and nutritional status

The prevalence of low birth weight has decreased from about 50% in 1993-95 to 19.5% in 1999-2000. The percentage of children with weight-for-age below international standards was 47.7% and that of height-for-age was 44.7 % (1994-99). About 69% of the

population suffers from iodine deficiency disorders (IDDs) as estimated by the urinary excretion of iodine. Among the population, the total goitre rate is 47.1%, of which 8.8% have visible goitre. The presence of cretinism is 0.5% (1993). The IDD control programme now targets hyperendemic areas with lipiodol injections as a short term measure and universal iodization of salt as the long term intervention.

The prevalence of anaemia among adult women was estimated at 74% and that of children under five years at 73% (1982/83). Studies conducted in 1990 and 1995 found the situation unchanged.

The prevalence of vitamin A deficiency (night blindness) among 1-6 year old children was found to be 1.78% (1993). Supplementation with liquid vitamin A for children under one year is linked to infant contacts for immunization and children 1-6 are administered high potency vitamin A capsules at six-monthly intervals. As a long term measure, health education is used to encourage the production and intake of vitamin A rich vegetables. With NGO collaboration, a major nutrition project is currently being implemented. Some constraints faced at improving nutrition are inadequate food supplies including micronutrients, economic and sociocultural factors, and the prevalence of diseases.

2.5 Lifestyle

The percentage of the male population aged 15 years and over who are regular smokers has steadily increased over the last five years. Data for 1995 show that the proportions of adult males and females who are regular smokers are 41% and 4.6% respectively. The Government and NGOs are making efforts to counter this trend by creating more awareness of the adverse effects of smoking, warning messages on cigarette packets, anti-smoking schemes among doctors, banning advertizements on radio, creation of smoke free zones, etc. There is a need to also address issues relating to substance abuse, drug trafficking and juvenile delinquency.

SECTION 3: HEALTH AND ENVIRONMENT

3.1 General protection of the environment

There are many legislative enactments pertaining to the environment that need to be modified and updated. In 1989 a new Ministry of Environment and Forests was created. In May 1992 a national environmental policy was approved and a national environmental action plan developed. In 1995 the Bangladesh Environment Protection Ordinance was enacted. Environmental objectives were also contained in the government’s Fourth Five Year Plan (1990-1995) and are also in the Perspective Plan (1996-2010). Monitoring and regulatory mechanisms for air pollutants mainly caused by vehicular emissions are operational only in four major cities. A standard for per capita water availability has yet to be set. A national monitoring system for contamination of drinking water has not yet been established. The regular collection of solid waste is only in municipal towns but handling and disposal is questionable. Bangladesh has no national food safety policy. A plan of action for food safety and an inter-ministerial committee for coordinating and monitoring food safety are operational. The incidence of food-borne diseases is high.

With regard to housing, the key issues identified are unplanned and unregulated urban growth, high population density, often with poor provision for sanitation causing a high

incidence of disease, and inadequate facilities for disposal of waste, sewage treatment and management. In 1993 the government adopted a National Housing Policy with provision to address the above issues. In 1991 for the first time, protection of the environment and environmental pollution were included in the industrial policy.

The main constraints include delay in the approval of national policy and work plans, lack of a monitoring system for environmental health concerns, insufficient budget, and insufficient trained manpower.

3.2 Water supply and sanitation

The availability of safe drinking water in urban areas has increased from 44.9% in 1991 to 99.2% in 1999-2000 and in the rural sector from 88% to 96.7% during the same period. Over 96% of the rural population use tube well water (safe water) for drinking purposes, but only about 16% use it for other domestic purposes due to the distance from the water source.

The proportion of the population with adequate excreta disposal facilities has also increased, from 38% (1991) to 74.6% (1999-2000) in the urban sector and from 10% (1991) to 49.3% (1999-2000) in the rural sector.

The main constraints are the shortage of trained manpower, limited funds, poor community awareness, and a weak information system.

SECTION 4: HEALTH RESOURCES

4.1 Human resources for health

Significant changes in human resources for health have taken place in recent years leading to overall improvement in the coverage of health services. These include production and deployment of more health and health-related personnel, refresher training for health personnel in service, and greater use of health volunteers. In 1997 the distribution of health personnel per 10,000 population was as follows: physicians 2.034, nurses 1.126, pharmacists 0.57, dentists 0.98, and other health providers 4.93. The main constraints were inadequate attention being paid to quality standards in basic and in-service training, inappropriate placement of personnel, lack of a good training institute for health workers, inadequate supervision, and poor accountability on the part of health personnel. Remedial actions are being considered which include the establishment of a permanent health institute, formulation of a human resource development plan, and enhancing the quality of medical education.

4.2 Financial resources for health

In 1993-94 the national health expenditure by both public and private sectors amounted to 3.04% of the GNP. It increased marginally to 3.8 % in 1998. Public expenditure on health as % of total expenditure on health was 36.5 % in 1998. Government health expenditure as a percentage of the total government expenditure was 6.9 %. In 1998 the total government health expenditure per capita was $ 4. Constraints to mobilizing financial resources for health and their efficient use are the inability of communities to finance health services due to poverty, unwillingness of donors to support infrastructure development, and

lack of coordination in financial mobilization. The government now gives priority to cost sharing, decentralization of authority, decision making and programme implementation at the peripheral level, promotion of community participation, delivery of a package of essential services to the poor, and mobilization of financial resources by negotiating with donors such as the World Bank.

4.3 Physical infrastructure

Since the mid 1980's the government has sought to improve its health services and teaching institutions. The explicit goal was to build one union subcentre (USC) or health and family welfare centre (HFWC) in every union (4415); one health complex in every thana (397); and one general hospital or tertiary facility in every district (59). As of 1996, there were 4200 USC's/HFWC's, 379 health complexes and 59 district hospitals. By 1999 there were 460 thana health complexes, 1362 Union Sub-Centres and 3315 Community Clinics There were also 10 medical colleges and 7 postgraduate/specialized hospitals. The total number of hospital beds were 43,293 (1999). To overcome many of the local constraints in the construction and maintenance of health facilities, the government is considering introducing a more need-based health planning process that will involve all stakeholders and the community.

4.4 Essential drugs and other supplies

As early as the 1980s Bangladesh had a national essential drugs policy and a list of essential drugs to be procured and used in health services. These have been maintained to date. Most of the essential drugs were known by their generic name and were less costly than brand name drugs. Production and distribution facilities, both in the private sector and public limited companies, are adequate. Despite these advantages, government run health facilities did not have sufficient essential drugs to meet their actual needs, since the budgetary allocation for the procurement of drugs was very small. In 1997 a sample of remote health facilities revealed that only 8% of essential drugs needed at those levels were available. Over the period 1990-1995, however, the investment (public and private) in essential drugs, vaccines and ORS increased from 4.31 million to 75.29 million taka. The government also launched an education programme for providers and users on the rational use of drugs. The government is considering implementation of a new cost sharing scheme based on a sliding scale which would benefit the poor.

4.5 International partnerships for health

Bangladesh willingly shares experiences and expertise with other countries, particularly in training, research and disease surveillance. WHO has played a major role in gradually building up the national capacity through regional collaboration. SAARC is another forum used to address regional issues including health. Partnership arrangements for health have been established with bilateral agencies, with funds usually channelled through nongovernmental organizations. An NGO bureau regulates and monitors the funding. There is a need to further strengthen coordination between NGOs and government activities/programmes.

SECTION 5: DEVELOPMENT OF THE HEALTH SYSTEM

5.1 Health policies and strategies

The cornerstone of national health policy is the Health and Piopulation Sector Strategy introduced in 1998. Priority is given to ensuring universal accessibility to and equity in health care, with particular attention to the rural population. MCH receives priority in the public sector and reproductive health has recently been a priority concern. There has been improvement in the government financial allocation for health. Efforts are being made to develop a package of essential services based on the priority needs of clients, to be delivered from a static service point, rather than providing door to door visits by community health workers. This is a major shift in strategy and will require complete reorganization of the existing service structure. This is expected to reduce costs and increase efficiency as well as meet "peoples' demand". Privatization of medical care at the tertiary level, on a selective basis, is also being considered.

5.2 Intersectoral cooperation

Intersectoral committees at the different levels from the national level to the periphery are formed whenever the need for cooperation exists. At national level for example, nutrition and population councils are chaired by the prime minister. At the district and thana levels intersectoral coordination committees also exist, while at the lowest administrative level (union), similar committees are formed, e.g. for water and sanitation projects. There is, however, a need to revitalize this process to make it more effective.

5.3 Organization of the health system

Committees have been formed, including an interministerial committee, to integrate/merge the health and the family planning departments. Functionally, health and family planning personnel work closely at thana, union and outreach levels, but a dichotomy exists at the district and national levels. An obstacle to this process is the resistance shown by certain agencies and officers. More decentralization of management is also being considered.

5.4 Managerial process

The government decided to formulate a national health policy during 1997, for which a health policy committee and five subcommittees were formed. There was a change from a top-down planning process for health to a participatory approach involving the stakeholders in the health sector. The first product that was formulated utilizing this approach was the health sector perspective plan. The health and population sector strategy document was also prepared following the same process.

A new approach to programme implementation, which is product oriented and emphasizes outputs rather than inputs, is being tried out with WHO assistance. Decentralization of the management process is also being considered. The major constraints have been the excessive centralization in the planning and implementation process and the non-utilization of the health management information system (HMIS) that has already been developed.

5.5 Health information system

A weekly epidemiological surveillance and outbreak control reporting system for selected communicable diseases have been initiated throughout the country. The routine HMIS is not functioning satisfactorily, though activities have been undertaken to strengthen it. Information support is not yet adequate. Use of data remains limited. Strengthening of the HMIS through training, use of data collection tools already designed, and the establishment of information networks with computer support have been planned.

5.6 Community action

The roles of the individual, family and community are emphasized in the intensified action programme for PHC implementation, which involves decentralized planning at thana and union level. A total of 12 districts (86 thanas) are now in the intensified PHC programme. Through intersectoral collaboration and community participation, a joint action plan has been implemented involving 60,000 village health volunteers (one for 50 households). The participation of teachers and religious leaders is encouraged. The information department and mass media inputs are also utilized to support IEC activities.

5.7 Emergency preparedness

Bangladesh is a densely populated delta whose land mass is sandwiched between the Bay of Bengal and the high Himalayan mountains. Throughout the centuries the country has suffered natural disasters such as cyclones, tornadoes and floods. During 1993-1996, two major floods, one cyclone and one tornado, with catastrophic effects, have affected millions of people.

Currently there is no legislation in the country that underpins the management of natural disasters at national and subnational levels. In the absence of any legislation, the Ministry of Disaster Management and Relief in 1997 issued revised "standing orders for disasters". These provide guidelines and instructions to various line departments and ministries. There are separate standing orders for different hierarchical levels of the health sector which include coordination committees, contingency plans for manpower deployment, essential medical relief supplies and maintaining a database, training in emergency preparedness and response, a communication network, and budgetary allocation for emergency management. A draft "Disaster Management Act" is currently under review.

5.8 Health research and technology

Three organizations [the Bangladesh Medical Research Council (BMRC), the Institute for Cholera and Diarrhoea Disease Research, Bangladesh (ICDDRB), and Essential National Health Research (ENHK)] spearhead biomedical and operational research. They undertake training and provide research grants. Many of the research findings are helpful in making policy decisions. Research units have also been opened by BMRC in medical colleges. Field study stations have been established by BMRC and ICDDRB. BMRC has reorganized itself internally to cope with the growing demands of young researchers. Literature search systems in BMRC and ICDDRB have been modernized.

Health systems research (HSR) is not handled as a separate, independent entity. Individual faculty members and other relevant people have been trained in HSR, but there is

no coordination among researchers. Health training institutions have yet to include HSR in their curricula. The research culture has not yet fully developed in Bangladesh, and there is no effective critical mass of researchers to form a strong advocacy group. Coordination and networking among researchers and funding agencies have still to be developed.

SECTION 6: HEALTH SERVICES

6.1 Health education and promotion

Educational support to national health programmes has been provided by the Health Education Bureau (HEB). Emphasis has been given in recent years to school health education, hospital health education and coordination with NGOs. Constraints include the lack of a national IEC strategy, the low priority given to health education by the health services, underutilization of health education officers, and lack of opportunities for professional advancement of those working in health education. Some issues under consideration are the inclusion of a health education component in the new national health policy and strengthening of coordination between the HEB and ongoing government health programmes and NGOs.

6.2 Maternal and child health/family planning

During 1999-2000 the proportion of women attended by trained personnel during pregnancy was 33.7 %, deliveries attended by trained personnel 21.8% , and women of childbearing age currently using family planning 53.8%. In maternal health there has not been much progress. The MMR reported for 1998 is 3 per 1000 live births. The TFR declined from 4.24 in 1991 to 3.3 in 1997-99, which is still high. Based on the causes of maternal deaths, a number of project activities have been initiated to reduce maternal mortality. These include providing comprehensive reproductive health, family planning and essential obstetric care (EOC) supported by UNFPA. UNICEF assistance to EOC is implemented through the Obstetric and Gynaecology Society of Bangladesh. The WHO-assisted programme on maternal and neonatal care including EOC is managed by the government and the ICDDRB. Training and logistic supply management for MCH/FP is also being strengthened. Some of the main constraints are lack of skilled manpower, weak management capabilities and limited resources. In the future, priority will be given to more training and utilization of midwives at the peripheral level.

6.3 Immunization

The proportion of infants (0-11 months) who have been fully immunized according to the national EPI schedule in 1999 was 52.8%. By individual vaccines, the proportions in 1999-2000 were as follows: DPT-70.2%, OPV-69.1%, measles vaccine 62.1% and BCG 90.0%. The percentage of pregnant women immunized with two doses of tetanus toxoid was 63.7%. Immunization services have been extended up to village level and community support is readily available. Three NIDs for polio have also been successfully implemented during the last three years. The morbidity and mortality rates of EPI-target diseases have been considerably reduced. A good opportunity is now available to utilize the already established and well known EPI outreach centres for delivery of other components of PHC as well.

6.4 Prevention and control of locally endemic diseases

The tuberculosis (TB) control programme has been integrated with the general health services. There was an increase in the case detection rate, at more than 25% compared to 2% with the earlier vertical programme. The cure rate of new cases has also increased. With the integration process, training/orientation of 26,000 health workers has been completed and cooperation between the government and NGOs involved in TB control strengthened. The directly observed treatment strategy (DOTS) was initiated for pulmonary TB patients with positive smears. The constraints have been weak supervision and monitoring and frequent transfer of trained staff. Future activities will include improving accessibility to treatment facilities by extension to union/ward level, training of family planning staff in TB control, obtaining the greater involvement of general practitioners and medical colleges, and intensification of IEC activities to promote self-reporting.

Significant changes have occured in the leprosy control programme since the second evaluation. As in the case of TB, the leprosy control programme was integrated with the general health services. There has been a decline in the prevalence of leprosy and in the deformity rate among newly detected cases. Treatment facilities for multidrug therapy (MDT) are available in 600 centres countrywide including all 460 thanas. Following integration, training/orientation was given to over 29,000 health personnel. The availability of antileprosy drugs was assured at treatment centres. The print and electronic media were utilized for IEC activities at district and thana levels. The main constraints were the same as those for TB. Future activities will include improving accessibility to treatment facilities by extension to union/ward level and intensification of IEC activities for improved self-reporting. Leprosy control is also supported by a special initiative (special action project for the elimination of leprosy - SAPEL).

The control strategy for malaria was revised and approved in 1995. The new strategy is being gradually implemented and emphasizes disease control aspects and endorses four technical elements (early diagnosis, prompt treatment, recognition of treatment failures and management of severe and complicated cases in hospitals). Emphasis is also placed on malaria surveillance, preparedness for control of malaria outbreaks/epidemics, and the introduction of insecticide impregnated bed nets. The main constraint is the reduced capacity of the core technical unit for control of vector-borne diseases to take on activities countrywide.

In Bangladesh kala-azar is a re-emerging disease since the cessation of DDT spraying operations. At least 20 million people in more than 27 districts are at risk. The estimated cumulative disease specific burden is 35,000 cases. Under the project for integrated control of vector-borne diseases, an emergency plan for the control of kala-azar was initiated in 1994-95 in 22 thanas of 11 districts (population 5 million). This has been successful and further expansion is now planned. At least 8000 kala-azar patients have been successfully treated to date. The major constraint is similar to that faced in the control of malaria.

Eighteen (18) million people in 12 districts are considered to be at risk of filariasis. A revised strategy for the elimination of filariasis is being pilot tested in one district. This strategy involves administering a single dose of ivermectin with albendazole yearly for a period of three years to the total population in the district.

Dengue has yet to become a public health problem, but in view of the high potential that exists, surveillance and preparedness capability have been strengthened.

To date 17 AIDS cases have been reported, but 13,000 cases of HIV infection are estimated. Current data available categorizes Bangladesh as a low prevalence country at present.

6.5 Treatment of common diseases and injuries

Acute respiratory infection (ARI) accounts for about 145,000 deaths annually among children under five years. The under-five mortality rate due to ARI was reported to be 33% (ICDDRB-1994). Forty to sixty per cent (40-60%) of outdoor visits and 30-40% of indoor admissions are attributed to ARI. The programme for the control of ARI continues to be implemented on a phased basis according to the recommended WHO strategies.

Diarrhoeal diseases continue to be responsible for much morbidity and mortality, but current strategies have considerably reduced mortality. Multisectoral partners were involved in mobilizing the community regarding correct home-based care and timely referral. The availability of ORS has increased through the formation of ORS depot holders in the community. Constraints include inappropriate use of anthelmintics and anti-diarrhoeals, especially in the private sector, and the underutilization of health facilities including ORT corners.

The incidence of measles has dramatically declined since the introduction of measles vaccine into the immunization programme. Malnutrition still remains a problem both in urban and rural areas, with the latter being more affected. Of the noncommunicable diseases, cancer and cardiovascular diseases are the leading causes of morbidity and mortality. The incidence of cancer is estimated at 200,000 per year.

SECTION 7: TRENDS IN HEALTH STATUS

7.1 Life expectancy

The life expectancy at birth for both sexes increased from 56.1 in 1991 to 60.8 in 1998, male life expectancy being 60.7 and female life expectancy 60.5. The gap between male and female life expectancies has narrowed from 0.8 years (1991) to 0.2 years (1998). The gap between urban and rural life expectancy is also narrowing. The main reason for the rise in life expectancy is the decline in infant and child mortality due to the successful implementation of the immunization programme as well as disease control programmes such as those for ARI and diarrhoeal disease.

7.2 Mortality

Between 1991 and 1998 the crude death rate (CDR) declined from 11.2 to 4.8, infant mortality rate (IMR) from 92 to 57.0. Neonatal mortality rate declined from 64 to 47.9 per 1000 live births between 1991 and 1995. The maternal mortality ratio (MMR) declined from 470 in 1991 to 300 per 100,000 live births in 1998. Though mortality rates have declined, infant and maternal mortality are still high.

7.3 Morbidity

There has been an overall decline in morbidity during the period of reporting. Morbidity is mainly due to infectious, parasitic and vector-borne diseases. Some information on morbidity is available from a sample survey conducted by the Bangladesh Bureau of Statistics (BBS). However, routine reporting of disease incidence is nonexistent or patchy at best, and disease surveillance has not been fully established.

7.4 Disability

Not much is known about the true prevalence of disability. The information available is from surveys. Visual impairment per 1000 population has been estimated at 11.98 and hearing impairment at 1.58. Some interventions/rehabilitation efforts have been made, including awareness raising, but are weak due to the low priority given and the lack of resources.

SECTION 8: OUTLOOK FOR THE FUTURE

8.1 Overall assessment and strategic issues

Since independence more than 30 years ago, the Government of Bangladesh has invested substantially in the institutionalization and strengthening of health and family planning services, with special attention to rural areas, and is committed to HFA with PHC as the key approach. Over the last 30 years there has been a substantial improvement in the health status of the people. Life expectancy at birth has increased to 60.8 (1998), CDR has declined to 4.8 (1998), and TFR reduced from 6.34 (1975) to 3.3 (1999). The IMR is around 57 (1998). Despite these improvements, much still remains to be done. Mortality rates, especially infant and maternal mortality, continue to be unacceptably high. The quality of life of the general population is still very low. Low calorie intake continues to result in malnutrition, particularly in women and children. Diarrhoeal disease continues to be a major killer. Communicable and poverty-related diseases that are preventable still dominate the top ten causes of morbidity.

The government is aware of this situation and the major shortcomings that need to be addressed, i.e. the development of an efficient project management mechanism across the health system; improvement in the logistics of drug supplies and equipment to health facilities at district and lower levels; improvement in the production and quality of human resources for health; a system to ensure regular maintenance and upkeep of existing health facilities; and the development of a comprehensive plan to improve and assure the quality of health resources provided.

8.2 Futures vision

The government has formulated a perspective plan keeping in view the needs of the health sector for the future. The formulation of a national health policy would provide strategy directives on major health issues. The future vision for the health sector would include universal access to basic health care and services of acceptable quality; improvement in medical education; improvement in nutritional status particularly of mothers and children; prevention and control of major communicable and noncommunicable diseases;

strengthening planning and management capabilities; improvement in logistics of production/procurement, supply and distribution of essential drugs, vaccines and other diagnostics and therapeutic equipment; increase in overall life expectancy of the population; survival and healthy development of children; the health and well being of women; protection and preservation of the environment; disability reduction, and the adoption and maintenance of healthy lifestyles.

8.3 Proposed strategies

The Health and Population Sector Strategy (HPSS) introduced in 1998, which forms the basis for the future national health policy is based on several key principles: greater orientation to client needs, especially those of women; improved quality, efficiency and equity of government health services; provision of a package of essential health services; expanded private sector role in providing health and population services; one-stop shopping via co-location of services; and expanded cost recovery and improved efficiency of resources by the public sector.

Some of the main objectives are:

- To allocate more resources to support services for poor, vulnerable groups (women and children).
- Unifying the existing bifurcated health and family planning service delivery system.
- To achieve an appropriate balance between the public and private sectors in financing and provision of services.
- Decentralization of management through devolution of authority.

The following activities have been identified to achieve the above objectives:

- Deliver an Essential Services Package to the whole population with the aim of maximizing health benefits relative to per capita expenditures. This is expected to meet the felt needs of the clients, strengthen service delivery, and improve system management.
- Service delivery mechanism unified restructured and decentralized, both at the Thana and hospitals.
- Other services, particularly hospital-level, are proposed to be provided through partnerships with or commissioning of services to NGOs and private not-for-profit hospitals. The public sector hospital services delivery will be improved through installing greater autonomy of management, local level accountability, cost-recovery, fee retention and utilization, and a drug revolving fund.
- Integrated support systems strengthened.

- Introducing a sector wide approach to manage the health sector, rather than having a series of projects with their own funding, management, implementation and reporting arrangements.

- In view of the potential resource gap between the sectoral resource envelope and projected sectoral expenditures, increased reliance on cost recovery for public sector services will be considered.

- Health insurance coverage in urban Bangladesh is proposed to be increased through development of a health insurance scheme for government employees and for employees of state-owned enterprises.

- At the centre, FP and health will be more integrated and decentralisation taken to lower levels.

- Hospital level services focused and improved.

- Policy and regulatory framework strengthened. Existing policies will be reviewed and revised for improving accessibility, affordability and quality of services and for further improvements in affordability, quality and safety of drugs and rational use of drugs. New policies on public-sector/private-sector mix and financing of services will be developed

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Country Reported Data for Basic Health and Health-related Indicators

Indicator		Latest available data	Year	Source	Remarks
Population and Vital Statistics					
Total population (in millions)		129.6	2000	1	Estimates
Population density (persons per sq km)		878[a]	2000	1	Computed value
Sex ratio (males per 100 females)		105	1996	2	
Population under 15 years (%)		40.0	1996	2	
Population 60 years and above (%)		5.9	1996	2	
Crude birth rate (per 1000 population)		19.9	1998	1	SRS[b]
Crude death rate (per 1000 population)		4.8	1998	1	SRS[b]
Annual population growth rate (%)		1.51	1998	1	Natural growth
Total fertility rate (per woman)		3.3	1997-1999	4	DHS 1999-2000
Urban population (%)		20.1	1991	1	Census results
Socioeconomic Situation					
Gross domestic product per capita (US$)		373	2000	3	Provisional
Adult literacy rate (%):	Male	71.9	1999-00	4	For population 6 years and above
	Female	62.2	1999-00	4	
Median number of years of schooling:	Male	2.6	1999-00	4	For population 6 years and above
	Female	1.2	1999-00	4	
Prevalence of low birth weight (weight <2500 grams at birth) (%)		19.5	1999-00	4	Mother's estimate of baby's size
Prevalence of underweight (weight-for-age) in children <5 years of age (%)		47.7	1994-99	4	<- 2SD from NCHS median
Prevalence of stunting (height-for-age) in children <5 years of age (%)		44.7	1994-99	4	<- 2SD from NCHS median
Environment					
Population with safe drinking water available in the home or with reasonable access (%)	Total	97.3	1999-00	4	
	Urban	99.2	1999-00	4	
	Rural	96.7	1999-00	4	
Population with adequate excreta disposal facilities available (%)	Total	54.1	1999-00	4	
	Urban	74.6	1999-00	4	
	Rural	49.3	1999-00	4	

Indicator	Latest available data	Year	Source	Remarks
Health Resources				
Facilities				
Number of hospital beds	43,293	1999	2	Public and private
Population per hospital bed	3,063	1999	2	
Hospital beds per 10,000 population	3.34[c]	1999	2	Computed value
Number of thana health complexes	460	1999	2	
Number of Union Sub-Centres (USC)	1,362	1999	2	
Number of Community Clinics (CC)	3,315	2001	2	
Human resources				
Number of registered physicians	29,746	2000	2	
Population per physician	4,521	2000	2	
Physicians per 10,000 population	2.29[c]	2000	2	Computed value
Number of registered nurses	16,972	1999	2	
Number of registered midwifes	14,915	1997	2	
Physician to Nurse ratio	2 to1	1997	2	
Budgetary resources				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	3.8 %	1998	5	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	36.5 %	1998	5	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	63.5 %	1998	5	
Public Expenditure on Health (PHE) as % of General Government Expenditure (GGE)	6.9 %	1998	5	
Social Security Expenditure on Health (SSHE) as % of Public Expenditure on Health (PHE)	0.0	1998	5	
Tax funded Health Expenditure (TaxFHE) as % of Public Expenditure on Health (PHE)	89.0	1998	5	
External Resources for Health (Ext Res HE) as % of Public Expenditure on Health (PHE)	11.0 %	1998	5	
Private Insurance for Health Risks (Pvt ins HE) as % of Private Expenditure on Health (PvtHE)	0.0	1998	5	

Indicator	Latest available data	Year	Source	Remarks
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	93.9 %	1998	5	
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US$)	12	1998	5	
Per capita Public Expenditure on Health (PHE) at official Exchange rate (X-Rate per US$)	4	1998	5	
Per capita Total Expenditure on Health (THE) in international dollars (int'l $)	42	1998	5	
Per capita Public Expenditure on Health (PHE) in international dollars (int'l $)	16	1998	5	
Health Services				
Pregnant women attended by trained personnel during pregnancy (%)	33.7	1994-99	4	
Deliveries attended by trained personnel (%)	21.8	1994-99	4	7.1% by doctors,5.0% by nurse/midwifes, 9.7% by trained TBA
Women of childbearing age using family planning (%)	53.8	1999-00	4	Married women 43.4% modern methods
Eligible population (i.e. infants reaching their first birthday) that has been fully immunized according to national immunization policies	52.8	1999-00	4	
Infants reaching their first birthday that have been fully immunized against diphtheria, tetanus, and whooping cough (%)	70.2	1999-00	4	
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	69.1	1999-00	4	
Infants reaching their first birthday that have been fully immunized against measles (%)	62.1	1999-00	4	

Indicator	Latest available data	Year	Source	Remarks
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	90.0	1999-00	4	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	63.7	1994-99	4	TT2+
Health Status				
Life expectancy at birth (years): Total	60.8	1998	1	SRS[b]
Male	60.7	1998	1	SRS[b]
Female	60.5	1998	1	SRS[b]
Infant mortality rate (per 1000 live births)	57.0	1998	2	
Under-five mortality rate (per 1000 live births)	82.35	1998	2	
Maternal mortality ratio (per 1000 live births)	3.0	1998	2	

[a] Based on total surface area of 147,570 square kilometers, [b] Sample Registration System
[c] Based on population estimates of 129.6 millions

Sources:

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4. Bangladesh, Demographic and Health Survey 1999-2000, Dhaka, May 2001
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