Report No. 53

Health Sector Programme in Bangladesh: Promoting Participation and Gender Equity

Centre for Policy Dialogue

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The Centre for Policy Dialogue (CPD)*, established in 1993, is an innovative initiative to promote an ongoing process of dialogue between the principal partners in the decision-making and implementing process. The dialogues are designed to address important policy issues and to seek constructive solutions to these problems. The Centre has already organised a series of such major dialogues at local, regional and national levels. These dialogues have brought together ministers, opposition frontbenchers, MPs, business leaders, NGOs, donors, professionals and other functional groups in civil society within a non-confrontational environment to promote focused discussions. The expectation of the CPD is to create a national policy consciousness where members of civil society will be made aware of critical policy issues affecting their lives and will come together in support of particular policy agendas which they feel are conducive to the well being of the country. The CPD has also organised a number of South Asian bilateral and regional dialogues as well as some international dialogues.*

In support of the dialogue process the Centre is engaged in research programmes which are both serviced by and are intended to serve as inputs for particular dialogues organised by the Centre throughout the year. Some of the major research programmes of CPD include The Independent Review of Bangladesh's Development (IRBD), Governance and Development, Population and Sustainable Development, Trade Policy Analysis and Multilateral Trading System, Corporate Responsibility, Governance, Regional Cooperation for Infrastructure Development and Leadership Programme for the Youth. The CPD also carries out periodic public perception surveys on policy issues and developmental concerns.

As part of CPD's publication activities, a CPD Dialogue Report series is brought out in order to widely disseminate the summary of the discussions organised by the Centre. The present report contains the highlights of a dialogue organised by CPD in collaboration with Columbia University, USA held at ***CIRDAP Auditorium, Dhaka*** *on* ***July 8, 2002*** *on the theme of* ***Health Sector Programme in Bangladesh: Promoting Participation and Gender Equity.***

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1. INTRODUCTION

A dialogue on the *Health Sector Programme in Bangladesh: Promoting Participation and Gender Equity* was held on July 8, 2002 at CIRDAP Auditorium, Dhaka. Columbia University (CU), USA and Centre for Policy Dialogue (CPD), Bangladesh organised the dialogue with *Professor Rehman Sobhan* as Chair and *Mr Fazlur Rahman*, Secretary of the Ministry of Health and Family Welfare (MOHFW), as Chief Guest. More than a hundred people representing the Government of Bangladesh (GOB), international development agencies, academia, NGOs, private sector, media and primary stakeholders (underprivileged users of public services who are poor and women) participated in the dialogue. An innovative feature of the dialogue was the presence of representatives of community based health watch groups. A list of participants is annexed.

This report briefly describes the objectives and background of the dialogue, the major arguments of the three panelists introducing the topics for debate, the issues raised in the general discussion and the response of the Chief Guest, Secretary, MOHFW. The tables and figures presented by the panelists are annexed.

The dialogue was organised with three major objectives:

- Create a space for interaction between primary stakeholders (underprivileged users of services who are poor and women) and other stakeholders (government, private sector, NGOs, civil society, development partners), in order to enable the former to present their personal experiences with the health system and make recommendations to the government.
- Identify concrete strategies and actions to reduce existing social and gender inequities in health and promote citizens' effective participation in the health sector programme.
- Strengthen the commitment of all stakeholders to make health policies and programmes pro-poor, gender sensitive, and participatory.

The dialogue, organised in the afternoon, was preceded by a consultation, held in the morning with representatives of primary stakeholder committees (SC) based in the unions and thanas and Community Groups (CG), which is the management committee of community clinics (CC). The SCs have been working at the community level as health watch groups since 1999. These committees emerged after Bangladesh introduced major reforms in the health sector by adopting, first, a Health and Population Sector Strategy

(HPSS) in 1996, and then a five year (1998-2003) Health and Population Sector Programme (HPSP) in 1998.

HPSS and HPSP were formulated after wide-spread, nation-wide consultation organised over a 24-month period with different categories of stakeholders including underprivileged users of services who are poor and women.[1] HPSP adopted as its main goal, improvement in the health of the most vulnerable groups—women, children, and poor—by providing a client-centred essential services package (ESP) delivered through the primary health care system. [2] HPSP stipulated stakeholder consultation as an integral part of the programme's implementation, monitoring, and review. As a result in 1999, MOHFW established a National Steering Committee (NSC), and NSC facilitated the formation of 16 union and 9 thana primary Stakeholder Committees (SC) on a pilot basis to promote the incorporation of the community's voice in the implementation of HPSP and to establish the programme's transparency and accountability. The members of the SCs were nominated by the community during workshops organised by the MOHFW through a transparent process and to ensure the participation of vulnerable (poor and women) users of services.[3]

Though HPSP mandated the promotion of social and gender equity and stakeholder participation, successive annual reviews of the programme's implementation have noted a lag in translating these commitments into concrete strategies and actions. [4] Available statistical data underscores continuation of social and gender inequities in access and utilization of health services and in health outcomes. National Steering Committee (NSC) hardly convened a meeting, and in the first two years of HPSP no national level stakeholder dialogue was organised as part of the annual programme review. However, despite this lack of initiative at the central level, primary stakeholder committees at the union and thana levels continued their work with enthusiasm, and as an evaluation in 2001 points out these committees had successfully performed as local health watch groups. [5] GOB also agreed to establish Community Groups (CG), consisting of MOHFW field workers, members of local government and representatives of primary stakeholders as management committees for the proposed country-wide network of community clinics. However, in most cases, CG was formed top-down by the Thana Health and Family Planning Officer (THFPO) without participation by the community and remains mostly non-functional. Here, again, there was a gap between commitment and implementation.

2. KEY ISSUES FOR DEBATE

The Columbia University- CPD dialogue was organised to reinstate the voice of civil society in the formulation and implementation of Bangladesh's health policies and programmes as envisioned in HPSP. *Professor Sobhan* began the dialogue by welcoming the participants and explaining the objectives and format of the dialogue: the dialogue

would start with brief presentations by three speakers who would introduce issues for discussion. This will be followed by general discussion and debate. *Professor Sobhan* stressed the importance of organising multi-stakeholder consultations to debate publicly the various policy issues, which are being negotiated by GOB and international agencies. He, then, invited *Professor Rounaq Jahan* of Columbia University to present the keynote paper highlighting the major issues for discussion.

2.1 Social and Gender Equity

In her presentation, *Professor Rounaq Jahan* underscored the achievements as well as shortfalls in Bangladesh's health sector. She noted that since independence there has been steady progress in health improvements, evident by various indicators. For example, life expectancy at birth has risen from 50 to 60 years and the male/female gap has diminished. Similarly, the infant mortality rate has declined by nearly half in the past two decades (Figure 1.1 and 1.2 in *Annex1*).

Successive governments, particularly in the 1990s, have prioritised and allocated resources to the education and health sectors. These resources have made a positive contribution in improving health. From 3 per cent in the First Five-Year Plan (1973-78), Health and Family Welfare's share of allocations in the latest Five Year Plan (1997-2002) has risen to 10 per cent.[6]

However, despite overall gains there are significant disparities in the health status of various groups, specifically the poor, women, and indigenous people. For example, DHS, 1999-2000 shows gender disparities in child mortality (male 108, female 111) and nutritional status (stunted growth: male 43% and female 46%) (*Table 2.1* in *Annex2*). Child mortality rate for the poorest is nearly double that of the richest. There are also class and gender disparities in immunisation and treatment for various health problems.

Though the government has established a network of facilities for preventive and curative health services, quality and service utilisation is poor. Less than 20 per cent of the population uses public services. [7] Service delivery in the public as well as private sector remains provider driven. Consumers have virtually little input into improving the delivery system since there are no mechanisms for redressing consumer grievances. *Professor Jahan* argued that a stronger and more accountable regulatory system needs to be established to monitor the quality of services and prescription medications.

She pointed out that though the Constitution and the Bangladesh government have made a commitment to strive for social and gender equity as exemplified by the current Health and Population Sector Programme's (HPSP) main goal to improve "the health and family welfare status among the most vulnerable women, children and poor of Bangladesh," there are wide gaps between policy and programme objectives and results.

Professor Jahan then, highlighted several questions for discussion and debate in the dialogue:

- What progress has been made in implementing the social and gender equity agendas of HPSP?
- How can we expedite the implementation of measures to improve maternal health? Bangladesh Bureau of Statistics (BBS) 2001 and Demographic and Household Survey (DHS) 1999-2000 indicate that skilled health care personnel attend only 13 per cent of births and 63 per cent of women receive no antenatal care, (Tables 2.2 and 2.3 in *Annex 2*).
- How can we make service delivery reach the poor and encourage gender sensitivity in services? MOHFW/CIET, *Service Delivery Survey 2001* illustrates that adult females report longer waiting period for services and receive fewer explanations about treatments than adult males. Poor and female clients are also less likely to receive referrals.
- How can we enable women to make their own healthcare decisions? DHS 1999-2000 reveals that only seventeen percent of women make the final decision about their own health care; forty percent reported husbands having the final decision. (Table 2.4 in *Annex 2*).
- How can we raise awareness and improve service delivery in Sexually Transmitted Infection (STI) and Reproductive Tract Infection (RTI)? Women's knowledge of STI/ RTI and other gynaecological problems is low; few seek and receive treatment (DHS 1999-2000).
- What can be done to improve requests and receipt of services by female victims of violence? MOHFW/CIET *Service Delivery Survey 2001*, reports that only a quarter of female victims of violence seek treatment and there is almost no specific process for dealing with such cases.
- How can we improve adolescent health care? Adolescents have little knowledge about reproductive health and few seek reproductive health services.
- How can we increase male awareness and utilisation of reproductive health services? DHS 1999-2000 shows that less than 20 percent of men have ever used modern contraception (e.g., condoms and sterilisation) compared to 55 percent women using pills (Table 2.5 in *Annex*).
- How can we improve data collection, analysis, and indicators to monitor progress towards social and gender equity in health?

2.2 Participation

Next, *Professor Jahan* turned to the second topic of discussion — stakeholder participation. Again she noted that though HPSP was designed after widespread consultation, participatory aspects of the programme did not receive priority attention during implementation. She urged the participants to discuss and debate the following questions:

- What progress has been made in involving communities and stakeholders in the implementation, monitoring and review of HPSP?
- Are there established mechanisms for systematic community and stakeholder participation? Do these mechanisms promote an open exchange of views and feedback?
- Does community and stakeholder participation improve services? Data from the ICDDR, B study shows service improvements in selected communities as a result of stakeholder participation (Table 2.6 in *Annex*).
- What specific steps can be taken to ensure the participation of marginalised groups in community-based and civil society organisations? Do we have examples of best practices?
- Are the patients asserting their rights as specified in the recently introduced Charter of Rights? What other measures can be taken to strengthen the Charter?
- How can consumer and citizens' groups engage service providers and policy makers to respond to their needs?

Finally, *Professor Jahan* conveyed two key messages that emerged from the consultation with the primary stakeholders held in the morning. The messages were:

- Health is a human right. Bangladesh's health policy and programming needs to adopt a rights based rather than a top down service delivery approach.
- Despite problems and lack of government support, community-based health watch groups have succeeded in improving responsiveness of health services.

2.3 Perspectives of Stakeholder Committee Representatives

The next panelist invited by *Professor Rehman Sobhan* was *Ms Shova Rani Halder*, President of Thana Stakeholder Committee (TSC) of Dumuria, Khulna who presented a brief report of the morning consultation highlighting the experiences of the SC members and their recommendations. She noted that the most positive aspect of HPSP was the opportunity it provided for the participation of the communities along with MOHFW officials in the planning, implementation, monitoring and management of the country's health programme. She noted that the Stakeholder Committees have been established with several objectives, most importantly to:

- raise awareness about health and health services;
- foster links between providers and users of services;
- monitor the availability and quality of health services and
- establish transparency and accountability in the health system.

Ms Halder described the various activities of Stakeholder Committees. She highlighted their achievements as well as challenges.

Activities of the Stakeholder Committees

Stakeholder Committees hold regular monthly meetings where local problems are identified and strategies and activities are planned. Activities are implemented through individual as well as collective initiatives of the SC members. The main activities are:

- Data collection within the programme area.
- Organisation of meetings in schools, rural markets, and open fields to create health awareness in communities and if needed, to hold separate meetings for men and women, and ensure the presence of doctors and health workers.
- Promote health awareness through issue based dramas, songs, rallies, discussions, and poster shows.
- Institute cleanliness campaigns with assistance from local patrons, students, teachers, and members of the local market committee.
- Create healthcare plans for the disabled and disadvantaged.
- Organise public discussions with health officials and initiate collaborative projects.
- Publish information about local health problems and activities in newspapers.
- Organise cultural programmes and satellite camps on the occasion of health related national and international days.
- Evaluate yearly activities and celebrate the anniversaries of SC.

Achievements

Stakeholder Committees have achieved success in several fronts:

- People have become aware of their health rights through SC activities.
- SCs are regarded as resource and information centres for health related questions by the community.
- SCs have facilitated increase of the number of immunisation centres and satellite clinics and provided mobile health care services.
- SCs have succeeded in removing superstitious beliefs and limiting unscientific treatments such as spiritual healing.
- SCs have increased public awareness about meeting nutritional requirements from locally grown food items.
- SCs have succeeded in bringing modest improvements in service quality. In many places, medication is being supplied along with a prescription to patients.
- SCs have been able to stop local pharmacy owners from selling free medicine samples, which they obtained illegally from government facilities.
- Government officials have started to cooperate with SCs in undertaking joint projects. They are participating in public discussions in communities.

Challenges

Though the SCs work on a voluntary basis and aim to improve the effectiveness of HPSP, MOHFW is yet to grant them formal recognition through a government order. *Ms Halder* argued that this lack of formal government recognition is a major constraint for the work of SCs. Health officials often question the legitimacy of SCs' monitoring role. The SCs send annual reports to the NSC, but they never receive any feedback.

Recommendations

On behalf of Primary Stakeholder Committees, *Shova Rani Halder* presented the following recommendations:

- Government policies and programmes should recognize health as a basic human right.
- Stakeholder Committees should be granted formal government recognition through a government order.
- Participation of community representatives should be ensured in the formulation and implementation of government health policies and programmes.
- Public sector health staff should not be allowed to do private practice.

2.4 Policy and Programme Options

The final speaker on the panel was *Dr Binayak Sen* from Bangladesh Institute of Development Studies (BIDS). He presented evidence on continuing social and gender inequities in health and raised several questions for policymakers. *Dr Sen* noted that although there has been a remarkable reduction in infant mortality and in the percentage of underweight children, a considerable amount of social, economic, gender and regional inequalities still persist in Bangladesh (Tables 2.7, 2.8, 2.9, 2.10, 2.11, 2.12 and 2.13 in *Annex 2*).

There are severe regional inequalities in health, which cannot be explained by economic factors alone. Districts having the highest average income do not always correlate with the lowest mortality rate. For example, Chittagong, which has the highest per capita income, has the second highest infant mortality rate. Rajshahi has the highest poverty rate in Bangladesh but has a very high level of Contraceptive Prevalence Rate (CPR). BRAC and ICDDR, B Health Equity Watch data show that there are regional inequalities in the immunisation rate.

Dr Sen observed that the pressing policy issue is whether the progress Bangladesh has achieved in reducing infant mortality and total fertility rate can be sustained in the coming decade. He felt that only pursuing the income route or general economic growth route would not necessarily result in the achievement of the health goals.

The Millennium Development Goals

Dr Sen also wondered about the possibility of Bangladesh achieving the Millennium Development Goals (MDG) by following the same policy and programme approach taken so far. He argued that other actions are needed within and outside Bangladesh in order to achieve and sustain a rapid rate of progress in the next 10-15 years. *Dr Sen* noted that without the accelerated reduction of the income poverty rate, a high degree of health sector achievement can never be expected. For example, to reduce the current level of 62 deaths per thousand live births to 22 deaths per 1000 live births, a considerable reduction of the income poverty rate is necessary. Such rapid reduction cannot be achieved through economic growth route or through health sector programme route alone.

Dr Sen also pointed out that additional international resource injection is essential to achieve higher levels of development of health services and income poverty reduction. Commission on Macroeconomics and Health has recommended that at least $35 per person a year in expenditures in order to meet the essential requirements in the health sector. But the Commission has found, in December 2000, that only $5 to $6 per person a year is actually being spent in developing countries. The resource gap is thus enormous, and can never be met by the government sector and domestic resources alone.

Partnership and Multi-sector Actions

Dr Sen argued that there is a real need for improving health sector governance, and building partnership between private, government and NGO sectors. At present resources are being inefficiently utilized. Even at the current level of resource allocation—about 1.2% of the GDP— Bangladesh has not done well in many areas. Public health has failed to address adequately the issues of the health care needs of the poor, both preventive and curative, particularly the emerging health problem of non-communicable diseases. *Dr Sen* pointed out that even if the health capacity of the public sector is doubled, it can only address twenty-five percent of acute health care needs and forty percent of major health care needs (in rural areas, the actual rate is twelve percent of the short term health care needs and twenty-five percent of the major health care needs). However, *Dr Sen* highlighted the need for standardization and regulation of the non-government sector, because of so-called quacks and pseudo- providers.

Finally, *Dr Sen* stressed the importance of multi-sectoral actions. Health is not exclusively affected by factors within the scope of the health sector. For example, problems in the environment cause many health problems and there is a need for industrial regulation.

3. DISCUSSION AND DEBATE

Following the presentation by the three panelists, the Chairperson invited discussion from the audience. He noted the presence of an enormously rich collection of people from different areas with a variety of interests and asked the participants to dwell on primarily two areas: actual functioning of HPSP and its impact, and experiences with the participatory processes. *Professor Sobhan* asked the representatives of community-based stakeholder committees to share their experiences first.

3.1 Experiences of Stakeholder Committees with the Health System

Ms Rokeya Buli, President of Thana Stakeholder Committee (TSC), Sariakandi, Bogra described her personal experience as a president of SC in her community. She highlighted the non-responsiveness of service providers by narrating the story of a young girl who wanted to remove her NORPLANT, due to side effects. Her family took her 12 times to the provider, who refused to remove it. Finally, the family had to take her to a private clinic. She also stated that despite achieving recognition from the community for her work she faced difficulty interacting with government health officials who questioned the legitimacy of the SC.

Mr Golam Akbar, President of TSC, Shudharam, Noakhali found a shortage of doctors, paramedics, medicine and equipment in thana and district health complexes. When the SC started working, they did not get cooperation from the Health Complex (HC) officials.

Ms Shova Rani Halder, President TSC, Dumuria, Khulna described the difficulties rural women faced in reaching Health Complex (HC). Women were often unaware of health services, and the distance of the HCs from their homes prevented them from seeking health care.

Hazi Mohammad Shahabuddin, President and *Ms Jahanara Begum,* Vice-President of Kafilatuli Community Group (CG) of Community Clinic (CC) in Sreepur, Gazipur noted that in their CCs there were no doctors or medications, and health workers did not visit regularly. *Mr Shahabuddin* felt that the establishment of the CC to provide healthcare for the poor was a good idea, but due to government mismanagement, CG members are losing their reputation in the community. Sreepur CC was closed during the entire month of May and on the National Immunisation Day (NID) thousands of people came but could not have their children immunised because the providers were absent. *Ms Jahanara Begum* persuaded some disadvantaged women to come to the CC, but they could not get medicine. They were referred to the union or thana health complex but the situation at those clinics were the same. The health workers asked patients to go to private health services. In many cases, *Ms Jahanara Begum* had to spend her own money to ensure the provision of health services to poor women of her community.

Mr Rezanur Rahman of Nijera Kori reported some positive changes brought about by the SC. Through meetings between community and GOB officials, people could seek answers to their questions and thus some form of accountability has developed over the years. Inter personal respect has increased between the SC members and the Health Complex (HC) staff.

3.2 Questions for the SC Members

Several participants raised specific questions for the SC members.

Dr Md Obayedullah Khan Wahedee from Dhaka Community Hospital posed the following questions to the SC members:

- Was there any positive change due to SC interventions?
- Was there any change in the HC doctors' behaviour where SC was present?
- Were the MBBS/ GPs of the community involved in the process?
- Was there any change in the behaviour of these MBBS/ GPs as a result?
- Did the HC doctors stop private practice?
- Was there an increase or was there a decrease in access to services as a result of SC activities?
- Were the UP Chairman /members and members of the SCs more favoured by the health officials?

Professor Muzaffar Ahmad, from Dhaka University and Transparency International, Bangladesh raised the following questions:

- Why was he not able to locate any SC in the greater Mymensingh area where he was doing research on health?
- Where are the SCs , located and why these locations?
- What is the methodology of work of these SCs?
- How are SC members selected?
- How are they monitored?
- What is the model on which SCs are based?
- Can these committees be termed as SCs or should these be called citizen's committees?

Professor Ahmad argued that being a member of a community does not automatically entitle one to become a stakeholder; making a cash or in kind contribution to the functioning of the health complex is necessary to becoming a stakeholder.

Dr Moazzem Hossain of Save the Children, UK raised some questions about the model of community participation as envisioned in the SCs. He argued that SCs should first start in communities without any government order and only if successful should later seek government support. He provided the model of private schools: generally a school is developed by private initiative in the community, and when it is well established it seeks government recognition. In the case of the SC model, he detected a flaw. SCs are first seeking government recognition without creating a firm community foundation. He further argued that SCs are only discussing issues. They are excluded from controlling funds. This is bound to result in frustration.

3.3 Responses of Stakeholder Committee Representatives

Ms Rokeya Buli noted that people in the community have enthusiastically supported the formation of SCs, though the health officials were not initially receptive. However, over time with continuous work the SC has been able to get some cooperation from the THC.

Mr Golam Akbar stated that when the SC members are able to explain to the health officials that the SC is not a vigilance group, but its work is to improve relationships between physicians and patients they get cooperation from the health officials.

At this point, *Professor Jahan* asked whether any impact had been created by the intervention of SCs or any improvements made in the health service provisioning.

Md Arshed Ali, President TSC, Bagatipara, Natore stated that SCs have made people aware of their health rights. Access to and quality of services have improved. They have mobilised people to attend immunisation camps.

Ms Shova Rani Halder narrated a positive case study of SC's effectiveness. One day a child staying in *Ms Halder's* house became sick. Without properly diagnosing the child or running any tests, the local health worker vaccinated the child. After 15 minutes the child died. Local people attributed the death to the vaccine and decided not to immunise their children anymore. *Ms Halder* found out that the child had pneumonia when the vaccination was given. The SC members then explained to the community that it was not the vaccine but the pneumonia and the reaction to the vaccine, along with the negligence of the health worker that had caused this tragedy. The explanation relieved the community and vaccination of children resumed. The SC has also put pressure on the government health workers to provide adequate family planning services to the people. This, accompanied by the SC's ability to complain to higher authorities, have resulted in improving the supply of contraceptives.

Ms Jamila Begum, President of Tangail Stakeholder Committee stated that the SC has succeeded to put a stop to the illegal trade of medicines, which were supplied to the HCs. The SC arranged successful joint meetings between local communities and service providers.

Ms Lutfun Nahar from Shibalaya TSC implored the audience present in the dialogue to utilize health services from the thana and union health complexes in the rural areas, rather than from the modern, well-equipped private clinics of the capital city. This is the only way to make policy planners understand the state of the health system in Bangladesh. She advocated increased resource allocation for health including establishment of additional hospitals.

3.4 Health Score Cards

Professor Muzaffar Ahmad shared the experiences of other health watch groups that are functioning in different regions of the country. He had observed groups monitoring the union, thana and district health centres in Muktagacha, Modhupur, Nalitabaari, Kishoreganj and Mymensingh areas. These watch groups issue report cards for the health facilities based on the information collected from the community. Topics include the number of visits to HCs, number of times they are refused, and whether they have to pay an extra amount for the treatment. A Scale of Satisfaction is formed from this information. According to this scale at the union health centres 53% women are satisfied; at the thana level the rate is 65%; in district health complexes, it is 37%; in specialized hospitals the rate is 27%; and in the city hospital it is 39%. The differences in the rate of satisfaction across social categories is also evident. Compared to the poor, those who have more money are reported to be more satisfied. Professor *Muzaffar Ahmad* also noted that these watch groups arrange meetings with the thana and union level providers and service users, when complaints are raised. Findings show that at the union level, complaints about service decline after such meetings. But at the Mymensingh

Medical College Hospital the watch groups were unable to arrange a meeting with doctors, and found it difficult to obtain permission to observe activities on the Medical College Campus. A USAID led survey revealed that in rural areas 46% people go to the UHFWC/THC, 11% to the NGOs, and 18% to the private practitioners.

3.5 Participation and Accountability

Speakers came up with a host of recommendations to improve stakeholder participation in the health system.

Professor Muzaffar Ahmad argued that if local government leaders could ensure accountability of the HCs, then the quality of service would improve. He reported that in 30 UPs, services improved due to local government initiatives. He also stressed the importance of economic empowerment of local governments and health watch groups.

Ms Tahera Jabin of the British Council pointed out that resource limitation of GOB and other problems are well known, but discussions about solutions should begin. In HPSP the issue of community participation is included but the process of developing a strategy is yet to be elaborated. She suggested that consultation is not enough, collaboration and joint decision making are needed to make stakeholder participation effective. The lessons from SCs indicate that service providers should be included in SCs. She further proposed that SCs should be registered as a social service and should act as a CBO.

Ms Joanna Reid of BPHC felt that one of the major problems of SCs is the lack of legitimacy and institutionalisation. The next HPSP should address this issue. The roles of the NGOs are very important, as they can help the government in service delivery and help the community to develop a voice. She recommended greater partnership among GOB, NGOs, INGOs and development partners.

Dr Ali Ashraf of ICDDR,B noted that SCs had a very good start, but the whole process is suffering because there are existing government health committees and GOB is not sure how to integrate SCs.

Dr Yasmin Ahmed of Marie Stopes Clinic reported that the Ministry of Commerce is preparing a Consumers' Bill of Rights for legislation. She argued that MOHFW should follow the same model. If legislated, the Clients' Charter of Rights would be more effective.

3.6 HPSP: Rationale and Objectives

The chairperson invited *Mr Mohammad Ali*, former Secretary of MOHFW to make his intervention. *Mr Ali* focused on the key concerns that led to the formulation of HPSP. He highlighted several problems of the health system: inequity in accessing health care between male and female, rich and poor, and rural and urban citizens; inadequate and poor quality of doctors, nurses, equipment and medicine; discrimination against women and lack of community participation in the service delivery system, and decision making.

HPSP was developed to address these problems. *Mr Mohammad Ali* stressed that the main goal of HPSP is to improve the health of the most vulnerable women, poor and children by providing a client-centred ESP package. He described different elements of HPSP which are meant to promote equity and participation objectives, for example community clinics to bring services closer to people; integration of the National Nutrition Programme (NNP) to address the nutritional needs of women, children and poor; promulgation of the Patient's Charter of Rights to raise awareness of people's rights; Behaviour Change Communication (BCC) and Local Level Planning (LLP). *Mr Ali* stated that though income poverty reduction will definitely help, he differed with *Dr Binayak Sen* and argued that by making health programmes effective one can have significant health gains.

At this stage *Professor Sobhan* intervened to point out that the logic behind HPSP was known to all, but the participants of the dialogue were interested to know what had actually happened over the years after the initiation of HPSP, whether the objectives have been met. He then invited participants to identify other issues, which are not being adequately addressed by the current health programme.

3.7 Adolescent Health and Drug Use

Dr Naila Khan of Shishu Hospital highlighted the health problems of the adolescents and stressed that their health issues should be addressed on a priority basis in the next health programme. About 50% of the total population is under the age of 15. Amongst adolescents a high percentage are drug addicts. But they often have no place to go for treatment. They do not receive health care in the Paediatric Hospitals as they are not children and the general hospitals treat them as mini adults. Adolescents want to know about their body and sexuality. But school teachers do not take the responsibility to provide this type of education. *Dr Khan* noted that research has shown a steady decline in the IQ level of children over a period of ten years. There has also been a reduction in speech and language communication, and an increase in behavioural problems due to a variety of factors such as malnutrition, stress, violence, migration, and under stimulation. Schools, doctors and psychologists should ensure better health care for adolescents and create space for a wider dialogue on adolescent health and drug issues.

3.8 Urban Poor

Dr Yasmin Ahmed of Marie Stopes Clinic argued that the needs of the urban poor must be prioritised in the next health programme. The urban poor cannot afford private services. She, however, noted that people do not always seek health care just because it is free. Specialised approaches are needed to attract the urban poor, and convince them to seek health services.

Ms Shirin Akter of Karmajibi Nari highlighted the health concerns of girls working in the garments sector. Though garment factory owners are supposed to provide workers with health care in the factory, in reality there are no such services. These women are the most vulnerable; they work long hours and when they come home at night, health facilities are closed.

3.9 NORPLANT

An interesting debate developed between *Dr Jahiruddin Ahmed*, Director – MCH, and Line Director ESP and *Ms Nasreen Huq* of Naripokkha about the side effects of Norplant and responsiveness of government health services. *Dr Ahmed* contested *Ms Buli*'s allegation that the NORPLANT is resulting in serious side effects and service providers are neglecting users' complaints. He stated that the hormone used in NORPLANT is similar to other widely used female contraceptives, such as oral pills. He informed the audience that in his 25 years of professional life in Family Planning, he never had a report of any death due to use of NORPLANT. Then he added that a few years ago *Ms Nasrin Huq* of Naripokkha filed a complaint about the same matter with the GOB but he did not find any basis for the complaint. He went on to describe the new venture of the Directorate of Family Planning — bladeless surgery —for sterilising men. About 90% males in Nilphamari who agreed to have vasectomies have used this method. He argued that this method would reduce fear about male sterilisation and become another contraceptive method.

Ms Nasreen Huq contradicted *Dr Jahiruddin's* claims. She shared her experience of working with the users of NORPLANT in Rajshahi. She supported *Ms Buli's* statement that one woman experiencing problems with NORPLANT went to the provider 12 times to remove it, but was denied. At last her family took her to a private clinic to save her life. Another girl had a barber remove the NORPLANT, as the service provider had been transferred. She submitted all these complaints to the then-Director of MCH, *Dr Jahiruddin*. He investigated and came to the conclusion that since the information about NORPLANT problems did not come from the respective doctors and providers, the allegations were baseless. *Ms Huq* noted that she was outraged by this government response and did not bother to reply to the government's letter.

Dr Jahiruddin then recommended greater partnership between GO and NGOs to make contraceptives less feared. He argued that erroneous ideas about male permanent contraception must be removed through the SCs. Further, NGOs should undertake training of skilled birth attendants.

3.10 Private Sector

Dr Naila Khan proposed that following the West Bengal model, separating practicing and non-practicing doctors might be a good idea. If government doctors are made non-practicing and provided with a good allowance, the poor quality of care and negligence will be reduced. Additionally, since the doctors in the medical schools are practicing, they do not have the time and interest to do medical research. This vacuum is being filled primarily by international consultants and research organisations such as ICDDR,B. She urged measures to promote research by doctors.

Mr Saiful Alam Khan of Ibn Sina Trust, claimed that the private sector had made great strides, but it has not been involved in the national health policy planning. The successes and problems of private sector are not being adequately researched and documented to draw lessons. In many private hospitals, some operations are less expensive than those in government hospitals. He stated that private sector is also experimenting with various methods to ensure patient's health rights within the premises of hospitals/clinics. These strategies need to be shared with the GOB. He recommended that the process of procuring a license for a private health facility should be made easier by GOB.

3.11 Gender Equity

Dr Makhduma Nargis, Vice-President, Bangladesh Mahila Parishad felt that although two issues —participation and gender equity —were to be discussed in the dialogue, the former had been emphasized by the participants at the expense of the latter. She noted that gender issues always lose priority amongst competing agendas. She stated that despite commitment in the plan document, the health issues of the poor and women were not adequately addressed during HPSP implementation.

Dr Maleka Banu, AGS of Bangladesh Mahila Parishad, pointed out that HPSP is the first government programme to integrate people's participation in the policy planning processes. However, there are areas that need to be revisited and improved. She stressed that adequate budgetary resources should be allocated to implement gender equity and participation dimensions of HPSP and the issue of violence against women must be addressed.

4. FUTURE DIRECTIONS:

4.1 Response of the Chief Guest

At the end of the discussions *Professor Sobhan* invited the Chief Guest, *Mr Fazlur Rahman*, Secretary, MOHFW to make his intervention. *Mr Rahman* made the following key observations:

- Basically, it is people who produce their own health outcomes. The family is responsible for the physical and mental health of its members; however in Bangladesh generally too much emphasis is given on curative health. Alma Ata declaration has rightly pointed out eight interventions important for health outcomes, which include water and sanitation, hygiene and immunisation. GOB is a signatory of Alma Ata, and all 24 services provided under ESP in the thana and union health centres and community clinics are built from this.
- HPSP is very ambitious. It includes many positive elements, but the new initiatives were not given a transition time and were not piloted for understanding their impact. As a result during implementation, HPSP is facing many problems. In the preparation of HPSP-2 —the next five year health programme—, GOB will take measures so that it does not face the same kinds of problems.
- The main problem of HPSP was delay in procurement, which happened due to inflexible guidelines of the donors. In HPSP-2, all Line Directors (LD), will procure their own goods with assistance from CMMSD.
- A decision on the functioning of the community clinics will be taken soon. In an effort to promote partnership, DFID and USAID supported NGOs will be asked to provide services at the community clinics.
- The next health programme will address the unfinished agendas of HPSP such as social and gender equity and adolescent health. It will include emerging issues such as HIV/AIDS, arsenic, and urban health. Additionally, it will cover the areas of nutrition, adult and child health, and hygiene.
- Bangladesh Integrated Nutrition Project (BINP) has produced good results for maternal and child health outcomes. All BINP thanas are included in the National Nutrition Programme (NNP). GOB will move forward with the programme.
- Unavailability of doctors is a major problem. To resolve this, GOB will fill all the existing vacancies by additional recruitment and doctors will get fewer opportunities to seek transfers. Similarly recruitment of nurses will be expedited. This is evident by the recruitment of 1,000 nurses this year. GOB wants to ensure the doctor and nurse ratio of 1:3.
- The government has already distributed the Patients' Charter of Rights to almost all of the government health facilities.
- In the Millennium Development Goals (MDG), three goals directly address health and four are health related. These goals can be achieved if accountability in the

health system is improved. The PRSP (interim) has made health a major entry point of development in Bangladesh.

- The Government is intent on spending more money on the health sector to improve preventive health care. For example, this year Saudi Arabia has donated 43 ambulances and GOB has purchased 80 ambulances.
- Work on legislation such as the draft of the Safe Blood Transfusion Act 2002 is progressing well. The Institute of Maternal and Child Health (IMCH) Bill has passed in parliament.
- Public-private and NGO partnerships are needed. During the formulation of HPSP, private and NGO sectors were involved. Similar engagement will be sought in the development of the next programme.

4.2 Concluding Remarks

Professor Sobhan invited *Professor Rounaq Jahan* to sum up the important points of the dialogue. *Professor Jahan* thanked all participants and thanked CPD for organizing the dialogue. She noted that though the dialogue was organised with three objectives, only one was met: it created a space for primary stakeholders to meet face to face with policymakers and other stakeholders. She proposed that another discussion with smaller number of people be held later to identify concrete strategies and solutions. She highlighted some key issues that emerged from the dialogue:

- Problems in the health system identified by the SC members are continuing to persist.
- There is need to investigate the alleged abuses of NORPLANT and other contraceptives.
- Different forms of SCs are functioning all over the country. All forms of health watch groups tend to ensure community participation and transparency. There needs to be a joint consultation of several such groups to exchange information. The work and contribution of watchgroups also need to be documented.
- The issues of adolescent health and drug use, arsenic, and HIV/AIDS should be addressed in the next programme.
- There were gaps and shortfalls in the implementation of HPSP, but its objectives are widely accepted. The unfinished agendas of HPSP should be continued and completed in the next programme. New issues might emerge, but ensuring social and gender equity and stakeholder participation should be prioritised.

Professor Rehman Sobhan thanked all the participants who attended the population and health sector dialogue. He expressed his delight to have a chance to collaborate with Columbia University and hoped such collaboration will continue in the future.

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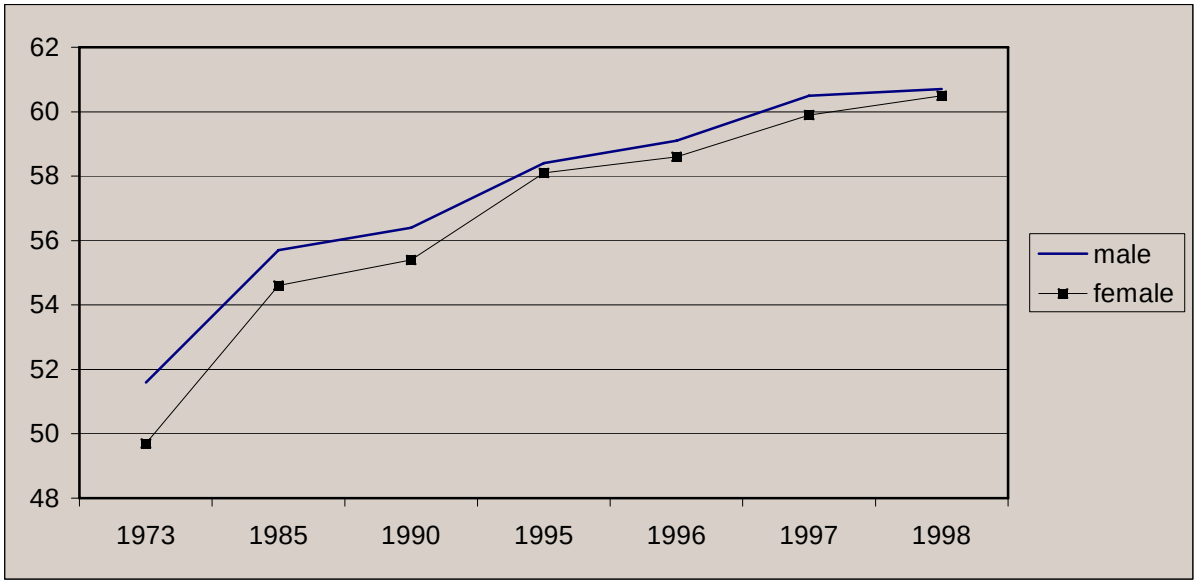
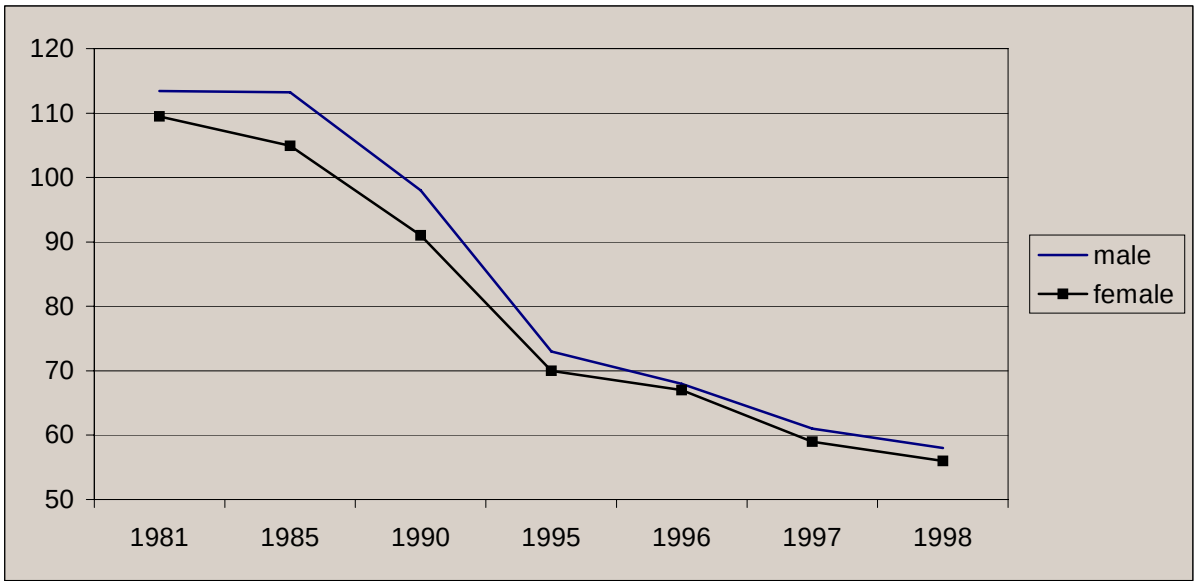
Annex 1

***FIGURE 1.1*: LIFE EXPECTANCY AT BIRTH**



Source: BBS (1987-1999), Statistical Yearbook of Bangladesh

***FIGURE 1.2:* INFANT MORTALITY RATE**



Source: BBS (1987-19929), Statistical Yearbook of Bangladesh

Annex 2

TABLE 2.1: **INFANT AND CHILD MORTALITY RATE BY DEMOGRAPHIC CHARACTERISTICS**

Characteristics	Neonatal mortality	Post neonatal mortality	Infant mortality	Child mortality	Under-five mortality
Sex of Child					
Male	54.7	27.5	82.2	28.4	108.3
Female	45.9	31.1	76.9	37.7	111.7

Source: Demographic and Household Survey, 1999-2000

TABLE 2.2: **CHILD BIRTH PLACE AND ATTENDANT USED**

Birth Attendant	Doctor	Auxiliary	Other
Total	5.8	6.9	87.3
At home	1.8	2.6	85.3
At facilities	4	4.3	2

Source: BBS, June 2001

TABLE 2.3: **ANTENATAL CARE BY REGION AND EDUCATIONAL CHARACTERISTICS**

	Antenatal Care Provider (%)				
Characteristics	Doctor	Nurse/ Midwife	Birth attendant	Other	No one
Residence:					
Urban	49.9	8.7	0.8	2.8	37.7
Rural	18.2	9.8	0.3	3.3	68.3
Mother's Education:					
No education	11.5	0.2	0.2	2.7	76.9
Primary incomplete	18.7	0.2	0.2	3.8	66.8
Primary complete	22.9	0.6	0.6	4	61.5
Secondary +	49.5	0.7	0.7	3.4	35.9
Total:	23.7	9.6	0.4	3.2	63

Source: Demographic and Household Survey, 1999-2000

TABLE 2.4: **PERSON WHO HAS FINAL SAY**

	Person who has the final say (%)				
Household Decision Making	Respondent only	Respondent and husband jointly	Respondent and someone else jointly	Husband only	Someone else only
Her own health care	17.1	32.1	5.1	40.2	5.4
Child health care	15.8	39.1	5.9	29.2	6.2
Large household purchases	7.3	42.5	10	31.9	8.1
Daily household purchases	16.5	36.3	8.9	29.5	8.8
Visits to family or relatives	10.7	41.4	8.4	31.9	7.5
What food to cook each day	66.4	11.3	9	4.4	8.9

Source: Demographic and Household Survey, 1999-2000

TABLE 2. 5: **TRENDS IN EVER USE OF FAMILY PLANNING METHODS OF ALL WOMEN**

Method	**1975 BFS**	**1983 CPS**	**1985 CPS**	**1989 CPS**	**1989 BFS**	**1991 CPS**	**1993 - 1994 BDHS**	**1996 - 1997 BDHS**	**1999 - 2000 BDHS**
Any method %	13.6	33.4	32.5	44.2	45	59	63.1	69.2	74.6
Any modern method %	unknown	23.8	25.9	37.5	unknown	49.2	56.4	63	67.9
Pill	5	14.1	14.3	23.3	22	34.1	42	48.9	55.4
IUD	0.9	2.2	2.7	4.6	4	6.2	7.3	6.9	6.9
Injectables	unknown	1.2	1.3	2.8	2	6.6	11	15.7	20.1
Vaginal method	0.5	2.2	1.6	2.4	1	2.9	unknown	unknown	unknown
Condom	4.8	7.1	5.7	9.3	6	13.4	13.9	15	18.6
Female sterilisation	0.3	5.8	7.4	8.7	9	8	7.9	7.6	6.6
Male sterilisation	0.4	1.4	1.6	1.6	1	1.4	1.4	1.2	0.6
Any traditional method %	unknown	17.3	11.9	15.3	unknown	29.6	24	23	28.8
Periodic abstinence	4.5	11	7.8	9.7	13	21.5	16.5	16.7	18.9
Withdrawal	2.6	5.3	2.9	3.6	7	11.1	10.1	9.5	14

Source: Demographic and Household Survey, 1999-2000

TABLE 2.6: PERCEPTIONS OF CONSUMERS ABOUT IMPROVEMENT IN HEALTH FACILITIES DUE TO WORK OF STAKEHOLDER COMMITTEES

Reported Areas of Improvement	Percentage of Respondents (n=85)
Cleanliness improved	63
Waiting arrangement improved	70
Waiting time for service decreased	65
Service providing hours increased	67
Availability of service providers increased	76
Behaviour of service providers improved	68
Sufficient medicines provided	38

Source: ICDDR,B, "Incorporation of Community's Voice into Health and Population Sector Programme of Bangladesh for its Transparency and Accountability, Working Paper No. 148, 2001, Page #16.

TABLE 2.7: **INFANT AND UNDER-FIVE MORTALITY RATE BY WEALTH QUINTILE**

Quintiles	IMR	U5MR
Poorest	96.3	141.1
Second	98.7	146.9
Middle	97.0	135.2
Fourth	88.7	122.3
Richest	56.6	76.0
All	89.6	127.8
Poor/Rich Ratio	1.70	1.85

Source: Sen (2001)

TABLE 2.8: **INFANT AND CHILD MORTALITY RATE BY WEALTH QUINTILE AND BY GENDER**

Quintiles	IMR		U5MR	
	Male	Female	Male	Female
Poorest	99.7	92.7	133.1	149.7
Second	104.8	92.6	142.3	151.4
Middle	116.1	79.8	157.8	114.5
Fourth	89.4	88.1	120.9	123.6
Richest	53.5	59.8	72.5	79.7
Poor/Rich Ratio	1.86	1.55	1.84	1.88

Source: Sen (2001)

TABLE 2.9: **NUTRITIONAL STATUS OF CHILDREN BY WEALTH QUINTILE**

Quintiles	Children Stunted (%)	Children underweight (% moderate)	Children underweight (% severe)	Immunisation coverage (%)			
				Measles	DPT3	All	None
Poorest	50.5	60.3	28.7	62.1	60.4	47.2	18.3
Second	50.8	53.5	26.2	59.8	60.7	43.7	14.5
Middle	41.9	49.2	21.7	74.1	73.3	60.8	12.4
Fourth	34.8	41.8	13.1	78.5	76.4	58.8	5.4
Richest	23.5	28.1	5.6	82.6	83.2	66.7	4.9
All	41.3	47.6	19.8	69.9	69.3	54.1	12.0
Poor/Rich Ratio	2.149	2.146	5.125	0.752	0.726	0.708	3.735

Source: Sen (2001)

TABLE 2.10: **PREVALENCE OF MALNUTRITION AMONG UNDER-FIVE CHILDREN BY WEALTH QUINTILE AND BY GENDER**

Quintiles	Children Stunted (%)		Children Underweight (% moderate)		Children Underweight (% severe)	
	Male	Female	Male	Female	Male	Female
Poorest	52.1	49.0	59.8	60.8	26.3	31.0
Second	52.4	49.2	54.7	52.2	26.9	25.4
Middle	45.8	38.0	50.9	47.6	24.3	19.1
Fourth	36.4	33.0	41.7	42.0	13.4	12.7
Richest	21.0	26.2	29.1	27.1	5.7	5.6
Poor/Rich Ratio	2.48	1.87	2.05	2.24	4.61	5.54

Source: Sen (2001)

TABLE 2.11: **EXCESS MORBIDITY BY SOCIOECONOMIC DIFFERENTIALS**

Household Defining Characteristics	Variable Considered	Poor/Rich Ratio	
		Mean Duration of Morbidity	Mean Duration in Bed
Gender	"Female" over "Male"	1.03	0.90
Location	"Rural" over "Urban"	1.36	1.34
Quality of Life	"Poor housing" over "Better housing"	1.28	1.29
	"Without sanitation" over "With sanitation"	1.15	1.05
Resource-Access	"Without electricity" over "With electricity:	1.34	1.39

TABLE 2.12: **MORBIDITY PREVALENCE RATIO FOR ILLITERATE VS. LITERATE**

Diseases/Symptoms	**Poor/Rich Ratio**
Immunisable diseases	2.21
Fever/Pyrexia of unknown origin	1.66
Malaria	1.65
Scabies	2.03
Diarrhea	2.73
Dysentery	1.57
Dyspepsia Gastric/Peptic Ulcer	1.56
Influenza	1.23
Common cold/URI/Acute Cough/Bronchitis	2.04
Asthma	1.53
Ear Inflection	1.00
Rheumatic Fever	1.68
Chicken Pox	0.46
Jaundice	0.68
Kaalazar/Typhoid	1.06
Blood Pressure/Heart Disease/Stroke	1.23
Reproductive Health Problems	1.67
Malnutrition/Anemia	1.81
Other Diseases/Conditions	1.28

Source: Sen (2001)

TABLE 2.13: **MORBIDITY RATE BY EXTREME POOR IDENTIFYING INDICATORS**

	Extreme Poor Identifying Indicators	Morbidity Rate (Per 1000 Population)
Household Heads, Occupation	Cultivator	12.3
	Agricultural labor	18.3
	Fisheries/Livestock/Cottage Industry	24.3
	Trade	12.6
	Transport	13.6
	Construction	17.3
	Self service	15.5
	Salaried service	12.1
	Non-agricultural wage	12.7
	Others	11.1
Housing	Jhupri	31.6
	1 Room hut	16.9
	1 + Room hut	15.7
	Tin house	11.1
	Pucca house	15.4
	Tully house	14.9
Land (acre)	<.50	15.3
	.51 – 1.49	13.0
	1.50 – 2.49	12.1
	2.50 – 4.9	10.5
	5.00 +	11.0

Source: Sen and Begum (1998).

Annex 3

List of Participants

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110.	*Mr Sajjad*	Staff Reporter, The Independent
111.	*Mr Sushanta Sarkar (Sujon)*	Reporter, The Daily Ajker Prottasha
112.	*Mr Nurul Alam Shaheen*	Reporter, The Daily Inqilab
113.	*Mr Asif Shawkat*	Reporter, The Matribhumi
114.	*Mr M.A. Zaman*	Reporter, The Daily Millat
115.	*Mr Asad-uz Zaman*	Staff Reporter, The Financial Express