BANGLADESH'S PROGRESS IN HEALTH:

Healthy partnerships and effective pro-poor targeting

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Development Progress

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Key messages

1. Infant and child mortality rates have reduced dramatically in Bangladesh, immunisation coverage has rocketed and life expectancy has risen steadily.

2. Government commitment and leadership, along with strong partnerships with NGOs, have combined with donor support to the health sector for positive results.

3. Innovative practices and approaches by both government and NGOs have enabled a comprehensive pro-poor health focus, particularly prioritising the poor, women and children.

"Infant and child mortality rates have reduced dramatically."

Summary

Bangladesh gained independence in 1971 after a brief civil war. Located between India, Myanmar and the Bay of Bengal, most of the country's territory is set on a low-lying delta with many rivers. As such, the country is subjected to frequent natural disasters, including yearly flooding during the monsoon season.

Despite still low social indicators and continuing prevalence of poverty (40% of the population lives below the poverty line), the health sector in Bangladesh has shown impressive progress. Among the most notable achievements, infant and child mortality rates have reduced dramatically, immunisation coverage has rocketed and life expectancy has risen steadily.

A few key converging factors have contributed to these achievements. The government of Bangladesh has shown policy continuity and commitment to improving health conditions, placing particular emphasis on improving the health conditions of its citizens and targeting the poor, women and children. Innovative practices and approaches for targeting and empowering the most vulnerable, together with effective partnerships with non-governmental organisations (NGOs), have contributed to these successes. NGOs have also played a key role in developing novel approaches and practices as well as in delivering services to hard-to-reach groups.

Donor assistance has also been critical to the development of Bangladesh generally and the health sector in particular. Underlying these factors is a strong sense of social contract and social solidarity, to which the struggle for liberation and relative cultural homogeneity contributed.

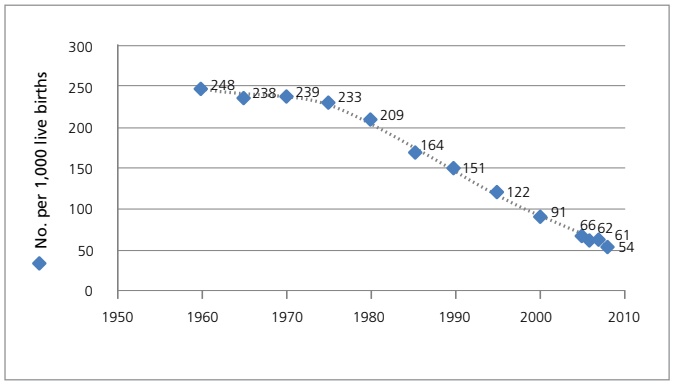
What has been achieved?

Since independence, the overall goal of the government's health policy has been to provide basic services to the entire population, focusing particularly on women and children in rural areas. The health care system in Bangladesh is a mix of public and private initiatives, with the public sector providing physical infrastructure and health services and the private sector (for profit and NGOs) providing wider and more diverse coverage. Donor assistance has been crucial to the development of the sector. In particular, donor funding has contributed by encouraging a sector-wide approach (SWAp), which moves away from projects towards programme funding and alignment and harmonisation under the government's plan.

The picture that emerges is one of remarkable progress. This has been notable not only in absolute terms but also when taking into account the distribution of progress within society. That is, real improvements have taken place for the poorest sectors of the populations.

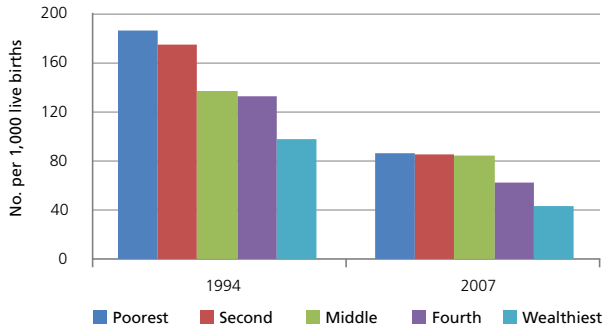
Life expectancy at birth has improved significantly: a baby born in 1970 could expect to live only until the age of 44, whereas a newborn in 2008 can expect to live 66 years. Infant mortality (0-1 years old) and under-five mortality (0-5 years old) (Figure 1) have both shown extraordinary improvements over the past three decades, across all income quintiles (Figure 2).

Figure 1: Under-five mortality rate, 1960-2008[1]



1 Millennium Development Goal (MDG) data and World Development Indicators (WDIs).

Figure 2: Under-five mortality rate by income quintile, 1994 and 2007[2]



The decline in child mortality can be explained by improvements in immunisation and nutrition. Immunisation coverage (measles, poliomyelitis and diphtheria) among children jumped from 1% in 1985 to 88% in the late 2000s. Improvements have been extremely equitable: the gap in coverage between the poorest quintiles reduced significantly from 22% in 1994 to 9% in 2007.

Over 20 years, the proportion of severely malnourished children plummeted by 74%, to reach its lowest level, 4.1%, in 2005. Moderate under-nutrition (underweight and stunting) is still high, at 47.8% and 42.4%, respectively, but still declined by about a third in the same period. There are still large differences in the weight of children across economic groups, but the rich-poor gap narrowed by 13% between 1997 and 2007.

Bangladesh has reported steady progress in reducing maternal mortality over the past three decades, from 650 per 100,000 live births in the 1980s down to around 320 in the early 2000s. The maternal mortality ratio is still very high, though, and it is predicted that the country will not achieve the MDG in this area.

The above progress has been facilitated by improvements in infrastructure throughout the country, focusing specifically on rural areas, although the sector still suffers from a serious shortage of skilled personnel. Meanwhile, some health indicators have lagged. HIV prevalence, for instance, although still low in the general population, has been increasing among high-risk groups. Tobacco consumption also represents a problem.

Table 1: Key health indicators in Bangladesh, then and now[3]

	Then	Now
Life expectancy	44 (1970)	66 (2008)
Under-5 mortality rate per 1,000 live births	233 (1975)	54 (2008)
Immunisation coverage	1% (1980)	89% (2008)
Underweight children under 5	70.5% (1985)	47.8% (2005)
Maternal mortality ratio per 100,000 live births	648 (1986)	322 (2001)
Total fertility rate	7 (1978)	2 (2008)
Contraceptive prevalence	7.7% (1975)	55.8% (2007)
Antenatal care coverage	25.7% (1994)	52.2% 2007)
Births attended by skilled health personnel	9.5% (1991)	24.4% (2009)

What has driven change?

Policy continuity and government coordination

In spite of the changing political scenario in Bangladesh, and highly unfavourable ratings on international measures of corruption, each administration has maintained primary health care as a priority focus alongside an overall goal of achieving health for all. Within this, the government has developed an efficient system for allocating services to NGOs and for maintaining overall regulation and coordination

2 Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) data.

3 Data from World Databank, MDG Indicators and Child and Mother Nutrition Survey of Bangladesh.

"Innovative practices and approaches by both government and NGOs have enabled pro-poor health focus."

of different actors. In this way, it has ensured a continued focus on priority areas and themes and also synchronisation of services with the public health system.[4] The strong social contract and solidarity underlying Bangladeshi society can be credited with this continuous commitment to health over time, in spite of various political differences.

Partnerships for pro-poor health services

Partnership between the government and NGOs draws on the comparative advantages of both sides. Most NGOs in Bangladesh work at the grassroots level, using innovative and participatory approaches. This allows them to gain the trust of local communities and to make themselves more sensitive to local needs.

NGOs can work in remote areas which government organisations are less able to reach and, as a result, are more able to deliver services to vulnerable populations.[5] On the supply side, NGOs have provided a range of health services; they have also empowered women (microcredit, informal education), which has had an indirect but important influence on demand for health services.

The government looks at the larger picture and draws up policies reflecting the needs and priorities of the entire country. It also enables NGOs access to government facilities and purchasing power, making the system both more efficient and more effective. Many successful programmes started as NGO pilots and were later mainstreamed and scaled up by the government.

A focus on pro-poor health interventions/programmes

A number of pro-poor targeted interventions have been particularly successful. These have included Oral Rehydration Treatment which, being made up of ingredients affordable by poor households (salt and unrefined brown sugar), represented a revolutionary solution to diarrhoeal diseases and was rapidly scaled up. The immunisation campaign against childhood diseases has also had remarkable impacts, as has the Family Planning Programme. Both interventions took a door-to-door and community participation approach to reaching people, helping transform villagers from passive recipients into active participants in their own development.

Empowerment of women and girls' education

NGO-driven microcredit programmes, government policy (in particular the emphasis on girls' education) and family planning successes have contributed to the empowerment of women, which has had direct and indirect positive health outcomes. For example, microcredit and family planning, though not un-contentious, have helped reverse women's historic lack of voice. The boom of the garment industry has allowed women to earn their own money and to become independent of men, meaning they can also make their own health-related choices and decisions. Meanwhile, the female net enrolment rate in primary schools rose from 33% in 1970 to 91% in 2006, and that in secondary schools rose from 13% in 1990 to 42% in 2006. Girls' education is identified globally as one of the biggest determinants of health and nutritional status.

Lessons learnt

- Policy continuity towards a clear goal, regardless of the ruling party, has proved effective in reversing potentially negative health trends. The health SWAp has ensured alignment and streamlining of strong donor support, while helping the government shape its health policy, strengthen implementation and make health financing more predictable and flexible.

- A focus on the comparative advantages of the different actors has been important, ensuring minimal overlap and a combined approach to meeting national priorities. Partnership and collaboration have been crucial in this regard, with both government and NGOs making efforts not to politicise any differences between them. The strong sense of social contract and the relative cultural homogeneity in Bangladesh have helped.

4 Ahmad, M.M. (2001) 'The State, Laws and Non-Governmental Organisations (NGOs) in Bangladesh.' The International Journal of Not-for-Profit Law 3(3).

5 Zohir, S. (2004) 'NGO Sector in Bangladesh: Overview.' Economic and Political Weekly 39: 4109-4013. .

- A few highly pro-poor public policy interventions can play a major role in improving key health indicators, alongside other interventions to strength health systems more broadly. The best of these have involved simple and pragmatic solutions to address health issues at an affordable cost.
- Community participation and door-to-door approaches have been critical in targeting and reaching the most vulnerable with health-related messages and services. Empowering women is also vital to achieving health benefits.
- New challenges have emerged, including a rise in non-communicable diseases, as well as a fast rate of urbanisation, which will require adapting policies and programmes originally designed for rural areas to urban settings.

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