Policy Discourse and Paradigm Shift on Reproductive Health in Bangladesh

By

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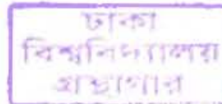
Thesis submitted for the Degree of Doctor of Philosophy



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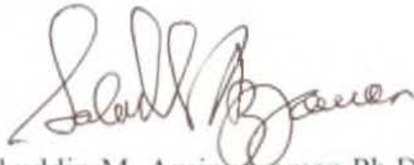

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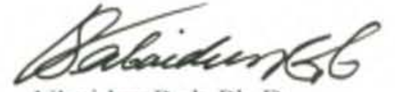

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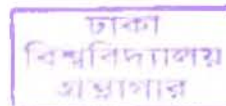

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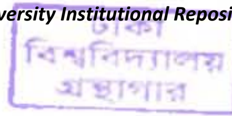

Abstract

This study aims at mapping and analyzing the development of policy discourses relating to reproductive health care in Bangladesh with a view to examining if there has been any paradigm shift in the policy frameworks and assessing complementarities and inconsistencies within the policy frameworks for addressing reproductive health.

Analysis of policy discourses in this study has been made along three policy regimes as identified by the study: a) FP-MCH policy regime; b) reproductive health policy regime with reformist approach; and c) reproductive health policy regime with conformist approach. It has analyzed the policy frameworks of the three regimes through the lens of rights-based approach to health. It has looked into the policy frameworks in terms of 'freedom' and 'entitlement'. Policy frameworks have been analyzed with a view to examining how policies, strategies, and interventions evolved under the influence of major actors and factors promoting 'freedom' in terms of freedom from coercion, restrain, and discrimination; and ensuring 'entitlement' through affecting the availability of, accessibility to, and quality of maternal health and family planning services.

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In FP-MCH policy regime availability, accessibility, and quality issues of reproductive health services were bounded within the fertility reduction goal of the policy regime. FP-MCH policy regime had significantly addressed availability and accessibility issue of family planning services but had ignored freedom and quality issues. Maternal health was not pursued by this policy regime because fertility reduction gain had not been perceived in maternal health. Thus, maternal health services and interventions remained very inadequate.

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Reproductive health policy regimes have established maternal health as the most important reproductive health in its own right and expansion of EmOC has been the principal maternal health strategy. However, family planning services have not been perceived as a means to reproductive health and hence, issues of availability, and accessibility relating to family planning services were not appropriately linked to reproductive health. The opportunity of viewing family planning services as a means to reproductive health got diminished and also led to de-emphasizing of family planning services. De-linking of reproductive health services through the split implementation arrangement of conformist reproductive health regime has significantly affected the accessibility to and quality of the reproductive health services. Absence of reversal of family planning programme focus and strategy to work within reproductive health framework has resulted in undermining the concept of freedom and quality of services, the core of rights-based reproductive health services.

Family planning like maternal health services requires fitting into the rights-based reproductive health framework for being recognized and emphasized as reproductive health agenda for achieving common health goal. Further improvement in reproductive health calls for more accessible, user centered, and quality reproductive health services. Creating effective linkage and coordination between and among all the reproductive health services through appropriate policy measures are crucial for improving accessibility and quality of services.

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Acknowledgement

I am grateful to many individuals and institutions for their assistance and cooperation at various stages of this research. To my supervisors, Professor Dr. Salahuddin M. Aminuzzaman and Dr. Ubaidur Rob, I owe special word of thanks for the instrumental role played by them in completing this thesis. Without their guidance, critical comments, insights, and advice at different stages of my study, it would not have been possible to complete this thesis. Further, I am indebted to those who have read and commented on all or part of the thesis.

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Abbreviations

ABCN	Area Based Community Nutrition
ADB	Asian Development Bank
AFPOs	Assistant Family Planning Officers
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic Health Survey
BHE	Bureau of Health Education
BHW	Bangladesh Health Watch
BINP	Bangladesh Integrated Nutrition Project
BMDC	Bangladesh Medical and Dental Council
BMMS	Bangladesh Maternal Mortality Survey
BNC	Bangladesh Nursing Council
BNP	Bangladesh Nationalist Party
BPC	Bangladesh Pharmacy Council
BWHC	Bangladesh Women Health Coalition
CDD	Control of Diarrhoeal Diseases
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CIDA	Canadian International Development Agency
CMSD	Central Medical Store Department
CPR	Contraceptive Prevalence Rate
CRHCC	Reproductive Health Care Centres
DD-FP	Deputy Director Family Planning
DFID	Department For International Development

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DFMHVS	Demand-side Financing Maternal Health Voucher Scheme
DGFP	Directorate General Family Planning
DGHS	Directorate General Health Services
DPT	Diphtheria, Pertussis and Tetanus
ECNEC	Executive Committee of the National Economic Council
EmOC	Emergency Obstetric Care
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ESD	Essential Services Delivery
ESP	Essential Service Package
FP	Family Planning
FPIs	Family Planning Inspectors
FP-MCH	Family Planning Maternal Child Health
FWAs	Family Welfare Assistants
FWVs	Family Welfare Visitors
FWVTIs	Family Welfare Visitors Training Institutes
GAD	Gender and Development
HACs	Health Advisory Committees
HAPP V	Health and Population Project V
HAs	Health Assistants
HIs	Health Inspectors
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HNP	Health Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Programme
HPSP	Health Population Sector Programme
HPSS	Health and Population Sector Strategy
HUFs	Health Users' Forums

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ICCPR	International Covenants on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IEC	Information Education Communication
IEM	Information Education Communication
IEM	Information Education and Motivation
IFA	Iron Folic-Acid
IMF	Monetary Fund
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
i-PRSP	Interim Poverty Reduction Strategy Paper
IUD	Intra Uterine Device
MAs	Medical Assistants
MCH	Maternal Child Health
MCWCs	Maternal and Child Welfare Centers
MDGs	Millennium Development Goals
MHVS	Maternal Health Voucher Scheme
MIS	Management Information System
MMR	Maternal Mortality Rate
MOs	Medical Officers
MO-CC-MCH	Medical Officer for Clinical Contraception and Maternal Health
MoHFW	Ministry of Health and Family welfare
MoHPC	Ministry of Health and Population Control
MoLGRD	Ministry of Local Government and Rural Development
MO-MST	Mobile Sterilization Team
MR	Menstrual Regulation

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MTP	Medical Termination of Pregnancy
MTR	Mid Term Review
NGOs	Non Government Organizations
NHP	National Health Policy
NIPORT	National Institute of Research and Training
NNP	National Nutrition Programme
NPC	National Population Council
NRR	Net Reproduction Rate
OGSB	Obstetric and Gynecological Society of Bangladesh
OPs	Operational Plans
PCFPD	Population Control and Family Planning Division
PIP	Programme Implementation Plan
PNC	Post Natal Care
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
PSTC	Population Services and Training Centre
RTIs	Reproductive Tract Infections
SACMO	Sub-Assistant Community Medical Officer
SBA	Skilled Birth Attendant
SC	Satellite Clinics
SIP	Strategic Investment Plan
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THCs	Thana Health Complexes
TT	Tetanus Toxoid
UDHR	Universal Declaration of Human Rights

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UFPO	Upazilla Family Planning Officer
UHCs	Upazilla Health Complexes
UHFPOs	Upazilla Health and Family Planning Officers
UHFWCs	Health and Family Welfare Centres
UMIS	Unified Management Information System
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations' Children's Fund
UNO	Upazila Nirbahi Officer
UPHCP	Urban Primary Health Care Project
USA	United States of America
USAID	US Agency for International Development
VDP	Village Defense Party
WHO	World Health Organisation
WID	Women in Development

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Chapter 1
Introduction

This study aims at mapping and analyzing the evolution of policy discourses relating to reproductive health services in Bangladesh. The study examines how far the policy frameworks have reflected a paradigm shift towards rights based reproductive health programme. It also investigates complementarities and inconsistencies within the policy frameworks for addressing reproductive health of the population.

The following sections give an account of the justification for the study; places the research questions, objectives, and scope; highlights the significance; presents the research methodology; draws the theoretical and conceptual framework; and lays down the outline of the study.

1.1 Background and Rationale of the Study

Prioritization and allocation of value is embedded in the policy process because policies are founded on goals and objectives. Policy process always involves choosing between and among competing alternatives. Public policies deal with allocation of public resources and have to set its priorities to reduce inequities in provisioning goods and services. The stake of public policies is much higher and thus, they not only invoke debates and arguments but also involve a political and complex process (Blank and Burau 2004). Responsive public policies embody democratic values like participation, transparency, and accountability in order to resolve the competing and often conflicting claims on the use of public resources (Roberts and *et. al.* 2004).

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Health care is considered one of the most controversial public policy issues (Roberts and Reich 2002; Barker 1996; Blank and Burau 2004; Lawn and *et. al.* 2006; Lawn and *et. al.* 2008). Controversies centering health care largely stem from differential valuing of health care by societies at large. Health care is argued by many as right; some see it as expenditure, while others consider it as an investment (Barker 1996). Conflicts emerge when resources are to be allocated among contending groups of health services i.e., particular type of health service, specific type of disease, etc. (Roberts and Reich 2002: 1055-56; Blank and Burau 2004: 17; 107; Lawn and *et. al.* 2006: 1474-75; Lawn and *et. al.* 2008: 919-20). Frequently sought ideas and values like efficiency, human rights, cultural respect, equity, and individual choice lead to different policy outcomes (Roberts and Reich 2002: 1055). Governments struggle over issues like coverage, access, equity etc. in health services, but at the same time confront with the challenge of cutting down health care expenses to allocate resources for other social sectors having reasons to value for.

Health care policies have been defined as "the network of interrelated decisions which together form an approach or strategy in relation to practical issues concerning health care delivery" (Barker 1996: 6). It has also been referred to as "course of action proposed or taken by government that impact on the financing and/or provision of health services" (Blank and Burau 2004: 16). Non action by government in any area of health care or health system has also been argued as part of government's policy (Blank and Burau 2004: 16).

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Health and population policies and programmes in Bangladesh have evolved in the context of global discourses and 'national mood' on health and population issues. Policy processes have involved political process at different levels. Donor dependant health and population sector has mostly relied on the policy prescriptions from donors. Major policy ideas and changes in the health and family planning sector were claimed to have been injected by the external sources (Buse and Gwin 1998; Rob and *et. al.* 2005; World Bank 2005a; Chowdhury and Osmani 2010). Often the changes were incremental in nature and built on the previous policies and often the changes were radical (Jahan 2003; MoHFWa 1998).

Reproductive health programme of Bangladesh, like many other developing countries, has its legacy in the family planning programme of the past. Family planning programme has always been the only programme intervention of the population policy in Bangladesh. Other elements of population policy i.e., migration, health, and urbanization have not been adequately integrated into its implementation strategy.

The prime objective of the family planning programme as directed by the policy documents has been fertility reduction. The range of activities and strategies within the family planning programme of Bangladesh got intensified and varied over time. Programme has been evaluated only in terms of its impact on fertility reduction. Programme monitoring has been done on the basis of increase in contraceptive users. Many have lauded family planning programme of Bangladesh for its commendable success in fertility reduction without substantial improvement in the socio-economic

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condition of the country (Cleland and *et. al.* 1994). Again, many of the activities and strategies particularly, method specific targets and incentives-disincentives within the family planning programme have raised serious controversy among different groups (Sen and *et. al.* 1994; Dixon-Mueller 1993; Hartmann 1987; Hartmann and Standing 1989).

In mid seventies government had integrated maternal child health (MCH) services with family planning services. Since then family planning programme in Bangladesh has moved from a uni-purpose programme into family planning maternal child health programme (FP-MCH) (World Bank 1979: 6). Neglect of maternal health had been a long standing issue in the realm of FP-MCH programme (Gill and Ahmed 2004). Maternal mortality remained very high even after the start of 'reproductive revolution' in the early nineties.

After the International Conference on Population and Development (ICPD) in 1994, along with the global shift in the area of health and population, there has been a major policy shift in Bangladesh from FP-MCH to reproductive health (Jahan 2003). Such a major shift from target driven family planning programme to broad based reproductive health called for massive changes in the policy focus, programme design, and strategic interventions. Like many other countries, this shift has not been very smooth and many of the policy shifts were made only on paper. Reproductive health is conceptually and qualitatively different from the previous stand alone vertical programmes and requires complete change in the policy orientation,

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programme design, and management system including monitoring and evaluation. Thus, provisioning of reproductive health services in a resource poor setting like Bangladesh has thrown big challenges before the government, like up-gradation of facilities, training of service providers, introduction of appropriate programme monitoring system etc.

Move towards reproductive health has necessitated changes in the programme direction more than ever before. Under the new realm of reproductive health, government has introduced various new programmes, arrangements, and measures to address reproductive health programme challenges of the country (MoHFW 1998a). While some of these changes have been hailed for broadening and strengthening the programme, some changes have been accused for causing disruption in the implementation of family planning programme (Jahan 2003; Islam 2003). Some have claimed that this disruption in family planning programme had resulted in the plateauing of total fertility rate at the level of 3.3 for several years (Mabud, 2007; Islam 2003).

At this backdrop, some fear that family planning efforts will be diluted if broader reproductive health services are provided. On the other hand, advocates of reproductive health claim that good family planning services cannot be provided without giving due attention to the reproductive health needs. For example, reproductive tract infections are very common among women and management of these infections is critical for providing contraceptives safely and effectively. Further, it has also been argued that

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while providing comprehensive reproductive health services is a desirable goal, it has to be considered to what extent we can deliver it without compromising the quality and effectiveness of the services. Therefore, some have argued to prioritize and develop a phased approach with an incremental addition of health intervention that requires greater skills and resources (Pachuri 1999). The real challenge is to design an available and accessible cost-effective package of good quality services in the context of the respective countries.

Reproductive health programme of Bangladesh is yet to address the very basic reproductive health issues of its people. Reproductive health services are still confronted with the issues of 'availability' of services. Equality issues like 'accessibility', 'quality' are far crying demands. Good progress has been made in curbing maternal mortality in the last decade from 322 in 2001 to 194 in 2010 per 100,000 live births (NIPORT 2011: 19). This has been reflective of government's commitment towards reduction of maternal mortality. However, maternal health care seeking needs to be significantly improved for further improvement in maternal health situation. Differentials in maternal health status and maternal health seeking needs to be lessened (NIPORT 2009: 91).

Even though determinants of health are broad based and not located only within the health sector, it is argued that good policy even in a resource poor setting can contribute a lot in promoting health of people and vice versa. Again, sound policies on paper without effective implementation do not

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have any practical utility. Successful policy reforms demand a set of interdependent and mutually reinforcing interventions especially when it makes a major shift from past practice at one go. While the operation of the health sector plays the most vital role in affecting health of the population, health status of population is also very much affected by the forces in other sectors (WHO 1986). Therefore, a comprehensive approach to health sector requires cross-sectoral coordination.

Given this context, it is important to examine: weather adequate policy attention was given to increase the availability of and accessibility to, and quality of reproductive health services; have policy frameworks been appropriately designed to address reproductive health needs of the population.

1.2 Research Questions

In view of the above context, this study attempts to address the following research questions.

1) How have the policy frameworks[1] in various policy regimes[2] affected the 'availability of, accessibility to, and the quality of reproductive health services'[3] in Bangladesh?

---

[1] 'Policy framework' in this study refers to as a set of policies, strategies, and interventions to form an approach for guiding and directing the programme.

[2] 'Policy regime' in this study refers to policy periods with similar content, focus, approach, and incremental changes. The study has categorized three major policy regimes: a) FP-MCH based policy regime; b) reproductive health policy regime with 'reformist approach'; and c) reproductive health policy regime with 'conformist approach'.

[3] For a detailed account on 'availability of', 'accessibility to' and 'quality of reproductive health services', see, below, conceptual framework of this chapter, pp. 31-33.

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2) How far has there been a paradigm shift relating to reproductive health services in Bangladesh?

3) How have major policy actors[4] and factors[5] influenced the policy frameworks, changes, and shifts?

4) Have the policy frameworks been appropriately interconnected to achieve the policy objectives?

1.3 Objectives of the Study

This study aims to examine the changes and shifts in the policies relating to reproductive health services in Bangladesh. The object has been to explore whether such changes were directed to respond to the reproductive health challenges of the country. This study intends to give an account of the development of the policy regime relating to reproductive health from its independence in 1971 to 2011. It aims to reveal and examine the complementarities and inconsistencies within the policies, and between and among the policies, strategies, and programme interventions. Further, the scope of the contemporary policies and programmes to address reproductive health challenges in Bangladesh has been analyzed.

1.4 Scope of the Study

The study examines policies and programmes relating to family planning and maternal health components of the reproductive health care services from the independence in 1971 of the country up to 2011. Thus, analysis of policies or programmes relating to other reproductive health services or after

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[4] 'Policy actors in this study refer to, individuals, groups or networks, agencies who influence the policy process either by giving input in the policy process or by bargaining in the policy process. They include both state actors and non state actors.

[5] Policy factors in this study refer to the situation or circumstances at the national and international level including political, economic, social and cultural those influence the policy process.

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2011 is beyond the scope of the study. The study discusses and analyzes child health services to the extent it deemed relevant for analyzing maternal health services. The study addresses its questions through analysis of policy discourses and opinions of the policy actors. Thus, beneficiary assessment or impact assessment is beyond the scope of the study.

The study attempts to examine how policy framework affects entitlement to services in terms of availability of and accessibility to, and quality of reproductive health services and thus, it brings in the implementation scenario of the respective policy regime to the extent it deems necessary for analyzing how policy framework affects implementation of the programme. The purpose of the study is not to examine how implementation achievement or failure affects availability of the services. Further, the study looks into the policy framework in terms of freedom and entitlement and brings in governance issues like accountability to the extent it has been connected to entitlement issue.

The study aims to examine how complementarities and inconsistencies between and among policies, strategies, and interventions affect the achievement of policy objectives through affecting the availability of, accessibility to, and quality of care of reproductive health services. Thus, other factors affecting the availability of, accessibility to, and quality of care of reproductive health services are beyond the scope of the study.

1.5 Significance of the Study

Rights-based approach is gaining currency in the contemporary policy frameworks particularly at the backdrop of Millennium Development Goals

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(MDGs). The study in the light of its analysis of different policy regimes relating to reproductive health, shows how rights-based approach promotes reproductive health in a better and sustained way. This study will add in having a critical insight on the entire gamut of policy changes in reproductive health from rights-based approach to health. The study will contribute in finding out the inconsistencies between and among the policy frameworks with respect to rights-based reproductive health and thus, will be helpful in giving future directions for rights-based reproductive health.

1.6 Limitations of the Study

The opinions of the policy actors used for the study are not free from their ideological and professional biasness and mind set. Further, some of the information could not be validated through cross checking. However, data and information were assessed with optimum level of objectivity and validation process within the given methodology.

1.7 Research Methods

The study based on its conceptual framework, investigates its research questions at two levels using two different methods. It has primarily used content analysis and in-depth interview method to gather data and information.

1.7.1 Content Analysis

Content analysis was done for: i) mapping the policies; ii) analyzing policy discourses in the context of broader policy environment; iii) examining the complementarities and inconsistencies within and among the policy frameworks.

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For examining the policy discourses, the entire period has been divided into three policy regimes. These policy regimes were categorized keeping the time line of major policy documents and the time line of the major policy shifts.

The contents of documents reviewed, among others, include the followings:

a. Long term plans of the government i.e., i) Five Year Plans;[6] (the first five year plan (1973-78) to the fourth five year plan (1990-95) ii) Two-Year Plan (1978-80); iii) Millennium Development Goals; and iv) Poverty Reduction Strategy Paper.

b. Policy documents, strategic plans, programme implementation plans of the concerned ministries or sectors like : i) Bangladesh Population Policy, 1976; ii) National Drug Policy, 1982; iii) Health and Population Sector Strategy (HPSS), Dhaka, 1997; iv) The National Health Policy, 2000 v) Health and Population Sector Progamme 1998-2003: Programme Implementation Plan; vi) Health Population Nutrition Sector Programme (HNPSP), July 2003-June 2006; vii) HNPSP revised 2003-2010; Bangladesh Population Policy, 2004; viii) National Strategy for Maternal Health, 2001; and ix) The National Communication Strategy for Family Planning and Reproductive Health, 2008.

c. Reports of the concerned ministries; mid term reviews and annual performance reviews of the government; independent review reports, project appraisal reports, project evaluation reports, policy briefs, notes being produced by different international donor agencies i.e., World Bank, UN bodies, and specialized research institutions.

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[6] Five Year Plan is the macro level plan prepared by the Planning Commission of Bangladesh. It is based on various input output and projection models. All development activities, programme and project interventions of government and private sector are guided by the plan. It provides broad outlines of all the sectors within which concerned ministries operate. Annual Development Programmes (ADPs) are implemented in accordance with the five year plans.

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The contents of other secondary sources that have been reviewed included: published research articles, review articles, research monographs, and conference papers relating to reproductive health programme and policies.

1.7.2 In-depth Interview

To supplement the analysis and findings through the content analysis of all the available literatures, this study has conducted in-depth interviews with two categories of policy actors to gather their views and opinions on major policy issues those have emerged through analysis of policy discourses in the three policy regimes.

The purpose was two fold: i) to examine how views and opinions of policy actors reflect on the contemporary policy frameworks; and ii) to find a common thread to resolve conflicting claims on various policy issues for contributing to future policy direction.

One group of these policy actors is called state actors. This group is drawn from the insiders of Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). They included top to mid ranking officials of DGHS and DGFP who are responsible for guiding, directing, monitoring and implementing the reproductive health programme of the government. The state actors consisted of: a) the policy makers (i.e., executive heads of the MoHFW, joint chief of MoHFW, chiefs of DGHS and DGFP); b) senior officials (i.e., respective line directors, divisional and district level chiefs of DGHS and DGFP; c) mid-level officials (i.e., mid-level programme managers assigned with operation, management, and

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implementation of the relevant operational plans, and district level programme managers and medical officers of DGHS and DGFP at district hospitals and MCWCs respectively).

Ten districts were chosen from four out of total seven divisions of the country. These four divisions are Dhaka, Chittagong, Khulna and Sylhet. Of these, Khulna is high performing division, Chittagong and Sylhet are low performing divisions and Dhaka is average performer. Four districts were chosen from Khulna, two from Chittagong, two from Sylhet and two from Dhaka. Of the total ten districts, six are old districts and four are new districts. These districts are: Jessore, Jhenidah, Magura, Khuna, Sylhet, Maulavibazar, Chittagong, Noakhali, Narayanganj, and Comilla.

In-depth interviews were held with a total of 65 state policy actors. They are: 8 policy makers (executive heads of MoHFW, Joint Chief, Chiefs of DGHS and DGFP including the former ones); 6 Line Directors of the operational plans of reproductive health services; 4 Divisional Directors of health and family planning; 20 District level heads of DGHS and DGFP i.e., Civil Surgeons (10) and Deputy Directors (10); 10 Mid level programme managers at the national level; 17 Mid level programme managers and medical officers at the district levels (7 from MCWCs and 10 from district hospitals).

Higher number of district level heads and mid level managers were interviewed because rights-based approach calls for a bottom-up policy process.

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Political heads of the ministry were not included for interview as state actors. It is due to the fact that major political parties do not exhibit major ideological difference regarding health and population policy and programme issues. Moreover, policy process in developing countries like Bangladesh is largely dominated by the bureaucrats as the state actors.

Non state-actors included academia, researchers and professionals contributing in the area of reproductive health outside the state machinery. The non-state policy actors were drawn from a range of external stakeholders of the policies and programmes relating to reproductive health. They are not employed in or do not directly work for the government's health sector. They are key persons who have been actively involved in providing input and support for policy process or have been involved in bargaining with the government in the policy process in various capacities. This group excludes representatives from donors. Policy actors under this category were identified in consultation with a pool of experts in this field. However, some alterations had to be brought in the list of the interviewees because of the non-availability of some persons. In-depth interviews were held with a total number of 25 non-state policy actors. Amongst them 7 were academicians with wide teaching and research experience in the field of health and population, 8 were the chiefs (former and current) of population and health related national and international organizations, 5 were researchers in the field of health and population and 5 were consultants. All of them have contributed in various capacities in the policy process.

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1.7.3 Interview Technique

In-depth interviews were held on thematic issues and concerns. Interviews were held in a conversational style. Policy issues were discussed with the policy actors as it came with the flow of conversation without following any preset sequencing of the issues. The interviewees were allowed to move from one issue to another without any interruption so that natural flow of conversation is not obstructed. Many interviewees themselves have moved in and out from one issue to another creating a link between and among the issues without any probing. This technique has added to the depth of the opinions of the interviewees. Some probing was employed to get more in-depth perspective on some policy issues. Further, sometimes other policy actors' opinions on some of the issues were discussed with the interviewees to help them formulate their opinions more clearly and also to be able to grasp their opinions more clearly.

1.7.4 Recording of Responses

Opinions and observation were recorded by category of the policy actors and by policy issues. Opinions of all categories of policy actors were filtered to fit into the policy issues identified through policy discourse. This process required repeated readings of the transcripts. This was done on one by one basis and was completed on the very day the interview was held. In some of the cases interviewees were contacted again to verify if their opinions were grasped appropriately.

1.7.5 Analysis of Interview Transcripts

Patterns and themes have been sought in the interview transcripts to locate meaningful categories or themes in the body of information. Patterns and

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themes have emerged through repeated readings of the transcripts and developing logical associations between and among the issues. The perspective for logical association between and among various issues was developed through analysis of policy discourse. Thus, some commonalities and differences in opinion on different policy issues were identified by category of policy actors.

1.7.6 Validation Techniques

The study has used triangulation method for ensuring the validity of the information obtained. Information obtained from one source was cross checked through another source.

1.8 Theoretical Framework of the Study

The study is premised upon the discourses on justice relating to health and health care and the rights-based approach to health. The following sections elaborate on the theoretical discourses on justice relating to health and health care and the rights-based approach to health.

1.8.1 Discourses on the Notion of Justice Relating to Health and Health Care

'Ethical doctrines' occupy and merit special place in the analysis of public policy specially policies pertaining to health. Ethical analysis provides an important insight to guide policy action in the health sector. 'Utilitarianism' has been one of the most dominant theories of justice for over a century and public policy was dominated by this approach for quite a long time (Sen 2000: 58). It has been one of the leading analytical models of health economics and has occupied a significant space in health policy discourse as

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a framework of analysis (Ruger 2006: 280). English philosopher Jeremy Bentham is credited for developing 'utilitarianism' as a specific school of thought. He believed that rightness of any action can be measured by calculating the pains and pleasures it produces. The action that produces the greatest happiness of greatest number is right (Bentham 1789, cited in Roberts and *et. al,* 2004: 42; Roberts and Reich 2002: 1055). John Stuart Mill was one of the greatest proponents of Bentham's philosophy of utilitarianism.

'Utilitarianism' is embedded in the concept of absolute utility and therefore, rationalizes resource allocations and social or institutional arrangements that maximize net social utility. A right to health is justified only if it contributed to the overall maximum of net social utility. Health care would be composed of those that maximize net social utility. As with the change in utility it would change (Ruger 2006: 280-81).

Utilitarianism justifies any action, choice, rule, and institution in terms of its consequences. It says that "end justifies the means" (Roberts and *et. al.* 2004: 41). Utilitarianism is also called a consequentialist theory because it is primarily concerned with the consequence of any action or decision. Bentham values each individual's judgment for their own happiness. In Bentham's philosophy of utilitarianism all individuals matter equally. Thus, Bentham's concept of utilitarianism requires adding up everyone's utility level for each policy option and then choosing the policy that leads to the greatest happiness for greatest numbers (Roberts and *et. al.* 2004: 41; Roberts and Reich 2002: 1055).

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According to this theory, an unjust society is the one in which people are significantly less happy together than they need be (Sen 2000: 59). In utilitarianism, policies are evaluated by examining the effects on the total well being of the society. Hence, it does not question the rightness of means employed to reach a goal (Roberts and *et. al*. 2004: 42). They are of the opinion that some individuals can be sacrificed for the sake of others (Roberts and *et. al*. 2004: 48). However, utilitarian reformers, who question the validity and reliability of arbitrary individual choices, argue for founding policy decisions on objectively defined individual well-being by a pool of experts (Roberts and *et. al*. 2004: 44). Objective utilitarians rely on expert-determined index of health status like Quality Adjusted Life Years (QALYs) or Disability-Adjusted Life Years like (DALYs) for policy decision on alternative choices (Roberts and Reich 2002:1055).

Utilitarian framework is concerned with the total gain and thus, disregards the negative consequences of any action or decision on a particular group or individual and is not sensitive to the actual distribution of justice (Sen 2000: 62). It ignores large inequalities in exchange of higher total or average social utility (Ruger 2006: 281). It has been argued by Amartya Sen that "calculation of utility can be deeply unfair to those who are persistently deprived . . . . The deprived people tend to come to terms with their deprivation because of the sheer necessity of survival . . . and may even adjust their desires and expectations to what they unambitiously see as feasible" (Sen and Nussbaum 1992, cited in Sen 2000: 63).

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As opposed to 'utilitarianism', 'liberalism' focuses on individual rights and equality of opportunities. Different schools of liberalism focus on different forms of rights. However, all liberals support some rights including right to life, liberty, and property. They are of the opinion that these rights would guarantee individual liberty and would allow people to exercise their own choice without the infringement of state. Liberalism emphasizes on extensive freedom of thought and speech, limited role and control of government, the rule of law, a market or mixed economy and a transparent system of government. Libertarians are the proponents of limited role of state for protecting individual property rights and individual liberty (Roberts and *et. al.* 2004: 49). Thus, they perceive liberty in its absolute form. Libertarians like Robert Nozik deny any social obligation to protect or promote health because increased taxation for provisioning health care by the society or state would violate the principle of individual liberty. Health is not considered as special goods or services. Libertarian approach endorses the fulfillment of civil and political life but not social, economic, and cultural rights on the argument that increased taxation on wealthy infringes wealthier individuals' liberty (Ruger 2006: 282). Thus, liberalism notion of right to life and liberty was incomplete in the sense that they were not founded on right to health.

'Egalitarian liberals' questioned this notion of 'liberty' and 'choice' propagated by the libertarians for not being able to see the link between making meaningful choice and having resources and power. 'Egalitarian liberals' argue that right to choose is meaningless without adequate

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resources and power. Making meaningful choices is less likely for those who do not have minimum resource base or other sources of power. Right to access or right to choose health care becomes meaningless without adequate resources i.e., money, information, power etc. Therefore, it has been argued that every individual needs a minimum level of services and resources needed to assure 'fair equality of opportunity'. Extremely poor, ill, uneducated or uninformed people do not have the scope for making meaningful choice (Roberts 2004: 49). Rawls's *Theory of Justice* is built on the notion that 'primary goods' that are natural to want are to be allotted on the basis of fair equality of opportunity. In Rawls's *Theory of Justice* natural goods like health, intelligence, and imagination are not on the list of primary goods. He argued that no society can guarantee health to its individuals (Ruger 2006: 283). However, later on Rawls in this *The Law of Peoples* included health care as one of the primary goods.

On this point some egalitarians are of the opinion that there should be fair equality in the distribution of resources and then individuals should buy health care like other goods and services (Drowkin 1993). Other egalitarians claim that state has a special obligation for protection of health. Daniels (2008) argues that 'fair equality of opportunity' demands protection of opportunity. Everyone has a positive right to the minimum level of services needed to assure fair equality of opportunity. Health is different from other goods and services. Health has an intrinsic value and therefore, it is an end itself. It also has instrumental value because good health is a precondition of normal functioning of people. Health and health care has been claimed to

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have special moral importance because meeting health needs are necessary for normal functioning. Thus, health protects opportunity or capability and meeting health care needs safeguards protection of that opportunity or capability. Fair protection of opportunity or capability requires meeting health demands fairly. Health inequalities are called unjust when they are the consequence of an unjust distribution of the socially controllable factors affecting the health of population (Daniels 2008: 27-31).

Amartya Sen argues that capability to function should be the central concern of ethical evaluation, not health, wealth etc. Wealth, health etc. are instrumental to the capability of people to function. Sen's capability approach is rooted in the freedom of individual. Capability is referred to as freedom to achieve alternative functioning. Capability approach to health takes into account, both wellbeing and the freedom to pursue wellbeing (Ruger 2006: 274). Capability to function is an indicator of well-being and the capability to achieving functions is an indicator for individuals' freedom for pursuing well-being.

Thus, Sen makes a distinction between health achievement, and the capability to achieve good health. Individuals may or may not exercise their capability to achieve good health. He therefore, argues that preventable and treatable illnesses resulting from controllable social factors have bearing on social justice (Sen 2004 in eds. Anand and *et. al.* 2004: 23). Sen opines that society or state should only be held responsible for heath achievements which he calls 'capabilities' through creating health facilities and not for individual choice which also have bearing on health achievements (Roberts

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and *et. al*. 2004: 50). From this perspective state is obliged to make health care available to its citizens. This perspective does not deny states' responsibility to educate its citizens on health issues rather limits its role in educational and informational access. For example, education provided on ill effects of smoking on health is considered appropriate and falls within the responsibility of state, however the state should not go beyond this educational and informational role and should not take more aggressive means to control smoking. In Sen's capability perspective the aim should be to maximize the set of capabilities available to each individual and the level of functioning achieved by individuals should be individuals' choice (Roberts and Reich 2002: 1057).

These scholarly thoughts have founded that a good health system does not only maintain or improve the average health of the population. It also has the responsibility to reduce inequalities by giving preference over improving the health of the worse-off. Hence, the objective of good health system is both goodness and fairness. Goodness implies best attainable average health of population and fairness implies the smallest differences among different individuals and groups (WHO 2000: 25). Thus, 'health as right' is premised on these notions of social justice, fairness, and equality.

1.8.2 Rights Based Approach to Health

Rights based approach to health is built upon the international human rights Conventions and Declarations adopted within the United Nations system. Nevertheless, the Universal Declaration of Human Rights, 1948 (UDHR); the International Convention on the Elimination of All Forms of Racial

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Discrimination (ICERD) 1965; the International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR); the Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (CEDAW); and Convention on the Rights of Child 1989 (CRC) are of utmost significance. Article 25(1) of UDHR states that, "everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care, and necessary social services". Even though initially, UDHR was non-binding for the states, later on it had earned the status of customary international law (Khan 1998: 38-43).

The ICESCR came into force in 1976 making it binding upon the ratifying states to ensure satisfaction of at least minimum level of the rights mentioned therein. Article 12 (1) of ICESCR recognizes the right of everyone to the highest attainable standard of physical and mental health. Article 12 (2) of ICESCR elaborates on the measures needed by the state parties for: the reduction of the still birth and of infant mortality and for the healthy development of the child; improvement of environmental and industrial hygiene; prevention, treatment, and control of epidemic, endemic, occupational and other diseases; and ensure all medical services in the event of sickness. The CEDAW and the CRC of 1989 have been landmarks in the international legal framework of human rights to health for women and children respectively.

The Committee on the Economic, Social and Cultural Rights of the United Nations has adopted *General Comment No. 14* in 2000, which elaborates on

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the right to health. It identifies two fundamental dimensions of right to health. On the one hand, it entails freedom i.e., freedom to make decisions about one's health and on the other hand, it entails entitlement to a system of health care. Freedom dimension of health in *General Comment No. 14,* included the right to be free from non-consensual treatment, such as medical experiments and research or forced sterilization, and to be free from torture, and other cruel, inhuman or degrading treatment or punishment. Entitlements included: the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment, and control of diseases; access to essential medicines; maternal, child, and reproductive health; equal and timely access to basic health services; the provision of health-related education and information; participation of the population in health-related decision making at the national and community levels.

The Committee in *General Comment No. 14* has worked out four interrelated and essential elements of right to health i.e., availability, accessibility, acceptability, and quality. Precise application of these elements will depend on the conditions prevailing in a particular state. Availability means and includes functioning public health and health-care facilities, goods and services, as well as programmes in sufficient quantity. The nature of the facilities, goods and services will vary, depending on the respective country's developmental level.

Accessibility includes four overlapping dimensions: *non-discrimination, physical accessibility, economic accessibility, information accessibility.*

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Non-discrimination means health facilities, goods, and services must be accessible to all, especially to the most vulnerable or marginalized sections of the population without any discrimination on the ground of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civic, political, social or other status. Acceptability means all health facilities, goods and services must be respectful of medical ethics and culturally appropriate i.e., respectful of the culture of individual, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality means health facilities, goods and services must be scientifically and medically appropriate and of good quality, and thus, requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and portable water, and adequate sanitation. However, quality of care has varying connotations. Quality can be used to mean quantity of health care services provided. Providers' perspective of quality of care is markedly different from the users' perspective. Health professionals generally perceive quality of care in terms of clinical quality. Clinical quality refers to the skill of the care givers and correct diagnosis and treatment decisions and availability of right inputs i.e., drugs, equipments to carry out appropriate care, existence of appropriate referral system etc. Providers' perspective of quality of care has been increasingly integrated with users' perspective of quality of care. The utilization of health services

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is very much influenced by users' perception of quality of care. Users' perception of quality of care has two dimensions i.e., convenience of the users and interpersonal dimensions between the providers and users. Users' perspective of convenience generally refers to travel time, waiting time, opening hours, and time needed for getting an appointment. Interpersonal dimensions of quality of care include providers' behavioural aspects (Roberts and *et. al.* 2004: 116 -117). Social and cultural beliefs, economic constraints, and gender also influence users' perception of the quality of care.

Measuring quality of care requires detailed data. Patients' reports are important mechanism to locate quality gaps. Further, outcome indicators like infection rates, operative mortality etc. are also used as indicators for measuring quality of care (Roberts and *et. al.* 2004: 116 -117). Utilization of services also gives partial indication of quality of care.

Right based health is founded on the *principle of equality and non-discrimination*. To ensure equality of access to health care and health facilities, state obligation has been emphasized with respect to providing those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services. In this context preference has been given to investments in primary and preventive health care benefiting a larger population over costly curative care which are often accessible to a small privileged section of the population. Rights based health, calls for identification and targeting of

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vulnerable groups and integration of gender perspective in health related policies, planning, programmes, and research in order to promote better health for both women and men (General Comment No. 14: paragraphs 12-19).

Women, children, adolescents, older persons, persons with disabilities, and indigenous people have received special attention in the rights based health framework. Women's health focus had been brought by the Committee's *General Comment No. 14* in the context of elimination of discrimination against women, where the need to develop and implement a comprehensive national strategy with a life cycle approach have been considered to be of utmost importance. Such strategy includes, interventions aimed at prevention and treatment of diseases affecting women, as well as polices to provide access to a full range of high quality and affordable sexual, reproductive and other health care services. The goal of such strategy is to reduce women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, educational, information, including in the area of sexual and reproductive health. Undertaking preventive, promotive and remedial action is crucial to protect women from the impact of harmful traditional, cultural practices and norms that deny them their full reproductive rights (General Comment No. 14: paragraphs 12- 21).

Right-based approach requires analyzing which rights and which population groups are positively or negatively impacted by each intervention. It is

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critical for policy analysis to look into who benefits most from each intervention and in what ways, and who would be left out (Daniels 2008: 323). The chief difficulty of a rights-based approach lies in establishing priorities among different claimants to different rights as well as among competing claimants to the same rights. Full realization of right to health and health care is beyond the capacity of even developed and resource rich countries. Therefore, priority setting within and among different rights is the real challenge of a right based approach (Daniels 2008: 323). Further, it has been argued that asserting a right to health leads to questions like, "if individuals have a right to a minimum level of health status, what should the minimum level be? Are there limits to society's obligation to very ill people, who require high-cost services to improve their health status even a little?" (Roberts and et al. 2004: 50). Therefore, it has been argued that a rights based approach to improving population health must resolve such disagreements and claims in a way so that the policy outcomes get legitimacy. That is why this approach insists on good governance, transparency, participation, and accountability (Daniels 2008: 226-228).

Thus, rights-based policy tends to prioritize minimum essential levels of service and the most vulnerable and marginalized group, and the content of the policy intends to meet both freedoms and entitlements (Steenbergen 2011: 23).

Adoption of rights based approach to health at international level is not only an academic exercise. Its object is to bring about effective and harmonized progress or change in national policies, laws, and practice. One of the factors

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influencing the effectiveness is the degree to which they are formally accepted by member states. The state obligations fall into three categories as per Article 12 of ICESCR, namely the obligations to respect, protect, and fulfill.

The obligation to respect requires the state to refrain from interfering directly or indirectly with the right to health. For example, states should refrain from denying or limiting access to health care services; from marketing unsafe drugs; from imposing discriminatory practices relating women's health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; and from withholding, censoring or misrepresenting health information.

The obligation to protect requires the state to prevent third parties from interfering with the right to health. It emphasizes adoption of legislation and other measures to ensure that private actors conform with human rights standards when providing health care or other services; control the marketing of medical equipment and medicines by private actors; ensure that privatization does not constitute a threat to availability, accessibility, acceptability, and quality of health care facilities. Under this obligation state has control function to ensure compliance from all health practitioners with respect to appropriate standard of education, training, and ethical codes of conduct. The state has the responsibility to protect its population from harmful traditional practices those interfere with access to pre and post-natal care and family planning.

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The obligation to fulfill entails three obligations; *to facilitate, promote, and provide*. Thus, it requires the state to adopt appropriate legislative, administrative, budgetary, judicial, and other measures to fully realize the right to health. The state must, for instance, adopt a national health policy or a national health plan covering the public and private sectors; among others, ensure that public health infrastructures provide for sexual and reproductive health services and that doctors and other medical staff are sufficient and properly trained; and provide information counseling on health related issues. The Committee in *General Comment No. 14* has detailed on formulation of coherent policy and plan for implementation and periodic review of the plan implementation.

Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect on the state. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete, and targeted steps towards full realization of the right to health, such as the preparation of a national public health policy, strategy, and plan of action. Progressive realization means the states has a specific and continuing obligation to move as expeditiously and effectively as possible towards full realization of the rights to health. Further, the state has an obligation to ensure that no international agreement or policy adversely impacts upon the right to health, and that their representatives in international organizations take due account of the right to health, as well as secure international assistance and cooperation, in all policy-making matters.

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1.9 Conceptual Framework of the Study

The state obligation to fulfill in terms of adopting rights-based national health plan for reproductive health services is crucial for moving 'reproductive health right agenda' forward. Coherence in policy and plan is important for following a right-based approach. A well knitted policy framework is considered crucial to enhance coherence in the policies. Rights-based policy framework is defined as set of policies, strategies, and interventions to form a coherent approach for guiding and directing right-based reproductive health programme. Disjointed activities or services those only incidentally contribute to the realization of reproductive rights do not necessarily constitute rights-based policy framework. Rights based reproductive health policy framework is conceived as the set of policies, strategies, and interventions to form a coherent approach for guiding and directing the entire programme for protection and promotion of reproductive health as an end goal in its own right. This study in the light of rights based approach to health policy considers *freedoms* in terms of freedom from coercion, restrain, and discrimination and *entitlements* in terms of availability of, accessibility to, and quality reproductive health services as central to rights-based reproductive health policy and plan. Freedom has been conceptualized as an end itself whereby people are able make informed choice and act on their choice without any coercion, restrain, or discrimination. Reproductive health has been viewed in terms of freedom as having choice and acting on choice without any coercion, restraint or discrimination on any matter relating to reproductive health and entitlement to a range of available, accessible, and quality reproductive health services.

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Thus, reproductive health has been conceived as having the opportunity to have desired and safe pregnancy and safe child birth and avoiding unwanted and unsafe pregnancy and risky child birth. Reproductive health services amongst others include safe and effective family planning services including information for regulation of fertility and appropriate health services including information for women to enable them to go safely through pregnancy and child birth. Thus, family planning services serves as an important means to achieve reproductive health. Improvement of health through right-based approach to health service provision is the central goal of all the reproductive health services.

Rights-based reproductive health policy is much more than pursuit of just overall gain in reproductive health of the population. Rights-based reproductive health policy and plan prioritizes health services that affect larger, poor, and the most vulnerable population towards promoting equality in reproductive health. Thus, reproductive health services need to be integrated with primary health care services.

Availability of reproductive health services in this study denotes: adequate numbers of functioning health facilities; adequacy of the formally trained service providers; a range of the reproductive health services offered, and integration between reproductive health services.

Accessibility will mean removal of geographical or physical, economical, informational, social, and cultural barriers to receive services offered at different levels.

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Quantitative target based family planning method promotion and incentives provided for promotion of particular method of contraceptive is considered as an undue influence of the providers and has been referred to as restraint on informed choice of services and therefore, a barrier to freedom.

Overt policy or legal barrier for receiving any service or covert restrictions to receive any service on the ground of age, sex, and economic class is referred to as discrimination and therefore, a barrier to freedom and access.

Quality of services in this study refers to: effective integration of all reproductive health services, effective management of side effects of contraceptives, and continuation of family planning methods. Users' perception of quality of care has been brought as far as information has been available.

Utilization of services, met demand for services, and continuation of contraceptives have been used as an indicator of accessibility to and quality of care. Quality of services, in this study has been used to the extent secondary data or information has been available.

1.10 Study Outline

The study in chapter 2 depicts the health system of Bangladesh with major focus on the government sector health system. This chapter also delineates the health issues and major reproductive health problems of Bangladesh to lay the perspective for the policy analysis in the following three chapters.

Policy discourse in this study has been made under three phases of policy regimes. The three phases of policy regimes have been discussed

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consecutively in chapters 3, 4, and 5. These three phases have been named after the basic philosophy of the policy regimes and are detailed below.

Chapter 3 examines the first phase of policy regime titled Family Planning Maternal Child Health (FP-MCH) based policy regime. It has been titled FP-MCH based policy regime because the basic premise of this phase was to establish integration between family planning and maternal and child health programmes so that they mutually reinforce each other. In this policy regime, the term reproductive health had not been coined, even though family planning and maternal health programmes are inherently reproductive health programmes. Evolution of the policies has been discussed in the context of major national and international level actors and factors. The strategic and programmatic interventions have been examined in line with the policy objectives of the said regime.

Chapter 4 analyzes the second phase of policy regime titled "Reproductive health policy regime with reformist approach". This phase has been named reproductive health policy regime with reformist approach because this policy regime had adopted the concept of reproductive health in its policy and programme formulation and envisioned necessary structural reforms to complement its shift to reproductive health. Theoretical premise of this policy regime was to make a paradigm shift from fertility reduction to promotion of reproductive health. This policy regime had envisaged necessary organizational and management reforms for implementation of the newly designed comprehensive integrated reproductive health programme under the Essential Services Package. This chapter, in accordance with the

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preceding chapter, has analyzed the paradigm shift at the policy level in the context of major actors and factors at the national and international level. Programme strategies and interventions have been examined in line with the policy objectives.

Chapter 5 investigates the third phase of policy regime titled "Reproductive health policy regime with conformist approach". This phase has been named reproductive health policy regime with conformist approach because theoretical premise of this policy regime remained the same as that of the second phase of policy regime while, this regime withheld the reform agenda of the second policy regime to minimize implementation challenges of the programme. This chapter in conformity with the preceding two chapters has analyzed the policies in the context of national and international actors and factors. Conformity between and among the policy objectives, programme strategies, and interventions have also been examined in this chapter.

Chapter 6 seeks to supplement and corroborate the observations and analysis made under three policy regimes in the preceding three chapters. It explores and analyzes the opinions and views of different categories of policy actors on key policy issues those had emerged in the course of policy and programme analysis under the said policy regimes.

Chapter 7 summarizes major findings and observations made in the preceding chapters with a view to addressing the research questions in the light of the broader objectives.

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Chapter 2

Health System and Reproductive Health Issues in Bangladesh

This chapter aims to delineate the health system of the country. Major focus of the health system is on the public sector health system. Present state of health care in Bangladesh, including major health care issues and reproductive health problems have been highlighted in this chapter.

2.1 Health System in Bangladesh

Health system plays the most vital role in affecting the population health in a country even though it is also affected by many other factors i.e., education, income etc. Hence, health care issues of a country to a great extent are related to the health system of a country. The importance of health system has been asserted by WHO by recognizing it as: the means to deliver health policy goals; the key to operationalizing any policy approach to address the health needs of a country; and an important platform for interaction between multi-sector stakeholders in health and interface between health and development (WHO 2006).

Health system comprises the facility-based services, activities in the household and community and the outreach, and the broader public health interventions (Talukder and Rob, 2007: 1). It encompasses all categories of health care providers i.e., public and private, formal and informal, for-profit and not-for-profit, allopathic, and indigenous. It includes inter-sectoral activities aimed at promotion, production or maintaining health. Health

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registration with government regulatory bodies. However, a clear distinction between public and private sectors providers becomes difficult by the fact that a significant percent of public sector providers work in the private sector after their office hour or even during office hours (World Bank 2003: 2). Health policy in Bangladesh has historically been focused on the public sector. Informal sector has hardly received any attention in the health policies.

Variant therapeutic treatments ranging from self-care to folk and western allopathic medicines are available in Bangladesh (Ahmed, 1993 cited in BHW 2008: 3). Semi qualified (having semi formal training but not accredited by government) and unqualified health care providers (not having any formal training) are the most dominant in the private sector. Traditional medical practitioners (*kabiraj*[1] or herbalists, *totka*[2], faith healers[3]) constitute almost 43 percent of the health care providers. Village doctors having some semi formal training and drug store sellers having no formal training represent 8.5 percent and 7.7 percent of the workforce respectively (BHW 2008: 7). Qualified modern practitioners (physicians, nurses and dentists) constitute only five percent of all health care providers. Thus, density of qualified providers is far shorter than the standard set by World Health Organization (WHO 2006) at 23 percent for achieving MDGs (BHW 2008: 49).

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[1] Who practice an ayurvedic system of medicine, based on ancient Hindi systems of medicine and practice on the basis of diet, herbs, and exercise.

[2] Who combine ayurvedic and unani traditional muslim system of medicine.

[3] Who rely on chants or sacred readings in their treatment.

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Health care services are provided by three broad categories of sectors i.e., public, private and NGOs. Despite having some overlapping, these three categories of sectors provide different categories of services. The public sector provides preventive and curative service, the private sector provides curative service, and the NGO sector basically provides preventive and primary health care (Choudhury and Osmani 2010: 220). The tertiary and specialized health services are available at the public sector and private sector in the important metropolitan areas. Usually in-patient and specialized health services are not available below *Upazila* (sub-district) level. Majority health services at the village level are provided by individuals including trained, semi trained, and untrained health practitioners and pharmacists (Choudhury and Osmani 2010: 219).

Public sector health service provision is most important in terms of wide scale physical infrastructure and other resources (Choudhury and Osmani 2010: 220). The public sector is largely used for in-patient and preventive care and run by accredited health care providers. The private sector is used mainly for outpatient curative care and is run by a heterogeneous group of providers with varying training, legal status, using varying medicines (World Bank 2002: 51; World Bank 2003: 2) . Private sector allopathic services in Bangladesh are mainly curative and urban based and provided through private clinics, nursing homes, private hospitals, private physicians and private pharmacists (Osman 2004: 97).

Private sector health care delivery system in Bangladesh is comprised of qualified health care providers and informal providers. A range of informal

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providers exist in the private sector including traditional healers (*kabiraj*, *totka*, faith healers i.e., *pir/fakirs*), homoeopathic practitioners, village doctors or rural medical practitioners (RMPs /*Palli Chikitshoks* or PCs), traditional birth attendants, community health workers, and the drugstores selling allopathic medicine on demand (BWH 2008: 4). The private sector's share in services produced is on increase.

Treatment quality is highly differential in the private sector for having a heterogeneous group of health care providers. While non poor people receive services from high quality private sector providers rural people and poorer people mostly seek curative care from private pharmacies except for other than maternal health care and immunization services (World Bank 2002: 51; BHW 2006: 16).

NGOs have been playing a significant role in the development and implementation of the reproductive health programme across the country. Over 400 NGOs operate in different areas of the country delivering various reproductive care services. These NGOs operate with the approval of government and as per the government's guidelines to complement and supplement the national programme (Nasreen and *et. al.* 2007: 25). NGOs are major providers of urban primary health care (MoHFW and UNFPA 2004: 22). There is also a growing cadre of semi-qualified community health workers/volunteers (CHWs or CHVs). They are trained by the NGOs who employ them. As with the expansion of the primary health care infrastructure in the country since 1990s, the number of these workers has been on increase (BHW 2008: 7-8; Ahmed and *et. al.* 2011: 6).

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Health expenditure of Bangladesh is featured supply-side financing of health services. A very high proportion of the total expenditure on health is finance through out of pocket expenses by the households. Almost 65 percent of the health expenditures are borne by household. Household expenditure for purchasing drugs from pharmacies per head is four times higher than public expenditure for drugs per head. Government financing through tax revenue accounts 60 percent and international development assistance accounts almost 40 percent of the remaining one third expenses. Alternative mechanisms for risk pooling are not existent (Chawdhury and Osmani: 225).

2.1.1 Pubic Sector Health Nutrition and Population Programme Management Structure in Bangladesh

The Ministry of Health and Family Welfare (MOHFW) is the lead agency of the public sector health, nutrition, and population services of Bangladesh. It is responsible for policy formulation, planning, designing, coordination and regulation of programmes at the macro level. Secretary of the ministry is the principal accounting officer of the ministry. There are four directorates under the ministry i.e., directorate of health services, directorate of family planning services, directorate of drug administration, and directorate of nursing services. Separate Director Generals head these directorates. The Director General of Health Services (DGHS) advises and supervises all health implementation activities; the Director General of Family Planning (DGFP) supervises implementation of family planning and a significant part of maternal and child health services; the directorate of drug administration supervises national drug regulation and manufacturing; the directorate of nursing services oversees nursing as a profession. All these directorates are

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staffed by the professionals and technical persons and are based in Dhaka. Medical college hospitals, district hospitals and *Upazila* health complexes are under the supervision of the directorate of health services and district-level Maternal and Child Welfare Centers (MCWCs) and union-level Union Health and Family Welfare Centres (UHFWCs) are under the supervision of the directorate of health services. Both directorates work at the domiciliary level to provide essential services (Gill and Ahmed 2004: 214; MoHFW and UNFPA 2004: 19).

There are seven Divisional Director offices each headed by Divisional Director for DGHS and DGFP. Divisional Directors do not have any service provision role (MoHFW and UNFPA 2004: 14). These offices are responsible for human resource development and management. The health service facilities in the public sector are arranged into three levels i.e., primary, secondary and tertiary (Chowdhury and Osmani 2010: 220; MoHFW and UNFPA 2004: 19). Primary, secondary and tertiary health services are provisioned along the administrative tiers of the country.

2.1.1.1 Primary Health Care Facility in Bangladesh

Primary health service delivery facilities have been developed at the ward level, union level and at the *Upazila* (sub-district) level.

Field staffs from both health and family planning i.e., Family Welfare Assistants (FWA) from the directorate of family planning and Health Assistants (HAs) from the directorate of health provide FP and MCH services at the door step level and community clinics (where operates). The number of HAs and FWAs serving in a union vary according to the size of

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the population. HAs are assigned with domiciliary level preventive healthcare services for cholera and malaria control, immunization, environmental health etc. FWAs distributes contraceptive pills, condoms, vitamin-A capsules, ORS etc., motivates for other forms of contraception, provide health education on antenatal care (ANC), postnatal care (PNC), new born care, nutrition, hygiene practices, adolescent health etc. HAs supervised by the Health Inspectors (HIs) and Family Planning Inspectors (FPIs) supervise the FWAs (BHW 2008: 4).

Satellite clinics (SCs) have had been introduced to bring health services closer to the community so that people can overcome the problems of distance, time and travel cost for receiving health services. Such clinics help people specially women to receive health services for them and their children much more conveniently. The Directorate of Family Planning has fixed eight sites in each union every month for such outreach services. The Family Welfare Visitor is supposed to visit each of these sites once every month. (WHO 2004; MoHFW 2005).

To complement the facility based approach to obstetric care the government has undertaken a skilled birth attendant training programme to create a new cadre of health workforce i.e., skilled birth attendants (SBAs) through providing additional midwifery training to the outreach workers of health and family planning i.e., female HAs and FWAs respectively. They are supposed to attend normal delivery at home and refer for any complications beyond their skill to appropriate health facilities. The SBA programme has been initiated with the financial assistance of WHO and UNFPA and with

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the technical assistance of Obstetric and Gynecological Society of Bangladesh (OGSB).The piloting of the program started in 6 *Upazilas* during March- August 2003 and the program got permission for up-scaling in July 2003 (WHO 2004). As per the new government order they in addition to their work as FWAs and HAs would also serve as SBAs. FWVs have been assigned for the technical supervision of works of SBAs at the union level. MO-MCHs have been assigned as the technical supervisors of FWA turned SBAs at the *Upazila* level. *Upazila* Health and Family Planning Officers (UH&FPOs) have been assigned as the technical supervisors of the female Health Assistant turned SBAs at the *Upazila* level.

Community clinics were established in the late nineties at the community level to deliver essential services during the implementation period of Health Population Sector Programme (1998-2003). Each community clinic was supposed to serve around 6000 population. Community clinics were built to provide one stop essential services. Most of the community clinics remained non-functional since their establishment following the failure of unification of health and family planning services as proposed by the health policy of 2000 (HPSP: APR 2003: 21). However, present government formed in 2008, has given renewed attention in the establishment and reinstatement of community clinics.

At the union levels there are Union Health and Family Planning Complexes (UHFWC). UHFWCs are the peripheral institutional corner stones of the Government's FP and MCH services. UHFWCs serve as the first referral facilities (MoHFW and UNFPA 2004: 19). UHFWCs serve as the first

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referral point for screening high-risk pregnancies, antenatal care, post-natal care and treatment of common maternal and child disorders. In unions where a UHFWC have not yet been built, generally there is a rural dispensary operated by the Directorate of Health Services of the MOHFW. UHFWCs or rural dispensaries are usually the only government health facility at the union level. In the unions where there is neither a UHFWC nor a rural dispensary, a facility is rented to provide clinic-based maternal, reproductive, and child health services (Perry 2000: 36).

UHFWCs provide only outpatient care including immunization, maternal child health and family planning and limited curative care. In some UHFWCs, there is provision for normal deliveries and obstetric first aid and adolescent health services (Chowdhury and Osmani: 2010: 220). UHFWCs are comprised of paraprofessionals i.e., a mid-wife, Family Welfare Visitor (FWV) and a Medical Assistant or Sub-Assistant Community Medical Officer (MA/SACMO). FWV and SACMOs are the staffs of the directorate of family planning. MAs are the staff of the directorate of health services. MA is responsible for the overall functioning of the UHFWC. They provide first aid, minor treatments, refer serious cases, and conduct health education in the schools and at other public locations (Perry 2000: 41). FWVs are responsible for administering MCH and clinical contraception including MR. Medical Assistants provide curative care (World Bank 1985: 11). All FWVs are women and they report to Medical Officer MCH at the *Upazila* Health Complex (UHCs). For managing complicated and referred cases a small number of medical officers have been placed in some of the UHFWCs (Nasreen and *et. al.* 2007: 22; MoHFW and UNFPA 2004: 19).

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UHCs are located at sub-district level and provide inpatient services as well as curative and preventive services to outpatients. UHCs are the first-level referral health facility. These are of 31-50 bedded hospitals with basic diagnostic and operative facilities. Six beds are reserved for MCH and family planning. At this level health and family planning staffs work under separate lines of command. They report to their respective directorates. Health staffs serving at the UHCs include nine doctors including dental surgeon, nursing supervisor and senior nurses, two MAs, Medical Technologists (pharmacy, radiology, dental) and an Expanded Programm on Imunisation (EPI) technician along with other support staff. Family planning staffs include an *Upazila* Family Planning Officer (UFPO), one Medical Officer (MO-MCH), and Assistant Family Planning Officer, one Senior Family Welfare Visitor, two FWVs and support staff (Mahmud 2004: 4086; MoHFW and UNFPA 2004: 19).

UHFPO is in charge of the management and coordination of all health services at the *Uapzilla* Health Complexes and is responsible for preventive and clinical health services. *Upazilla* Family Planning Officer (UFPO) is responsible for reproductive health services including family planning. MO-MCH heads the Maternal Child Health (MCH) unit of UHC.

2.1.1.2 Secondary Health Care Delivery Facilities in Bangladesh

District hospitals are the secondary health care hospitals with 50-250 bed facility. There are such secondary health care hospitals in all districts. At the district level there exist separate management structure for health and family

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planning. These hospitals provide specialist, laboratory and diagnostic services. These hospitals are supposed to provide referral services for UHCs.

MCWCs at the district level are meant to provide Emergency Obstetric Care (EmOC) in addition to child health care and clinical contraception. Most MCWCs have ten beds. Small number of MCWCs also exists at the *Upazila* level and union level (MoHFW and UNFPA 2004: 20).

Civil Surgeon is the head of the health directorate at the district level and Deputy Director Family Planning (DD-FP) is the head of the family planning directorate at the district level. Civil Surgeon is in charge of the administration of both domiciliary and institutional health services in the district. DD-FP is in charge of the administration of domiciliary and institutional family planning and MCH and reproductive health services. DD-FP is assisted by Medical Officer for Clinical Contraception and Maternal Health (MO-CC-MCH) who monitors the quality of clinical contraception and institutional MCH care.

2.1.1.3 Tertiary Health Care Hospitals

Tertiary health care hospitals are regional teaching hospitals and have specialized facilities for treatment of complicated cases. These are supposed to provide referral services for district hospitals and Upazila Health Complexes. These hospitals include the followings: (a) thirteen Medical College Hospitals, (b) ten Post Graduate Institutes and Hospitals, (c) one Dental College Hospital, (d) twenty Specialized Hospitals (e) one Homeopathic Medical College Hospital and (f) one Ayurvedic Degree College Hospital.

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Specialized institutions function at the national level. Specialized public health institutes include the followings: (a) Institute of Public Health, responsible for production of vaccine, serum and I/V fluid (b) Institute of Public Health and Nutrition, responsible for controlling Iodine and Vitamin-A deficiency diseases, research and training, and (c) Institute of Epidemiological Disease Control and Research, responsible for epidemiological surveillance, diagnosis of STI/AIDs, *Kala zar* and identification of vector.

2.1.2 Urban Primary Health Care

Primary health care in urban areas is the mandate of the Ministry of Local Government and Rural Development (MoLGRD) and is delivered through city corporations. City corporations implement Asian Development Bank financed Urban Primary Health Care (UPHCP) through the contracted NGOs (MoHFW and UNFPA 2004: 22). Urban Primary Health Care Project was initiated by the Government of Bangladesh and the Asian Development Bank (ADB) in 1998. MoLGRD is implementing Urban Primary Health Care Project in all the six city corporations and in the five largest municipalities each covering 200,000 to 300,000 population. In each partnership area there are one Comprehensive Reproductive Health Care Centres (CRHCCs) and at least one Primary Health Care Center (PHCC) for 30,000-50,000 population, and at least one satellite clinic or mini clinic for 10,000 population (Nasreen and *et al* 2007).

In the PHCCs, out-patient primary health care services are provided on the basis of the Essential Health Service Package (ESP) i.e., ANC, basic Emergency Obstetric Care (EOC), PNC, family planning, immunization,

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general diseases, tuberculosis, Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs). Complicated pregnancies and deliveries are referred to CRHCCs. CRHCCs have Comprehensive Emergency Obstetric Care, new born care and specialized ESP+ services. In CRHCCs in-patient service is available only for reproductive health services i.e., delivery, complicated pregnancies, post natal complications etc. All partner NGOs have at least one CRHCC in one project area.

2.2 Logistic Management System of the Government

The responsibility of procuring the major drug and other supplies lies with the Central Medical Store Department (CMSD). All the supplies are distributed to the district level stores by CMSD and the lower level facilities receive supplies from the district level stores.

Necessary supplies of DGFP are purchased centrally by DGFP and are stored in a central ware house and sent to the district head, Deputy Director Family Planning for distribution to the MCWCs and UHCs. UFPOs provides necessary supplies to FWAs.

MoHFW has evolved a system for forecasting contraceptive requirement of the entire country including the NGO sector. A forum composed of key persons from MoHFW, DGFP, USAID, UNFPA and CIDA and DELIVER-Bangladesh reviews the contraceptive stock position for the entire country every six months and gives projection on future demand for contraceptives for a particular period (MoHFW and UNFPA 2004: 21). Procurement plan is based on this demand forecast for contraceptives.

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2.3 Regulatory and Statutory Bodies for Health Services

A distinctive feature of health policy in any country is its regulatory role. Regulation exits for most of the key inputs for health services including premises, equipment, education and licensing of medical and other health workers, and pricing of goods and services (World Bank 2003: 34). A number of regulatory and statutory bodies have been established by the government to perform stewardship function in the health sector governance. They include: Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC), Bangladesh Pharmacy Council (BPC), Bangladesh Board of Unani and Ayurvedic System of Medicine, State Medical Faculty. Followings are the regulatory authorities of these bodies (BHW 2010: 15-21).

Bangladesh Medical and Dental Council (BMDC) was formed under the Medical Council Act in 1973. It undertakes and enforces registration of physicians and dentists. It also approves curriculum for medical educational institutions for standardization of the medical education system. Bangladesh Nursing Council (BNC) established in 1983 looks after standardization of nursing education and regulation of nursing practice. Bangladesh Pharmacy Council (BPC) was established in 1971 for registration and monitoring of educational institutions for standardization of pharmacy education system. Bangladesh Board of *Unani* and *Ayurvedic* System of Medicine is entrusted with the responsibility of standardization of *Unani* and *Ayurvedic* education system and registration of the practitioners of *Unani* and *Ayurvedic* System of medicine. State Medical Faculty looks after coordination of diploma

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course on LMF, compounder, nurse, midwives. It also conducts paramedic and medical assistant course and awards diploma and certificates to successful candidates.

However, in practice there is very limited exercise of all these regulations because of varied reasons. Capacity of the government bodies to ensure compliance is weak in terms of inadequate trained personnel, lack of resources for monitoring compliance. Standards set in these regulations are largely outdated and thus, looses their applicability (World Bank 2003: 34).

2.4 Major Reproductive Health Care Issues in Bangladesh

Bangladesh has made impressive gains in certain areas of health i.e., decreasing infant mortality, total fertility, increasing life expectancy. Targeted interventions like immunization, family planning, nutrition supplementation, the national oral dehydration solution etc. have contributed in making these health gains (World Bank 2002; BHW 2006). Life expectancy for men in Bangladesh has always been higher in contrast to the worldwide natural higher life expectancy for women. It is encouraging to note that the age old gender gap in life expectancy in Bangladesh no more exists (BHW 2006: 7). Despite several achievements made by the health and population sector in Bangladesh, accessibility of the disadvantaged people to quality primary health care services still remains a major challenge (World Bank 2002; BHW 2006; BHW 2008; NIPORT and *et. al.* 2008; 2011; 2012).

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2.4.1 Equity in the Health System

Despite having a comprehensive physical infrastructure to deliver health and family planning services and a vast network of primary health care facilities in rural areas, progresses in health have not been evenly distributed across the country. There exist wide disparities in the health status and health care seeking behaviour across the country between the rich and the poor, men and women, urban and rural residents (NIPORT and *et. al.* 2008; 2012; BHW 2006; BHW 2008). Addressing these inequities in the health status and health care consumption is a great challenge of the nation.

Health system is featured with overall poor health consumption in comparison to many other developing countries (World Bank 2003:45-47). Differential pattern of health consumption exists on the basis of wealth, gender, and residence (BHW 2006: 13). While similar incidence of illness are experienced by poor and non poor, poor are less likely to seek treatment than the non poor (World Bank 2003: 45-47). Poor tend to seek health care when they consider it to be life threatening or consider it may have an impact on income earning of family. Families are not willing to spend on women's health (Schuler, Bates, and Islam 2002: 275). Global findings show that wealthiest population of Bangladesh consumed more than 26 percent of the government financial subsidies in health expenditure where as, poorest 20 percent population consumed only 16 percent (Gwatkin, Bhuiya, and Victoria 2004) .

Utilization of most facilities at the primary level i.e., (*Upazilla* level and below) is very low. On the other hand utilization of facilities at the

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secondary and tertiary i.e., district and teaching hospital is very high (Mahmood 2004: 4086; Nasreen and *et. al*. 2007: 73). The foremost reasons for low utilization of primary health care facilities are poor service quality and negative perception of the community about the services (Nasreen and *et. al*. 2007: 73).

In Bangladesh informal sector plays a very dominant role in the health system. Informal health care providers constitute 95 percent of the health care providers and cater to the needs of 80 percent of population. They are embedded in local health system (BHW 2008: 5). Informal providers include, traditional practitioners, unqualified allopathic practitioners such as sales persons at drug retail outlets and drug vendors and unregistered village doctors. They possess varying types and duration of training in diagnosing and treating common illnesses from varied private training organizations without any regulation. Most of the drugstores are unlicensed and unregulated. Moreover, sellers at these drugstores also diagnose and treat illnesses in addition to dispensing medicine without having any formal professional training in any of these areas (Ahmed and Hossain 2007; BHW 2008; World Bank 2003). The unqualified health care providers mostly provide drug and advice to their patients. They very rarely advise for laboratory investigation (BHW, 2008: iii). Poor people prefer seeking health services from informal health care providers often without any formal training and accreditation because they are easily accessible, compassionate and they understand their problems better (BHW 2008: 13-19; Schuler, Bates, and Islam 2002: 275).

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2.4.2 Health Workforce Challenges

For any health system, health workers are the most critical driving force for promoting health, preventing disease and curing sickness. Human resource for health has been identified as a critical factor affecting the health outcome (WHO 2006). The issue of the health workforce (i.e., their production, training, practice, attrition and motivation) has been identified as a major constraint towards reaching the MDGs and other national health goals (BHW 2008; Ahmed and *et. al.* 2011). Bangladesh has been identified as one of the countries having critical shortage of health service providers including doctors, nurses and midwives (WHO 2006: 12).

Even though there has been significant increase in the number of registered physicians and nurses in the last three decades this growing number of physicians and nurses are far from the requirement. Registered physicians have increased from about 10,000 in 1980 to almost 50,000 by 2009; nurses have increased from 3,000 to over 24,000; registered midwives have increased from 1,350 in 1980 to almost 22,000 by 2009 (Choudhury and Osmani 2010: 221).

A study conducted by Ahmed and *et. al.* (2011) on health workforce in Bangladesh has identified shortages, misdistribution of staff, and skill mix imbalance as the foremost workforce challenges in the health sector. Shortage of trained and qualified health care providers, imbalance in the skill mix of the health care providers along with inequitable distribution of the health care providers are some of the major impediments in the way to delivering health care to the people in Bangladesh (BHW 2008). There is

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acute shortage of qualified practitioners. It has been estimated by Bangladesh Health Watch that Bangladesh has a shortage of over 60,000 doctors, 280,000 nurses and 483,000 technologists. This estimation was done on the basis of doctor-population ratio prevalent in low-income countries and the recommended ratio of three nurses and five technologists per doctor (BHW, 2008: ii).

The threshold density for the doctors, nurses and midwifes has been set by WHO at 2.28 per 1000 population. Coverage of essential services including those necessary to meet the health Millennium Development Goals is considered not possible below this threshold of density of health care providers. Physicians, nurses and dentists constitute only 7.7 percent of all health care providers. This is far below the estimation made by WHO (2006) for achieving MDG targets. This is even much below than other countries in the region like India, Nepal, Pakistan and Srilanka (BHW 2008: 49).

High rates of vacancy in the public health system especially in rural and poor regions contribute to rural-urban imbalance of health status and health consumption. It has been estimated by the social sector performance survey on primary health and family planning in Bangladesh in 2005 that overall vacancy for class I officers are around 42 percent for directorate of health and 27 percent for directorate of family planning in non-sadar *Upazilas*. The survey reported that 39 percent of the *Upazila* Health Complexes (UHCs) had no Resident Medical Officers and 60 percent of UHFWCs had no Medical Officers (Hunt 2005: 10).

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Attendance of the providers in the public sector facilities is a major concern. Absenteeism is the highest among physicians in the peripheral facilities. Absenteeism among the physicians has been estimated 40 percent at the UHCs and it is as high as 74 percent at the UHFWCs (Chowdhury and Hammer 2004: 15). Unexplained absenteeism had been found to be higher among the medical officers of health directorate at the union levels, medical officers of the family planning directorate at UHCs, and medical assistants and nurses (Hunt, 2005: 11). One of the major reasons for limited efficiency of government service is that government employed physicians are engaged in private practice (Chowdhury and Hammer 2004: 16; World Bank 2002: 53). Thus, a rural health facility where there is only one doctor suffers most (BHW 2008: 25). Staff shortage of staff is more acute at the primary health care facilities. Studies have found that due to staff shortage emergencies in upazila health complexes and MCWCs are sometimes run by the paramedics (BHW 2010: 58).

2.4.3 Urban Poor

Urban population growth rates in the six metropolitan areas are estimated at around 3.5 percent per annum. It is projected that by the middle of this century Bangladesh will be more urban than rural. This growth in urban population will mainly occur due to migration from rural to urban areas. Urban slum population growth rates within the urban areas have been estimated at around 7 percent per annum. Population in Dhaka has been growing with an approximate influx of 320,000 migrants annually and three quarters of these migrant end up in urban slums (Streatfield and Karar 2008: 265-66) . Such an increase in urban population if not matched with the

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development in health, education and infrastructure will have serious implication on the quality of life especially urban poor. The health of urban poor is severely challenged because of very limited access to the basic services like water and sanitation. Scarcity of safe drinking water is very likely to exacerbate water borne diseases. Over crowding makes urban slum population vulnerable to air borne diseases like influenza, pneumonia and TB (Streatfield and Karar 2008: 267).

It has been projected that such increase in urban population will be accompanied with increase in urban poverty. Projections show decline in rural households living under poverty line and increase in share of urban households living under poverty line. Poverty reduction programme in the country has all along been rural biased. Urban poor have always been associated with crime and squalor. The prevailing notion has been that investment in the urban poor would encourage further migration. Thus, there has been consistent policy neglect and consequently lack of investment for poverty reduction in urban areas. This policy neglect has discouraged NGOs to visibly operate in urban areas (Banks, Roy, and Hulme 2011: 491-93). Thus, there exits very scanty health care facilities for urban poor. Urban Primary Health Care Project under the Ministry of Local Government and Rural Development is very inadequate to meet health needs of the urban poor.

2.5 Reproductive Health in Bangladesh

The most important reproductive health challenge of the country is its very high maternal mortality. However, maternal mortality in Bangladesh had

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registered 40 percent decline from 322 per 100,000 live births in 2001 to 194 per 100,000 live births in 2010 (NIPORT and *et. al.* 2011:19). This decline in maternal mortality has been accompanied with improved maternal health seeking behaviour in the recent year. There has been marked improvement in facility based delivery and antenatal care. However, these improvements were not even across all the subgroups. Postpartum causes constitute a major reason for maternal deaths. Women and children in Bangladesh suffer from most from acute malnutrition (NIPORT and *et. al.* 2009).

Bangladesh is one of the most extreme cases of early marriage in the world as those of some West African countries. Teen age marriage in Bangladesh remains one of the highest in the world (Streatfield and Karar 2008: 267). Thirty percent of adolescents began child bearing when they were sixteen years old and more than sixty percent of adolescents began child bearing by the time they were seventeen years old (NIPORT and *et. al.* 2009: 56). It is one of the exceptional countries where fertility transition has not been accompanied with delayed age at marriage. Investment of female education also could not bring marked improvement in this respect (Streatfield and Karar 2008: 264). Early child bearing is a very crucial risk factor for maternal death. Maternal health seeking is much lesser among the adolescent mothers. Adolescent pregnancy is associated with increased risks in pregnancy outcome (Alam 2000).

Violence on women is highly prevalent in Bangladesh but is underreported. One of the reasons for such under reporting is that violence on women is condoned in the society. Even women themselves condone it and consider it

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as part of their life (Schuler and Islam 2008: 53-55). Dowry is found to be one of the major reasons of violence on women in Bangladesh (Bates and *et. al.* 2004). Almost half of ever married women have reported to have had experience some form of physical violence by their husbands (NIPORT and *et. al.* 2009: 200-204). Rural women are more likely to report both physical and sexual violence than urban women.

2.6 Summary and Assessment

Health system in Bangladesh is a mixed one having varied categories of providers i.e., public, private, NGO, and with varying levels of training and skill. Variant therapeutic treatments are available here. Qualified providers constitute very small percentage of the providers and semi qualified and unqualified providers constitute the largest group of the providers. Health care financing is featured with very high out of pocket spending.

Most of the health infrastructure is under the public sector. Ministry of Health and Family Welfare (MOHFW) is the apex body of Health, Nutrition, and Population (HNP) sector of the country. The public sector provides preventive and curative service, and the private sector provides curative service, and the NGO sector provides basically preventive and primary health care.

There exists an extensive service delivery infrastructure in rural Bangladesh for delivering reproductive health services. This includes both domiciliary and facility based services. However, a very large percent of these facilities remain underutilized. While primary health care facilities are very much underutilized, secondary and tertiary health facilities are over utilized.

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Public sector health services are mostly consumed for in-patient and preventive care and private sector health services are consumed mostly for outpatient curative care. Poor people mostly seek health care services from the informal providers because of accessibility and less expense. There is acute shortage of all categories of trained service providers at all levels. Vacancies at the public health sector are also very high.

Maternal health in Bangladesh is still in a very poor state. A large percent of mothers do not seek health care during pregnancy, in child birth and after child birth. This problem is greater for the adolescent mothers. Early marriage for girls and adolescent motherhood is one of the major reasons for poor health of women and children in Bangladesh. Adolescents constituting one fourth of our total population are increasingly getting exposed to varied reproductive health risks. Poor knowledge of adolescents on various reproductive health matters adds to their vulnerability.

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Chapter 3

Policy Discourse in the Family Planning and Maternal Child Health (FP-MCH) Regime

This chapter outlines and examines the policy discourses in the first phase of policy regime in the light of the objectives of the study. This has been called as family planning and maternal child health policy regime because the concept of reproductive health had not evolved at that time and the policies and programmes relating to family planning and maternal and child health (FP-MCH) are related to and relevant for reproductive health. This chapter aims to analyze the policy frameworks of this regime with a view to examining how policies, strategies, and interventions evolved under the influence of major actors and factors have affected the availability of, accessibility to, and quality of FP-MCH services and contributed in achieving the policy objectives.

3.1 Contextualizing Policy Development in the Family Planning and Maternal Child Health Based Regime

Evolution of FP-MCH programme in the country has been intricately linked to the global paradigms on health, population, empowerment, gender, and development issues. Paradigms on these areas again grew in connectivity with each other. This section reviews discourses on population and family planning from 1960s to late eighties.

The population issue had received attention at the national and international platforms prior to 1960s. However, it was not until 1960s that the

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governments and UN systems started giving more weight on population issue and initiated adoption of policies aimed at controlling fertility (Finkle and McIntosh 2002: 12). Family planning movement had thrived from the mid sixties to late eighties. Initially two separate schools of thought and action contributed to bring this movement to the fore. The first school of thought led the birth control movement by Margaret Sanger, Marie Stopes, and other pioneers originated in the first years of the 20th century. Their prime concern was women's rights and empowerment, particularly the right to avoid unwanted pregnancies. The second school of thought led the population control movement. It was fraught with worry about the rapidly growing numbers of people in the then Western Europe and the problem of stagnating agricultural production (Sinding 2007: 1-2 in (eds.) Robinson and Ross, 2007). This school of thought had its origins in the late 18th century British social philosophy widely known through the writings of Thomas Malthus.

After the World War II, neo-Malthusian view holding concern on the imbalances between rapid population growth and other resources including food supply had dominated in 1950s and 60s. Neo-Malthusians were concerned about the potentiality of political instability from poverty and deprivation induced by rapid population growth (Sinding 2007: 2 in (eds.) Robinson and Ross, 2007). As a result, population field had mobilized and promoted public support in favour of birth control, development of better contraceptive technologies, and family planning programme. Birth control movement pioneers in the initial years had fear that population control

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movement would lead the government to impose restrictions on individual reproductive freedom. Later on voluntary contraception was the common ground that had brought convergence between the birth control movement and population control movement. This convergence between the two groups has not always been smooth. Initially the population activists aimed at modest and incremental gains (Sinding 2007: 2 in (eds.) Robinson and Ross, 2007). The resolutions passed by the intergovernmental bodies of the UN gradually contributed in legitimizing family planning and mobilized government support in provisioning family planning services (Finkle and McIntosh 2002: 11-12).

In the wake of neo-Malthusian view, many developing countries were convinced that their birth rate and population growth rates were too high and would be a threat for the development. Thus, these countries had gradually started implementing voluntary family planning programme since 1960s along with efforts to increase education and health facility. However, until 1970s success of family planning with respect to increasing demand for contraception and reducing fertility was limited (Bongaarts and Sinding 2009: 35).

International population conferences over the decades have given impetus to the subsequent national and international population policies and programmes. These conferences were heavily influenced by the ideology of the different power blocks at that time. The World Population Conferences in the initial decades were of different nature. The first World Population Conference was held in 1954 in Rome and the second one in 1964 in

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Belgrade organized by the United Nations in collaboration with the International Union for Scientific Study of Population (IUSSP) primarily to discuss and share scientific ideas on population along with some general problems regarding population. These conferences did not pursue population policies. Participants of these conferences were the experts in the relevant field. Their opinions did not intend to represent the position of their country (Finkle and McIntosh 2002: 12).

However, public concern for rapid population growth had been growing in Sri Lanka, Egypt, India and Pakistan in the sixties. At the onset of seventies, rapid population growth became a concern for many countries. The United States of America (USA) had renounced its earlier position about population assistance and committed its foreign aid for population control. However, at the same time United States had shrunk its development aid. As with the change in the position of USA, United Nations had also committed itself to the cause of rapid population growth. With the assistance of United States, United Nations had sought to create a UN body for population activities. Thus, United Nations Fund for Population Activities (UNFPA) was created in 1967 which was renamed later as United Nations Population Fund (UNFPA). UN position on population growth had also caused change in the focus of the succeeding world population conferences held in the 70s, 80s and 90s. These conferences had shifted their focus from scientific inquiry to population policy. Thus, subsequent population conferences held by the UN were very less represented by the population scientists. Government officials and political leaders, civil society members selected

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by the respective governments held the most prominent positions in these conferences (Finkle and McIntosh 2002: 12).

The World Population Conference held in 1974 at the backdrop of a political situation which was supportive of seeking governmental intervention for curbing population growth in the developing countries. Northern governments went to the World Population conference in Bucharest in 1974 with the proposition that family planning should be the primary means to achieve population control. A group of western powers including the United States of America, the United Kingdom, Canada and Germany were of the opinion that rapid population growth was a major hindrance in the way to development. Population control had been thought of as a panacea to all socio-economic problems. Thus, they had considered Bucharest conference as a platform for building commitments of the government and international agencies to foster population and family planning programmes (Finkle and Crane 1975). Their policy recommendations were directed towards integrating population policy with development planning through introducing population component into various programmes and projects in the development sectors.

However, third world countries' demand in the conference was in sharp contrast with the position taken by the USA and its allies. They had strongly opposed the basic premise of the plan that rapid population growth was a major cause of underdevelopment rather than its consequences. They claimed that only major economic concessions could contribute in the development of the third world and population problems were considered as

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a consequence of underdevelopment. It was argued that lessening of population pressures would not automatically solve socio-economic and environmental problems. They sought New International Economic order to foster development. USA with its allies was not prepared for this serious opposition from the Third World community backed by the Socialist nations (Finkle and Crane 1975; Finkle and McIntosh 2002).

The developing countries had pushed two agendas in the final Plan of Action agreed to in Bucharest, that their main objective was development, not population control and that they would not concede their sovereignty to a coordinated global plan for population control as designed by the western rich industrialized countries (Finkle McIntosh 2002: 14). However, the World Population Conference in Bucharest in August 1974, at last re-conciliated the claims of both sides by asserting that population policies and programmes must work within the context of development and that population growth and development are integrated.

Ideological conflicts in the Bucharest had been explained by Finke and Crane (1975) as a perceived threat on their sovereignty by the developing countries. The developing countries had seen the roots of the global population control movement in the eugenics movement. Hence, these countries were under the impression that the global plan was aimed at reducing their population growth. However, at the same time these countries did not underscore the need of controlling population growth rate. In the successive years the countries had developed their population policies and strategies and programmes to link demographic issues with development.

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They had devoted much more recourses to the family planning programme than to health programme. Finally, ten years after the Bucharest conference, these developing countries had held a different position with regard to population control (Finkle and McIntosh 2002: 14).

Population conference held in Mexico City in 1984 had a different experience than that of the conference held in Bucharest in 1974. USA made a sharp turn with regard to their stand on population and development in the conference held in 1984. It had been asserted by them that population growth itself was a neutral phenomenon. They prescribed that developing countries should minimize their interference in their economies for promoting economic growth and thereby reduce fertility. However, many delegates of the developing countries found that assertions by the USA were made more on political considerations than by genuine interest in the demographic substance of the conference. Nevertheless, developing countries were more interested in the objectives of the conference. Finally recommendations of conference in Mexico City strongly endorsed that the government should urgently make family planning services universally available. This declaration and recommendations were regarded as major achievement for the UN and international population network (Finkle and Crane 1985).

By the 1980s, family planning activities expanded throughout the world. Contraceptives were made widely available. Significant decline in fertility was observed across the developing countries; from more than six during 1960-65 to fewer than four per woman during 1985-90. It has been claimed

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that fertility decline that had occurred in the developing countries over a single generation had taken around a century to occur in the present industrialized countries. Remarkable programme success had been recorded in the East Asian countries in 1960s and was followed by successes in other developing countries in 1980s. Despite this decline in fertility level, Asia, Africa and Latin America were challenged with large increase in population because total fertility rate was significantly higher than the replacement level needed for population stabilization and also because of the effect of population momentum (Bongaarts and Sinding 2009: 40; Sinding 2007: 1-2 in (eds.) Robinson and Ross, 2007).

However, population programmes has been facing new challenges by nineties at the backdrop of changes in the global policy environment on issues of health, population and development.

3.2 Legacy of FP-MCH Programme in Bangladesh

Family planning programme in Bangladesh was initiated in the early 1950s, much before Bangladesh became an independent state in 1971. Initially it was confined to the voluntary efforts of some social and health professionals in 1953 who eventually facilitated establishment of the first chapter of the International Planned Parenthood Federation (IPPF) in the formal name of Bangladesh Family Planning Association. The Association primarily aimed to advocate family planning as a basic human right and motivate people towards smaller families. The programme was based in the urban areas and contraceptive distribution held basically through the hospitals and clinics.

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The programme received only modest support from the government (Rob and Cernada 1992: 53-64).

Family planning turned into a government sector programme through launching it as part of the Third Five Year Plan (1965-70) by the erstwhile government of Pakistan in 1965. Thus, a national family planning programme was adopted in 1965. East Pakistan Family Planning Board was established having a field structure up to village level. The Provincial Board was placed under a similar central level body which was chaired by a Family Planning Commissioner (Rob and Cernada 1992: 53-64). The Family Planning Board was independent of health service. Thus, the family planning programme originated as a uni-purpose programme in mid 1960s.

The programme did not have any full-time field workers. Programme managers were employed for managing and implementing family planning programme. Traditional mid-wives were recruited, one for every two villages, on a part time basis. The programme had little effect on contraceptive practice and fertility. Less than ten percent eligible couples were using contraception in 1969 (World Bank 2005a: 7; World Bank 1985: 5). Thus, family planning programme that the country had inherited was largely clinic-based isolated birth control programmes.

The country had inherited an urban cendtered and curative services oriented health care system. Health facilities were very inadequate in terms of both quantity and quality. There were only 150 rural health centers. Most of these were again inadequately manned and equipped. There was severe shortage

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of all categories of health care providers. Only about 7,000 doctors, 700 nurses, 250 midwives and 275 Lady Health Visitors were available in the health services. Over 75 percent of these doctors were also working in the urban areas. Same was true about the para-medical and auxiliary forces (GoB 1973: 498-501).

In absence of any organized system of health data at that time, health indicators could not be estimated with precision rather they were roughly estimated on the basis of various sources. Life expectancy at birth was only 47 years. Death rate of children under 5 years was estimated at 260 per 1,000 children. This very high death rate among children under five years had been largely due to communicable diseases i.e., diarrhea, diphtheria, tetanus, whooping cough, measles, tuberculosis, malaria, scabies, worm infections, bacterial and viral infections etc. Maternal mortality rate was roughly estimated at 30 per 1000 births. Crude birth rate and death rate as estimated from various sources were 47 and 17 per thousand respectively, and hence, population growth rate in the country had been one of the highest at that time (GoB 1973: 498-501).

At this backdrop immediately after the independence of the country, government strongly felt the necessity of strengthening health and population programmme of the country and took it as one of the priority intervention areas (World Bank 2005a: 7).

3.3 Policy Framework in the FP-MCH Regime

Policies in the family planning and maternal child health based regime are discussed under the successive five year plans from the independence of the

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country up to fourth five year plan. Five year plans were the chief policy documents of the family planning-maternal child health programmes. Population policy adopted in 1976 was the only policy document outside of the five year plans. In the sections below, from the first (1973-78) to the fourth five year plan (1995-97) covering the period from 1973 to 1997[1] and population policy, 1976, are analyzed as policy documents in the FP-MCH based regime.

3.3.1 Policy Framework in the First Five Year Plan

The First Five Year Plan (1973-78) formulated under the leadership of *Bangabandhu* Sheikh Mujibur Rahman was the first policy document for population and health of independent Bangladesh. Planning Commission at the outset had sought assistance of World Bank as the coordinator of the Bangladesh consortium for economic aid, for policy ideas and inputs for population programme activities and a population project to support the activities (World Bank: 1979: 75).

Integration among various health services had been the philosophy of the plan. Community based primary health care was the prime focus of the plan. Communicable diseases constituting the major health problems of the country the plan had shifted from curative health care to preventive health care and gave utmost importance in the increasing the number of health facilities and service providers at the primary level. It had prescribed for phased integration of all uni-purpose projects concerned with communicable diseases (Malaria, Cholera, Small Pox, and Tuberculosis etc) to reduce

[1] Fourth Five Year Plan (1990-95) was extended up to 1997.

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duplication, expenditure and ensure efficient utilization of manpower (GoB 1973: 506).

It had envisaged a network of primary health infrastructure through establishing *Thana* health complex (subsequently known as *Thana* Health Complex or *Upazila* Health Complex) at the *thana* level (sub-district level) for each *thana* and Union health centers (subsequently known as Family Welfare Centers and Union Health and Family Welfare Centers) at *union* level (at the village level) for each union (GoB 1973: 507). It had sought integration between health and family planning at the *Thana* Health Complex under the leadership of *Thana* Health Administrator (GoB 1973: 504).

The first five year plan had made a groundbreaking contribution by founding the community based integrated health and family planning programme. The plan had proposed for creating a team of one male and one female multipurpose field workers for domiciliary services (GoB 1973: 541). For increasing the availability of preventive health services in rural areas, it had emphasized on developing the paramedical and auxiliary forces and proposed for creation of a new category of paraprofessional i.e., Medical Assistants (GoB 1973: 520).

It had also laid the foundation of broad-based multisectoral family planning programme and multisectoral Information Education Communication (IEC) based family planning programme.

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The importance of reduction in child mortality had been recognized by the plan in the context of achieving the goal of population programme. Thus, maternal health was not perceived important for pursuing the goal of fertility reduction. It had proposed for establishing maternal and child health (MCH) unit at each THC (sub-district level) and FWC at the *union* level rather than establishing isolated MCH as was established by the Pakistan government before independence. Thus, with the establishment of health complexes in all the *thanas* and health centers at each union, a network of MCH unit would be made available throughout the rural Bangladesh. MCH unit at the union health centers would be under Family Welfare Visitors who would provide MCH and family planning services. For MCH care in urban areas the plan had proposed for establishing Maternal and Child Health Welfare Centers (MCWCs) attached to each sub-division and district hospitals (GoB 1973: 514). Despite envisioning of MCH services as part of the mainstream health services the plan had neither defined the content of MCH programme nor had indicated any strategy for MCH programme.

The first plan made the start of a comprehensive national effort towards curbing fertility in conformity with the international population programme activities at that time. Population growth had been perceived as the most important threat for sustainable development of the country. Thus, government had taken the route of population control through strong family planning programme as a pre-requisite for sustainable development of the country. The plan had urged that "no civilized measure would be too drastic to keep the population of the country on the smaller side of fifteen crore

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(150 million) for sheer ecological viability of the nation". The plan felt the urgency of fertility decline in the country and set a target of reducing the population growth from 3 percent to 2.8 percent by 1978 with a goal of fertility reduction to the replacement level by the end of the century (GoB 1973: 541). An intensive domiciliary service delivery for supplying contraceptive to married women of reproductive age along with massive educational and motivation campaign had been perceived as the most effective means to achieve its demographic goal. It had called for adequate role by the ministries in population activities those maintained wider public contact like, Ministry of Rural Development, Agriculture, Education, Labour, Social Welfare, and Information and Broadcasting (GoB 1973: 539). Various social and legal measures for promoting smaller family norm were suggested including raising legal age of marriage (GoB 1973: 545). Even though voluntary acceptance of contraceptive methods on the basis of informed consent was proposed by the plan it at the same time had recommended a target and incentive based family planning programme (GoB 1973: 543). It had approved of giving actual conveyance cost to the sterilization acceptors (GoB 1973: 544).

The plan had created the platform for making menstrual regulation (MR) services available in the country. It had emphasized on the urgency of incorporating abortion into the family planning programme in a way so that it gets social acceptability and had urged for making avenue to allow abortion to play its role in controlling the population growth (GoB, 1973:

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539; 545). However, the plan did not recognize the role of abortion services in promotion of maternal health.

The plan had envisioned a population policy and a National Population Council chaired by the Prime Minister to formulate population policy. Nevertheless, the plan while had recognized the need of a population policy, it did not envision a health policy for developing health system of the country. It had also proposed for creating a central Population Planning Division to coordinate the multi-sectoral population programme.

3.3.1.1 First Population Policy of Bangladesh during the First Five Year Plan

Government had approved a national population policy in 1976. The population policy of 1976 had echoed the policies adopted in the first five year plan (GoB 1976). Population growth reduction was the main objective of the policy. It had only focused on the fertility component of population process ignoring other aspects important for population policy, i.e., migration, urbanization etc. However, other important determinants of fertility i.e., employment, education, improved health, reduction of maternal and child mortality had been recognized by the policy. The policy had recognized the need to make improvement in child survival as a prerequisite for altering high fertility behaviour. In other ways, child survival was perceived as a means to the ultimate goal of fertility reduction. Thus, maternal health was not conceived as a prerequisite for affecting the fertility behavior and the reason for pursuing maternal health within MCH got diminished.

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The policy in line with the first five year plan gave clear direction for shifting away from the erstwhile isolated clinic-based birth control programme to a community based integrated family planning programme. The policy had strongly recommended an incentive based family planning programme. It had recommended incentive for clients, communities and field workers.

It had urged the necessity of making population control and family planning programme an integral part of social mobilization and national developmental efforts and therefore, recommended for: further expansion and strengthening of multi-sectoral approach, FP-MCH service delivery in rural areas, Information Education and Communication (IEC) activities, and community involvement for developing social approval for the family planning programme.

Recognizing the acute shortage of doctors and administrators in the directorate of family planning, the population policy suggested some measures i.e., deputation of doctors from the health directorate; introduction of special field allowance; making service in rural *thanas* for family planning programme compulsory for all fresh medical graduate for two years after graduation; and increasing salaries and fringe benefits for attracting more qualified personnel in the directorate of family planning.

On issue of abortion the policy had stated that "the law on abortion would be liberalized on medical grounds". Consequently, Medical Termination of Pregnancy (MTP) by a qualified medical practitioner within 12 weeks of

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pregnancy was declared permissible under the policy provided the woman with the consent of her husband or in absence of her husband her legal guardian voluntarily submits for MTP for socio-economic or medical reasons. Thus, the policy had paved the way for making MR services widely available in the health facilities.

3.3.1.2 Policy Framework vis-a -vis Implementation Scenario of the First Five Year Plan

The first population and family health project was formulated to implement the relevant activities in the plan. The World Bank with six bilateral agencies i.e., Australia, Canada, Germany, Norway, Sweden and the United Kingdom co-financed the first population and family health project. USAID and UNFPA had signed their own agreements with the government due difference in opinion on issue of leadership and design of programme. Total cost of the project was US$ 45.7 million (World Bank 1985: 15). Government's contribution to the project was only 10 percent (World Bank 2005c: 9). World Bank for the first time in its history co-financed such social sector project and the population issue was also new to the World Bank (World Bank 1979: 75; Buse and Gwin 1998: 665-669).

Major project expense were made for creating health infrastructure for service delivery; training field workers; increasing the number of the field workers; establishing pilot schemes for introducing family life education into the activities of five ministries; introducing women's vocational training; strengthening the capacity of the mass media to incorporate

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population topics; and building research and evaluation capabilities (World Bank 1989: V).

There were 150 Rural Health Centers when first five year plan was launched. A total of 290 THCs (including 150 converted Rural Health Centers with 3800 beds) were made functional by 1980 against the target of 356 THCs with 11036 bed. However, majority of the THCs required further construction and development to turn them into full fledged THCs. Physical work of only 48 union level sub-centers could be completed against the target of 1068 sub-centers. A total of 1275 erstwhile rural dispensaries were nationalized by the government and were partially functioning as sub-centers (later named as FWC) at the union level (GoB 1980: XVII1).

It was very encouraging to note that government had moved towards implementing almost all the activities proposed by the plan. However, the degree of completeness and success of these activities varied (World Bank 1979: 6). The implementation of the first five year plan had experienced a couple of changes in the government[2] in the middle of its implementation followed by the assassination of *Bangabandhu* Sheikh Mujibur Rahman, the President of Bangladesh in August, 1975. It is worth mentioning that, subsequent changes in the government within a short span of time had not

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[2] After the assassination of *Bangabandhu* Sheikh Mujibur Rahman, Khandakar Mostaque Ahmed by a Proclamation issued on the 20th of August 1975 became the President of Bangladesh with effect from 15th August 1975. His presidency continued until the 8th November, 1975, when he handed over the office of the President to Justice Abu Sadat Mohammad Sayem who also assumed the powers of the Chief Martial Law Adiministrator. However, on the 21st of April 1977 Justice Sayem resigned from the office of President after appointing Major General Ziaur Rahman as the President (Khan, B. U., and Supan, M. H., 2002).

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affected implementation of health and family planning programme in accordance with the plan. There had not been any fundamental change in the policy or programme focus in the following years by the successive governments. Formulation of population policy was envisaged by the first five year plan under the leadership of the President *Bangabandhu* Sheikh Mujibur Rahman, and it was formulated in 1976 under the Presidency of Justice Abu Sadat Mohammad Sayem. Further, creation of the grassroot level health and family planning workforce, IEC activities, multisectoral programmes, provisioning MR services, involvement of NGOs etc. were carried through by the successive government of President Ziaur Rahman with full political support and commitment. However, at the implementation stage of the plan, a landmark shift had taken place in the programme structure outside the proposal of the plan.

Even though the philosophy of the plan had been to integrate all health services, government in 1975, with the influence of international policy block dominated by USAID favouring a vertical family planning programme had established a separate division for population programme activities within the MoHPC (World Bank 1979: 6; World Bank 1986: 75). Accordingly Population Control and Family Planning Division was created and family planning programme was brought under the newly formed division (World Bank 1979: 6; MoHFW 1996: 40). The external agencies had preferred a separate family planning division because a vertical programme deemed more efficient for concerted effort for fertility reduction. A segregated structure for family planning was also preferred by

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the donors because that would allow segregated fund for family planning (Mahmud 2004: 4085).

Shortly after establishing a separate division of family planning, government had realized the weakness of a vertical structure for family planning and thus, felt the necessity of establishing a link between family planning and maternal and child health. In the mid-seventies government reverted on its earlier premise that, for fertility reduction, effective control of infant and child mortality is a precondition. Thus, the basic premise of integrating MCH with family planning was to give attention to child survival as a means to fertility reduction. Accordingly MCH services were brought under the Population Planning Division (World Bank 1979: 6). As with the transfer of MCH services, Population Planning Division was renamed as the Population Control and Family Planning Division (PCFPD). The ministry was again renamed as Ministry of Health and Population Control (MoHPC). Through this transfer of MCH services under the PCFPD government claimed to have retained the integration of health and family planning. Since then family planning programme in Bangladesh has moved from a uni-purpose programme into a FP-MCH programme. PCFPD was headed by an additional secretary (World Bank 1986: 8).

FP-MCH unit was established within the THCs and the then family planning clinics got merged with FP-MCH units. FP-MCH unit was headed by a medical officer and assisted with two FWVs (World Bank 1979: 27). Job descriptions of FWAs and FWVs got wider to include basic MCH services at the primary level. However, problems arose from sharing of common

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physical facility between health and PCFPD at the THCs and recruiting medical officers for PCFPD (World Bank 1989: 8). The National Population Council (NPC) chaired by the head of the government was established as proposed by the first five year plan.

Given the position of the first five year plan with respect to abortion, government cautiously initiated menstrual regulation (MR) service in 1974 in selected urban clinics. Even though objective of this service was primarily 'birth control' as had been conceived in the plan document, however, in practice it was not only regarded as a family planning method for fertility reduction but also as a back-up service for contraceptive failure (Piet-Pelon 1997: 2; 14). Willful termination of pregnancy has always been a very sensitive and controversial issue. Bangladesh had successfully avoided this controversy. Abortion in Bangladesh is governed by the Penal Code of 1860 where abortion is clearly illegal except to save the life of mother. Rather than challenging this law and making abortion universally legal government had permitted to provide first trimester MR by declaring MR as an "interim method of establishing non-pregnancy for a women at the risk of being pregnant". Thus, MR had been effectively brought out of the purview of the Penal Code (Piet- Pelon 1997: 2; 14). Government under the leadership of President Ziaur Rahman had included MR in the national family planning programme through issuing a circular in 1979. Since then MR services were made available in all government and health and family planning complexes (Piet-Pelon 1997: 2).

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First five year plan was marked by founding broad-based multisectoral family planning programme and multisectoral IEC activities to influence the fertility behaviour of people. Thus, the First Population Project incorporated several multisectoral components and had a complex design. The Ministry of Health and Population control was responsible for the major components of the project. Ministry of Local Government, Rural Development and Cooperatives, Ministry of Labor and Social Welfare, Ministry of Agriculture, Ministry of Education, Ministry of Information and Broadcasting were conducting population and family life education and information programmes for spreading contraceptive knowledge (World Bank 2005a: 8). Each of these ministries had a population cell and assigned a population programme officer and field staff to implement systematic population communication progarmmes (World Bank 1979: 9). These ministries also implemented other activities like income generation for women, because increasing the status of women was considered instrumental in reducing fertility (World Bank 2005a: 8).

IEC programme got a great deal of attention during 1975-79. It got its institutional base through the establishment of the Information, Education and Motivation (IEM) Unit in 1975. IEM was assigned with planning, directing and executing IEC activities. Population communication programmes made intensive use of various media like radio, television, films and printed materials in the late seventies (GoB 1980: VII-30). NGOs were encouraged to participate in the communication activities on FP. Involvement of multi-sectoral ministries in the areas of population

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communication was a milestone in the family planning programme of Bangladesh.

In the late seventies there had been a number of crucial additions in the primary level service providers like FWAs, MAs and FWVs. Launching of outreach family planning programme through wide scale recruitment of grass-root level female family planning workers, i.e., Family Welfare Assistant (FWAs) has been a landmark for Bangladesh family planning programme in 1978 during President Ziaur Rahman's regime. This outreach service cadre was created at the back drop of the restricted mobility of rural women that had prevented them from seeking health and family planning services even from outreach health centers (Bazle and Phillips 1996: 98-106). FWAs had been considered as the change agents in the remote villages where FWAs were the only contacts for family planning for many women (Kamal 1994: 59).

A new category of paramedical staff of health division i.e., Medical Assistants (MAs) was created in 1976 in accordance with the plan (World Bank 1979: 30). Provision of another critical workforce i.e., FWV for FP-MCH had been made in the late seventies (BHW 2008: 53). A cadre of village doctors titled *Palli Chikitshaks* was also introduced in 1978 (GoB 1980: XVII-3).

As part of the global public health strategy to reduce maternal mortality by World Health Organization and other agencies of the United Nations, Traditional Birth Attendant (TBA) training program was initiated by the

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government in the late seventies to provide at least one TBA for each village. (Nasreen and *et. al.* 2007:). TBA training programme had been initiated by WHO outside the plan.

3.3.1.3 The First-Five Year Plan: FP-MCH Policy and Programme Issues, Gaps, and Challenges

Shift in the policy framework from facility based curative health programme to community based preventive health programme had facilitated in shifting health sectors resources to rural areas and reorientation of health providers towards community based preventive health care.

The health facilities and manpower had increased during the plan period even though it was far from achieving its target. However, availability of minimum health services remained far away for the majority rural people. While production of physicians reached near the target, only ten percent of the total 8,500 doctors were available in the rural areas (GoB 1980: XVII-6). Unavailability of doctors and nurses at the THCs had aggravated largely because of the reluctance of the doctors to serve in the rural areas and emigration of doctors and nurses outside the country (World Bank 1989:10).

Most of the primary level health facilities were underutilized and had been reflective of poor quality of services. In THCs bed utilization was only 30 percent whereas it was more than 100 percent in the urban areas (GoB 1980: XVII-6). Shortage of essential drugs and high cost of drugs for primary health care had been a major concern even though they were supposed to be free (Reich 1994:131). Another important reason for underutilization of

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services at the primary level was absence of a referral system (Osman 2004: 301).

The programme did not expect to show noticeable change in the outcome indicators for FP-MCH programme i.e., fertility, maternal mortality and infant mortality as because health or family planning programme needs to be viewed in long time frame. The Crude Birth Rate (CBR) in Bangladesh was 43.25 and crude death rate was 16.75. Infant mortality rate was 150 per thousand live births and child mortality (1-4 years) rate was 229 per thousand children. Maternal mortality rate was estimated at 30 per 1000 live births and accounted for 27 percent of all deaths of female aged 15 to 45 years. Life expectancy was only 47 years on an average (GoB 1980: XVII-6). Bangladesh Fertility Survey, 1975 registered a TFR of 6.5 for the period 1971-75 (NIPORT and *et. al.* 2009: 50).

Major programme achievement of this period was the marked increase in the knowledge of contraceptive and increase in the Contraceptive Prevalence Rate (CPR). CPR had been reported 7.7 percent by Bangladesh Fertility Survey, 1975, and 19.1 percent by Contraceptive Prevalence Survey 1983 (Mitra and *et. al.* 1994: 45). This achievement was possible largely because of making wider availability of and accessibility to contraceptives through domiciliary family planning force, and demand creation through massive IEC programme, and the multisectoral projects (World Bank 1979: 6; Kamal 1994: 59-65).

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The plan had envisioned integration of MCH and mainstream health facilities at the outset, however did not have any programme approach to increase availability of MCH services(GoB 1980: XVII-19). Nutritional status of the vulnerable population particularly mothers and children even deteriorated (GoB 1980: XVII-7).

Field workers' performance was much less than satisfactory in absence of technical supervision and logistics support (World Bank 1979: 14). Even though IEC was successful in setting off social movement in favour of smaller family norm, it was observed that most IEC activities focused only on motivating people towards building smaller families and achieving social approval for family planning programme activities. It was not designed to influencing health behavior and health care seeking practice (World Bank 1986: 25).

Multi-sectoral approach was not considered viable by the audit of the World Bank. Audit was not convinced with the institutional or technical rationale of the multi-sectoral approach. It was opined by the audit of the World Bank that instead of having different types of scattered activities all over the country, few selected pilot schemes in selected regions would provide more feedback and would be more replicable (World Bank 1986: 20).

3.3.2 Policy Framework in the Second Five Year Plan

Before the second five year plan for 1980-85 government had decided for an interim two year plan for 1978-80. The two year plan formulated mainly to achieve objectives those were left incomplete at the end of the first five year plan. Hence, it was a continuation of the first five year plan and during this

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period unfinished activities under the first population and health project were completed (GoB 1980: XVIII-5; World Bank 1989: IV).

The second five year plan (1980-85) was formulated by the regime of President Ziaur Rahman. The second plan was conceived at the back drop of the land mark WHO Declaration of Alma Ata, in the International Conference on Primary Health Care in 1978. The declaration had considered primary health care as the key to achieving 'health for all by 2000'. The theme of primary care as the global strategy had reinforced the country planners' attention to preventive care at the primary level. Concept of primary health care had been conceived by the plan documents both in terms of primary tier for health services delivery as well as the most important health services to be offered at the primary tier. The second five year plan had adopted primary health care as the nucleus of the health care system providing preventive services and treatment for common diseases from village to *thana* level (sub-district level). Thus, primary health care was about the basic health services delivered at the primary tier of health system.

The plan envisioned a health system arranged in four layers i.e., primary health care, secondary health care, tertiary health care, and specialized health care. Primary health care was planned to be delivered through: i) domiciliary integrated health and family planning services provided by the health and family planning field workers, i.e, HAs and FWAs; ii) FWCs at the union level; and iii) Health Complexes at the *thana* level (GoB 1980: XVII-10).

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This four layer health care system was planned to be established on a regionalized health care (GoB 1980: XVII-10). Thus, referral system which was virtually absent at that time had received attention in the context of four tier public health system envisioned by the plan.

The second five year plan had recognized population growth as the 'number one problem' of the country and called for strong political commitment for population control programme. Population programme activities got intensified in eighties like many other developing countries. The plan had followed the approach and pathways of the population policy, 1976, for developing the family planning programme and pursuing fertility reduction. The plan with the objective of reducing population growth at an accelerated rate had re-fixed the earlier demographic target. It had re-fixed the demographic goal of reaching Net Reproduction Rate (NRR) 1 by 1990. With this challenging demographic target in view, the plan accordingly set its target of reducing TFR from 5.85 to 4.1 by 1985 and reducing CBR from 43 per 1000 in 1980 to 32 per 1000 by 1985. This target would require an increase in the CPR from 14 percent to 38 percent (GoB 1980: XVII-31).

MCH targets under the Second Five Year Plan were also equally challenging. It was targeted to make a 20 percent reduction in the infant mortality rate from an estimated 125 per 1000 live births in 1980 to around 100 in 1985 and 75 in 1990, and for a reduction in child mortality from 23 per 1000 live births in 1980 to 15 per 1000 live births in 1985 and 11 per 1000 live births in 1990. It was assumed that 30 percent of children under

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two years of age would be immunized against diphtheria, pertussis and tetanus (DPT) by 1985 and 55% by 1990 (World Bank 1985: 6).

However, while the plan had set ambitious targets for MCH, it did not provide any guideline or any programme approach to be followed for MCH intervention. MCH package at the primary health were very ill defined to achieve the numeric MCH targets of the plan. MCH targets were not substantiated with appropriate interventions and thus, were not founded on genuine commitment.

The plan had recognized malnutrition as a major health issue. It had proposed for setting appropriate multisectoral nutrition programme guideline and conceiving public health nutrition programme (GoB 1980: XVII-19).

To achieve the challenging demographic target the plan had worked out multidimensional strategies. As suggested by the population policy of 1976, the plan had recommended for raising legal age of marriage and prescribed and endorsed various social measures in line with the population policy of 1976. In line with the population policy of 1976, MTP, by a qualified medical practitioner within 12 weeks of pregnancy was declared permissible under the second five year plan. Further, the plan had recommended incentive for clients, communities and field workers in accordance with the population policy (GoB 1980: XVII-36-42).

The second plan had strongly recommended further expansion and intensification of multisectoral population projects (women's cooperatives, vocational training programmes, mothers' club etc.) despite the reservation

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of audit report of the first population and family health project. Similarly Multisectoral IEC had received extensive focus in the second five year plan (GoB 1980: XVII-34).

Recording and reporting the vital events i.e., births, deaths, marriage by the grass root level workers got attention at the policy level. The plan had emphasized on regular reviews at all levels to ensure continuous tracking of the programme progress (GoB 1980: XVII-36).

The second plan in line with the first plan had envisioned integration of health and family planning services at the primary health care level under the management of the *Thana* Health Administrators (THAs). *Thana* Family Planning Officer would be the principal aid to the *Thana* Health Administrator to implement health and family planning programme through effective utilization of the field workforce (GoB 1980: XVII-36).

Functional integration was strongly advocated by the plan to reduce worker-population ratio, ensure optimum use of all other inputs of the programme and promote sterilization (GoB 1980: XVII-34).

3.3.2.1 The First Drug Policy in Bangladesh

Bangladesh led the world in establishing an essential drug policy in early eighties by the new government formed under the leadership of President Hossain Mohammad Ershad. The Bangladesh Drug Control Ordinance of 1982 was issued upon the recommendations of the Expert Committee on Drugs. WHO's concept of essential drugs was followed by the policy for the pharmaceuticals in Bangladesh. The drug policy basically aimed at

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excluding all non essential drugs from the market, promoting local manufacturer and restricting foreign firms. A list of 150 essential drugs was created by the policy of which 45 were for primary health care (Reich 1994: 132). Dr. Zafarullah Chaudhury is referred to as the architect of the policy. It is to be mentioned that Dr. Zafarullah Chaudhury had been actively working for a national pharmaceutical policy since late seventies during the Presidency of Ziaur Rahman but could not make it through because of resistance from different corners (Reich 1994: 133).

The drug policy of 1982 had also received severe resistance from home and abroad. Resistance primarily came from the national and multinational pharmaceutical companies. Dominant external players in the health and population sector like the United States of America strongly opposed this policy along with West Germany, United Kingdom, and the Netherlands (Reich 1994: 133; World Bank 2005a: 10).

Under the resistance some changes were brought in the policy without changing its main goal and strategy. Basically the list of the drugs those were allowed had been changed to permit few banned items. The policy got overwhelming support from WHO and international consumers group (Reich 1994:134). Ignoring the resistance of such strong international power blocks needed a lot of courage from the newly formed government by the President Ershad. However, this positioning of the government has been analyzed by some as a political strategy to form its domestic power base through creating alliance with some power blocks at the national level (Reich 1994:133).

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3.3.2.2 Policy Framework vis-à-vis Implementation Scenario of the Second Five Year Plan

During formulation of the second five year plan (1980-85) government had invited all the donors as technical advisors to work out programme strategy. Subsequently a follow on project that is the second population and health project was conceived to implement the programme activities of the second five year plan (World Bank 2005a: 8). The Second Health and Population Project was primarily based on the health and population programme priorities and strategies identified in the plan document (World Bank 1979: 21-23).

Second five year plan of the country during its early stage of implementation had experienced changes in the government following the assassination of the President Ziaur Rahman on 30th May, 1980.[3] However, health and family planning programme implementation in accordance with the plan was not affected and had received full political support from the subsequent governments. Initiatives taken by the preceding government for improved FP-MCH services and fertility reduction got full support from the highest policy making level. Successive government formed by President Ershad also upheld the spirit of the population policy 1976, in formulating and implementing the national population programme as was done by the President Ziaur Rahman's regime.

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[3] The first was, taking over the office of the President, according to the Constitution, by Justice Sattar, followed by Lieutenant General Hossain Muhammad Ershad on the 24th March, 1982, through proclamation of Martial Law (Khan and Supan 2002).

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ঢাকা বিশ্ববিদ্যালয় গ্রন্থাগার

The second plan was marked by the formal introduction of functional integration of health and family planning at the primary care level. However, the process of integration had started in 1979 during the two-year plan period (World Bank 1986: 8). Actual plan was total integration from top to bottom. However, government's move towards integration had faced strong opposition with frequent actual and threatened work stoppage. Finally, in April 1983, the present structure of MOHFW was created. Health and family planning services were functionally integrated at the primary care level and health and family planning divisions were brought under a single secretary (World Bank 1985: 10).

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Government's initiative towards administrative decentralization in the early eighties had instituted a number of mechanisms to ensure local participation in the implementation of health and family planning activities at the primary level. During the second five year plan period President Hossain Mohammad Ershad upon entering into the office of President in 1982, promulgated *the Local Government Upazila Parishad and Upazila Administration Reorganisation Ordinance, 1982* whereby all *Thana Parishads* became *Upazila Partishads,* and THCs were renamed as *Upazila* Health Complexes (UHCs).[4] The *Upazila Parishad* was headed by an elected Chairman.[5]

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[4] This renaming had historical significance as *thana* had its origin in the colonial period in the united India denoting police station for maintenance of law and order. Districts were the centre of the colonial administration in Bengal like other parts of India. Districts were consisted of sub-districts composing of a number of police stations locally called *thanas* for maintenance of law and order. However, even after the independence of the country these administrative tiers were continued to be called *thanas*.

[5] Administrative control over the Parishad retained through the Chief Executive Officer of the *Upazila* Parishad. *Upazila* Nirbahi Officers (UNO), the central government officials were the Chief Executive Officers. The Upazila Parishad was assigned with

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As part of the administrative decentralization government had created mechanisms to promote local participation in the implementation of health and family planning as well ensure accountability of the health and family planning management to the local representatives. *Upazila Parishad* Chairman was made responsible for coordinating health and family planning services through an order issued by the government. *Upazila* Health and Family Planning Officer (UHFPO) would report to the *Upazila* Chairman. *Upazila* Family Planning Committees were constituted, in each *Upazila* having the Chairmen of the respective *Upazila Parishads* as the Chair (World Bank 1989: 53).

During the second five year plan a number of programme initiatives had contributed in increasing the availability of MCH and family planning services at the village level. Establishment of union-level FWCs (renamed subsequently as Union Health and Family Welfare Centers) (UHFWCs) on a massive scale had contributed in increasing the availability of FP-MCH services at the union level. Production, recruitment and training of a range key of service providers including doctors, nurses, FWVs and FWAs had received increased attention (GoB 1985: 360). Thus, staffing situation at UHFWCs had improved significantly during this period and all the functioning UHFWCs had FWVs (World Bank 1985: 12). Deployment of FWVs in UHFWCs had increased the availability of clinical contraceptives

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wide ranges of functions of two categories i.e., retained subjects and transferred subjects. Retained subjects were law and order, justice, central revenues, development activities having regional or national coverage i.e., larger-scale irrigation, industries, higher and technical education etc. Development activities those were local in nature were categorized as transferred subjects and were the responsibility of the *Upazila Parishads*.

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and ante natal care, post natal care and delivery care services at UHFWCs (World Bank 1985: 17).

Programme for the training of TBAs was also expanded with United Nations' Children's Fund (UNICEF) support, making the total number of trained TBAs to 24,000 by the end of 1985 (World Bank 1985: 14). In this period screening of high risk pregnancy by the field workers was introduced at the field level (World Bank 1989: 55). Expanded Programme on Immunization was officially initiated in Bangladesh with the financial assistance of UNICEF in 1979. During the second five year plan period immunization services were made available in the fixed centers (World Bank 2005a). However, MCH programme remained severely under-funded (Osman 2004: 163).

Introduction of 'Satellite Clinics'[6] in the early eighties was one of the innovations of government's service delivery network (Mitra and *et. al.* 1997: 75). Satellite clinics were introduced to increase the physical accessibility of rural people to the key primary health services. Concept of satellite clinics was evolved through a process of interactions between community people and grass root level health and family planning personnel. Government proposed establishment of Satellite Clinics in 1982. Nevertheless, actual operations of the satellite clinics started in 1988 (MoHFW, Haider (eds.) 1995: 49).

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[6] Satellite clinics are temporary clinics set up at a pre-scheduled time. At the satellite clinics basic health and family planning services are offered i.e., health and nutrition education, antenatal care, screening for high risk pregnancies, family planning advice and supplies including clinical contraception. Family Planning Visitors are key service providers in the satellite clinics.

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NGOs were permitted to carry out health and family planning programmes in the rural areas in 1985. Since then involvement of NGOs in health and family planning programme had increased remarkably (Mabud in Rob and *et. al.* (eds.), 2007: 25).

Government had taken comprehensive effort to improve the quality of sterilization i.e., training of doctors, preparation and distribution of sterilization manuals, supply of emergency equipment including oxygen cylinders to all sterilization centers and establishment of four sterilization teams in 1982 (World Bank 1989: 42).

To meet the challenging family planning programme target massive expansion of IEC activities and multisectoral programmes had taken place (World Bank 1989: 18; GoB 1980: XVII-30).

By the end of the second five year plan a total of 341 UHCs were made functional against the target of 356 for achieving national coverage. Government had nationalized around 1275 rural dispensaries and some of those were partially functioning as UHFWCs by the end of the first five year plan. Population Control Wing of the Ministry had constructed 1,054 UHFWCs. Therefore, during the second five year plan, 2,329 UHFWCs were made available against the target of 4,500 needed for national coverage (GoB 1985: 359). Twenty Regional Training Centers were established during the second five year plan to provide training and retraining of the FWAs and FPAs (GoB 1985: 386).

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3.3.2.3 The Second Five Year Plan: FP-MCH Policy and Programme Issues, Gaps, and Challenges

Increase in CPR had been most impressive in the decade of 1975-85 from almost 8 percent in 1975 to 25 percent in 1985 (Mitra and *et. al.* 1997: 47). The increase was in threefold and the steepest. Increase in CPR was largely attributed to the addition of FWAs in the family planning programme by many studies (Kamal 1994: 59-65; Cleland and Mauldin 1991:1-18; Hossain, and Phillips 1996: 98-106). Further, intensive IEC activities had made immense contribution in large scale dissemination of information about family planning and influenced contraceptive practice and fertility behaviour. Sterilization performance of the government had reached its peak in 1984. Recruitment of FWAs, integration of family planning services with health care system at the primary level, incentives for the providers and clients for promoting IUD and sterilization all these had contributed in achieving sterilization performance (Rob and Cernada 1992: 53-64; Mitra and et al. 1994: 47). All the activities taken to improve the quality of sterilization had contributed in bringing down the number of deaths per 100,000 sterilization from 5.76 (1982) to 1.67 (1987) (World Bank 1989: 42).

Functional integration at the primary level again left the supervisory controls bifurcated. Mechanisms for coordination and integration at the district and divisional level were not clearly defined. As a result, health care at the primary level had suffered most (GoB 1985: 361). FWAs were not working as teams with their male counterparts from the health division i.e., Health Assistants (HAs) and their technical supervisors FWVs (World Bank 1979:

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4). Inadequate cooperation was persistent among the health and family planning divisions on issue of utilization of personnel and facilities and had created serious problems in the delivery of services (World Bank 1979: 6). Coordination between the activities of FWVs and FWAs remained weak largely because of having separate supervisors of FWAs and FWVs. MO-MCH, the supervisor of FWV did not have any command and control over FWAs and UFPO, the supervisor of FWAs did not have any command over FWVs. Technical link between FWVs and FWAs could not be established because FWVs did not make regular weekly visits to FWAs (World Bank 1989: 18).

Supervision at all levels was very weak mainly because of lack of supervisory skills, transport, fund etc. Further, in 1982, as part of President Hossain Muhammad Ershad's decentralization move, the posts of divisional directors of family planning were abolished and total numbers of district level staff were also reduced. Abolition of four posts of Divisional Directors who provided supervision at the national level, and reduction of district level staffs (Assistant Directors in family planning from three to one) had created severe crisis in the supervision of the programme. While number of districts was raised from 21 to 64, divisional posts were abolished. Under such a situation, it became very difficult for the Director General of Population Control wing to effectively supervise field operations. With the abolition of the district level posts of Assistant Directors, technical supervision became very weak because most of the Deputy Directors of Family Planning at the district level were non-medical personnel. This weakening of supervision

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both at the central level and district level took place at a time when government had emphasized on increasing the clinical contraception and strengthen MCH care (World Bank 1985: 18).

Despite increase in the number of UHFWCs, their utilization remained significantly low. Most of the UHFWCs also lacked essential physical facilities. Location of some of the UHFWCs was far away from human settlements (World Bank 1985: 11-12; GoB 1980: 361). Usefulness of the field staff to rural people was limited because they provided only a limited range of services, mainly, contraceptives. UHFWCs were primarily viewed by the community as family planning services facility than as a facility where MCH services were also available (World Bank 1986: 23). Thus, increase in the number of UHFWCs could not increase the availability of the services largely because of the quality and narrow content of the service.

Further, virtual absence of any formal mechanism for establishing referral system for effective functioning of four tier based public health care services had also contributed to underutilization of primary health care. While the plan had envisioned a regionalized public health service structure, it did not institute any formal mechanism of referral from one level to another which would deter people to bypass the primary levels of services.

While impressive gains were made by the family planning component of the programme in achieving its demographic goal, hardly any progress was made by the MCH component of the programme towards improving maternal and child health. Policy document of the government did not have

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any concrete approach for development of MCH programme as it had for the family planning component. Only scanty fragmented programme interventions were taken at the global public health initiatives by WHO, UNICEF, and UNFPA mostly outside the activities of the plan document. The neglect of MCH had its root in the fact that external resource was available for family planning programme and very limited for MCH programme (Osman 2004 :163).

Programme monitoring did not focus on MCH services. Even though FWAs and FWVs were assigned with the responsibility of specified MCH services, their performance target was set only on family planning services. Further, supervision concentrated only on achieving family planning targets (World Bank 1989: 18). Thus, FWAs and FWVs were basically turned into family planning workers (World Bank 1986: 23). FWAs were not adequately trained on MCH. Incentives for the providers were only tied to the performance with respect to family planning. This had been a major source of neglect of MCH by the providers.

Population communication strategy was directed more towards accepting family planning method and building small family norm. Promotion of MCH was very much neglected in the communication strategy (World Bank 1985:20). Link between performance reporting and availability of essential inputs such as personnel, contraceptives and MCH supplies was missing. Reporting system also did not include MCH activity and mainly consisted of data on new acceptors of clinical methods than to data on continuation rates and changes in the contraceptive method mix (World Bank 1985:22).

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Very logically the challenging MCH target of the plan could not be met. Under-five mortality and child mortality estimated at 173 and 63 respectively per 1000 live births for the period 1982-86 (Mitra and *et. al.* 1997: 100). Maternal mortality was estimated at 6 per thousand live births and infant mortality rate was estimated at 125 per thousand live births (GoB 1985: 385). Malnutrition situation had even deteriorated with decrease in nutrition intake and increase in vitamin-A deficiency blindness, iron deficiency anaemia, iodine deficiency goiter, protein-calorie deficiency marasmus (GoB, 1985: 362).

3.3.3 Policy Framework in the Third Five Year Plan

Third five year plan (1985-90) was formulated by the political regime of President Hossain Mohammad Ershad. Primary health care remained the major focus of government policy. The plan had exerted renewed emphasis on the interdependence between fertility reduction and child survival and hence, given increased attention to child health intervention. The third plan made a breakthrough by following a programme approach for MCH for the first time. Until the third five year plan, MCH had been operating through fragmented MCH activities mostly initiated by WHO, UNICEF, and UNFPA on a small scale outside the activities of the plan documents.

The third population and health project had also marked a difference from the earlier two projects for extending its support for MCH programme in three major areas: reduction of diarrhoeal deaths through oral rehydration therapy, expansion of immunization services for the children below two years of age and pregnant women, and expansion of the training of TBAs in

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safe delivery practices. However, these three MCH interventions were already in operation in a very small scale by the late seventies outside the activities of the plan document.

UNICEF had initiated and supported development of these three MCH interventions on a small scale outside the activities of the plan during second five year plan implementation period. The third five year plan had envisioned to strengthen, intensify, and expand these three interventions through a programme approach. Experience in implementation of these interventions was expected to facilitate the government in dealing with MCH problems more comprehensively over the following years (World Bank 1985: 43). In fact, immunization, oral rehydration, and TBA training were chosen as the areas of MCH interventions because interventions in those areas seemed to be managerially and technically feasible. Amongst all these three interventions TBA training was the least costly without having to add any substantial input in the service delivery system. No additional maternal health intervention was conceived. Thus, maternal health services at the primary level confined to very basic preventive maternal health services like ante natal care, screening 'at-risk'[7] pregnancies, and training of TBAs for safe home delivery. The community based maternal health strategy had not been supplemented with facility based strategy and therefore, maternal health services were not built on the principle of continuum of care. Malnutrition despite being recognized by government as

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[7] Women belonging to very young, old and high parity group, pregnancy with short birth interval, women with short stature, and women those who had troubled pregnancy are identified as 'at-risk' of developing complications during pregnancy or child birth.

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one of the most important health issue of mothers and children, was not included in government's 'priority MCH interventions'.

MCH targets of the plan were founded on these interventions. MCH targets of the plan were to reduce: maternal morality from 6 per 1000 live births in 1985 to 4 in 1990; infant mortality from 125 per 1000 live births in 1985 to 100 in 1990; and neonatal mortality from 85 per 1000 live births in 1985 to 65 in 1990. The plan had targeted of training additional 40,000 TBAs so that almost all the villages had at least one TBA (GoB 1985: 378). Immunization target for DPT was set at 80 percent for children below two years of age and target for BCG was set at 90 percent for children under 15 years (GoB 1985:365).

For expansion of immunization services the plan had adopted the strategy of integrating immunization services with the outreach services particularly with services offered at the satellite clinics through the involvement of FWAs and MAs. Immunization services were proposed to be delivered in coordination with other FP-MCH activities. The plan had adopted the strategy of introducing decentralized system of detection and epidemic control of diarrhoeal disease, developing capability to provide oral re-hydration therapy at the household level, and local production of oral rehydration therapy.

Even though malnutrition was not among the priority MCH intervention area, malnutrition had been recognized a major health problem by the plan document. It had proposed for establishment of nutrition unit including

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rehabilitation centers at the UHCs and committed for introduction of growth monitoring, nutritional surveillance, blindness prevention. A complete goiter control was committed through iodation of all edible salt in the country.

The third plan like the second plan had followed the population policy of 1976 for family planning programme and fertility reduction. Like the preceding plan it had also recognized the role of MR services in achieving the demographic goal of the country as the most effective method to deal with the failures of other methods (GoB 1985: 384). The plan targeted to increase the rate of contraceptive practice from 25 percent in 1985 to 40 percent in 1990. This increase in contraceptive acceptance was expected to bring a decline in TFR from 5.8 to 4.8 in 1990 and a decline in the crude birth rate from 39 in 1985 to 31 in 1990 (GoB 1985: 378; World Bank 1985: 23).

Family planning programme activities remained focused towards increasing the availability of, accessibility to family planning methods, and creating additional demand for contraceptives (GoB 1985: 379). The plan had committed towards supporting social marketing programme as an additional channel for non-clinical contraceptive provisioning. The role of NGOs for providing clinical and non-clinical contraceptives in rural and urban areas was recognized by the plan (GoB 1985: 384). Multisectoral programmes (women's cooperatives, mothers' centers, women's vocational training), IEC activities received increased attention as a means to influence fertility behaviour. The plan had advocated on shifting the focus of communication strategy from promoting awareness to behavioural change and incorporating MCH into IEC strategy. Issue of involvement of *Upazila Parishads* in

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implementation of health and family planning activities had been an additional feature of the plan (GoB 1985: 389).

3.3.3.1 Policy Framework vis-à-vis Implementation Scenario of the Third Five Year Plan

The third population and family health project was conceived to facilitate government in implementing its programme activities under the third five year plan. The third population and family health project commenced in 1986. Encouragingly government's contribution to total project cost rose to 17 percent in the third population and family health project. It was only 10 to 11 percent under the first and second project (World Bank 2005c: 9). Third five year plan was the first one which could be implemented under the political leadership it was formulated.

The third plan had been marked by creating crucial supervisory posts at the *Upazila* and district level for improving supervision of programmes and expansion and strengthening of the existing three MCH interventions. Four posts of Directors for Supervision were created as a supervisory tier between the Director-General (DG) of family planning and the 64 district level Deputy Directors of family planning (DD-FP). These posts were expected to ease the burden on the Director General of family planning. Further, a total of 464 posts of Senior Family Welfare Visitors (Sr. FWV) were created, at the rate of one per UHC. Sr. FWVs of UHCs would report to the MO-MCH&FP. Sr. FWV post was created as a promotion post for FWVs and hence, career development for this cadre was opened up. They were assigned with the responsibility of quality control and in-service training on clinical contraception and TBA training and for supervision of MCH services

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delivered by the FWV at each UHFWC. Until creation of the post of Sr. FWV, doctors were the only technical supervisor available at the *Upazila* level. As the doctors were mostly male they were not suitable for this job. The second population and health project had financed for these two supervisory posts (World Bank 1985: 34).

Government had re-designated the post of Medical Officer, Mobile Sterilization Team (MO-MST) under the DD-FP at the district level to Medical Officer, Clinical Contraception, Maternal Child Health (MO-CC-MCH). Primary responsibility of MO-CC-MCH would be to monitor and improve the quality of clinical contraception and institutional MCH care. Clinical Contraception Surveillance Team would provide technical supervision to MO-CC-MCH. However, these posts would continue to be financed through the GoB revenue budget (World Bank 1985: 34).

Immunization programme got its impetus during the third five year plan at the backdrop of the country's commitment of reaching universal immunization by 1990 at the United Nations. Expanded Programme on Immunization (EPI) was strengthened through procurement of cold chain equipment, vaccination tools, portable vaccination kits, training of immunization teams, development of effective system of immunization delivery and promotion of demand for immunization through various communication media etc. (Jamil and *et. al.* 1999: 49). A maternal health intervention had been added into the immunization programme during this period. The programme included Tetanus Toxoid (TT) immunizations for women of reproductive age in addition to prevention of six major common

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childhood diseases. Integration of maternal health intervention within the existing immunization programme through inclusion of TT for women of reproductive age had given this programme an unusual feature (World Bank 2005a: 11). Immunization services were delivered through fixed facilities i.e., UHCs, UHFWCs, MCWCs, divisional and district hospitals as well as through the outreach services i.e., satellite clinics (World Bank 1985: 44). Oral rehydration therapy to control diarrhoea was widely promoted and was institutionalized at home level through massive educational campaign (World Bank 1989: 55).

Training of Traditional Birth Attendants (TBA) also continued so that all most all villages in the country had at least one TBA (GoB 1985: 386). Another pool of 10,000 new FWAs was recruited to increase the density of FWAs. The newly recruited FWAs were planned to phase in on a priority basis to those areas where new MCH services were to be introduced first (World Bank 1985: 39).

Multisectoral programmes including women's cooperatives, mothers' centres, women's vocational training programmes and IEM activities were further exapanded. There had been significant increase in the broadcasting of population related programmes in the radio and television. Immunization and rehydration therapy constituted a major part in the communication programme.

Despite making considerable progress in establishing health infrastructures, government could not achieve its target of reaching national coverage of UHCs and UHFWCs even by 1990. A total of 245 UHCs and 725 FWCs

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(including 225 FWCs spilled over from the second five year plan) were constructed and made functional against the target of 397 UHCs and 1200 FWCs (GoB 1990: XI-1; XII-4).

To meet the increasing demand of essential drugs for primary health programme two pharmaceutical plants at Tejgaon and Bogra had been set up during third plan period. At that time almost 50 to 60 percent of the public sector drug requirements were met through the national drug plants (GoB 1990: XI-2).

3.3.3.2 The Third Five Year Plan: FP-MCH Policy and Programme Issues, Gaps and Challenges

Until late eighties while the family planning programme received recognition in terms of delivery of programme output, it was still considered inefficient in terms of fertility outcomes. However, series of surveys carried out during that period had been giving a different picture about the fertility outcome of the programme. The Bangladesh Fertility Survey held in 1989 reported a TFR of 5.1 for the period 1984-88 and Bangladesh Contraceptive Survey held in 1991 recorded a TFR of 4.3 for the period 1989-91 (NIPORT and *et. al.* 2009: 50; GoB 1990: XII-2). Bangladesh Bureau of Statistics and World Bank had also noticed similar trend. The third population and family health project completion report had also reported remarkable progress. Cleland and others (1994) were of the opinion that fertility transition had started without remarkable socio-economic change. However, others had differed with this opinion and claimed that socio-economic change had taken place and had contributed in fertility transition (World Bank 2005a).

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Issue of financial sustainability of the programme came to the front at the back drop of increase in CPR over the period. Because of population momentum, reproductive age group would continue to grow in Bangladesh. Under such a situation, programme sustainability would largely depend on the method mix of contraceptive use. Even though there had been a significant increase in CPR, the programme showed a declining trend in the use of longer acting methods and an increasing trend in the use of pills and injectables. Clinical contraceptive performance continued to fall because quality of clinical contraceptive services was not satisfactory (World Bank 1993: 7). Heavy reliance on temporary methods of contraception had entailed significant recurrent cost for the programme (World Bank 1993: 9). Thus, the issue of cost efficiency had created ground for the programme planners for universal promotion of longer acting family planning methods.

This cost implication for the programme had turned more serious because of extreme dependence of the programme on external resources. However, government's contribution to this sector had been on increase over the period. GoB had planned to gradually absorb the costs of FWA salaries over the following years. Government had already been absorbing some of the workers into its revenue budget. This had demonstrated commitment of the government to the programme. Even though government's contribution to the programme cost had been on increase, it was felt both by the donors and government that in future, government would not sustain a totally subsidized programme with its own resources. Therefore, development of people's ownership of contraceptive responsibility coupled with promotion of longer-

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acting and more cost-effective methods through IEC was considered essential in ensuring programme sustainability. NGOs functioning in this field were also dependent on external resources. Thus, it was urged that unless the NGOs create their own resource base they would not also contribute to the sustainability of the programme (World Bank 1993: 10).

Issue of sustainability also revolved around the programme achievements. Sustaining the achievements of the programme had also turned into a vital issue. The quality of service delivery was questioned in view of the consistent lower utilization of the facilities at the primary level. Over the period experience had shown that mere physical expansion of health facilities would not ensure their utilization unless effective measures were taken to improve quality of the service, improve availability of the service providers and other necessary supplies. Further, to maintain the increase in CPR, more effective IEC, women's development and other inter-sectoral activities were needed (World Bank 1993: 10).

Incentive within the family planning programme had raised serious controversy among the donors on question of the principle of voluntarism in contraceptive choice, malpractices, coercion to accept sterilization, neglect of follow-up, and of all neglect of health responsibilities in particular, MCH. On the other hand, some donors had no objections with the system of incentive as long as appropriate safeguards were taken to prevent coercion, misinformation, and other health activities were maintained (World Bank 1989: 70).

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Programme achievements with respect to reduction of fertility were not followed by similar improvements in maternal and child health. Under-five mortality was estimated at 139 per 1000 live births for the period 1987-91, child mortality and infant mortality was estimated at 47 and 96 per 1000 live births respectively for the same period (Mitra and *et. al.* 1997: 100). Maternal health situation was the worst. Maternal mortality was estimated at 5.7 per 1000 live births (GoB 1990: XII-4). Malnutrition in Bangladesh continued to remain one of the highest in Bangladesh. Children, pregnant and lactating mothers remained the most vulnerable to malnutrition (GoB 1990: XI-12). This had added to the controversy centering around the goal of the FP-MCH programme among the women health advocates. Maternal health interventions undertaken by MCH programmes were considered too inadequate to address maternal morbidity and mortality (Rosenfield and Maine 1985). Interventions like, antenatal care, TT vaccine, screening at risk pregnancies, safe home delivery by TBAs primarily grew on the existing interventions and personnel with little additions in the service delivery input. Maternal health interventions were very scanty and preventive in nature and were built on risk screening approach. These interventions could hardly address obstetric complications of pregnant women, the leading cause of maternal mortality in the country. Risk screening approach remained ineffective in dealing with obstetric complications because of the fact that most obstetric complications cannot be predicted beforehand (Rosenfield and Maine 1985: 84).

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The programme continued to suffer from weak coordination between health and family planning division. Modalities of coordination and integration between and among the services delivered by the directorate of family planning and the directorate of health were not clearly spelled out and enforced (GoB 1990: XI-4). Weak coordination had affected the quality of health and family planning services at the field level. Intersectoral coordination was also weak which had affected implementation of the multisectoral projects. Coordination was also poor between NGO's operations and GoB activities. The programme also suffered from a lack of procurement plan and inadequate local procurement capacity (World Bank 1993: 7).

3.3.4 Policy Framework of the Fourth Five Year Plan

Fourth five year plan (1990-95 extended up to 1997) was also formulated during the political regime of President Hossain Mohammad Ershad. At the time of formulation of the fourth five year plan, situation with respect to fertility, immunization coverage, health infrastructure etc. was more favourable than ever before. Even though achievement in child health had been far from its target, an improving trend was evident. BDHS 1993-94 had estimated child mortality, under-five mortality and infant mortality for 1989-93 at 50, 87, and 133 per thousand live births respectively. Estimated TFR for 1989-91 was 4.3 (Mitra and *et. al.* 1994: 92; 27). Despite remarkable strides made in fertility reduction by nineties, demographic indicators of the country made it clear that NRR 1 by 2000 was not achievable. Thus, NRR 1 was targeted by 2005 by the plan. Other demographic targets of the plan were: reduction of population growth from

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2.16 in 1990 to 1.81 in 1995 and TFR from 4.5 in 1990 to 3.3 in 1995. This would require an increase in CPR from around 33 percent to 50 percent (GoB 1990: XII-5). MCH targets of the plan were to reduce: Maternal Mortality Rate (MMR) from 5.7 in 1990 to 4.5 in 1995 per 1000 live births; Infant Mortality Rate (IMR) from 110 in 1990 to 80-85 per 1,000 live births; and neonatal mortality from 80 in 1990 to 60 per 1000 live births (GoB 1990: XII-5).

The fourth plan had focused on child health through further expansion and intensification of the previous three intervention areas identified by the third five year plan coupled with two new interventions, i.e., acute respiratory infections and nutritional supplementation by Vitamin A (World Bank 1991: 11). Vitamin A supplementation had been the first specific health intervention initiated by the government to address one of the many health disorders resulting from malnutrition for children.

The fourth five year plan was formulated after the Safe Motherhood Conference held in 1987 in Kenya, Nairobi. The main object of the conference was to bring maternal morbidity and mortality into global health agenda and create a platform for maternal health programme intervention. However, the fourth plan did not conceive any new maternal health intervention or strategy as an aftermath of the conference. The plan had committed to build maternal health programme through strengthening and expansion of the three existing maternal health interventions, i.e., safe delivery at home through TBAs, screening for high risk pregnancies and provision of tetanus toxoid to pregnant women (GoB 1990: XII-6). The plan

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did not include any intervention for improving the availability of emergency obstetric care for curbing maternal mortality.

Primary health care remained the key strategy for delivery of FP-MCH services like the preceding plans. In line with the second plan, satellite clinics had been emphasized as the most critical conduit for integrated FP-MCH service delivery through the paraprofessionals of health and family planning directorate. Involvement of community leaders in organizing satellite clinics was emphasized for successful implementation of the programme.

At the backdrop of administrative decentralization in the eighties, the fourth five year plan gave special focus on increasing local level participation in implementation of health and family planning programme. Local participation was encouraged for ensuring community ownership to the programme and developing social monitoring for programme implementation. Further, decentralization of authority and responsibility for programme planning, strategy formulation, resource utilization, and integration of population programme with development programme at the local level also received considerable attention (GoB 1990: XI-5; XII-6).

The policy approach to family planning programme remained the same. Programme strategies for family planning programme were also the same. The plan reiterated the necessity of well coordinated inter-sectoral and multi-sectoral population programmes, and non-family planning interventions for influencing fertility behavior (GoB 1990: XII-6).

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To improve supply system, the plan had given emphasis on accelerated domestic production of increased number of essential drugs including antibiotics, vaccines, and contraceptives for primary health care by government pharmaceutical plants and private sector plants. It had proposed for two more pharmaceutical plants in two other divisions of the country. Publication of a national formulary of essential drugs had also been declared by the plan (GoB 1990: XI-10).

3.3.4.1 Policy Framework Vis-a Vis Implementation Scenario of the Fourth Five Year Plan

Fourth five year plan (1990-95) was formulated at the fag end of the regime of President Ershad. However, few months after the formulation of the fourth plan President Ershad had to resign on the 6th December, 1990, following a large scale movement in the pursuit of democracy. Thus, the implementation of the plan had taken place under the newly elected government in 1991. The new government was formed by the Bangladesh Nationalist Party (BNP) led by Begum Khaleda Zia, the wife of the former President Ziaur Rahman following a landslide victory in the general election held in 1991.

The fourth population and health project was conceived covering the period 1992-96 to support implementation of the fourth five-year plan which extended from 1990 to 1995. All the project components and subcomponents were formulated matching with those of the government's fourth five year plan for FP-MCH (World Bank 1991: 12). Despite the fact that the third and fourth population and health project had given some

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attention to child health interventions, resource allocation had been disproportionately lopsided towards family planning. Almost 54 percent of the total project cost had been allocated for family planning activities of which largest share went for salaries of the outreach workers and contraceptive supply (World Bank 1991: 64).

The project put more emphasis on quality of care over mere expansion of physical facilities. For promoting quality of care a multifaceted approach was undertaken i.e., training of the service providers, maintaining adequate supplies, improvement in management and supervision, appropriate incentives and targeting of health services (World Bank 1991: 64; 12).

Health and family planning programme implementation continued in accordance with the plan under the new government without any major policy shifts. However, with the scraping of *Upazila Parishad* by the new government, the mechanisms evolved to promote local participation in the implementation of the family planning programme through the involvement of *Upazila Parishad* ceased to exist. No new mechanism was introduced to promote local participation. Further, *Upazilas* were again renamed as *Thanas* and thus, UHCs were renamed as THCs without ascribing any reason.

A number of initiatives were taken to improve the supervision and management of the programme. The fourth population and health project assisted government in using the volunteer force to supplement the work of the field force and thereby ensure further increase in the availability of and

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accessibility to contraceptives to rural women (World Bank 1991: 20). To reduce the burden of HAs and FWAs government took initiatives to involve female members of the Village Defense Party (VDP), *Swanirvar* (NGO) and the Mothers' Clubs and Women's Cooperatives as volunteers to work as agents between FWAs and clients. Programmes were taken in imparting training to these volunteers (World Bank 1991: 20). Further, recognizing the crucial role of the FWAs for the programme, the new government had recruited additional 3,500 FWAs and decided to absorb the cost of the salaries of FWAs over the periods. Further, decision was taken to fill 5,000 vacant positions of HAs by female workers. There also held an agreement to work out a common job description for FWAs and HAs to reduce the number of household they cover (World Bank 1991: 20).

The fourth population and health project had suggested for another post of FWV for each UHFWC instead the post of pharmacist. There were three sanctioned posts for each union level UHFWC, one Medical Assistant, one FWV and, one pharmacist. The post of pharmacist mostly lied vacant and was not considered a necessary one. On the other hand, it increasingly became difficult for one FWV to provide prenatal, natal, and postnatal care, inserting IUDs, providing injectables etc. The pharmacists who were already posted at FWCs were recommended to be deployed at UHCs and district hospitals (World Bank 1991: 20).

The supervisory post of Assistant Directors (FP-MCH) at the district level which was abolished under the third five year plan was revived (World Bank 1991: 21).

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Training of TBAs initiated under the third five year plan was further expanded. Likewise, strengthening and expansion of immunization programme and CDD programme had continued through strengthening service facilities and training programmes (World Bank 1991: 31). Interventions for prevention and management of Acute Respiratory Infection (ARI) and nutritional supplementation by Vitamin A to children ageing from 6 weeks to 6 years to prevent night blindness were introduced under MCH programme (World Bank 1991: 31).

To further increase the availability of and accessibility to family planning and MCH services, satellite clinics had been expanded considerably during this period in accordance with the plan (World Bank 1991: 21).

Even though the plan document of government relied on the earlier interventions for maternal health, government in collaboration with UNFPA had initiated a pilot project for introducing comprehensive EmOC services in the Maternal and Child Welfare Centers under the Directorate of Family Planning in 1993. Until then comprehensive EmOC were not available in the district hospitals. EmOC were only available in the specialized hospitals. The pilot project started in eleven MCWCs in Rajshahi division. After successful piloting, the programme was expanded to include all MCWCs (Gill and Ahmed 2004).

Bangladesh Integrated Nutrition Project (BINP), the first comprehensive national nutrition project supported by World Bank was started in 1995. The time frame of the project was from May 1995 to December 2002. It began as

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a pilot programme in six *Upazilas* in 1996. However, this was funded by the World Bank as a separate project outside the fourth health and population project (World Bank 2005a: 12). The project got extended upto June 2002 and was assigned to cover a total of 61 *Upazilas*.

A total of 390 UHCs were made functional by 1995 against the target of 397. Cold chain had been established in each THCs/UHCs to maintain the quality of drugs and vaccines. At the union level 4,062 health centers were made available by 1995. Of these health centers 2,700 were UHFWCs and 1,362 were upgraded rural dispensaries (GoB 1998: 456).

3.3.4.2 The Fourth Five Year Plan: FP-MCH Policy and Programme Issues, Gaps, and Challenges

Impressive gains had been made by 1995 with respect to decline in fertility and child mortality, increase in life expectancy, immunization coverage etc. Life expectancy at birth had reached 58 years in 1995. Small pox, malaria and cholera no longer remained the major killer diseases (GoB 1998: 455). Fertility decline had been the highest in the early part of the fourth five year plan. It had declined from 4.3 in 1989-1991 to 3.4 in 1991-1993. However, fertility plateauing had started at around 3.3 from 1993-94 for almost a decade (NIPORT and *et. al.*, 2005: 54). The BDHS 1993-94 and 1996-97 had shown that small family norm was accepted by the couples. Both surveys found that the average ideal family size among married women was 2.5 children. Almost fifty-eight percent of married women had reported that they did not want any more children. This change in the attitude among

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women was indeed a remarkable achievement (Mitra and *et. al.* 1997: 87-88).

Decline in fertility had been a logical outcome of the consistent increase in contraceptive use over the last two decades. Contraceptive use had increased from 8 percent in 1975 to 49 percent in 1996-97. This increase in the use of contraceptive was largely attributed to increase in the use of oral pill. Use of oral pill accounted 42 percent of the total contraceptive use in 1996-97 (Mitra and *et. al.* 1997: 50).

Despite the fact that there had been consistent increase in contraceptive use, discontinuation rate in contraceptive use remained nearly fifty percent. Side effects of the contraceptives and other health reasons constituted the major causes of contraceptive discontinuation. Unmet need for family planning services even though had declined from 1993-94, it remained at 16 percent (Mitra and *et. al.* 1997: 92).

Further, teenage fertility also remained very high. BDHS 1996-97 showed that thirty-one percent of teen aged girls in Bangladesh were mothers and five percent were pregnant with their first child. Age at first marriage also remained one of the lowest in the South Asia. About 60 percent of girls were married by the time they were 15 years old (Mitra and *et. al.* 1997: 40, 82).

Despite massive recruitment and placement of field workers over the preceding years, visitation by the field workers remained far below the satisfactory level. Only 35 percent of the married women had reported that they were visited by a family planning field worker in the previous six

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months. It was indeed a major programme concern that that only one third of the married women were visited by the field workers while almost the entire country had been covered by the field workers (Mitra and *et. al.* 1997: 75).

MCH programme had registered its gain during this period in terms of improvements made in child survival and immunization coverage. Under-five mortality came down from 173 per 1,000 births for the period 1982-86 to 116 per 1,000 births for the period 1992-96. Decline in child mortality was much faster than infant mortality decline from 1982-86 to 1992-96. Child mortality declined from 63 per 1,000 live births in 1982-86 to 36 per 1,000 live births in 1992-96. Infant mortality declined from 117 in 1982-86 to 82 per 1,000 live births in 1992-96 (Mitra and *et. al.* 1997: 100).

Immunization programme in Bangladesh had received international recognition for its success by the mid nineties. Coverage for BCG and measles was very impressive. Coverage for BCG and measles of children ageing 12-23 months was 80 percent and 70 percent respectively. Similarly coverage of first dose of DPT and Polio was also very high (Mitra and *et. al.* 1997: 116). Besides impressive coverage of immunization for BCG, there remained disparity between urban and rural areas and boys and girls (Mitra and *et. al.* 1997: 119).

Prevalence of Acute Respiratory Infection (ARI) among children under three years of age declined from 24 percent in 1993-94 to 15 percent in 1996-97. The proportion of children had taken to a health facility also increased from 28 percent in 1993-94 to 36 percent in 1996-97 (Mitra and *et. al.* 1997: 121).

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MCH programme could not make any dent on maternal mortality. It remained as high as 4.5 per 1000 live births (GoB 1998: 461). No noticeable improvement had taken place in maternal health care seeking. Survey findings recorded that three quarters of mothers received no antenatal care during pregnancy and ninety-five percent births in Bangladesh occurred at home (Mitra and *et. al.* 1997: 109; 114). However, eighty-five percent of women recognized that antenatal care was beneficial (Mitra and *et. al.* 1997: 110). Thus, accessibility factors as an impediment in pre-natal care seeking had got some recognition. Encouragingly, proportion of pregnant women receiving tetanus toxoid injections had risen significantly. Percent of pregnant women receiving at least one tetanus toxoid injection was 66 percent for the period 1991-93. It got increased to 75 percent by 1992-96 (Mitra and *et. al.* 1997: 113).

TBA program could not make noticeable contribution in averting maternal deaths. It has been widely recognized that TBA based maternity program did not work or was not sustainable, because of the fact that TBAs were left unsupervised and TBAs were not linked with a functioning health care system (WHO 2004; Lawn and *et. al.* 2006).

Satellite clinics became increasingly popular among the users (MOHFW, Barkat and *et. al.* 1997: 11). There was significant increase in the proportion of ever married women who reported satellite clinics in their community from 54 percent in 1993-94 to 70 percent in 1996-97 (Mitra and *et. al.* 1997: 75).

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However, utilization of primary health care continued to remain very low. Most of the UHCs and UHFWCs had been suffering from shortage of essential physical and logistic facilities. Many district hospitals also had inadequacy of equipment, supplies, and manpower. Weak coordination between health and family planning directorate continued to affect the quality of services, and impede referrals and generate internal conflicts. Further, referral system from UHFWCs to the district hospitals or specialized institutions remained weak and ineffective in absence of a clearly spelt out linkage and communication (GoB 1998: 463).

3.4 Summary and Assessment

Policies under the family planning and maternal child health based regime were primarily conceived as part of the subsequent five year plans of the government. External resources for implementation of the programme activities in the plan were allocated under health and population projects with funding from donor consortium led by the World Bank. Project components and subcomponents were formulated along activities and interventions in the government's plan documents. Thus, donors' input in the plan formulation was crucial and an open practice for assurance of external resource flow for the programme.

The country had experienced quite a many changes in the government in quick succession from the mid seventies to early eighties. However, despite changes in the governments, FP-MCH programme continued to grow with a consistent policy direction. Successive governments had adopted,

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intensified, and strengthened the programme initiatives or strategies those yielded positive results in the preceding years.

The first policy regime (1973-1997) had considered population growth reduction as its utmost national priority and prerequisite for sustainable development of the country. Family planning programme for fertility reduction had received strong support at the policy level from the government as well as from the donors all through the period.

Government in the first five year plan had shifted from curative care to preventive care and from clinic-based vertical family planning programme to community based integrated health and family planning programme at the primary level. Primary health care remained the central theme of the policy regime. The plan document at the outset had approached for an integrated health and population programme. In the mid seventies donors' alliances favouring vertical programme had induced government for creating separate division for family planning on the ground that fertility reduction agenda might get diffused within the huge umbrella of health. Accordingly a separate division for family planning was created. However, very soon it was realized by the policy makers and other major policy actors that family planning programme without having any broader health component in it was less likely to have acceptability. MCH programme was then merged with the family planning directorate on the premise that control of infant and child mortality is a precondition for convincing fertile couples for contraception or lower fertility. Conceptualization of child survival as a means to fertility control and family planning as the primary means to maternal health had

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been the source of consistent neglect of maternal health services in the entire FP-MCH policy regime.

Even after merging MCH with family planning, the necessity of having functional link between health and family planning was not over. Functional link between the two was strongly advocated by the major policy actors in view of the recognition that the quality of family planning services would be questioned without having link with health programme and thus, would have limited acceptability. Another very important reason to support integration with health was to promote clinical methods of contraception. Functional integration of health and family planning programme at the primary health care level was instituted under the unified command and control of THA in the early eighties. The need for integration between health and FP-MCH ran throughout the policy regime and the central concern for integration of family planning and health services was to increase acceptability of the family planning programme. Nevertheless, functional integration could not be effectively enforced and lack of coordination remained the weakest part of the programme affecting the availability and quality of services at the primary level.

The first five year plan had made a remarkable contribution in reproductive health services by founding the community based integrated health and family planning programme and creating the platform for wider availability of MR services in the country. In the late seventies there had been a number of crucial additions in the primary level service providers including FWAs, MAs, and FWVs. These additions in the programme had significantly

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impacted on the availability of FP-MCH services. FWAs have been the corner stone of the family planning programme in Bangladesh and played the most crucial role in the onset of fertility transition by the end of FP-MCH regime through increasing the availability of and accessibility to contraceptives. There had been significant increase in the total number of FWAs by mid nineties. Similarly, number of FWVs and MAs had also increased significantly. As a result, staffing situation in UHFWCs got improved considerably by the late eighties. Thus, UHFWCs were made functional to improve the availability of FP-MCH services. However, deployment of female field force for contraceptive delivery had resulted in distancing men.

Massive IEC programme in the mid seventies for social mobilization towards small family norm had made immense contribution in increasing people's knowledge about contraceptives and family planning services and affecting people's reproductive behavior and contraceptive practice. However, IEC programme were largely confined to promoting family planning method acceptors and small family norms.

Introduction of satellite clinics had contributed enormously in increasing the accessibility of people to the health and family planning services. Satellite clinics had been widely used for immunizations, vitamin A supplementation, and tetanus injections. Institutional facilities for sterilization were made available in all functional UHCs, 84 MCWCs, district and medical colleges' hospitals, and selected UHFWCS. MR services have been made widely available in all the health facilities.

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As reported by BDHS 1996-97, 95 percent of ever-married women lived in communities with family planning field workers, 91 percent lived in an area covered by a satellite clinic and 87 percent of women lived in communities covered by health workers (Mitra and *et. al.* 1997: 146-47).

However, despite contributions made in increasing the availability of and accessibility to family planning services, FP-MCH based programme had generated serious controversy within home and abroad on the incentive system within the family planning programme and setting method specific targets for the providers. These strategies deemed necessary for the achievement of demographic goal of the country, but had been a source of poor quality services. Incentives for the clients and acceptors had received serious objection as a major violation of rights from the human rights activist. Questions on the quality of services remained wide spread in view of such strategies. Coordination remained very weak between FWAs, the first-line field force and FWVs, the front-line paramedics. Therefore, increase in the health facilities and service providers did not go hand in hand with availability of services and quality of care. These issues got reflected through high discontinuation of contraceptives and high unmet need for family planning.

Wide scale community based contraceptive delivery, IEC activities, multisectoral programmes, involvement of NGOs etc. were instrumental in the onset of fertility transition by the early 1990s. Fertility decline continued all through the policy regime. Fertility decline was most dramatic in 1984-88 and 1991-93. TFR had declined from 6.3 in 1971-75 to 5.1 in 1984-88 and

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from 4.3 in 1989-91 to 3.4 in 1991-93. However, in the following period (1994-96) TFR had declined only by point one percent being at 3.3.

Despite initial visioning of a network of MCH facilities through integrating it with mainstream health facilities at all levels, FP-MCH regime had depicted a contrasting position about MCH programme. The rationales those had theoretically been posed by the major policy actors for merging MCH with Family Planning (FP) got lost in the mainstream programme strategies and interventions conceived in the policy regime. Basically, merger of MCH within family planning had created ground for placement of physicians within family planning programme. In reality MCH programme from then on had been used more for increasing the availability of clinical contraception, lesser for child health, and the least for maternal health. MCH basket had very little in it to improve maternal health.

Initially MCH services were not clearly defined and no programme approach was followed for MCH services. Scanty fragmented MCH interventions were introduced on a limited scale by the initiatives of WHO, UNICEF and UNFPA outside the activities of the plan documents. These interventions were then formed the basis for initiating a programme approach by the third five year plan. Child health services and interventions had gradually been on increase since the third five year plan as a prerequisite for fertility decline but maternal health programme interventions remained very narrowly focused all through the policy regime. Immunization and diarrhoeal diseases control programme under MCH programme yielded success in bringing down child mortality. Maternal mortality and morbidity situation remained

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very grim. Almost half of the mothers were categorized acutely malnourished and nearly one-fifth were considered too short to increase the risk of child birth (Mitra and *et. al.* 1997: 138). Maternal health seeking remained very poor. Only 25 percent mothers received antenatal care from a medically trained provider. Almost 95 percent deliveries occurred at home and only 8 percent of births were assisted by medically trained personnel i.e., doctors, nurses, midwives and family welfare visitors (Mitra and *et. al.* 1997: 110-15).

Despite increase in the number of health facilities and service providers, availability of and accessibility to the services had been constrained by the fact that many of these health facilities could not be made fully functional because of inadequate availability of service providers, drugs, equipment etc. Further, quality of services got affected largely due to weak technical and managerial supervision, and weak coordination between health and family planning. Quality of care was compromised most at the primary health care level causing most suffering to the poor and the vulnerable. That is why utilization of the services was the lowest at the primary level. Therefore, the programme in the mid nineties was left with the challenge of addressing these problems and issues.

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Chapter 4

Policy Discourse in the Reproductive Health Regime: The Reformist Approach

This chapter outlines and examines the policy frameworks in the second phase of policy regime in the light of the objectives of the study. This policy regime has marked a point of departure from the FP-MCH policy regime by embracing the concept of reproductive health and envisaging complementary structural reforms. That is why this regime has been called reproductive health policy regime with reformist approach. This chapter aims to analyze the policy frameworks of this regime with a view to examining how policies, strategies, and interventions evolved under the influence of major actors and factors have affected the availability of, accessibility to, and quality of reproductive services and contributed in achieving the policy objectives.

4.1 Contextualizing Policy Development in the Reformist Reproductive Health Regime

Women's movement has been intricately linked to reproductive health movement in the entire world. The United Nations Decade for Women (1976-85) had given birth to the land mark CEDAW in 1979. Decade for women and CEDAW had created a normative framework and environment which provided the women's rights advocates a platform to voice their demands (Razavi and Miller 1995: 6). 'Women in Development' and 'Gender and Development' framework had thrived during the UN

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decade for women. Decade of women had brought together the women rights advocates working for various rights. Women's health rights based movement particularly reproductive rights movement also got its impetus during this decade (Correa 1994: 57; Petchesky and Judd 1998: 11-12). This movement had its roots in women's right to choose abortion and access to safe and subsidized abortion services, and voluntary contraception (Finkle and McIntosh 2002:17-18). With the expansion of family planning programme throughout the world by 1980s, dissatisfaction with vertical contraceptive delivery system also mounted among diverse interest groups.

Some Asian countries where rapid population growth concern was the most had employed some controversial measures in the family planning programme. The measures included targets for field workers for enlistment of new contraceptive acceptors, incentive for client and providers for adopting longer acting contraceptives (Bangladesh, India), disincentives regarding larger families, community pressure to use contraceptives, and outright coercion (China). Such practice within the family planning programme had regarded as coercive and aroused uproar among the human rights activists and many of the promoters of voluntary family planning. Emphasis on longer-acting family planning methods or hard-to reverse methods, such as intra uterine device, the injectable Depo-Provera, and sterilization were accused of limiting women's control of their reproductive life cycles (Bongaarts and Sinding 2009: 35-42: Finkle and McIntosh 2002: 17-18; Lubben and *et. al.* 2002: 668).

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The child survival movement and the safe motherhood initiatives in the late eighties had brought new actors into the debate over vertical contraceptive delivery system. Global commitment to children's health was rejuvenated through the Convention on the Rights of the Child 1989 and World Summit for Children in 1990. A renewed commitment was built towards reduction of infant and under-five mortality, malnutrition, universal access to basic education, safe drinking water etc. (Lawn and *et. al.* 2008: 920). With their joining into the debate over vertical contraceptive delivery system, the move for integration of family planning with broader programmes for health and women's advancement got further momentum. In the 1990s women's health movement have mobilized support against the narrow goals of fertility reduction and demanded broader issues of women's empowerment (McIntosh and Finkle 1995: 227). Further, rising apprehension about STI/HIV/AIDS pandemic had also changed the context of narrowly focused family planning programmes in the 1990s. Thus, reproductive health concerns in the contemporary world are challenged with a more complex set of problems and interventions. Integration of sexually transmitted diseases within health and family planning programme turned into a concern (Lubben and *et. al.* 2002: 671; May 2012: 3).

Under the changed scenario and context in the field of reproduction and sexuality, the third decennial population conference held in Cairo in 1994. ICPD in 1994, held a markedly different orientation towards population issue in the developing world. However, ICPD had also been considered as

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the 'mirror image' of the Bucharest Conference[1] in many ways because the Bucharest Conference had recognized the fact that reduction in population growth would largely be determined by broader socioeconomic change (Finkle and McIntosh 2002: 14). The ICPD program of action had reviewed and redefined the role of population policy and had given much more importance to reproductive health and empowerment of women than the demographic rationale for population policy (McIntosh and Finkle 1995: 223; May 2012: 3). The framework adopted at Cairo in 1994 called for a move towards client-centeredness and democratization. The ICPD program of action had called for restructuring the population policies to address such issues as the reduction of maternal mortality, the prevention and treatment of sexually transmitted diseases, including HIV/AIDS, the prevention and treatment of unsafe abortion, and, above all, the empowerment of women (McIntosh and Finkle 1995: 225).

Despite working from different platforms, women health advocates and population controllers held some common grounds during preparation of ICPD (McIntosh and Finkle 1995: 224-25). While, women's health advocates were working as a pressure group to safeguard reproductive rights through empowerment of women as an 'end' itself, and not a 'means' to population control, demographers were also convinced that improving women's health status through educating them, through providing employment opportunity, would contribute as a means to fertility decline. It has been argued that family planning services meet the needs of only those

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[1] See above chapter 3, pp. 65-67.

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who have strong desires for smaller families and who would have experienced unwanted fertility without the family planning services. For those who have strong desire for larger families would be unlikely to change their position just because of the proximity, availability and quality of care of the family planning services (Jain 1998: 2-4).

Women's health advocates have been emphasizing quality of care and opposing, quantitative targets for achieving demographic goal because, emphasis on achievement of quantitative target and physical coverage tend to undermine women's health need. On the other hand, proponents of population control were also convinced that, it was essential to ensure quality of care in the family planning programme for ensuring the sustainability of the acceptors. It was on the basis of these common grounds, the population establishment and women health advocates succeeded in reaching a consensus at the ICPD in 1994. ICPD gave momentum on the growing concern about the integral relationship between and among family planning, reproductive health, education, and status of women. ICPD had condemned coercive and unethical policies and practices within the family planning programme and called for reproductive health programmes including voluntary contraceptive provision by family planning services. Main message of ICPD has been to provide family planning services within the broad framework of reproductive health and enable women's empowerment through education, enhancing their economic opportunity, and promoting their good health. ICPD had brought changes in the entire programme focus across the world accept for China. India, after ICPD had

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adopted a target-free approach in its family planning programme (Bongaarts and Sinding 2009: 42).

UN fourth World Conference on Women held in Beijing in 1995 had echoed ICPD's declaration for promoting reproductive health and reiterated the need for mainstreaming reproductive health and gender issues in the development discourse. These declarations have called for an integrated approach and women's empowerment, as the immediate and most effective means to deal with health and population problems. ICPD had emphasized on providing a range of primary health care services in a package which would make shared use of various inputs and thus, minimize the cost.

Major changes had also taken place in the form of investment made in the health sector since mid nineties. Project based aid had been the most common form of assistance in the health sector until nineties. While certain well-designed projects had yielded positive health outcomes, more or less they could not contribute in the required policy reform or improved resource planning and allocation. Too many projects made it increasingly difficult for the government to develop coherent sector policies. Further, because of having too many projects government had to maintain many parallel project administrative systems (Peters and Chao 1998: 181). Under this situation, development assistance had moved out from project based funding in the mid nineties. Sector Wide Approach (SWAp) had been introduced as a model for international development assistance. Since then this model has gained increasing popularity among the development partners (White 2007; Sundewall and *et. al.* 2006). In SWAp, partners commit their resources to a

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long-term programme and all major donors coordinate their aid within the sector programme, hence, the framework allows enhanced donor coordination and harmonization. Donor finance is provided through government system, meaning a programme (budget support) than a project approach (White 2007).

External assistance was conditional on compliance with SWAp in 1990s. Development assistance in 1990s while required compliance with SWAp, it at the same time sought placing health sector programme in the context of broad based poverty reduction strategic framework. The World Bank and WHO have been involved in developing strategy for dealing with poverty. The World Bank and International Monetary Fund (IMF) had been actively engaged in encouraging the developing countries to increase their commitment to health and education for the disadvantaged people (Gwatkin 2000: 5). Development of poverty reduction framework was urged in the context of the agreement reached by the world leaders towards building a more egalitarian world to mark the up-coming millennium. Thus, health sector programmes ought to have been designed with a more pro poor focus by the side of having a sector wide policy framework.

The population and health sector in Bangladesh had gone through a major transition in the late nineties as a product of all the major global shifts in the area of population and health primarily led by transnational health rights based movement, and introduction of SWAp by the international lending institutions for sectoral investment. However, while changes in the international policy environment had immensely influenced the onset of

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national change process, it was also true that national policy environment had also been changing with respect to future directions of FP-MCH programme. There had been a realization among the national policy actors that further success of the programme would call for substantive change in the entire programme focus particularly with respect to quality of the services and increased attention to maternal and child health (World Bank 1993: 10; Piet-Pelon and *et. al.* 1999: 17). Further, women's transnational movement for reproductive health had its link with the in-country struggle of women's health advocates against the narrow family planning programme. These advocates were arguing for prioritization of women's health over fertility control. Unfortunately, they were too small a group to influence the national policy process until joined by international actors for policy change (Jahan 2003: 184-85).

4.2 Policy Framework in the Reproductive Health Regime with Reformist Approach

After the fourth five year plan period (1990-95 extended up to 1997), programme implementation plans for health and population sector has been guiding health and population programme of the country. In 1997, in the context of change in the global policy environment a strategy paper titled Health and Population Sector Strategy (HPSS) was formulated by the government under the direction of World Bank. HPSS was then fed into the fifth five year plan (1997-2002). Subsequently this strategy paper was translated into five year programme implementation plan in 1998 titled Health and Population Sector Programme (HPSP) for the period 1998-2003. HPSP then turned into the principal plan document for health and population

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programme of the country. Hence, fifth five year plan (1997-2002) unlike the previous five year plans ceased to remain the chief policy document for health and population programme of the country. Policy framework for reproductive health programme in this policy regime has been analyzed on the basis of HPSP, health policy 2000, and maternal health strategy 2001.

4.2.1 Reproductive Health Programme Framework in the Health and Population Sector

In the wake of changes in the global policy environment, health and population sector in Bangladesh had gone through a major transition in this period. Even though changes in the official plan and policy documents took place in 1997, dialogue over these changes had been going on since mid nineties. In the light of global discourses on health, population, and development issues and health sector investment mechanism, broad based agreements were reached between government and donors on future directions of health and population sector in Bangladesh. In the GoB-donor consultation in Paris in September, 1995, future course of the programme had been mapped out. At the Paris meeting, government of Bangladesh had agreed: in adopting sector-wide approach for health and population programme; framing health and population programme in the context of broader poverty reduction strategy; and developing an essential package of services for primary health care (Piet-Pelon and *et. al.* 1999: 7-9).

At the backdrop of such agreements at the GoB-donor consortium in 1995, the World Bank in 1996 in consultation with other major donors had insisted the government of Bangladesh which was formed in 1996, by Awami

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League to formulate a strategy that would call for substantive reforms for health sector. Most importantly, funding for health and population interventions and activities was contingent upon formulation of this strategy with major reform agenda (Buse and Gwin 1998: 667-68). Consequently the MoHFW had formulated the HPSS in 1997 with the advice of the World Bank. The strategy document was therefore, very much influenced by the policy ideals of the World Bank (Buse and Gwin 1998: 668). It was almost at the same time that the major international lending institutions like the World Bank and IMF were on move to influence resource poor highly indebted countries for developing broad based poverty reduction strategy papers that would focus on the underpinning multidimensional investments required to accelerate poverty reduction. At this backdrop, HPSS was designed with a pro poor focus and sector wide policy framework was adopted . In fact HPSS was the basis for dialogue between government and donors for seeking assistance from the donors' consortium (Piet-Pelon 1999: 12).

In the meanwhile a number of strategy papers were prepared by MoHFW: a) Strategic Directions for Bangladesh Family Planning Programme (1995-2000); b) National Plan of Action, 1996; and c) National Reproductive Health Strategy, 1997. All these documents had intended to provide programme directions at the backdrop of the contemporary challenges. However, they were lacking a holistic and comprehensive approach needed for building program directions. Strategic Directions for Bangladesh Family Planning Programme (1995-2000) had envisioned changes in the focus of

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the programme for addressing unmet need for family planning, and improving quality of family planning services to lower down unwanted pregnancies, frequent method switch, method failures and side-effects and illness from contraceptive use. It had also included the issue of male involvement in the programme. The document confined only within family planning programme without giving any directions on how family planning services will be relocated within and among other reproductive health services. National Plan of Action 1996 had outlined the additions, alterations, and modifications required in the services and activities at different levels in the light of Programme of Action of ICPD. National Reproductive Health Strategy 1997 like the National Plan of Action 1996 had prepared an action plan for reproductive health services to be offered at different layers. However, all the documents had urged the need of addressing the issue of clients' need and quality of services. A package of services at the primary level and one stop service provisioning by static clinics were also mentioned in these documents. All these policy inputs had been fed into HPSS and consequently into HPSP.

HPSS was also built on the implementation experience of Fourth Population and Health Project for supporting health and family planning programme under the fourth five year plan. Major learning of Fourth Population and Health Project were as follows: a) pursue health and family planning activities within the broader context of poverty reduction strategies; b) identifying sectoral objectives, priorities and strategies; c) harmonization of

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parallel systems for health and family planning; and d) manageable number of projects etc. (Allison 1999).

HPSS could mobilize strong political as well as civil society support (Jahan 2007: 1188). Thus, it got approved by the Executive Committee of the National Economic Council (ECNEC) in August, 1997.

The main feature of HPSS was its adoption of a single Sector Wide Approach for health and population and Essential Services Package (ESP) instead of broad based primary heath care services. In view of the resource constraints for wide range of services for all groups of population, it was required to prioritize interventions and services which would maximize health benefits relative to per capita expenditure through shared production costs and efficient use of specialized manpower. HPSS was directed towards improving the health of the vulnerable population i.e., women, children, and poor (MoHFW 1998: 2). Thus, ESP has evolved as a set of most urgently needed interventions and services those impact the health of poor and vulnerable group of population most. Its main objective was to channel increased public health expenditure to ESP and delivery of ESP at the *Upazila* (Sub-district) level and below including domiciliary services with a functional referral system.

'Package health service delivery' had been advocated many years before the concept of ESP was launched in different countries. Comprehensive primary health care delivery as proposed by the Alma Ata conference in 1978 was considered too expensive and therefore, a selective service package was

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recommended by many afterwards. Given the increasing challenges of health demands amidst scarcity of resources a selective approach was considered more feasible, measurable, and rapid (Lawn and *et. al.* 2008: 921). However, the concept of ESP got wider attention and acceptance by the world community in the 1990s only after coining of the concept by World Bank. ESP was introduced in a large number of countries after the World Development Report 2003 was published (Ensor and *et. al.* 2002: 247).

Fifth five year plan (1997-2002) had been formulated immediately after HPSS came into existence. Therefore, policy approach of the fifth plan for health and population was complementary to HPSS. Accordingly a single sector for health and family planning had been envisaged under the plan. Fifth Five Year Plan aimed at twin goals; universal access to ESP with acceptable quality and replacement level fertility by 2005. Eventually during the fifth five year plan period HPSS was translated into a five year programme that is HPSP (1998-2003) (MoHFW 1998: 16). Approval of HPSS by ECNEC had given the legitimate basis to both HPSS and HPSP even in the absence of a health policy. HPSP had turned into the principal plan document for health and population sector during the fifth five year plan period. In other words, fifth five year plan no longer remained the chief policy document for health and population sector like the preceding five year plans.

The commencement of HPSP had marked a significant change in the design of health and population sector in Bangladesh. Being founded on HPSS it

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had followed SWAp and ESP constituted the focus of its primary health care.

HPSP claimed to be the first national programme that had recognized the importance of stakeholder consultation and participation as required by the rights based approach to health. It had also mobilized political support for health system reforms. It had envisioned different mechanisms like Patients' Charters of Rights, Health Watch Group etc. for making health services more accountable to its users (MoHFW 1998; Schurmann and Mahmud 2009; White 2007; Jahan 2003; Jahan 2007).

It was recognized at the policy level that a true sector wide approach requires to include health services provided by others outside of MoHFW i.e., other ministries like ministry of social welfare, ministry of education etc., local bodies, urban councils, communities, NGOs and private sector. However, HPSP only included activities and services provided by the MoHFW and the NGOs. HPSP was confined within the government health and family planning services (MoHFW 1998:15).

HPSP had upheld pro poor focus through channeling maximum resources of the sector to ESP. ESP had followed a targeting approach to address the health needs of the most vulnerable by targeting: a) facilities used more by the poor; b) areas where health status of population is the lowest and c) health services those have most impact on the most vulnerable i.e., the poor, women and young children. Thus, HPSP did not operate in urban areas because rural areas were generally and some times wrongly considered more

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impoverished than urban areas. Further, health in urban areas was considered the primary responsibility of the city corporations and municipalities (Ensor and *et. al.* 2002: 249).[2]

ESP was planned to be delivered at the different levels of the primary health care system i.e., community level, union level, *thana* level (sub district). At the community level ESP services was planned to be delivered from 'community clinic', a fixed service centre, each serving a population of around 6,000 population (MoHFW 1998: 21).

With the advent of the concept of reproductive health, necessity of fixed clinic based service delivery at the community level became very pertinent and imperative because reproductive health services require tests, examinations, and screening and thus, could not be delivered through domiciliary based outreach services (Mahmud 2004: 4087). The shift towards reproductive health posed a challenge for a country like Bangladesh which had set the tradition of domiciliary based health and family planning services at the community level. Thus, the concept of 'community clinic' had emerged. Further, availability of a cluster of services at one point would enable household members to receive their required services from a single facility at one go. Community participation was ingrained in the concept of community clinic. Community clinics were perceived as community owned

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[2] Urban Primary Health Care Project was initiated by the Government of Bangladesh and the Asian Development Bank (ADB) in 1998. The Local Government Division of the Ministry of Local Government and Rural Development and Cooperatives has been entrusted as the executing agency for the project. The project targets provisioning of primary health care services in the urban areas of Bangladesh. The government contracts NGOs to provide services (Nasreen *et. al.* 2007).

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and managed clinics. Ownership was supposed to be ensured through community contribution in the construction of the clinics and assuming the responsibility of maintaining the clinics. Community ownership was perceived as an effective mechanism for making the service providers accountable to the community. Gradual phasing out of the domiciliary service, and hence, reducing the cost of service delivery was also another important reason for establishing community clinics (Chowdhury and Osmani 2010: 211).

ESP components included reproductive health, child health, limited curative care, communicable disease control and Behaviour Change Communication (BCC) (GoB 1998). However, comprehensive reproductive health was the center-piece of the ESP (Jahan 2007: 1187). Reproductive health care consisted of safe pregnancy and delivery, fertility regulation, treatment of infertility, prevention of unwanted pregnancy, menstrual regulation, and reproductive morbidity and mortality including STI/HIV and reproductive health of adolescents. Aims of reproductive health care included safe pregnancy and delivery, including fertility regulation and treatment of abortions, avoiding unwanted pregnancies, and postpone birth (MoHFW 1998: 20-21).

Crux of reproductive health services was maternal health services. Maternal health was emphasized more than ever before. Until HPSP, focus of maternal health care was limited within very basic, preventive, low cost, and, easy deliverable interventions i.e., antenatal care, screening 'at-risk' pregnancies and safe home delivery through training of TBAs.

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Comprehensive Emergency Obstetric Care was very limited and was only available at the tertiary level. At the international level Emergency Obstetric Care (EmOC) approach had dominated maternal health programme since 1993 with the initiative and assistance from the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and Averting Maternal Death and Disability programme. It was in this connection a pilot project had been initiated with the assistance of UNFPA for introducing EmOC services in the Maternal and Child Welfare Centers (MCWCs) under the Directorate of Family Planning in 1993.[3] Until then comprehensive EmOC were not available in the district level health facilities. MCWCs used to deliver family planning and ante natal services. Child birth and immunization services were delivered by MCWCs on a very limited scale (Gill and Ahmed 2004).

HPSP had adopted this EmOC approach for addressing maternal morbidity and mortality. Prime focus of reproductive health care was to ensure safe motherhood through provisioning of EmOC at all levels. Coverage of EmOC was planned to be increased coupled with decentralization of EmOC services and community mobilization.

HPSP had recognized family planning services as an integral part of reproductive health care and had also urged for re-conceptualization of family planning activities at the outset (MoHFW 1998: 21-22). Menstrual regulation continued to receive attention under HPSP. Quality of MR services was emphasized with the aim of lowering the number of septic

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[3] See chapter 3, p. 118.

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abortions and reducing morbidity and mortality relating to unsafe abortion practices (MoHFW 1998: 23).

Awareness services for adolescents were introduced within reproductive health care. Until HPSP, unmarried adolescents did not have access to reproductive health care. Only married adolescent girls had access to maternal care or family planning services. HPSP included awareness programme for adolescents on reproductive health i.e., proper nutrition and hygienic practices; information about puberty, safer sexual behavior, and avoiding health risks including STI/HIV/AIDS (MoHFW 1998: 23).

Infertility, for the first time had been officially recognized as a reproductive health problem. In a high fertility country like Bangladesh, infertility had never been conceived as a problem at the macro level. HPSP had outlined the following interventions for addressing infertility: a) educate both husbands and wives about the factors contributing to infertility; b) preventing secondary infertility through: prevention and treatment of STI/RTIs; safe abortion services; safe delivery and post natal care (MoHFW 1998: 23).

Reproductive morbidity relating to STIs/RTIs had been totally ignored in FP-MCH policy regime. Inclusion of services for management and referral of morbidity resulting from STI/RTI had been a very significant addition in the cluster of reproductive health services within ESP. However, prevention and control of STIs/RTIs of reproductive health component envisaged to be mainly confined to BCC and condom promotion and would be targeted for

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women of reproductive age. Syndromic management of STIs/RTIs at the primary care level and diagnostic laboratory at UHCs and district hospitals with appropriate referral services would be gradually phased in. Prevention and control of STI/AIDS had also been incorporated under communicable disease control component of ESP so as to include service provisioning for males of reproductive age and other special high risk behaviour groups. However, the National Policy for HIV/AIDs and STI formulated in 2006 had recommended a separate programme for HIV/AIDs and STI under the directorate of health services (MoHFW 1998: 22).

HPSP had emphasized on increasing the scope and coverage of the nutrition programme with a view to have a comprehensive nutrition programme (MoHFW 1998: 24-25). However, nutrition programme was not brought within the purview of HPSP.

Neonatal care under reproductive health component was primarily educational and motivational and was planned to be delivered at the domiciliary and union levels.

Reforms were an integral part of HPSP. Its shift from: a) project approach to SWAp; b) broad-based primary health services to an integrated package of essential health services; and c) FP-MCH services to reproductive health services could not have been envisaged without being founded on essential reforms for the entire health sector. Further, reforms were necessary for delivering clients' need based, and quality health services. Moving out from FP-MCH programme to reproductive health has been an ideological shift

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and called for substantive reform. Thus, HPSP had envisaged a number of interrelated reforms in the service delivery system at all levels. These reorganization and reform of health and population sector was considered critical for achieving the goal of HPSP because many of the reproductive health services needed to be directly under the management of health services. These reforms included: a) reorganization of services i.e., unification of health and family planning under a single management structure; b) decentralized planning and management system i.e., decentralization of decision making, financial management system, hospital autonomy c) the development of a one-stop service at the community level; d) GO-NGO collaboration where for the first time NGOs would be contracted out to implement several service delivery programmes like, STI/HIV/AIDS prevention, nutrition programmes, urban primary health care projects; and e) gender mainstreaming under which gender issues were addressed as cross cutting issues and not under separate women's projects.

To facilitate efficient delivery of ESP and other services, HPSP had given utmost importance to a set of support services like human resource development, management information system, research etc. As part of unification of health and family planning, HPSP had envisaged a unified management information system (UMIS). Five subsystems were established for this purpose. They included service performance, logistic management, personnel management, financial management and epidemiological surveillance. Data for family planning and health was to be integrated for each of these subsystems. Thus, separate management information system for health and family planning got changed into unified management

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information system. Indicators and targets for maternal health like maternal mortality ratio, deliveries by skilled attendants, use of antenatal care, nutritional status of women and children, hospitals certified as women friendly etc. were included for the first time under this system (MoHFW 1998: 41; Jahan 2007: 1188).

The former national level Information Education and Monitoring (IEM) unit of the directorate of family planning and the Health Education Bureau (HEB) of the directorate of health services got merged into Unified Behaviour Change Communication Unit (UBCC). Four separate sections were identified within BCC for giving attention to the priority target groups of all the service components of ESP i.e., community and cluster level BCC programmes, institutional level BCC programmes, selected target group programmes and support unit for development and coordination. BCC would work in collaboration with the Line Directors of ESP, hospitals and other public health and nutrition services (MoHFW 1998: 41-42). Improving the quality of hospital services was considered crucial towards establishing effective referral system for ESP. HPSP had envisioned partnership with NGOs and private not-for-profit hospitals as well as greater management autonomy for public sector hospitals coupled with local accountability (MoHFW 1998: 44).

HPSP has been the land mark plan which made major shifts from: project-based planning to sector-wide planning, management and financing; vertical to integrated delivery of health and family planning services; bureaucratic and technocratic to participatory planning process; centralized planning and

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management to decentralization; public sector being the primary provider to partnership with private and NGO sectors; broad-based primary health care to an essential services package for primary health care; from separate women's projects for gender equity to gender mainstreaming (Jahan 2003: 183).

4.2.2 Linking Health and Population Sector Programme (HPSP) and the First National Health Policy

The successive five year plans were substituted for the health policy in Bangladesh since its inception. The first National Health Policy (NHP) was formulated in August 2000 by the Awami League led government which was formed in 1996. In this connection it is worth mentioning that formulation of a health policy had been attempted a number of times however, without any success.

Government of President Hussian Mohammad Ershad had attempted in formulating a health policy in July 1990. Two committees were formed for providing input for the health policy. Having discussed the reports of the two committees in the Cabinet in 1990, the report of the Health Care System Improvement Committee was selected as the basis for the proposed health policy.

The policy proposal was presented in the parliament. It had 16 objectives and 14 structural reforms towards building a decentralized and more accountable health system. It included sensitive proposals like banning private practice by all academic staff and junior doctors with concomitant increase in service benefits. Towards building decentralized health system it

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had proposed of constituting health authority comprised of local public representatives at different administrative levels.

Such radical measures in the health policy were vehemently opposed by the Bangladesh Medical Association. Medical professionals were fully in disagreement with the idea of being accountable to the local representatives. The policy could never see the light of the day rather it had added fuel to the already on going democratic movement against Ershad's regime in the late eighties. With the doctors joining into the movement, down fall of Ershad's regime got even more accelerated and inevitable. After the down fall of Ershad government in December 1990, the interim government formed thereafter, had repealed the health policy (Reich 1994: 138-139; Osman 2004: 149-154).

The first democratically elected government formed by BNP in 1991 had attempted to formulate a health policy in 1993 through formation of a committee. However, the committee could not complete its task until 1994. Out of the seven sub committees formed by the main committee only two (sub committee no. 4 and no. 6) had submitted their report to the ministry in October 1994. Thus, during the tenure of the government, health policy could not be formulated (Osman 2004: 154). This dilly dally in the health policy process reflects lack of political commitment for formulation of health policy.

The new government formed by Awami League in 1996 was entrusted with the responsibility of transforming the health and population sector of

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Bangladesh through adopting World Bank fed strategy paper HPSS. It has already been discussed in this chapter that HPSS has been the landmark strategy paper in van-guarding the transformation of the health and population sector to match with the contemporary world view on health and population issues. HPSS had been the basis on which the revolutionary programme implementation plan, HPSP was prepared in 1998. The Fifth five year plan (1997-2002) had been founded on HPSS. In the context of HPSS and HPSP, it deemed necessary to formulate a health policy which would envision health system in accordance with HPSS and HPSP. Thus, government had initiated formulation of the national health policy. This was the first time that a government could formulate a health policy for the country. Policy ideas and programme elements developed in HPSS and HPSP were incorporated into the NHP 2000. Thus, NHP 2000, fifth five year plan, HPSS, and HPSP had similar vision and upheld similar spirit and therefore, complementary to each other. Being the implementation tool of the health policy, HPSP ought to have been based on the features of the health policy. Actually it had been the reverse because HPSP came into existence before the health policy.

The NHP 2000 had been based on its 15 goals and objectives, 10 principles and 32 strategies. Increasing the availability, accessibility, and quality of health services through ensuring the availability of the service providers at the primary level had been the crux of goals and objectives of the policy. Reduction of maternal and child mortality constituted the primary health goals of the policy. Strengthening of family planning programme for

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increasing the availability of and accessibility to family planning services particularly among the poorer section of the population had been emphasized towards achievement of replacement level fertility by 2005. It had also recognized the health service need of the poorer urban population. Its goal and objectives had highlighted on the health services needed for mentally and physically challenged persons and aged population. It had envisioned of a clear policy for direction, regulation, and quality of private sector health care.

Its key principle were: ensuring availability of primary health care services for all with particular focus on the poor, deprived and vulnerable population; making people aware about their health rights through use of mass media; decentralization of health service management; demand based human resource development; stake holder participation in programme planning and management; and public-private partnership in health service delivery.

The strategies identified by the policy for achieving its goals and objectives had features similar to HPSP. The policy had envisioned of a Health and Population Council chaired by the head of the government. It had focused on the need for client centered service delivery. It had endorsed: SWAp for managing all the activities of health and family planning programme; unified management of health and family planning services through unification of health and family planning management structure; an integrated management information system; delivery of ESP from a 'single service point' as a cost effective mechanism of providing primary health care to all; and establishment of community clinics for every 6,000 population in order

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to bring health services to the door steps of the population and placement of doctors in each UHFWC with accommodation facility.

The NHP 2000 was formulated by the government almost at the end of its tenure. Therefore, government could not initiate implementation of the policy. The NHP 2000, like HPSP could not go far because of the struggle over unification of health and family planning.

The first attempt of a health policy by President Ershad in 1990 was thwarted by the doctors and implementation of the first NHP 2000 was thwarted by the insiders of the family planning wing of MoHFW. As with the reversal of unification and restoration of domiciliary services by HNPSP, the successor of HPSP, the NHP 2000, was considered redundant by the new government formed in 2001. Therefore, the new government formed by the Bangladesh Nationalist Party pursued updating of the NHP 2000, in 2003. The NHP 2000 was revised in 2006 and forwarded by the ministry to the Cabinet. However, it was not finalized. Thus, HPSP in absence of formulation of a new health policy remained the major plan for health and population sector.

4.2.3 Linking Health and Population Sector Programme (HPSP) and Maternal Health Strategy

Maternal Health Strategy 2001 had been formulated in the light of the maternal health services identified by the HPSP. The strategy has been formulated on the theoretical premise that recognizes: a) all pregnant women are at risk of developing life threatening complications; b) most complications can neither be predicted accurately nor prevented; c) once a

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woman develops complications she needs prompt access to emergency obstetric care services (EOC) if death or disability is to be prevented.

Maternal health strategy had marked a major shift from earlier risk-based approach to right-based approach for maternal health services. The crux of the strategy was EmOC services. Utmost importance was given to expansion and decentralization of EmOCs. The strategy had recognized the importance of the back -up services i.e., family planning, ante natal care, post natal care and community based skilled birth attendant services for EmOC services to serve its intended purpose.

The strategic interventions planned by it were based on the "Three Delays" framework of factors creating impediments for women in timely seeking and receiving the right service. Thus, the strategy had identified three intervention layers i.e., community level intervention for awareness raising, decentralization of EmOC services starting from the community level through provision of basic EmOC services and up-gradation of EmOC facilities through training of the providers, and supply of the essentials for EmOC. For aiding safe home delivery the strategy had made a shift from the previous TBA training to six months period Skilled Birth Attendant training to FWAs, female HAs for conducting normal home delivery and appropriately referring complicated cases.

Aims of the Maternal Health Strategy were in accordance with the priorities set for maternal health in HPSP: i) to strengthen provision of essential and emergency obstetrical care and improve referral and utilization of services; ii) improve nutritional status of women and adolescents; iii) ensure that right

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people with right skills are trained to provide quality maternal health services at all levels of the health system; iv) promote women friendly health services; v) bring about changes in perception and behaviour of individuals, family, service providers and community to support women in realization of their right to safe motherhood and a life free of violence and discrimination.

The Maternal Health Strategy set out its objectives in line with above aims to be achieved by the year 2010. The strategy pointed out the priority actions to be taken in the area of EmOC, ante natal care, skilled birth attendants, post natal care, and family planning during the remaining period of HPSP. Priority actions were: building a pool of trained medical officers; placement of full team providers; retention and ensuring residential status of the provider; emergency preparedness of facilities; use ante natal care for birth preparedness, and build capacity of FWAs and Female HAs as community mid-wives etc.

The strategy had focused on violence as an important maternal health issue. It had pushed forward the demand for first aid and treatment for women and girls subject to violence in all facilities at *Upazila* (sub-district), district and tertiary level. Further, it had urged the need for making women friendly hospitals to increase accessibility of women to health facilities. Family planning services have been recognized an important element of maternal health services.

The strategy has elaborated on human resource requirements for effective implementation of maternal health services. It had recommended one year training in obstetrics and anesthesia for medical officers to provide

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comprehensive EmOC in the *Upazila* Health Complexes. The strategy has recognized the importance of career building incentives for ensuring retention of the trained physicians at the *Upazila* Health Complexes. It had suggested obligatory two years service for the trained physicians at the *Upazila* Health Complexes. After completion of two years they would be designated as 'Specialist' at their place of postings. Other incentives mentioned included selection for fellowship, support for higher education, and special capacity development visits and tours.

4.3 Policy Framework *vis a vis* Implementation Scenario of Reproductive Health Programme

HPSP has been marked with its attempt for unification of health and family planning directorate. It had followed a bottom-up approach for unification and thus, the unification process started first at the *Upazila* level and below. Support services including monitoring, training, communication and procurement were also attempted to be unified. However, initiation of unification at the *Upazila* level was thwarted with the strong resistance of the state actors of the directorate of family planning (White 2007: 459-60; Jahan 2003: 189). At the policy formulation stage their resistance was managed by the political leaders through ensuring greater involvement of civil society. Nevertheless, government had managed to neutralize the resistance of the lower ranking staffs of family planning at the *Upazila* level and below by the promise of providing job security through transfer of salaries from the development budget to revenue budget. Some field staff had also been transferred to revenue budget and their job descriptions were revised to match with their new job responsibility. However, middle and

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higher ranking family planning officials at the district level continued their resistance to unification from the fear of loosing career advancement compared to those belonging to the medical profession (White 2007: 459-461; Jahan 2007: 1188). The physicians on the other hand, had strongly favoured the unification partly because of bringing efficiency in the service delivery and largely because they had envisioned their enhanced importance in the service. Therefore, even though physicians serving in the health sector were politically divided between the two major political parties of the country, at that time they were united on the unification issue irrespective of their political inclination (Chowdhury and Osman 2010: 213).

When the new government was formed in 2001, family planning officials had asserted their position through lobbying with the political leaders. The issue was politicized through massive campaign and mobilization. They asserted their position on the argument that unification move led by the earlier government had demoralized the family planning workers and they had stopped domiciliary services out of frustration. Thus, they had argued that such initiative of unification would seriously impact on family planning programme performance at the field level (Jahan 2003: 189; Jahan 2007: 1188; Chowdhury and Osman 2010: 213). Phasing out of domiciliary services proposed by HPSP was also appeared controversial to them. Ultimately they had succeeded in convincing the new government to reverse the unification by taking advantage of the political culture of the country. In February, 2003, the ministry had officially announced that there would be no unification of the two wings. It was decided by the government that

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unification of the two wings would not take place during HPSP and nor would it happen during the upcoming programme. Therefore, health and family planning services would be delivered through the de-united structure. However, it was agreed by the government that the decision to de-unify was mainly political (Sundewall and *et. al.* 2006).

Development partners were divided on government's decision of not unifying the two wings. One group had considered it as a breach of contract between the government and development partners and therefore, infavour of withdrawing their support from the programme. The other group saw this as a sign of true government ownership and therefore, in favour of continuing their support. The former group was more interested in restoring the confidence in the government and the development partners (Sundewall and *et. al.* 2006: White 2007).World Bank along with some others had partially suspended their contribution to the programme. The World Bank had justified that funding was suspended because the government had taken the decision not to unify without consulting the development partners. However, the suspension was revoked in July 2003, as the ministry had chalked out a reform plan to achieve the HPSP objectives (Sundewall and *et. al.* 2006).

As part of the reform process i.e., unification of health and family planning services, a unified management information system and behaviour change communication was envisaged. The process was started in 1997 with overwhelming support from the government and donor. It had aimed to

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develop a comprehensive system of paper forms and computer software to produce integrated information as a tool for decision making by the management at all levels. However, before making the new system functional the existing system was suspended. This had created enormous problem for the managers because for about four years they were running the programme virtually without any systematic information needed for management (World Bank 2005c: 39). Only the logistic information was functional with the technical assistance of DELIVER (World Bank 2005c: 40).

With the failure of unification, the process of decentralization and unification of all the subsystems including Management Information System (MIS) and BCC were effectively foiled (World Bank 2005c: 39-40; 47). Because UMIS and UBCC were tied to ambitious organizational change of unification (World Bank 2005c: 40). It was argued that following a bottom up approach for unification was a mistake because it had complicated the command chain because of the bifurcated structure at the center. The policy makers justify that bottom up approach was followed in the unification process because unification at the upper level would need working with the Ministry of Establishment and that would entail significant time.

Community clinics were a new layer of health facility introduced under HPSP as one stop essential service delivery centre for providing services at the community level (World Bank 2005c: 40). Community clinics were supposed to be owned and managed by the community. Community was supposed to donate the land for the clinic. Further, maintenance of the clinic

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i.e., cleaning, security etc. was to be ensured by the community (Schurmann and Mahmud 2009: 539). It was planned to build Community Clinics in each village and phase out domiciliary and out reach services over the period (World Bank 2005c: 40). Therefore, 16,000 new community clinics were supposed to be built during the time frame of HPSP (White 2007: 458). ESP accounted nearly 60 percent of the total expenditure of HPSP of which a significant portion spent for the construction of the community clinics. However, community clinics were a total failure.

HPSP was initiated under one government and implemented under another government. The new government which came in power in 2001 had suspended construction of these clinics when around 10,000 constructions were already complete. The newly built clinics were barely of any use. Some consider that failure of community clinics were the logical outcome of the failure of unification process while others argue that it was politically motivated and not directly linked to the issue of unification. Failure of the community clinics has been marked by some as a glaring example to show "how a change in government can push plans off track". Nevertheless, the change in the government in the middle of the programme had seriously disrupted the implementation of the programme (White 2007: 458-459; Jahan 2007: 1188).

Towards establishing a network of EmOC facilities throughout the country, comprehensive EmOC services were made available in all district hospitals and selected UHCs by 2003. Training capacity was developed at the central,

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district and *Upazila* level to improve the technical competence of the providers for delivering ESP. Financial support for the lead training organizations had been increased. District Training Coordination Committee headed by the civil surgeon was established in each district. *Upazillas* which were the principal venues for ESP and field worker training had functional *Upazila* training teams. Due to lack of relevant data it could not be ascertained whether these trainings had resulted in improving the technical competence of the providers (World Bank 2005c: 29-30).

Community-based Skilled Birth Attendant programme has commenced in March, 2003 with the assistance of WHO and UNFPA. This programme has been initiated to replace the previous TBA training programme. Skilled Birth Attendant training is provided to the FWAs and female HAs under forty-five years of age (BHW 2008: 36). Thus, the main objective of this programme is to reduce maternal mortality by increasing skilled attendance at birth through government sector Skilled Birth Attendants (SBAs).

HPSP had stepped forward in providing gender disaggregated data through disaggregating key performance indicators by socio-economic status. The Gender Equity Strategy was also developed (World Bank 2005c: 43). Clients' Charter of Rights and Health-Care Providers' Charter of Rights was publicized by the UBCC.

Government had piloted the implementation of Integrated Management of Childhood Illness (IMCI) in some *Upazilas* through health care facilities (MoHFW 2005: 65). EPI programme had received massive resource since

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2002 from the Global Alliance for Vaccines and Immunization (GAVI) programme. Under this programme Hepatitis-B immunization had been introduced (MoHFW 2005: 63). Since 2003, EPI has been providing vaccination against seven preventable diseases. The major activities of EPI included routine vaccination, supplementary immunization (National Immunization Day, measles campaign etc.) and surveillance activities for AFP, NT and measles (MoHFW 2005: 62).

4.4 Reproductive Health Policies and Programmes: Issues, Gaps and Challenges

HPSP had marked a paradigm shift from project to sector wide approach, vertical health and family planning services to an integrated essential services package, and conventional FP-MCH services to reproductive health services. In line with these shifts, HPSP had envisaged a unified management structure for delivery of ESP. Unified management structure was deemed most suitable for delivery of an integrated primary health service package.

In HPSP shift towards reproductive health was accompanied with significant attention to maternal health. Maternal health services had been considered as the most important reproductive health service and thus, received highest priority among all reproductive health services. Maternal health had been pursued on its own right. For the first time obstetric care centered maternal health intervention dominated the policy regime. Expansion of EmOC has been taken as the prime maternal health strategy to address the major

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reasons of maternal mortality. However, nutrition as maternal and child health issue remained as neglected as before.

Shift towards reproductive health framework had not been accompanied with a clear direction for family planning services. Family planning services had been subsumed under reproductive health services. Family planning programme needed revision in its programme strategy and intervention to transform it into reproductive health service. However, while family planning had been placed under reproductive health, it had been viewed as a means to fertility reduction and not as a means to reproductive health. The programme continued to be evaluated in terms of its success in fertility reduction and not reproductive health promotion through addressing unmet need for family planning, averting unwanted child birth, delaying child birth, reducing unsafe abortion etc. Programme strategy was focused on increasing longer acting contraceptive acceptors. Central to reproductive health focused family planning is voluntary contraception free from coercion or providers' bias. Thus, family planning was not established as a reproductive health service. Failure of establishing family planning as a reproductive health service had resulted in its identity crisis. It remained as a stand alone programme within the broader reproductive health framework.

There had been no scope for intersectoral or cross sectoral collaboration within the programme design. Concept of reproductive health is built on multisectoral approach. No special strategy was taken to integrate men within the progarmme. Women were continued to be focused as a means for fertility reduction. Link between and among family planning services,

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reproductive health, and child health could not be clearly established in the policy framework. Appropriate strategies or interventions for working on such links had been missing.

In the context of paradigm shift towards reproductive health, new population policy was not conceived. Population policy 1976[4] was contradictory to reproductive health framework. Thus, the family planning programme had lost its policy direction for it got caught in between the population policy, 1976, and reproductive health programme framed under HPSP. In FP-MCH regime[5] family planning was developed under a consistent policy direction and thus, grew in a cohesive fashion with full commitment and support from all the political regimes. However, in the reproductive health regime the policy framework had failed to give the programme a clear position and direction. Failure of repositioning of family planning within the context of reproductive health had its effect on implementation of its reform agenda. Confusion at the policy level about the role and function of family planning under the reproductive health programme framework had generated feeling of insecurity and identity crisis within the family planning programme insiders. The decision to phase out from domiciliary services had added to the fuel against reforms. The family planning insiders were resistant to any change deemed necessary for implementation of ESP in general and reproductive health in particular. This, resistance got even stronger when the process of unification was done in a manner which could hardly create a meaningful platform for family planning programme insiders to contribute

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[4] For details see, chapter 3, pp. 75-77.

[5] For a detailed account on this policy regime see, chapter 3.

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from for promotion of reproductive health. Thus, constellation of comprehensive reproductive health services could not be achieved because of the failure of unification process (World Bank 2005c: 30).

HPSP had broadened the services to be offered within the cluster of reproductive health however, there had been serious inattention to the issue of continuous supply of the service providers. There had been negligence in recruitment of critical workforces for reproductive health services during this period.

The transition from a project-based approach to a sector-wide approach had not been smooth as the support services could not be integrated efficiently. In the pre-HPSP period each donor funded project had its own system for procurement, training, communications and information system. During HPSP these support services were brought under the line directors towards making a unified support service system. However, this was done in haste without adequate capacity building at that level. Thus, it was claimed to have had resulted in deterioration in the quality of services (HPSP: APR 2003: 42). Resource allocation system was not changed along HPSP's move towards sector wide approach. Funding for the ESP continued to be allocated by the traditional line-budget criteria i.e., staff and medical supplies. Even though much of the ESP was of ambulatory nature, funding was linked to inpatient capacity (Ensor and *et. al.* 2002: 253).

The philosophical underpinnings of SWAp was largely ignored by HPSP for remaining confined only to public sector health and family planning and by diminishing the scope of inter-sectoral and multisectoral collaborations.

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ESP was designed as a pro-poor intervention. However, indicators developed for monitoring the performance of HPSP were not poverty sensitive. Around forty monitoring indicators were developed to monitor the sector performance as a whole. However, there was no indicator for specific income groups to monitor its pro poor performance (Ensor and *et. al.* 2002 : 249). Identification of hard core poor for providing health care at low cost was planned under HPSP. However, during the HPSP period, guidelines for identifying and targeting the poor and vulnerable groups were not developed in accordance with the Action Plans (HPSP: APR 2003). Gender equity strategy was also hardly implemented.

HPSP had targeted to allocate more resources to ESP to address the health needs of poor, women, and children as defined 'vulnerable' by it. It had been claimed that HPSP had contributed in making health services more pro-poor in the sense that over 65 percent of public expenditure in the sector was made towards ESP. Among the users of *Upazilla* and lower level facilities, 60 percent belonged to the poorest income quintile (World Bank 2005c: 40). Even though, budget allocated to ESP package had exceeded its target of 60 percent, consumption of ESP services could not achieve its target of 80 percent (HPSP: APR 2003: i). Further, it was argued that ESP resource allocations were based on the number of facility beds and staff posted to specific locations rather than the health needs of the poorest groups. Health Economics Unit (HEU) of MoHFW had observed significant difference between these two and thus, claimed that the resource allocation in HPSP

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had benefited better off groups of the population and better of regions of the country (HPSP: APR 2003: 34).

ESP was once again a supply driven intervention. Even though maternity care in the government health facilities is supposed to be free, people have to bear expenses related to drugs, blood, transportation etc. because government facilities are quite often under-funded. People have to make unofficial payments to support staff for services like moving patients between wards or taking them to toilets etc. Families make out of pocket expenses for availing the services those are supposed to be free. Cost was found an important barrier in seeking emergency obstetric care in Bangladesh by many studies (Pitchforth and *et. al.* 2006; Koenig and *et. al.* 2007; Nahar and Costella 1998; Afsana 2004; Collin, Anwar and Ronsmans 2007). However, HPSP did not have any demand side intervention to address accessibility barriers of the poor users.

Despite publicizing a Clients' Charter of Rights and Health-Care Providers' Charter of Rights by the UBCC, they were not displayed in most of the health centers and as a result, clients and providers were mostly unaware of these rights. Nevertheless, Health Watch Groups were formed and had been reported to be functional (HPSP: APR 2003: 36).

Availability of EmOC was very limited because of lack of trained obstetricians and anesthetists (Koblinsky and *et. al.* 2008: 290).

Survey findings show that HPSP performance was no way near to its commitment of pro poor, client centered, and quality service delivery. Public

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ratings about government health service, users' perception about quality of services provided, utilization of government services were quite disappointing. Quality of care in the HNP services provided by the government has posed a major challenge. Findings of the CIET surveys (1999, 2000 and 2004) revealed that HPSP was far from achieving its pro poor objective or providing accessible, client centered, and quality service delivery. Users' perception about the quality of care and services in the government facilities was indeed alarming. More people resorting to unqualified providers indicate severe deterioration of the quality of care in the government services. Public rating about the government health and family planning services even deteriorated during this period. Household rating about government services as 'good' in 2003 came down to 10 percent from 38 percent in 1999 while it went up for the private services from 25 percent in 2000 and 37 percent in 2003. This was complemented by the decreased use of government health services for treatment purposes in the same period (from 17 percent in 2000 to 13 percent in 2003) with an increase in the use of unqualified health service providers (from 52% in 2000 to 60% in 2003) for treatment purpose. There was also decline in the use of private and NGO services for treatment purpose (from 31% in 2000 to 27% in 2003).

Poor rating of government services was further corroborated with the survey findings on quality of care in terms of the interpersonal relations of the providers. Users of government facilities satisfied with the overall services declined from 62 percent in 2000 to 54 percent in 2003. On the other hand,

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users of private and unqualified providers satisfied with the overall service were as high as 88 percent and 87 percent respectively in 2003. Similarly, users of government services for treatment who considered that they had received a full explanation of their illness also declined from 50 percent in 2000 to 44 percent in 2003. However, this was significantly higher among the users of private/NGO services (71% in 2000 and 80%) and unqualified service providers (68% in 2000 and 73% in 2003).

CIET (2004) findings showed that patients from the poorest households were less likely to be prescribed medicines in the government facilities. Waiting time for the poor was longer than the less poor. People had to pay unofficial fees to the providers. Women from the poorest household were found less satisfied with government services in the all the three surveys by CIET.

Focus group discussions brought complaints about the behaviour of the service providers specially the doctors. Doctors were considered rude, disrespectful with an indifferent attitude and biased towards looking after the economically better off patients. Absence of doctors was cited a major problem by almost half of the focus group. In their opinion doctors work more in the private clinics then in the government health service facilities (CIET 2004: 43).

However, national surveys showed improvements in the national performance with respect to some health and demographic indicators like TFR, MMR, IMR, under-five mortality rate etc. TFR had declined to 3.0 in

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the later part of this policy regime (2001-03) from a stagnating 3.3 during (1994 to 2000). The period of fertility plateauing (1994-2000) had overlapped between last few years of FP-MCH policy regime (1994-97) and the first two years (1998-2000) of the reformist reproductive health policy regime (NIPORT and *et. al.* 2005: 54; and 2009: 49-51). This decline in TFR in the later part of the policy regime was accompanied with decline in age-specific fertility for all age groups excepting 20-24 years of women. Increase in the use of modern methods of contraceptives had increased to 47 percent in 2004 from 43 percent in 1999/00 (NIPORT and *et. al.* 2005: 67). However, this improved performance of family planning sector could not be attributed solely to government family planning programme because during this period public sector's contribution in the service delivery had declined significantly. During 1997 to 2004 outreach programme of the government shrank. Field workers of the public sector in provisioning contraceptives had fallen down from 39 percent to 23 percent. Hence, its contribution in the contraceptive provision fell down from 74 percent to 57 percent (World Bank 2005c: 29). Nevertheless, despite this decline in fertility the target of replacement level fertility by 2010 were not reachable. Family planning programme was featured with 19 percent of discontinuation rate of contraceptives and side effects constituted the major reason for discontinuation for pill, IUD, injectables and norplant. Unmet need for family planning was 11 percent (NIPORT and *et. al.* 2005: 79-80; 105).

There had been slight improvement with respect to maternal mortality situation during this period. Pregnancy-related mortality ratio (PRMR) had

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declined from 485 per 100,000 live births in the early 1990s to 400 by the late 1990s. Maternal mortality ratio had been estimated at 322 per 100,000 live births by the Bangladesh Maternal Mortality Survey, 2001 (NIPORT and *et. al.* 2003). BDHS, 2004 had marked a significant increase in the use of antenatal care. Antenatal care by a trained provider rose from one third in 1999-2000 to almost half in 2004. Nevertheless, no improvement was marked with respect to facility based delivery. Only nine percent of births occurred at a health facility (NIPORT and *et. al.* 2005: 135-141). Further, there were wide disparities among different subgroups of women in all types of maternal care-seeking behaviour (Koenig and *et. al.* 2007: 75-82).

Child mortality and under-five mortality continued its declining trend over the preceding five years. Child mortality came down from 30 per 1,000 births during 1995-1999 to 24 during 1999-2003. Under-five mortality came down from 94 per 1000 live births in 1995-99 to 88 during 1999-2003 (NIPORT and *et. al.* 2005: 117). Nevertheless, due to deficiencies in data it was difficult to infer whether these improvements were the impact of HPSP (World Bank 2005c: 31).

4.5 Summary and Assessment

This policy regime had made a paradigm shift from project to sector wide policy framework, separate health and family planning services to integrated primary health care package, broad based primary health care to basic package of primary health care services, and from FP-MCH services to reproductive health services. These shifts were made in view of rendering pro poor, client centered, cost effective, and quality health service delivery.

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While these shifts were accompanied with compatible reform agenda and necessary revisions and additions in the programme design, there also remained many incompatibilities and omissions within the policy framework.

The most significant contribution of this policy regime was its shift towards reproductive health with major focus on maternal health. Even though its shift to reproductive health remained largely incomplete in view of the fact that it could not establish integration between the reproductive health services because of failure of unification, it had made a great stride through establishing maternal health as the most important reproductive health issue in its own right. Maternal health has been conceived and pursued as an end itself. Expansion of EmOC had been adopted as its basic maternal health strategy to complement community based maternal health interventions with facility based interventions. Step towards expansion of EmOC up to primary level has been a landmark in the journey towards increasing the availability of and accessibility to the most important maternal health service to address the most important reason for very high maternal mortality in the country.

Broadening of reproductive health services has been a major step towards increasing the availability of and accessibility to the services needed for addressing the very basic reproductive illness like STI and RTI etc.

Introduction of awareness programme for adolescents has been the first step towards removing overt policy barrier on adolescents' access to reproductive health services. However, covert policy barrier on men continued to remain

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a feature of the programme in absence of any measure to include men in the reproductive health programme.

Its shift towards reproductive health was not accompanied by a clear policy direction for family planning programme. The programme was not redesigned or refocused towards promoting reproductive health. The programme continued to have its demographic objectives and targets. Thus, family planning services were not transformed into reproductive health services. Family planning services were placed in a cluster of other reproductive health services without making appropriate strategic linkages with those services. Further, its demographic objectives were not translated into reproductive health objectives. No new strategy or interventions had been evolved to link family planning services with reproductive health promotion. Family planning activities could not be appropriately linked with reproductive health framework. Family planning activities were continued to be conceptualized as fertility reduction services and its availability was designed to be linked to fertility reduction than to promotion of reproductive health.

It appears that policy makers were ambivalent about making a choice between 'a family planning programme to promote reproductive health' or 'a family planning programme to attain demographic goal'. Thus, at the surface level family planning programme was brought under the reproductive health component with the objective of promoting reproductive health to respond to the global demand. On the other hand, they were convinced within themselves that family planning programme in our country

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still needs to play a strong role in bringing down fertility to the replacement level along with other development interventions i.e., education, employment etc. That is why, demographic targets were set and strategy to promote longer acting contraceptives was pursued. However, such a dilemma over the role of the programme at the policy level had its affect on the programme implementation and programme momentum. This dilemma over programme direction had affected the programme momentum at the time when the programme was at its peak and also far from achieving its long term goal of replacement level fertility. This confusion at the policy level had resulted in the failure to translate how HPSP would achieve its twin goals of fertility reduction and reproductive health promotion. Under this situation family planning activities were designed to be linked to fertility reduction and not to reproductive health.

Absence of a clear policy and programme direction had created a feeling of insecurity among the family planning programme insiders. Failure of creating a meaningful space or platform for family planning insiders to work for reproductive health promotion within the envisaged unified management structure had severely affected the implementation of the entire sectoral programme. Issue of unification for the insiders of family planning programme had turned into an issue of the existence of the programme. Hence, they were resistant to unification of health and family planning from the very beginning. However, the then policy makers and political leaders had overpowered the family planning officials during the policy formulation stage through strong mobilization of civil society. Overpowering such strong stakeholders brought only temporary solution. Even though low ranking

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family planning staff was managed by the government with the promise of job security, higher ranking officials did not see their career prospect in the unified system. Thus, policy of unification was never owned by the family planning officials and hence, they remained non-functional. However, they remained active to reverse the unification through mobilization of media and political leaders. Hence, the whole matter was overturned at an opportune time. They mobilized political support when the new government led by the Bangladesh Nationalist Party took power in 2001. They could convince the new government to overturn the whole matter of unification taking advantage of the antagonistic political culture of the country. Thus, policy of unification did not materialize because due consideration was not given to one of the most important stakeholders' stake. The process of doing it was not considered right in many ways. It was alleged that unification was not designed and implemented in a functional or fair manner. One of the most design errors identified by the annual review team of HPSP was its decision regarding supervision and support of the non-clinical aspects of ESP service delivery at the primary care level by the clinical (health) managers. This was considered undesirable because they neither had experience nor had any natural or tangible interest for giving that service. Further, the decision to phase out from domiciliary services was also considered a great mistake by many.

HPSP experience reconfirms that policy making is a political process involving bargaining between different stakeholders. Hence, it must take the route of dialogue in resolving any conflict irrespective of the merit of the reform programme. HPSP implementation had suffered because it could not

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integrate one of the very strong groups of stakeholders. Hence, HPSP did not yield wide programme support and its success was limited. Unified management structure for health services is embedded in the concept of package primary health services and reproductive health services. Tussle over unification of services had dismantled the entire philosophy of HPSP. Linkage and integration between and among the services, the crux of reproductive health, were beginning to diminish when unification of services came under threat.

HPSP deserves recognition for making the first move towards adopting rights based approach to health policy and programme. HPSP upheld the sprit of human rights in many ways i.e., brought a pro poor focus by targeting the services those impact on the health of poor most; broadened reproductive health services; established maternal health as the most important reproductive health; removed age based discrimination to receiving reproductive health services by targeting adolescents and elderly population; developed mechanisms towards making participatory and accountable health system; and brought the issue of gender mainstreaming. For the first time in Bangladesh, a Clients' Charter of Rights and Health-Care Providers' Charter of Rights were published by BCC as a move towards promoting citizens' rights and accountability of the health service delivery system.

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Chapter 5

Policy Discourse in the Reproductive Health Regime: The Conformist Approach

This chapter outlines and examines the policy frameworks in third phase of policy regime in the light of the objectives of the study. This policy regime has taken a conformist approach for reproductive health to escape the challenges encountered by the reformist reproductive health policy regime. It has reversed the structural reforms envisaged by the reformist reproductive health policy regime and took the conventional route for management and implementation of health and population programme in general and reproductive health in particular. That is why this regime has been called reproductive health policy regime with conformist approach. This chapter aims to analyze the policy frameworks of this regime with a view to examining how policies, strategies, and interventions evolved under the influence of major actors and factors have affected the availability of, accessibility to, and quality of reproductive services and contributed in achieving the policy objectives.

5.1 Contextualizing Policy Development in Reproductive Health Regime with Conformist Framework

Five year plans used to be the long-term policy document of the government in Bangladesh until the end of the Fifth Five Year Plan (1997-2002). After the fifth five year plan (1997-2002), no five year plan was prepared until

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2011.[1] Poverty reduction strategy paper (PRSP) continued to be the major medium-term plan document of the government of Bangladesh during plan holyday period (2002- 2011). Poverty reduction strategy paper was formulated with the vision to achieve millennium development goals (MDGs) (Planning Commission 2003: 7).

The new millennium was marked with the Millennium Declaration in the Millennium Summit held in 2000 with the goal of building a world free from hunger and extreme poverty. The declaration was endorsed by 189 countries. World leaders have agreed to eight specific goals. These goals were set as a framework for guiding and tracking development process and progress respectively. These goals have 18 targets and 48 indicators. These targets are to be achieved by 2015.

The World Bank and IMF in making their commitment towards MDGs have evolved an institutional mechanism for enabling the resource poor and highly indebted countries for framing sector plans and programmes aiming at poverty reduction for achieving MDGs. In the late nineties, the World Bank and IMF, in the context of rising debt liabilities among the less developed countries had proposed granting of debt relief to highly indebted countries on condition of formulating effective national strategy document for poverty reduction. Recognizing the multidimensional nature of poverty, multisectoral engagement was sought by them in pursuit of poverty reduction and MDGs. In fact PRSP had to be formulated to develop national

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[1] The Sixth Five Year Plan (2011-2015) has been formulated in 2011 after the Fifth Five Year Plan (1997-2002).

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plan for multisectoral poverty reduction programmes towards achieving MDGs and seek external assistance along that line. Thus, Poverty Reduction Strategy Paper (PRSP) had been evolved as loan instrument for the resource poor countries towards making pro poor and MDG focused sector investment (Gwatkin 2000: 5).

In this backdrop, poverty reduction strategy papers were prepared by the highly indebted countries like Bangladesh. Initially government of Bangladesh had prepared interim Poverty Reduction Strategy Paper (i-PRSP) titled "A National Strategy for Economic Growth, Poverty Reduction and Social Development". It was finalized in March, 2003. This had actually been a ground work for a full fledged Poverty Reduction Strategy Paper. As an interim step i-PRSP had laid out the framework for pro-poor health sector planning for the upcoming programme implementation plan, Health Nutrition Population Sector Plan (HNPSP). I-PRSP claimed to have had followed a comprehensive approach for poverty reduction based on a rights-based framework and pledged towards progressive realization of rights within the shortest possible time (Planning Commission 2003: 7).

The World Bank had developed its country assistance strategy in accordance with the requirement of i-PRSP. Focus of the country assistance strategy of the World Bank 2001-03 for Bangladesh remained on poverty reduction through human development. It had emphasized on strengthening priority health interventions. World Bank had emphasized on partnership between the public and non-public sector. It had also proposed for improving regulation and supporting community driven approaches, improving health

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sector financing, and adopting performance based lending (World Bank 2005b: 4).

MDGs and i-PRSP had laid down the policy and programme directions for health sector and thrown new challenges for the health programme. Therefore, under the new circumstances, after completion of the time frame of HPSP, government moved towards preparing a new programme plan titled Health Nutrition Population Sector Programme (HNPSP) in 2003. Conceptual framework for the Health Nutrition Population (HNP) sector was prepared through dialogue with the key stakeholders. Based on the conceptual framework, HNPSP (2003-06) had been approved by the Executive Committee for National Economic Council (ECNEC) in March, 2004 (MoHFW 2008a: 2). However, the programme implementation had not started until 2005 (HNPSP: APR 2009a: 1).

On completion of i-PRSP in 2003, a full blown Poverty Reduction Strategy Paper (PRSP) titled "Unlocking the Potential: National Strategy for Accelerated Poverty Reduction" was formulated for three years time period (2005- 07). Later on it was extended up to June 2008. PRSP had put equal weight on income dimensions of poverty and human dimensions of poverty i.e., deprivation in health, education, nutrition, and gender related gaps (Planning Commission 2005). Thus, MoHFW as well as other sectoral ministries were entrusted with health related PRSP targets. This had necessitated preparation of long-term strategic objectives for HNP sector. Therefore, the Strategic Investment Plan (SIP) for HNP sector was prepared in November 2004 in accordance with the MDGs and PRSP targets and

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strategies of the government of Bangladesh. SIP for HNP had identified key investments for accelerating modernization of HNP sector (MoHFW 2005: 15).

For addressing health inequalities SIP gave four broad policy directions: (a) shifting resource allocations to poorer districts (or districts with poor health outcomes); (b) targeting and demand-side subsidies; c) diversification of service provision i.e., diversified service provision through public-private partnerships; d) inter-sectoral collaboration (World Bank 2005b: 3).

In this backdrop, HNPSP (2003-06) needed revision to incorporate the inputs of SIP. Even though the timeframe of HNPSP was 2003-2006, its actual implementation got started in 2005. Revised plan of implementation for HNPSP with the time frame 2003-10 was prepared in line with the goals and objectives of PRSP, MDGs, and policy directions of SIP (MoHFW 2008a: 2, 16). Even though time line of HNPSP and SIP was up to 2010 (up to June, 2011), they were conceived as part of the longer term plan towards achievement of MDG. However, the strategies were not chalked out up to 2015 (World Bank 2005b: 4).

5.2 Policy Framework in the Conformist Reproductive Health Regime

Policy framework in this policy regime has been primarily analyzed on the basis of HNPSP, PRSP, population policy 2004, and the national communication strategy for family planning and reproductive health. At the backdrop of implementation failure of some of the vital features of the NHP 2000, the new government formed by the Bangladesh Nationalist Party in

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2001 pursued updating of the NHP 2000, in 2003. The NHP 2000 was revised in 2006 and forwarded by the ministry to the Cabinet. However, it was not finalized. Thus, HNPSP was assumed to be the major plan document in absence of a new health policy.

After completion of the timeframe of the first PRSP in 2008, the second PRSP was formulated in 2009. Second PRSP has not been analyzed in this study because HNPSP was formulated at the backdrop of the first PRSP. Similarly the second NHP 2011, which was published on the 23rd of January, 2012 i.e., after the time frame of HNPSP (2003-2011), has also not been analyzed as a policy document in this chapter. There was no scope of analyzing it, given the time frame drawn for the study. Further, the said policy has been outlined in the context of the new programme implementation plan, Health Population Nutrition Sector Development Programme (HPNSDP) that had commenced on July, 2011.

5.2.1 Reproductive Health Programme Framework in the Health Nutrition Population Sector Programme

HNPSP had been a thematic successor of HPSP and was built on SWAp. The content of the policy in HNPSP in terms of health services to be focused on had not differed from that of HPSP. Its central goal was to accelerate health related MDGs and PRSP targets through increasing availability and utilization of the essential services as defined by ESP under HPSP.[2] Its objectives relating to reproductive health included: reducing maternal, neonatal and childhood mortality and improving maternal and childhood

[2] See chapter 4, pp. 142-151.

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nutrition along MDGs and PRSP targets; and reducing total fertility to replacement level.

MDGs relating to health adopted in the United Nations Millennium Declaration of 2000 were: a) to promote gender equality and empowerment of women; b) to reduce child mortality, by 2015, by two-thirds compared to 1990 levels; c) to improve maternal health by lowering maternal mortality within 2015 by three-fourths compared to 1990 levels (Planning Commission 2009; MoHFW 2005). Health sector targets set by i-PRSP for meeting MDGs to be achieved by 2015 were to: a) reduce infant and under-five mortality rates by 65 percent, and eliminate gender disparity in child mortality; b) reduce maternal mortality rate by 75 percent; c) ensure access to reproductive health services to all; d) reduce the proportion of malnourished children under five by 50 percent; and e) substantially reduce social violence against the poor and the disadvantaged groups, especially violence against women (Planning Commission 2003: 7-8).

Central to MDGs are maternal and child health. Family planning services have been conceived as a means to reproductive health and thus, it should contribute towards increasing accessibility to reproductive health services to all for promotion of reproductive health.

HNPSP objectives were the same as those of MDGs with respect to maternal and child health. However, family planning services had been conceived as a means for increasing accessibility to family planning methods for fertility reduction towards achieving replacement level fertility.

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Despite being the thematic successor of HPSP, HNPSP had been premised upon the recommendation of Implementation Monitoring and Evaluation Division (IMED) given in the light of HPSP implementation. The recommendation had clearly spelt out independent operation of the two directorates i.e., health and family planning as they did prior to HPSP period and therefore, HNPSP had launched two separate PIPs for the two directorates. It had reiterated the need for following SWAp in both PIPs (MoHFW 2008a: 4).

HNPSP required adopting strategies in conformity with the challenges identified and policy directions chalked out by SIP. Vital changes in the programme features were also brought on the basis of implementation experience of HPSP as reflected through the recommendation of IMED. Thus, HNPSP, as a thematic continuation of HPSP, while had retained, modified and enhanced many of the features of HPSP, it at the same time had reversed the fundamental feature of HPSP.[3]

Three reform areas had been focused by HNPSP: strengthening public health sector management and stewardship capacity through development of pro-poor targeting measures as well as strengthening sector-wide governance mechanisms; health sector diversification through the development of new delivery channels for publicly and non-publicly financed services; and stimulating demand for essential services by poor households through health advocacy and demand-side financing options (World Bank 2005b: 5).

[3] For detailed analysis of HPSP, see chapter 4.

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Role of HNPSP had been envisaged in the development of policies and strategies for emerging challenges in four areas and if possible implementation of the policies and strategies at a later stage. These included: reduction of injuries and implementing improvements in emergency services; prevention and control of major non- communicable diseases; urban health service development; and HNP response to disasters (World Bank 2005b: 6).

Essential Services Delivery (ESD) remained at the nucleus of the sector programme as the strategic conduit for pro poor resource allocation as it had been in HPSP. Programme design for reproductive health remained the same within Essential Services Delivery (ESD) in HNPSP as it had been chalked out by HPSP.[4] However, HNPSP had restored domiciliary services for ESD and included nutritional elements for mother and children in it. Reproductive health continued to remain at the top of the pro poor resource allocation agenda of ESD. In other words, reproductive health intervention was established as poverty reduction intervention and maternal health had been identified as the most important area for reproductive health intervention. Reproductive health programme objectives and strategies heavily reflected on maternal health. Principal maternal health strategies remained the same. Giving due consideration to obstetric causes as the most important reason for maternal deaths, HNPSP like HPSP had given special attention for strengthening EmOC in accordance with the maternal health strategy 2001[5]. The strategies adopted by HNPSP were geared towards building

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[4] For details, see chapter 4, pp. 143-145.

[5] For more information on maternal health strategy, see chapter 4, pp. 155-158.

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countrywide EmOC facilities through strengthening comprehensive emergency obstetric care at UHCs, MCWCs, and district hospitals; increasing basic emergency obstetric care in every feasible facility at the union and lower level; and training of medical officers in obstetrics or anesthesia and placing them in teams at the district or *Upazila* (sub-district) health facilities.

HNPSP had adopted the skilled birth attendant (SBA) training programme as a community based maternal health strategy to ensure safe home delivery in accordance with the maternal health strategy, 2001. Thus, HNPSP had supplemented its facility based obstetric care intervention with community based SBA intervention. It is to be mentioned that skilled birth attendant training programme commenced in Bangladesh in 2003 with the technical support of World Health Organization and UNFPA (WHO 2004).[6] Six-month SBA training are imparted to FWAs, and female HAs, the domiciliary service providers of family planning and health directorate respectively with the assistance of WHO to attend delivery at home.

Maternal health services in HNPSP had been further strengthened by adding demand side intervention in it. Increased accessibility to maternal health seeking had been sought by HNPSP through introduction of Maternal Health Voucher Scheme (MHVS), a demand side intervention. This intervention in maternal health services had brought an additional feature in HNPSP. The scheme provides vouchers to pregnant women to purchase antenatal, normal delivery, and postnatal services from a designated provider of their choice

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[6] See chapter 4, p. 163.

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for their first and second pregnancy. The providers are reimbursed for the services delivered upon producing the voucher (MoHFW 2005: 45; HNPSP: MTR 2008: 16). However, the scheme has been initiated in a limited number of *Upazilas*. Initially poverty had been the eligibility criteria for vouchers except for the 19 *Upazilas* where eligibility was universal. However, later on it was made universal for all *Upazilas* where MHVCs were operating. The scheme also provides incentives to the providers and 'seed money' for institutions to meet any additional cost (HNPSP: MTR 2008: 16).

Awareness services for reproductive health had put special emphasis on promotion of universal awareness on danger signs during pregnancy, and delivery, delivery planning, emergency preparedness for pregnant women and home care for maternal and early childhood nutrition (HNPSP: MTR 2008: 15).

As the programme title HNPSP suggests, nutrition was very logically integrated into the sector. Nutrition being the focus of PRSP had for the first time got some attention in the mainstream health sector programme of the country. Reduction of child malnutrition by half, within 2015 was one of the goals of poverty reduction strategy. Hence, donors' assistance was ensured for nutrition programme and the National Nutrition Programme (NNP), funded by World Bank which had originated as a stand alone project and continued as a separate project outside HPSP, was brought within the purview of HNP sector from July 2004 (MoHFW 2005: 20; White 2007:

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462).[7] Operational plan of NNP was housed in MoHFW itself and thus, was under the direct supervision of the Secretary, the executive head of MoHFW.

HNPSP had planned to expand nutritional intervention through NNP to cover 232 *Upazilas* by 2011 (MoHFW 2008a: 24). It had two components i.e., a) area based community nutrition (ABCN) services for children under 2 years, pregnant and breast feeding women, newly-wed couples, adolescent girls and national level nutrition services; and b) programme management and development, monitoring and evaluation, operations research and training and Behavior Change Communications functions (MoHFW 2005: 20). Area based community nutrition activities were implemented through contracted NGOs. NNP supports the NGOs with training, procurement of iron foliate, and de-worming tables (HNPSP: APR 2009: 32). Micronutrient interventions Vitamin A supplementation and Iron Folic Acid supplementation were among the core MCH services delivered through public sector mainstream health services.

The urgency of an urban health development plan had been recognized at the policy level for improving infrastructure, service delivery strategies, incorporating government, private and NGO services, and defining appropriate role for MoLGRD and MoHFW. Re-examination of further funding for the on-going urban primary health services was considered

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[7] See chapter 3, pp. 118-119.

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important upon such plan.[8] Thus, an urban primary health care plan or strategy had been envisaged by HNPSP. Consultation between MoLGRD and MoHFW had been emphasized in this policy process (MoHFW 2008a: 39).

HNPSP had conceived some new institutional mechanisms for reflecting people's voice in health policies and programmes and ensuring accountability of health service systems. It had planned for forming Health Users' Forums (HUFs) starting at the local level up to the national level involving stakeholders from government, health care providers, clients, and communities. HUF were supposed to have access to international research and advocacy group and lay the basis for local planning, monitoring and evaluation. HNPSP has also planned to form Health Advisory Committees (HACs) composed of elected public representatives, service providers, local government officials, and NGOs to oversee service provision in a health facility.

5.2.2 Linking Poverty Reduction Strategy and Reproductive Health Programme Framework in the Health Nutrition Population Sector Programme

Upon analyzing key dimensions and determinants of poverty situation in Bangladesh, PRSP had identified some strategic blocks for interventions

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[8] Urban Primary Health Care Project had been initiated in 1998 with the funding from ADB. Urban primary health being the mandate of city corporations MoLGRD is the authority for implementation of the programme through city corporations. The implementation arrangement of the project had been made through the contracting NGOs. Contracting out of the services to NGOs for urban primary health services had started under various public-private partnership developed in the later part of HPSP outside the framework of HPSP (HPSP:APR 2005: 43).

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towards creating a road map for poverty reduction. Major themes of poverty had been focused by major public sector Ministries and Divisions as part of the participatory process in the preparation of PRSP. The theme presented on health including population planning, nutrition, and sanitation had identified over population as one of three principal health problems of Bangladesh (Planning Commission 2005: 34).

Human development had been identified by PRSP as a strategic block for developing roadmap towards poverty reduction. It had called for investing in education and health as the two most important paths of human development. Child, maternal, and reproductive health interventions including nutrition had been asserted as human development intervention. Maternal health had been championed as reproductive health intervention. Introduction of demand side financing for maternal health programme and expansion of SBA for ensuring safe home delivery were emphasized.

It had followed the rights based approach to reproductive health and thus, had emphasized on enabling people to meet their reproductive intent and reproductive health needs safely. While it had touched upon the importance of population control for poverty reduction in a line, it had laid more emphasis on responding to women's reproductive health need and ensuring their health safety because the burden of reproductive ill health is chiefly borne by women. In this connection, it had recognized the importance of addressing unwanted pregnancies and contracting diseases. However, it had not set any clear direction for transforming family planning programme into reproductive health services.

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On the other hand, output indicator and outcome indicator set for family planning services was limited within CPR and TFR respectively (Planning Commission 2005: 225-226). Thus, PRSP did not take a clear position on family planning. This contradiction at the policy level has brought family planning services in a dwindling position.

It had touched upon the importance of population control for poverty reduction very superficially without signifying important links between fertility reduction and maternal, child, and reproductive health and therefore, human development (Planning Commission 2005: 136). It had not established family planning services as an important means to maternal, child, and reproductive health. Thus, family planning had not been adequately advocated as maternal health intervention or reproductive health intervention in PRSP. It has been established only as means to fertility reduction. Thus, strategic linkage between family planning services and maternal, child, and reproductive health were missing.

Adequate attention was not given to the urban primary health care situation. It also did not provide any direction on the role of MoHFW with respect to urban primary health care services.

PRSP's strategic position on maternal health services and family planning services got reflected upon the HNPSP's strategic position on family planning services and maternal health services.

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5.2.3 Linking the Second National Population Policy and Reproductive Health Programme Framework in Health Nutrition Population Sector Programme

The first population policy was formulated in 1976. Nearly after three decades the second population policy was formulated by the government in 2004 to address the changing population challenges of the country. Both population policies' prime objective remained the same, bringing down fertility rate and population growth rate towards achievement of replacement level fertility. However, the contexts of the two policies were quite different. The population policy 1976 was formulated soon after the independence of the country when government had recognized population growth as the prime challenge for sustainable development of the country.[9] Necessity of a strong family planning programme was felt at the policy making level of the government for curbing high fertility. There was strong political commitment for family planning programme. Therefore, population policy of 1976 was chiefly focused on curbing fertility. Hence, strategies were also conceived towards achieving that objective of the policy. Subsequent five year plans and programmes were conceived in line with the population policy, 1976.[10]

Second population policy was formulated in 2004 when the global policy environment centering population and health had changed considerably. The policy environment was very much influenced by the proclamations of the ICPD in 1994, International Conference on Women and Children in 1995,

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[9] This has been discussed in chapter 3, pp. 75-77.

[10] For discussion on five year plans, see chapter 3, pp. 71-119.

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Millennium Summit in 2000. Thus, population policy, 2004, had a broader focus and hence, focused upon migration, urbanization, and also mortality as other important factors of population process besides fertility. Its objectives even included reduction of IMR, under-five mortality and MMR, maternal and childhood malnutrition and RTI, STI and prevention of HIV/AIDS. However, the link between family planning services or fertility reduction and improvement in the health outcome indicators was not established by the policy.

The population challenge in meeting the goals of PRSP and MDGs had been brought into focus by the policy. The urgency of achieving replacement level fertility was focused in the context of human development challenges. Recognizing the interrelationship between population growth, population distribution and development, the policy had called for integration of population variable in the development plans of the relevant ministries. Similarly, it had urged on integrating demographic factors into the activities of health, education, women's development, urbanization, housing, environment, poverty alleviation, and addressing inequality and inequity.

The population policy objective was to attain NRR 1 by the year 2010 through reducing TFR. The policy had advocated for a multisectoral approach for population programme. It had called for giving increased attention to the strategies those address unmet need for family planning and promotes quality of care. Addressing unmet need for family planning and promotion of quality of care had been considered very critical for reduction of fertility, maternal, and child mortality and morbidity. Prevention of

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unsafe abortion had also been highlighted in the context of promotion of maternal health. MR had been recognized as the corner stone of population policy. The policy had neither recommended an incentive based family planning programme nor negated it. However, demographic target based family planning programme was main theme of the policy. The policy had endorsed reinstatement of domiciliary services as had been done by HNPSP. Similarly it had endorsed the skilled birth attendant training strategy for safe home delivery as conceived by HNPSP.

Reproductive health perspective was brought in the population policy in the context of the declaration of ICPD and International Conference on Women and Children. While the main objective of the policy was accelerated fertility reduction to achieve replacement level fertility by 2010, it had also urged on clients' needs based provisioning of contraceptives. Gender equity and empowerment was a major focus of the population policy. It had called for mutisectoral intervention for gender equity and empowerment i.e., create equal opportunity for boys and girls in education system and at work and ensure equality in providing health and nutrition services. Elimination of violence and sexual abuse on women and trafficking of women were considered vital for gender equity and empowerment. Male involvement in household responsibilities, reproductive health, and family planning was recognized crucial for promoting health and gender equity.

The policy had conceived reproductive health from life cycle approach and hence, its target population did not confine only within couples of reproductive age. Adolescents were considered prime target population for

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counseling services aiming at delaying age at marriage, delay in first birth as far as possible, adequate spacing between children, and providing reproductive health education and life skill education.

However, while the policy had urged on the need for refocusing family planning programme it did not give clear direction for repositioning family planning programme within the reproductive health framework.

The elderly population got focused in the population policy for the first time. Strategies were chalked out for improving the quality of life of the elderly population i.e., increasing the existing old age allowance and expanding its coverage and free medical care for childless and helpless elderly people.

The policy had recognized the pressure on urban facilities and services to meet the demand of the ever growing urban population. It had called for slowing down urban migration on a priority basis and for planned urbanization, and conservation of environment. Strategies outlined for curbing urban migration included establishment of satellite towns and growth centers with good communication and health and education facilities; skill development training for youth for manpower export etc. However, the policy did not give any future direction for urban primary health care services including reproductive health services.

HNPSP had set its target for fertility reduction in accordance with the population policy, 2004. However, population variables were not properly integrated in the sector plan. Further, HNPSP did not conceive any mechanism to promote other sectors' participation in population programme

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activities or promoting gender equity and empowerment. Gender equity and empowerment had received attention by the population policy and HNPSP both. Adolescent and elderly population was also focused by the population policy and HNPSP.

5.2.4 Linking the National Communication Strategy for Family Planning and Reproductive Health and Reproductive Health Programme Framework

The naming of the strategy suggests family planning has been perceived as a separate entity and not an integral part of reproductive health. Communication strategy for reproductive health automatically includes family planning and thus, need not be mentioned separately. Similarly, the strategy at the outset mentions its objective to serve as a roadmap for: a) increasing knowledge, improving attitudes, and changing behaviour with respect to family planning and reproductive health; b) improving the quality of reproductive health services; c) increasing stakeholders' participation and coordination in the areas of family planning and reproductive health.

The strategy has developed audience specific communication and advocacy activities for increasing knowledge and changing attitude and behaviour with respect to broader reproductive health. Communication activities are designed for increasing knowledge and changing attitude at the individual levels through mass media communication and awareness activities by the service providers. Communication activities are primarily media campaign and audio visual presentations for use at the courtyard meetings. Advocacy activities are primarily orientation meetings with different target groups

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particularly community leaders (i.e., religious leaders, teachers, union *parishad* chairmen) who are expected to work as catalyst for bringing change in the attitude and behaviour at the community level.

Different categories of audiences have been identified by the strategy. These include: newly weds and low parity couples, married couples with desired family size, males, adolescents, unmarried youth, religious and community leaders etc.

The strategy has given emphasis on increasing knowledge and changing attitude and behaviour with respect to maternal health through focusing on communication and advocacy activities for birth planning and birth preparedness. The major theme of the strategy is on limiting family size, child spacing and improved maternal health seeking. Family planning services has been focused in the context of limiting family size and spacing child birth. The strategy has focused communication activities for promotion of joint decision making for family planning and choice of contraceptive, promotion of condom for preventing sexually transmitted infections, promotion of longer acting methods among couples with desired family size, and male involvement in reproductive health care seeking.

Awareness about the importance of delaying marriage and first pregnancy has been included in the communication activities for unmarried adolescents and unmarried. For unmarried youths the strategy has recommended culturally sensitive media materials about healthy perceptions of the opposite sex, negative impacts of dowry exchange, domestic violence, and

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women's rights. For adolescents the strategy has recommended for adolescent life-skills programmes into school curriculum and creating an environment for adolescents to seek information and services at local health facilities.

The strategy has not included communication activities for child health particularly neo natal care. The strategy has not focused on promotion of responsible parenthood as the key for family welfare as a whole. Responsible parenthood is very important for protection of child right. Communication and advocacy activities for averting early marriage, early child bearing, violence, and dowry need to the included for all groups of audiences.

5.3 Implementation Scenario of Health, Nutrition and Population Sector Programme (HNPSP)

Expansion of EmOC services at UHCs has been difficult and very slow while good progress has been made in creating EmOC facilities at the district level. It has been reported that EmOC facilities have been created in 112 UHCs by 2008 (HNPSP: APR 2009a: 47). In all district hospitals and MCWCs, comprehensive EmOC facilities have been created even though they are yet to be fully functional. MoHFW had implemented demand-side financing through Maternal Health Voucher Scheme (MHVS) for ANC and delivery care in 33 *Upazilas* (sub-districts) of the country. Evaluation of the scheme was under process for taking a decision on scaling up the scheme (HNPSP: APR 2009a: 60).

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No effective steps have been taken to address the long term challenges of HNP sector as identified by SIP. Mid term review of HNPSP had noted that long term challenges of HNP sector as identified by SIP were not made operational by HNPSP. It appears that many ideas put into policy papers are not meant to be implemented.

Few *Upazilas* and districts had prepared local level plans. Nevertheless, DGHS and DGFP had separate plans. No progress has taken place regarding implementation of these local level plans because resources were not allocated for these plans (HNPSP: APR 2009b: 98). Programme management remained as centralized as before.

Voice and accountability mechanisms evolved by HNPSP through formation of HUFs, HACs, and Clients' Charter of Rights had limited success. HUFs were to be formed from the local to national level involving stakeholders from government, health care providers, clients, and communities. These mechanisms even though appeared promising on paper were not implemented with seriousness. No initiative was taken to implement HUF. A number of HACs at various levels under DGHS and DGFP have been formulated. However, HACs have remained largely non-functional in absence of clear goal and mandate, support, training and resources (HNPSP: APR 2009a: 48; Chowdhury and Osmani 2010: 211; 261-262).

Citizens' Charter of Rights was launched in 2004 and was revised in 2007 (HNPSP: APR 2009a: 46). Individual charters were also developed. However, these charters were developed without any consultation with

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citizens (Chowdhury and Osmani 2010: 261-262). Even though citizens' charter of health has been displayed in health facilities nation wide, majority of population and service providers are unaware of the charters (Chowdhury and Osmani 2010: 211; 261-262). A draft bill on hospital autonomy was prepared in 2007. However, it was not finalized.

Gender mainstreaming in health and population programme is the crux of the reproductive health movement. However, gender issues remained confined within policy level. Institutional mechanisms for gender mainstreaming remained almost inactive (HNPSP: APR 2009a: 46). Institutional approach to address violence as a major reproductive health issue has been lacking. The women friendly hospital project and the One Stop Crisis Centers have been conceived within the Improved Hospital Services Management under which DGHS has been working with UNICEF to upgrade selected district hospitals and UHCs with the goal of ensuring that women receive timely and adequate care and treatment with respect, dignity, and equity. However, progress in this respect has been very slow. Only a very limited number of hospitals have achieved the standards required to be qualified as women friendly hospitals (HNPSP: APR 2009b: 74). One Stop Crisis Centers have been established in 8 Medical College Hospitals under the Multi-sectoral Project on Violence Against Women (HNPSP: APR 2009b: 53).

Government has promoted internationally accepted three cost effective nutrition interventions: a) micronutrient supplementation for pregnant women and under-five children; b) growth monitoring and nutrition

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counseling; and c) promotion of exclusive breastfeeding. Micronutrient intervention i.e., Vitamin A, Iron Folic-Acid (IFA) are delivered by health and family planning directorate of the government. Growth monitoring, nutritional counseling including promotion of exclusive breastfeeding are delivered through NGOs by ABCN approach under the management of National Nutrition Programme.

Renewed emphasis has been brought on the community clinics during the later stage of HNPSP after the formation of a new government in 2008. The reactivation of the community clinics has brought impetus in recruitment of various categories of services providers. Recently government has devoted much energy to address acute manpower shortages in this sector through filling the vacant posts of various categories of health personnel within DGHS and DGFP. Civil Surgeons, the district level heads of DGHS, were directed by DGHS in April 2009 to fill up 6391 vacancies against the posts of MAs to make most of the community clinics operational (HNPSP: APR 2009b: 173). Moreover, filling up the vacant post for doctors and nurses are already under way.

A Gazette Notification, "Transfer and Posting Policy for Officers in Health Service" has been issued by the government in December 2008. It contains the principles to be followed for: deployment of newly recruited physicians; postings to special posts and training posts; and service prerequisites for qualifying for higher education. It has made a requirement of minimum two years service at UHFWCs for better career ladder (HNPSP: APR 2009b: 174).

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Recently some important developments have taken place towards addressing the issue of human resource for the sector. Approval of midwifery strategy and a policy on community paramedics in the private sector with curricula developed and supervised by NIPORT are indicative of good progress and commitment for addressing the issue of workforce challenges for the sector (HNPSP: APR 2009a: 67).

5.4 Reproductive Health Policy and Programme Issues, Gaps, and Challenges

HNPSP as HPSP has established maternal health as the prime reproductive health agenda and has reinforced maternal health strategy through MHVS. However, family planning services were far less emphasized as reproductive health services or human development intervention. Objectives set for reproductive health programme had hardly reflected on family planning services as it had reflected on maternal health services (MoHFW 2005: 60-61). Similarly strategies outlined for reproductive health programme did not encompass family planning services. Further, strategies of the population sub sector had integrated maternal health components within their outreach services whereas health sub sector strategies did not integrate any family planning component in their outreach services.

Family planning services had received attention to the extent it was related to the fertility reduction agenda of the reproductive health programme. Family planning services were encased within the fertility reduction domain of the programme. Confining family planning again within the boundary of fertility reduction in a broader policy environment that calls for pro

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reproductive and maternal health or pro poor health intervention had automatically under stated the importance of the family planning programme.

The importance of delaying the age at first birth had been recognized by HNPSP in the context of fertility reduction through counteracting population momentum, by discouraging under-age marriage and childbearing during adolescence. In fact, encouraging delay in age at first birth and discouraging childrearing during adolescence are as crucial for maternal health as they are for fertility reduction. It is an area where collaborative approach is vital. However, HNPSP had not evolved any inter-sectoral or cross-sectoral collaboration for augmenting such social change which remains crucial for achieving replacement level fertility as well as promoting reproductive health. Cross-sectoral collaboration has been totally missing in HNPSP.

Essential services had been the main theme of primary health care envisaged by HNPSP like HPSP. The concept of a package service is embedded in the principle of integration and connectivity without which efficacy of the package service gets diminished. Design of ESP and reproductive health programme within ESP remained the same in HNPSP as had it had been chalked out by HPSP. HPSP had envisioned a unified management structure for health and family planning to complement the concept and the design of ESP. Integrated package service was compatible with unified management of services. Similarly comprehensive integrated reproductive health was also compatible with unified management structure for health and family

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planning. HNPSP had retained the programme design, while reversed the unified management structure envisioned by HPSP.

Separate management structure for health and family planning has been reinstated and domiciliary services have been restored by HNPSP. Where the basic philosophy of the entire sector plan was to reinstate a single sector for health, population and nutrition, moving back to separate structure for health and family planning had been absolutely contradictory. SWAp framework calls for mutually supportive and reinforcing strategies and interventions for health, population, and nutrition. Separate management structure has blocked the way to sector wide linkages. This has resulted in inefficient use of resources for HNP services, one of the major reasons for moving out from project approach.

Under the separate management structure all the subsystems like, MIS, BCC, human resource management also got separated as they were before the onset of reproductive health policy regime. At the backdrop of separate management structure, implementation of ESP has been split up between health and family planning. In total 38 Operational Plans (OPs) were made for implementation of HNPSP. Implementation of 24 OPs was under the authority of DGHS and implementation of nine OPs was under the authority of DGFP and five were under MoHFW. Of these 38 OPs, five were directly related to reproductive health components. These were, Essential Services Delivery, Improved Hospital Services Management, Clinical Contraception Services Delivery, Family Planning Field Services Delivery, and Maternal, Child and Reproductive Health Services Delivery. Of these, five OPs,

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Essential Services Delivery, Improved Hospital Services Management were under DGHS and Clinical Contraception Services Delivery, Family Planning Field Services Delivery, and Maternal, Child and Reproductive Health Services Delivery were under DGFP. However, operational plans for subsystems like, MIS, BCC, human resource management were also linked to reproductive health. Separate operational plans for all these subsystems were made in accordance with separate structure for health and family planning (MoHFW 2005: 58-59).

Posts of Line Directors were created for implementation of each OPs. These positions of Line Directors were created from within the existing posts of Directors in DGHS and DGFP. Posts of Directors within the health and family planning were converted into the line directors for the relevant OPs: i) Director, Primary Health Care of DGHS was made the Line Director, ESD, DGHS; ii) Director, Hospital and Clinics, DGHS was made the Line Director, Improved Hospital Services Management, DGHS; iii) Deputy Director, Services, DGFP was made Line Director for Clinical Contraception Services Delivery, DGFP; iv) Director, Finance, DGFP was made Line Director, Family Planning Field Services Delivery, DGFP; and v) Director, MCH Services, DGFP was made Line Director, Maternal, Child and Reproductive Health Services Delivery, DGFP (MoHFW 2005: 58-59).

Hence, a patchy arrangement had been evolved for delivery of comprehensive integrated reproductive health services. This patchy arrangement of programme management and implementation has affected the availability and quality of the programme in many ways. This

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implementation mechanism has further weakened the link between maternal health and family planning services. This de-linking of the two had reduced the efficacy of maternal health programme in particular and reproductive health programme in general. This weakening of the linkage has significantly affected the scope for family planning services to function as an important means to maternal health. This has happened when maternal health has received highest priority at the policy level. Thus, de-linking of family planning and maternal health under split implementation arrangement had weakened the position of family planning even more.

Separate BCC programme for health and family planning directorate deters the quality of BCC programme and coherence in the BCC activities towards a common goal.

In absence of unified MIS system, health and family planning service delivery data are not complied at any level. This has been a serious problem for programme monitoring, planning, and evaluation. Maternal health services are delivered by both DGHS and DGFP. Similar maternal health programme activities are implemented by health and family planning. In absence of consolidated data it is difficult to identify poor performing areas and look for the trends in the utilization of different categories of maternal health services (HNPSP: MTR 2008: 17). Thus, planning and monitoring maternal health service became very difficult in the absence of compiled MIS data.

HNPSP had prioritized maternal health above all the reproductive health services. Wide expansion of maternal health services had been envisioned

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by it. However, it did not have any plan for human resource that would require providing expanded HNP services despite the fact that SIP had recognized the urgency of developing workforce for HNP sector. Workforce has been identified as a major problem in improving the maternal health situation by the mid term review of HNPSP. Problems related with workforce include absolute shortage of workforce, mal-distribution of the existing workforce, vacancies, absenteeism, poor accountability to the community, and compliance with professional standards (HNPSP MTR 2008: 14).

While there had been broadening in the services to be offered within the cluster of reproductive health, there was serious negligence at the policy level in ensuring continuous supply of the service providers. There had been marked inattention in recruitment of critical workforces for reproductive health services in the policy regime. Recruitment of FWVs in late seventies has contributed immensely in filling a critical gap of technical providers at the *Upazila l*evel and below. However, after 1997, for more than a decade there had been no recruitment of FWVs. No new recruitment coupled with retirement of many FWVs had created enormous shortage on this vital workforce for reproductive health. A total shortage of about 600 FWVs had been calculated by a study on workforce for health sector in Bangladesh (BHW 2008: 53). Such shortage of FWVs had seriously affected clinical contraception and MR services at the primary level. FWVTIs were lying vacant without rendering any training services (BHW 2008: 53). Training of MAs has also been neglected from the late nineties for about a decade. FWAs were also not recruited for more than a decade. SBA production has

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been considered grossly inadequate to increase skilled attendance at birth (BHW 2008: 53). All these factors had affected the availability and quality of reproductive health care services in the public sector health care facilities.

EmOC facility at the *Upazila* health facilities and district hospitals are not functional either because team of providers is not there, or the operation theatre is not functioning (HNPSP: MTR 2008: 15). Providing 24 hours EmOC services of acceptable quality at all levels is constrained by the acute shortage of midwifery skilled providers. It is very difficult to retain the trained team for EmOC in their designated position especially in rural areas (HNPSP: MTR 2008: 15).

Skilled attendance at birth is very less likely to get increased only through the existing SBA training programme. SBA training is constrained because the pool of eligible candidates for SBA training has almost been exhausted. There exists a pool of ageing FWAs and FWVs who do not meet the training criteria (HNPSP: MTR 2008: 14; HNPSP: APR 2009a: 59). Under this situation it has already been proposed by many studies to expand the SBA training by taking candidates from the private sector and also reassess the TBA training (HNPSP: APR 2009a: 143; BHW 2008: 61).

Violence as a maternal health issue has not been seriously dealt within reproductive health programme. While gender has been addressed as a cross cutting issue, very little progress has been made in this regard.

Nutrition has been hastily brought within the scope of HNPSP without any serious commitment towards it. Very little homework was done to

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appropriately integrate health, nutrition, and population programme. The title of the programme implementation plan had incorporated nutrition in it and thus, got changed into Health Nutrition Population Sector Programme. However, change in the title had not been complemented with any strategy or interventions for integrating nutrition into primary health care services. Nutrition was integrated to HNPSP halfheartedly only by brining projects under NNP within the purview of HNPSP without effective mechanism for mainstreaming with ESP and without effective mechanism for its regulation, monitoring, and coordination. Nutrition programme has been implemented with little linkage to other line directors. Contracting NGOs' operate maintaining little linkage with the mainstream health system and hardly any referrals from NNPs or other mobile clinics are managed or handled at the UHCs or district level hospitals. Hence, children with acute malnutrition are not managed or treated adequately.

ABCN services provided by NGOs and managed by NNP cover only 25 percent of the population. Scientific research has shown that community based nutrition programme needs at least 70-80 percent coverage to create any impact (Chowdhury and Osmani 2010: 211; HNPSP: APR 2009b: 157).

Concern has been expressed over the feasibility of expansion of nutritional intervention with this approach. It has been recommended that ABCN services delivered through the contracted NGOs should be considered as complementary to the mainstream public sector services and not as an alternative to the mainstream service provision (HNPSP: APR 2009a: 29).

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Nutrition interventions implemented by the health and family planning services have mixed results. Vitamin A supplementation has reached 88 percent of the population largely because it is delivered through the EPI programme. Iron Folic Acid (IFA) coverage is very low because it is delivered as part of antenatal care. Because of poor utilization of antenatal services, IFA supplementation coverage is also poor (HNPSP: APR 2009a: 29-33).

No initiative has been taken by HNPSP to develop the urban development strategy. Role of MoHFW and MoLGRD with respect to urban primary health services remained unclear. Urban primary health care particularly reproductive health care remained very scanty in spite of the fact that urban slum population is ever increasing specially in bigger metropolitan cities like Dhaka, Chittagong, Khulna.

Low utilization of curative services particularly by the poor remained very much a feature of health consumption pattern of the country. Lack of availability of drugs, services providers, quality of care, high and very uncertain out-of pocket expenditures remains the most frequently cited reasons for such low utilization particularly by the poorer people. It has been reported that about 35 percent of public health services by volume are used by the bottom wealth quintile, but they constitute only 14 percent of the utilization of curative care. Men benefit more than women in all the health service consumption except for reproductive health services particularly family planning services and this is more evident at the tertiary level care (HNPSP: APR 2009a: 5, 19, 48).

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It has been argued that HNP plans and programmes have become extremely donor driven and were prepared primarily by external consultations with little involvement of ministry working groups (White 2007: 466-67). This has resulted in lack of ownership among the programme managers and service providers. Successive annual programme reviews have found that many senior officers were not well aware of the basic programme documents. Many of them also did not recognize HNPSP as their core responsibility. Independent reviews of the programme suggest that programme suffers from poor management practices. Control measures are not enforced. Even though line directors are responsible for respective programme implementation, they are not held accountable for programme performance. Coordination meetings are poorly organized and not followed up regularly (Martinez 2008).

Ownership crisis of programme does not only result from lesser involvement in the policy or programme formulation process. It is also evoked when the service providers or programmes managers do not find or see clear link between their career progression and programme output and outcome. In absence of such clear link they only mechanically implement the programme without taking into account the spirit of the programme. There exists neither any incentive for better performance nor any penalty for poor performance and system of accountability on behalf of the service providers within the existing personnel management system. Thus, retention of the doctors and trained team for EmOC in the rural health facilities has become a real challenge for the government (HNPSP: MTR 2008: 174; HNPSP: APR

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2009b: 174). The regulatory bodies remained almost non-functional because of the poor governance relating to human resource management and regulation (HNPSP: APR 2009b: 174). The health professionals are reluctant to serve in the rural areas and are inclined to be placed in the large metropolitan cities for a variety of reasons; opportunity of professional advancement, better employment prospect, easy access to private practice, better institutional facilities etc. Further, studying medicine entails much more time, cost and labour. Therefore, doctors expect to be better paid in terms of salary and other benefits (BHW 2008: 25). It has been observed that incentive structure of the government has induced seeking project appointments (White 2007: 466-67). Government needs to redesign incentive structure to address this urban bias of health workforce especially the physicians.

Lack of ownership of the programme among the van guards of the programme had its serious logical consequences. Services remained far from being client centered, accessible, and equitable especially for the poor. Utilization of government HNP services deteriorated or stagnated. Poor quality of care has been repeatedly cited as a major barrier to use HNP services delivered by the government (HNPSP: APR 2009a: 5, 9).

Despite these programme challenges, Bangladesh has made remarkable improvements in fertility reduction, and maternal and child health in the last decade. Commendable progress has been made in child and infant mortality. Bangladesh is one of the 16 countries recognized to be on the track to achieve MDG 4 on child mortality by UNICEF (UNICEF 2008; UNICEF

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2010; NIPORT and *et. al.* 2012). There had been 60 percent decline in under-five mortality and 50 percent decline in infant mortality between 1989-93 and 2007-11. Twenty percent decline in infant, child, and under five mortality rates has been registered since 2007 (NIPORT and *et. al.* 2012: 24). Significant improvement in child and infant survival has been possible because of contributions made by the programmes for immunization, diarrhoeal diseases, and vitamin-A supplementation.

Bangladesh has been lagging behind in combating neo-natal mortality. It has been estimated by UNICEF (2010) that as high as 14 babies under one month die every hour in Bangladesh. Neonatal deaths constitute 57 percent of under-five mortality (NIPORT and *et. al.* 2009: 227). Neonatal death and health is very much affected by maternal health care throughout pregnancy, at child birth, and neo born care after child birth. Very low rate of simple neo natal care practice like, drying, and wrapping within 5 minutes of birth had been reported (NIPORT and *et. al.* 2009: 227). A study carried out by Baqui and *et. al.* (2008) on effect on community-based newborn-care intervention package in Sylhet in Bangladesh had demonstrated that simple home care techniques promotion strategy can reduce neonatal mortality even up to 34 percent. The significance of postnatal care by medically trained providers is very high for reduction of neonatal deaths. Similarly effective integration of neonatal care within maternal health services is urgently needed.

Maternal Mortality Survey 2010 has recorded a significant 40 percent decline in maternal mortality from 2001. It has gone down from 320 per

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100,000 live births in 2001 to 194 per 100,000 live births in 2010. Certainly this has been possible because of increased attention to maternal health. Crucial additions in maternal health interventions have also increased availability of maternal health services over the last decade. Decline in mortality has taken place in most of the reproductive age groups. Mortality decline from direct obstetric causes has been very significant and is indicative of improved access to obstetric care. Despite declines in hemorrhage and eclampsia, these two causes still account for fifty percent of maternal deaths. While there has been decline in abortion related maternal deaths from 5 percent in 2001 to 1 percent in 2010, postpartum maternal deaths constitute a large share being 67 percent (NIPORT 2011: 23-25). Thus, further decline in maternal mortality would require improvement in receiving postnatal care by medically trained personnel. The likelihood of receiving postnatal care by mothers within two days of child birth has been reported to be 27 percent in 2011 (NIPORT and *et. al.* 2012: 24).

Reduction in maternal mortality has been associated with improved maternal health seeking practice over the last decade. Antenatal care by medically trained providers has increased from 40 in 2001 to 54 percent in 2010 (NIPORT 2011: 31). Women making four antenatal visits have increased from 22 percent in 2007 to 26 percent in 2011 (NIPORT and *et. al.* 2012: 20). Maternal Voucher Scheme implemented in 33 *Upazillas* reported to have contributed in increased antenatal care visits (NIOPRT and *et. al.* 2009: 222). However, ironically Bangladesh Maternal Mortality Survey 2010 shows that only 1 in 3 women receiving antenatal services were given advice

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on danger signs. Thus, one of the main purposes of antenatal care has been neglected and severely affecting the maternal health care seeking and maternal health achievement.

Bangladesh Demographic and Health Survey (BDHS) had registered an upward trend in the percent of facility based delivery since 1993-94 (4 percent in 1993-94; 9 percent in 2004; 15 percent in 2007; and 29 percent in 2011). However, increase in facility based delivery has occurred more in non public sector than in public sector. Further, 2 percent of births at facilities were reported to be attended by untrained providers. Almost two folds increase in delivery by trained providers from 2001 to 2010 and five folds increase in delivery by C-section from 2001 to 2010 had been reported by Bangladesh Maternal Mortality Survey 2010. It had reported 52 percent of facility based deliveries by Caesarean-sections. Deliveries by Caesarean-sections rose to 60 percent in 2011 as reported by BDHS 2011.

While, women receiving complete maternity care including antenatal care, delivery care, and postnatal care have increased from 5 percent in 2001 to 19 percent in 2010, still little over 40 percent women did not receive any care (NIPORT 2011: 56-57). Moreover, maternal health care seeking shows wide disparity by wealth and education. Women from the top wealth quintile and women with secondary complete are almost six times more likely to give birth at the health facility than women in the lowest quintile and women with no education respectively (NIPORT and *et. al.* 2012: 21). Similar disparity exists in antenatal care across different subgroups of women on the basis of wealth, education, and residence (NIPORT and *et. al.* 2012: 20).

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Birth planning indicators still appear to be very poor. Very grim picture has been depicted about SBAs' contribution in skilled attendance at delivery in the communities where SBAs are present. Only 4.4 percent deliveries at home are reported to be attended by medically trained providers (NIPORT 2011:41) Increased skilled attendance at delivery has been mostly contributed by increase in facility based deliveries (NIPORT 2011: 73). Thus, a systemic review and strengthening of SBA programme has been recommended (NIPORT 2011:73). Strengthening the monitoring and supervision of SBAs and linking them with effective referral system is crucial for SBAs to be effective. Further, the number of SBAs is very inadequate to make any significant contribution.

Nutrition being the center of good health remained a far cry for majority. Malnutrition in Bangladesh is highly prevalent especially in women and children in Bangladesh. It remains one of the highest in the developing countries. Recent findings on children's nutrition status shows that 41 percent of children under five are stunned and 15 percent are severely stunned; 61 percent are wasted and 4 percent are severely wasted; thirty-six percent are underweight and 10 percent are severely under weight (NIPORT and *et. al.* 2012: 30-31). Wide wealth and divisional disparity exists in stunning (NIPORT and *et. al.* 2007: 146). Even though stunning for children under five years of age has come down from 51 percent in 2004 to 43 percent in 2007 and 41 percent in 2011, it is still far away from reaching the target of 25 percent by 2015.

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Impressive gains have been made in terms of fertility reduction across the groups. After a decade long plateauing in fertility at around 3.3 from 1993-94 to 2004 there has been a declining trend in fertility in each of the following periods. TFR came down from 3 in 2004 to 2.7 in 2007 and to 2.3 in 2011 (NIPORT and *et. al.* 2011: 7-8). It is encouraging that four out of seven divisions have already reached replacement level fertility. There had been impressive decline in TFR across the regions and groups. However, in view of the fact that target for achieving replacement level fertility has so far been shifted a number of times and the country has already failed to achieve the target many a times, there is little scope of complacence over fertility decline. Delay in reaching replacement level fertility by almost one and a half decade has serious implications on sustainable human development (Streatfield and Karar 2008). Sustaining this fertility decline is also important to bring down TFR below the replacement level to counteract the affect of population momentum. Promotion of responsible parenthood is important for sustained fertility reduction and protection of child rights.

The programme has been featured with high discontinuation of family planning methods and unmet need for family planning methods. Discontinuation for all methods had varied between 47 to 49 percent in 1993 to 2004. It had gone up to 57 percent in 2007 and then again went down to 36 percent in 2011 (NIPORT and *et. al.* 2012: 12-13). Side effects or other health concerns have all along been the most important reason for discontinuation. Unmet need for family planning had risen from 11 percent in 2004 to 17 percent in 2007. This rise in unmet need had occurred across

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all groups (NIPORT and et al, 2009: 91). However, in 2011 unmet need had again declined to 12 percent (NIPORT and *et. al.* 2012: 17). Therefore, discontinuation for all methods and unmet need for family planning had shown a declining trend after 2007. BDHS (2007) had reported that over two-thirds of births (71%) were planned, 15 percent were mistimed and 14 percent were unwanted. BDHS (2007) had calculated total wanted fertility rate being 1.9 children. Wanted fertility had been lower than replacement level fertility across all subgroups of women except for women in Chittagong, Sylhet, and women in the lowest wealth quintile. Total wanted fertility being 30 percent lower than TFR of 2.7 implies if all unwanted fertility could have been averted total fertility rate would have been 2.1 by 2007 (NIPORT and *et. al.* 2009: 98; 16). The findings by BDHS show a major change in attitude among women with respect to their desire for children. As high as 57 and 59 percent of women expressed that they did not want any more children in 2007 and 2011 respectively (NIPORT and *et. al.* 2012: 16). The family planning programme requires meeting this demand for fertility control, focusing on quality of care without employing any strategy that undermines women's reproductive health. Thus, family planning programme in Bangladesh has achieved a position to shift its primary goal from fertility control to wanted fertility control. This large percent of women's desire for fertility control gives family planning services the scope to operate for promoting reproductive health. Facilitating their fertility control will also lead to replacement level fertility. Further, promotion of responsible parenthood will also contribute to fertility reduction and protection of child rights.

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There remains high reliance on the temporary methods of contraception and a declining trend in the use of longer acting and permanent method after 1991 (NIPORT and *et. al.* 2012: 12; 2007: 63; 2004: 67). High reliance on temporary methods of contraception is argued to be inefficient in a society where very early marriage is highly prevalent and most women complete their child bearing in their mid-twenties. Thus, women completing their child bearing within mid-twenties and relying on temporary methods are exposed to the risk of unwanted fertility for twenty more years (Streatfield and Karar 2008: 271). This applies more for women in the lowest wealth quintiles, women with no education, and women with primary level education. Unwanted fertility remains highest for these groups of women (NIPORT and *et. al.* 2009: 98). While unmet need and unwanted fertility reduction is the central concern of family planning services as a means to achieve reproductive health, promotion of sterilization, and longer acting methods on the justification of deterring unplanned fertility in no way should compromise women's health and their choice. It implies that universal promotion of any particular family planning method, even if proves efficient to control unwanted fertility given the very high early marriage pattern of the country, has possibilities of compromising and undermining women's health and choice without having installed adequately skilled and motivated workforce and appropriate screening for contraindications.

Adolescent marriage and fertility still remains one of the highest in the world. Substantial investment in female education including stipend

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programme for female could not bring a dent in very early age at marriage. The median age at marriage has increased from 14.2 years in 1996-97 to is 15.3 years in 2007 (NIPORT and *et. al.* 2009: 78). BDHS 2007 shows two in every three women marry before their legal age for marriage i.e., 18 years and one-third of women start child bearing before they reach 20 years of age. Twenty-seven percent of teenagers reported to have given birth and six percent were reported to be pregnant with first child (NIPORT and *et. al.* 2009: 56). Adolescent fertility has severe implications on maternal and child health. Childhood mortality tends to be the highest among children born to the youngest age groups (NIPORT and *et. al.* 2009: 105). It has been estimated on the basis of current fertility rates that women will have 25 percent of their child birth before they reach 20 years age (NIPORT and *et. al.* 2012: 7). This estimation on early child bearing has important implications for maternal health and fertility reduction. Early marriage and early child bearing can hardly be curbed by the policy and programme interventions of MoHFW alone. All the sectors will have to be involved in taking a holistic approach towards addressing this issue. Multisectoral IEC strategy is crucial for social mobilization against early marriage and early child bearing.

5.5 Summary and Assessment

HNPSP had taken an ambiguous position about family planning services. It had not focused family planning services in outlining its reproductive health programme objectives and strategies at the outset. Family planning services had not been appropriately established as a means to contribute towards

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universal access to reproductive health services for improved maternal health as was envisaged by the MDGs.

Family planning programme strategy continued to focus on increasing longer acting methods and incentives for the providers and clients for sterilization. It had not reflected on population policy in designing family planning services. This policy regime had reflected similar contradictions within its framework as those were in the reformist reproductive health regime. It had not repositioned family planning services within its reproductive health framework. Family planning services continued to be viewed as a means to fertility reduction. Thus, family planning services had not been established as reproductive health. Similarly PRSP had also compartmentalized family planning services within fertility reduction and could not establish it as human development agenda.

This policy regime continued to assert maternal health as the most important reproductive health. Expansion and strengthening of basic and comprehensive EmOC care facilities has been at the center of the programme focus to complement community based maternal health interventions. Multilayered maternal health interventions had been taken to improve maternal health situation in line with the maternal health strategy. However, inadequate availability of workforce remained a major challenge in the way to making maternal health facilities fully functional. SBAs has not been effective in increasing skilled attendance at birth largely in absence of effective supervision, monitoring, and referral system. Maternal nutrition and violence as maternal health issues were not adequately addressed.

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National Nutrition Programme largely remained a vertical programme having little scope of integration with the mainstream maternal health programme.

HNPSP as the thematic successor of HPSP had retained the reproductive health programme design. However, the reforms envisaged by HPSP were abandoned by HNPSP. At the backdrop of reinstating separate management structure for health and family planning, this regime had effectively weakened the foundation of its reproductive health services. This regime has assumed a contrasting position with respect to its reproductive health programme design and implementation strategy for reproductive health. Health and family planning directorate continued to function in their conventional vertical structure and delivery of reproductive health services got split into the two structures. Contradiction between reproductive health programme design and its management structure have brought many of the reproductive health care services in a dwindling position. Family planning services are implemented under the management of respective Line Directors located in DGFP without any linkage with the Line Director, ESD or any other relevant Line Director in DGHS. Similarly, maternal health services provided by the two directorates are also not coordinated. Hence, hardly any linkage exists between family planning and maternal health services. This weakening of the linkage has lessened the efficacy of both the services. Further, this arrangement has been a source of misuse of human and other resources.

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Increased attention to maternal health after FP-MCH policy regime has brought significant achievement in maternal mortality decline, and demonstrated how policy attention makes great difference in improving health and meeting health goals. However, this achievement is yet to address disparity across different groups. There remains wide disparity on the basis of wealth and education in maternal health seeking practice. Further, increase in facility based delivery has largely occurred in the non-public sector. Increase in skilled attendance at birth has happened due to increase in facility based delivery. SBAs so far have hardly made any contribution in skilled attendance at birth.

It is encouraging that fertility declining trend has continued since 2004 and it is near to replacement level fertility, however, fertility reduction target to replacement level could not be met many a times. This delay in reaching replacement level fertility has serious implications for development of the country as a whole. BDHS 2007 has shown that only by targeting the unmet need for family planning services, the country could have already achieved replacement level fertility. Unmet need for family planning remains a challenge in the way to achieving both reproductive health as well as replacement level fertility. Similarly recent findings show that 59 percent of women had expressed their desire for fertility control. It implies that family planning programme should focus on this group of women in need for controlling fertility and thus, achieve both reproductive health and replacement level fertility.

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Early marriage has been one of the most daunting reproductive health concerns of the country having implications for fertility decline and maternal health. Cross-sectoral collaboration is crucial in addressing such an important reproductive health issue. Urban primary health care is very inadequate in terms of quantity and quality to address reproductive health needs of the ever growing urban slum population. This poses a serious challenge in increasing the availability of maternal health and family planning services for urban poor. HNPSP could hardly make any progress with respect to giving any future direction for urban health care. Governance issues particularly relating human resources and other necessary supplies continue to retard the performance of the entire sector including reproductive health programme. Future programme achievements would largely depend on: combating early marriage and early child bearing with the involvement of all the sectors; ensuring availability of reproductive health services for the poor urban population; controlling unwanted fertility; reducing method failures; integrating all the reproductive health services; and addressing governance issues particularly with respect to human resource and necessary supplies those inhibit availability and quality of the services.

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Chapter 6

Contemporary Policy Issues and Programme Implementation Challenges: An Analysis of Views and Opinions of the Policy Actors

In the preceding three chapters the development of the policy discourse has been detailed and analyzed. This chapter aims to explore and evaluate the opinions and views of the policy actors on key policy issues those have emerged in the course of policy analysis of the three policy regimes. Their views and opinions have been sought on contemporary issues of reproductive health services in general and family planning and maternal health services in particular including: efficacy of the contemporary programme strategies and programme design; management structure for programme implementation; human resource challenges; governance issues; strengths and weaknesses of the programme; and future directions for the programme.

In-depth interviews were held with two categories of policy actors i.e., state actors or insiders and non-state actors.[1] State actors were drawn from the insiders of health services and family planning services. They included top to mid ranking officials of DGHS and DGFP for guiding, directing, monitoring, and implementing the reproductive health programme of the government.

[1] For details see chapter 1, pp. 12-14.

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The second group is called non-state policy actors. They were drawn from a range of external stakeholders of the policies and programmes relating to reproductive health. Non state-actors included academia, researchers and professionals contributing in the area of reproductive health outside the state machinery. They are not employed in or do not directly work for the government's health sector. They are key persons who have been actively involved in providing input and support for policy process or have been involved in bargaining with the government in the policy process in various capacities. This group excludes representatives from donors. In-depth interviews were held with a total number of 25 non-state policy actors.[2]

6.1 Major Policy Issues

Opinions of the policy actors have been sought on major policy issues those have emerged in the policy discourse of the three policy regimes.[3] Following policy issues have been discussed at length with different categories of policy actors.

6.1.1 Family Planning Services

In the present policy regime family planning has been subsumed under reproductive health care component of essential services delivery. This repositioning of the family planning programme requires substantive change in the programme strategy and interventions, and effective linkage with other components of reproductive health.

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[2] See chapter 1, p. 14.

[3] Policy discourse in the three policy regimes have been analyzed in chapters 3, 4, and 5.

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It has been opined by all the policy actors that the family planning programme has lost its momentum in the reproductive health policy regime. Most policy actors have expressed their concern over slacking of family planning programme in the reproductive health regime. However, their opinion had differed by their category on ascribing reasons for slacking of the programme.

Majority non-state actors and state actors belonging to the family planning directorate have attributed this slacking of family planning programme to lack of attention at the policy level. On the other hand, state actors of health directorate have linked it with the internal conflict within the family planning directorate. They have stated that this conflict had its root in the recruitment of officials under varied arrangements i.e., cadre, non cadre. Some have mentioned that recruitment of physicians for family planning directorate had also contributed in this conflict of interest. All these categories of staff had turned into different interest groups leading to conflicting professional claims. Conflict among the cadre and non cadre officials, physicians and non physicians have mounted over the periods and caused serious debacle of the programme. These internal discords have generated conflicting claims over seniority. Hence, government has been appointing persons from administrative cadre in the key positions of the programme. It has been opined by most policy actors that most of these people severely lack professional competence and commitment to lead the programme and also do not take any stake for the development of the programme. Some of them enjoy the privilege of the positions without making any substantive contribution to the programme.

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However, almost all the policy actors unanimously recognized serious lacking of political commitment for the programme. They opine if government had commitment for strengthening family planning programme, then government would have taken effective measures to resolve the conflict among different categories of officials of the family planning directorate rather than running the programme on *ad hoc* measures by appointing people from administration cadre. Political commitment demands development of the programme on long term vision rather than giving temporary solution to the problem. In this connection some have pointed out that many of the DGFP who had given very successful leadership to the programme in the eighties were appointed from outside the family planning services. However, they were motivated to give efficient leadership for the growth of the programme because there was strong commitment for the programme from the highest policy making level of the government. In other words, when programme leaders feel that the programme is not a priority for the government they do not get encouraged or motivated to involve them in the programme development and thus, run the programme without any commitment. Hence, lack of political commitment has been identified as one of the most important reasons for slacking of the programme across the board, except for the policy makers.

Most of the non-state actors have opined, role and function of family planning programme within the reproductive health framework was not clearly defined and left hanging in between reproductive health and fertility reduction. The programme was not appropriately linked with other

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reproductive health services. Even though programme had targeted achieving replacement level fertility by 2010, adequate measures were not taken to attain that goal. Programme strategies remained the same for the entire country. No special strategy was formulated for low performing areas, underserved population, and geographically hard to reach population. This has been considered as the failure of the government to comprehend the consequence of population growth in all respect. Most of the external policy actors and all state actors from family planning are of the view that dominance of the physicians at the policy level has resulted in the neglect of the family planning programme.

Role of fertility reduction in improving maternal health situation has been emphasized by everybody. Thus, every body except few policy makers has opined the need for a robust family planning programme for fertility reduction as well as maternal health improvement of the country. However, a few policy makers were of the view that in near future, with the accelerated economic growth of the country and increased opportunity for women in the job market, further changes will occur in the fertility behaviour, and thus, eventually the need for a big family planning programme would diminish. Thus, they were not in favour of pouring more resources into further expansion of the programme and add to its workforce.

6.1.2 Maternal Health Services

All the policy actors have unanimously acknowledged that reproductive health policy regime had given attention to maternal health more than ever before. They have lauded the policy regime for broadening its programme

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arena through focusing on EmOC and spreading out EmOC down to the district and *Upazila* (sub-district) level facilities from the specialized hospitals.

Nevertheless, almost all the policy actors were of the opinion that implementation of maternal health programme had suffered most because of lack of adequate measures for ensuring adequate availability of the service providers. Lack of availability of the service providers has been identified as the most important reason for lack of availability of the maternal health services, particularly EmOC at the *Upazila* (sub-district) level. Insiders have also mentioned lack of technical readiness of the facilities as an impediment in provisioning EmOC.

Lack of policy measures for ensuring retention of the service providers in the rural areas have been mentioned as a reason for scarcity of service providers by almost all. Most insiders have mentioned lack of motivation of the service providers as one of the most important reasons for inadequate availability of service providers and poor quality of services. They have accused politicization of promotion and transfer etc. for lack of professional commitment among the service providers.

About demand side intervention, MHVS, most of the policy actors opine, maternal voucher scheme strategy can yield desired outcome, provided health facilities offering EmOC are fully functional and within the physical proximity of pregnant mothers' household. Thus, they consider MHVS can significantly improve maternal health if EmOC facilities at the *Upazila* (sub-

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district) health complexes are made available. However, lack of built-in quality assurance mechanism within MHVS has been identified as one of the major weaknesses of this demand based intervention. State-actors have opined that incentives introduced for the providers under MHVS would be a motivator for the providers to effectively implement the scheme. Some policy actors including some state-actors have opined that incentives introduced under this scheme should only be applicable to hard to reach areas. Most of the non-state actors have opined that incentives for the providers should be integrated within the career development plan. Nevertheless, many policy actors including the policy makers have expressed their concern on the sustainability of such donor financed demand based intervention, particularly if scaled up nationally.

Mixed opinion came in about SBA intervention for safe home delivery. Most of the state-actors from DGFP except the physicians and some externals have stressed on increasing the number of SBAs. They are of the opinion that until percentage of institutional delivery reaches a level, SBAs are required to facilitate safe home delivery. Few non-state policy actors opined that in view of the very limited availability of the SBAs at the field level, revival of training for TBAs could be reconsidered.

On the other hand, most physicians from the state-actors and majority non-state actors have considered that maternal health programme should focus on institutional delivery rather than spending resources on safe home delivery through SBAs. In this connection, they have emphasized on strengthening union level facilities for basic EmOC so as to increase physical accessibility

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to EmOC. In fact everybody recognized the need of strengthening the union level facilities irrespective of their opinion about SBAs. Similarly, almost all the policy actors have emphasized on the need of strengthening, monitoring, and supervision of the work of SBAs at the field level.

6.1.3 Participation in Health and Population Sector

Multisectoral approach was one of the key features of the family planning programme in FP-MCH policy regime. However, the multisectoral programme activities were discontinued with the onset of reproductive health regime and sector wide approach. Population policy 2004, had elaborated on other ministries' role in implementing population activities. HNPSP being programme implementation plan did not incorporate population policy prescription for multisectoral interventions. Nevertheless, it had been recognized by HNPSP that issue of age at marriage or empowerment of women which have serious implication for reproductive health cannot be addressed by the programme interventions of the health and poplulation sector alone. However, there has been no scope for cross-sectoral collaboration or inter-sectoral collaboration for any of the programme interventions or activities in the programme implementation plan.

Sector wide approach calls for shifting from narrow project approach towards broader programme approach and demands for looking at sectoral issues from broad sector wide spectrum. This broader view at the sectoral issues requires looking at the linkages beyond the sector and thus, requires

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creating linkages with other sectors at some points. However, in the present sector wide programme approach, scope for any other sectors' participation in reproductive health programme has been missing totally. This has been considered a major weakness of the plan document by majority policy actors because reproductive health care seeking and fertility behaviour are the outcome of complex interplay of various factors and thus, not contingent only on the health and population sector's interventions. It was recognized that effective integration of other sectors could significantly contribute in generating demand for reproductive health and improving the programme outcome. The need for cross-sectoral collaboration has been very much emphasized by almost all policy actors particularly for combating issues like early marriage, malnutrition, violence on women etc. Hence, confining to single sector intervention in the name of SWAp has been considered a major conceptual mistake by majority policy actors except for few policy makers. It has been opined that platform for participation by other sectors in the promotion of reproductive health got severely damaged for leaving no scope for cross sectoral collaboration within the sectoral plans.

However, few policy makers opine intersectoral interventions or multisectoral interventions do not necessarily contribute in effective demand generation for reproductive health services. Measuring the impact of intersectoral and multisectoral interventions was considered difficult by them. Further, implementation of such interventions was also claimed to be challenging because of difficulty in establishing ownership to these

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interventions and coordination of these programmes. Some policy makers have commented that if all social sectors perform well independently then automatically that would contribute positively in attaining health and population sector goals. Thus, there is no need of intersectoral or multisectoral collaboration for achieving the goals of health and population sector. They were of the opinion that interventions like stipend programme for female students has its impact on health and population programme without involving multi-sectors.

6.1.4 Behaviour Change Communication Activities and Demand Generation

Information Education Communication (IEC) activities had been one of the principal strategies of the family planning programme of Bangladesh for demand generation of family planning services in FP-MCH policy regime. The growth of the family planning programme in Bangladesh and its achievements were largely attributed to the IEC activities of IEM unit by almost all the policy actors. Eventually, IEC activities got changed into Behaviour Change Communication (BCC) activities. In the reproductive health policy regimes, BCC has been recognized as a crosscutting issue by the plan documents. However, majority policy actors opine BCC had not been made adequately active in demand creation for reproductive health services even though the plan document had sufficiently emphasized on BCC. Role of BCC in creating informational accessibility of people has been considered even more insufficient. Content of BCC has also been considered much less than effective in creating informational accessibility particularly

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on the types of reproductive health services available at different health centers. BCC is not adequately targeted for different age groups of population. Slacking of BCC has been largely viewed by majority policy actors as a crisis of professionalism within IEM and HEB of DGFP and DGHS respectively. Little scope of professional growth for the programme managers has largely been held responsible for this crisis of professionalism. It has been urged that BCC programme should revitalize its activities to meet the need of the time and create effective demand generation and informational accessibility for broader health. Most of the policy actors have also urged on the role of BCC with respect to social mobilization against early marriage, early child bearing, violence, and dowry.

Media campaign for BCC has been considered very weak by majority policy actors. Participation of private channels for BCC activities was considered very low. However, programme leaders and programme managers of IEM unit of family planning directorate and HEB of health directorate reported that they did not have sufficient fund for airing programme in the private channels. Bangladesh Television and Radio Bangladesh reported to have the same allocation of air time for BCC activities as before. However, they have informed that time slot given for BCC in both Bangladesh Television and Radio Bangladesh has changed. Programmes are aired generally at the time when most people remain at work in the morning. In this connection most policy actors have urged the necessity of building corporate social responsibility by the government for sponsoring BCC activities by the private channels. Involvement of other business houses in sponsoring BCC

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activities in the television and radio have also been suggested by all categories of policy actors. Most policy actors have urged that BCC programme should revitalize its activities to meet the need of the time and create effective demand generation.

However, programme managers of IEM unit of family planning services were of the opinion that demand generation activities had played their due role in creating demand generation for contraceptives. Now timely and adequate supply of the contraceptives is most critical for reaching replacement level fertility. They have opined that replacement level fertility could not be achieved because timely and adequate supply of contraceptives had been hampered due to severe scarcity of manpower and poor monitoring and supervision. In this connection, they have added that scarcity of manpower, poor monitoring, and supervision are linked to lack of political commitment for the programme.

6.1.5 Management and Implementation Structure

Shift from FP-MCH based programme to reproductive health had been initiated to increase the efficacy of the family planning programme through broadening the scope of the programme and making it enable to address the broader reproductive health need rather than narrow contraceptive need. With the shift towards reproductive health, government had conceived unification of health and family planning as one of the reform agenda of the health and population sector in 1998. Unified structure of health and family planning programme had been considered compatible for the package primary health care service both by the government and the donors.

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However, unification of health and family planning could not be implemented and was overturned. After the failure of unification, health and family planning was again brought back under separate management structure as it had been operating before. Thus, at present health and family planning have been operating almost like two vertical programmes within the ministry of health and family welfare.

Essential services were designed as a package service for primary health care. Package services need to have inter-linkage. Vertical delivery of the different components of a package service does not uphold the spirit of the package service and weakens the efficacy of the services in many ways. However, this issue has not received due attention from the subsequent governments. The design of the reproductive health programme within the essential services package was made with the vision of the unified structure of health and family planning. However, this overturning of structure was not followed by the changes in the entire programme design. After dismantling of the unification process, posts of the directors within DGHS and DGFP were made into line directors for the relevant operational plans. However, there hardly exists any mechanism for coordination between the Line Directors of the DGHS and Line Directors of DGFP for implementation of reproductive health services.

Almost all the policy actors opine provisioning of interrelated reproductive health care services by the two vertical programmes has been challenging. Effective linkage has not been established between and among the reproductive health services. Maternal health services are not appropriately

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linked with the family planning services and vice versa. This linkage gets even more difficult because of the existing non cooperation between health and family planning. This de-linking of the services has been considered as a major weakness of the policy and programme by most of the policy actors. Majority of the non-state actors recognized the urgency of creating effective linkages between health and family planning services for both fertility reduction and maternal health promotion.

On the other hand, while the two wings have been operating like vertical programmes, they deliver many similar services at the facility and domiciliary level. Maternal health services are provided by both the directorate of health and the directorate of family planning. Field workers of both departments are visiting the same households. Most policy actors, in particular non-state policy actors and state-actors from health services consider this arrangement as a source of duplication and conflict between the directorate of health and the directorate of family planning. Further, this has also added to the already acute crisis of workforce. Acute shortage of obstetricians and anesthetists providing EmOC at the district level get even more acute when they are divided between MCWCs under the management of DGFP and district hospitals under the management of DGHS.

However, amongst the policy actors, most of the state actors of family planning except some physicians held different opinion about the whole issue. State actors of family planning directorate consider delivery of reproductive health services under separate management structure do not

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create any problem. In their view, family planning gets diffused under the unified structure. To them unification implies "deemphasizing of family planning services" and accordingly "degradation of family planning professionals and staff". Many programme managers of the family planning department opine that parallel provision of maternal health services delivery by the directorate of health services and directorate of family planning does not create duplication because there remains acute shortage of maternal health services at all levels. They also claim that maternal health services are much better delivered at the facilities under the management of family planning directorate than those under the management of the directorate of health services. In this connection they have mentioned the pioneering role of the directorate of family planning with the assistance of UNFPA in expansion of EmOC services up from the specialized hospitals down to the district level hospitals through initiating EmOC in the district level MCWCs in 1994. Thus, they establish their legacy in expansion and decentralization of maternal health services.

Nevertheless, majority policy actors were of the opinion of bringing changes in the organizational structure. They consider incompatibility between the management structure and the programme design had put reproductive health care services in a dwindling position. They opine either the reproductive health programme design should be made compatible to the organization structure or the organization structure should be made compatible with the reproductive health programme.

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6.1.6 Integration of Nutrition Programme

Almost all the plan documents have had acknowledged the urgency of addressing malnutrition. However, actually no effective measures were taken to address this vital health issue. Even though all the successive plans have had urged on the necessity of establishment of nutrition unit in the UHCs, it was never carried through seriously. Thus, treatment of malnutrition at the primary care level remained severely neglected. Nevertheless, a number of programme interventions were integrated for prevention and control of malnutrition within the MCH programme. These interventions included vitamin-A supplementation as an anti-night blindness intervention and distribution of iron tablets to address anemia, and distribution of iodine salt to address iodine deficiency. These preventive interventions integrated within MCH services have been quite successful in reaching their intended goal. However, except these specific limited interventions, malnutrition at large and maternal and child nutrition in particular remained a much neglected area in all policy regimes.

Majority policy actors have considered malnutrition as much more complex health outcome than just lack of food. They have recognized malnutrition as an outcome of poor food habit, cooking pattern, sanitation, hygiene etc. Therefore, they have opined that addressing malnutrition needed cross-sectoral interventions. Most of the policy actors have stated that the national nutrition programme that has been brought within the scope of HNPSP had limited success largely because it was designed as a vertical programme in HNPSP. OP of nutrition programme under HNPSP was housed in MoHFW. In HNPSP where issue of nutrition was expected to come to the forefront of

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the programme, nutrition programme needed to be appropriately integrated with reproductive health programme. Majority policy actors consider that nutrition programme was not appropriately designed to creating linkage with reproductive health services at the primary care level. Almost all the policy actors opined nutrition programme for mothers and children should be appropriately integrated with primary health care and health and family planning directorate should have much more defined and clear role in the management of nutrition programme. In this connection, they have also emphasized on strengthening the monitoring of the activities of the contracting NGOs.

6.1.7 Human Resource Challenges

Human resource has been considered one of the most daunting challenges of reproductive health programme of the country by almost all categories of policy actors. As had been reported by the state actors, maternal health and family planning service delivery have been severely disrupted due to inadequate availability of community and facility level service providers and programme managers. It has been reported by all the district level heads of DGHS and DGFP that very high number of vacancy for the sanctioned posts is the most important reason for inadequate availability of service and very weak monitoring and supervision of the programme. Further, inequal distribution has been reported as one of the important reasons for inadequate availability of the physicians. On the other hand, no recruitment of field forces for a long period has been cited as the most important reason for their shortage, particularly FWAs or SBAs and FWVs.

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Almost all the state actors have reported that due to acute shortage of physicians, EmOC service is not available even at the district level for twenty-four hours. In each MCWC there is only one team of obstetrician and gynecologist, and therefore, one team cannot provide twenty-four hours service. Thus, in most of the MCWCs, EmOC service is available until afternoon. Similarly domiciliary service and clinical contraception service delivery has also been disrupted because of inadequate availability of physicians and paraprofessionals and field workers.

This shortage of human resource under various categories has been considered by the policy actors as an outcome of the absence of any system of future demand forecast for manpower. Thus, recruitment of workforce has never been based on demand forecast. All the programme leaders have pointed out that political commitment of the present government for making a 'digital Bangladesh' did not get reflected by any policy move of the ministry towards evolving a digitized forecast system for manpower of all categories. Almost all the policy actors except the policy makers have stated that mass scale recruitment of the field force at one go after almost one and a half decade reflects virtual absence of any human resource plan of the government. Recruitment of all categories of workforce should be an on going process on the basis of demand forecast of the programme.

Absence of any transparent career development plan has been cited as one of the most important reasons for inadequate availability of the service providers. Absence of any transparent career development plan for human

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resource has been linked with the de-motivation and lack of accountability among the workforce. It has been opined that recruitment, placement, and promotion have hardly any connection with the performance of the service providers and managers. This has resulted in inadequate availability and poor performance of the service providers, and poor monitoring and supervision of the programme.

Most policy actors opined that unless and until government can establish a transparent career development plan towards opening equitable opportunity of career development for all, availability of service providers and programme managers is less likely to be ensured. Most of the physicians have reported that placement of the physicians were made solely on the basis of political consideration. They have added that people with strong political link always manage to get desirable placements or postings. Further, there is no career incentive for serving in the remote areas even though it has been explicitly recognized by the maternal health strategy of the country. Thus, physicians are always reluctant to remain in the remote areas. They opt to be posted in the larger districts and cities because of wider scope of private practice.

Politicization of public office by the successive governments and narrow interest of the vested professional groups within the service have been identified as barriers in the way to evolving transparent career development plan for the human resource in the public office by almost all categories of the policy actors.

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6.1.8 Urban Poor

Almost all the policy actors have stated that very little attention has been paid at the policy level to meet the primary health care demand of the ever increasing urban population of the country. It was unanimously agreed that without due policy attention to urban health and family planning programme, health and demographic goals of the country would not be achieved. This has been considered true particularly for urban slum population. Very inadequate access to primary health care in the urban population will have serious consequences in terms of the demographic and health outcome.

Further, they have added that because of lack of availability of primary health care at the urban places, people crowd at the secondary level district hospitals for primary health care. This over crowding at the district level facilities deteriorates the quality of the reproductive health care services. Thus, everybody urged the necessity of increasing the availability of health and family planning services for urban poor.

However, policy actors were divided on the issue of the authority of urban primary health care service delivery. All the insiders have opined that since MoHFW is ultimately held accountable for health indicators of the country, urban primary health care service should be the mandate of the MoHFW. They have added that Ministry of Local Government does not have the infrastructure or manpower to provide or supervise health services.

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External policy actors were divided on the issue of the authority of providing urban primary health care. Some external policy actors held views similar to those of the insiders for similar reasons. However, some opine urban primary health care should be the mandate of City Corporations. They consider MoHFW is already overburdened with their work and therefore, has not been able to make primary health care services adequately available in the rural areas. Further, they consider local government is in a better position to make health care service providers more accountable for their services. Nevertheless, they have mentioned that contracting out of services to the private sector and NGOs is very less likely to yield desired outcome in absence of standardization of services, training of the service providers and strict monitoring, and supervision of the programme. They have recognized the weaknesses of the City Corporations in all these respects and therefore, stressed on strengthening their management capacity for efficient management of the urban primary health care programme.

However, all the policy actors opine that whoever holds the authority for provisioning urban primary health care services, the greatest need is to increase the availability of the services, ensure quality supervision and monitoring of the work of the implementing organizations and standardization of the services.

6.1.9 Unmet Demand

Most policy actors opine, meeting unmet demand for family planning is the real challenge of the programme because only by meeting the existing

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demand for family planning services for fertility regulation, the country's demographic goal as well as reproductive health goal can be achieved. Therefore, ensuring timely uninterrupted delivery of family planning services is critical for the family planning programme. Most of the policy actors have expressed their concern for not taking adequate policy measures to address this demand of the programme. Almost all the policy actors have stated that programme strategy and design should differ on the basis of their geographic location, cultural and religious orientation, and programme performance level. Majority policy actors opine very little has been done towards taking special measures to smooth out the supply chain for delivery of family planning services in the areas where unmet need and unwanted fertility is higher. This has been considered a major concern for the programme by almost all the policy actors. However, some policy makers have reported that there were incentives for all categories of workforce serving in the Hill Tracks and *Haor* area. Further, they have mentioned that recently government has already taken a number of initiatives to address unmet need for family planning services, like, increase in the transportation cost for inaccessible areas, mapping out hard to reach areas of the country, and mass scale recruitment of workforce.

6.1.10 Community Clinics

Community clinics at the village levels were initiated in 1998 under HPSP to increase the physical accessibility of people to preventive health services, limited curative care, and family planning services. Community clinics were

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intended to gradually replace the domiciliary services. However, as soon as the new government was formed by the Bangladesh Nationalist Party in 2001, domiciliary services were reinstated and ten thousand community clinics established earlier were not made of any use. Thus, construction of new community clinics was stopped and the existing ones were lying vacant.

About discontinuation of community clinics mixed opinion came in. Some opined discontinuation of community clinic was a logical decision in the backdrop of reinstating domiciliary services. However, they have stated that clinics those were already constructed ought to have been made of use. Others opined discontinuation of community clinic was 'political motivated' and reflective of antagonistic political culture of the country.

However, reactivating the community clinics was one of the political manifestoes of the Awami League in the ninth parliamentary election held in 2008. Therefore, after a landslide victory in 2008, the new government formed by Awami League has given top most priority to reactivate the already existing community clinics and establish the new community clinics for every 6000 population at the village level.

Varied opinions came in about establishing new community clinics by different categories of the policy actors. All the policy makers and some insiders have opined that community clinics for every 6000 population would immensely contribute to increase the physical accessibility to the primary health services including reproductive health care. They have stated that community clinics were imbued with the concept of people's

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participation. It had emerged as a community owned and managed health facility. Community groups formed with representatives from local government representatives, service providers and local people were to be responsible for the operation and maintenance of the facility.

However, most state actors from family planning have expressed their concern about the already stressed out domiciliary service. They have stated that spending three days in the community clinics by the field workers would strain the already short supply of field workforce and would deter the quality of domiciliary services.

Majority non-state policy actors have termed restoration of community clinics as a 'political agenda'. They have stated that community clinics were initiated in 1998 when domiciliary service was planned to be phased out. That situation does not prevail any more. Therefore, before giving enough attention to strengthening the already existing union level facilities, establishment of another level of facility is considered wastage of resource by many. Many of them have termed this initiative of the government as "addition of a sick child to an already sick family". They have emphasized on taking measures for making the union level facilities more functional before creating another new layer of facility. In their opinion, union level facilities should be good enough to increase the physical accessibility to the essential health services if proper measures can be taken to ensure availability of the service providers, drugs, and improve the quality of care. Some policy actors have voiced for the emergency of creating hospital facility particularly basic EmOC facility at the union level by upgrading

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them rather than spending resources on constructing more new facilities. Nevertheless, almost all the policy actors irrespective of their opinion about community clinics have expressed the urgency of strengthening the union level facilities particularly upgrading them with basic EmOC facilities.

Nevertheless, almost all categories of policy actors irrespective of their opinion about establishing community clinics were doubtful about the sustainability of the community clinics because of the existing antagonistic political culture of the country. Thus, almost all have expressed their concern about possible of wastage of national resource.

6.1.11 Responsiveness of the Service Providers

All the policy actors have recognized the need of evolving some mechanism for making health care providers responsive to their clients. Most of them have agreed that without effective existence of such mechanisms, service providers remain responsive only to their direct supervisors and policy makers, and not to their clients.

Almost all the policy actors have opined that empowering clients through providing adequate information about the services and their right to services is one of the most effective ways to make the service providers responsive to their clients. However, they have stated that adequate programme attention has not been given to empower people through dissemination of information about entitlement to various health services at different levels of facilities. Further, majority policy actors also recognized the urgency of linking professional growth of the providers and managers with their job

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performance for increasing their responsiveness. Otherwise all other mechanism for promoting responsiveness would fail.

While almost all the non-state policy actors have recognized strengthening local government bodies as one of the very effective means to ensure responsiveness of the service providers, the state actors did not emphasize on this much. Rather some of the state actors have mentioned that this could rather be another source of conflict. Many state actors have mentioned that local government bodies' representation is already there in different levels of health and family planning committees. Thus, they have emphasized on reactivating various level health and family planning committees and activating *Union Parishad* and *Upazila Parishad* chairmen and members in these committees.

Some have considered community mobilization as an effective mechanism for ensuring accountability of the service providers. Thus, they have lauded formation of community groups as a mechanism for ensuring community participation for managing the community clinics. Some programme managers have opined that responsiveness of the service providers cannot be separated from the responsiveness of the highest policy making level. They opine policy making level should be responsive to the demand of the service providers because a responsive management system and structure can only yield responsive service.

6.2 Strengths and Weaknesses of the Reproductive Health Programme

Opinion on the strengths and weaknesses of reproductive health programme did not vary much among different categories of policy actors. Network of

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infrastructure down to the village level as well as extensive field force for outreach service has been considered the most important strength of the programme by all the policy actors. Further, evidence based success of many of our health and family planning programme interventions has also been considered a major strength of our programme by many policy actors. Some have stated that our transition to a more supportive socio cultural environment where resistance to programme implementation by any social group remains minimal is a major strength of our programme.

Absence of human resource plan and transparent career development policy and politicization of public office have been considered the most important weaknesses of the programme by almost all the policy actors. Most external policy actors and state actors of family planning have mentioned lack of consistency in the policy direction and lack of political commitment as the major weaknesses of the reproductive health programme.

Weak monitoring, lack of coordination and cooperation between health and family planning directorate, weak referral system, and lack of ownership to the programme were some other weakness mentioned by the policy actors.

6.3 Future Directions

Opinions of the policy actors with respect to future direction of reproductive health programme were centered on three major aspects i.e., role of government in provisioning primary health care; management structure for reproductive health service delivery; continuation of outreach services. However, future direction of the management structure of reproductive

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health service delivery remained the core area of the discussion for all categories of the policy actors.

Varied opinion came in about the future direction of the programme. On issue of the role of government in provisioning primary health care, majority policy actors opine primary health care should be the mandate of government. They opine secondary and tertiary hospitals should be made autonomous. Only some policy actors think government should only perform regulatory function and all types of health care should be provisioned through private sector. They argue that if the regulating authority itself turns into a competitor in the market then its accountability becomes questionable.

On issue of management structure for reproductive health service delivery everybody has recognized the need for change in the existing management structure and direction of the reproductive health programme. However, opinion differed significantly on the kind of change should be brought in the management structure and direction of the programme.

Opinion of the state actors differed substantially from one group to another on issue of the kind of change should be brought in the management structure and direction of the programme. State actors of family planning held completely different opinion from those of health. Almost all the state actors of family planning except some physicians have stated that all reproductive health care services should be delivered by DGFP under a

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separate management structure from top to bottom. This claim of the state actors from DGFP has roots in the location of MCH within DGFP in the past. Some of them have opined for a separate ministry for family planning and thus, a complete separate policy making level for family planning. Some have opined for a separate division with separate executive head for family planning under the single ministry with the same political head of the ministry i.e., minister. All state actors of family planning have expressed that in the existing management structure where two directorates are unified at the policy making level under single political head i.e., minister and single executive head i.e., secretary, family planning always gets less priority and focus. They have opined that this neglect has turned most acute at present where the minister himself is a physician who upholds the interest of the physicians only.

State actors from directorate of health services consider that all the reproductive health care components including family planning should be integrated. Hence, all reproductive health services including family planning should be delivered under a unified management structure from top to bottom because unless management structure is unified, effective integration of services is not possible. They consider that division between health and family planning has been an artificial one. Family planning service cannot be effectively delivered without effective integration with health services. Further, they have argued that achievement of demographic goal of the country would require reliance on the longer acting method acceptors and

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technical persons and thus, requires effective integration with health services under unified command structure. Some state actors of the health services have opined that inclusion of MCH services within the family planning department has been a historical mistake. They have stated that inclusion of MCH within family planning had contributed in the weakening of family planning activities over the periods. This has also been viewed by some as a source of conflict between the technical and non-technical staff within the family planning department. Further, in virtual absence of any coordination between the two directorates this situation has even worsened. Health and family planning staff have been delivering services almost without any coordination among themselves.

In this connection state actors from the family planning directorate have claimed that maternal health services are well integrated with family planning services in the district level MCWCs under the management of directorate of family planning because they equally emphasize maternal health and family planning. It has been added that this integration is not maintained at the district hospitals under the management of health services because they do not emphasize on family planning.

Almost all the non-state policy actors have also opined for urgency in brining change in the management structure for reproductive health service. Some of the non-state policy actors have opined that even though ideally all reproductive health services should be integrated and be delivered under a unified management structure, reality of the present day situation would not

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allow for such an organizational arrangement. They apprehended that family planning would be deemphasized in the unified management structure.

Some of the non-state policy actors have suggested for a complete division of responsibility between the directorate of health services and the directorate of family planning to minimize conflict between them and minimize duplication of activities and misuse of resources. They have opined that all facility based reproductive health service should come under health and all outreach reproductive health service should be delivered by family planning. Thus, they have opined for creation of separate management structure for facility based and outreach reproductive health services.

Many non-state policy actors were of the opinion of installing a unified management structure for reproductive health. To them reproductive health services cannot be delivered in vertical management structure and it is the responsibility of the government to negotiate with all the stakeholders about this through dialogue.

On issue of outreach services, many policy actors particularly non-state actors and state actors from DGHS have opined that at this stage of the programme, domiciliary services should continue only in low performing areas and worker density should increase for low performing, and hard to reach areas.

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On issue of recruitment of field workers majority have opined that field workers at this stage of the programme should get appointed on a temporary basis for a particular period of time because home visitation at an older age becomes difficult. Further, social status of the field workers also change as their children grow up and thus, their family members do not wish them to work as field workers. Some have opined that field workers are employed on a permanent basis then there should be scope of career advancement for them so that they do not have to go for home visitation life long. Opinions of the policy actors on these issues of future direction of the programme did not vary by category of the policy actors.

6.4 Synopsis of the Opinions of the Policy Actors

Following two tables present major points of agreements and disagreements between majority policy actors on some vital policy issues.

Points of Agreements on Major Policy Issues by Majority Policy Actors

Policy Issues	Points of Agreements by the Most Policy Actors
Family planning services	• Inadequate attention to family planning programme at the policy level • Slacking of family planning programme • Lack of political commitment for the programme • Lack of professional commitment within the programme • Need for area specific programme strategy to address unmet demand for family planning • Need to focus on quality of services • Urgency of resolution of professional conflict and crisis within the programme by the government

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Policy Issues	Points of Agreements by the Most Policy Actors
Maternal health services	• Significant increase in the commitment for maternal health service at the policy level • Focus on EmOC has broadened the scope of reproductive health programme • Lack of availability of the service providers as the foremost crisis of the programme • Strengthening of the union level facilities for maternal health services • Apprehension on the financial sustainability of the MHVS if up scaled nationally
Linkage between family planning and maternal health programmed	• Very weak linkage between family planning and maternal health programme under the present management structure
Nutrition programme	• Inadequate attention to nutrition programme at the policy level • Lack of integration of nutrition programme with reproductive health programmed
Urban Primary Health Care	• Very inadequate provision of urban primary health care in general and reproductive health care in particular • Inadequate policy attention to urban primary health care in general and reproductive health care in particular • Strengthening monitoring and supervision of the urban primary health care programme by government • No standardization of services provided by the contracted NGOs
Management structure of reproductive health service delivery	• Complete revision in the existing management structure for reproductive health service delivery • Very weak linkage between maternal health and family planning services within the existing management structure
Behaviour change communication	• Necessity of building corporate social responsibility by the government for sponsoring BCC activities by the private channels. • Involvement of other business houses in sponsoring BCC activities in the television and radio.

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Policy Issues	Points of Agreements by the Most Policy Actors
Mechanism for increasing responsiveness of the service providers	• Empowering the clients through adequate information about the reproductive health services
Major Challenges of the programme	• Unmet demand for maternal and family planning services • Acute shortage of service providers • Weak linkage between maternal health and family planning services
Important strengths of the programme	• Network of infrastructure down to the village level
Important weakness of the programmed	• Absence of human resource plan and acute shortage of manpower • Lack of political commitment • Politicization of the service
Future direction of the programme	• Change in the management structure for reproductive health services delivery • Strengthening of union level facilities • Creating linkages between maternal health and family planning services • Appropriate integration of nutrition with the reproductive health services • Standardization of urban primary health care services • Commitment from the highest political level

6.5 Summary and Assessment

Opinions of different categories of policy actors have echoed some common policy and programme concern while they held different opinions on the way out of these problems. Some patterns have emerged from the opinions of different categories of policy actors on major policy issues. Highest differences in the opinions were observed within state actors on issues of their professional interest. They have differed most on issue of the management structure for reproductive health service delivery and future

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direction of the programme. While state actors of health directorate have opined that integrated comprehensive reproductive health programme could be delivered best under unified command structure, state actors from family planning directorate have opined for a separate management structure from top to bottom. Some of the state actors from family planning preferred a complete separate management structure with separate political and executive head meaning a separate ministry. Some preferred to have a segregated management structure with separate executive head under a single political head meaning a separate division under single ministry. State actors of health directorate consider that reproductive health programme requires integration between and among its components and between and among different categories of reproductive health service providers. Hence, they have argued that the programme will loose its efficacy in terms of its contribution to availability of, accessibility to, and quality of reproductive health services if implemented under separate management structure. On the other hand, state actors of family planning programme opined that family planning programme would be deemphasized if implemented under unified management structure and availability of, accessibility to, and quality of family planning services will be affected.

All the non-state policy actors have opined for a complete revision and overhauling of the management structure. Almost all the non-state policy actors have opined that ideally reproductive health service delivery requires a unified management structure for health and family planning because reproductive health components are inherently interrelated and therefore,

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requires integration between and among them. Nevertheless, some of the non-state policy actors have expressed that under the given situation, unification of the two directorates might not be feasible for practical reasons even if it had appeared conceptually and technically sound. They believe good policies besides being technically sound also require to be politically feasible. Experience of unification could not reap benefit to all groups of insiders and therefore, caused strong resistance within different subgroups. Further, they have also expressed their apprehension that family planning programme could be deemphasized under the unified command structure. Thus, this group of non-state policy actors has recommended a complete division of responsibility between health and family planning. On the other hand, other group of non-state policy actors considers that separate management structure for health and family planning is against the concept of integrated provisioning of reproductive health services. Thus, they have stated that unification of the service structure is the most important requirement for increasing the efficacy of reproductive health services. They have emphasized on the responsibility of the government to negotiate with the stakeholders within the programme through dialogue on issue of unification of the management structure.

All the policy actors have unanimously agreed that family planning programme have significantly slacked in the reproductive health regime. Non-state actors and state actors belonging to the family planning directorate have attributed this slacking of family planning programme to lack of attention at the policy level. On the other hand, policy makers and state

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actors of health directorate have linked it with the internal conflict within the family planning directorate. However, all the policy actors have agreed that political will could have resolved the conflict and brought back the momentum of the programme. Except for the policy makers all the policy actors have opined that not enough attention was given in formulating appropriate strategies and programme interventions to address the contemporary challenges of the family planning programme. All the policy actors have urged the necessity of conceiving area specific programme strategy to address high unmet demand for family planning. Most of them have felt the necessity of special programme strategies for low performing and hard to reach areas.

All the policy actors acknowledged that maternal health programme received significant policy attention in the reproductive health regime. However, most of the policy actors except the policy makers have pointed out that this policy attention was not adequately complemented with measures to make availability of the service providers. Thus, despite renovating and updating physical facilities for EmOC at the district level and down to the *Upazila* level, EmOC services could not be made available because of very inadequate availability of the physicians. Nevertheless, everybody has pointed out that maternal nutrition remained neglected and the national nutrition programme was considered inappropriately designed to have link with maternal and child health programme.

All the policy actors except policy makers held similar opinion on nutrition programme. They have opined that nutrition as maternal health issue

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remained neglected all along in the health and population programme. In HNPSP, nutrition programme had been conceived as a vertical programme under the ministry. They have opined that nutrition programme should have been integrated with the mainstream primary health care services of the government.

Likewise urban primary health care has been considered very scanty by all. However, differences in opinion have been observed on issue of authority and responsibility for provisioning urban primary health care. Most of the state actors consider that provisioning urban primary health care should be the mandate of the ministry of health and family welfare because in the end it remains accountable for health and fertility outcome indicators. However, non-state policy actors were divided on the mandate of urban primary health care. Some of them held similar opinion to those of the state actors. Others have considered that urban primary health care should be the mandate of MoLGRD, because local government bodies hold the position to make the service providers accountable. On the other hand, state actors have stated that in many cases in absence of fairness and transparency in dealings between the local bodies and the contracting NGOs, issue of accountability hardly arise. Nevertheless, everybody has emphasized on the urgency of significant increase in the availability of the urban primary health services, quality supervision, and monitoring of the work of the contracting NGOs by the local bodies.

State actors were unanimous about politicization of recruitment, transfer, and promotion in the service. Recruitment, transfer, and promotion reported

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to have hardly any link with the performance of the service providers and managers. This politicization of service reported to have very negative effect on the motivation and accountability of the employees. Thus, everybody has recognized the urgency of a transparent career development plan to promote motivation of the workforce.

Differences in the opinions between the state actors and the non-state actors were noticed on issue of involvement of local bodies in the implementation of health and family planning programme for promoting responsiveness of the service providers. While non-state actors have expressed the urgency of effective involvement of the local bodies in health and family planning programme, state actors did not consider it as a solution. They have emphasized on ensuring motivation of the service providers and managers for increasing their responsiveness.

Mixed opinions came in about community clinics. Majority non-state actors viewed it as a political agenda of the present government. They have opined that before making the existing union level facilities functional, spending national resource on creation of another layer of facility can hardly be justified. However, all the policy makers and some state actors have opined community clinics would significantly add to the availability of the services in the remote areas.

All the policy actors were unanimous about the existing strengths and weaknesses of the programme. Wide scale infrastructure down to the village level has been identified as the major strength of the programme. On the other hand absence of any human resource plan and acute shortage of human

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resource and politiciization of service, lack of political commitment have been considered major weaknesses of the programme.

The pattern of response shows that state actors held similar opinion when it served their common professional interest and they held completely different opinion with each other when there was a conflict of interest between them. Policy makers tend to justify most policy matters. They also appeared defensive on many policy issues. Non-state actors' opinion reflected their concern for de-emphasis on family planning programme at the highest policy making level. Nevertheless, lack of political will in reinvigorating the family planning programme has been considered a major concern by all categories of policy actors except few policy makers. Similarly the urgency of conceiving multifaceted measures for ensuring the availability of the service providers had been emphasized by all.

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Chapter 7
Conclusion

This study has analyzed the policy discourses and paradigm shift relating to reproductive health care in Bangladesh. The study has examined how far the policy frameworks have reflected a paradigm shift towards rights-based reproductive health programme. It has investigated how the complementarities and inconsistencies within the policy frameworks have affected reproductive health through 'the availability of, accessibility to, and quality of reproductive health services'. This concluding chapter first, summarises the findings of the study and revisits the research questions in the light of its findings. Secondly, places the findings of the study in its conceptual framework and finally concludes.

7.1 Summary of Study Findings

Delineating the health system and reproductive health issues of Bangladesh in Chapter 2, Chapter 3 through its analysis of policy discourse in FP-MCH policy regime, has shown that within the broader theme of primary and preventive health care, fertility reduction had been the central goal of FP-MCH programme. Policy framework of the entire FP-MCH regime had followed a coherent approach for fertility reduction. Thus, the strategies and interventions in this regime were mostly designed to increase the availability of and accessibility to family planning methods. Quality of services, clients' needs etc. were compromised and undermined to achieve demographic goal. However, wider increase in the availability of family planning methods

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through extensive community based intervention and availability of MR services had enabled disempowered poor women to avert or delay child birth. Merger of MCH with family planning in mid seventies were primarily contributed in increasing the availability of clinical contraception. Attention to child health had shown gradual increase in the later part of the policy regime as a pre-requisite for motivating couples towards smaller family. Maternal health remained much neglected in the entire policy regime.

Chapter 4 has depicted that 'reformist reproductive health policy regime' had evolved in the context of a paradigm shift at the international level at the backdrop of ICPD in 1994, the Fourth World Conference on Women in 1995 etc. This policy regime made a shift to sector wide approach and introduced a pro poor ESP for primary health care, of which reproductive health had been the crux. Maternal health had received significant policy attention and was corroborated by programme interventions. This regime had adopted EmOC as its chief maternal health strategy. Maternal health has been established as the most important reproductive health in its own right. Expansion of EmOC at all levels has marked a significant stride towards increasing the availability of and accessibility to maternal health services.

Family planning services' focus and strategies remained the same as it had been before in FP-MCH policy regime. It has continued to be viewed as a means to fertility reduction and thus, could not be adequately established as reproductive health intervention. Therefore, family planning services could not be appropriately linked to promotion of maternal health.

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This policy regime had envisioned necessary organizational reforms for management and implementation of the programme. Unification of health and family planning was considered most vital for successful implementation of ESP. However, unification could not be implemented in the face of strong resistance by the state-actors of family planning. This had disrupted the implementation of the entire programme and had affected the basic philosophy of reproductive health.

Chapter 5 has analyzed formulation of the subsequent programme implementation plan, HNPSP in the context of MDGs and Poverty Reduction Strategy and the Second Population Policy. The chapter in its analysis of the policies, plans, and strategies, has shown that all the documents had a consistent policy and strategic position on the issue of maternal health services. However, they did not have a clear position on the direction of family planning services. Strategic framework of PRSP did not properly link family planning services to human development or poverty reduction. Thus, PRSP could not establish fertility reduction and family planning services as means to human development. Similarly, HNPSP like HPSP had not established family planning as reproductive health agenda, as it had established maternal health services.

At the back drop of reinstating bifurcated management structure for health and family planning services, the implementation arrangement for reproductive health services was split up without establishing coordination mechanism. This had disintegrated all the reproductive health services and affected the accessibility to, and quality of the services.

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Chapter 6 has shown that opinions of different categories of policy actors have echoed some common policy and programme concerns while they held different opinions on the way out of these problems. Most policy actors opined that the present management structure is contradictory to the reproductive health programme design and thus, had strongly recommended for bringing change in the management structure. Creating effective linkage between all the reproductive health services and redesigning of family planning services has been considered very important by most of the policy actors.

Almost all the policy actors have stated that very little attention has been paid at the policy level to meet the primary health care demand of the ever increasing urban population of the country. Similarly, neglect of maternal and child nutrition had also been recognized by majority policy actors as a major concern. Absence of any transparent career development plan for the human resource has been considered the main reason for de-motivation as well as lack of availability and accountability among the workforce. Almost all categories of policy actors irrespective of their opinion about establishing community clinics were doubtful about the sustainability of the community clinics because of the existing antagonistic political culture of the country. Thus, almost all have expressed their concern about possible wastage of national resource in view of the renewed emphasis on community clinics.

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7.2 Revisiting Research Questions

Having summarized the findings of the study, it is pertinent to refer back to the research questions founded on the conceptual framework of the study. The following sections revisit the four research questions of the study.[1]

7.2.1 Policy Frameworks of the Three Policy Regimes and Entitlement to Reproductive Health Services in Bangladesh

All the policy regimes in Bangladesh have assumed the state obligation for provision of health care services. Primary health care has all along been the focus of the health programme of the country. All the regimes had focused on resource allocation for pro poor health services in varied nomenclatures like preventive care, communicable disease, primary health care, and essential services. However, attention to particular services within the primary health care or the essential services has varied in different policy regimes. Policy frameworks of the three policy regimes have variably affected the availability of, accessibility to, and quality of reproductive health services in Bangladesh. Increase or decrease in the availability of, accessibility to, and quality of services were not absolute. However, utilization of primary level facilities has all along been very poor mainly because of inadequate availability and poor quality of services.

Reproductive health services for urban poor have not been the focus of any of the policy regimes. Similarly, nutrition being one of the most important maternal and child health issues of the country was not appropriately integrated in the policy framework even in the reproductive health policy

[1] See chapter 1, pp 7-8.

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regimes. Nutrition programme remained almost like a vertical programme without appropriate mechanism for integrating it with reproductive health in general and maternal health in particular.

Fertility reduction had been the prime objective of *FP-MCH policy regime (1973-1997)*, and thus, its policy framework was consisted of interventions and strategies for strengthening family planning programme. Despite being FP-MCH programme, its policy framework was not designed to mutually reinforce family planning and MCH services. Basically, MCH was merged with family planning to increase the acceptability of family planning programme so as to facilitate accelerated and sustained fertility reduction. Thus, MCH was merged with family planning as a means to fertility reduction. Child health services had received increased attention at the later part of the policy regime as a pre-requisite for fertility reduction. On the other hand, fertility reduction has been viewed as the only means to maternal health. Thus, maternal health services were limited to low cost, easy deliverable, and preventive services like, pre-natal care and safe home delivery through TBAs. Field workers were inadequately trained and motivated to deliver these basic maternal health services. Their performances were measured in terms of quantitative targets in increasing family planning acceptors. Thus, maternal health services and interventions were too limited and availability of maternal health services was markedly inadequate.

Integration of MCH with family planning had contributed in increasing the availability of clinical contraception. Programme strategies, interventions,

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and services in this policy regime were designed to achieve fertility reduction through increasing the availability of and accessibility to family planning services. Increasing the availability of and accessibility to MCH services was always secondary. However, deployment of wide scale female field workers, introduction of satellite clinics were very effective in increasing the physical accessibility to services like family planning, immunization, pre-natal care etc. Wider availability of contraceptives to women in remote areas, who did not have mobility and freedom to decide for their own health, had enabled them in exercising their reproductive right of averting child birth or delaying child birth. Similarly, availability of MR services at all levels of facilities had enabled women in exercising their reproductive right. However, the programme was too narrowly focused and designed to address even very basic reproductive morbidities of women. The programme was too much demographic target driven and hardly focused on quality of services and clients' need. IEC programme was focused towards changing fertility behaviour for building smaller family norms. Eventually information on immunization services and oral rehydration therapy were included in the IEC activities. However, clients hardly had informational accessibility in terms of side effects and contraindications of various contraceptives. Incentive introduced in the guise of increasing economical accessibility for sterilization had received serious objection as a major violation of rights from the human rights activists.

Programme remained almost exclusively focused on married women of reproductive age and thus, making covert barrier to freedom for men. The

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programme had overt policy barrier for adolescents. There had not been any educational programme or informational services for unmarried adolescents on health or family planning restraining their freedom and access.

Prime policy objective of *reformist reproductive health policy regime (1998-2003)* was to promote reproductive health through broadening of reproductive health services and focusing on clients' need and quality of services. It had introduced integrated reproductive health services within ESP and adopted SWAp. Reproductive health has been the centre piece of ESP and maternal health has been the core area of reproductive health services. Maternal health services have been established as the prime reproductive health services. A range of reproductive health services including awareness on and basic syndromic management and treatments of STI, RTI were introduced within this package. This broadening of reproductive health services has been very crucial in making the first step towards addressing some basic reproductive morbidity of women. This regime has envisaged a package of reforms including unification of health and family planning for efficient delivery of integrated ESP. It had introduced static community clinic as a one stop service point in the light of introduction of a range of reproductive health services. Community clinics were introduced to increase the physical accessibility of people to the basic health services at the community level. This policy regime has established maternal health as the most important reproductive health in its own right. Maternal health services and interventions had increased more than ever before. Major focus of maternal health services has been on EmOC.

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However, availability of EmOC at the *Upazila* level has been very limited because of inadequate availability of providers. EmOC at the district level facilities could not be made fully functional primarily because of inadequate availability of the physicians.

Family planning services, interventions, and strategies remained the same in the reformist reproductive health regime as they were in FP-MCH policy regime. Family planning continued to be viewed as a means for fertility reduction and thus, the opportunities of viewing family planning as a means to reproductive health got diminished. There has not been any role reversal of family planning services for reproductive health promotion. Therefore, role of family planning in terms of availability of, accessibility to, and quality of reproductive health services was bounded within fertility reduction. There has not been any qualitative change in the family planning activities and services as such. Thus, family planning could not be established as an important means for maternal health. However, introduction of awareness programme for adolescents had been a first step towards removing overt policy barrier on adolescents' choice and access to reproductive health services. Further, availability of and quality of family planning services at the level of primary care got affected because of the fact that there had been a neglect of government in recruiting the crucial field level staff like FWAs and FWVs for more than a decade. With the failure of unification of health and family planning, integration between reproductive health services, the basic tenet of reproductive health got lost. As a result,

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family planning and maternal health services also got disintegrated and affected the quality of and accessibility to the services.

Policy framework of the *conformist reproductive health policy regime (2003-2011)* did not change much from that of the *reformist reproductive health policy regime (1998-2003)* with respect to reproductive health programme design and content. However, this policy regime had reinstated separate management structure for health and family planning as it had been in the FP-MCH regime. A split implementation arrangement between health and family planning directorate has been made for reproductive health services. Hardly any mechanism has been evolved to coordinate the services offered by the directorate of health services and the directorate of family planning. Thus, under this regime all the reproductive health services including family planning and maternal health services have been designed to be operated and implemented in a de-linked way. De-linking of maternal health and family planning services has resulted in undermining of family planning services as an important means to achieving maternal health. De-linking of the inherently integrated services has dismantled the concept of reproductive health. Majority policy actors, except state-actors from family planning have considered that split implementation arrangement had caused de-linking between all the reproductive health services and thus, had affected the accessibility to and quality of the services.

Maternal health services remained the crux of the reproductive health services and its focus also remained on increasing EmOC at the district and

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Upazila level facilities. This policy regime had introduced demand side intervention MHVS, on a limited scale to increase economical accessibility of maternal health services. Comprehensive EmOC service availability has increased significantly at the district level, if not at the *Upazila* level. Basic EmOC could hardly be made available at the UHFWCs. Inadequate availability of service providers remained the major challenge in the way to making EmOC facilities fully functional. It has been claimed by most of the state policy actors that the issue of non-availability of the service providers has its root in the politicization of public services by the respective political governments.

Family planning services remained the same in the reproductive health policy regimes as it had been in FP-MCH policy regime. Family planning programme strategy continued to focus on increasing longer acting methods. Issues of major contention from human rights perspective like incentive for the clients and providers still remains very much a programme strategy. Thus, providers' bias and interference in contraceptive delivery creates hindrance in exercising clients' freedom to choose on the basis of their health needs. Quality issues are not adequately addressed and are reflected through high discontinuation rate of contraceptives. Thus, family planning programme has been undermining the rights issues while working within the broader rights-based policy framework. Issue of male involvement in reproductive health services had hardly been addressed. Thus, covert accessibility barriers on men have not been addressed.

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7.2.2 Policy Framework and Paradigm Shift

Paradigm shift in the policy framework of the reformist reproductive health policy regime has taken place in terms of shifting from: project approach to sector approach, FP-MCH services to reproductive health services, and broad based primary health services to targeted essential health services package at the primary level. However, sector approach has not been accompanied by government's stewardship role in the sector. Government's leadership is seriously challenged in the context of ever increasing influence of donors in the policy process. Shift to SWAp has been incomplete because of the fact that the programme remained confined to public sector. Further, there has not been any scope of inter or cross sectoral collaboration for health, nutrition, and population programme activities. SAWp has ended with single sector intervention for health, nutrition and population programme.

Paradigm shift to reproductive health services has marked a great stride in asserting maternal health as the prime reproductive health in its own right and envisioning expansion of EmOC at all levels. Further, this shift has led to the broadening of reproductive health care services. Paradigm shift from FP-MCH to reproductive health services could not be complemented by shift from vertical FP-MCH and health to integrated reproductive health because of failure of unification of the management structure of health and family planning as envisaged by the reformist reproductive health policy regime. The shift to reproductive health has been incomplete in absence of strategic linkages between and among the reproductive health services. Further, the shift to reproductive health was incomplete because of its failure to re-

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conceptualization of family planning from rights perspective and repositioning of family planning services within the rights-based framework. Gender mainstreaming, the core of reproductive health remained hardly addressed. Interventions on gender issues remained fragmented and isolated as before.

7.2.3 Policy Frameworks and Major Policy Actors and Factors

Role of external agencies has been inseparable in the development and growth of population and health programme in Bangladesh since its inception. Donors' influence in the planning process has always been encouraged by the respective governments to ensure external resource flow for implementation of the programme. Major policy ideas, inputs, and interventions were introduced at the initiative of donors or specialized UN agencies for health like WHO, UNICEF, and UNFPA. Interventions not endorsed by the external agencies did not continue. At the influence of the donors, two separate divisions were created for health and family planning in the mid seventies. Major shifts in the policy framework like SWAp, reproductive health etc. has been brought to accommodate the shifts in the global policy environment. Increase and decrease in prioritization to any particular service has been linked to external resource flow. Maternal health intervention remained very inadequate until it was prioritized by the donors. Similarly, family planning programme growth was possible largely because of donors' support. Maternal and child nutrition despite being identified as major health concerns by the plan documents did not get much attention because of lack of donors' support. Donors' influence has increased even

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more under SWAp. The HPSP and HNPSP were prepared under the direct influence of the donors.

The state actors' influence has been minimal in terms of initiating any particular policy idea, health intervention or services. Their influence has been most pronounced in health system reforms. Reforms relating to unification of management structure for health and family planning and regulation on private practice by the physicians etc. had received highest resistance from the state actors. Involvement of local bodies in implementation of health and family planning programme at the primary level has also received resistance by all categories of state-actors. The state-actors have always been divided on issue of unification of management structure of health and family planning. The state actors of health directorate have always been in favour of unified management structure, whereas, the state actors of family planning directorate have always been against unified management structure. It is because of the resistance of the state-actors of family planning directorate that unification of the management structure of the two as envisaged by HPSP could not be implemented. The issue of unification of the management structure has become synonym to 'de-emphasizing of family planning' to the state-actors of family planning. Functional integration of health and family planning has also been equally difficult to achieve all through because of the non-cooperation of the two wings. However, while all of the state-actors agree that functional integration does not appropriately work they blame each other for non-cooperation.

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Change in political regime has been not been associated with major changes in the health policy or plan or strategy as a whole. Mechanisms evolved to involve representatives of the local government bodies in the implementation of health and family planning in the eighties have diminished with the onset of democratic political regimes in the nineties. However, community clinics appeared to have earned a 'political branding'. Community clinics were introduced by HPSP during the later part of the political regime of Awami Legaue led government (1996-2000). Community clinics were introduced as a one stop service point at the backdrop of initiation of reproductive health services under ESP and gradual phasing out of domiciliary services. As with the reversal of unification and reverting back to domiciliary services in HNPSP, community clinics had been discontinued. This change had taken place under the new government formed in 2001 by the Bangladesh Nationalist Party. Discontinuation of community clinics has been considered politically motivated and therefore, with the change in the government in 2008 i.e., during the implementation period of HNPSP, renewed emphasis has been given to community clinics by the government formed by Awami League in 2008. While many policy actors consider addition of community clinics will contribute to increase in the physical accessibility to primary health care services at the community level; majority policy actors consider that renewed emphasis on community clinics has been a 'political agenda' of the government. Thus, they opine that existing union level facilities should have been strengthened before channeling resources for creating another layer of facility. However, all the policy actors have expressed their concern over the sustainability of

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community clinics because of the antagonistic political culture of the country.

7.2.4 Interconnectivity between and among the Policy Frameworks

Policy frameworks in both reproductive health regimes have followed a coherent approach regarding maternal health services. All the policies and strategies have placed maternal health as the most important reproductive health issue. EmOC has been the central theme of the maternal health strategy besides community based preventive services and SBA strategy.

None of the reproductive health policy regime could appropriately reposition family planning programme within reproductive health framework because of inconsistencies between and among the policy frameworks. Family planning services have not been re-conceptualized from rights perspective in any of the reproductive health regimes. Family planning services could not be transformed into reproductive health services. Family planning activities were founded only on fertility reduction. PRSP, maternal health strategy, population policy, and programme implementation plans for health, nutrition, and population sector (HPSP and HNPSP) did not have coherence in conceiving family planning programme activities within their respective frameworks. Programme implementation plans (HPSP and HNPSP) for health and population sector and poverty reduction strategy, maternal health strategy had been based on rights based framework for the entire sector. However, these plans did not link family planning with the rights based framework. Neither any change has been brought in the family planning programme design nor has any new strategy been evolved after its

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theoretical repositioning under reproductive health care. On the other hand, method specific target for family planning has continued. Further, linkage between maternal health care and family planning programme has not been established appropriately.

Poverty reduction framework of PRSP did not establish family planning services as human development intervention as it had established maternal health. On the other hand, it did not also adequately signify fertility reduction for promotion of reproductive health. Thus, family planning has not been adequately advocated as maternal health intervention or reproductive health intervention in PRSP. Similarly strategic linkage between family planning services and maternal, child, and reproductive health services was not established.

Family planning service output indicators and outcome indicators has been limited within CPR and TFR. Thus, programme performance has been tracked along CPR and TFR only. Its contribution in reproductive health in averting unwanted births, high risk pregnancies, reducing unsafe abortion through met need for family planning services were not brought into focus.

Situation was further worsened by taking a conformist approach for implementation of reproductive health programme. Reproductive health programme had been designed by HPSP with the vision of unified management structure. To get along with the reversal of separate management structure, a patchy implementation arrangement has been evolved by HNPSP which resulted in a vertical programme for family

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planning. This implementation arrangement has further de-linked all the reproductive health services and grossly violated the spirit of the reproductive health concept.

SWAp framework calls for interlinking and mutually reinforcing strategies and interventions for health, population, and nutrition. Separate management structure has blocked the way to sector wide linkages. This has resulted in inefficient use of resources for HNP services, one of the major reasons for moving out from project approach. Further, ending up with single sector intervention in the guise of SWAp, also limited the scope of cross-sectoral or inter-sectoral collaboration. The need for cross-sectoral collaboration has been emphasized by almost all categories of policy actors particularly for addressing issues like early marriage, early child bearing, malnutrition, violence etc. Hence, confining to single sector intervention in the name of SWAp has been considered a major conceptual mistake by majority policy actors except for few policy makers.

7.3 Relevance to Conceptual Framework of the Study

This study has analyzed the policy framework of the three policy regimes through the lens of rights-based approach to health. It had looked into the policy frameworks in terms of *freedom* and *entitlement*. Freedom has been conceived as the ultimate goal of reproductive health services where people are able to exercise their informed choice without any coercion, threat or interference from any one. Entitlement to services has been looked through the concepts of 'availability of, accessibility to, and quality of services'. The study has revealed that the policy frameworks in all the policy regimes have

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partially addressed the availability and accessibility issues of reproductive health services. Quality of services remained neglected all through. In FP-MCH policy regime availability, accessibility, and quality issues of reproductive health services were bounded within the fertility reduction goal of the policy regime. FP-MCH policy regime had focused on availability, accessibility, and quality issues of family planning services for fertility reduction. This policy regime had significantly addressed availability and accessibility issue of family planning services but had ignored freedom and quality issues. FP-MCH programme for being too much demographic target driven had ignored clients' actual need and choice and thus, had undermined freedom and quality of services. In this regime, maternal health was not pursued because gain in fertility reduction, the main goal of the policy regime had not been perceived in this pursuit. Fertility reduction had been considered the principal means to pursue maternal health. Thus, maternal health services and interventions were very limited and availability and accessibility issues of maternal health services had been addressed very inadequately in FP-MCH policy regime.

Reproductive health policy regimes have broadened the reproductive health services to address the basic reproductive health morbidity with particular emphasis on maternal health services. Maternal health services have moved from risk-based interventions to rights based intervention. However, inadequate availability of the service providers remains the major challenge in the way to making facilities fully functional and thus, impedes the availability of reproductive health services particularly at the primary level.

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MHVS has been introduced on a limited scale to increase economical accessibility to maternal health services. However, advocacy programmes are not appropriately designed to remove socio-cultural accessibility barriers to maternal health services. Informational accessibility to broader reproductive health services remained inadequately addressed.

Disintegration of reproductive health services made through split implementation arrangement of reproductive health services has affected both accessibility to and quality of reproductive health services.

Reproductive health services still remain focused on women and thus, reflect covert barriers for men restricting their freedom and accessibility. Quality of reproductive health services have been restrained under the demographic target driven strategies of the family planning programme. Absence of reversal of family planning programme focus and strategy to work within reproductive health framework has resulted in continuing undermining of the concept of freedom and quality of services, the core of rights-based reproductive health services. The strategy of promoting particular contraceptive methods, incentives and disincentives for the acceptors and providers for accepting and providing certain family planning methods etc. have restrained promotion of clients' need and choice and thus, freedom and quality of services were undermined.

Rights-based approach to health has been reflected in the policy frameworks of all the policy regimes in terms of prioritization of health services that affect larger, poor, and the most vulnerable population towards promoting

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equality in reproductive health. Therefore, policy frameworks relating to reproductive health services while exhibited some elements of rights-based approach to health, have largely failed to follow a coherent approach to reflect on rights-based approach to reproductive health.

7.4 Epilogue

Further improvement in reproductive health will require accessible, user centered, and quality reproductive health services. Having effective linkage between all the reproductive health services is crucial for improving accessibility and quality of services. Change in split arrangement of the services is inevitable for ensuring mutually reinforcing quality reproductive health services. Failure of repositioning family planning services within reproductive health framework is linked to its de-emphasis in the reproductive health policy regime. De-emphasis of family planning services within the policy framework has its link with split arrangement of reproductive health services. Reversal of family planning services to fit within reproductive health framework will ensure regaining its emphasis in a policy environment that calls for improvement in reproductive health. Family planning services need to be viewed as a means to achieving reproductive health through meeting wanted fertility regulation or averting unwanted or miss-timed child birth, reducing unsafe abortion and sexually transmitted infections. Focusing on quality of services, meeting wanted fertility regulation, reducing method failures, side-effect management, and promotion of responsible parenthood will give a common ground for achieving a win-win situation for fertility reduction to replacement level and

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reproductive health promotion. Regaining the emphasis of family planning services is crucial for both sustained fertility reduction and improved reproductive health. Improvement in maternal health calls for its effective linkage with other reproductive health services including family planning and nutritional intervention. Early marriage being the major reproductive health concern of the country having its implication on fertility reduction and maternal health needs to be addressed through cross-sectoral collaboration. Addressing governance issues relating to human resources and other supplies should lie at the centre of all efforts to increase the availability of, accessibility to, and quality of services.

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