Review Articale

An Assessment of Government Health and Nutrition Programmes for Women and Children in Bangladesh

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Introduction

According to recent estimates, there are one billion absolute poor in the world and half of them are women. Most of these impoverished women live in the less developed countries of the world and they suffer from various diseases and malnutrition. The incidence of maternal mortality is also high among them. Poor status in maternal nutrition is responsible for infants' low birth weight. According to World Health Organization estimates, 21 million low birth weight infants are born in the world each year.[1] Most low birth weight babies are born in the third world. Low birth weight babies are likely to die of infectious diseases and those among them who survive the initial danger generally suffer from malnutrition and diseases.

Policy-makers, health practitioners, and nutritionists in the third world are aware of the situation with respect to health and nutrition of women and children, particularly in the poorer section of the society. Policies are made and programmes are implemented in the less developed countries to provide health care services for women and children. The question is how far women and children benefit from government health and nutrition programmes? The present paper evaluates government health and nutrition programmes in Bangladesh, particularly the programmes for women and children.

Health and Nutrition Situation in Bangladesh

Bangladesh is one of the poorest countries of the world with a population of 110 million in an area of 56,000 square miles (144,000 square kilometers). Population density in Bangladesh is the highest in the world—2,100 person per square mile (821 person per square kilometer). More than 80% of the population live in the rural area and are dependent on agriculture.[2] Fifty percent of

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the rural population are landless and about 80% of the population live under the proverty line[3]. The per capita income is Tk. 6,000 (US $150) per annum.

The Nutrition Survey of Rural Bang-ladesh in 1982 revealed that 76% of all rural households were calorie deficient and about 48% were protein deficient[4]. People living in the poorer families are generally the victims of malnutrition and diseases, and within these families women and children are more vulnerable. Health care in Bangladesh is poorly developed and concentrated in the urban areas.[5]

The effect of women's malnutrition and undernutrition is manifest in the form of anaemia, low resistance to disease and maternal mortality. Malnutrition and undernutrition are also the major cause of infant mortality.[6] According to a World Bank document,[7] Bangladesh has the severest malnutrition problems in the world, because 68 per cent of the children under five years are highly or moderately underweight, 64 percent of them are severely or moderately stunted and 17 percent are suffering from wasting. The rate of infant mortality in Bangladesh is 88 deaths per 1,000 live births[8].

Health and Nutrition Programmes in Bangladesh

Since the emergence of Bangladesh as a new country in 1971 the govern-ment's policy objectives in health care services have been to provide a minimum level of health services for all. To achieve the objectives, government efforts were directed toward construction of health care facilities (hospitals, dispensaries, and clinics for outpatient care) and training of health care workers. The Ministry of Health and Family Welfare is responsible for develo-ping, coordinating and implemen-ting the national health, maternal and child health care and the family planning programmes.

Health care system was designed to consist of three levels of infrastructures :

Level 1. (1) Union Health and Family Welfare Center, which provi-des the first contact between people and the health care system and is the nucleus of primary health care delivery.

(b) Thana Health and Family Welfare Centre.

Level 2. District Hospitals in the district head-quarters.

Level 3. General and Specialized Hospitals attached to medical colleges and in other urban areas.

A distribution of health care facilities under different levels mentioned above is shown in Table 1.

Table 1. Distribution of healthcare facilities in Bangladesh (1992)

Thana Health Complex	400
Rural Health Centre	12
Union Sub Centre	1362
Post-Graduate Hospital	5
District Hospital	60
T.B. Hospital	4
T. B. Segregation Hospital	8
Infectious Diseases Hospital	5
Leprosy Hospital	3
Urban Cispensary	35
T. B. Clinic	44
School Health Centre	25
Maternity and Child Welfare Centre	96

Soruce : BBS - 1993 Statistical Year Book of Bangladesh.

An average of 3.7% of total government expenditure per year during the period between 1972 and 1976 was spent for medical facilities[9]. Government expenditures on human development, which includes health and populations, has been increased since 1976. On average 13.5% of public expenditure had been on human development, and 40% of this expenditure has been allocated to health and population.[10]

Health care programmes were focused mainly on curative services, but beginning in the mid-1980s the nature of services has been changed toward a larger role for prevention. The government's main preventive health programme—the Universal Immunization Programme was initiated in 1986 with the assistance of the World Health Organization and the United Nations Children's Fund in eight Thanas. The aim of this programme was to provide protection for children under two years of age through immunization against major diseases like diphtheria, pertussis, tetanus and poliomyelitis. This programme also aimed at the protection for women of childbearing age against tetanus. In addition to the new Immunization programme, the government strengthened the already existing immunization programmes against small pox, eradication of malaria and the control and treatment of diarrheal diseases.

Maternal and child health care services have been provided at the maternity clinics of the hospitals in the urban areas and at the Union and Thana level Health and Family Welfare Centers in the rural areas. Maternal care in the rural areas is provided largely through the informal system of traditonal birth attendants. A programme for the training of traditional birth attendants began in 1978 but it was stopped in 1982. This training programme was reinstated in 1984.[11]

Planning and implementation of nutrition programmes is the responsiblity of the Ministry of Health and Family Welfare. Except for the programme on the distribution of Vitamin A capsules through the hospitals and the Union and Thana level Health and Family Welfare Centres, no other specific nutrition programme has been implemented to date. However, the government has upgraded its nutrition policy-making capacity by creating the National Nutrition Council in 1988.

Evaluation of Health and Nutrition Programmes

Bangladesh has achieved the objective of constructing health care infrastructure. By 1980s, there were basic health care infrastructures in Bangladesh.[12] But the main dangers to health in the 1980s were still much the same as they were at the time of independence in 1971. Even in the late 1980s, the incidence of communicable diseases was extensive and there was widespread malnutrition.[13] Table 2 shows a percentage distribution of deaths due to different diseases as found in a mid-1980 survey. According to another source, potentially avoid-

Table 2. Distribution of deaths in Bangladesh by disease in 1992

Disease	Number of Deaths
Diarrheal disease	2477
Whooping Cough	7
Diptheria	5
Dysentery	419
Tetanus	67
Measles	5

Source : BBS - 1993 Statistical Year Book of Bangladesh.

able illnesses (tetanus, pertussis, measles and diarrhea) accounted for nearly 50% of infant death and over one third of childhood deaths in the mid-1980s.

Only 30% of the population had access to primary health care services, and overall care performance remained unacceptably low by all conventional measurements.[14] Until the mid-1980s, only 3% of children received immunization against common infectious diseases.

The implementation of health care programmes was limited by severe financial constraints, insufficient programme management and supervision, personnel shortages, inadequate staff performance, and insufficient numbers of buildings equipment, and supplies[15]. Mother and child health services have been neglected, although there was specific programme designed for such services. In the mother and child health care services programme, Family Welfare Assistants in the rural areas have been entrusted with the responsibility of identifying pregnant women in the rural areas and refer them to the family Welfare Vistitor for antenatal care and to the Health Assistant for tetanus immunization. But these activities were rarely performed. The implementation of this programme was hindered by lack of supervision of activities performed by the health workers.

Maternal services were also limited in the urban areas. Both the number of maternal service centers and the services provided in the urban areas were inadequate. The number of health workers to provide services for children in the urban areas was insufficient. In Dhaka city, for example, there are only 180 municipal health workers with the responsibility of immunizing the estimated target population of 315,000 children less than two years old, providing Vitamin A to one million children less than six years old and providing oral rehydration treatment in case of diarrheal diseases.

Malnutrition remained a pervasive and widespread problem. Children under five years of age and pregnent women were affected most seriously. According to 1981-82 National Nutrition Survey, over 60% of all children under five years of age were estimated to be moderately or serverely malnourished by accepted international standards. The greatest prevalence of acute malnourishment was 61% among rural children in the weaning age between one and two years, and chronic malnutrition was 75%

among children between four and five years.

Women and children in the impoverished families could have been saved from the danger of death and suffering by improving their nutritional status. But there was lack of strategies for dealing with problems of malnutrition and institutional arrangements for implementing nutrition programmes. Food security is the main pre-requisite for ensuring the minimum level of nutrition for the poorer families. But the nutrition programme failed to provide any help in this respect.

However, the poor and landless women in the rural areas received help from two programmes, Food-for-Work and Vulnerable Group Feeding, planned and implemented by the Ministry of Relief and Rehabilitation. Over 600,000 of the most distressed and vulnerable women are being reached each year by these programmes. These women are provided with employment and food. In addition, the participants are given training in basic health and literacy. According to mid-1980 surveys, these programmes have been successful in reaching the target group. The incomes of beneficiary households increased. With an increase in income, their expenditure on health care, housing, cereals and proteins increased.[16]

Strategies adopted by one Non-Government Organization (NGO) - Grameen Bank - to help rural poor women to increase their income and living standard was found effective in improving their health and nutritional status. The primary objectives of Grameen Bank is to raise income of the disadvantaged sections, including women, through providing access to credit and other resources. Eighty-six percent of the recipient of Grameen Bank credits are women. A social development programme has been incorporated into the credit programme. Under this programme, women are given training in nutrition and maternal health and child care. As a result, there has been improvement in the health and nutritional status of the participating women and their children[17].

Need for Health and Nutrition Programme for Women and Children

Women and children of Bangladesh, particularly those in the poor and landless families in the rural areas, deserve special attention. Women in the poorer families are malnourished primarily because of inadequate diet. The income of such families is generally insufficient for

providing the required food for all the family members. Women receive less adequate diet than men, because the intra-family food distribution favours adult men against women and young children. Illiteracy and food faddism prevent women from the consumption of good sources of proteins and calories.

Women's health and nutritional status is related to their children's health and nutritional status. Short birth intervals deplete mothers nutritionally and result in low birth weight babies. Children's health and nutritional status is affected by poor weaning practices and inadequate diet during the most critical period of their development. In Bangladesh, approximately 250,000 children die each year from malnutrition and dehydration linked to diarrheal infections, and about 20,000 become blind. Almost 50% of the surviving children are physically stunted by the age of four years.[18]

Conclusion and Recommendations

It is evident that government of Bangladesh has made efforts to help people improve their health and nutritional status. Policies were made and programmes were implemented towards this end. Programmes were implemented specifically for women and children. Government attempts are appreciable. But programme accomplishment have been insufficient to improve the situation significantly.

It will be difficult for Bangladesh to make further improvement because of an ever-increasing population, limited funds for implementing programmes, poorly trained manpower, inefficiencies in the use of existing resources, and weak institutional capacity to formulate and implement programmes. Therefore, the most important task is to find out the reasons for failure of the already existing programmes and make necessary corrections. More work is needed to strengthen the existing mother and child health care programme and to develop new approaches. Considerable improvements in the supervision and performance of the health workers will be necessary for proper functioning of this programme.

Nutrition programme will have to be coordinated with food security programme. Institutional arrangements should be made for implementing food and nutrition programmes. Monitoring and evaluation should be included in the programme design.

The NGOs should be encouraged to get involved in more programmes. However, government activities

should be coordinated with the NGO activities to minimize duplication of efforts. The role of NGOs should be defined clearly and their performances should be evaluated, supervised and monitored.

References

1. Ghassemi. H. Women, Food and Nutrition-Issues in Need of a Global Focus. An Administrative Committee on Corrdination/Subcommittee on Nutrition. Women and Nutrition Nutrition Policy Discussion Paper No. 6. United Nations, 1990; 146.
2. Islam N. Development strategy of Bangladesh. Pergamon Press. Oxford. 1978; 2.
3. Administrative Committee on Coordination/Subcommittee on Nutri-tion. Recent Trends in Nutrition in 33 Countries. Section on Bangladesh. United Nations. 1989; 106.
4. Quanine J. Women and nutrition : Grameen Bank Experience. An Administrative Committee on Coordination/ Subcommittee on Nutrition. Women and Nutrition. Nutrition Policy Discussion Paper No. 6. United Nations, 1990; 109.
5. Alamgir M. Poverty and income distribution in Bangladesh : Evidence and Policies. Harvard Institute for International Development Paper. Harvard University, Cambridge, M. A. 1981; 45.
6. Hartman B, James K. Needless Hunger : Voices From a Bangladesh Village. Institute for Food and Development Policy. San Francisco, C. A. 1979; 9.
7. World Bank Bulletin. 1993.
8. Bangladesh Bureau of Statistics. Statistical Yearbook of Bangladesh 1993; 62.
9. Alamgir M. *op. cit.*
10. World Bank Bulletin *op. cit.*
11. *Ibid.*
12. *Ibid.*
13. Heitzman J. Worden RL. Bangladesh : A Country Study, Library of Congress, Federal Research Division, 1989.
14. World Bank Bulletin *op. cit.*
15. Heitzman J. Worden RL. *op. cit.*
16. World Bank, *op. cit.*
17. Quanine J. *op. cit.*
18. World Bank, *op. cit.*