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MINISTRY OF HEALTH AND FAMILY WELFARE

Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP)

2011 to 2016

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ALRI/ARI	Acute (Lower) Respiratory Infection
ANC	Antenatal Care
APR	Annual Program Review
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guerin (Tuberculosis)
BINP	Bangladesh Integrated Nutrition Programme
BWHC	Bangladesh Women's Health Coalition
CAR	Contraceptive Acceptance Rate
CBR	Crude Birth Rate
CC	Community Clinic
CDR	Crude Death Rate
CIET	Community Information & Epidemiological Technologies
CMMU	Construction & Maintenance Management Unit (MOHFW)
CPR	Contraceptive Prevalence Rate
CHT	Chittagong Hill Tracts
CHTDF	Chittagong Hill Tract Development Facilities
CHSW	Community Health Services Worker
DDS	Drug and Dietary Supplement Kit
DGFP	Director – General (Family Planning)
DGHS	Director – General (Health Services)
DH	District Hospital
DHS	Demographic and Health Survey (Macro International)
DP	Development Partner
DPA	Direct Program Aid
DPT	Dipteria/Pertussis/Tetanus
EIS	Epidemiological Information System
ELISA	Enzyme Linked Immuno Sorbent Assay
EmOC	Emergency Obstetric Care
EOC	Essential Obstetric Care (Basic / Comprehensive)
EPI	Expanded Immunization Program
ESP	Essential Services Package
FP	Family Planning
FPHP	Fourth Population and Health Program
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
GOB	Government of Bangladesh

HA	Health Assistant
HDS	Health and Demographic Survey (BBS)
HEU	Health Economic Unit
HIU	Health Information Unit
HIV	Human Immuno-deficiency Virus
HKI	Helen Keller International
HPSP	Health and Population Sector Program
HRD	Human Resource Development
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDU	Injecting Drug User
IEDCR	Institute for Epidemiology and Disease Control and Research
IMCI	Integrated Management of Childhood Illnesses
IPH	Institute for Public Health
IST	In-Service Training
IUD	Intra Uterine Device
LD	Line Director
LE	Life Expectancy
MAU	Management Accounts Unit (MOHFW)
MCWC	Maternal and Child Welfare Centre
MICS	Multiple Indicator Cluster Survey (UNICEF)
MMR	Maternal Mortality Ratio *(Number of maternal deaths / 1000 live births)*
MMRate	Maternal Mortality Rate *(Number of maternal deaths / 1000 women aged 15-49 years)*
MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTR	Mid Term Review
NCES	National Coverage Evaluation Survey (for EPI)
NGO	Non Governmental Organization
NID	National Immunization Day (for Polio vaccination and Vitamin A)
NIPHP	National Integrated Population and Health Program (USAID)
NNP	National Nutrition Programme
OBGYN	Obstetrics and Gynecology
ORS/ORT	Oral Rehydration Salts / Oral Rehydration Therapy
PFC	Project Finance Cell
PIP	Program Implementation Plan
PM	Program Manager
QA	Quality Assurance
RHF	Recommended Home Fluids (to treat diarrhoea)
RIBEC	Reform in Budgeting and Expenditure Control Project
RPA	Reimbursable Program Aid
RTI	Reproductive Tract Infection
SDS	Service Delivery Survey
SM	Syndromic Management
STD	Sexually Transmitted Disease

STI	Sexually Transmitted Infection
SW	Sex Worker
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFIPP	Thana Functional Improvement Pilot Project
TFR	Total Fertility Rate
THC	Thana Health Complex
THNNP	Tribal HNP Plan
UHFP	Union Health and Family Planning
UHFWC	Union Health & Family Welfare Centre
UMIS	Unified Management Information System
UNICEF	United Nations Children's Fund
UPHCP	Urban Primary Health Care Project
USAID	United States of America International Development
VA	Verbal Autopsy
VGD	Vulnerable Group Development Programme
VRS	Vital Registration System
WHO	World Health Organization

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1. Introduction

In Bangladesh there are about 45 different tribal groups spread across the country. The proportion of the tribal population in the 64 districts varies from less than 1% in majority of the districts to 56% in Rangamati, 48.9% in Kagrachari and 48% in Bandarban in the Chittagong Hill Tracts (CHT)[1]. The tribal groups belong to different ethno-lingual communities, profess diverse faith, have unique cultures which is different to mainstream culture and are at varied/different levels of development (economically and educationally). Most of them inhabit in hard to reach areas such as hilly terrains or the forest areas where access is generally difficult. Moreover, many of these tribal groups are also characterized by slow/low growth rate compared to the mainstream population.

Recognizing the specific social, cultural, economic and special factors that need to be taken into account for improving both service delivery and quality of life in tribal areas, the Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh (GOB), made provisions in the Tribal Health Nutrition and Population Plan (THNPP) 2004. This THNPP of 2004 was to be implemented during the ongoing health sector program (Health, Nutrition and Population Sector Program, HNPSP)[2]. The core strategies advocated by the THNPP 2004 were to have a 'Tribal/Ethnicity Sensitive' and a 'Participatory Implementation' approach to health, nutrition and population (HNP) services in the tribal areas. During the midterm review of the HNPSP it was observed that the implementation progress of THNPP 2004 was very limited and in order to speed up the process a Tribal Health Plan Committee and a Task force for implementation were setup. The report produced by the Task Force provided important insights into how to deliver services among tribal/ethnic community, strategic action plan and a tentative budget. Even though HNPSP has made some satisfactory improvements overall, very little progress has been made in the implementation of THNPP between 2005 and 2011, except for the UNDP CHTDF initiative in 15 Upazilas of the CHT..

Due to the variations (in terms of culture, socio-economic situation) across the different tribal/ethnic groups, GOB recognizes the need to approach these communities differently in order to ensure that the health care delivery system is accessible and acceptable to them. The Government is committed to have a more targeted approach for the tribal/ethnic communities in order to achieve better outcomes. As a result of its firm commitment to improve the status of tribal/ethnic communities and honor the various international (Millennium Development Goals) and national goals (Vision 2021), MOHFW under its new sector program Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016 is making provision to implement HNP services to the tribal/ethnic communities through this THNPP 2011. In line with the past plan the focus of THNPP 2011 would be on participatory planning implementation, tribal/ethnicity sensitive service delivery and will take a multi-pronged approach (including learning from past challenges) to address HNP problems. This Plan promotes the idea that health care service should be area specific and need based. Since the tribal/ethnic groups are distributed

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[1] Implementation of Tribal Health, Nutrition and Population Services Plan (2008)

[2] HNPSP is a USD 5.1billion GOB led program of which development partners' contribution amounts to USD 1.2billion. HNPSP implementation in scheduled in end in June 2011.

in varying proportion, characterized by diverse social, cultural, economic situations and are at different stages of development a need based approach in geographically contiguous areas would be appropriate.

2. Rationale for THNPP

Centrally administered projects/programs designed on a nationwide basis provide HNP services across the country. Additional components such as satellite clinics, EPI, family welfare outreach activities, and nutritional centers provided within the framework to improves service delivery. Whilst such an approach was useful in taking the service close to patients/consumers, utilization of services remained low for various other reasons, arising out of behavioral aspects of provider and users. Organic growth of services, in response to perceived importance of certain issues, resulted in less attention to quality of services, HRD, equity and sustainability. Difficult terrain, locational disadvantages of health facilities, non-availability of service providers, lack of appropriate HRD policy to encourage /motivate service providers to work in remote areas and weak monitoring and supervision systems are some of the barriers to access. Lack of information on tribal/ethnic groups, especially their HNP status, health-seeking behaviour, and needs (health, population, nutrition, and communication) limits the utility of any interventions planned. Formation of NGOs/CBOs by tribal/ethnic groups has been slow or non-existing in tribal/ethnic areas. All these point to the relevance of developing Culturally and Linguistically Sensitive Services (CLSS), which take into account location specific situation and needs of the people. Such a plan would, therefore, depend on decentralized mechanism with broad directives and guidelines. Adequate provision of resources, capacity building and reviewing of existing modalities of service provisions become imperative. Understanding the specific cultural practices and differences is imperative for evolving a suitable framework to provide appropriate health service delivery to all communities in tribal/ethnic areas.

In CHT a CLSS would ensure that non-tribal concerns are also addressed. In addition, tribal/ethnic group living outside CHT might be left out and their needs would be subsumed under non-tribal population living in that area. Considering the fact that HPNSDP inherits a broad supply driven approach applicable across the regions and ethnic groups, it is important to take adequate corrective measures to make HPNSDP culturally and linguistically sensitive to serve tribal/ethnic people. Community consultation should provide basis for designing health and family welfare program, taking into account local needs and morbidity pattern as otherwise needs of ethnic groups, such as tribal/ethnic people will be over looked.

THNPP 2011 is not a standalone plan, but a component, which ensures policy makers, service providers and people at large appreciates the necessity of addressing social and cultural issues of tribal/ehtnic people while planning and implementing HNP services. One of the key thrust of this tribal/ethnic plan would be to bring about a perceptible change in providers attitude towards tribal/ethnic people and empowerment of tribal/ethnic people to enable them to participate in planning, implementation as well as policy making for improving HNP status of tribal/ethnic people and those living in tribal/ethnic area, especially at upazila level and district level, through the process of consultation and active participation in stakeholder committee at various levels.

3. Socio-economic situation of tribal/ethnic communities[3]

There are confusions regarding the estimated tribal/ethnic population in Bangladesh. As per the MOHFW, there are about 45 tribal/ethnic communities and in total there are about 2.5 million tribal/ethnic people[4]. However, according to a UNDP report in 2009[5] there are roughly 1.3 million tribal/ethnic people as of 2009. It is believed that the tribal/ethnic population ranges between 1.5-2.5 million.

According to the 1991 Census about 82 per cent of tribal/ethnic were living in rural areas and 18 per cent in urban areas. A very high proportion of tribal/ethnic people follow Buddhism (37 %), followed by Hinduism (21 %), Islam (18 %), Christianity (11 %) and other belief system (13 %) (Census1991).The data is 20 years old and needs updating. They speak a variety of languages, have their own distinct cultures and bound by their own customary laws. The largest group of tribal/ethnic people lives in the CHT, but tribal/ethnic people also live on plain land especially near in the border district. Annex A provides details of distribution of tribal/ethnic community and districts in which they are found.

3.1 Tribal/ethnic communities and diversity

Tribal/ethnic communities in Bangladesh are known for their distinct culture, belief system, economic activities, political system, customary laws, and anguages. Local beliefs and customs influence what food is consumed during pregnancy and given to newborn and children. The socio-economic needs, health-seeking behavior, perception of family planning, practices affecting nutritional intake and aspirations vary from one tribal/ethnic community to another. Reach of development programmers are not even. Same can be said of health, population and nutrition services. Tribal/ethnic women are less educated compared to their male counterparts as well as compared to national figure of 32.4 per cent as per the 1991 Census. Literacy level among various tribal/ethnic communities is also uneven. From the programme point of view diversity of tribal/ethnic community in a geographically contiguous area introduces another challenge. It would not be uncommon to find in one mouza one finds four different tribal/ethnic communities speaking four different languages, practicing four different religions, varying levels of development, variations in educational attainment and having their own sets of worldview.

3.2 Distribution of Ethnic Communities by Linguistic Affiliation

There is a high degree of variations in the languages spoken and scripts used by the tribal/ethnic communities in Bangladesh. Tribal languages belong to different language families. A distribution of the tribal/ethnic communities by language categories (d. Maloney 1984; Grierson1903) is given below. There are some tribal communities in Bangladesh as elsewhere

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[3] Due to lack of data and research, finding good quality information on all tribal groups has been a major challenge. Therefore the socio-economic baseline discussed in this section mainly focuses on CHT (where majority of the tribal people live) and information is available. By understanding the socio-economic status of the tribal population in CHT, will provide useful insights into other tribal communities living in other parts of the country.

[4] MOHFW's Strategic Plan for HPSDP 2011-2016 (January 2011), page 26

[5] Socio-Economic Baseline Survey of Chittagong Hill Tracts, UNDP 2009

who have their own written scripts. Many of these communities on contact with missionaries and non-tribal adopted other language scripts.

Language Family	Branch	Communities
Tibeto-Burmese	Bodo-Garo	Bawm, Chakma, Khumi, Khyang,Lushai, Manipuri, Marma, Mro, Pankho, Sak, Tanchangya, (Other groups: Bawm,),
		Garo, Hajong, Koch, Mrong, (Bodo) Rajbansi, Tipra Other groups: Dalu, Hadi, , Paliya, Pathor, Riang)
Austro-Asiatic	Khasi Khasir	(other group: Pnar); Munda, Santal, Other groups: Mahili, Ho)
	Dravidian Indo-Aryan Bede	Oraon, PahariaBhuimali, Bhuiya, Ganghu, ,, Kurmi, Mahato, Malia,

Note: “Other groups" mentioned in parentheses, as well as the groups listed under the Indo-Aryan language family were found in some sources, but not in the 1991 Census Report.

3.3 Socio-Economic Profile of CHT[6]

The Chittagong Hill Tracts (CHT) comprises of three hill districts, Bandarban, Khagrachari and Rangamati. The formal administrative structure of the hill district is as follows: the District is headed by the Deputy Commissioner, Upazilla by UNO and Union by UP Chairman. Moreover apart from the formal system of governance, CHT is divided into three circles: a) Chakma Circle, b) Mong Circle and c) Bhomong Circle. Each circle is headed by a Circle Chief known as *Raja*. The Circle Chiefs are entrusted with responsibility of collecting taxes and are empowered to bestow justice in accordance with customary laws of tribal/ethnic people living in their jurisdiction. The Circle Chiefs are represented at the *mouza*[7] level by a headman and at the *para*[8] level by a *karbari*. It is to be noted that the CHT Regulation1900 gives the authority of the general administration of Chittagong to the District Commissioner (DC) of GOB. The DC by law has to act with the Chiefs in matters affecting administration of the CHT. The DC has to work closely with the headmen in matters of land and revenue. For the last 20 years, there exists a Hill District Council (HDC) in each district of CHT. The Chief, Headman, HDC and the DC are entrusted with the responsibility of running the general administration. Since the 1997 Peace Accord a Hill Regional Council has been set up for over all coordination of administrative and development affairs in the region. Regional council has some legislative power but legislative role but is yet to be seen

In CHT there are about 12 ethnicities (11 indigenous and Bangalees). Essentially there are 11 ethnic multi-lingual minorities in CHT they are: Bawn/Bawm, Chak, Chakma, Khyang, Khumi, Lushei/Lushai, Marma (Maghs), Mrus/Mro (Moorangs), Pangkhua/Pankhua, Tangchangya, and Tipperas (Tipras). Anthropologists divide these three groups (*Kuki-Chin, Tripura and Arakanese)* according to their customs, religious beliefs and pattern of social organization.CHT has a population of roughly 1.3 million (UNDP 2009) and has remained outside mainstream development.

3.4 Village Profile

The average population of a *para* in general is 241 and the average number of a household in a *para* is 46.In terms of population composition, Para`s can be divided into four categories and they are a) Para with only one indigenous group, b) Para`s where only indigenous communities live and c) Para`s where only Bangalees live ,d) Para`s where both indigenous community and Bangalees live. Majority of these Para comprises of the category (a) where only one indigenous group live followed by Para where only indigenous communities live. Only in 7% of the paras IP and Bangalees live together. The condition of the roads are poor and only 16% of the villages

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[6] The socio-economic profile discussed in this section has been summarized from the 2009 UNDP report on Socio-economic Baseline survey of the Chittagong Hill Tracts

[7] Mouza: In Bangladesh, a **mouza** is a type of administrative district, corresponding to a specific land area within which there may be one or more settlements. Before the 20th century, the term referred to a revenue collection unit in a *pargana* or revenue district. The term mouza is now synonymous to gram or village.

[8] Para: The *para* in CHT is synonymous to the *village* in the plain land.

have acess to metallic roads. Average distance between para and a metallic road is 4.5 km and the average time to visit metallic road from para is one hour. Moreover, Upazilla HQ (5.7 km), Union Parishad (2.2 Km) economic hubs such as haats (7 km), UH & FWC (5.5 km) are some distance away from the average para thus highlighting the accessibility problem. Moreover in roughly 33.33% of the paras, NGO schools and government primary schools are present also interestingly secondary schools are a rarity in paras in CHT. Moreover CPR are available in 1/3 of the paras and accessible forest and river are around 2 km away from the average para.

3.5 Household Features

The average household size of CHT is 5.2 and this is higher than the national average of 4.8. Bangalees tend to have a bigger household size (5.4) than the tribal/ethnic people (5.1). Age structure in CHT is younger than that at the national level (the mean age in CHT is 23). At least 58% of the populations are below 24 and 5% belong to the age group more than 60 years. Overall 72% of the population (15+ years of age) in CHT is married. Only 7.8% of the CHT people have completed primary education while secondary school completion rate is around 2.4 %.

For about 18% of the population in CHT, cultivation/ploughing is the main occupation. *Jhum*[9] cultivation is the main source of occupation among 14% of the tribal/ethnic people. The proportion of people deriving income from salaried jobs and business is low compared to cultivation and day laborers. Roughly 25% of household members are students and 20% are senior citizens. Overall in CHT 9% of the household are female headed. Female headed household are found higher in the Bangalees than the indigenous communities.

Majority of the houses in indigenous community are either *kutcha* (temporary structure) or *machan* (built on bamboo poles). On average Bangalee households' living space was almost 18% more than the average indigenous household. Within indigenous communities, *Bawm* have the highest amount of living space and *Chak* has the least amount of living space. Roughly 91% of indigenous people and 73% of Bangalees do not possess household electricity

3.6 Land Ownership

Compared to the rest of Bangladesh there is huge diversity in type of land, ownership of land, unit of measurement and management of land in the CHT. Almost all household in CHT (93%) irrespective of their ethnic identity own land(2009 UNDP report on Socio-economic Baseline survey of the Chittagong Hill Tracts). There are three major type of land ownership a) Individual registered ownership, b) traditional ownership (recorded or non-recorded with Headmen) under usufruct rights and c) usufruct rights to ownership of Common Property Resources[10] .When looking in to land ownership in CHT it has to be noted that both registered ownership and traditional customary ownership (recorded and non recorded ownership) has to be taken into

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[9] Jhum Cultivation: Is commonly known as slash and burn method or shifting cultivation.

[10] For example, if an IP household uses part of *para* common property as homestead or as cultivated land, all members from his/her community/*para* traditionally honor his/her usufruct right of ownership on that part of common property.

account. In Bangladesh an average rural household owns 235 decimals of land (inclusive of Common Property Resources) and in CHT indigenous people on average own 318 decimals of land and Bangalees own 132 decimals of land on average. Essentially, there are two major types of crop agriculture land in CHT a) Plough and b) Jhum land.

It is estimated that indigenous people owned more *jhum* land then Bangalees. UNDP report(2009) that there is roughly 364,000 acres land available for cultivation out of which 73,000 acres are under plough cultivation. 99,000 acres in available for *jhum* and 66,000 acres of land is used as homestead. In case of indigenous communities most of the land falls under traditional customary property, however most of the properties owned by Bangalees and a small proportion of indigenous people have in the modern sense registered their property (21%).

3.7 Household Assets

Rural CHT households do not have posses a lot of furniture and other modern appliances. Bangalees tend to own more furniture and modern appliances compared to indigenous communities. However, indigenous communities owned more agricultural appliances than Bangalees. In 2009 (UNDP 2009), Bangalee households' asset on average was worth at Taka 66,730 and this was at least 30% higher than that of the average indigenous household in CHT. Among indigenous communities the valuation of asset among *Khyang* community is the highest and *Pangkhua* community registers the lowest valuation of household assets.

3.8 Employment Situation

On average about 52% of Households in CHT are either employed or employable. Almost 90% are employed full time .The patterns discussed can be seen across all the communities. Across the communities, two-thirds of the employed persons are self-employed. 94% of the employed IPs and 72% of the Bangalees are income-earners. A 47% of the IPs and 30% Bangalee income-earners are females. The income-earners, on average, have employment for 9.36 months per year.

3.9 House hold Income/Expenditure/Savings

The annual household net income of an average rural household CHT was around Tk. 66,000 (Bangladesh rural being Tk. 84,000). The households' annual net income of the Bangalees was around Tk. 71,000 and income for indigenous peoples around Tk. 62,000 on average in 2009,(UNDP 2009). Agriculture-related activities are the prime sources of household income across the Communities (ranging between 49% and 72% of the net income). Contribution of female to household income is low.

Annual expenditure of a household in rural Chittagong is lower compared to rest of the country, this statement holds true across all tribal/ethnic groups. The share of expenditure on food is higher than expenditure on health and education.

In 2009 at least 87% of the household had some savings. The average CHT house has savings of Tk 3,542. Bangalee communities tended to have more savings than indigenous groups. About

54% of households in CHT had access to microcredit. The money obtained through microfinance was usually used for day to day expenses.

3.10 Education

About 82% of the children aged 5-16 are enrolled in primary or secondary schools. Enrollment rates are higher among Bangalees than other groups. Three-fifths of all children go to Government primary schools irrespective of the distance from the residences. The average travel time for going to a nearby school, irrespective of communities, is around half an hour. Dropout rates are high with 65% children discontinuing their education before completion of primary schooling and 19% after completion of the same. Financial problem is the main reason for school dropouts. The other reasons include distance of the school from the residence, children are not welcomed at schools, and medium of instruction is not understandable, parents not supportive, insecurity, and lack of interest of the child.

4. HNP Situation of Tribal/Ethnic Communities

4.1 A snapshot

a) Disease control

Malaria, diarrhea, and acute respiratory infection are the most common diseases in CHT as highlighted in the tables below. Malaria causes most of the deaths in the area and over the course of time a number of initiatives have been taken to prevent and treat malaria. The charges for treating malaria are quite high, and in places where there is no malaria control program, households pay up to Taka 200 for treatment. Government clinics, satellite clinics and NGO supported clinics all have capacities to test malaria. In areas where access to health facility is more than three hours walking distance away, communities diagnose themselves and resort to traditional healers and/or untrained personnel. In some cases where community based workers have been trained properly, they are able to diagnose and provide treatment. The HDC in collaboration with BRAC also supported an initiative to raise awareness about malaria.

Currently only a limited package of curative health care is offered at the union level by MOHFW in CHT. Due to staffing problem, lack of diagnostic equipments, etc. facilities at the Union level are unable to provide curative services. But BRAC has a network of services and CHTDF has many CHSWs at the para level making diagnostic and immediate treatment of diseases such as malaria at the para level,

Patient cases reported in 3 CHT Districts from 2007-2009

Source: CHT, Civil Surgeons Office 2010

Diarrhea						
District	2007		2008		2009	
	Cases	Death	Cases	Death	Cases	Death
Rangamati	12,492	4	12,714	5	14,183	2
Khagrachari	35,490	6	31,222	0	21,577	0
Bandarban	13,769	5	14,376	8	14,232	7

Accute respiratory infection						
District	2007		2008		2009	
	Cases	Death	Cases	Death	Cases	Death
Rangamati	11,344	10	12,827	11	11,715	21
Khagrachari	22,462	56	19,870	58	15,537	41
Bandarban	15,042	46	18,108	50	20,216	39

Malaria						
District	2007		2008		2009	
	Cases	Death	Cases	Death	Cases	Death
Rangamati	20,434	70	27,335	33	18,136	12

Khagrachari	87,127	99	45,810	55	21,299	12
Bandarban	53,216	34	28,524	11	16,809	3

b) Reproductive Health and Family Planning

One of the key determinants of maternal mortality is reproductive health. In 2005, a survey on Reproductive Health of Young Adults found that at least 76% of adolescent girls (median age of 16.9 years) in Bangladesh have no access to health facilities. The percentage of adolescent pregnancies is high at 35%. In CHT 52% of the girls get married before their eighteenth birthday, which increases the risk of dying due to complications related to early pregnancy. The contraceptive prevalence rate (CPR) and total fertility rates (TFR) have gone down – CPR in Chittagong is currently 53.3% and TFR 2.33. Although TFR is low, maternal mortality is still high about roughly 4.71 per 1000 births (UNFPA).

Infant mortality rate in CHT is close to the national level (51/1000 compared to 45/1000). The main reason behind this has been attributed to the fact that there have been a high number of births performed without professional/trained assistance. The Bangladesh Multiple Indicator Cluster Survey reported that only 17% of deliveries in CHT were assisted by medically trained personnel in 2006. At the union level in CHT only a handful of community workers are trained as skilled birth attendants. Even though difficult deliveries are referred to higher level facilities, by the time patients reach the hospital situation may become irreversible and hence increase the likelihood of death. A few ambulances are available at the district level, but the numbers of ambulance available at the Upazilla level are not known.

c) Food and Nutrition

Food habit of people in CHT is almost similar to that of the plain land. However they do eat a few items which are not commonly eaten in the plain land such a nappi (fish) bamboo shoots dried vegetables etc**.** In general food poverty is wide spread in CHT with majority of the indigenous people not secured with respect to food. The problem of food security is common in all the ethnic groups. It has also been observed that 62% of all the household irrespective of ethnic backgrounds according to the direct calorie intake are living below the absolute poverty line.

d) Mother and Child Health

Antenatal care (ANC) and post-natal care (PNC) visits to trained personnel by women in CHT are lower than the national average of ANC which is 32.7% and PNC which is 9.8% respectively (Bangladesh Maternal Mortality Survey 2001). ANC and PNC visits are only made by women in CHT if they are going to the clinic for some other reason. So the a challenge arises in terms of following up with maternal and child health issues until and unless this is done by community based workers.

Immunization coverage in CHT is also low. Full immunization coverage by age is 12 months is 51% in CHT compared to 71% overall in Bangladesh according to the Coverage Evaluation Survey under taken in 2006. Immunization schedules are often lost or forgotten. Therefore,

community health workers for GOB, UNICEF, CHTDF and others provide some immunization but it is not followed up systematically.

e) HIV/AIDS

Although HIV prevalence is low in CHT, it is important to provide HIV preventive services and raise awareness as CHT has a porous border with India and Myanmar where prevalence of HIV is high. At present, level of knowledge regarding HIV is low. Only 46% of the population has heard of HIV and only 13% of women have complete information on HIV transmission. As it currently stands there is little or no HIV/AIDS related intervention in the three hill districts despite it being a potentially high risk (street, hotel and residence based sex workers, drug users etc).

Some useful tables for planning in the tribal/ethnic areas have been attached in Annex B.

4.2 Health Service Providers

The Hill District Councils (HDC) are responsible for delivering health services across all upazilas in the respective district in Chittagong Hilll Tracts, and is responsible for more than 235 health facilities at District, Upazilla, Union and community level. HDC is also actively involved in implementation and supervision of services provided under the Chittagong Hill Tracts Development Facility (CHTDF) of UNDP Health component. Through the office of the Civil Surgeon and the Deputy Directors of Family Planning, it supervises over 300 doctors and nurses and over 800 community health workers supported by MOHFW. The type, size and number of government health facility per household provided in Chittagong follow the same national standard as applied in the plains. Improving Health, Nutrition and Population in Chittagong Hill Tracts Proposal, *Prepared by Hill District Councils*, August 2010 highlights that most of the communities avoid using the facilities provided by the government simply because a) road condition is poor, b) costly transport, c) rough terrain etc. The standards applied (in terms of type, size number and location) by the Government do not adequately reflect the geographical aspects of the region. Apart from accessibility issues other problems as highlighted by the report of the Hill District Council that have hampered the performance of the government hospitals are poor maintenance, lack basic utilities, poor management of drugs and other medical supplies, facilities are understaffed or staffed in certain days of the week, noblood bank etcThe HDC is aware of these problems and is committed to find practical solutions.

4.3 Utilization of Health Care

The utilization rate of public healthcare facilities is quite low in CHT as is the case for all of Bangladesh. Only 7.56 percent of the total population who reported sickness opted for services from the public facilities. As a result, private providers play an important role in the healthcare sector of Bangladesh. Nearly one-fourth (24.4 percent) relied on private practitioners and another 15.1 percent consulted with government doctors at private practices. It is also evident from the Household Income and Expenditure Survey 2005 that 38.7 percent sought services from the pharmacy/dispensary and another 7.6 percent received healthcare services from unqualified

traditional providers. The utilization of unqualified traditional providers is significantly higher among the rural community (Bangladesh Bureau of Statistics 2006).

4.4 Quality of Health Care Service

MOHFW provides HNP services at three different levels – primary, secondary and tertiary. A stakeholder consultation survey was undertaken in 2009 to get an overview of the status and quality of health care services provided through the public sector in Bangladesh. The survey was conducted across the country (including CHT) through focus group discussions among service providers, beneficiaries and other stakeholders. Listed below are some of the findings mainly from the primary and secondary levels as highlighted in the Stakeholder Consultation Review Report (SCRR) of 2009.

Consultation time: On an average, an outpatient received only 3.3 minutes of consultation time from the providers at district hospitals (DHs), 2.9 minutes at Upazila Health Complexes (UHCs) and 3.1 minutes at Union Health and Family Welfare Centers (UHFWCs). Inpatients usually received more time for physical.

Cost of Treatment: At the public facilities services are free or very minimal fees are charged for particular services. However, significant amount of money is spent on transportation.

Accessibility of Public Health care Services: Lack of satisfactory physical accessibility is an issue for a number of selected facilities. A patient on an average traveled 5.5 km to reach DH and 3.1 km to UHC and 1.3 km to UHFWC. Moreover, the distribution of the waiting time by different facilities showed that an exit patient on an average had to wait approximately for 54 minutes at DHs, 36 minutes at UHCs and 22 minutes at UHFWCs.

Quality of Care and Client Satisfaction: The quality of the service providers was, in general, acceptable to the patients. But, roughly 50 percent of the patients were not satisfied with the quality of the treatment.

Quality of services suffers due to shortages of skilled personnel, lack of private space for physical examination, shortage of drugs, etc. Lack of clean water supply and toilets have also been highlighted as constraints. Majority of the selected delivery points (surveyed as part of the stakeholder consultation) had most equipment working but they were not sufficient in number.

4.5 Existing Number of Health Care Providers

As of 2009 there were 48,104 registered doctors but a number of them are either studying or employed abroad. As per the Directorate General of Health Services, the doctor population ratio was 1:3000 in 2008. The international standard set by the World Health Organization for nurse-patient ratio is 1:4 for general care and 1:1 for intensive care. In Bangladesh, however, nurse patient ratio is 1:13 for general patients (Aminuzzaman 2007). The WHO standard Doctor: Nurse: Technologist ratio is 1:3:5 and the corresponding Bangladesh ratio is 1:0.43:0.29. This situation observed in CHT.

4.6 Health Care Seeking Behavior

The stakeholder consultation 2009 found that among the clients visiting the public facilities at Upazila and below levels, women constituted the overwhelming majority. This is true for CHT as well. In the age group of 15 to 49 years, women visited these facilities mostly for their children and sometimes also for their own benefit. Among the patients of older age group the majority were males. In the rural areas, the poor, lower middle and middle income groups of people go to the primary level public healthcare facilities.

Many people still did not visit the qualified providers for a number of reasons: low accessibility (distance, transport), non-availability of doctors, non-availability of medicine, inadequate consultation time and unsuitable timing. Many also consulted with drug sellers. A significant portion of clients in hard-to-reach areas (HTR) did not take any treatment at all due to non-availability of service providers in the area. Of the people in HTR who sought treatment, it was from the public health providers.

5. Current Health Care Service Structures in the Tribal Areas

The following are the main HNP services/interventions that are being implemented in the tribal areas.

5.1 BRAC

BRAC (Bangladesh Rural Advancement Committee) is a local non-government organization involved in poverty alleviation and social mobilization). BRAC expanded its health program in Rangamati, Khagrachari and Bandarban in 1998 together with economic development and education programmes to serve the most disadvantage people in this area covering 1.45 million people to increase access to quality health care. Initially BRAC started its essential health care (EHC) packaged including malaria control in limited geographic areas and gradually scaled it up to 25 upazilas by 2004. It pays particular attention to the vulnerable groups, e.g., women and children in hard to reach areas. The EHC package comprises of the following:

- Health and nutrition education
- Family planning
- Immunization
- Pregnancy related care
- Basic curative service
- Tuberculosis control
- Malaria control program

Shasthya Karmi (SK, health worker) together with *Shasthya Shebika* (SS, health carer who supervises SK) conduct health education and provision of services at community level on child health, immunization, antenatal and postnatal care, family planning, personal hygiene etc. *Shasthya Shebika* identifies potential pregnant women through home visit while *Shasthya Karmi* the immediate supervisor, conducts antenatal and post-natal care to the identified pregnant women. *Shasthya Shebika* mobilizes and motivates women to use modern methods of contraception through household visits. They provide pills and condom to Eligible Couple as per their demand. They refer people to Government health facility for taking permanent method. *Shasthya Shebika* have been trained on diagnosis and treatment on basic ailments, such as, diarrhea, dysentery, anemia, common cold etc. They refer complicated patients to local public and private health facilities.

BRAC introduced tuberculosis (TB) control program in 25 upazilas in 2003. SS play key role in identifying suspected TB patients, collect sputum and refer them for TB test. Sputum from suspected patients is examined at the BRAC laboratories at the upazila and peripheral levels.

BRAC started malaria control program in 1998 through a pilot project in Matiranga of Khagrachari Upazila and then covered all 25 upazilas in 2003. Blood slide is examined at BRAC

upazila and peripheral level laboratories. In addition, blood slides are also examined through 106 sub-centers at union level to reach hard to reach areas in collaboration with local health authority, i.e., with the support of DGHS, the World Health Organization and recently with the Global Funds to fight AIDS, TB and Malaria (GFATM). Until 2007 SS and SK were responsible to identify uncomplicated presumptive malaria patients and provide treatment to them. Program Organizer (laboratory)[11] identifies malaria cases and refers these patients to SS for treatment. SS and SK refer severe patients to the public health facilities at the upazila and district levels. Since November 2007 M&PDC of DGHS is providing rapid diagnosis treatment (RDT) and ACT for treating confirmed malaria cases.

BRAC has developed an independent health care infrastructure parallel to the public sector infrastructure. This has introduced some element of inefficiency in resource management. BRAC and public sector infrastructural facilities could be used in a complementary manner, which could also enhance sustainability of the enunciated services.

5.2 Chittagong Hill Tracts Development Facility of UNDP

CHTDF has been working in 15 Upazilas of the CHT in close collaboration with the HDC and with the MOHFW. The strategies include a network of female outreach workers or Community Health Service Workers who are recruited and posted in their own remote para after two months residential training. They provide basic health care including diagnosis and treatment of malaria, mobilize communities for immunization, family planning services and refer cases to satellite clinics and other health facilities. The 940 Community Health Services Workers are Hill District Councils (HDCs) staff. The CHSWs are supported by para visits of their supervisors every 6 weeks and by attending weekly satellite clinics. Satellite clinics are held by mobile medical teams (one doctor, one nurse, one pharmacist, one lab technician and one health promoter) once a week at the same location. The location of satellite clinics[12] is approved by Union facilitation Committee which is headed by UP Chairman after a series of consultation with relevant stakeholders. The satellite clinic provide an important link between community health service provided at the community level and the services delivered through government health facilities at the upazilla and district levels

One fully staffed mobile team, with a medical officer, pharmacist, laboratory technician, health promoter and nurse each, visit the same place for under-served populations once a week. The mobile clinic provides curative care, ANC, PNC, reproductive health care, health education, immunization and family planning with MOHFW field-level staff. The team provides support to the Community Health Service Workers also.

CHTDF covers Rowangchari, Thanchi, Alikodom, Ruma and Lama Upazilas of Bandarban Hill District, Rajastali, Langudu, Barkal, Billaichari, Juraichari and Baghaichari (for Baghaichari 2

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[11] Labotary : Blood samples along with other symptoms are tested and analyzed

[12] Satellite clinics (SC) provide service similar to the services provided by the UHC but at a union level or lower. There are as of August 2010 75 satellite clinic across 15 upazilas and are staffed by a mobile team. It gets around 1600 patients per month. Essentially it provides a number of HNP services such as Family planning, Vitamin A, ANC and PNC etc.

mobile team) upazilas of Rangamati Hill District and Matiranga, Panchari and Laxmichari and Mahalchari upazilas of Khagrachari Hill District. However, UNDP funding will be ending in 2011 and MOHFW, therefore, will have to initiate steps to ensure there services and infrastructure are kept and maintained properly to ensure the well being of the tribal/ethnic communities. In August 2010 the three HDCs through MOCHTA submitted a proposal for the coming years to the MOHFW outlining their suggested strategies to address and addressing the priority needs and costing them

Other UN bodies such as UNICEF, WFP and UNFPA are also providing technical support. For instance the ICDP program run by UNICEF among other things aims at raising awareness about health, water and sanitation activities, WFP supports nutritional supplement through ICDPand UNFPA provides technical support to mother and Children Welfare center in each district.

5.3 Family Planning Association of Bangladesh (FPAB)

FPAB (not regularly and subject to availability of funds) serves three upazilas in Rangamati district, i.e., Naniarchar, Rangamati Sadar and Kaptai. Kaptai is also served by the Christian Mission Hospital of Chondroghona. FPAB works with the adolescents and for safe motherhood programs including caesarian operations. It also provides treatment for minor illnesses through outreach sites. FPAB has river crossable transports for carrying emergency patients or ferrying physicians. Christian Mission Hospital provides essential health care services to the remotest population in some of the upazilas of Rangamati. LAMB[13] Hospital are also well known as a hospital based service provider in Dinajpur

5.4 Community Based Services (CBS)

At the community level there are a number of agencies in some selected upazilas (pilot project) with trained community health workers delivering health services directly to the community. Their interventions cover both preventive and curative measures. Geographical coverage and household covered varies with agencies but services are the same.

5.5 Traditional Medicine

Various communities in CHT practice a tradition system of health care following traditional customs and practices. The price of these services can be expensive and normally a religious person or traditional healer performs the care services. There is also a practice of traditional

[13] Lamb hospitals are Christian Mission Hospitals. It provides primary care clinical services provision, health promotion Services etc .

medicine. These medicines are usually plant based and is a common alternative to modern medicine.

6. Consultations for evolving tribal/ethnic plan, issues raised and suggested interventions

A bottom up approach has been taken to ensure that pertinent issues in relation to health care and service delivery are taken into account while developing the new sector program. The MOHFW, in order to ensure that all relevant stake holders are consulted including Development Partners in designing program, held a number of consultations across Bangladesh. In 2010 one such meeting was held in Rangamati in CHT. Some of the key problems highlighted and recommendations that have been made are (List not exhaustive):

- Outreach curatives services are not accessible enough to remote communities, geographically, economically and culturally
- The ratio of MOHFW staff and satellite facilities to population is inadequate (too low)
- Absenteeism among MOHFW staff is prevalent as working and living conditions as well as support and supervision are deficient.
- HA and FWA should be recruited from distant ethnic communities to cope with the geographical, language, cultural conditions and perform efficiently.
- Doctors are transferred quickly
- Improve the manpower of hospitals
- Improve co-ordination
- Need to procure ambulances
- Improvement of water and Sanitation situation
- Make the remuneration package of doctors more attractive
- Improve community level service delivery in order to ensure less pressure on hospitals.
- Improvement in cleanliness of health facilities.
- Improve the efficiency of the utilization of funds
- The referral system in hard to reach areas at times have been difficult to manage and have not proven to be cost effective. Therefore it has been recommended by some stakeholders that a survey in these areas should be carried out and based on that specialized hospitals should be developed
- Better Management of Drugs
- Recommendations were also made to improve HNP situation by developing programs which is aimed at child, maternal, old age health etc.
- Other recommendations were : common micro planning for all agencies, online MIS, implementation of local level planning, developing a check list for monitoring purposes,

Furthermore, as part of the stakeholder consultation review held across the country in 2009, men and women of the tribal/ethnic communities along with important people from these

communities were interviewed to understand the key issues affecting HNP services and to get useful insights into problems faced by tribal/ethnic community in CHT and elsewhere. The inputs obtained through FGDs, interview and small group consultation are presented below.

Many of the tribal/ethnic dwellings do not have Government facilities in the vicinity. Some of the respondents felt that non-availability of private qualified practitioner as one of the main problems. Transport was next important problem and lack of health consciousness was also mentioned.

6.1 Issues and recommendations of tribal/ethnic people

On the issue of improving HNP the following suggestions were provided. These are in line with the findings presented in the previous THNPP of 2004. The recommendations included:

- Special programs to reach effectively the tribal/ethnic in districts other than CHT, especially in north and eastern part border districts which have substantial tribal/ethnic population.

- Adequate communication network set up in areas inhabited by tribal/ethnic areas, which would help in reaching the facilities.

- Different set of beliefs governs practices of health, family planning and nutrition (during pregnancy, lactation, etc.), which needs to considered for evolving appropriate programmes.

- Tribal/ethnic people speak different language and appropriate information should be available in the language spoken by tribal/ethnic people

- Recruit and appoint tribal/ethnic women and men for various post in HNP services, which would help in providing tribal/ethnic friendly services

- Educational and training facilities to impart required skill to tribal/ethnic people to serve in facilities run by government

- Recognition and promotion of tribal/ethnic system of medicine

- Improve water and sanitation situation in tribal/ethnic in habitation

- Qualified doctor at UHFWC

- Adequate supply of medicines at government facilities

- Improving awareness regarding HNP issues through health education
- Improving communication system

- Immunization of children

- Providing better maternal health to stop maternal deaths
- Attention to health care needs of aged

- Special arrangement for aged in government facilities (to reduce waiting time, etc.)

- Ensure good behaviour of the staff towards the patients

- Adequate attention from doctors to alleviate suffering of the patients when they approach doctor for health care services.

- Do away with malpractice in the form of bribe (which the patients have to pay) in the government health centres.

- Equip UHFWC with pathological testing facilities, operation theatre, x-ray machines, etc., to ensure quality services to people in the rural areas.

6.2 Activities suggested for improving HNP status of tribal/ethnic people

Based on the review of available literature, one-to-one consultations and inputs from the stakeholder consultation the following activities could be included under the new sector pgoram (HPSDP). These are applicable to both CHT and non-CHT areas

- Recognizing social, economic, cultural and linguistic differences of tribal/ethnic communities, to ensure reach of services a tribal/ethnic plan may be considered to channelize the resources and implementation of HNPSP.

- Redesign service delivery model in tribal areas and for tribal/ethnic groups. Doorstep delivery of services may have to be encouraged. As the tribal/ethnic population live in areas with low density, which means smaller population spread across larger geographical areas, and considering the fact that they live in hilly regions and forest areas, there could be one trained health visitor and family welfare visitor for every 500 households.

- Reviewing coverage of CCs in tribal/ethnic areas: For households at a distance of more than 3 Kms or cut off by stream/river or steep slope, satellite clinics or mobile clinics should be considered to extend the coverage.

- Support to infrastructure and service delivery in the public sector to fill in gaps and make the services more user friendly. Supplement the public sector service delivery by engaging the private sector and NGOs at all levels, more so at the community level.

- Manpower development by way of better recruitment, training and rewards systems. Preference to be given for recruiting individuals from tribal/ethnic community, as they understand their community and needs.

- Training and working with other systems of medicine and tribal/ethnic system of medicine practitioners.

- Developing a need based and culturally sensitive Communication Program

- Development of a referral system for institutional deliveries, emergency obstetric care and terminal method of family planning.

7. THNPP activities and implementation arrangements

The Task Force set which was set up in 2008 to speed up the pace of THNPP 2004 implementation proposed the following strategies. These will be implemented as part of THNPP 2011.

1. Contract out: (i) to conduct ethnographic studies and mapping, (ii) map the health care delivery services and structures, (iii) baseline, mid-term and final survey for output, effect and impact, (iv) need assessment to understand socio-cultural and economic aspects of influencing current perception of disease, health seeking behavior, and preference of health care providers, (v) communication need assessment, communication strategy development for providers and users, communication material development and production, and for communication campaigns, (vi) responsibility of provision of the THNPP earmarked services, (vii) training need assessment, development of training modules and provision of training of service providers and community representatives as stakeholders in the management of the health care delivery system under the plan.
2. Facilitate periodic stakeholder meetings.
3. Formation of stakeholders committees at district, upazila and union level with effective representation of tribal/ethnic people, women and disabled to review and monitor THNNP implementation.
4. Improve water and sanitation situation in tribal/ethnic inhabitation.
5. Organize mobile and satellite services (with the help of mobile transports) effectively. There should be village level sub-centers in addition to CCs, which will be established and managed by the local people like in case of the CCs. Government would provide medicines for the first three years. Village management committees will have arrangements with local transport owners to rush emergency cases to hospitals, cost of which will be borne by the Government, for safe motherhood related services.
6. Development of strong and effective referral system.
7. Integration with other departments to promote better resource utilization (forest department, education department etc.).
8. Capacity to resolve conflicts and grievances in a culturally and linguistically sensitive manner and capacity to identify, prevent and resolve cross-cultural conflicts of complaints
9. Provision of health cards to clearly specify name of the tribal/ethnic group and language spoken

10. Consultation with associations of forums of unqualified practitioners and traditional healers providing services to tribal/ethnic people, train them and use them for providing contraception, counseling to improve nutrition and utilization of facilities for child birth.
11. Establishment of a project support office/unit under the leadership of PSO which will monitor the progress every quarter. (The unit needs review. As a huge structure has been suggested in the consultant's report. Which should not be required as the plan is to contract out the responsibility of actual provision of services. A chief coordinator with an accountant, a data entry operator, a messenger, a vehicle with driver and required number of area coordinators with similar office structure should be sufficient.

THNPP 2011 needs to be implemented to enable service providers and tribal/ethnic people to review collectively HNP program in tribal/ethnic areas and come up with appropriate modifications for improving reach and effectiveness. Union would be the unit for such collective reviews of HNP programme by service providers and tribal/ethnic people. Union with tribal/ethnic population of 25 per cent and above would take up this process of reviewing. To ensure effective participation of tribal/ethnic people, social mobilization would be carried out in these unions. Initially, for a year, local community organizations would act as catalyst to form appropriate management committees / groups. Subsequently these empowered tribal/ethnic community groups would take the responsibility for local level planning and managing of HNP services. These community management groups / stakeholder committees would receive funding support for organizing their meetings. However, the emphasis would be on community mobilizing its own resources or manage the user fees collected to meeting these expenses as well.

The following programmatic areas of HPSDP will ensure services to the tribal/ethnic people:

- Maternal, Neonatal and Child Health Care
- Essential Services Delivery
- Community Based Health Care
- TB and Leprosy Control
- HIV/AIDS And STD Program
- Communicable Diseases Control
- Non-Communicable Diseases Control
- National Eye Care
- Hospital Services Management and Safe Blood Transfusion
- Alternate Medical Care
- In-Service Training and Human Resources Management
- Behavior Change Communication
- National Nutrition Services (NNS)
- Maternal, Reproductive and Adolescent health
- Clinical Contraception Services Delivery
- Family Planning Field Services Delivery
- Information, Education and Communication
- Physical Facilities Development
- Nursing Education and Services

7.1 Service through existing network

HNP services would continue to be provided through existing service network. It is expected that tribal/ethnic plan would ensure that more tribal/ethnic utilize HNP services, which would contribute to improving their health, nutrition, and family planning status, through systematic collection of relevant information, appropriate communication and educational inputs to service providers as well as patients / consumers, empowering tribal/ethnic community through training and formation of community management groups to manage health facilities and plan HNP services for their community.

Since 2009, 10,000 Community Clinics are in operation across the country. The community clinics are staffed with both health care and family planning workers. This is the lowest tier of the health system. These clinics provide health and family care packages. As part of the THNPP 2011, efforts will be made to establish and/or operationalize community clinics catered to the needs of the tribal/ethnic people, and where applicable, staffed by tribal/ethnic people to ensure maximum utilization of services.

7.2 Culturally and Linguistically Sensitive Services

A policy to provide Culturally and Linguistically Sensitive Services (CLSS) to patients. A CLSS strategy would be useful for policy makers, planners, and administrators and staff at all levels to appreciate socio-cultural and linguistic differences. CLSS would help in improving effective utilization of services and its benefits reaching socioculturally distinct groups.

Given here is Cultural and Linguistic Sensitivity (CLSS) Framework[14]

1. HNP services should ensure that tribal/ethnic receive from all functionaries (staff members) effective, understandable, and respectful care in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Adopt strategies for recruiting, retaining, and promoting at all levels of the organization staff and leadership that are representative of tribal composition in an area, especially at Upazila and below.

3. Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Health facilities should have staff with bi-lingual capabilities, in areas with tribal and Bengali speaking population.

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[14] CLSS is adopted from Culturally and Linguistically Appropriate Services (CLAS) standards for meeting the requirements of ethnic groups and minorities. The point of departure here is in the emp hasis on inculcating sensitivity of existing mechanism to provide culturally appropriate services

5. Health facilities should provide written notices informing them of the services available and bill of citizen rights.

6. Health facilities to have appropriate signage in languages of the commonly found groups (tribal/ethnic and non-tribal), represented in the service area.

7. Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services to tribal areas.

8. Integrate cultural and linguistic competence-related measures into performance improvement programs, patient satisfaction assessments, and outcome based evaluations.

9. Ensure that data on the individual patient's ethnicity and spoken and written language are collected in health records, integrated into the MIS, and periodically updated.

10. Maintain a current demographic, cultural, and epidemiological profile of tribal/ethnic communities as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

11. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing HNP activities.

12. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving crosscultural conflicts or complaints by patients/consumers of HNP services.

13. Encourage facilities at community level to regularly make available to the public information about their progress and successful innovations in implementing culturally and linguistically sensitive services and to provide public notice in their communities about the availability of this information.

7.3 Decentralization and ensuring local participation

THNPP 2011 will aim to address the issue of local participation by:

- *Social mobilization strategies:* Participation of community, headmen, chiefs, HDC (in CHT) are essential for successful implementation of tribal/ethnic plan. Equally important is gaining the support of non-tribal communities. To obtain the involvement and support of tribal/ethnic and non-tribal community at local level, a social mobilization strategy needs to be put in place. To ensure larger participation the focus would be on tribal/ethnic, forums, women groups, youth and other influential persons. Social mobilization campaigns during HPSDP will aim to create awareness among the partners, especially the private practitioners, and the community about existing HNP programs,

potential benefits, areas in which their participation will be solicited. One of the aims of this social mobilization is to evolve an institutional mechanism to involve community and their leaders (stakeholder committees, forums,etc.)

- *Preparation of simple operational definitions of various activities:* To simplify the process involvement of tribal/ethnic simple and easy to use concepts and definitions would be used. A simple to use system would be developed to enable community to understand the information periodically collected as well as the feedbacks for improving HNP services.

- *Sensitization and training programs:* Sensitization though social mobilization, BCC and training programmes would not only emphasize on culturally and linguistically sensitive approach but also adequately "gendered" so as to sensitize field level staff to the special needs of tribal/ethnic women.

- *Behavior change communication (BCC) plan:* A BCC plan that specifically addresses the tribal/ethnic groups' perspective will be developed through a systematic process of communication needs assessment and implemented based on a communication strategy guideline. BCC strategy to address all the issues that are likely to improve the sensitivity of providing HNP services, particularly the prevalent socio-cultural beliefs and gender disparities; increasing the reach of the campaign through the use of all channels of communication; these will include electronic media, press, hoardings, hand bills, posters, and inter-personal communication through health providers at all levels; creating targeted campaigns in terms of content and messages for health workers, private practitioners, the community and local influential persons.

Roles that the Traditional Leaders could play for involvement of tribal/ethnic group

Traditional leaders are expected to play an important role in development and implementation of HNP services in tribal areas and for tribal/ethnic people. They are highly respected and wield considerable influence in shaping the perception of their community. Successful implementation of tribal/ethnic plan requires ensuring traditional leaders involvement during various stages of implementation, especially during:

- Awareness generation and opinion mobilization,
- Ensuring involvement of and dissemination of information to the communities,
- Overall cooperation in HNP activities.
- Provide leadership roles in organizing the communities,
- Overcoming misconception and distractions keeping people away from utilizing quality services.
- Playing the role of advisor to providers and communities.

Targets for the THNPP

1. Proportion of tribal/ethnic population utilizing HNP services should be increased by 50% from the baseline by end FY2016.

2. One trained family welfare visitor should be available for every 500 households in sparsely populated areas.
3. Program duration will be for five years starting from June 2011.
4. An agency/consultants will be hired for establishing THNPP and it would start functioning sometime in between July 2011-July 2012
5. Field workers would be recruited from the local tribes
6. Hardship allowances and other benefits for the staff will be enhanced
7. Plans to be developed locally through a participatory approach
8. Communication materials including signage and notices will be produced in a way that it is usable locally.
9. Stakeholder committees formed at district to village levels with tribal/ethnic representatives, who actively participate in the monthly meetings

7.5 Institutional Mechanism and Implementation Plan for THNPP

The Tribal HNP plan emphasizes on three institutional initiatives, which would address the needs of the tribal/ethnic people, both in CHT and in other areas:

1. Decentralization of planning and implementation to the district, upazila and union levels. This would increase the involvement of functionaries and communities at upazila and below level to build capacity for managing and administering the tribal plan over the long term. Guided by local needs, committees at union and upazila will prepare and implement location-specific annual plans with emphasis on the needs of special groups. This includes carrying out special mobilization campaigns in the tribal areas;

2. Encouraging expansion and formation of community clinics with initiatives from communities to plan and provide for primary health care, referral services and transport services to nearest UHC for appropriate medical treatment;

3. Forging better relationship between HNP system and the tribal/ethnic through volunteers, who are recruited from local community. Community volunteers will be instrumental in improving geographical coverage, particularly in remote and unreachable tribal areas. Stakeholder committees would assist in providing mapping of tribal/ethnic groups, group-specific socio cultural information and channels to expand HNP outreach. Stakeholder committees along with PU representatives could play a role in ensuring participation of tribal/ethnic groups in improving HNP services. Tribal/ethnic group specific information will be used to develop culturally sensitive IEC materials for both public and providers.

7.5 Monitoring and Evaluation

Sampling design of evaluation studies would include tribal districts/unions on a representative basis. Community monitoring at village health centre, CCs, UHFWCs, and UHC, a key issue of

tribal plan, would strengthen inputs to M&E by helping to capture information that would have gone unrecorded due to socio-cultural barriers and gender discrimination faced by communities, especially vulnerable groups. These data would demonstrate the extent to which tribal/ethnic people have participated in and benefited through the implementation of tribal plan. Annual and half yearly evaluations would be carried out to assess the progress of implementation as well as outcome. Moreover, monitoring and evaluation will be carried out both internally by Ministry staff and independently by external consultants/firm The results from monitoring and evaluation can be used as early warning system so that corrective action may be taken. The following indicators could be monitored:

Suggested Indicators

1. No. of unions where social mobilization have been initiated and completed
2. No. of CCs handed over to community management groups
3. No. of village health sub-centers formed
4. Percentage of stakeholder committees with tribal/ethnic representatives, who actively participated in the monthly meetings
5. No. of facilities covered under provider training program
6. No. of workers serving in tribal areas trained
7. Locally effective BCC strategy evolved and implemented
8. Proportion of providers and consumers/ patients remembering key messages
9. Proportion of tribal/ethnic aware of HNP services
10. Proportion of tribal/ethnic utilizing HNP services
11. No. of cases of referred by village level health care providers to upper level health care facilities.
12. Data for HNP indicators disaggregated for tribal/ethnic people and tribal/ethnic areas
13. Disaggregated data is utilized for planning and evaluating impact
14. Data base on tribal health indicators established and incorporated in MIS by end FY07
15. Proportion of tribal/ethnic utilizing HNP services increased by 50% from the baseline by end FY10.
16. Health indicators of the tribal/ethnic people are closer to the national average.

7.6 Timeline and budget for THNPP activities

The budget below indicates the resource requirement for operationalising and implementing the THNPP.

BUDGET (IN LAKH TAKA)

Activity	Budget

Activity	**Budget**
Processing and preparing EOIs/ ToRs/ bid documents for contracting out services	10.00
Establishment and operationalization of a project support office/unit under the leadership of PSO which will monitor the progress every quarter. (The unit needs review. As a huge structure has been suggested in the consultant's report. Which should not be required as the plan is to contract out the responsibility of actual provision of services. A chief coordinator with an accountant, a data entry operator, a messenger, a vehicle with driver and required number of area coordinators with similar office structure should be good enough)	300.00
Contracting out of services for (1) ethnographic studies and mapping, (2) mapping of the health care delivery services and structures, (3) baseline, mid-term and final survey for output, effect and impact, (4) need assessment to understand socio-cultural and economic aspects of influencing current perception of disease, health seeking behavior, and preference of health care providers, (5) communication need assessment, communication strategy development for providers and users, communication material development and production, and for communication campaigns, (6) training need assessment, development of training modules and provision of training of service providers and community representatives as stakeholders in the management of the health care delivery system under the plan, and (7) responsibility of provision of the THNNP earmarked services	450.00 for survey, 140.00 for training and 2100.00 for provision of services = 2690.00
Formation of stakeholders committees at district, upazila, union and village level with effective representation of tribal/ethnic people, women and disabled to manage, review and monitor THNNP implementation	4.0
Facilitate periodic stakeholder meetings	280.00
Improve water and sanitation situation in tribal/ethnic inhabitation	600.00
Organize mobile and satellite services (with the help of mobile transports) effectively. There should be village level sub-centers in addition to CCs, which will be established and managed by the local people like in case of the CCs. Government would provide medicines for the first three years. Village management committees will have arrangements with	300.00

Activity	Budget
local transport owners to rush emergency cases to hospitals, cost of which will be borne by the Government, for safe motherhood related services	
Development of strong and effective referral system	NIL
Integration with other departments to promote better resource utilization (forest department, education department etc.)	NIL
Capacity to resolve conflicts and grievances in a culturally and linguistically sensitive manner and capacity to identify, prevent and resolve cross-cultural conflicts of complaints	NIL
Provision of health cards to clearly specify name of the tribal/ethnic group and language spoken	NIL
Consultation with associations of forums of unqualified practitioners and traditional healers providing services to tribal/ethnic people, train them and use them for providing contraception, counseling to improve nutrition and utilization of facilities for child birth.	120.00
TOTAL (Lakh Taka)	4304.00

Furthermore another Taka 375 million taka would be required for the period between 2012-2016 once UNDP withdraws funding in order to run the various activities of the CHTDF program without hassle. (This sum should be allocated for utilization by the Hill District Councils, and as part of a special OP). More funding would be required to run the existing government facilities.

ACTIVITY	TIME LINE	PROCESS INDICATORS
Processing of EOIs/ ToRs/ bid documents for contracting out services	July-December 2011	BIDs have been invited
Establishment of a project support office/unit under the leadership of PSO which will monitor the progress every quarter. (The unit needs review. As a huge structure has been suggested in the consultant's report. Which should not be required as the plan is to contract out the responsibility of actual provision of services. A chief coordinator with an accountant, a data entry operator, a messenger, a vehicle with driver and required number of area coordinators with similar office structure should be good enough)	July-August 2011	A functioning PMU
Contracting out of services for (1) ethnographic studies and mapping, (2) mapping of the health care delivery services and structures, (3) baseline, mid-term and final survey for	Jan- June 2012	Contracted agency is providing services

ACTIVITY	TIME LINE	PROCESS INDICATORS
output, effect and impact, (4) need assessment to understand socio-cultural and economic aspects of influencing current perception of disease, health seeking behavior, and preference of health care providers, (5) communication need assessment, communication strategy development for providers and users, communication material development and production, and for communication campaigns (6) responsibility of provision of the THNNP earmarked services, (7) training need assessment, development of training modules and provision of training of service providers and community representatives as stakeholders in the management of the health care delivery system under the plan		
Formation of stakeholders committees at district, upazila, union and village level with effective representation of tribal/ethnic people, women and disabled to manage, review and monitor THNNP implementation	Jan- June 2012	Committees managing CCs and sub-centers
Facilitate periodic stakeholder meetings	Jan 2012-June 2013	Periodic meetings are held as per planned scope
Improve water and sanitation situation in tribal/ethnic inhabitation	Jan 2012-June 2013	Availability and utilization of safe water and sanitary latrines shows improvement
Organize mobile and satellite services (with the help of mobile transports) effectively. There should be village level sub-centers in addition to CCs, which will be established and managed by the local people like in case of the CCs. Government would provide medicines for the first three years. Village management committees will have arrangements with local transport owners to rush emergency cases to hospitals, cost of which will be borne by the Government, for safe motherhood related services	Jan 2012-June 2013	Committees managing CCs and sub-centers
Development of strong and effective referral system	Jan 2012-June 2013	Referral system is functioning
Integration with other departments to promote better resource utilization (forest department, education department etc.)	July-December2011	Joint review meetings held at upazila and district levels with other departments
Capacity to resolve conflicts and grievances in a culturally and linguistically sensitive manner and capacity to identify, prevent and resolve cross-cultural conflicts of complaints	June 2011-June 2012	No job dissatisfaction among the tribal/ethnic workers
Provision of health cards to clearly specify name of the tribal/ethnic group and language spoken	Jan-June 2012	No complaints by the service recipients
Consultation with associations of forums of unqualified practitioners and traditional healers providing services to tribal/ethnic people, train them and use them for providing contraception, counseling to improve nutrition and utilization of facilities for child birth.	Jan-June 2012	Joint meetings held at upazila and district levels with the unqualified practitioners

Annex A: Name of tribal/ethnic communities and districts where they are found in Bangladesh[15]

Sl No.	Name of tribal/ethnic communities	Districts
1	Assam	Rangmati, Sylhet
2	Bagdi	Kustia, Natore, Jinaidaha, Khulna, Josore
3	Banai	Mymensingh, Sherpur, Jamalpur
4	Bawam	Bandarban
5	Bedia	Sirajganj, Chapainababganj
6	Bhumiji	Dinjapur, Rajshahi
7	Chak	Bandarban, Cox's Bazaar
8	Chakma	Rangmati, Khagrachari, Bandarban
9	Dalu	Mymensingh, Sherpur, Jamalpur
10	Garo	Mymensingh, Tangail, Sherpur, Netrakona, Gazipur, Rangpur, Sylhet, Sunamganj, Moulabi Bazaar
11	Gorkha	Rangmati
12	Hajong	Mymensingh, Sherpur, Netrakona, Sylhet, Sunamganj
13	Kharia	Sylhet
14	Khasi	Moulabi Bazaar, Sylhet, Sunamganj
15	Khyang	Bandarban and Rangamati
16	Khondo	Sylhet
17	Khotrio Barman	Dinajpur, Rajshahi, Gazipur
18	Khumi	Bandarban
19	Koch	Mymensingh, Tangail, Sherpur, Netrakona, Gazipur
20	Kole	Rajshahi, Sylhet
21	Karmarkar	Rajshahi, Chapainababganj
22	Lushai	Rangamati, Bandarban
23	Mahali	Rajshahi, Dinajpur, Bogura
24	Mahato	Rajshahi, Dinajpur, Pabna, Sirajganj, Bagura, Jaypurhat
25	Malo	Dinajpur, Rajshahi, Nogaon, Bogura, Chapainababganj, Rangpur, Panchagargh, nature, Thakurgaon, Pabna
26	Manipuri	Moulabi Bazaar, Sylhet
27	Marma	Rangmati, Khagrachari
28	Munda	Dinajpur, Rajshahi, Nogaon, Bogura, Chapainababganj, Rangpur, Panchagargh, Natore, Thakurgaon, Sylhet
29	Muriyar	Rajshahi, Dinajpur
30	Mro	Bandarban
31	Musohor	Rajshahi, Dinajpur

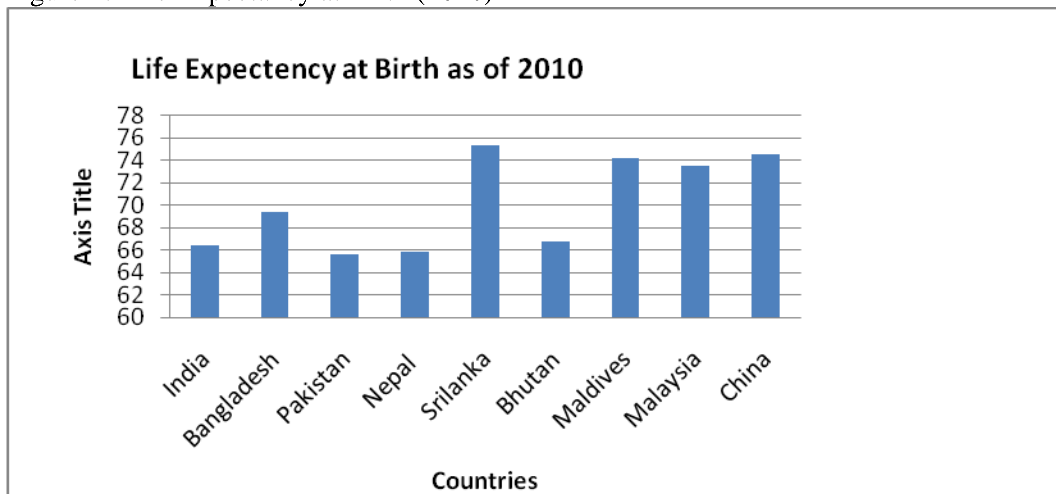
[15] Source

Sl No.	Name of tribal/ethnic communities	Districts
32	Oraon	Dinajpur, Rajshahi, Nogaon, Bogura, Chapainababganj, Rangpur, Panchagargh, Natore, Thakurgaon, Pabna
33	Pahan	Rajshahi
34	Paharia	Dinjapur, Rajshahi, Nogaon, Bogura, Chapainababganj, Rangpur, Panchagargh, Natore, Thakurgaon, Pabna
35	Pangkho	Bandarban
36	Patro	Sylhet
37	Rai	Rajshahi, Dinajpur
38	Rajbongshi	Mymensingh, Rajshahi, Gazipur, Dinajpur, Tangail, Khulna, Josore, Faridpur, Kustia, Dhaka, Sherpur
39	Rajuar	Rajshahi
40	Rakhain	Cox's Bazaar, Barguna, Patuakhali
41	Santal	Dinjapur, Rajshahi, Nogaon, Bogura, Chapainababganj, Rangpur, Panchagargh, nature, Thakurgaon, Sylhet, CHT
42	Singh	Pabna
43	Tanchangya	Rangamati, Bandarban, Khagrachari
44	Tripura	Rangamati, Bandarban, Khagrachari, Sylhet, Rajbari, Chandpur, Comilla, Chittagong
45	Turi	Rajshahi, Dinajpur

Annex B: A Snapshot of HNP Situation in Bangladesh

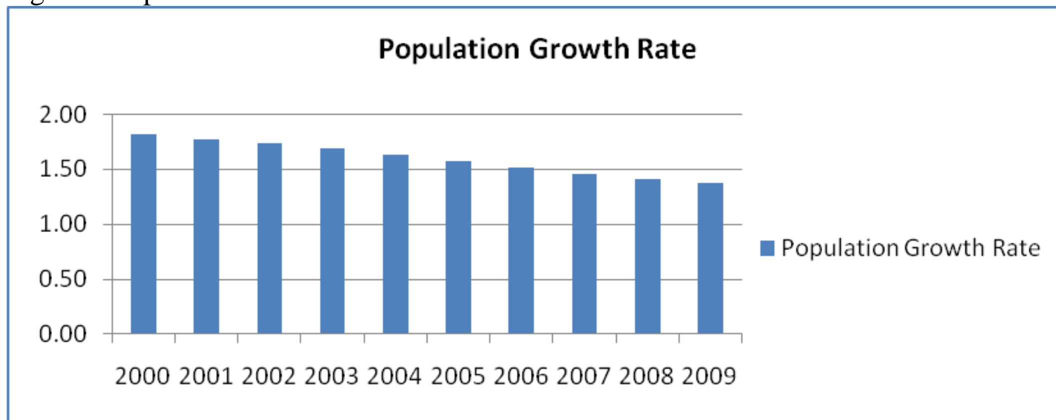
Since the inception of Bangladesh, the country has made substantial strides in the last three decades. For instance in terms of life expectancy at birth, Bangladesh has fared pretty well for instance life expectancy at birth increased from 49.0 in 1980 (UNDP 2008) to 69.44 in 2010 (CIA Fact book) .From the figure below we can see that even though Bangladesh has done considerably well compared to some of its South Asian neighbors such as India, Pakistan and Nepal, it compares poorly to Srilanka and the East Asian countries namely China and Malaysia.

Figure 1: Life Expectancy at Birth (2010)



Data: CIA World Fact Book 2010

Figure2: Population Growth Rate



Data: World Bank, World Development Indicators

Moreover the country has been relatively successful in keeping the population growth rate down. The contraceptive prevalence rate (CPR) has increased significantly in Bangladesh during last three decades from 7.7 percent in 1975 to 55.8 percent in 2007, with an average of 1.5 percent increase each year. In the mid- 1970s, the infant mortality rate (IMR) was 153/1000 live births. By 2007, it had declined to 52/1000. Under-five mortality (U5MR) is estimated to 65/1000 in 2007 (NIPORT, Mitra & Associates and ORC

Macro, 2007). However, considerable effort needs to be directed to improve the health care situation for instance mortality rates in the poorest household are twice as high for the wealthiest household. Furthermore, maternal mortality has come down substantially in the period between 1980-2000 but still remains relatively high at 322/1000. A review of various performance measures in maternal health so far indicates that meeting the MDG 5 goal of lowering the MMR to 143 per 100,000 by 2015 will be a huge challenge for Bangladesh. Listed below are brief discussions on a number of key factors affecting the HNP situation in Bangladesh as a whole.

Nutritional Status

Prevalence of childhood malnutrition is still high in Bangladesh. Roughly 40 percent of under-five children in Bangladesh are undernourished with weight-for-age below 2 standard deviations.. Moreover, it is worth noting that half (50.5 percent) of all the under-five children of lowest quintile are undernourished while the prevalence is only 26 percent for the highest quintile (NIPORT, Mitra & Associates and ORC Macro, 2007).

Supplementation of mothers with vitamin A doses after delivery is quite low - only 20 percent of women received a vitamin A dose following child birth. Furthermore, results from 2007 BDHS show no improvement in overall rates of exclusive breastfeeding in the first six months of life. Currently, 42.9 percent of the children up to 6 months were exclusively breastfed.

In the age group of 15-49 the mean BMI for ever married women in 20.6.Moreover the proportion of under nourished or thin is 29.7.Furthermore the proportion of undernourished women varies significantly across wealth groups. For instance it cab discerned from BDHS 2007 that only 13.4 percent of the women of highest quintile have BMI less than 18.5 while 43.4 percent women among lowest quintile are undernourished.

Fertility Levels

Between 1971-75 women in Bangladesh were on average having 6.3 children. Interestingly in the next 32 fertility rate declined substantially and in 2007 Total fertility rate (TFR) was found to be 2.7 BHDS (2007).Furthermore, in terms of international comparison Bangladesh compares favorably to some south Asian countries such as Pakistan, Philippines etc however comparison with Vietnam (1.9 in 2002, BHDS) and Indonesia (2.6 in 2002/2003, BHDS) shows that Bangladesh has to do more to bring down its TFR to the TFR levels of these countries. Within Bangladesh according to the last DGHS survey in 2007, TFR in Sylhet was the highest at 3.7 and it was lowest in the Khulna region at 2.0. Moreover educated women and economically more well off women were more likely to have lower TFR and the results indicated this. Even though the use of contraception has gone up unplanned pregnancies are very common in Bangladesh. three in ten births in Bangladesh are either unwanted (14 percent) or mistimed and wanted later (15 percent). Interestingly, a good proportion 57% of women in the age group of 15-49 reported in the 2007 BDHS that they did not want to take another child and additional 6% were already sterilized and 21 % of women wanted to space child birth. Over the course of time the pattern that can be discerned is that slowly the proportion of women who want to limit child bearing has increased.

Current fertility rates

Age-specific fertility rates, the total fertility rate, the general fertility rate, and the crude birth rate for the three years preceding the survey, by residence, Bangladesh 2007

Residence			
Age group	Urban	Rural	Total
15-19	90	137	126
20-24	161	177	173

25-29	123	129	127
30-34	66	71	70
35-39	31	35	34
40-44	7	11	10
45-49	0	1	1
TFR	2.4	2.8	2.7
GFR	92	109	105
CBR	24.7	26.5	26.1

Note: Age-specific fertility rates are per 1,000 women. Rates for age group 45-49 may be slightly biased due to truncation. Rates are for the period 1-36 months prior to interview.
TFR: Total fertility rate expressed per woman
GFR: General fertility rate expressed per 1,000 women
CBR: Crude birth rate, expressed per 1,000 population

Trends in current fertility rates
Age-specific fertility rates (per 1,000 women) and total fertility rates (TFRs) among women age 15-49, selected sources, Bangladesh, 1975-2007

Survey and approximate time period								
	1975 BFS	1989 BFS	1991 CPS	1993-1994 BDHS	1996-1997 BDHS	1999-2000 BDHS	2004 BDHS	2007 BDHS
Age group	1971-1975	1984-1988	1989-1991	1991-1993	1994-1996	1997-1999	2001-2003	2004-2006
15-19	109	182	179	140	147	144	135	126
20-24	289	260	230	196	192	188	192	173
25-29	291	225	188	158	150	165	135	127
30-34	250	169	129	105	96	99	83	70
35-39	185	114	78	56	44	44	41	34
40-44	107	56	36	19	18	18	16	10
45-49	35	18	13	14	6	3	3	1
TFR 15-49	6.3	5.1	4.3	3.4	3.3	3.3	3.0	2.7

Family Planning

Knowledge on family planning is widespread in Bangladesh. Commonly used family planning family planning techniques are the pill (100 percent knowledge), injectables (99 percent), female sterilization (95 percent), and condoms (90 percent); these are followed by the IUD (84 percent), implants (81 percent), male sterilization (73 percent), periodic abstinence (59 percent), and withdrawal (50 percent). In general as mentioned above contraceptive prevalence among women is high and is going up every year. Another interesting change that can be seen is the decrease in tradition method of abstinence and withdrawal. The contraceptive method mix observed from the BDHS 2007 show that short-term methods, especially the pill, are gaining in popularity against long-term methods, such as the IUD, Norplant, and sterilization. The pill now accounts for more than half of all contraceptive use, compared with 35 percent in 1991.

Women in urban areas use contraception more than women in rural areas. Moreover, within Bangladesh usage of any methods of contraception varies from 32% in Sylhet, 44% in Chittagong to 66% in Rajshahi etc. In general economically well off women are more likely to use contraception than women from economically worse off groups this hypothesis has been validated by the BDHS 2007.The proportion of contraception usage increase with number of children. In Bangladesh both the private and the public sector are involved in supplying contraception .FWCs, UHCs, privately run Pharmacies are important sources of modern methods. Finally two important statistics that have come out from the 2007 BDHS is that 77% of demand for family planning are currently unmet and discontinuation rates of condom usage has increased in Bangladesh.

Maternal Health

Antenatal Care (AC): Since 2004 AC from skilled providers has increased slightly to 52%. Thirty-six percent of women received antenatal care from a doctor, and 16 percent received care from a nurse, midwife, or paramedic. Around four in ten women received no antenatal care this was the highest in the Sylhet region (46%). Moreover, roughly sixty percent of women received at least two doses of tetanus toxoid for their most recent birth in the five years preceding the survey (BDHS2007). About nine in ten women were protected against neonatal tetanus.

Postnatal Care: 21% of women with live births in the five years preceding the survey received post natal care within a short time of delivery (roughly 2 days)

Maternal Complications around Delivery: (BDHS 2007) One in seven births in the five years preceding the survey had at least one of the following maternal complications around delivery—prolonged labour, excessive bleeding, baby's hands or feet came first, fever with foul-smelling discharge, convulsions/ eclampsia, and retained placenta. The most common complication was prolonged labour of over 12 hours. In 43% of the cases women with maternal complications around delivery patient sought help of a medically trained provider. Unfortunately the percentages for women who sought no help and women who sought help from traditional sources are still very high.

Child Health

Childhood Mortality: A steep decline has been observed in both child mortality (age 1-4 years) and post neonatal mortality. One of every 15 Bangladeshi children dies before reaching age five, compared with one in 11 in the 2004 BDHS. A strong relationship exist between under five mortality and mother education for instance 32 deaths per 1,000 live births among children of women with secondary complete or higher education to 93 deaths per 1,000 live births among children of women with no education. Furthermore, as in BDHS 2004, under five mortality was highest in Sylhet 107/1000 and the lowest was observed in Khulna 58/1000 born.

Childhood Vaccination Coverage: Roughly 82% of Bangladeshi Children aged 18-23 months are fully immunized while 2 percent have received no vaccinations. More than nine in ten children have received BCG and the first dose of DPT and polio vaccines. There is a decline in coverage of subsequent doses. Ninety-one percent of children have received three doses of DPT and the same percentages have received three doses of polio vaccine. Eighty-three percent of children have received measles vaccine. Full vaccination coverage is highest in Barisal division (90 percent) and lowest in Sylhet division (71 percent) .Mothers education level and vaccine coverage is correlated and the results prove this statement.

Child illlness and treatment: BDHS (2007) finds that among children aged 5 5% were reported to have had symptoms of acute respiratory illness in the two weeks preceding the survey , ***37*** percent were taken

to a health facility or a medically trained provider for treatment while 13 percent received no treatment at all. Ten percent of children under five years had diarrhea in the two weeks preceding the survey. Of these, one in five was taken to a health provider. Four in five children with diarrhea were treated with oral rehydration therapy, including 77 percent who received commercially available packets of oral rehydration salts (ORS), compared with 67 percent in the 2004 BDHS. In general, 85 percent of children with diarrhoea received ORS, recommended home fluids (RHF), or increased fluids. Moreover, according to the survey Thirty-eight percent of children under five years had a fever in the two weeks preceding the survey. Of these, 24 percent were taken to a medically trained provider or health facility for treatment. For 23 percent of children with fever, help was sought at a pharmacy.

HIV AIDS and STIs

It has been observed that Knowledge of HIV/AIDS among ever-married women increased from 19 percent in 1996-1997 to 31 percent to 67 percent in 2007. An individual's wealth groups, level of education, location of residence are key factors determining AIDs/ HIV awareness. For example only 42% of the women with no education has knowledge of aids compared to an astounding 95% of women who has finished secondary school. Moreover thirty-two percent of ever-married women and 66 percent of ever-married men age 15-49 know that condom use is a way to avoid contracting HIV. About one in three ever-married women and 63 percent of ever-married men know that limiting the number of sexual partners can reduce the likelihood of getting HIV.

BHDS 2007 finds that overall, 11 percent of ever married women and 4 percent of ever-married men age 15-49 reported experiencing an STI or symptoms of an STI. Among women, the most commonly reported symptom was abnormal discharge, whereas a genital sore or ulcer was the most common symptom reported by men.