



The **POLICY** Project

**Reproductive Health
Case Study**

BANGLADESH

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The Futures Group International

in collaboration with

Research Triangle Institute (RTI)

**The Centre for Development and
Population Activities (CEDPA)**

POLICY is a five-year project funded by the U.S. Agency for International Development, under Contract No. CCP-C-00-95-00023-04. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).



Contents

Acknowledgments.....	iv
Executive Summary	v
Abbreviations	vi
1. Introduction	1
2. Background	2
3. Policy Formulation.....	4
A. Structures for Policymaking	4
B. Evolution of Policies from Family Planning to Reproductive Health	5
C. Definition of Reproductive Health	7
D. Knowledge about Reproductive Health.....	8
E. Support and Opposition.....	9
4. Policy Implementation	10
A. Operational Policies and Plans	10
B. Service Delivery Structure.....	10
C. Implementing Agencies and Actors	12
D. Integration	12
E. Constraints.....	13
5. Resource Allocation.....	16
A. Funding Levels for Reproductive Health.....	16
B. Major Donors	17
C. Financial Sustainability.....	17
6. Challenges.....	18
7. Lessons Learned.....	19
Appendix 1.....	21
References.....	22

Acknowledgments

The author gratefully acknowledges the invaluable contribution of all of the people who were interviewed for this case study. Each interview required an hour of the respondent's time, although some respondents graciously devoted more time. Many of the questions required serious thought about and discussion of events that took place several years ago. The respondents also passed along many documents such as written policies pertaining to reproductive health, studies, and implementation plans that proved particularly useful. The enthusiasm conveyed by respondents for the new direction of family and reproductive health programs in Bangladesh was refreshing; however, respondents acknowledged that more needs to be done to deliver high-quality services to the people of Bangladesh.

I would also like to thank Abul Barkat and M. Abdus Samad of University Research Corporation, Bangladesh, who provided excellent logistical support during my visit. As an active participant in the reproductive health policy formulation process, Dr. Barkat was able to arrange interviews with many key representatives from the government and other organizations. Mr. Samad accompanied me to every interview, assisted with gathering documents, and took excellent care of my professional needs.

David Piet and Kanta Jamil of USAID/Dhaka were instrumental in allowing the case study in Bangladesh to go forward. They also provided a great deal of useful information and helped obtain many important documents regarding reproductive health in Bangladesh. Their assistance is greatly appreciated. Additional persons who reviewed this paper include Nancy Piet-Pelon, Margaret Neuse of USAID/Dhaka, and James Kocher and Dennis Chao of RTI.

I would also like to thank my colleagues on the POLICY Project who worked on the reproductive health case studies. Ellen Wilson and Nancy Luke developed the survey instrument and the documentation systems. Kokila Agarwal and Karen Hardee offered guidance and direction during the planning, implementation, and documentation phases of the case studies. POLICY Project Director Harry Cross provided encouragement and guidance on the development and implementation of the studies. Finally, I would like to thank USAID colleagues Barbara Crane and Elizabeth Schoenecker for their support and reviews of the completed work. The views expressed in this paper, however, do not necessarily reflect those of USAID.

Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health.

The field work for the Bangladesh Reproductive Health Case Study was conducted from August 17 to 27, 1997. Respondents included 29 persons from 26 organizations active in the population sector. All respondents were based in Dhaka and represented government organizations, nongovernmental organizations (NGOs), U.S. technical assistance organizations, research organizations, donors, the private sector, and service providers.

Bangladesh has made tremendous progress in policymaking for reproductive health. The government, NGOs, and the Ministry of Health and Family Welfare (MOHFW) have supported the goal of making reproductive health services available to all Bangladeshis through the provision of an Essential Services Package (ESP). Many of the reproductive health policies have been translated into operational guidelines. Working with other ministries, NGOs, and donors, the MOHFW has developed the Health and Population Sector Strategy (HPSS), which moves from vertical projects to an integrated program approach that addresses the health needs of the population. The MOHFW has completed an implementation plan based on the HPSS whereby it will provide an Essential Services Package that follows a client-centered reproductive health approach and addresses women in particular.

Although many policies are in place, much needs to be done before high-quality reproductive health services can be delivered through public sector clinics. Currently, some reproductive health services are available at separate service delivery sites through both the Directorate of Health and the Directorate of Family Planning. These two separate structures frustrate an integrated approach to the delivery of reproductive health services. Other obstacles to integration include a lack of trained service providers; poor quality of care, particularly at clinics; and inefficient public sector services. Representatives from organizations involved in the reproductive health arena in Bangladesh are aware of these problems and are working to ensure that the reproductive health needs of the people of Bangladesh are met through high-quality, client-oriented services.

Abbreviations

AIDS	acquired immune deficiency syndrome
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FP	family planning
FPAB	Family Planning Association of Bangladesh (IPPF affiliate)
FWA	family welfare assistant
HAPP-V	Fifth Health and Population Program (World Bank)
HEU	Health Economics Unit at Dhaka University
HIV	human immuno-deficiency virus
HLCOM	High Level Committee
HPSS	Health and Population Sector Strategy
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IDA	International Development Association
IEC	information, education, and communication
IUD	intrauterine device
MCH	maternal and child health
MOHFW	Ministry of Health and Family Welfare
MR	menstrual regulation
NGO	nongovernmental organization
NIPHP	National Integrated Population and Health Program (USAID)
NIPORT	National Institute for Population Research and Training
RTI	reproductive tract infection
STD	sexually transmitted disease
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U. S. Agency for International Development
WHO	World Health Organization

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on their epidemiological significance and recommendations from the ICPD *Programme of Action*, reproductive health care in these case studies is defined as including the following elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services**;
- prevention and treatment of reproductive tract infections (**RTIs**) and sexually transmitted diseases (**STDs**) and **HIV/AIDS**;
- provision of **reproductive services to adolescents**;
- improvement of **maternal and infant nutrition**, including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers**, including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with key individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, NGOs, women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support of and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

The field work for the Bangladesh reproductive health case study was conducted from August 17 to 27, 1997, with 29 persons from 26 organizations interviewed. All respondents were based in Dhaka. Appendix 1 lists the organizational affiliation of respondents.

2. Background

Bangladesh's population totals approximately 123 million. Given the country's relatively small land area, Bangladesh is one of the world's most densely populated nations with over 850 people per square kilometer. It is also one of the world's poorest countries; the per capita gross national product is \$240 and about 45 percent of the population lives below the poverty line (USAID, 1997). Bangladesh has made tremendous strides in its family planning program, increasing the contraceptive prevalence rate from 7 percent in 1975 to over 49 percent in 1997. Despite these impressive gains, the unmet need for family planning services is 16 percent with wide variation across the country. Unmet need is highest in Sylhet and Chittagong divisions at 21 percent and lowest in Rajshahi and Kulna divisions at 11 percent (Mitra et al., 1997). The total fertility rate has fallen from a high of 6.3 in the early 1970s to 3.3 today. If, however, the present population growth rate of 2 percent continues, Bangladesh's population will more than double to 250 million in the next 35 years. The government of Bangladesh has set a goal of reaching replacement-level fertility by 2005; to achieve this goal, the number of contraceptive users must more than double during the next eight years to 21 million (USAID, 1997). However, even if Bangladesh achieves replacement-level fertility by 2005, the country will need another 40 to 45 years before the population stabilizes at 170 million (*The Fifth Five-Year Plan 1997–2002*, 1997).

Although many health statistics for Bangladesh point to improving conditions in recent years, much work remains to be done. The officially reported maternal mortality ratio is 450 maternal deaths per 100,000 live births. A recent study, however, estimated the maternal mortality ratio at 850 maternal deaths per 100,000 live births and the life-time risk of maternal death at 1 in 21 (WHO and UNICEF, 1996). Table 1 shows the causes of maternal mortality in Bangladesh. The lack of antenatal care contributes to the high rates of maternal mortality. Only 26 percent of pregnant women had at least one antenatal care visit and only 19 percent had two or more visits (Mitra et al., 1997). The low level of antenatal care is attributable to the fact that Bangladeshis perceive pregnancy as a natural state rather than an illness, and therefore do not seek care unless they experience a significant problem. Only 8 percent of women deliver their babies with the assistance of a physician or nurse-midwife. Of the estimated 33,000 maternal deaths per year in Bangladesh, many could be prevented through low-cost interventions (WHO and UNICEF, 1996). Although abortion is illegal, menstrual regulation (MR) is legal and widely available through many trained providers. Even so, only one-third of MR procedures are performed by trained providers and many women

do not know where to obtain safe MR services (Piet-Pelon, 1997). Many poor women do not realize that they are pregnant until it is too late for MR to be performed, and thus resort to illegal and unsafe abortions from untrained providers or traditional healers.

Breastfeeding statistics and child mortality rates are good indicators of the status of child health. Breastfeeding is nearly universal; 98 percent of infants are still breastfed at the end of their first year of life. Even though the level of breastfeeding is high, supplementation begins at an early age

Table 1: Causes of Maternal Mortality

Causes	Percent
Postpartum hemorrhage	26
Abortion	21
Eclampsia	16
Puerperal sepsis	11
Obstructed labor	8
Other obstetric causes	18
Total	100

Source: Piet-Pelon, 1997.

with water and other liquids. Only 50 percent of 0–3 month-old infants and 25 percent of 4–6 month-old infants are exclusively breastfed. Among infants age 10–12 months, lack of supplementation is a problem; 20 percent receive only breastmilk. Early supplementation in the lower age groups and lack of supplementation in the older age groups are responsible for some infant and child mortality. Although infant and child mortality rates are declining, the infant mortality rate remains high at 82 per 1,000 live births and the child mortality rate at 37 per 1,000. The mortality rate for children under five years of age is 116 per 1,000, which means that nearly 12 percent of children will not live to their fifth birthday (Mitra et al., 1997).

With no national studies of STDs in Bangladesh, national data about prevalence are nonexistent. According to a private sector representative, some small studies that asked questions about RTIs found that approximately 60 percent of women self-report some type of infection, such as bacterial vaginosis, candidiasis, or an STD. A small study of select groups conducted by an NGO revealed STD rates of 60 percent in males, 42 percent in the general population, 72 percent in commercial sex workers, and 61 percent in truck drivers (private sector representative). A study conducted by Wasserheit et al. (1989) found that 21.9 percent of 2,929 women respondents reported symptoms of an RTI.

The current prevalence of AIDS and HIV is also unknown but is estimated to be low. There is no routine screening program except among Bangladeshis sent overseas to work, and no sentinel surveillance system is in place. Given the estimated high levels of STDs in Bangladesh and the rates of HIV incidence in neighboring countries, such as Myanmar and India, Bangladesh faces a potentially rapid increase in both HIV incidence and prevalence in the coming years. The government is aware of the risk and is addressing the issues of RTIs, STDs, and HIV/AIDS in its fifth five-year plan. The government has also approved the *National Policy on HIV/AIDS and STD Related Issues*, which is an important step in addressing these health problems (MOHFW, 1996a).

The population of Bangladesh is predominantly Muslim (83 percent) with the remainder Hindu (16 percent) and other (1 percent). Women's status in Bangladesh is markedly low but is improving. Among the Muslims, the practice of seclusion of women (*pardah*) is still common, especially among poor populations in rural areas. Because many women are not allowed outside the compound without their husband's approval, they experience difficulty in obtaining family planning and other health services. Literacy rates are low at 47 percent for men and 22 percent for women. Among respondents to the 1996-1997 Demographic and Health Survey (DHS), 55 percent of women had no formal education and 82 percent had primary education or less. Women's labor force participation rates are low at approximately 20 percent but have been increasing (BBS, 1996). In recent years, many NGOs and other organizations such as the Grameen Bank have developed programs that provide low-interest loans to poor women for developing income-generating activities (Schuler and Hashemi, 1994; Schuler et al., 1996). These programs and the increased participation of women in the garment and other industries are continuing to raise the status of women.

3. Policy Formulation

A. Structures for Policymaking

National Level

In Bangladesh, the Ministry of Health and Family Welfare (MOHFW) is the government body ultimately responsible for policymaking in the area of reproductive health. Service delivery activities are divided between two bodies within the MOHFW—the Directorate of Family Planning and the Directorate of Health. The directorates rely on their own vertical service delivery structures, with collaboration and coordination between the agencies weak at best. The Directorate of Family Planning provides public sector family planning services, including maternal and child health (MCH) services. The Directorate of Health provides services such as preventive and curative health care, immunizations for children, and tetanus toxoid for women.

The structures and processes of health policymaking in Bangladesh are highly participatory. Several participatory committees, task forces, and technical review committees are charged with policymaking in collaboration with the MOHFW. One donor representative stated, “Everybody in Bangladesh is involved in policymaking—the government, the MOHFW, local governments, local government rural development committees, donors, NGOs, the private sector, and everyone at the national level. The MOHFW is ultimately informed by the directorates’ task forces and committees.”

“Everybody in Bangladesh is involved in policymaking—the government, the MOHFW, local governments, local government rural development committees, donors, NGOs, the private sector, and everyone at the national level. The MOHFW is ultimately informed by the directorates’ task forces and committees.”
Donor representative

Several national committees, such as the National AIDS Committee and the Safe Motherhood Committee, address specific components of reproductive health. Many of the committees have been created or reorganized since the 1994 ICPD, but they are effective and meet regularly. Chaired by the prime minister, the National Population Committee is composed of 64 members from NGOs, research organizations, the cabinet, and other government organizations. Many multisectoral government agencies are also involved in reproductive health policymaking, including the Ministries of Women’s Affairs, Social Welfare, Youth, Agriculture, Education, and Religious Affairs. All of these ministries oversee multisectoral population programs that address issues such as family planning, health, and advocacy. Representatives of these ministries participate in the subcommittees, task forces, and technical review committees that report to the MOHFW.

NGOs

“Policymakers recognize that NGOs are important, and NGOs are involved in all aspects of policymaking. Now that government organizations and NGO sectors are working together, the whole system has improved—health, family planning, and all sectors of development. This clearly illustrates that active participation is necessary.”
NGO representative

The NGO sector in Bangladesh is both large and active. One NGO respondent estimated that over 2,000 NGOs are in some way concerned with reproductive health—whether through the mechanism of service delivery, education, behavior change communication, or demand creation. As a representative from a service delivery NGO commented, “There is a lot of participation of NGOs in reproductive health policymaking and planning, and over the past five years, many mechanisms have been put into place to bring government organizations and NGOs together.” A representative from a different service delivery NGO stated, “Policymakers recognize that NGOs are important, and NGOs are involved in all aspects of policymaking. Now that government organizations and NGO sectors are working together, the whole system has improved—health, family planning, and all

sectors of development. This clearly illustrates that active participation is necessary.” Even though NGOs participate widely, one international donor noted, “NGOs are a very powerful partner; however, they have not had an impact on forcing government to be more accountable to the people.” The same donor was optimistic that government accountability would improve as the clients of public sector services become more actively involved in program planning and implementation at the local level.

Private Sector

The Bangladesh government has actively encouraged the participation of NGOs in reproductive health policymaking, but it has not fostered the involvement of the private sector. With the exception of the Social Marketing Company, a private sector company established upon the conclusion of a donor-driven social marketing project, the private sector has played a marginal role in reproductive health policymaking and planning. It has, however, played an important role as a provider of services, logistical support, and commodities. A common remark about the private sector is that it is overly concerned with earning a profit and has not been interested in participating in policymaking except when issues arise that could adversely affect its earning capacity. A respondent from a service delivery organization stated that “during the last three to four years, people are thinking that the private sector should be involved in policymaking, and they are now participating on a small scale.”

Local Level

Participation in the policymaking process has not yet filtered down to local levels.¹ The local levels generally support the policymaking process, but few actively participate in reproductive health policymaking even when their local service is concerned. At the ward level, structures established for MCH and family planning committees are supposed to discuss family planning issues. According to one researcher, however, “60 percent of these committees are dysfunctional, 40 percent are active, and only 20 percent of these are very active. Policymaking at the local level is limited to the active 20 percent of committees.” As a goal of the fifth five-year plan, broad participation at the local level will help make service delivery systems more accountable to their clientele.

B. Evolution of Policies from Family Planning to Reproductive Health

For several decades, rapid population growth has been a major concern in Bangladesh. In fact, the government adopted the country’s first official population policy in 1973. As one researcher commented, “Consistent implementation of the population policy is the only policy that has been continuously followed [by the government] for the past 25 years. Population has been given high priority under all of the socialist governments, in spite of frequent changes in leadership.” The current prime minister speaks knowledgeably about the importance of both reproductive health and male involvement in reproductive health. The government’s strong and continuous support is the primary reason for Bangladesh’s effective family planning program.

Bangladesh was an active participant in both the government and NGO forums at the 1994 ICPD. One donor described the general attitude among participants returning from Cairo as “euphoric.” Early discussions following the ICPD focused on moving away from population targets toward a reproductive health approach and shifting the focus of both the public sector and civil society away from the provision of

¹ Administrative hierarchy—national, division, thana (district), union, ward, village.

family planning services to women and toward a reproductive health approach for all people. Many meetings were held among the stakeholders to determine the definition of reproductive health to be used by Bangladesh; the overall consensus called for adopting the official ICPD definition.

Many Bangladeshi policies, most of which were adopted before the 1994 ICPD, address individual elements of reproductive health, including family planning, maternal mortality reduction, maternal and child health, nutrition, and breastfeeding. Nonetheless, for Bangladesh, the 1994 ICPD was significant in inducing policymakers to think in terms of an integrated approach to reproductive health rather than in terms of individual elements that constitute vertical programs in reproductive health.

Several new policies targeted to specific reproductive health elements, such as STD/AIDS and emergency obstetric care, are now under development. In addition, the MOHFW established five subcommittees in June 1996 and is drafting a comprehensive health policy that will include reproductive health. A technical committee on reproductive health formed to advise the government on the fifth five-year plan, which places a strong emphasis on reproductive health. The draft of the comprehensive national reproductive health strategy document was completed in August 1997 and is undergoing review and refinements (Hussain, 1997).

Many of the “pre-Cairo” projects and programs are being revised to focus on reproductive health. Various ministries and NGOs are adopting specific elements of reproductive health as resources become available. Standards and protocols for service delivery are undergoing revision to move away from goals and targets toward an integrated approach to reproductive health. The development of new policies and revision of established policies and operational guidelines illustrate Bangladesh’s commitment to moving toward a reproductive health approach. Good policies do not, however, ensure that the people of Bangladesh will receive comprehensive, high-quality, client-focused reproductive health services. In any event, the issue of reproductive health service delivery at all levels within the public, private, and NGO sectors is increasingly receiving attention.

No respondent specifically mentioned Matlab, which is the field research station for the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). Matlab has played an important role in shaping the public sector family planning program by delivering intensive family planning and health services to a treatment area for comparison to an area provided with regular government services. Since the establishment of Matlab in 1977, a family welfare visitor has visited all married women in the target area twice per month. The result has been much higher contraceptive prevalence than in the comparison area. Although the research findings from Matlab are not replicable within Bangladesh as a whole, they have led to changes in the national policy process as well as revisions to government programs (Phillips, 1994).

Initiated in 1982, the Maternal and Child Health and Family Planning (MCH/FP) Extension Project was created both to identify barriers to generalizing the results of the Matlab experiment and to determine how those barriers might be removed through organizational change. The MOHFW has adapted many of the Matlab project strategies to the public sector family planning program. Strategies include client-oriented services, enhanced supervision, worker accountability, and improved relationships between the family planning program and the community. Caldwell and Caldwell (1992) concluded, based on the Matlab research, that merely supplying contraception does not lead to program success; high-quality female village workers visiting households helped legitimize contraception; and a large latent demand for limiting family size can exist even in the poorest societies. Haaga and Maru (1996) assert that the greatest effect of the Matlab research was the expansion of the workforce of female field workers in the public sector program.

C. Definition of Reproductive Health

As previously mentioned, Bangladesh has officially adopted the ICPD definition of reproductive health. In addition, ministries, NGOs, and donors have “bought into” the definition, which follows:

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (*Programme of Action*, 1994).

Bangladesh’s goal is to make reproductive health services available to all its citizens through the provision of an Essential Services Package (ESP). The package’s priority services include

- maternal health, including antenatal, delivery, and postnatal care, menstrual regulation, and postabortion complication care;
- adolescent health;
- family planning;
- management and prevention/control of RTIs/STDs and HIV/AIDS; and
- child health, including EPI (Expanded Program of Immunization), ARI (acute respiratory infections), CDD (control of diarrhoeal disease), and prevention of malnutrition (HPSS, 1997).

The elements in the essential package all carry equal weight. A steering committee and 10 task forces following up on the ICPD discussed and analyzed Bangladesh’s health situation and, based on the assessed magnitude of various health problems, determined which services would be included in the ESP. The committee and task forces gave preference to low-cost primary health care services that would have the greatest positive health impact for large numbers of people.

Bangladesh does not emphasize some of the health interventions specified in the ICPD *Programme of Action*. For example, reproductive tract cancers and infertility receive less attention because these problems affect a small number of people and are expensive to treat. However, much of the primary infertility caused by RTIs will be addressed when service providers implement protocols for STD/RTI treatment. In addition, given the absence of female genital mutilation, Bangladesh need not address this practice.

Moreover, gender-based violence is receiving attention in Parliament as well as in the arena of reproductive health policy. Specifically, the Ministries of Women and Youth and the Directorates of Health and Family

Planning are collaboratively addressing violence perpetuated primarily by men against women. Parliament is legislating against gender-based violence by updating laws, closing many loopholes, and increasing the severity of punishment for offenders. The Cruelty to Women Act covers rape, abduction, trafficking of women, and a particularly brutal form of violence referred to as “acid throwing.” If a man feels that he has been rejected, he will occasionally seek revenge by throwing acid in the face of the woman who spurned his advances. Unfortunately, the practice has become so widespread as to necessitate national legislation prohibiting it. A study conducted in the Matlab treatment area found that, between 1976 and 1986, 6 percent of deaths to women of reproductive age were related to gender-based violence. The primary cause of death was homicide or suicide related to stigma over rape, unwed pregnancy, or beating for dowry. The 6 percent figure would rise to 21.5 percent if it included abortion deaths related to unwed pregnancies (MOHFW, 1996b).

D. Knowledge about Reproductive Health

Within Bangladesh, knowledge of family planning is universal. By contrast, the level of knowledge about reproductive health varies widely among different groups. As addressed in more detail in a subsequent section, service providers in particular demonstrate variable knowledge of reproductive health. In general, the public is not especially knowledgeable about reproductive health. The ICPD, however, has spawned many workshops and seminars, and policymakers are generally aware of, interested in, and knowledgeable of reproductive health but may not understand all of its elements. Some policymakers have a narrow understanding of reproductive health and think that it is just a new name for family planning.

The literate, urban population is knowledgeable about the need for reproductive health services. In rural areas, only the elite with access to media are knowledgeable. The poor, rural, and illiterate population, which is the group that could realize the greatest benefit from receiving services (Goodburn et al., 1995), is not aware of the concept of reproductive health. A researcher said, “Rural women understand their own needs but are not familiar with the reproductive health elements. There is no concept of preventive care among rural women, and they seek treatment only when there is a problem.” Behavior change communication is an important part of the reproductive health program.

“Rural women understand their own needs but are not familiar with the reproductive health elements. There is no concept of preventive care among rural women, and they seek treatment only when there is a problem.”
Researcher

E. Support and Opposition

Support for Reproductive Health

Overall, policymakers at all levels have been highly influential in lending their support to reproductive health policies and programs. Many respondents stated an absence of opposition, although others pointed to individual organizations that oppose the concept of reproductive health. As a rule, the groups opposed to reproductive health are small and lack support and influence.

Opposition to Reproductive Health

The current opposition to reproductive health is limited to a few fundamentalist religious and other conservative groups and to a few women’s groups. Some conservative groups have used Muslim sentiments and other religious arguments to oppose reproductive health, maintaining that family planning interferes with the will of God to grant children. A few powerful, conservative policymakers are

sympathetic to fundamentalist ideals and, though opposed to reproductive health, do not speak out freely. Recognizing that the government supports the program, they do not want to fuel controversy. These same policymakers, however, sometimes try to subvert action on reproductive health issues. Moreover, the government occasionally takes a conservative position when it fears that religious groups are likely to oppose an issue and stir up adverse public reaction to the program.

Despite limited controversy surrounding reproductive health, the family planning program has been the focus of past criticism. Even though respondents stated that there is currently no organized opposition to reproductive health in Bangladesh, the family planning program came under criticism in the 1980s, both within Bangladesh and internationally, for its aggressive sterilization program (Barkat-e-Khuda et al., 1997). In addition, a woman's organization named Ubinig was extremely vocal in its opposition to family planning.

Some women's groups feel that contraception and family planning infringe on women's rights. Other groups oppose specific methods of family planning such as the intrauterine device (IUD) and Norplant®, which are perceived as posing hazards to women (Hardee et al., 1997). According to a technical assistance organization representative, some husbands and in-laws oppose family planning because they fear it will give women too much power and cause them to rebel against performing their traditional roles in the household. With the move from family planning to reproductive health, many people who previously opposed the family planning program may become allies once they learn that the integrated program emphasizes overall health rather than simply limiting the number of children a woman may bear. One researcher stated, "There were some women's NGOs who were not in favor of family planning and were very critical of the program. However, with ICPD, which furthers reproductive health and the Women in Development program, they now have become friends of family planning. This is very positive development."

4. Policy Implementation

A. Operational Policies and Plans

The MOHFW has translated many of the individual reproductive health policies into operational guidelines. Working with other ministries, NGOs, and donors, the MOHFW has developed the Health and Population Sector Strategy (HPSS), which moves from vertical projects to an integrated program approach that addresses the health needs of Bangladesh's population. In August 1997, the Planning Cell of the MOHFW completed and submitted to the World Bank an implementation plan based on the HPSS, whereby the ESP will follow a client-centered reproductive health approach and address women in particular. The government has written its fifth five-year plan, which, based largely on the HPSS, lays out the policies, strategies, and objectives for the period 1997–2002.

The two largest donors in Bangladesh have also developed assistance programs in accordance with the HPSS. USAID's National Integrated Population and Health Program (NIPHP) lays out the guidelines for USAID assistance to Bangladesh for the period July 1997 to June 2004. The mission of NIPHP is to reduce fertility and improve family health by working "closely with the government of Bangladesh on contraceptive logistics and urban immunization, national operations research, and information, education and communication [IEC] programs, and through support of selected service delivery programs at the Ministry of Health and Family Welfare [MOHFW] thana/union-level" (USAID, 1997). The World Bank's Fifth Health and Population Project (HAPP-V) will provide broad health sector support to the government

for five years beginning in July 1998. The HAPP-V consortium includes the World Bank, the International Development Association (IDA), United Nations agencies (UNICEF, UNFPA, WHO), and development organizations from the United Kingdom, the Netherlands, Sweden, Germany, the European Community, and Canada.

B. Service Delivery Structure

This section focuses primarily on the public sector, which delivers 80 percent of all family planning services nationwide in Bangladesh. Specifically, the MOHFW is responsible for the delivery of public sector services. At the same time, though, both the NGO and private sectors play an important role in service delivery. NGOs deliver services at project sites in areas of the country not served by the public sector.

Two directorates within the MOHFW provide services as follows:

- Directorate of Health—breastfeeding counseling; child immunization, including tetanus toxoid for pregnant women; and preventive and curative health services.
- Directorate of Family Planning—family planning services and commodities and MCH services, including antenatal care and curative services for RTIs and STDs.

Bangladesh's family planning program has achieved notable success. Aside from continuous, high-level support, one reason for the program's achievements has been the doorstep provision of services by a large number of family welfare visitors. With doorstep service provision, women unable to leave their homes can receive services, although their choice is limited to resupply methods such as oral contraceptives, injectables, and condoms. Doorstep services have been popular because they require little effort on the part of the user to obtain services; however, service delivery is expensive and may not be sustainable (*The Fifth Five-Year Plan, 1997–2002*, 1997; Janowitz et al., 1997). In fact, the public sector program is gradually shifting away from doorstep services and is encouraging clients to obtain services at fixed clinic sites. The shift will help move the program toward a more balanced method mix that will include longer-term methods, such as the IUD, Norplant®, and sterilization, all of which require a clinic setting. Through IEC, the MOHFW is trying to increase male awareness of reproductive health so that husbands become more receptive to their wives' needs to obtain services. All sites will not offer all reproductive health services, but an effective referral system will ensure that women receive the services they need.

Despite the success of the family planning program, respondents commented almost unanimously that the existence of two directorates is a problem that must be addressed. For example, a pregnant woman receiving antenatal care from Directorate of Family Planning facilities must visit a Directorate of Health facility to receive a tetanus toxoid injection. The artificial separation of the two directorates runs counter to integration goals; indeed, the primary goal of the ESP is to provide "one-stop" reproductive health services. The challenge is how to improve and unify the service structure. In any event, the process required to integrate the Directorates of Health and Family Planning will be fraught with difficulties. The High Level Committee (HLCOM), which consists of government, NGO, and private sector representatives and was formed at the request of the World Bank, is studying this issue.

The government realizes that the current structure of the MOHFW poses a problem. The following is an excerpt from the HPSS (1997):

The present organizational structure of the health and population sector needs further improvement to ensure a more sustainable and cost-effective delivery of essential services ... The Ministry's [MOHFW] bifurcation into Population and Health Wings, with separate cadres at all levels, dates back to the 1970s. This structure does not adequately respond to the needs of maternal health and clinical contraception and limits the potential for increasing the range, quality, and effectiveness of services. On the cost side, the current structure is a major cause of waste and inefficiency. Functionally, the bifurcation impedes referrals, generates internal conflicts, and contributes to the low utilization of public facilities. In addition current management systems provide few incentives to improve quality of care and respond to clients' needs. The management culture in the sector needs to be changed so that the providers are motivated to serve the needs of consumers. Public sector services will be the main focus for institutional reform. Public sector reform is also needed to improve the operating environment for all providers, and to effectively utilize the potential of the voluntary and private sectors.

There is a "need for organization and management reform within the MOHFW, and if the two directorates don't get together, then the Essential Services Package won't happen."
Donor representative

Respondents cited a general lack of coordination and collaboration between the two directorates. The technical staff of the directorates do not get along with each other and do not work together. The Directorate of Family Planning employs only a few physicians at the planning level, while an overabundance of administrators and bureaucrats neither delivers services nor completely understands technical issues. The reproductive health elements of the two directorates

overlap, and the respective service delivery structures are vertical. A donor stated that there is a "need for organization and management reform within the MOHFW, and if the two directorates don't get together, then the Essential Services Package won't happen."

C. *Implementing Agencies and Actors*

The MOHFW will be responsible for implementing reproductive health services in the public sector. Although many reproductive health policies are in place, the actual delivery of reproductive health services through public sector service outlets has to occur on a large scale. Some pilot tests, however, are underway to deliver reproductive health services through public sector clinics in selected districts; the preliminary results have been positive. In addition, several NGOs are beginning to implement reproductive health services at their clinic sites; again, the early results are positive. Many NGOs are small and deliver services in limited geographic areas. By virtue of their size and localized areas of operation, NGOs can be more flexible and adapt their programs quickly to meet the needs of their clients. Donors have also played a major role in influencing reproductive health policy development and are providing essential funding for program implementation, especially in the public and NGO sectors. The private sector has the potential to provide reproductive health services to people who are willing to pay; however, no information was available about this sector's provision of integrated reproductive health services.

D. *Integration*

Integration of services is necessary for the successful implementation of the ESP. The 1975 merger of family planning and MCH (Larson and Mitra, 1992) in part explains

"In the NGO system, they are trying to integrate all reproductive health elements including postabortion care under the Essential Services Package. I am hopeful that the government will also be able to achieve an integrated system."

U.S. technical assistance
organization representative

the success of today's family planning program, according to a government representative. In fact, most public sector facilities now offer both family planning and antenatal care services. Some facilities even provide both postnatal care and management of RTIs/STDs. However, the government's plan calls for integrating all seven reproductive health elements of the ESP at different levels of service delivery to enable people to receive at one service delivery site all the routine services they need. In January 1995, the MCH/FP Extension Project (Rural) began field testing satellite clinics that combine both family planning and EPI services. Both clients and providers have found the delivery of combined services to be more convenient, as evidenced by a 300 percent increase in client utilization (ICDDR,B, 1997). For its part, the NGO sector is successfully integrating reproductive health programs and services and has addressed all elements of the ESP, including postabortion care. A representative of a technical assistance organization commented, "In the NGO system, they are trying to integrate all reproductive health elements including postabortion care under the ESP. I am hopeful that the government will also be able to achieve an integrated system." Although the need for integrated services has gained general recognition throughout the health sector, some respondents expressed concerns. One service provider cautioned that the reproductive health package might dilute family planning and safe motherhood efforts.

"Yes, integration will be difficult, but the advantages of integration far outweigh disadvantages. It will cost much less to incrementally build on existing services and service delivery sites."

U.S. technical assistance
organization representative

As previously mentioned, the existence of the two Directorates of Health and Family Planning has led to the creation of many parallel systems and thereby poses a challenge to integration. One donor representative stated, "This is a big issue. Dr. Nafis Sadik [Executive Director of the UNFPA] made it clear to the prime minister that integration is crucial to the success of the reproductive health focus. We must integrate the Health and Family

Planning Wings, and they must work together. Currently, the Family Planning Wing is strong, but the Health Wing is weak. Our program will not remain successful if there is no integration. Many facilities are underutilized, and the different facilities and their staffs don't collaborate. How to integrate is a key issue." In the words of one U.S. technical assistance organization representative, "Yes, integration will be difficult, but the advantages of integration far outweigh disadvantages. It will cost much less to incrementally build on existing services and service delivery sites."

E. Constraints

Bangladesh has made tremendous strides in addressing the reproductive health agenda at the policy level; however, it still faces many constraints to full implementation. This section examines some of the existing constraints and their implications for moving from the current program to a reproductive health approach.

Human Resources Development

Many respondents complained about the lack of a sufficient number of trained personnel to deliver reproductive health services. "Cairo assumes that there is already a good service delivery system in place, but the system in Bangladesh has many problems. Without trained health personnel, they cannot effectively deliver reproductive health services to the people who need them," according to a researcher. MOHFW staff at all levels generally have not developed an integrated view of reproductive health and are poorly versed in population issues. At the same time, service providers are not well trained in the concept of reproductive health. "NIPORT's [National Institute for Population Research and Training] training programme has not been evaluated, despite having an evaluation specialist. No course evaluation report

based on pre- and postcourse training could be made during last [sic] seven years” (*The Fifth Five-Year Plan 1997–2002*, 1997).

Beyond the need for more trained service providers, personnel need drugs, supplies, and equipment to perform their work as well as logistical support, supervision, and monitoring and evaluation to ensure greater program impact. One researcher stated, “We have a good infrastructure in the government system, but the weakest part concerns management issues, including supervision and monitoring.”

Institutions that train workers will have to revise their curricula to reflect the new focus on reproductive health and the ESP. NIPORT, originally formed to provide program-oriented FP/MCH training to administrators of the Directorate of Family Planning, has trained family planning field workers and paramedics through field institutes located outside Dhaka. Personnel working for the Directorate of Health receive training under a separate system. When the directorates are integrated, the separate training systems will need to be integrated as well. One government representative noted, “Stakeholders and people in the community will need to be informed of changes in how services will be delivered once the directorates are integrated and how they can become involved.” Integration will require many difficult changes in the current system, but all respondents agreed that change is essential for the effective and efficient delivery of reproductive health services.

The quality of education delivered to workers in the health sector needs dramatic improvement. One researcher noted, “Cairo assumes that every country has a strong clinical base, but Bangladesh is really starting at the beginning with so many of these interventions. Workers don’t know how to handle RTIs. The whole medical education has deteriorated in recent years. About 20 years ago, they expanded [the] medical college system to put a medical college in each region. Physicians and nurses graduate with no clinical training. There is no natural cadre of people to do reproductive health. Family planning visitors have limited clinical skills and their training is terrible. However, in spite of this, some manage to be extremely effective, probably because they had a good mentor once they began delivering services. The MCH medical officer is not trained to do the clinical work. The district medical officer is supposed to supervise but is not technically competent. Bangladeshi women are very modest and want to receive services from other women, but women are not trained. In short, the quality of training and the lack of practical experience is the problem.”

Institutional

In addition to the bifurcation of the MOHFW, other institutional constraints undercut the implementation of reproductive health policies and programs. For example, groups working within the health sector tend to protect their own interests rather than collaborating to improve the current system and meet the needs of clients. In addition, the unionization of providers protects health personnel against charges of poor performance. Jobs are secure regardless of whether workers perform the roles for which they were originally hired. Moreover, regulations that place limits on the types of services performed by paraprofessionals serve the interests of physicians. Not surprisingly, infighting often characterizes the relationships between medical and nonmedical personnel, undermining program success and impeding adequate client access to long-term contraceptive methods. “There are internal conflicts between medical and nonmedical staff within the Family Planning Directorate. This occurs primarily between the TFPOs [Thana Family Planning Officers] and MO/MCH [Medical Officer for Maternal and Child Health] with regard to pay scale and status; financial drawing and disbursement authority; and career advancement opportunities” (Barkat-e-Khuda et al., 1997). Another institutional constraint relates to donors’ personnel practices. Donors often hire high-performing staff out of public service and reward them with salaries that

exceed those offered in the public sector. A donor representative also noted that donors tend to advance their own interests such that donor commissions and projects have at times overwhelmed Bangladesh.

Finally, the structure of MOHFW programs is designed for rural areas, although the annual rate of population growth in these areas is 2 percent compared to 6 percent in urban areas and 13 percent in the slums due to in-migration, according to a researcher. Bangladesh needs a public sector urban strategy that will ensure the delivery of reproductive health services in the cities, especially the rapidly growing slums. In the absence of a public sector preventive health care infrastructure in urban areas, the government relies on NGOs and the private sector for preventive services (HPSS, 1997). Some donors are working with NGOs in urban areas to expand services.

Another constraint to program implementation is corruption, which needs to be addressed to ensure that both health workers and the reproductive health delivery system are accountable. While it is a common and legal practice among physicians to work in the public sector during the morning and then work in their private practices in the afternoon, some physicians charge private sector fees for delivering services in the public sector, even though public sector services are supposed to be provided free. In addition, public sector commodities provided by donors are sometimes “sold” in the private sector. One NGO representative stated, “Corruption is a big problem, and I feel a stronger local government council will help with this. A common complaint that I hear from village level workers is ‘When I go to get supplies, I must write 25 when I get 20. I get a set amount for my traveling bill, but must give 50 percent to the clerk who gives the bill.’ The end result is that fewer commodities go to the people who need them, and women don’t get services. Also, to get a government job, people must pay money, then they feel like they don’t have to do their work.”

Quality of Care

Another constraint to reproductive health policy implementation relates to quality of care. Many clients feel that the current program does not adequately meet their needs. As part of the USAID worldwide reengineering process, USAID/Dhaka conducted a “Population and Health Customer Appraisal” to elicit information from clients about population, MCH, and broader primary health care issues (USAID, 1995). A “majority of women protested about a number of shortcomings: irregular visits by fieldworkers and paramedics or the failure of these personnel to visit all (including newlyweds); closed facilities, unavailable doctors, and shortages of suitable contraceptives, especially clinical methods; demands to purchase ostensibly free contraceptives, medicine, and immunizations; brusque, inconsiderate treatment; and failure to answer questions or motivate clients or to provide them with counseling and follow-up services” (USAID, 1995). Many respondents in the USAID study reported that they received higher-quality services from NGO clinics than from government clinics, and some stated that they preferred private providers.

Respondents raised several other quality-of-care issues during the case study interviews. Some commented that many service providers lack a “client focus” and deliver the services that the providers think clients need with little regard for client preferences. Given insufficient patient counseling on how to take oral contraceptives and the possible side effects associated with hormonal methods, many women take their pills incorrectly. In addition, many women who want no more children discontinue their use of the pill in response to real or perceived adverse effects such as headaches and weakness (*Comprehensive National Reproductive Health Strategy: Bangladesh*, 1997). Furthermore, many women continue to use the pill long after they could have shifted to long-term methods, according to one researcher. Increasing numbers of women resort to menstrual regulation, an indication that the quality of family planning services needs improvement.

“If the program is focused only on family planning, incorporating other reproductive health elements is not an easy task. Service providers are not ready to accept and provide new services. Incorporation of reproductive health elements into the service delivery system is going to be difficult.”

Researcher

In recent years, the prevalence of long-term methods such as sterilization and the IUD has been declining. Decreasing reliance on IUDs is probably the result of high levels of RTIs that went untreated. Little effort is directed to promoting long-term clinical methods such as tubal ligation and vasectomy. In fact, misinformation regarding vasectomy is widespread, and many women fear that their husbands will lose their virility if they undergo this procedure. In addition, the public sector lacks a referral system that would direct people to services not delivered by their local provider. Moreover, many public sector clinics are unsanitary, poorly stocked, and lack privacy. A researcher commented, “If the program is focused only on family planning,

incorporating other reproductive health elements is not an easy task. Service providers are not ready to accept and provide new services. Incorporation of reproductive health elements into the service delivery system is going to be difficult.”

The public sector continues to be the largest provider of family planning and MCH services in Bangladesh. Improvements in the quality of these services will dramatically improve the reproductive health of Bangladesh’s population. Small pilot programs have already demonstrated that enhanced service quality leads to increased levels of contraceptive use (POPTECH, 1995; Koenig et al., 1997). By extension, quality improvements should also spur increased use of other reproductive health services. Additional ways to improve quality of care include upgrading monitoring and supervision; relying on pilot projects to demonstrate that quality improvements increase client satisfaction; expanding the available range of contraceptive methods; and encouraging both medical and nonmedical staff to become involved in administration, management, and improvement of both their clinics and the services they deliver.

5. Resource Allocation

A. Funding Levels for Reproductive Health

During the past few years, funding levels for reproductive health have been increasing in real terms, suggesting a stronger government commitment to the program. Nonetheless, respondents agreed unanimously that the program is overly dependent on donor funds. Approximately 63 percent of the total development budget, which funds development programs, is donor-funded. The revenue budget, which covers the salaries of government workers, is 10 to 13 percent donor-funded. Yet, donor funding is decreasing such that more local resources must be provided while the program must become more cost-effective, especially given that demand for services is expected to double in the next 10 to 12 years.

The Fifth Five-Year Plan 1997–2002 includes some basic budget information for health and for population and family welfare. For example, despite considerable discussion about the need to merge the Directorates of Health and Family Planning, the plan includes separate chapters for health and family planning. Several donors were upset over the continuing bifurcation and have called for the two chapters to be merged into a single one. The total public outlay for health activities under the fifth five-year plan will be 62.3 billion Taka (US\$1 = 44.85 Taka), with 34.2 billion Taka earmarked for primary health care and 9.3 billion Taka for manpower development. The total public outlay for population activities will be 28.6 billion Taka, with an additional 5 billion Taka in private funds. The government also plans to use monies

gained through user fees for reproductive health services to fund additional population activities. The government expects the private and NGO sectors to contribute 30 percent and 10 percent, respectively, over and above the government's allocation.

Respondents raised several issues during the interviews regarding resource allocation. A respondent from a government organization stated, "Resource allocation does not yet reflect the priority placed on reproductive health in Bangladesh. Population is the biggest problem, but education receives the most money, followed by health and then family planning. Although it is necessary to increase educational levels to ensure development will happen, overall human development and an increase in quality of life are the goals which can be achieved through reproductive health." As a U.S. technical assistance organization representative pointed out, "Only 2.5 percent of total government budget is spent in the health and family planning sector, but 40 percent is spent in supporting unproductive government sectors." An ongoing debate rages between the Directorates of Health and Family Planning over who controls budgets. Currently, each directorate is responsible for reproductive health elements that fall within its respective portfolio of services. As noted by several respondents, this division of responsibilities and budgets further illustrates that the two directorates should be merged.

"Resource allocation does not yet reflect the priority placed on reproductive health in Bangladesh. Population is the biggest problem, but education receives the most money, followed by health and then family planning. Although it is necessary to increase educational levels to ensure development will happen, overall human development and an increase in quality of life are the goals which can be achieved through reproductive health."
Government representative

B. Major Donors

Nearly all international donors are involved in Bangladesh, and the high level of donor commitment is partially responsible for program success. The USAID-sponsored NIPHP will provide about US\$200 million to support the ESP during the next seven years. The World Bank and its development partners will provide more than US\$700 million through HAPP-V for broad-based sector support. Even though donor support is substantial, it is decreasing.

Many respondents, including some donors, expressed dissatisfaction over the role of donors in both influencing and directing the process of policy development in Bangladesh. One donor said that there are too many donors in Bangladesh and that they are pulling the government in too many directions. A researcher disagreed over the issue of numbers of donors but did note that donors are intrusive and insert themselves into government activities. Donors promote their own programs and keep changing their agendas. For example, one researcher stated, "There is currently an over-emphasis on HIV/AIDS. In the past, we were overdriven by the donors in family planning, now it is in HIV/AIDS." Furthermore, donor participation in many meetings means that discussions must be conducted in English. A representative of a U.S. technical assistance organization stated, "Many Bangladeshis working in the public sector do not speak English fluently, and they are hesitant to speak up in these meetings." Donors want to be involved in the policy process to ensure that their funds are spent wisely, but they need to be conscious of how host-country counterparts perceive their efforts.

One donor representative was particularly skeptical of the role of donors in Bangladesh. "Maybe there is too much money here. All of the major international donors are here and it is a big business. Bangladesh has a big program, and the government and the NGOs can play donors against each other. This system sometimes leads to inefficiencies. For example, nutrition is not being addressed properly, and some donors

are pushing family planning but not considering an integrated approach. They are also currently establishing a separate vertical HIV/AIDS program. Frankly, I don't see financial sustainability as a problem—the donors and their money will always be here.”

C. Financial Sustainability

The program's financial sustainability is increasing as the government funds a greater share of program costs. In fact, plans are being developed to introduce user fees for public sector services; such fees would promote cost recovery and further increase program sustainability. Studies by the Population Council and ICDDR,B have revealed that people are willing to pay for public sector services (Islam et al., 1997). Indeed, some service delivery sites have been charging user fees. In 1973, the Family Planning Association of Bangladesh (FPAB), an affiliate of the International Planned Parenthood Federation, introduced fees for services delivered through its clinics. Many NGOs have also started charging for services. The MOHFW is looking into costing individual reproductive health elements through its Health Economics Unit (HEU). The HEU would follow the disability-adjusted life year (DALY) approach applied in the World Bank's 1993 World Development Report, *Investing in Health*. Both the MOHFW and the HEU agree that fees can be successfully introduced. To that end, the MOHFW is pilot testing user fees in two thanas. While the effort is moving slowly, the MOHFW is encouraged by the early results. Despite some declines in contraceptive use in the first three months of the pilot test, the use of contraceptives has recovered quickly. The initial goal is to charge a small participatory amount but not to attempt full cost recovery. Once the MOHFW has introduced user fees in all public sector clinics nationwide, it will gradually raise the fees to recover a larger proportion of costs.

Full implementation of the ESP will be a costly undertaking. According to the budget of expenditures by logframe activities in the *Programme Implementation Plan Part II* of the Health and Population Sector Programme (MOHFW, 1998), the ESP will cost US\$271.4 million in the first fiscal year and a total US\$1.75 billion for all five program years (1999–2003). Other activities that will take place at the same time as implementation of the ESP include reorganization of service delivery, integration of support services (human resource management, facilities, procurement and logistics, quality assurance, behavior change communication, management information systems), hospital services, sectorwide management, and other public health and nutrition services. The total cost of these activities is estimated at US\$3.12 billion in the five-year period.

6. Challenges to Implementing Reproductive Health

Since the 1994 ICPD, Bangladesh has made tremendous progress in developing reproductive health policies. Good policies are important, but the challenge of implementing them remains. In addition to many of the constraints already discussed, several legal, regulatory, and cultural barriers need to be addressed before full implementation of the reproductive health approach can occur.

Legal and Regulatory Barriers

In terms of legal and regulatory barriers, abortion is forbidden by Islamic law and is illegal under Bangladeshi law, except in cases of incest or when the life of the mother is at risk. MR is legal and widely performed, but the quality of services is poor. While no spousal consent is required for MR, some clinics still require a husband's permission, according to a researcher. Owing to severe underreporting, no one knows how many MR procedures are performed. Moreover, many women still receive MR from untrained

providers, even though public sector services are available from trained providers at no charge. The rates of menstrual regulation and abortion are relatively low in areas where the contraceptive prevalence rate is high, and conversely, the rates of menstrual regulation are much higher in religiously conservative areas where contraceptive prevalence is low (USAID, 1995). According to Piet-Pelon (1997), until the MOHFW is willing to study MR, many women will continue to receive poor-quality services. In the meantime, the government is reluctant to focus on MR services.

As a consequence of the efforts of the Bangladesh Medical Association, clinical contraception is highly regulated. Tubal ligation is provided only under extremely strict conditions and requires spousal consent. A woman must have a minimum of two children older than one year of age before she can undergo sterilization. For a man to receive a vasectomy, spousal consent is not required. For persons seeking sterilization, the government pays an allowance for transportation, food, and lost wages, but only within that person's locality. If a person receives services outside his or her locality, the government pays no allowance. The process for obtaining approval for new contraceptives to be used in Bangladesh is time-consuming and fraught with difficulties. According to a service provider, even methods that have undergone rigorous clinical testing abroad and are in widespread use in other countries must be subjected to the approval process. Clearly, a wide variety of barriers impedes implementation of reproductive health activities.

Cultural Barriers

Several cultural barriers, including the relatively low status of women, hamper the implementation of a reproductive health approach in Bangladesh. Although the status of women is improving, it is still quite low (Schuler et al., 1995). On a positive note, many changes favorable to women occurred in the past 25 years. More women are in leadership positions at the local government level than ever before. A new bill in Parliament would stipulate a 30 percent quota for women in locally elected positions. Legally, the penal codes favor women, and NGOs have been working hard to help women understand their rights.

Despite these developments, the traditional culture in rural areas continues to stymie implementation of reproductive health activities. For example, in the divisions of Sylhet and Chittagong, which are strongly conservative, religious beliefs and customs restrict women's mobility and role in society. The contraceptive prevalence rate in these divisions is one-third that of the national rate. The move away from doorstep delivery of contraception to a clinic-based system could further constrain the ability of rural women to obtain needed services.

Although all government documents discuss the provision of contraceptive services to adolescents, the unwritten but understood definition is "married adolescents." Nonetheless, some oppose the provision of contraception to adolescents regardless of marital status, even though the average age at marriage is 18 for women and problems with pregnancy and delivery are more common among women of young maternal age. In addition, in an era of expanding economic opportunities for women, many women are delaying marriage in favor of developing a skill and working for a few years. The garment factories in Dhaka employ thousands of young women, 40 percent of whom are unmarried and between the ages of 14 and 19. No specific programs target these women with education and services.

"We need more anthropological studies to find out why people are not seeking medical care. If we could understand how people think, we could more effectively target our message."
Researcher

More informal education about health is needed in Bangladesh. As illustrated by low rates of antenatal care (Barkat-e-Khuda et al., 1997), the concept of preventive health care is not well understood. Reproductive processes and their consequences are considered a

way of life and not conditions that demand treatment. People do not realize that early treatment costs much less than more complicated treatment rendered during the later stages of an illness. Many people do not recognize the physical symptoms that indicate the need for medical intervention. Only 10 percent of people visit public health facilities when they are sick; the remainder see a private practitioner, take no action, or visit a traditional healer of questionable qualifications, according to a donor representative. The actual demand for health services falls far short of real demand, and many clinics are underused. Through both IEC and behavior change communication, residents can learn about the services provided at their local clinic and about when to seek care for themselves and their children. One researcher said, “We need more anthropological studies to find out why people are not seeking medical care. If we could understand how people think, we could more effectively target our message.”

7. Lessons Learned

The final question of the interview asked respondents to comment on both the progress achieved in moving toward a reproductive health approach and what other countries can learn from Bangladesh’s experience. The answers were objective and infused with a sense of pride that such a poor country as Bangladesh has been able to achieve so much without the concomitant increase in economic and social indicators that has occurred in other Asian countries such as Taiwan and South Korea. In spite of the progress, respondents recognized that more needs to be done to implement the policies that have been developed and to meet the reproductive health needs of the population.

One government representative said, “The contraceptive prevalence rate is now 50 percent, up from 7 percent in 1975. We have achieved this even though our country is poor, the level of illiteracy level is high, and the level of education is low. Most people are in agriculture. The purchasing power parity is similar to other poor countries, but when measured in U.S. dollars it is low. The cooperation of couples and motivation of field workers have been keys to our success. Still there is 20 percent unmet need. About 67 percent of contraceptives are field distributed, but actual use is about 20 percent less than that. We still have more work to do.”

According to a researcher, “It is remarkable what this program has achieved in family planning where so little else has changed. The doorstep program has revolutionized the family planning program and made a huge difference. Finally, women didn’t have to ask their husbands for money or permission to leave the compound.”

A donor representative remarked, “Bangladesh is a success story and has adjusted her programs to meet the current situation. The donors are supportive but are sometimes critical of government actions... They [the government] adjusted the strategy when it was needed and moved from static clinics to the doorstep program using FWAs [family welfare assistants]. They have taken into consideration the cultural dimension and religious leaders, and there is strong commitment from all levels of government.”

One NGO representative commented, “Our accomplishments regarding reproductive health are difficult to judge at present because we have just started our journey. Reproductive health gives a new vision of the whole program through the emphasis on services for the entire family. The most important lesson from Bangladesh can be learned from NGO activities among low-income groups. Involving and organizing women has created mobility and aspiration among the poorest sector and shows that it is possible to achieve success in society with high illiteracy and high infant and child mortality. We have also achieved success in spite of secluded women with less empowerment, cultural rigidity, religiosity, and an almost

stagnating socioeconomic condition. The entire situation has been changed with the high level of NGO activity. The dream for a better life has changed Bangladesh a lot and shows that aspirations can come true even within extreme poverty.”

Finally, a service provider said, “It is difficult to see the effect of the reproductive health program at present. Adding reproductive health will increase acceptability and accessibility and will eliminate stigma associated with family planning only. Reproductive health is comprehensive and broad. It addresses both women and men. It provides a comprehensive package of services and a more holistic approach. We have moved in a positive direction from population control to family planning to reproductive health.”

Appendix 1

Organizations Represented in the Interviews

Government Organizations	Ministry of Health and Family Welfare, Directorate of Family Planning, Directorate of Health; Planning Commission, Population, Development and Evaluation Unit; National Institute for Population Research and Training (NIPORT); Programme to Motivate, Train and Employ Female Teachers in Rural Secondary Schools (PROMOTE); Bangladesh Bureau of Statistics (BBS)
Nongovernmental Organizations	Nijera Kori; Association of Development Agencies in Bangladesh; Family Planning Association Bangladesh (FPAB—local IPPF affiliate); Family Planning Management Development (FPMD)/Local Initiatives Project (LIP)
U.S. Technical Assistance Organizations	The Population Council; Pathfinder International; Access to Voluntary and Safe Contraception (AVSC); International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B)
Research Organizations	University Research Corporation, Bangladesh (URC, B); Program for the Introduction and Adaptation of Contraceptive Technology (PIACT); Independent consultant working in reproductive health
Donors	U.S. Agency for International Development (USAID); Canadian International Development Agency (CIDA); World Bank; United Nations Population Fund (UNFPA)
Private Sector	Social Marketing Company
Service Providers	Marie Stopes Clinic Society; Associates in Training and Management (AITAM) Welfare Organization

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