Query response

Bangladesh: Health sector and public health services

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- Access to qualified health personnel
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General health situation

Bangladesh has made great advances in the health sector in recent years. This was set forth by the World Health Organization (WHO) in a meeting with Landinfo in Dhaka in March 2014, and is also shown by various health indicators.

For example, life expectancy at birth[1] has risen from 60 years in 1990 to 70 years in 2012 (WHO, undated). In comparison, the figures for Norway are 77 years (1990) and 82 years (2012) respectively. Bangladesh has lower infant and child mortality rates than neighbouring India, Pakistan and Nepal, even though the country is far poorer than both India and Pakistan (IRIN 2013). Of the aforementioned four countries, Bangladesh has the highest vaccination rate: 86 percent of children between one and two years old are vaccinated according to internationally recommended standards. Moreover, Bangladesh has the most widespread family planning program (52 percent of married women under 50 years of age use modern contraceptive methods) and the lowest maternal mortality rate (194 per 100,000 live births), despite relatively few women (32 percent) giving birth with a skilled birth attendant present (IRIN 2013).

Bangladesh has in many ways experienced a health revolution. Maternal mortality has decreased by 75 percent since 1980, child mortality has more than halved since 1990, and life expectancy is higher than in India and Pakistan (Abed 2013). WHO (meeting in Dhaka,

[1] Average life expectancy at birth for women and men.

March 2014) was of the opinion that Bangladesh scores very well on several health indicators, when taking the country's young age, large population and widespread poverty into account.

However, there is no doubt that Bangladesh has health-related challenges, to a great extent related to overpopulation and poverty. With a population of more than 165 million in an area that is less than half the size of Norway's,[2] Bangladesh is among the most densely populated countires in the world. Poverty is widespread; 31.5 percent of the population lives below the poverty level (CIA undated).[3] As a consequence, undernourishment and malnutrition are, together with the accompanying diseases, very common.

High population density, poverty and poor hygiene are contributing factors to diseases spreading quickly, and the spreading of diseases is a constant challenge (WHO, meeting in Dhaka, March 2014). WHO further pointed out that relatively frequent traffic across the border from Myanmar to Bangladesh also brings with it diseases, such as HIV, malaria and tuberculosis. The HIV rate in Bangladesh is none the less very low, with about 0.1 percent HIV positive people between 15 and 49 years of age (World Bank, undated). In the case of tuberculosis, Bangladesh belongs to a group of countries with the highest incidence in the world for this disease. In 2012 Bangladesh had a prevalence of tuberculosis of 434 cases per 100,000 people. The number of new cases is 225 per 100,000 people per year, a number that supposedly has not changed since 1990 (World Bank undated).

According to WHO (meeting in Dhaka, March 2014) the occurrence of chronic kidney failure is relatively high. Contaminated drinking water is one of the causes. Big natural occurrences of arsenic in the ground water and a high usage of fertilizers pollute the sources of drinking water. According to IRIN (2009) WHO has described the arsenic level in Bangladesh as "the largest mass poisoning of a population in history". The offer of dialysis treatment is still supposed to be very limited, and is most likely only given at private clinics and teaching hospitals. Dialysis treatment is not free.

WHO further reported (meeting in Dhaka, March 2014) that Bangladesh is currently declared "free of polio", which means that there has not been any new registered cases of poliomyelitis (polio) in more than five years. WHO underlined, however, that the disease can return, as polio exists in the region (Pakistan) and can spread back to Bangladesh.

Access to qualified health personnel

Bangladesh has the lowest health budget in South Asia, and a large shortage of qualified doctors and nurses (IRIN 2013). Bangladesh is described by WHO as a country with severe lack of qualified health personnel. Both the number of nurses per 1,000 people and the number of nurses per doctor are among the lowest in the world (Mahmud 2013).

According to Dhaka Medical College and Hospital (DMCH, meeting in Dhaka, March 2014) there is one doctor per 2,500 people in Bangladesh. The same source further stated that there are twice as many doctors as nurses, i.e. on average one nurse per 5,000 people. An article dealing with the workforce crisis in the Bangladeshi health sector operates with very similar

[2] Bangladesh has an area of about 144,000 km². Norway has an area of about 324,000 km².

[3] National estimate of how large a percentage of the population lives below the poverty level. The definition of poverty varies significantly between different countries, and the more prosperous nations generally apply more generous standards for poverty than poor countries (CIA undated).

numbers, claiming that nationwide there are five doctors and two nurses per 10,000 people. That is one doctor per 2,000 people and one nurse per 5,000 people (Ahmed, Hossain, Chowdhury & Bhuiya 2011). The article further points out that there is considerable variation within the country, with a far lower doctor and nurse coverage in rural areas than in the cities. According to Mahmud (2013) less than 20 percent of the health workforce is available in rural areas, even though 75 percent of the population lives there. There is one doctor per 1,500 people in urban areas, whereas the ratio is 1:15,000 in rural areas. There are also large variations found between the different Divisions.[4] Dhaka has the highest doctor density, followed by Chittagong (Mahmud 2013). WHO claimed in its meeting with Landinfo in March 2014 that the skewed distribution of doctors is a far bigger problem than the fact that there are too few doctors in the country. This is true for both the public and the private sector.

According to DMCH (meeting in Dhaka, March 2014) 40 percent of the doctors in Bangladesh work in the public sector, and 60 percent in the private sector.

Public health services

Bangladesh has both public and private health services. Any private health service has to be paid for, and is therefore not genuinely available for a large part of the population. Public health services across the country, on the other hand, are basically free. The following information concerns public health services only.

In the meeting Landinfo had with WHO in Dhaka in March of 2014, we were given an outline of the structure and organization of the country's public health services on different geographical and administrative levels.

Bangladesh is administratively divided into seven *Divisions* (cf. footnote 4). Each Division is divided into *Districts*, also known as *Zila*, with a total of 64 on a national basis. The Districts/Zilas are further divided into *Sub-Districts*, either *Upazila* or *Thana*. These are again divided into *Union Parishad*, then *Ward*, and finally *Village*. There are about 500 Upazilas, 4,500 Union Parishads and more than 87,000 Villages in Bangladesh (UK Home Office 2013, p. 9).

The following description, which starts with health services at the lowest geographical level, is based on information provided by WHO during the above-mentioned meeting.

Community clinics

There are about 12,500 clinics at the local level, so-called community clinics, in Bangladesh. One clinic covers several villages. Ideally, it should take no longer than 30-40 minutes to walk from any village to a community clinic. The goal is to reach 18,000 such clinics in the country, to improve the access to primary health services.

No doctors work at these clinics. Instead, they are run by so-called trained community health care providers, who receive about three months of training. They rarely get any further training or follow-up beyond this. Trained community health care providers simply cannot treat everything, but can refer to the next level of health service, which is Union Health

[4] Bangladesh is divided into seven Divisions: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur and Sylhet.

Centres (see below). The personnel at the community clinics are permitted to dispense 27 different types of medicines.[5] This medicine is free.

Diabetes is an example of a disease that can, unless there are any complications, be treated at a community clinic.

WHO emphasized (meeting in Dhaka, March of 2014) that the lack of training given to health personnel at these clinics is a major challenge.

Union Health Centres

The next level of health services is Union Health Centres at Union Parishad level. The personnel at these health centres/clinics have received about one year's training.

Upazila Hospital

The level above Union Parishad is Upazila. Each Upazila must have one hospital. All the hospitals at this level have doctors, although the number varies. Ideally, there should be twelve doctors at each hospital, according to WHO, but many hospitals have far less, and some only have one or two. Some of the larger Upazila hospitals have specialists such as gynaecologists and anaesthetists.

Often there are not enough health personnel at Upazila level, and the shortage of doctors is substantial in most Upazila hospitals outside Dhaka and other large cities.

WHO also reported that the size of these hospitals varies. Some have only ten beds, while others have far less. Furthermore, there are considerable variations as to how well equipped the hospitals are. Some Upazila hospitals are well equipped, others are not.

District Hospital

Hospitals at the district level are better equipped, both in regard to specialists as well as equipment. District Hospitals should be able to treat most diseases, including myocardial infarction.

Teaching Hospitals (Medical College Hospital)

In 15-20 of the Districts, there are public Teaching Hospitals with Medical Colleges. These are, according to WHO, good hospitals with a mandatory standard.

Dhaka Medical College and Hospital (DMCH), which Landinfo visited and had a meeting with in March of 2014, is the largest public hospital in Bangladesh. Officially this hospital has 2400 beds, but according to them, they have, at any given time at least 3000 patients.

Pharmaceuticals

Bangladesh has a significant pharmaceutical industry. Bangladesh exports medicines to more than 80 countries, and covers 97–98 percent of the country's own demand (Shawon 2011; WHO, meeting in Dhaka, March, 2014; DMCH, meeting in Dhaka, March, 2014). That means that only 2-3 percent of medicines are imported. According to both DMCH and WHO, some cancer medicines, among others, are imported, but principally, Bangladesh is self-sufficient when it comes to medicines.

[5] Landinfo does not have any information regarding the sort of medicine this is.

The pharmaceutical industry in Bangladesh produces around 5600 different types of medicines. To market and sell these, around 1500 wholesalers and 37,700 medical shops are licensed to sell medicines (retail drug license holders) around the country (Habib & Alam 2011, p. 64).

WHO claimed in its meeting with Landinfo in March of 2014 that medicines in Bangladesh are "extremely cheap". Whether this is in comparison to international prizes, or in relation to the average purchasing power in the country, is unknown.

WHO reported that medicines and treatment at a public hospital are mostly free for the poor people. WHO added that there is no fixed definition of "poor" in that regard, and that questions can be raised about who is considered poor and who is not. According to WHO, people have to purchase and pay for medicines if public hospitals do not have what they need.

In India, so-called counterfeit medicines are a major problem (WHO, meeting in Dhaka, March, 2014). These are medicines/pharmaceutical products that are deliberately labelled with false information regarding the origin, authenticity, strength and/or effect of the product. A counterfeit medicine can contain incorrect and potentially harmful amounts of active ingredients, or none at all. Such medicines can contain ingredients that are not stated on the label, and which can be harmful, or they can be delivered with inaccurate or fake packaging and labelling. According to WHO, there are more than likely counterfeit medicines on the market also in Bangladesh, but it is unknown how widespread this is.

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