



**MDG Goal 4 and 5 indicators: Under-five mortality rate male 71, female 73 per 1,000 live births; Infant mortality rate 51 per 1,000 live births; Proportion (%) of 1 year-old children immunized for measles 77; MMR 230 per 100,000 live birth; Births by skilled attendant 21.8%.**

*Data source: Basic Indicators: Health Situation in South-East Asia, World Health Organization, South-East Asia Region, 2004.*

The population of Bangladesh has been steadily increasing at a moderate rate of 2.3%, and now stands at an estimated 135 million. This presents a formidable challenge to the policy makers for improving the quality of life through socio-economic development. Improvements however are being made. Life expectancy at birth has increased from 44 in 1970, to the present 62 years (UNICEF 2004).

The Government of Bangladesh seeks to create conditions whereby people have the opportunity to reach and maintain the highest attainable level of health. The Ministry of Health and Family Welfare (MOHFW) has adopted the Health, Nutrition and Population Sector Program (HNPS) to provide quality, affordable reproductive health services, including family planning, to contribute directly to the attainment of the Millennium Development Goals (MDGs). Although there has been considerable success in the health services, still more than 60% of the population do not have access to basic health

care, despite the fact that many government health facilities at various levels are not being adequately utilized (MOHFW 2003). Although the total fertility rate (TFR) has dropped significantly, maternal mortality ratio remains high – the latest national data shows it to be around 300 per 100,000 live births (BMHS/MMS 2003).

A serious challenge to government efforts to improve the health of women, newborns and children is, that the number of urban poor has increased from 7 million in 1985 to 12 million in 1999, and their health indicators are worse than these of the rural poor. According to the 2001 population census, the urban population in Bangladesh is 29 million, and has increased at the rate of 38% during the last 10 years, which is about 4 times the rural rate (MOHFW 2001). This shift may have a negative impact on the urban health service delivery system, and it is usually women and children that suffer the most.

There has however been substantial improvement between 1994 and 2004 in the survival

of children. Prevention and control of diseases, such as measles, poliomyelitis and diphtheria, along with widespread use of ORS for diarrhoeal disease, have greatly reduced childhood mortality and morbidity. Bangladesh has not had a case of polio since 2000, and has already achieved the goal for elimination of leprosy at the national level.

Side by side with the Government, the NGOs and private sectors are playing an important role in providing health services, especially to mothers and children. The challenge has been to broaden the service base, in particular to the ultra poor. The Government of Bangladesh (GoB) has acknowledged the importance of government, private and NGO partnership to meet this challenge.

## Status of maternal health

Although improving, in terms of national averages, maternal health status for many Bangladeshi woman remains poor. Around 50% of Bangladeshi women suffer from chronic energy deficiency. Over 43% of the pregnant women are iodine deficient and more than 2.7% develop night blindness during pregnancy (Bangladesh Demographic Health Survey (BDHS) 2001). Despite very low level of the use of antenatal and skilled care at birth, the situation in respect of Tetanus Toxoid vaccination among women is much better. About 81% of mothers who gave birth during 1995-1999 received Tetanus Toxoid vaccination (BDHS 2001).

Bangladesh has a high maternal mortality ratio (MMR). The high MMR directly relates to the high perinatal (newborn) mortality rate in the country. The estimated lifetime risk of dying from pregnancy and childbirth-related causes in Bangladesh, is around 100 times higher than that in developed countries. The tragic consequence of these deaths is, that about 75% of the babies born to these women, also die within the first week of their lives. Although a high proportion of such deaths are attributed to a lack of emergency obstetric services and trained personnel, 14% of deaths of pregnant women are associated with injury and violence.

The major causes of maternal deaths are postpartum haemorrhage, eclampsia, and complications of unsafe abortion, obstructed labour, postpartum sepsis and violence and injuries

(MOHFW 2004). Abortion complications are responsible for the death of nearly 25% of the mothers (MOHFW 2004). A study on safe motherhood programme in Bangladesh assessed that women's low status in society, poor quality of maternity care services, lack of trained providers, low uptake of services by women, as well as infrastructure and administrative difficulties - all contribute to the high rate of maternal deaths (Haque et. al. 1997). In addition to the large number of deaths, about nine million women suffer from lasting complications of pregnancy and childbirth, such as fistulae, uterine prolapse, inability in controlling urination or painful intercourse.

Antenatal care coverage, especially by a trained provider, has increased over time although remains low; in 2000 only one third of women reported receiving antenatal care from a medically trained person. Only 56% of pregnant women surveyed received at least one antenatal care from any provider (BDHS 2001).

Doctors, trained nurses, or midwives assist at the birth of only very few babies - estimates suggest 13% of births. Other midwifery trained health providers assist in another 14% (BDHS, 2004). Estimates show that almost two in three births are assisted by dais (untrained traditional birth attendants) and one in eleven are assisted by relatives or friends. Only one in ten births in Bangladesh take place in a health facility.

Care after birth is equally inadequate. Only 18% of mothers receive postnatal care (PNC) from a trained provider within six weeks after birth. Among mothers who do not give birth at a health facility, only 8% receive postnatal care. The likelihood of receiving PNC for mothers has improved only slightly, from 14% in 1999-2000, to 18% in 2004. (BDHS 2004).

## Family planning and the burden of unsafe abortion

There has been significant improvement over the years in access to family planning. Overall, 58% of the currently married women in Bangladesh are using a modern contraceptive method and 11% are relying on traditional methods. The pill is by far the most widely used method (26%), followed by injectables

(10%), periodic abstinence (7%), female sterilization (5%) and condoms and withdrawal (4%) (BDHS 2001).

Due to the past efforts of both the government and the development partners, the total fertility rate (TFR) declined from 6.3 in 1975, to 3 in 2004. The decline of the fertility level is largely due to the impressive increase in the contraceptive prevalence rate (CPR) from 9.6% in 1975, to 58% in 2004 (BDHS 2004).

## Status of health of children under-five

The recent Demographic and Health Survey showed that neonatal, post-neonatal, infant, child and under-five mortality rates are improving (Table 1) (BDHS, 2004). Comparison of the 2004 data with the earlier BDHS survey results, show a substantial (20%) improvement in child (1-4 years of age) survival; but there is no evidence of change in infant survival in recent years.

**Table 1:** Neonatal, post-neonatal, infant, child and under-five mortality rates for five-year periods preceding the 2004 BDHS

Approximate reference period	Neo-natal mortality	Post-neonatal mortality	Infant mortality	Child mortality	Under-five mortality
1999-2003 <sup>a</sup>	41	24	65	24	88
1995-1999 <sup>b</sup>	42	24	66	30	94
1992-1996 <sup>c</sup>	48	34	82	37	116
1989-1993 <sup>d</sup>	52	35	87	50	133

Source: <sup>a</sup>BDHS, 2004; <sup>b</sup>BDHS, 2000; <sup>c</sup>BDHS, 1997; <sup>d</sup>BDHS, 1995

**Immunization:** The government's policy for childhood immunization, which follows the World Health Organization guidelines, calls for all children to receive: a BCG vaccination against tuberculosis, three doses of DPT vaccine to prevent diphtheria, pertussis and tetanus; three doses of polio vaccine, a measles vaccination. A pilot programme on Hepatitis B vaccination has recently commenced. As many as 73% of Bangladeshi children aged 12-23 months can be considered to be fully immunized.

Although the level of coverage for BCG and the first two doses of DPT and polio is above or around

90 percent, the proportion who go on to complete the third dose of these two vaccines falls to around 81-82%, while a much lower percent (76%) receive the measles vaccine. Only 3% of children aged between 12-23 months do not receive any childhood vaccinations (BDHS 2004).

**Vitamin A Supplementation:** Deficiencies in vitamin A can be avoided by given children supplements of Vitamin A, by capsule, every six months. About 82% of the children aged 9-59 months receive vitamin A supplementation.

**Childhood communicable diseases:** Dehydration from diarrhoea is an important contributing cause of childhood mortality. Data show a slight decline in the prevalence of diarrhoea over time: from 8% of children under five in 1996-1997, to 6% in 1999-2000, and an increase in the use of oral rehydration solution (ORS) from 49% 1996-1997, to 61% in 1999-2000 (BDHS 2001).

Data from 2004 BDHS also show, that about 40% of children under-five had fever and around 21% suffered from acute respiratory infection. (ARI) The proportion of families seeking care from a trained provider for children with ARI was only 20% in 2004, compared with 27% in 1999-2000 (BDHS 2004).

In 1998, the GoB, with the experiences gained through implementation of various health programmes like EPI, ARI and Control of Diarrhoeal Disease (CDD), adopted the Integrated Management of Childhood Illnesses (IMCI) strategy, to reduce child mortality and morbidity. Between 2001 and 2003, the GoB piloted the implementation of IMCI interventions in 3 upazillas. Experiences were carefully documented. The Government also agreed to participate in the WHO Multi-Country Evaluation of IMCI Effectiveness, Costs and Impact. In February 2003, those involved in the pilot, concluded that the IMCI strategy was feasible and effective to address the needs of children in Bangladesh, and recommended that the Government make provisions for rapid scaling up (GoB/WHO Report of the review of early implementation of IMCI, February 2003). By December 2004, IMCI interventions were introduced in 48 new upazillas. The Government of Bangladesh is committed to accelerating the implementation of IMCI, as a key strategy to reduce childhood mortality. IMCI has been included in the

proposed Health Nutrition and Population Sector Program. Functional arrangements have been made to merge previous ARI and CDD programmes into the guide for the implementation of IMCI.

**Nutritional status:** Data from BDHS 2004 show that 43% of Bangladeshi children under-five are short for their age or stunted, while 17% are severely stunted. The prevalence of stunting increases with age from 10% of children under six months of age, to 51% of children aged 48-59 months. Additionally, 13% of the Bangladeshi children are seriously underweight for their height, or wasted, and 1% are severely wasted. The wasting peaks at age of 12-23 months with around 24% of under-fives in that age group diagnosed as suffering from wasting. The proportion of young child with wasting decreases after 23 months of age, and is 10% for children aged 48-59 months. Forty eight per cent of children are considered under weight (low weight for age), and 13% are classified as severely underweight (BDHS 2004).

## Health care delivery systems for maternal, newborn and child health

The Ministry of Health and Family Welfare (MOHFW) is responsible for health policy formulation, planning and decision making at the macro level. Under MOHFW, there are two implementation arms: the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The DGHS is responsible for implementation of all health programmes and providing technical guidance to the Ministry. The DGFP is responsible for implementing Family Planning (FP) programmes and providing FP related technical assistance to the Ministry.

Most of the country's health infrastructure and health service system are under the government's management and control. At the local level, 3,275 Union Health and Family Welfare Centres (UHFWCs) exist to serve the 4,470 unions. Additionally there are upazila health complexes, with 31 beds in 391 rural upazilas, 64 district hospitals, 13 government medical college (MC) hospitals, 6 postgraduate hospitals and 25 specialized hospitals. A further 64 Maternal and Child Welfare Centres (MCWCs) have been established to provide maternal services at the district level (MOHFW 2000). In addition, the

government recently undertook an initiative to construct a community clinic (CC) at the village level, one CC for every six thousand population.

The health service delivery system in the public sector is divided into primary, secondary and tertiary levels. Table 2 provides a summary of the level of care and type of facilities available at every level of public administration in the country.

**Table 2:** Level of care and type of health facility

Level of care	Administrative unit	Health facility
Tertiary level	Division or national/capital	Teaching hospital/institute (16), 250-1050 beds each
Secondary level	District	District hospital (59), 50-150 beds each Maternal and child welfare centres (MCWCs) (64) have 13 beds
Primary level	Upazila	Upazila health complex (397), 31 beds each
	Union	Union health and family welfare centres (3275)

Source:Rahman, Syed Azizur, 2003

Besides the public sector, the private for-profit providers, and private not-for-profit groups or non-government organizations (NGOs), also play large roles in the Bangladesh health sector. NGOs are mostly involved in the provision of primary health care, in both rural and urban areas. A significant number of tertiary hospitals are run on a not-for profit basis. NGOs run a total of 613 health facilities, which have a total of 11,271 beds (BHB 1998-99).

The MCWCs, established mainly at the district level, provide the only maternal and child health services under the direct control of Directorate of Family Planning. These facilities are expected to be equipped to provide basic essential obstetric care and obstetric first aid. The district hospitals (DHs), in the district headquarters, provide maternal services through an outpatient consultation centre and labour ward. Between 25-40% of hospital beds are reserved for maternal patients in every hospital. Many of the DHs are not providing 24 hour essential and emergency obstetric care (EOC) services, due to lack

of trained staff and other support-facilities. Similarly, more than 80% of the upazila health complexes are not ready to provide 24 hour EOC services.

The child health and nutrition component of the essential services package (ESP), includes, the control of vaccine preventable diseases through the EPI programme, management and control of acute respiratory infections (ARI), childhood diarrhoeal diseases and administration of vitamin A capsules. All component of ESP are being provided at all levels of the health care delivery system.

## Human resources for maternal, newborn and child health

With a view to reducing the maternal and child mortality and morbidity, comprehensive programme efforts have been made over the past years through increasing access to health care services, with special emphasis on human resource development. Maternal and child health (MCH) services have been given highest priority in the health system. Maternal and child health services are provided through the countrywide facility network as described in Table 2.

At the community level the maternal and child health care (MCH) services are provided by the family welfare assistants (FWAs) and health assistants (HAs). At the union level a family welfare visitor (FWV) and a sub-assistant community medical officer, or medical assistants, are mainly responsible for providing MCH services. There are also 250 graduate medical officers posted in 3,275 UHFWCs for providing MCH services (Rahman 2003). FWV trainees, secondary school certificate (SSC) pass graduates, undergo an 18-months training course in one of the 12 FWV Training Institutes. On completion of the training they receive midwifery registration from the Bangladesh Nursing Council.

At the upazila level, the MCH unit of the upazila health complex (UHC), headed by a graduate medical officer who is responsible for providing MCH services. There is also a position of junior consultant (gynaecological), who provides services in case of emergencies, attends all births at the UHC and all referred maternal patients. In addition the FWAs will mainly conduct specific services related to family planning. Nursing and midwifery care is provided by senior staff nurses (SSN). Most of the female senior

staff nurses have also undertaken a 1-year midwifery programme. The activities of the MCH unit and other maternal health care services, are supervised by the Upazila Health and Family Planning Officer in the UHC.

Medical assistants (MAs) (SSC graduates) receive a four-year course in basic health care, EPI, antenatal, postnatal and intranatal care, childhood illness, and general health services. The Director General of Health Services (DGHS) is responsible for delivering this training service through 8 institutes located across the country.

Family welfare visitors (FWVs) are the female paramedics in the national programme. One FWV is posted in each union. They are also posted in the Maternal and Child Welfare Centers (MCWC) and the Maternal and Child Health (MCH) unit of the Upazila hospitals. They are involved in providing antenatal check-ups and in conducting normal births, besides providing curative treatment and contraceptives.

Senior staff nurses receive a four year programme of which 1 of the specialities that can be taken is a 1-year course midwifery. In the non-government sector, Bangladesh Red Crescent Society is providing a 1-year programme on midwifery to young women who do not have a nursing qualification. This training is mainly related to normal (uncomplicated) antenatal, intra-natal and postnatal care.

In addition to the above mentioned formally trained health providers, there are a large number of traditional healers in Bangladesh who have considerable influence on local health care practices. Homeopathy and traditional medicines, such as Ayurvedic, Unani etc. are very commonly practised. The GoB has taken up a project to develop the indigenous system of medicine. There are 2 public and 10 private Unani teaching institutes, one public and 5 private institutes for Ayurvedic and for Homoeopathy there are one public and 24 private teaching institutes (Table 3).

## Providing skilled attendant for care at birth – a major challenge

In Bangladesh, almost 90% of births take place at home, mostly attended by women living in the neighbourhood called Dais, or traditional birth

**Table 3:** Number of Unani, Ayurvedic and Homeopathic practitioners

Type of practitioner	Type of practice	Number
Practitioners with certificate	Unani	8,000
	Ayurvedic	6,000
	Homeopathy	16,000
Practitioners without certificate	Unani	30,000
	Ayurvedic	12,000
	Homeopathy	8,000

Source: Bangladesh Health Bulletin, 1998-99

attendants (TBAs). In the late 1970s the Government initiated a TBA training programme with an ultimate goal of providing one trained TBA for each of the 68,000 villages, to help reduce maternal deaths. However, contrary to the expectations, no significant decline in maternal mortality occurred. Moreover, several studies have since shown that the trained TBAs were not attending sufficient proportion of births in the communities. Consequently, the government and the development partners abandoned TBA training.

Having abandoned TBA training, the Ministry of Health and Family Welfare piloted a six-month competency based programme to develop a community based Skilled Birth Attendant (SBA- at a level of auxiliary midwife). The training programme was piloted in 6 districts from March 2003 to August 2003. WHO and UNFPA Bangladesh provided technical and financial support for this new programme, while the Obstetrical and Gynaecological Society of Bangladesh (OGSB) provided additional operational technical assistance. Ninety basic health workers (FWA and Female HAs) were trained at district level in selected essential midwifery skills and abilities (WHO 2004). The training aimed to enable them to provide antenatal care, conduct normal home births, postnatal care and newborn care, and also to identify early and refer obstetric complications. FWA and FHAs having minimum SSC with  $\geq$  two years experience in basic or family welfare health services and residing in the place of posting were selected for the training. The trainees were evaluated through examinations and certified and registered by Bangladesh Nursing Council as SBA (community auxiliary midwife). The evaluation of the pilot programme showed that the SBAs are making a significant contribution to

increasing the proportion of births by a trained health provider. On average, each SBA performs 3-4 births per month, it is believed that this could easily be raised to 5 or 6 with further strengthening of the field programme. MOHFW had decided to scale up this training programme, and also importantly, to simultaneously establish a supervisory mechanism and accreditation system for the training programme. Consideration is being given to increasing their capacities to be able to offer obstetric first-aid so that they can comply with the international definition of SBA.

## Improving maternal and child health through health policy

In 1998, the Sector Wide Approach (SWAp) was adopted in the health and population sector. The GoB developed the *Health and Population Sector Strategy* (HPSS) in consultation with development partners. Subsequently, the *Health and Population Sector Program* (HPSP) was formulated.

Implementation Plan (PIP) of HPSP was also put in place from July 1998. The major component-wise outcomes of the programme were:

- ▶ Essential Service Package defined, funded, promoted and implemented
- ▶ Services delivery mechanism unified, restructured and decentralized
- ▶ Integrated support systems strengthened
- ▶ Hospital-level services focused and improved
- ▶ Policy and regulatory framework strengthened
- ▶ Strengthening Public Health services.

The Fifth Five-Year Plan (FFYP) (1997-2002) of the GoB was formulated in 1998, and aimed at creating a greater degree of public awareness of the population issue through a social movement, in order to reach replacement level of fertility by the year 2005. The focus of the FFYP was on a reproductive health sub-programme, which aims at extending the coverage of reproductive health services, including efforts to improve safe motherhood, quality obstetric care, clinical methods of contraception and the management of RTIs and STIs. Issues of gender equity and equality and reproductive rights were introduced in the programmes of education, law enforcement,

religious affairs, the garments and tea plantation industries and other sectors. The FFYP also completed a phased programme to upgrade a network of 64 Maternal and Child Welfare Centers (MCWCs) to ensure they have the needed equipment and training staff in EmOC so that these can offer a package of comprehensive maternal health service.

The HPSP came to an end on 30<sup>th</sup> June 2003. In order to encompass all the activities of the health sector, the GoB has revised the HPSP and formulated the new “Health Nutrition and Population Sector Program” (HNPS) (2003-2006). The vision and targets outlined in the Interim Poverty Reduction Strategy Paper (i-PRSP) have been taken as an overarching long-term policy framework and a signal of the political commitment of the Government.

The goal of the HNPS is the sustainable improvement of health, nutrition and family welfare status of the country’s population, especially the vulnerable, e.g., the poor, women, children and the elderly. The purpose of HNPS will be to increase the availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package, plus other selected services. The priority objectives of this effort are to achieve the targets set in the Millennium Development Goals.

### Financing healthcare

The healthcare sector in Bangladesh is mostly financed by private households. The Bangladesh National Health Accounts, 1996-97 estimates that around 63% of the total healthcare expenditure of the country comes from households. The rest are divided among MOHFW, NGOs, donors, non-profit organizations and others.

**Table 5:** Source of financing in healthcare sector in Bangladesh

Source	Percentage
Private households	63
MOHFW budget	31
Non profit, NGOs, donors	3
Other public revenue	3
Firms and private insurance	0.04

Source: Bangladesh National Health Accounts, 1996-97

The Government of Bangladesh has allocated around 3% of the total national budget to the health sector. The per capita allocation comes to only US\$3.6. In total, the government health sector expenditure during 1995-96 stood at \$374 million, which was up from \$102 million in 1985-86 (MOHFW 1995). The total expenditure of the Ministry of Health and Family Welfare during the 1998-2003 periods has been estimated at US\$3,373.20 million (including development assistance) (BDHS 2004).

### Implementation and operational constraints

Under the HPSP, the major service delivery issue at the community level has been a shift away from domiciliary services, to static clinic services. This has affected the functioning of the Family Welfare Visitors and Health Assistants. Fears were expressed that such changes in the service delivery system would adversely affect use of contraceptives and that many women would drop out from house delivery contraceptive acceptance and move to the private clinics (Khan et. al. 2000).

The BDHS Survey 2000 (BDHS 2001) shows that 80% of women feel that not having a health care facility nearby is an obstacle to accessing health care. About half the women mention that lack of confidence in the services, and physically going to the health centre, present problems in accessing women’s health care. Seventy one percent of women said that getting money for treatment and 44% said that permission to go for health care are obstacles in access to health care. Almost two-thirds said that not knowing where to go is a major obstacle in accessing care.

In order to overcome the implementation and operational constraints, ICDDR,B (2002) has identified the following priority action areas for improving reproductive and child health:

- ▶ Improving emergency and essential obstetric care and ensuring safe motherhood
- ▶ Improving family planning services including developing services for men as well as women
- ▶ Prevention and treatment of STI/RTI/HIV/AIDS

- ▶ Minimizing the need for and improving post-abortion care
- ▶ Developing programmes to increase male involvement in reproductive health
- ▶ Improving newborn care, and
- ▶ Understanding the issue of violence against women in the social context and development of public health strategies to reduce violence against women.

Other factors contributing to the operational constraints are, unfavourable doctor to nurse ratio (which is 2:1, the internationally accepted standard is 1:3); non-availability of trained nurses and paramedics in required numbers; low coverage (especially in the urban slums and inaccessible rural areas); lack of an institutional mechanism to bring the very poor and vulnerable people within the ambit of health service delivery; poor attitude of the service providers towards the poor; and gender bias encouraging mothers to keep childbearing until they have a male child.

Until now in Bangladesh, tax and donor-financed supply side subsidies have been the main strategy for improving the access of poor people to health, nutrition and population services. These services are in the main through public service delivery by MOHFW, or by direct contracting of NGOs, therefore it is they, as suppliers, that receive the subsidies. The limitation of supply side subsidies is that the target group do not receive the subsidy directly. Instead they receive them from service providers. As a result, in the absence of an effective exemption system, in many cases such efforts are often poorly targeted and fail to achieve the objective.

Additionally, the continuing low status of women in Bangladesh society, along with the low priority given to women's health, have a severe impact on maternal and child health. Social and cultural changes are needed before the obstacles to seeking healthcare by women start to disappear. According to UNICEF (UNICEF 1999) as many as 27 different types of superstitions have been identified in Bangladesh which are harmful in achieving healthy and safe motherhood. The social taboo in some places on feeding the newborn with breast milk deprives the infant of much needed colostrum. In Bangladesh there are many social practices which take place

during the actual time of birth. Some of these delivery-period practices are potentially harmful, and are likely to contribute to postpartum morbidity. The common harmful practices during pregnancy and childbirth include:

- ▶ Internal manipulations and massage
- ▶ Introduction of oils into vagina
- ▶ Use of fundal pressure or tight abdominal bands during labor
- ▶ Pulling on the umbilical cord
- ▶ Choking or inducing vomiting in the mother to expedite placental delivery
- ▶ Not using uterine massage to prevent and treat postpartum haemorrhage.

Culturally, hospitalization of women is not considered important and pregnancy is not looked upon as a risky event. These perceptions lead to increased maternal mortality and morbidity rates.

Finally, the under-15 age population constitutes above 40% of the total population, which is high. This has serious implications for the continuing population growth rate due to "population momentum" and will impact on future demands on the country's infrastructure, including health.

## Best practices/innovations to improve maternal, newborn and child health

Bangladesh has made substantial progress in the health and population sector in recent times, particularly in reducing fertility and child mortality, and in increasing the coverage of health and family planning services to the people.

The most dramatic achievements in child health has been the children's immunization, which has greatly augmented the chances of their survival. About 73% of Bangladesh children can be considered to be fully immunized. Although the level of coverage for BCG and the first two doses of DPT and polio is around 90 percent, the proportions who go on to complete the third dose of these two vaccines fall to 81 or 82 percent, while a much lower percentage (76%) receive the measles vaccine. Only 3% of children aged 12-23 months have not received any childhood vaccine (BDHS 2004).

Introduction and implementation of Integrated Management of Childhood Illnesses (IMCI) is also playing an important role in child survival. IMCI was introduced in 2001, with the objective to reduce the morbidity and mortality associated with major childhood diseases and conditions, and to promote child growth and development by preventing diseases and promoting healthy practices. By the end of 2004 IMCI has been expanded in 48 upazillas. From 2005 to 2007, the pace of expansion of IMCI should triple to engage 50, 70 and 100 new upazillas in each respective year. By the end of 2007, 265 upazillas will be implementing IMCI activities. The overall aim is to initiate IMCI activities in all 470 upazillas by the end of 2010, and to reach full coverage of implementation in the period 2010-2015.

Limited experiences on community financing schemes show that they can empower the users of services to demand more and better services from a range of providers in the public, private and NGO sector.

Finally, all the relevant ministries of the government are represented in the National Population Council, the highest policy making body headed by the Prime Minister. The Government has also formed a National Council for Women's Development and a National Committee for the Implementation of the Program of Action of ICPD. These Committees have the potential to build a shared vision and define areas and actions for improvement of maternal and child health in Bangladesh.

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