



Bangladesh Health Equity Watch

BHEW is a Bangladeshi initiative established to determine whether the health situation in the country is improving and if these improvements are equitable. It is a collaborative initiative of four organisations that share a common concern for equitable health and development in Bangladesh:

- Bangladesh Bureau of Statistics (BBS)
- Bangladesh Institute of Development Studies (BIDS)
- BRAC
- ICDDR,B

The initiative expects to attract more member organisations in the near future.

Although the initial focus is on health the scope of the initiative may be broadened in the future to include development issues such as poverty and human rights issues.

The need for BHEW

Inequalities in health refer to differences in health status, between different groups in the population. *Inequity* is inequality which is deemed unfair, unacceptable, or avoidable. Over the last two decades, Bangladesh has witnessed large declines in mortality and improvement in health of its population despite economic hardship and inadequate health services. However, it is not known whether such improvements have been equitable.

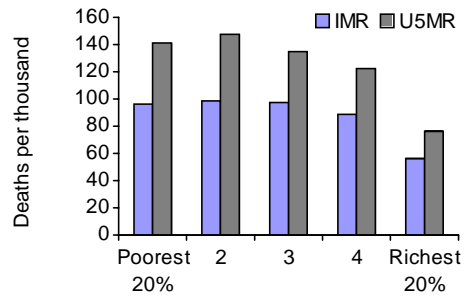
If the gain is experienced differently between groups then it is likely that socio-economic inequities in increased risk, and utilisation and accessibility of health care services may also exist. This in turn may be due to inequitable resource allocation and expenditure on health care services, which also deserves scrutiny from an equity perspective. Existing poverty alleviation and other development programmes also need critical assessment in terms of their equity impact. Only through a continual scrutiny of the above issues can awareness be raised and inequity in health eliminated.

Three pillars of BHEW

BHEW is an active approach for monitoring and addressing inequity in health and health care through partnership of key stakeholders. It moves beyond mere description and passive monitoring of equity indicators to a set of concrete actions designed to effect real change in reducing unacceptable disparities in health and health care.

Inequity in health status

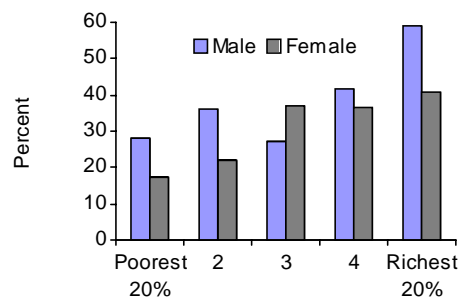
Infant and under-five mortality (1996/7)



Although the richest 20 percent of the population only experience 13 percent of childhood mortality, the overall decline in infant and under-five mortality during the last 15 years has been equitably distributed for the remaining 80 percent of the population.

Inequity in the utilisation of health services

Children brought to a health facility for acute respiratory infection (ARI) (1996/7)



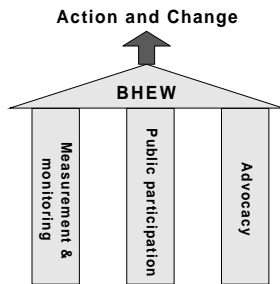
Male children are more likely to be taken to a health facility when ill than female children (29.6 percent vs. 24.6).

BHEW relies upon three “pillars of action”, each considered to be equally important and essential to eliminate inequity: measurement and monitoring; public participation; and advocacy.

Measurement and monitoring refers to the development of methods and tools to identify and map important inequities.

Public participation refers to involvement of community groups and stakeholders in health policy formulation and delivery, and to the principles of community empowerment, bottom up development, and accountability.

Advocacy refers to a broad set of actions designed to influence policy to redress inequities in health and health care.



BHEW will combine activities around these pillars in a complementary manner with an aim to stimulate action to tackle existing and emerging inequities.

BHEW activities

BHEW will plead for incorporating equity dimensions in existing and new data collection systems by including indicators to enable analysis by socioeconomic group, gender, geographical area (urban and rural, slum and non-slum) ethnic group, religion, and by any other indicators that identify vulnerable populations. BHEW will also initiate new data collection. An equity focus will guide all stages of the research process in addition to reporting.

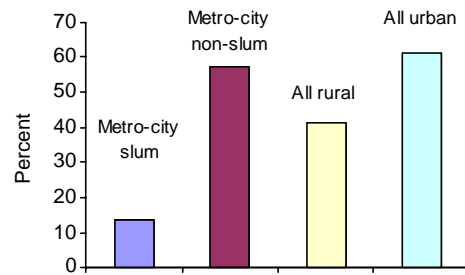
In order to sensitise the society on how to best devise strategies to combat inequity in health BHEW will regularly disseminate findings among policymakers, programme implementers, researchers, NGO leaders and civil society through mass media, seminars, and conferences.

A number of initiatives will be taken to disseminate research findings and stimulate debate on equity issues. BHEW will regularly publish the "Equity Watch Report", a working paper series that contains current equity relevant research findings. "Equity Dialogue", a quarterly bilingual newsletter that will summarise findings of equity studies and provide a forum for exchanges on equity issues will also be published.

BHEW will also make special efforts to build national capacity to carry out equity related activities and research, by involving young researchers and development activists. Sensitisation workshops on equity issues ("Equity Tours") will also be organized for policy makers, advocates, researchers, programme implementers, and academics on a regular basis.

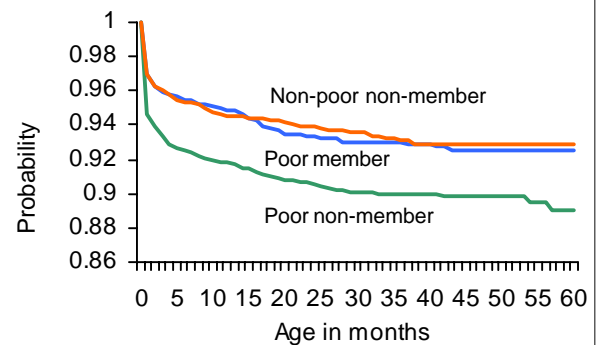
Inequity in access to improved sanitation

Households using improved latrines (2000)



Despite significant improvements in the use of safe latrines during the last decade, a slum dweller is still four times less likely to use a water sealed or home-made pit latrine than a non-slum dweller.

The health equity impact of poverty alleviation programmes (1993-97)



That it is possible to challenge health inequities with focused policy action is illustrated by the impact of BRAC's women centred development interventions on child survival. Survival probability of children belonging to BRAC member households are better than that for children of comparable non-member households; their survival chances are almost equal to those of children from non-poor households.

International partnership

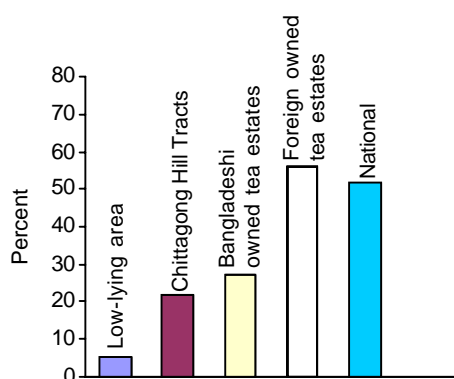
The impetus for BHEW came from the Global Health Equity Initiative (GHEI), started by a small group of researchers from various countries, including Bangladesh, who were concerned by growing inequities in health within and between countries. GHEI has now led to the Global Equity Gauge Alliance (GEGA) and broadened its scope to include action-based programmes aimed at policy-oriented monitoring and remediation of inequities in health.

The immunisation divide

The Expanded Programme on Immunisation (EPI) was launched in 1979, and intensified in 1986. From a coverage of 2 percent in 1986, it reached 62 percent nationally and 80 percent in Rajshahi division for children under 12 months by 1991. However, coverage then started to slide downwards, and by 2001 had dropped down to 52 percent nationally.

There are large differences between the administrative regions of the country. Coverage for children between 12-23 months in Sylhet was lowest at 45 percent, with the highest coverage found in rural Khulna, where it was 69 percent.

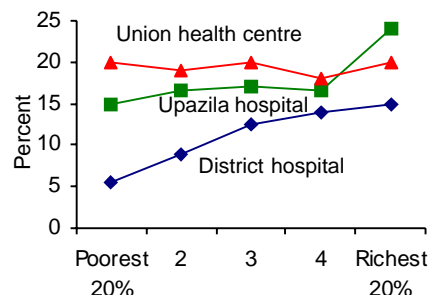
Children aged 0 to 11 months fully immunised by geographic location (1999-2001)



Large intra district differences also exist. In Kishoreganj the total coverage of 28 percent demonstrates this differential coverage; in low-lying (haor) areas marooned by flood waters for most parts of the year coverage was as low as 5 percent. Lower than average coverage was found in some tea estates of Sylhet district where labourers working for Bangladeshi owned companies had coverage of 27 percent. Labourers who worked for foreign companies had coverage of 56 percent. In the Chittagong Hill Tracts, huge disparities emerge between the various ethnic minorities; the immunisation rate of Bangalees was the highest at 33.7 percent, whereas the range for the ethnic minorities varied between 8 percent and 17 percent.

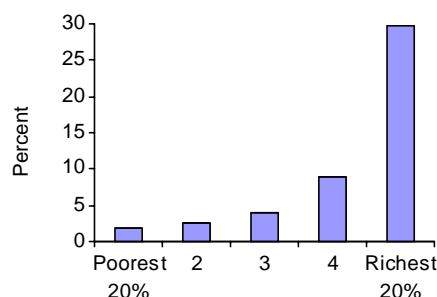
Inequity in utilisation of public sector health services

Inequity in utilisation of different levels of health care services by all age groups when ill (1997/98)



The poorest segments of Bangladeshi society were less likely to seek care at district and sub-district (upazila) hospitals. The only level of care delivery where the poor and the rich were likely to seek care equally was the lowest level of service delivery provided at union health centres. These facts combined with the higher unit cost for using hospitals and health complexes, suggests that the poor in Bangladesh have realised a considerably smaller share of the health subsidy than the rich.

Inequity in utilisation of medically trained personnel during childbirth (1997/98)



A rich woman in Bangladesh is over 15 times more likely than a poor woman to have a medically trained person present when she delivers a child.

GEGA envisions that:

“By the year 2015 every country should have an integrated system for monitoring health inequities that informs, monitors and evaluates health and other socio-economic policies. The systems should be responsive to the national or local contexts in terms of priority indicators to be monitored and strengthened by access to a common global fund of knowledge and technical expertise”.

Currently 11 countries, including Bangladesh, have initiated equity monitoring activities with the support of the Rockefeller Foundation.

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