

**Refugee Review Tribunal
AUSTRALIA**

RRT RESEARCH RESPONSE

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Questions

- 1. Please provide general information about the health system in Bangladesh.**
- 2. Please provide information on the treatment of the elderly or disabled.**

RESPONSE

- 1. Please provide general information about the health system in Bangladesh.**

Overview of Bangladesh health system

The World Health Organisation (WHO) provides general information about the Bangladesh health system, and pertinent information from four WHO reports follows below. The WHO's *World Health Report 2008* puts Bangladesh in the category of countries having "an absent or dysfunctional health-care infrastructure", with particular problems in "poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only". A 2008 article published in *Regional Health Forum – WHO South-East Asia Region* states that infant and maternal mortality rates remain high, malnutrition is common in women and children, "[d]iarrhoeal disease continues to be the major killer", and "[c]ommunicable and poverty-related diseases that are preventable still dominate the top ten causes of morbidity", but that "[o]ver the last 30 years there has been substantial improvement in the health status of the people". The WHO's Country Office for Bangladesh 2007 strategy report notes the prevalence of arsenic contamination in groundwater supplies and the need for better sanitation to avoid diarrhoeal diseases. This report also expresses concern over "indoor air pollution, food safety and climate change", and states that there is a chronic shortage of trained medical staff and that health expenditure is well below levels required for effective public health strategies. An August 2007 report from the WHO Regional Office for South-East Asia provides details on

public health expenditure, actions being taken to increase health personnel, numbers of medical facilities operating in Bangladesh, and policies on medical drug distribution (World Health Organisation 2008, *The World Health Report 2008: Primary Health Care – Now More Than Ever*, pp.27-28 http://www.who.int/whr/2008/whr08_en.pdf – Accessed 17 December 2008 – Attachment 1; Rahman, A. 2008, ‘Climate change and its impact on health in Bangladesh’, *Regional Health Forum – WHO South-East Asia Region*, Vol. 12, No. 1, pp. 16-26, pp. 20-21, 24-25 http://www.searo.who.int/LinkFiles/Regional_Health_Forum_Volume_12_No_1_Climate_change_and_its_impact.pdf – Accessed 17 December 2008 – Attachment 2; World Health Organisation, Country Office for Bangladesh 2007, *WHO Country Cooperation Strategy – Bangladesh*, pp. ix-xi, 12-13 http://203.90.70.117/PDS_DOCS/B0680.pdf – Accessed 17 December 2008 – Attachment 3; World Health Organisation Regional Office for South-East Asia 2007, ‘Country Health System Profile: Bangladesh – Health Resources’, 6 August http://www.searo.who.int/en/Section313/Section1515_6124.htm – Accessed 24 December 2008 – Attachment 4).

The WHO’s *World Health Report 2008* characterises Bangladesh as a country having “an absent or dysfunctional health-care infrastructure”, and “poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only”:

In some countries, a very large part of the population lives in extremely deprived areas, with an absent or dysfunctional health-care infrastructure. These are countries of mass exclusion typically brought to mind when one talks about “scaling up”: the poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only. Such patterns occur in low-income countries such as Bangladesh (World Health Organisation 2008, *The World Health Report 2008: Primary Health Care – Now More Than Ever*, http://www.who.int/whr/2008/whr08_en.pdf – Accessed 17 December 2008 – Attachment 1).

A 2008 article titled ‘Climate change and its impact on health in Bangladesh’, published by the WHO in *Regional Health Forum – WHO South-East Asia Region*, claims that “the Government of Bangladesh has invested substantially in the institutionalisation and strengthening of health and family planning services, with special attention to rural areas”, and that “[o]ver the last 30 years there has been substantial improvement in the health status of the people”. Nonetheless, the report states that infant and maternal mortality rates remain high, malnutrition is common in women and children, “[d]iarrhoeal disease continues to be the major killer”, and “[c]ommunicable and poverty-related diseases that are preventable still dominate the top ten causes of morbidity”. The report also provides information on the health policies and strategies of the Bangladesh government:

Since the country’s independence more than 30 years ago, the Government of Bangladesh has invested substantially in the institutionalisation and strengthening of health and family planning services, with special attention to rural areas, and is committed to the key health-for-all (HFA) and primary health care (PHC) approaches. Over the last 30 years there has been substantial improvement in the health status of the people. However, despite these improvements, much still remains to be done. Mortality rates, especially infant and maternal, continue to be unacceptably high. The quality of life of the general population is still very low. Low calorie intake continues to result in malnutrition, particularly in women and children. Diarrhoeal disease continues to be the major killer. Communicable and poverty-related diseases that are preventable still dominate the top ten causes of morbidity.

The government is aware of the situation, as well as of the major shortcomings that need to be addressed, such as development of an efficient project management mechanism across the health system; improvement in the logistics of drug supplies and equipment to health facilities at district and lower levels; improvement in the production and quality of human resources; a system to ensure regular maintenance and upkeep of existing health facilities; and development of a comprehensive plan to improve and ensure the quality of health resources.

Bangladesh's response to its existing disease burden

Health policies and strategies

The cornerstone of Bangladesh's national health policy is the Health and Population Sector Strategy (HPSS) which was introduced in 1998. The priority of the strategy is to ensure universal accessibility to and equity in health care, with particular attention to the rural population. The Maternal and Child Health (MCH) programme receives priority in the public sector while "reproductive health" has recently become a priority concern. Moreover, government's financial allocation for health has also improved. Efforts are being made to develop a package of essential services based on the priority needs of clients, to be delivered from a static service point, rather than through door-to-door visits by community health workers. This will be a major shift in strategy that will require complete reorganisation of the existing service structure. Such reorganization is expected to reduce costs and increase efficiency as well as meet peoples' demands. Privatisation of medical care at the tertiary level, on a selective basis, is also being considered.

...Policy and institutional strategy

The HPSS (introduced in 1998), which forms the basis for the future national health policy, is based on several key principles: greater orientation to client needs, especially women; improved quality, efficiency and equity of government health services; provision of a package of essential health services; expanded private sector role in providing health and population services; and a one-stop shopping via co-location of services.

Some of the main objectives of the new strategy are to:

- allocate more resources to support services for the poor, and for vulnerable groups (women and children);
- unify the bifurcated health and family planning service delivery system;
- achieve an appropriate balance between the public and private sector in the financing and provision of services; and
- decentralise management through devolution of authority.

The following activities have been identified to achieve the above-mentioned objectives:

- Deliver an "essential services package" to the whole population with the aim of maximising health benefits, relative to per capita expenditures.
- The service delivery mechanism should be unified, restructured and decentralised at both thana and hospital levels. Other services, particularly at the hospital level, are proposed to be provided through partnerships with or by commissioning the services of NGOs and private, not-for-profit hospitals. The public sector hospital services delivery will be improved through greater autonomy of management, local-level accountability, "cost-recovery", fee retention and utilisation, as well as a "drug-revolving" fund. Integrated support systems should be strengthened. A sector-wide approach to manage the health sector be introduced, rather than having a series of projects with their own funding, management, implementation and reporting arrangements. In view of the potential resource gap between sectoral resources and projected sectoral expenditures, increased reliance on "cost recovery" for public sector services will be considered.

- Health insurance coverage in urban Bangladesh is proposed to be increased through development of a health insurance scheme for government employees and for employees of state-owned enterprises. At the Centre, health services will be more integrated, while at lower levels, they will be decentralised. Hospital-level services will be improved.
- The policy and regulatory framework will be strengthened. Existing policies will be reviewed and revised for improving accessibility, affordability and quality of services and for further improving affordability, quality and safety of drugs, as well as the rational use of drugs.
- New policies on public and private sectoral mix and financing of services will be developed (Rahman, A. 2008, 'Climate change and its impact on health in Bangladesh', *Regional Health Forum – WHO South-East Asia Region*, Vol. 12, No. 1, pp. 16-26, pp. 20-21, 24-25
http://www.searo.who.int/LinkFiles/Regional_Health_Forum_Volume_12_No_1_Climate_change_and_its_impact.pdf – Accessed 17 December 2008 – Attachment 2).

The WHO's Country Office for Bangladesh 2007 strategy report also notes that progress has been made in key health indicators, but that "there remain many areas of concern over health development". The report claims that "Bangladesh is at risk of an HIV/AIDS epidemic...due to the high prevalence of the disease in neighbouring countries and the limited access to counselling and testing services on account of social stigma", and that "[m]alaria is endemic in the east and north-east parts of the country". The report also notes the prevalence of arsenic contamination in groundwater supplies, the need for better sanitation to avoid diarrhoeal diseases, and concerns over "indoor air pollution, food safety and climate change". Of the Bangladesh health system as a whole, the report claims that access to health services is poor in general and worse in rural areas; that there is a chronic shortage of trained medical staff; and that health expenditure is well below levels required for effective public health strategies:

There are clear indications that considerable progress is being made to improve the health of the people of Bangladesh. Over the last decade life expectancy at birth has increased, and both infant and child mortality rates have decreased. Signs of a beginning of a demographic transition suggest that strategies aimed at reducing fertility are taking effect, though this also implies that the health system must plan its response to an increasingly older population with accompanying specific health needs. Nevertheless, there remain many areas of concern over health development. For example, maternal mortality remains unacceptably high. Lowering maternal mortality is contingent upon improving the management of pregnancy, though underlying causes including maternal malnutrition must also be addressed.

Child health in general has improved, though the neonatal mortality rate remains high and contributes disproportionately to overall infant mortality. The immunisation programme has been recognised for its sustained high coverage; however, only 71% of infants are fully immunised. Measles presents an additional challenge to the immunisation programme with an estimated 20000 children dying from the disease each year. Efforts must be intensified to ensure access to safe immunisation and strengthen surveillance of all vaccine-preventable diseases. Malnutrition continues to be a serious problem with nearly half of the children being moderately underweight, one-third suffering from stunting and a large number of adolescents, girls in particular, being malnourished. Adolescent health requires closer attention, particularly in the context of reproductive health.

Bangladesh is at risk of an HIV/AIDS epidemic. This is due to the high prevalence of the disease in neighbouring countries and the limited access to counselling and testing services on account of social stigma. There are also concerns of HIV-tuberculosis co-infection, with

Bangladesh being among the countries with the highest burden of tuberculosis. Malaria is endemic in the east and north-east parts of the country with nearly 11 million people at risk of the most dangerous type of infection, *P. falciparum*, which has the highest rate of complications and mortality.

Neglected diseases such as kala-azar and filariasis demand more attention if they are to be eliminated as planned. Dengue outbreaks occur on an annual basis in urban areas and more effort is needed to control mosquito breeding. There are also threats from emerging diseases including SARS and avian influenza.

It is estimated that by 2010 non-communicable diseases (NCDs) will be responsible for 59% of deaths compared to 40% in 1990. Underlying factors that contribute to the increasing burden of NCDs include unplanned urbanisation, changing dietary habits, unregulated tobacco consumption, air pollution, road traffic injury and lack of awareness about healthy behaviour. Tobacco in particular is a major risk factor, having caused 57000 deaths and 382000 disabilities in 2004 alone.

Environmental determinants of health contribute to communicable and non-communicable diseases. The extensive levels of arsenic contamination of the shallow groundwater puts an estimated 20 million people at risk of arsenicosis. More efforts to ensure safe drinking water together with improved sanitation will help reduce the burden of diarrhoeal disease. Other important environmental health issues include indoor air pollution, food safety and climate change.

Bangladesh is prone to natural disasters such as floods and cyclones that lead to outbreaks of communicable diseases. During the floods of 2004, more than 400000 people suffered from different diseases in the aftermath and required treatment. The health system must be further strengthened, both in terms of its preparedness and response capability, to cope with this scale of emergency.

In spite of palpable improvement in various sectors, the country's health system still requires further development to meet the basic health needs of the population. The centralised management system of state health services contributes to the inequitable access to quality health services, particularly in rural areas. Although the health workforce has been steadily growing, Bangladesh continues to face a chronic shortage of and imbalance in their skill mix and deployment. The supporting roles of community-based health workers and volunteers need to be better integrated into the system. Effective regulation is required to ensure the quality of health professionals' education and practice, blood safety, and compliance of local pharmaceutical companies with the international good manufacturing practice (GMP) requirements.

At about US\$ 12.16 per capita per annum, the total health expenditure is well below the level needed to scale up essential health interventions. Historically, supply-side financing of healthcare services has been used to increase access to essential health services for the poor. Based on a recent review, a consensus has been reached over the piloting of some alternative financing mechanisms. The government is now piloting a "demand side financing" option in the form of maternal health voucher schemes to provide support to poor pregnant women.

...According to the World Health Report 2006, Bangladesh in 2004 had 38 485 medical doctors, 20 334 registered nurses, 5 658 medical technologists, 5 743 public and environmental health workers, and 46 202 community health workers (CHWs). Additionally, about 720 00 village health volunteers (VHV) have been trained to serve the community. Large numbers of national and international NGOs are also working at the grass-roots for providing necessary services to the population through their community-based health-care providers. (pp. ix-xi)

...In spite of the progress made, Bangladesh has been identified as one of 57 countries with a critical shortage of the health workforce (doctors, nurses and midwives number below 2.28 per 1000 population). The nurses to population ratio of 0.14 per 1000 and nurses to doctors' ratio of 1:1.85 are among the lowest in the world (Figure 5). There is also an increasing demand for nurses, midwives and medical technologists by the rapidly growing private health sector. Therefore, scaling up and bolstering the development of these categories of the health workforce is a challenging imperative.

...Repeated health workforce assessments have revealed an uneven distribution of the health workforce. While the majority of the population lives in rural areas, most health professionals work in urban areas or close to major cities. (p12)

...The total health expenditure constitutes 3.2% of the national Gross Domestic Product (GDP) (National Health Accounts [NHA] 2003). The sectoral share of the GDP of the health sector (at 2000-01 prices) has increased only marginally from 0.71% in 1998-1999 to 0.83% in 2004-2005 (Public Expenditure Review [PER] 2003- 2004). Health expenditure in Bangladesh, at US\$ 12.16 per person per year (NHA 2003), is far below the minimum expenditure for scaling up a set of essential health interventions in the country. The government's health expenditure is only around US\$ 4 per capita per annum (NHA 2003) and prospects for its substantial increase, are limited. An effective increase in the public health allocation to meet the minimum needs of the population is a challenging task. (p13) (World Health Organisation, Country Office for Bangladesh 2007, *WHO Country Cooperation Strategy – Bangladesh*, pp. ix-xi, 12-13 http://203.90.70.117/PDS_DOCS/B0680.pdf – Accessed 17 December 2008 – Attachment 3).

An August 2007 report from the WHO Regional Office for South-East Asia provides details on public health expenditure, actions being taken to increase health personnel, numbers of medical facilities operating in Bangladesh, and policies on medical drug distribution:

Significant changes in human resources for health have taken place in recent years leading to overall improvement in the coverage of health services. These include production and deployment of more health and health-related personnel, refresher training for health personnel in service, and greater use of health volunteers. In 1997, the distribution of physician per 10,000 populations was 2.03, which has increased to 3.0 in 2005, whereas nurses available per 10,000 populations were only 1.4 in 2004 [Management Information System (MIS), Directorate General of Health Services (DGHS), Bangladesh]. Actions are being taken, which include the establishment of a permanent health institute, formulation of a human resource development plan, and enhancing the quality of medical education.

...In 1993-94, the national health expenditure by both public and private sectors amounted to 3.04 percent of the GNP. It has increased to 3.4 percent in 2003. Public expenditure on health as percentage of total expenditure on health was 36.5 percent in 1998, which has declined to 25.2 percent in 2002. Government health expenditure as percentage of the total government expenditure was 6.9 percent in 1998 but it has also declined to 4.4 percent in 2002 (World Health Report 2005). In 1998, the total government health expenditure per capita was US \$ 4, which has increased to US \$ 11 in 2002. Constraints of mobilising financial resources for health and their efficient use are the inability of communities to finance health services due to poverty, unwillingness of donors to support infrastructure development, and lack of coordination in financial mobilisation. The government now gives priority to cost sharing, decentralisation of authority, decision making and programme implementation at the peripheral level, promotion of community participation, delivery of a package of essential services to the poor, and mobilisation of financial resources by negotiating with donors such as the World Bank.

...Since the mid 1980s the government has sought to improve its health services and teaching institutions. The explicit goal was to build one Union Sub centre (USC) or Health and Family Welfare Centre (HFWC) in every union (4415); one health complex in every thana (397); and one general hospital or tertiary facility in every district (59). As of 1996, there were 4200 USCs/IFWCs, 379 health complexes and 59 district hospitals. By 1999, there were 460 Thana health complexes, 1362 Union Sub-Centers and 3315 Community Clinics; there were also 15 government medical colleges and 7 postgraduate/specialised hospitals. There are another 33 private medical and dental colleges. The total number of hospital beds was 43,293 (1999), which has increased to 51, 684 in 2005. In 2005, 3.43 beds per 10,000 populations were available (MIS, DGHS, Bangladesh). To overcome many of the local constraints in the construction and maintenance of health facilities, the government is considering introduction of a more need-based health planning process that will involve all stakeholders and the community.

...As early as the 1980s, Bangladesh had a national essential drugs policy and a list of essential drugs to be procured and used in health services. These have been maintained to date. Most of the essential drugs were known by their generic name and were less costly than brand name drugs. Production and distribution facilities, both in the private sector and public limited companies, are adequate. Despite these advantages, government run health facilities did not have sufficient essential drugs to meet their actual needs, since the budgetary allocation for the procurement of drugs was not enough. In 1997, a sample of health facilities in remote areas revealed that only eight percent of essential drugs needed at those levels were available. Over the period 1990-95, however, the investment (public and private) in essential drugs, vaccines and ORS increased from 4.31 million to 75.29 million taka.

The government also launched an education programme for providers and users on the rational use of drugs. The government is considering implementation of a new cost sharing scheme based on a sliding scale, which would benefit the poor (World Health Organisation Regional Office for South-East Asia 2007, 'Country Health System Profile: Bangladesh – Health Resources', 6 August http://www.searo.who.int/en/Section313/Section1515_6124.htm – Accessed 24 December 2008 – Attachment 4).

Recent reports on health in Bangladesh

Four recent *IRIN News* reports provide information on aspects of the health system in Bangladesh. A November 2008 report quotes a UN Children's Fund (UNICEF) report which claims that "Bangladesh has one of the highest rates of child and maternal malnutrition in the world", but that "Bangladesh has halved the child mortality rate since 1990". A December 2008 report provides information on the successful polio immunisation campaign in Bangladesh, while a September 2008 report provides details on the extent of arsenic poisoning in Bangladesh, noting that "[l]evels of arsenic in the drinking water are so high in Bangladesh that the WHO has described it as 'the largest mass poisoning of a population in history'". A June 2008 report notes the low government spending on health and the need for more medical staff, particularly in rural areas, and quotes a UNICEF report which claims that "Bangladesh has the worst maternal mortality rate (MMR) in South Asia" ('Bangladesh: Children and women suffer severe malnutrition' 2008, *IRIN News*, 19 November <http://www.irinnews.org/PrintReport.aspx?ReportId=81544> – Accessed 2 January 2009 – Attachment 5; 'Bangladesh: Some 22 million children immunised against polio' 2008, *IRIN News*, 1 December <http://www.irinnews.org/PrintReport.aspx?ReportId=81754> – Accessed 2 January 2009 – Attachment 6; 'Bangladesh: Arsenic in food chain raises health concerns' 2008, *IRIN News*, 19 September <http://www.irinnews.org/PrintReport.aspx?ReportId=80476> – Accessed 2 January 2009 – Attachment 7; 'Bangladesh: 21,000 women die annually in

childbirth' 2008, *IRIN News*, 13 June

<http://www.irinnews.org/PrintReport.aspx?ReportId=78721> – Accessed 2 January 2009 – Attachment 8).

A November 2008 report from *IRIN News* quotes claims from a UNICEF report that “Bangladesh has one of the highest rates of child and maternal malnutrition in the world”, that “48 percent of all children under-five are underweight”, and that “[m]alnutrition contributes to about half of all child deaths”. Nonetheless, the UNICEF report also claims that “Bangladesh has halved the child mortality rate since 1990”, and that “[b]etween 1996 and 2005, the prevalence of underweight children fell from 56 to 45 percent, while stunting fell from 55 to 40 percent”:

Bangladesh has one of the highest rates of child and maternal malnutrition in the world, say health experts.

According to the State of the World's Children (SOWC) Report 2008, issued by the UN Children's Fund (UNICEF), eight million or 48 percent of all children under-five are underweight.

Millions of children and women suffer from one or more forms of malnutrition, including low birth weight, stunting, underweight, Vitamin A deficiency, iodine deficiency disorders and anaemia.

Malnutrition passes from one generation to the next because malnourished mothers give birth to malnourished infants. If they are girls, these children often become malnourished mothers themselves, and the vicious cycle continues.

Malnutrition contributes to about half of all child deaths, often by weakening immunity. Survivors are left vulnerable to illness, stunted or intellectually impaired.

Newborn deaths make up nearly half of all under-five deaths (57 percent) and 71 percent of infant mortality. One neonate dies in Bangladesh every three to four minutes; 120,000 neonates die every year, according to UNICEF.

MDGs on track

However, Bangladesh is on track to achieve several Millennium Development Goals (MDGs), including reducing by 2015 the under-five mortality rate to 50 per 1,000 live births from 65, the UNICEF report claims.

Matching achievements of only five other countries, Bangladesh has halved the child mortality rate since 1990.

...Between 1996 and 2005, the prevalence of underweight children fell from 56 to 45 percent, while stunting fell from 55 to 40 percent.

...Seventy-five percent of all under-fives were fully immunised against all preventable childhood diseases in 2007, up from 64 percent in 2005. Immunisation has helped to prevent infectious diseases that cause malnutrition ('Bangladesh: Children and women suffer severe malnutrition' 2008, *IRIN News*, 19 November

<http://www.irinnews.org/PrintReport.aspx?ReportId=81544> – Accessed 2 January 2009 – Attachment 5).

A December 2008 *IRIN News* report notes the success of the polio immunisation programme in Bangladesh, and states that children are being supplied with vitamin A capsules to combat measles and diarrhoea:

Health experts in Bangladesh have successfully immunised 22 million under-five children against polio, a debilitating disease that mainly strikes children.

“We hope we will be able to make Bangladesh polio-free by 2011,” Salma Begum, a local field worker told IRIN in a suburb of Dhaka, adding that there had not been a single case of polio in the country since November 2006.

...About 22 million under-fives, or about 97 percent of that age group, were immunised against polio, as part of Bangladesh’s current (17th) national immunisation day (NID), with each one receiving two drops of OPV and a vitamin A capsule as part of the first round of the campaign.

Vitamin A is given to children to bolster their immune system against diseases such as measles, diarrhoea and night blindness.

Coverage of vitamin A supplementation increased from around 50 percent in the mid-1990s to above 95 percent in recent years, according to the UN Children’s Fund (UNICEF).

...“The current NID round is sure to go much beyond containing the recurrence of polio alone,” said Carel de Rooy, UNICEF representative in Bangladesh.

“By combining OPV and vitamin A supplementation, the NID campaign will be able to reduce a host of other illnesses like measles, diarrhoea and night blindness that pose threats to the lives of children in Bangladesh,” he said.

Measles and diarrhoea contribute to over 25 percent of deaths among children aged 1-5 in Bangladesh, UNICEF has reported (‘Bangladesh: Some 22 million children immunised against polio’ 2008, *IRIN News*, 1 December

<http://www.irinnews.org/PrintReport.aspx?ReportId=81754> – Accessed 2 January 2009 – Attachment 6).

A September 2008 *IRIN News* report provides details on the extent of arsenic poisoning in Bangladesh, noting that “[l]evels of arsenic in the drinking water are so high in Bangladesh that the WHO has described it as ‘the largest mass poisoning of a population in history’”:

A high concentration of arsenic in the water and soil is infiltrating Bangladesh’s food chain, raising serious health concerns for millions of residents, specialists warn.

The acceptable level of arsenic in drinking water has been set at 50 parts per billion (PPB) or 0.05 microgrammes per litre of drinking water in Bangladesh, while the approved global standard set by the World Health Organization (WHO) is 10PPB.

According to new field surveys of arsenic contamination in soil, water and plants in various parts of the country by scientists from Japan’s Nihon University and local researchers, arsenic was found in all types of crops in the worst-affected areas.

...Levels of arsenic in the drinking water are so high in Bangladesh that the WHO has described it as “the largest mass poisoning of a population in history” .

In rural Bangladesh, many wells pump water with arsenic concentrations exceeding 500 microgrammes per litre. Groundwater is contaminated with arsenic in 61 out of 64 districts.

According to a 2006 UN Food and Agriculture Organization (FAO) report, people might be exposed to arsenic not only through drinking water, but indirectly through food crops irrigated by contaminated groundwater ('Bangladesh: Arsenic in food chain raises health concerns' 2008, *IRIN News*, 19 September <http://www.irinnews.org/PrintReport.aspx?ReportId=80476> – Accessed 2 January 2009 – Attachment 7).

A June 2008 *IRIN News* report quotes a UNICEF report which claims that “Bangladesh has the worst maternal mortality rate (MMR) in South Asia”, and that “skilled birth attendants account for just 13 percent of all deliveries in Bangladesh”. According to UNICEF, “[t]he problem is particularly pronounced in rural areas, where more than 75 percent of the country’s 150 million inhabitants live”. The *IRIN News* report also notes the low government spending on health and the need for more medical staff, particularly in rural areas:

According to the UN Children’s Agency (UNICEF) State of the World’s Children Report 2008, Bangladesh has the worst maternal mortality rate (MMR) in South Asia at 570 per 100,000 live births.

In comparison, the rates in neighbouring India and Pakistan are 450 and 320 respectively, the report states.

According to Bangladesh’s 2007 Demographic and Health Survey, 21,000 mothers die annually of pregnancy and childbirth-related causes, principally because skilled birth attendants account for just 13 percent of all deliveries in Bangladesh, according to government health experts.

The problem is particularly pronounced in rural areas, where more than 75 percent of the country’s 150 million inhabitants live.

“Eighty percent of maternal deaths happen in the countryside,” said Sabera Khatun of the department of gynaecology and obstetrics at the Bangabandhu Sheikh Mujib Medical University in Dhaka. “Medical facilities have not reached the rural areas as extensively as they should.”

Major causes

Most women die of haemorrhaging, followed by anaemia, hypertensive disorders, obstructed labour and abortion, explained Ferdousi Begum of the Dhaka Medical College Hospital.

CARE Bangladesh, which has been organising community initiatives to promote maternal and neo-natal health for past 25 years, cites delays in seeking medical assistance and receiving the appropriate healthcare, as well as transportation problems, as contributing factors.

Findings from the 2007 Demographic and Health Survey concluded that just over half of all pregnant women received any institutional health services during childbirth, while significantly fewer received institutional post-natal healthcare.

...Abul Barakat of the Bangladesh Economic Association blames the high maternal mortality rate on poor budgetary allocation by the government.

Health accounts for just 5.9 percent of Bangladesh's overall national budget, with safe delivery services receiving just a fraction of that.

"Safe delivery services make up only 9.5 percent of the health budget," Barakat explained.

"A two to three times increase in budget is required for delivery care components," he said, adding that the number of service providers in emergency obstetric care, particularly doctors and nurses, should be increased.

However, Bangladesh's per capita health expenditure is just US\$4.62, while only 1 percent of gross domestic product goes on health, he said. In addition, coverage is limited. Since 1998, a comprehensive maternal healthcare project has been introduced to only 80 of the country's 482 sub-districts.

...To reduce maternal and infant mortality, according to the Bangladesh Nursing Council, the country needed another 10,000 midwives to boost the 22,000 employed at present ('Bangladesh: 21,000 women die annually in childbirth' 2008, *IRIN News*, 13 June <http://www.irinnews.org/PrintReport.aspx?ReportId=78721> – Accessed 2 January 2009 – Attachment 8).

2. Please provide information on the treatment of the elderly or disabled.

Treatment of the elderly in Bangladesh

The WHO's Country Office for Bangladesh 2007 strategy report states that "there are about eight million elderly people in Bangladesh", and that "an adequate strategy and health programme for improving the quality of their lives is yet to be developed". A 2002 study of elderly people in Matlab, a poor rural area of Bangladesh, claims that "[o]ld people depend on their adult children, particularly sons for old-age support and security, as there is no public system of social security". A 2007 article on geriatrics in Bangladesh, published in the *Middle East Journal of Age and Ageing*, also notes the centrality of family in caring for the elderly, and characterises the "service delivery system targeted for the elderly" in developing nations such as Bangladesh as "utterly dismal". A November 2005 article from Bangladesh newspaper *The Daily Star* states that the country faces a rapid increase in the proportion of elderly citizens in the population by 2025, and claims that "there have been little efforts by the policy makers at addressing how they can be accommodated as productive members of the society" (World Health Organisation, Country Office for Bangladesh 2007, *WHO Country Cooperation Strategy – Bangladesh*, p.6

http://203.90.70.117/PDS_DOCS/B0680.pdf – Accessed 17 December 2008 – Attachment 3;

Mostafa, G. & Razzaque, A. 2002, 'Determinants and causes of death of elderly people in Matlab, Bangladesh', ICDDR,B: Centre for Health and Population Research

<http://iussp2005.princeton.edu/report.aspx?submissionId=50828> – Accessed 19 December 2008 – Attachment 9; Abedin, 2003; Audinarayana and Kavitha, 2003 and Sattar and Dreze, 2003)

(Tareque, M. 2007, 'Future Appeal of Geriatrics in Bangladesh', *Middle East Journal of Age and Ageing*, Vol. 4, No. 4, August [http://www.me-jaa.com/me-](http://www.me-jaa.com/me-jaa12Aug07/futuregeriatrics.htm)

[jaa12Aug07/futuregeriatrics.htm](http://www.me-jaa.com/me-jaa12Aug07/futuregeriatrics.htm) – Accessed 19 December 2008 – Attachment 10; Ahmed, S. 2005, 'Mainstreaming ageing in health systems', *The Daily Star*, November 27

<http://www.thedailystar.net/2005/11/27/d511276102105.htm> – Accessed 2 January 2009 – Attachment 11).

The WHO's Country Office for Bangladesh 2007 strategy report provides the following brief summary of the position of the elderly in Bangladesh:

Currently there are about eight million elderly people in Bangladesh. The number has been increasing due to the steady improvement of health services and the consequent longer lifespans of the population. They are yet to receive adequate attention as a vulnerable group, and an adequate strategy and health programme for improving the quality of their lives is yet to be developed. Healthy and active ageing through effective welfare and support systems needs to be promoted (World Health Organisation, Country Office for Bangladesh 2007, *WHO Country Cooperation Strategy – Bangladesh*, p.6 http://203.90.70.117/PDS_DOCS/B0680.pdf – Accessed 17 December 2008 – Attachment 3).

A 2002 study of elderly people in Matlab, a poor rural area of Bangladesh, claims that “[o]ld people depend on their adult children, particularly sons for old-age support and security, as there is no public system of social security”:

Bangladesh society is experiencing ideational changes of family formation, family relationship, kinship structure, and many others. Old people depend on their adult children, particularly sons for old-age support and security, as there is no public system of social security. Increased migration of work force, changes in family structure, increased small family-size, and other socioeconomic changes may adversely affect the old age support system in the village.

...Regarding the influence of living arrangements on the survival chances of the elderly, the analysis shows that the elderly who were not staying with children experienced a significantly higher risk of dying, in comparison to those who were staying with children. Owing to inadequate institutional sources of support (pensions, insurance) either through the government or the private sector, the elderly in Bangladesh are for the most part completely dependent on kin (spouse, adult children and siblings) for aid.

...Elderly who had higher level of education had experienced lower mortality than the elderly with no education and individuals who were household heads had experienced a lower mortality rate than others. The presence of children prove to be more beneficial for the survival of the elderly people. Those who were married had a lower risk of dying than those who were widowed (Mostafa, G. & Razzaque, A. 2002, 'Determinants and causes of death of elderly people in Matlab, Bangladesh', ICDDR,B: Centre for Health and Population Research <http://iussp2005.princeton.edu/report.aspx?submissionId=50828> – Accessed 19 December 2008 – Attachment 9).

A 2007 article on geriatrics in Bangladesh, published in the *Middle East Journal of Age and Ageing*, describes the “service delivery system targeted for the elderly” in developing nations such as Bangladesh as “utterly dismal”. This report also notes the centrality of family in caring for elderly in Bangladesh, stating that “[f]amily cohesiveness and filial piety has been the main factor behind this tradition of care from the children to the parents”. Nonetheless, the report claims that “many older people spend their lives in poverty and ill health”, and that “old age is likely to mean ill health, social isolation and poverty”:

...The tragedy lies in the fact that though the industrialised nations have a well-equipped service delivery system targeted for the elderly, the scenario remains utterly dismal in the developing nations.

...The traditional norms and values of Bangladesh society stress the importance of showing respect and providing care for the older population. Although traditions and norms are

changing over the course of time, there still remains a section of the elderly who have no family or are very poor and are looked after by the community or religious organisations. Sometimes these older people live with little care from the relatives, friends or neighbours (Kabir, 1994b). In Bangladesh, like most developing countries of the Asia and the Pacific Region, care for the elderly is still considered as a family responsibility despite the fact that family structure is steadily changing in some of these countries. Family cohesiveness and filial piety has been the main factor behind this tradition of care from the children to the parents (Kabir, 1996).

In Bangladesh many older people spend their lives in poverty and ill health, which is a major risk for the elderly population. After a lifetime of deprivation, old age is likely to mean ill health, social isolation and poverty. Poverty and exclusion are the greatest threats to the well-being of older people.

...In many societies, the tradition of older persons co-residing with their family members is generally the norm (Nizamuddin, 2003). Following the oriental tradition, living with son and being taken care of by his family in old age has been considered as a symbol of prestige. An overwhelming majority of caregivers felt that children/family should be responsible for the elderly. Most of the caregivers also felt that the elderly should be taken care of at home by the members of the family and a hired carer (Samad and Abedin, 1999). The community services for the elderly available, and preferred to have available, include free medical services, exercise center, day care, health equipment, service centre, occupational training, entertainment and regular health check (Cheung, 1996). The findings of a village study conducted in Manikgonj and Rajshahi areas, especially in rural areas, show that community services available for the elderly, are greatly lacking (Samad and Abedin, 1999). The elderly in Bangladesh will face many problems such as insolvency, loss of authority, social insecurity, insufficient recreation facilities, lack of overall physical and mental care, problems associated with the living arrangements etc. (Abedin, 2003; Audinarayana and Kavitha, 2003 and Sattar and Dreze, 2003) (Tareque, M. 2007, 'Future Appeal of Geriatrics in Bangladesh', *Middle East Journal of Age and Ageing*, Vol. 4, No. 4, August <http://www.me-jaa.com/me-jaa12Aug07/futuregeriatrics.htm> – Accessed 19 December 2008 – Attachment 10).

A November 2005 article from Bangladesh newspaper *The Daily Star* states that the country faces a rapid increase in the proportion of elderly citizens in the population by 2025, and claims that “there have been little efforts by the policy makers at addressing how they can be accommodated as productive members of the society”. The report states that “changing lifestyles with small family norms is eroding the traditional family support system for the elderly”, and notes the difficulties experienced by the elderly in obtaining health services:

According to the 2001 census, 6.2% of the population was more than 60 years, the absolute number being above 4.5 million. Approximately 80,000 new elderly people are added to this cohort every year. The projected increase in elderly population in Bangladesh during 190-2025 (17 million+) will be much faster (219%) than that of European countries such as Sweden (33%), UK (45%) or Germany (66%). The country will have much less time to deal with its consequences. Despite steady growth in the elderly population, there have been little efforts by the policy makers at addressing how they can be accommodated as productive members of the society.

In low-income countries like Bangladesh, older persons are often characterised as frail, dependent and unproductive. Experiences of special events in later life such as sudden drops in income and reduced socioeconomic opportunities increase the probability of economic deprivation and social isolation of elderly persons. Increasing landlessness, rural to urban migration and changing lifestyles with small family norms is eroding the traditional family

support system for the elderly. Poverty and social exclusion are the greatest threats to their well-being.

The vulnerability of elderly people is also reflected in a higher burden of ill health and disability. Though the poor elderly experience high levels of sickness, yet their use of health services is below average. There are many potential barriers for older persons to access health services in countries like Bangladesh. These include financial barriers, physical barriers related to problems of mobility and geographical location of the health facilities.

Infrastructural barriers (lack of services for the group at Primary Health Care/ PHC level), attitudinal problems of the health care providers and care-givers (ill health at old age is taken for granted and attracts less priority in family), and informational barriers (availability of services) due to high level of illiteracy among the elderly which also contribute to the problem. Elderly women are especially disadvantaged due to their marginal position in the society. They lack possession of and control over economic resources and endure more disease burden than their male counterparts (Ahmed, S. 2005, 'Mainstreaming ageing in health systems', *The Daily Star*, November 27

<http://www.thedailystar.net/2005/11/27/d511276102105.htm> – Accessed 2 January 2009 – Attachment 11).

Treatment of people with disabilities in Bangladesh

A November 2007 report from the Bangladesh disability rights group Action on Disability and Development states that the Bangladesh government has ratified the UN Convention on the Rights of Persons with Disabilities, and an April 2008 report from the *UN News Centre* states that the Convention will come into force on 3 May 2008. A June 2008 report from *PRNewswire*, located on the *Reuters* website, states that the Bangladesh government has approved a “pilot project on developing a National Database on Persons with Disabilities”. Nonetheless, a July 2007 article in *The Daily Star*, which provides an overview of the legal status of persons with disabilities (PWDs) in Bangladesh, claims that despite ostensible legal protection “poor and severely disabled persons...are facing deprivation that makes them marginalised and vulnerable to all forms of repression”. A September 2008 report sourced from the rethos.com website (a progressive website with the slogan “a platform for change”) notes that Bangladesh has ratified the “UN Convention on the Rights of Persons with Disabilities (PWDs)”, but claims that although “there are laws in Bangladesh to ensure rights for persons with disabilities” there is “very little action”. A December 2007 article in *The Daily Star* puts the number of PWDs in Bangladesh at between 9 and 10 million, and claims that they “remain deprived of fundamental rights due mainly to government negligence”, as the 2001 disability rights law “could not be implemented in the last six years in absence of a set of rules”. A December 2007 article in *The Daily Star* reports on the lack of access to education for PWDs in Bangladesh, and a November 2008 article from the same source claims that PWDs are “regularly being denied of their rights by bus operators”, as seats reserved for PWDs are occupied by other passengers, and “disabled people are in most cases barred from boarding public buses” (Hossain, M. 2007, 'Bangladesh ratifies the UN Convention', Action on Disability and Development website, 25 November http://www.add.org.uk/case_study.asp?ref=90 – Accessed 2 January 2009 – Attachment 12; 'Fruition of groundbreaking treaty on disability rights hailed by UN officials' 2008, *UN News Centre*, 4 April <http://www.un.org/apps/news/story.asp?NewsID=26213&Cr=disab&Cr1> – Accessed 22 December 2008 – Attachment 13; 'Pilot Project in Bangladesh for National Database on Persons with Disabilities Receives Bangladesh Government's Approval for the Data Collection Form' 2008, *Reuters* (source: *PRNewswire*), 25 June <http://www.reuters.com/article/pressRelease/idUS231649+25-Jun-2008+PRN20080625> – Accessed 22 December 2008 – Attachment 16; Sultana, S. 2007, 'Disability related laws and

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A November 2007 report on the website of the NGO Action on Disability and Development (ADD) states that the government had ratified the UN Convention on the Rights of Persons with Disabilities:

The disabled people of Bangladesh have learnt with great pleasure and satisfaction that the Council of Advisers of the present Caretaker Government have decided to ratify the UN Convention on the Rights of Persons with Disabilities today.

The Rights Movement and Action on Disability and Development (ADD) would like to thank the Chief Adviser and his Council of Advisers for this commendable step towards promotion of the rights of challenged people in our country.

We look forward to the full implementation of the provisions of the Convention by the government as soon as possible. ADD pledges its full support to all official measures in implementing the provisions (Hossain, M. 2007, 'Bangladesh ratifies the UN Convention', Action on Disability and Development website, 25 November http://www.add.org.uk/case_study.asp?ref=90 – Accessed 2 January 2009 – Attachment 12).

An April 2008 report from the *UN News Centre* states that the Convention on the Rights of Persons with Disabilities, ratified by the Bangladesh government in November 2007, will come into force on 3 May 2008 ('Fruition of groundbreaking treaty on disability rights hailed by UN officials' 2008, *UN News Centre*, 4 April <http://www.un.org/apps/news/story.asp?NewsID=26213&Cr=disab&Cr1=> – Accessed 22 December 2008 – Attachment 13; for the text of the UN Convention, see: United Nations Secretariat for the Convention on the Rights of Persons with Disabilities 2006, 'Final report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its eighth session', 6 December <http://www.un.org/esa/socdev/enable/rights/ahcfinalrepe.htm> – Accessed 22 December 2008 – Attachment 14).

A June 2008 report from *PRNewswire*, located on the *Reuters* website, states that the Bangladesh government has approved a "pilot project on developing a National Database on Persons with Disabilities":

The data collection form to be used for the survey in the pilot project on developing a National Database on Persons with Disabilities in Bangladesh has been approved by the Ministry of Social Welfare, Government of the People's Republic of Bangladesh on May 15, 2008.

...“With this approval, the project is taking a big step forward,” said Priyanka Kabir, who is coordinating it from Therap’s end. “The form will be used in the survey keeping in mind the project’s goals, which includes identification of the actual number of persons with disabilities in the country, demographic and disability data management, and statistical reports generation. We will now begin the most important phase which is data collection and entry.”

...The pilot project is being implemented in 6 out of 64 districts of Bangladesh. The database will store demographic and disability related information of around 200,000 (two hundred thousand) persons with disabilities. The database software will use fingerprint recognition technology for identification and verification of the data entered into the database. Once completed, the database will be available online for the authorised government officials (‘Pilot Project in Bangladesh for National Database on Persons with Disabilities Receives Bangladesh Government’s Approval for the Data Collection Form’ 2008, *Reuters* (source: *PRNewsire*), 25 June <http://www.reuters.com/article/pressRelease/idUS231649+25-Jun-2008+PRN20080625> – Accessed 22 December 2008 – Attachment 16).

A July 2007 article in *The Daily Star* provides an overview of the legal status of PWDs in Bangladesh, claiming that despite ostensible legal protection, “poor and severely disabled persons...are facing deprivation that makes them marginalised and vulnerable to all forms of repression”. According to this article, PWDs in Bangladesh “face environmental and attitudinal barriers while trying to enjoy or exercise human rights and fundamental rights in the political, economic, social, cultural, civil or any other field on an equal basis with other citizens of the country”:

In Bangladesh approximately 14 million people are with disabilities that constitute a significant part of the extreme poor people. They have not received adequate attention of the policy makers. As a result poor and severely disabled persons with are [sic] facing deprivation that makes them marginalised and vulnerable to all forms of repression. They face environmental and attitudinal barriers while trying to enjoy or exercise human rights and fundamental rights in the political, economic, social, cultural, civil or any other field on an equal basis with other citizens of the country.

...**Protibandhi Kollyan Ain, 2001**

The purpose of the Act is to protect and safeguard the rights and dignity of the persons with disability, ensure their participation in the national and social programmes and their general welfare. This text consists 23 Articles and 10 Parts (Part A to J). Being the first Act in Bangladesh to address disability issues it bears major structural deficiencies e.g. accountability, enforcement, immunity from suit, scope of the authorities to exercise arbitrary and undue power, lack of adequate representation in the committees, weakness in the committees, lack of adequate detail and a meaningless schedule having no implementation mechanism. It is a thin Act having weak and inadequate provisions. Practically we need a comprehensive new Act rather than its amendments or else it is not possible to ensure the rights of this oppressed section of our society.

...All citizens and the government of our country should recognise persons with disabilities as ‘citizens’ of the country on equal basis without any discrimination. Without effective participation of this large number of population no development can reach its envisaged goal. Hence we need adequate disability-friendly laws and policies in our country and their effective implementation mechanism (Sultana, S. 2007, ‘Disability related laws and policies in Bangladesh’, *The Daily Star*, 28 July <http://www.thedailystar.net/law/2007/07/04/analysis.htm> – Accessed 22 December 2008 – Attachment 17).

A September 2008 report sourced from the rethos.com website (a progressive website with the slogan “a platform for change”) notes that Bangladesh has ratified the “UN Convention on the Rights of Persons with Disabilities (PWDs)”, but claims that although “there are laws in Bangladesh to ensure rights for persons with disabilities” there is “very little action”. According to this report, the main legislation regarding PWDs in Bangladesh is the “Disability Welfare Act (Act of 2001)”, but the report claims that the government is ill-equipped to enact the provisions of the act, and that since the passage of the act, PWDs in Bangladesh “reported there was no improvement in their life or any assistance offered to them”:

UN Convention on the Rights of Persons with Disabilities (PWDs) was put in place as a human rights instrument with a social development dimension to protect rights of PWDs and to help break this vicious cycle of poverty and disabilities. The UN Convention makes a paradigm shift in approaches to PWDs – moving away from viewing PWDs as objects of charity towards viewing them as subjects with rights who are capable of making decisions about their own life and taking care of themselves. Eighty-eight countries ratified the UN Convention, including Bangladesh, but as I have discovered through research and spending time here, there are laws in Bangladesh to ensure rights for persons with disabilities, but very little action.

Bangladesh government enacted Disability Welfare Act (Act of 2001) to emphasise the need to identify all persons with disabilities and provide them with identity cards which would help them in accessing public and private amenities/utilities. Seven years later, disabled employees at BERDO still don't have these identity cards. The Act led to a creation of a National Foundation for Development of the Disabled Persons. The Act also covers these areas: prevention, curative treatment, education, health care services, rehabilitation and employment, transportation, social securities and self-help organisations.

Ministry of Social Welfare has been the leading ministry catering for all issues of people with disabilities in Bangladesh since early 1960s, including the areas of education, employment and rehabilitation. Many argue that Social Welfare Ministry isn't equipped to handle issues such as education, rehabilitation and employment of the PWDs, and that these areas demand an active involvement of other ministries and departments. Furthermore, the country has not yet integrated concerns of PWD in any of its generic laws other than the Welfare Act which makes me question how will the PWDs get those 10% of the jobs promised by the government (a part of the Welfare Disability Act – 2001)?

Also I am questioning Ministry's budget allocation and project's priority as I glanced through their website and found projects they are funding, and projects that are under revenue budget. To give examples, there are three projects funded by the government concerning PWDs: (1) Establishment of Bangladesh Rehabilitation Institute for the Disabled which reported zero cumulative physical progress, but 5,950,000 taka (\$87,500) were released for this project; (2) Establishment of six vocational training institute in six divisions for the orphan and disabled children which reported 5% cumulative physical progress while 84,681,000 taka (\$1,245,309) was released; and (3) Establishment of Training and Rehabilitation Centre for Distress Youth and Disabled reported 40% progress and 14,900,000 taka (\$219,118) released (Source: Ministry of Social Welfare, Bangladesh). Let me point out that two out of these three projects are not solely focusing on PWDs, but are combined with other marginalised groups therefore it is hard to access how much attention is devoted to PWDs alone.

When I asked disabled employees at BERDO what change have they noticed since Bangladesh enacted the Disability Welfare Act in 2001, they reported there was no improvement in their life or any assistance offered to them. Another common argument I heard was that they don't want charity and welfare services, but they want what is rightfully

theirs such as access to education, rehabilitation programs and possibilities of employment. Just as the approach discussed in the UN Convention, disabled persons in Bangladesh are waiting when that approach will be the main focus here. They are patient because they know the country is strained for resources, but they are hopeful it will be in the near future (Topcagic, D. 2008, 'Disability at BERDO', rethos website, 15 September <http://www.rethos.com/news/view/1598-Employing-Disabled-Persons-Bangladesh> – Accessed 22 December 2008 – Attachment 15).

A March 2008 article in *The Daily Star* reports on a conference addressing the issue of disability and development in Bangladesh, and pertinent extracts follow below:

Chowdhuri appreciated the efforts of the Bangladesh government in establishing 46 focal points in different ministries, divisions and departments to oversee the interest of people with disabilities in their planning, resource allocation and execution. "Disability is the cause and effect of poverty," said Chowdhuri, pointing out that very little resources are allocated for disabled people.

He also reiterated the reality of a lack of awareness, technical capacity, skilled human resources and financial resources that stand in the way of allowing disabled people to actively participate in the development process.

...One of the important themes discussed was access to information, which is a right for all persons with disabilities. This is perhaps the biggest hurdle that people with disabilities have to face in their pursuit of sustainable employment or regular education. In countries like Bangladesh where information is still inaccessible to most of its citizens, one can only imagine the limitations inflicted on people with disabilities.

...Getting access to education is one of the biggest challenges a disabled person faces from a very early age, one that can actually decide whether such an individual will be able to lead an independent, rewarding life or constantly be at the mercy of other people's charity. There are innumerable instances of children with even minor disability not being accepted at regular schools just because the teachers do not want to make the effort, of kids with disability dropping out of school after being taunted by their classmates or ignored by their teachers. Higher education such as at the university level is even more of a far-fetched dream.

...An unforgivable number of people become disabled all over the world because of avoidable causes. The conference highlighted the different strategies to prevent avoidable disablement. The first step is of course, giving people information on prevention such as identifying a medical condition in an infant at the early stage and getting medical help. The government and development agencies must take initiatives to provide improved training and better ante and post natal care, better nutrition to prevent avoidable diseases that may cause disabilities. The public health system must be reorganised so that it provides preventive, curative and rehabilitative services (Amin, A.M. 2008, 'The Practical Approach to Disability', *The Daily Star*, 14 March <http://www.thedailystar.net/magazine/2008/03/02/hr.htm> – Accessed 22 December 2008 – Attachment 18).

A December 2007 article in *The Daily Star* puts the number of PWDs in Bangladesh at between 9 and 10 million, and claims that they "remain deprived of fundamental rights due mainly to government negligence", as the 2001 disability rights law "could not be implemented in the last six years in absence of a set of rules". According to this report, "the disability act in Bangladesh does not provide for action against those violating or abusing the rights of the disabled people. It does not have any provision ensuring accountability of government officials and employees":

About 35 years after adoption of the constitution enshrining equal rights and status for every citizen, around one crore [10 million] disabled people across the country remain deprived of fundamental rights due mainly to government negligence.

Though a law titled “Bangladesh Disability Welfare Act, 2001” was passed in 2001, it could not be implemented in the last six years in absence of a set of rules.

Legal experts say that the act itself is flawed and it calls for some major amendments. It does not even have clear-cut definitions of disability.

...In the developed countries, the state ensures basic rights and status of the people with disabilities. It provides them with allowance and jobs in both private and public sectors. But things are grim for the disabled in our country.

“Successive governments had been indifferent to meeting the needs of people with disabilities. The present one however is working sincerely to secure the rights of the disabled people,” said MA Hye Howlader, social welfare secretary and also vice-president of the national coordination committee for the disabled persons.

...That the government does not have the exact number of people with disabilities and that no public census has ever been done in this regard bear testimony to government apathy over the years.

However, a census conducted a couple of years ago by different NGOs put the number of persons with disabilities at 90 lakh [9 million].

...Experts say the basic rights of the disabled people could not yet be ensured as only social welfare ministry is entrusted with the job, whereas at least 30 ministries need to work in this regard.

Access to special treatment and training facilities, rehabilitation and employment could not be confirmed as the ministries like education, labour and employment have not been made legally responsible for dealing with the issue.

The government even could not begin its work with the disabled at district and upazila levels as the disability law does not involve the local government and rural development ministry in the task.

It, however, has formulated a plan of action this year involving 40 ministries with the work for the disabled populace, but the experts believe it would not be of much help as the ministries have yet to be made legally bound to perform the duties in this regard.

Unfortunately, the disability act in Bangladesh does not provide for action against those violating or abusing the rights of the disabled people. It does not have any provision ensuring accountability of government officials and employees.

The act also does not say anything clearly about employment or rehabilitation of the disabled segment of the population. It does not have any provision for building up trained manpower to help them.

The government has a 10% quota of public service jobs for those with disabilities. But the private institutions have yet to be made legally obliged to ensure access to employment for them (Hossain, E. 2007, ‘Disabled denied rights’, *The Daily Star*, 9 December

http://www.thedailystar.net/pf_story.php?nid=14771 – Accessed 22 December 2008 – Attachment 19).

A December 2007 article in *The Daily Star* reports on the lack of access to education for PWDs in Bangladesh:

Most of the disabled remain beyond the purview of primary education, leave alone higher levels, thanks to the government's rules of business considering the issue as an act of 'welfare' rather than ensuring a constitutional and fundamental right.

Around 20,000 disabled people enjoy primary education provided in limited arrangements by the government and the NGOs (non-government organisations) every year. But these people don't have access to either secondary or tertiary education and eventually end up as a burden to the society.

The government attitude to this particular issue is evident as only 12.25 percent of Tk 100 crore budget allocated for the disabled is meant for their education, social welfare ministry sources say.

...A lack of an effective curriculum, trained teachers, technical and special supports and a planned structure has miserably failed the projects and educational programmes taken by the government and around 400 NGOs, experts say.

Moreover, international policies including the UN convention signed over the last 50 years by the government have also yielded little result, they observe.

...A USAID report on "assessment of educational needs of disabled children in Bangladesh", however, claims only 1,500 out of 2.6 million disabled children are under the government education programme.

Around 10,000 to 15,000 children are under the education programmes of around 400 NGOs, the report adds.

...“For ensuring quality education a competent and sensitise policymaking body is required in national level,” says Sabbir Bin Shams, executive director of Advancing Public Interest Trust.

“The people working in national level have hardly any idea about the issue of disability while the government's policies don't seem to have been taken considering fundamental rights and needs of these people,” Shams adds.

“Even if education is ensured to the disabled under the existing curriculum, which has little application, the disabled would hardly be able to bring any change to their life or make themselves self-dependent” (Hossain, E. 2007, 'Education still a dream for most disabled', *The Daily Star*, 25 December http://www.thedailystar.net/pf_story.php?nid=16421 – Accessed 22 December 2008 – Attachment 20).

A November 2008 article in *The Daily Star* claims that PWDs are “regularly being denied of their rights by bus operators”, as seats reserved for PWDs are occupied by other passengers, and “disabled people are in most cases barred from boarding public buses”:

Although people with disabilities are supposed to have seats reserved for them in all public buses in the city as per a government order, they are regularly being denied of their rights by bus operators including the state-run BRTC.

According to a government decision taken in September this year all the public buses in the city are supposed to have two designated seats for people with any type of disabilities. The two seats are supposed to be marked and positioned in easily accessible location.

However, very few buses were found following the new order.

In reality the disabled people are in most cases barred from boarding public buses. The designated seats mostly remain occupied by other passengers.

The blind and the disabled persons are also allowed to travel in Bangladesh Road Transport Corporation (BRTC) buses with half fare. To avail the service the disabled persons need to have a card issued from the BRTC office.

However the special offer remains only on papers. BRTC workers said they have no such instructions from the authorities.

...BRTC Chairman Colonel Aktar Kamal said, "Most people with disabilities are unaware of the BRTC social service mostly for lack of publicity. We are trying to develop a service friendly to everyone but our workers are not aware enough. With a little support from NGOs it is possible to train the workers on how to handle a disabled person."

Khandakar Rafiqul Hossain (Kajal), president of the Association of Bus Companies of Bangladesh, admitted the fact of denying the rights of the disabled. He said, "It is a social issue. Most of our workers are illiterate and they come from a class where they have to struggle to earn a living. They are also ignorant of rights issues."

"For them helping to a disabled person to board the bus means waste of time when they drive fast to the next stoppage and get more passengers," he added.

Kajal also blamed the general commuters for not cooperating. "Sometimes commuters refuse to give up the seat. They even tear up the stickers marking the designated seats. Drivers and helpers who are often abused by passengers remain silent just to avoid quarrels," he said (Parveen, S. 2008, 'Buses blind to the disabled', *The Daily Star*, 23 November http://www.thedailystar.net/pf_story.php?nid=64459 – Accessed 22 December 2008 – Attachment 21).

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