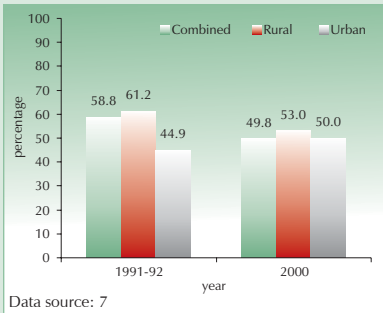




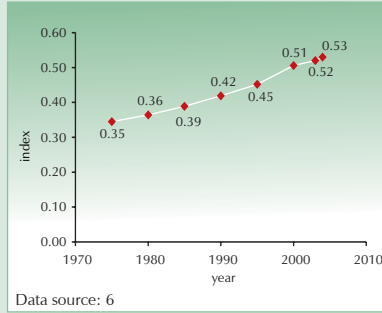
Bangladesh

Basic information	Latest available value	Year	Source
Total population (million)	140	2005	{8}
Area (sq.km.)	147,570		{CC}
Density of population (per sq.km.)	948	2004	{3}
Administrative divisions	6 divisions and 64 districts		
Development	Latest available value	Year	Source
Gross national income per capita (US\$)	470	2005	{5}
Highest in the world – Norway	59590	2005	{5}
Highest in the Region – Thailand	2750	2005	
Population below poverty line – Intl.\$1 per day (%)	36	2000	{5}
Lowest in the Region – Maldives	<1	2004	
Population below national poverty line (%)	50	2000	{7}
Lowest in the Region – Maldives	8	2004	
Adult literacy rate >15 years (%)	50	2002	{8}
Highest in the Region – DPR Korea	100	2003	
Net enrolment ratio – primary (%)	94	2004	{6}
Highest in the Region – DPR Korea	100	2003	
Human Development Index	0.530	2004	{6}
Highest in the Region – Thailand	0.784	2004	
Human Poverty Index (%)	44.2	2006	{6}
Lowest in the Region – Thailand	9.3	2006	
Gender-Related Development Index	0.524	2005	{6}
Highest in the Region – Thailand	0.781	2006	

Percentage of population below national poverty line



Human Development Index



Salient basics

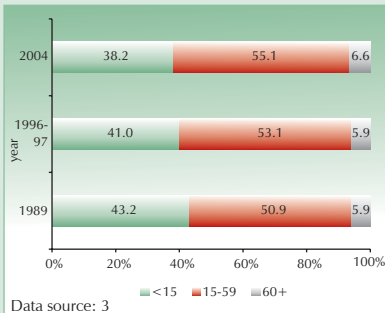
- Bangladesh is a densely populated country. It is home to more than 2% of the world's population.
- It is a low-lying country and is affected by frequent cyclones and floods.
- It is in the category of least developed countries but has shown marked improvement in the recent past.
- Income inequalities rose in the nineties with the Gini coefficient going up to 0.306 in 2000 from 0.259 in 1992.

Q1

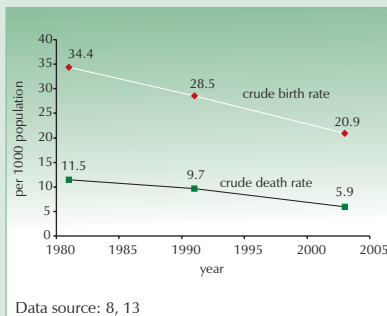
What are the basic demographic features?

Indicators	Latest available value	Year	Source
Population			
Total population (million)	140	2005	{8}
Percentage of world's total	2.14	2004	{C}
Population growth rate per year (%) – natural	1.54	2001	{8}
Urban population (%)	31	2003	{CC}
Age-sex structure			
Sex ratio (F/1000M)	943	2003	{CC}
Children <15 years (%)	38	2004	{8}
Elderly >60 years (%)	7	2004	{CC}
Highest in the world – Italy, Japan	26	2005	{10}
Highest in the Region – DPR Korea	12	2002	
Dependency ratio (%)	60	2005	{35}
Fertility			
Birth rate (per 1000 population)	20.9	2003	{CC}
Lowest in the world – Germany, Ukraine	8.0	2004	{11}
Lowest in the Region – Thailand	12.7	2002	
Total fertility rate (TFR) (per woman)	3.0	2004	{8}
Lowest in the world – Ukraine	1.1	2004	{12}
Lowest in the Region – Thailand	1.6	2000	
Contraceptive prevalence (%)	58.1	2004	{3}
Gross mortality			
Crude death rate (per 1000 population)	5.9	2003	{CC}
Lowest in the world – UAE	1.0	2004	{11}
Lowest in the Region – Maldives	3.0	2005	

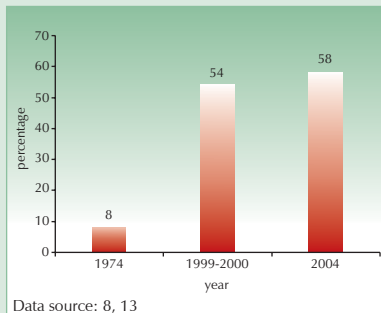
Percentage of population in different age groups



Crude birth rate and crude death rate



Contraceptive prevalence



Salient demographic features

- Bangladesh has an adverse sex ratio with nearly 943 females per 1000 males.
- Child population <15 years is 38%.
- Both the birth rate and death rate have declined considerably in the recent past. The crude death rate at 5.9 per 1000 population shows a declining trend.

2

What is the progress regarding some health-related MDGs?

Indicators	1990	2000	2005	2015 (Target)
Poverty and hunger				
Population below minimum level of dietary energy consumption (%)	35	32	30 (2002)	17.5
Under-weight (<-2SD) children aged 6-71 months (%)	66	51	48 (2004)	33
Child mortality				
Infant mortality rate (per 1000 live births)	94	56 (2001)	53 (2003)	32
Under-five mortality rate (per 1000 live births)	151	94	88 (2003)	50
One year olds immunized against measles (%)	54 (1991)	61	77 (2004)	>90
Maternal health				
Maternal mortality ratio (per 100,000 live births)	574	400	380 (2002)	143
Deliveries attended by health staff (%)	5	12	13 (2004)	
HIV/Malaria/Tuberculosis				
HIV prevalence in 15-49 years (per 100,000 population)	N/A	N/A	<100 (2004)	
Malaria incidence (per 100,000 population at risk)	N/A	N/A	54	
Tuberculosis prevalence (per 100,000 population)	640	N/A	435 (2004)	
Tuberculosis cases detected (%)	N/A	N/A	61	
Water and sanitation				
Population with access to improved water source (%)				
Combined	79	99	97 (2004)	90
Rural	88 (1991)	97 (2001)	97 (2004)	
Urban	45 (1991)	100 (2001)	99 (2004)	
Population with access to improved sanitation (%)				
Combined	23	22	59 (2004)	
Rural	11	N/A	55 (2004)	
Urban	71	N/A	71	

MDG progress

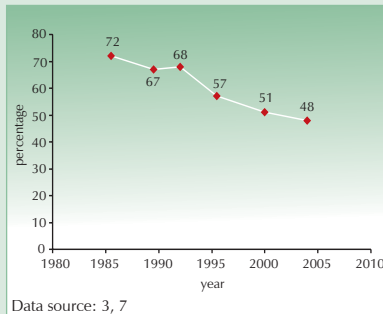
- Except for reduction in underweight children and provision of water supply, the progress with regards to health-related MDGs may not be on track.
- For diseases such as HIV, malaria and tuberculosis, baseline information is not available.

3

What are the major health problems?

Indicators	Latest available value	Year	Source
In children under-five years			
Low birth weight prevalence (%)	40	2005	{7}
Lowest in the Region – Indonesia	6	2002	
Stunted children (%)	43	2004	{3}
Lowest in the world – Croatia	1	1998-2004	{11}
Lowest in the Region – Sri Lanka	14	2000	
Under-weight children (%)	48	2004	{3}
Lowest in the world – Chile, Croatia, Ukraine	1	1998-2004	{11}
Lowest in the Region – Thailand	9	2003	
Childhood diseases			
Diarrhoeas – incidence (per 1000 children <5 years)	75	2004	{3}
Acute respiratory infections – incidence (per 1000 children <5 years)	208	2004	{3}
Other diseases			
Tuberculosis incidence (per 100,000 population)	221	2005	{CC}
Malaria incidence (per 100,000 population)	44	2004	{CC}
% of population having unsafe level of arsenic (>50 ppb) in drinking water	8.5	2004	{3}
Kala Azar prevalence (per 100,000 people at risk)	175	2004	{13}
HIV prevalence (per 100,000 population) – Total population	9	2004	{13}
– 15-49 years	<100	2004	{7}
Diabetes prevalence (per 100,000 population)	2283	2005	{15}
Cancer prevalence (per 100,000 population)	143	2005	{13}
Comprehensive indices			
Expectation of healthy years lost (years)			
Male	7.3	2002	{16}
Female	9.3	2002	{16}
As % of expected life at birth (ELB) lost			
Male	11.7	2002	{16}
Female	14.8	2002	{16}

Percentage of under weight children



Major health problems

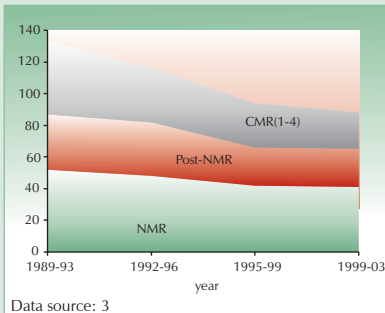
- Nutrition and childhood infections.
- Communicable diseases are still predominant. Data on noncommunicable (chronic) diseases may not be adequate.
- More than one-tenth of equivalent life is lost due to various illnesses.

4

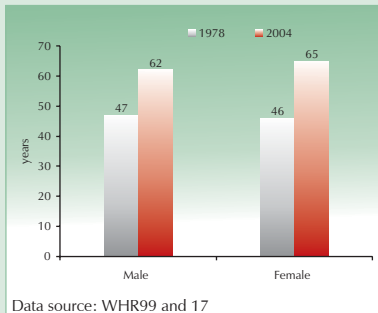
What is the mortality profile?

Indicators	Latest available value	Year	Source
Mortality rates			
Neonatal mortality rate (per 1000 live births)	41	1999-2003	{3}
Lowest in the world – Singapore	1	2000	{12}
Lowest in the Region – Maldives	8	2005	
Infant mortality rate (per 1000 live births)	53	2003	{CC}
Lowest in the Region – Sri Lanka	11	2003	
Under-five mortality rate (per 1000 live births)	88	1999-2003	{3}
Lowest in the world – Iceland, Singapore	3	2004	{11}
Lowest in the Region – Maldives, Sri Lanka	16	2005	
Maternal mortality ratio (per 100,000 live births)	380	2002	{8}
Lowest in the Region – Thailand	14	2003	
Age at death			
Expectation of life at birth (ELB) (years)	65	2002	{8}
Highest in the world – Japan	82	2004	{17}
Highest in the Region – Maldives, Sri Lanka	73	1996-2001	
Deaths under-five years (% of total deaths)	31	2003	{C}
Lowest in the Region – Thailand	4	2002	
Causes of death			
Three major causes of deaths (% of <5 years deaths)			
Acute respiratory infection	21	2004	{3}
Birth asphyxia	12	2004	{3}
Premature births/LBW	7	2004	{3}
Three major causes of deaths (% of total deaths)			
Pneumonia	14	2002	{8}
Other Respiratory Diseases	7	2002	{8}
Tuberculosis deaths	7	2002	{24}
Malaria death rate (per 100,000 population)	0.5	2003	{18}
Diarrhoea (% of total deaths)	6	2002	{5}
Cerebrovascular disease deaths (% of total deaths)	6	2002	{24}

Comparison of mortality rates



Comparison of expectation of life at birth in male and female



Mortality profile

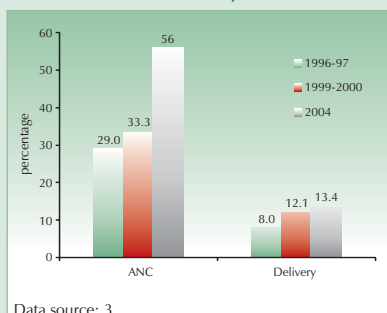
- Child mortality is declining. Correspondingly expectation of life is increasing.
- Maternal mortality continues to pose a challenge.
- Major causes of death in total population are pneumonia, other respiratory diseases and diarrhoea.

5

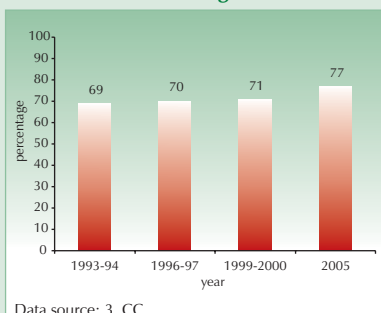
What resources are available for the health sector?

Indicators	Latest available value	Year	Source
Expenditure on health			
Percentage of GDP	3.4	2003	{17}
Highest in the world – USA	15.2	2003	{17}
Highest in the Region – Timor-Leste	9.6	2003	
Per capita (US\$)	14	2003	{17}
Per capita (Intl.\$)	68	2003	{17}
Highest in the world – USA (Intl.\$)	5711	2003	{17}
Highest in the Region – Maldives (Intl.\$)	364	2003	
Food			
Average dietary energy consumption (kcal/day/person)	2200	2001-2003	{19}
Services			
Health centres (per 100,000 population)	1.0	2004	{C}
Antenatal care coverage (at least one visit) (%)	56	1999-2004	{3}
Deliveries by skilled birth attendant (%)	13	1999-2004	{3}
Pregnant women immunized with TT (at least one) (%)	85	1999-2004	{3}
Children immunized by age one year (%)	70		
BCG	99	2005	{CC}
DPT-3	83	2005	{CC}
Polio-3	90	2005	{CC}
Measles	77	2005	{CC}
Beds (per 10,000 population)	4.0	2005	{CC}
Highest in the world – Monaco	196	1995	{12}
Highest in the Region – DPR Korea	132	2002	
Human resources			
Doctors of modern system (per 10,000 population)	3.0	2004	{18}
Highest in the world – Cuba	59	2002	{17}
Highest in the Region – DPR Korea	32	2003	
Nurses (per 10,000 population)	1.4	2004	{18}
Highest in the Region – DPR Korea	37	2003	
Midwives (per 10,000 population)	1.8	2004	{17}
Dentists (per 10,000 population)	0.2	2004	{17}
Pharmacists (per 10,000 population)	0.6	2004	{17}
Public and Environmental Health Workers (per 10,000 population)	0.4	2004	{17}
Community Health Workers (per 10,000 population)	3.1	2004	{17}
Lab Technicians (per 10,000 population)	0.3	2004	{17}
Other Health workers (per 10,000 population)	0.4	2004	{17}

Trend of ANC coverage and delivery in different years



Percentage of measles vaccination coverage



Health resources

- Of the total GDP, 3.4% is spent on health.
- Immunization coverage is increasing.
- Number of health workforce is limited.
- Regarding parents of sick children under five years, 8% are able to seek care from a qualified health care provider.

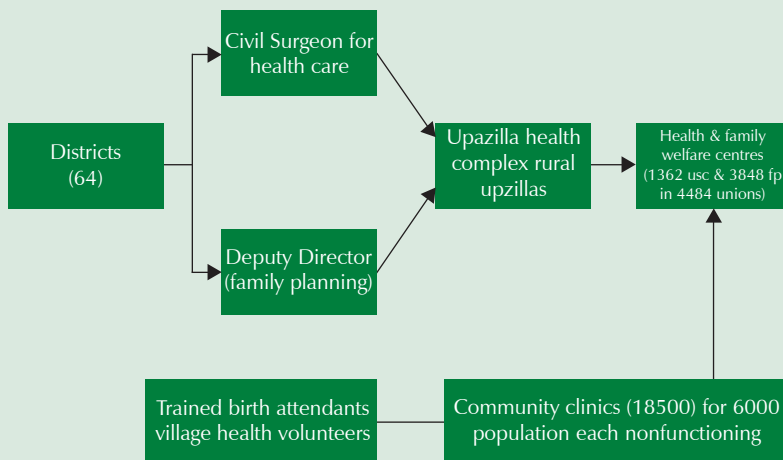
6

What is the system of health governance?

The Ministry of Health & Family Welfare is responsible for policy, planning and decision making at macro level. There are four directorates.

- Directorate General of Health Services
- Directorate General of Family Planning
- Directorate of Drug Administration
- Directorate of Nursing Services

Each of the six Divisions in Bangladesh has a Divisional Director from both the Health and Family Planning department. At the District level, the Civil Surgeon reports to the Directorate of Health Services and is responsible for general health services and the district referral hospital, and the Deputy Director (Family Planning) looks after family planning, MCH and reproductive health services.



Out of 476 Upazillas, all 400 rural Upazillas have health complexes, and are functioning with 31-50 beds. At the next level of 4484 Unions, 1362 Union subcentre functioning through health services, and 3648 Health & Family Welfare Centres run by the Family Planning (FP) Department. There are duplication of both health and FP facilities in some unions, and there are some unions with no facility.

Besides, there are 671 hospitals with total number of 35500 beds operated by Directorate General of Health Services and 91 Maternity and Child Welfare Centres run by Directorate General of Family Planning.

Traditional system

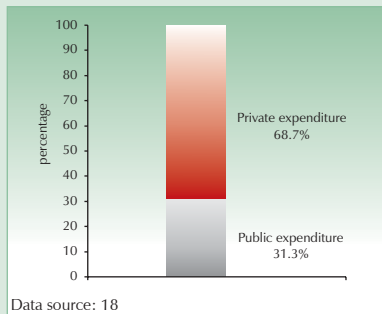
The traditional systems of which practiced are Unani and Ayurvedic. The Board of Unani and Ayurvedic Systems of Medicine controls the teaching in five Unani and four Ayurvedic institutions.

7

Who pays for health care?

Indicators	Latest available value	Year	Source
Government expenditure on health			
Out of total health expenditure (%)	31	2003	{17}
Per capita (US\$)	4	2003	{17}
Per capita (Intl.\$)	21	2003	{17}
Highest in the world – Monaco (Intl.\$)	3403	2003	{17}
Highest in the Region – Maldives (Intl.\$)	324	2003	
Private expenditure on health			
Out of total health expenditure (% of total expenditure on health)	69	2003	{17}
Per capita (US\$)	10	2003	{C}
Per capita (Intl.\$)	47	2003	{C}
Lowest in the Region – DPR Korea	0.4	2004	
Out-of-pocket expenditure (% of private expenditure on health)	86	2003	{17}
Lowest in the world – Tuvalu	13	2003	{17}
Lowest in the Region – Timor-Leste	26	2004	

Health expenditure



Health expenditure

- Public health expenditure is less than one-third of the total health expenditure.
- Per capita public health expenditure is 21 Intl.\$.
- Nearly 86% of private expenditure is out-of-pocket.

8

What are the recent reforms and achievements of the health system?

Health sector reforms

- The Health, Nutrition and Population (HNP) Sector Programme (HNPSPP), launched in 2003 and revised in 2005, aims to reform the health and population sector with the long-term vision of creating a modern, responsive, efficient and equitable HNP sector. The programme entails provision of a package of essential and quality health care services responsive to the needs of people, especially those of children, women, the elderly and poor.
- The health sector strategy has been formulated using the participatory approach involving stakeholders in the health sector. Earlier the top-down approach was used.

Achievements

- Child mortality is rapidly declining and life expectancy is increasing.
- The prevalence of severely under-weight children (age 6-71 months) was halved from 25% in 1990 to 13% in the 2000. Yet, child malnutrition in Bangladesh remains among the highest in the world.
- Since 1997, prevalence of night blindness, an indicator of vitamin A deficiency, has been maintained at below the threshold of 1% so that it is no longer a public health problem. This success is largely due to the vitamin A supplementation programme.
- Since 2000, no case of wild polio virus transmission has been confirmed in the country. But, in 2006, the disease reemerged due to importation of 17 wild polio cases.

- Bangladesh achieved elimination of leprosy at the national level at the end of 1998 with prevalence of less than 1 per 10,000, two years ahead of the target. The present effort is to achieve this at subnational level.
- Diarrhoeal diseases continue but the mortality has considerably declined. The availability of ORS has increased through the ORS depot-holders in the community which have been augmented.

Legislation

- Tobacco Control Law – 2005, and Tobacco Control Regulations - 2006 are being implemented in the country.

9

What are the constraints and challenges of the health system?

Financial constraints

- The estimated health expenditure amounts to 6% of the total government budget. A large part of expenditure is incurred on salaries that leaves not much for development. A significant part of development budget comes from external sources.
- Although all citizens should get free service in all government facilities, a survey in 1999 indicated that 22% of people make extra payments and 27% pay a registration fee. More than half of the respondents reported willingness to officially pay if the government health services improve.

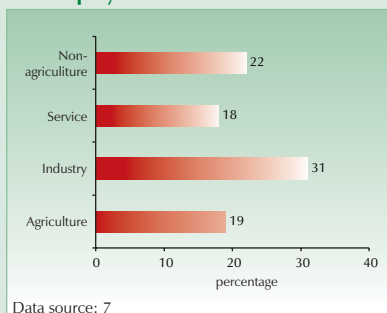
Expertise and other physical constraints

- The infrastructure needs to be strengthened to tackle the health problems.
- Involvement of NGOs in the health and population sector is very wide and dispersed. While this should be an asset, specific roles of each are not well defined. NGOs have proved their excellence, and they would do well if their priority areas are specified.
- Local communities may supervise low-performing areas and the management of hospitals as they are being made more autonomous. However, they require training for the adoption and utilization of existing tools and techniques for participatory appraisals, planning, implementation and monitoring.

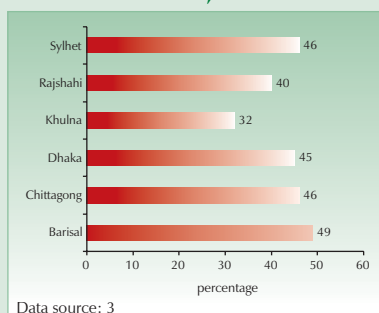
Social constraints

Indicators	Latest available value	Year	Source
Inequalities – Gender			
Expectation of life at birth F:M	1.01	2002	{8}
Professional and technical workers (% women)	25	1992-2001	{20}
Female share in non-agricultural sector (%)	22	2000	{7}
Ratio of earned income (female as % of males)	0.50	2002	{20}
Seats held in parliament – F (%)	2.0	2004	{7}
Ratio of girls to boys in primary schools (%)	104	2002-2003	{21}
Adult literacy rate (F as % of M)	82	2001	{29}
Inequalities – Spatial			
Total fertility rate (per woman)			
Urban	2.5	2001-2004	{3}
Rural	3.2	2001-2004	{3}
Children with diarrhoea taken to a health provider (%)			
Urban	31	2004	{3}
Rural	12	2004	{3}
Under-five mortality rate (per 1000 live births)			
Urban	52	2001	{7}
Rural	89	2001	{7}

Percentage of female share of employment in different sectors



Provincial distribution of stunted children, 2004



Inequalities are visible. While more than 30% of children in urban areas with diarrhoea were taken to a health provider, this was a meagre 12% for rural areas. While 49% of children in Barisal were stunted, it was a relatively low 32% in Khulna.

Health sector constraints

- Though the national policy and workplans are approved, there is a limited monitoring mechanism for environmental health concerns.
- Incompletely functioning information system.
- Supervision and accountability of the health personnel.
- Centralization in the planning and implementation process and non-utilization of the health management information system (HMIS).
- Limited awareness and inadequate utilization of health services in public sector.

Challenges

Nutrition

- Despite impressive gains made in the recent past, Bangladesh remains among the countries with the highest rate of under-nourishment.

Health services

- Substantially increasing the coverage of antenatals and deliveries. So far, attendance of deliveries by skilled personnel is 13% and antenatal care is accessed by only 56%. The Bangladesh Demographic Health Survey 2004 reported improvement over these rates.

- About two-thirds of infant mortality is in the neonatal period as a direct consequence of factors such as low birthweight, preterm delivery and birth asphyxia. This underscores the need to improve maternal nutrition and antenatal care.
- Bangladesh has no national food safety policy. The incidence of food-borne diseases is high.
- Need for development of an efficient project management mechanism across the health system; improvement in logistics of drug supplies and equipment for the health facilities at lower level; improvement in quality and quantity of human resources for health; a system to ensure regular maintenance and upkeep of health facilities; and a plan to improve and assure the quality of health services.

10

What does the country hope to achieve in the near future in health?

- The main objectives of the National Health Policy are to improve the health and nutritional status, and reduce the infant and maternal mortality through:
 - affordable and cost-effective strategy for the rural population;
 - quality domiciliary and institutional health care at the peripheral level;
 - universal access to health care; and
 - improving availability of health care personnel.
- Bangladesh has identified population control as the top priority for government action. The objective is to reduce the total fertility rate and attain a net reproduction rate of 1 by 2010 so as to stabilize the population by 2060.
- The goal is to build one Union Subcentre or Health & Family Welfare Centre in every Union (4484); one health complex in every *thana* (397); and one general hospital or tertiary facility in every district (64).
- Strengthening of the health management information system (HMIS) through training, use of data collection tools that are already designed, and the establishment of information networks with computer support.
- Deliver on Essential Services Package to the whole population with the aim to maximize health benefits per capita expenditure. This is expected to meet the felt needs of the people, strengthen service delivery, and improve system management.

- Introduce a sector-wide approach to manage the health sector, rather than a disparate series of projects as done so far.
- Increase health insurance coverage in urban areas through development of a health insurance scheme for public sector employees.
- Review and revise existing policies for improving accessibility, affordability and quality of services; and develop new policies on public and private sectoral mix for health financing.
- Greater allocation of public-sector funds to support services for the poor, vulnerable groups, especially women and children.

11

How is WHO collaborating with the country?

Policy development and planning

- Support is provided for intensified PHC Project in 20 districts. This contributed to the Health System Development Programme at the PHC level.
- Developing the Strategic Investment Plan 2003-2010 and revising the HNPSF for 2003-2010.
- Introduction of alternative health care financing: Pilot Demand Side Financing.
- Introduction of Community Based Skill Birth Attendants for improvement of maternal health.

Health system management

- Technical support to the government to implement different components of the Health Nutrition and Population Sector Programme (HNPSF). WHO is involved in the initiatives for improvement of maternal health and implementation of the Essential Services Delivery package under HNPSF. Through the initiative of WHO, development and scaling-up of Community-based Skill Birth Attendants (SBA) and piloting of the Maternal Health Voucher Scheme, a Demand Side Financing approach, are implemented in the country, which will contribute to the improvement of maternal health. WHO support was instrumental in introducing and scaling-up IMCI in the country and adolescent-friendly health services. The priority areas for WHO assistance include malaria, kala-azar elimination, elimination of leprosy, dengue haemorrhagic fever, control of tuberculosis, scaling-up of facility and community-based IMCI, HIV/AIDS, nutritional deficiency, and blood safety, epidemic alert and emergency preparedness and response.
- Technical support has been provided to build national capacity in disease surveillance, in setting standards for case definitions and laboratory diagnosis, outbreak investigations, and in developing simple diagnostic and clinical management guidelines for health workers.

- Continuous support has been provided to check the human resource for health, particularly in the area of capacity building through external and in-country training of different categories of auxiliary health personnel. Moreover, support has been provided for health systems and institutional strengthening and capacity building of mid-level managers on leadership development and improved amangement of services.
- Assistance is being provided in strengthening, expanding and improving EPI. Support is closely being provided to implement the strategy to achieve a sustainable reduction in measles mortality and morbidity through a 'Measles Catch-up Campaign' throughout the country with successful immunization of 35 million children against measles.

Promotion of healthy lifestyles and settings

- In the area of environmental health, the major WHO strategic interventions include (a) development of training and information modules, (b) water quality measurement, (c) arsenic-safe water supply solution, (d) mitigation of health effects of exposure to arsenic, and (e) baseline health survey and linked health research. WHO has supported piloting of healthy settings with the development of a Local Environmental Health Action Plan.
- Support has been provided to develop a National Plan of action on NCD surveillance and a National Plan of Action for Tobacco Control and integrated guidelines for prevention of major NCDs at the primary health care level. WHO support was instrumental in enacting the "Tobacco Control Act – 2005" and Tobacco Control Regulations – 2006".
- Support was provided for institutional capacity building in the health sector for emergency preparedness, health risk assessment, vulnerability reduction and disaster mitigation.

Prevention and control of priority diseases

- About 65% of the TB cases in the country have been brought under DOTS strategy with more than 85% cure rate through successful partnership between the government, WHO, NGOs, other stakeholders and the community. The strategy has been extended to cover all rural upazillas.
- WHO plays a strong catalytic as well as technical role in supporting common-border related diseases such as poliomyelitis, HIV/AIDS, tuberculosis, malaria, dengue and cholera, which are crucial to reduce adverse health consequences following a disaster.

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