Report No. 60

Health System and Women's Health : Priorities for the Next Programme

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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 the dialogue on ***Health System and Women's Health: Priorities for the Next Programme*** *held at the* ***CIRDAP Auditorium, Dhaka*** *on* ***February 20, 2003*** *jointly organised by the Columbia University and CPD.*

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Dialogue on

HEALTH SYSTEM AND WOMEN'S HEALTH: PRIORITIES FOR THE NEXT PROGRAMME

1. Introduction

The Centre for Policy Dialogue (CPD), Bangladesh in collaboration with Columbia University, USA organised a dialogue on ***Health System and Women's Health: Priorities for the Next Programme*** on February 20, 2003 at the CIRDAP auditorium, Dhaka. *Professor Rounaq Jahan* of Columbia University made the keynote presentation at the dialogue. The Special Guest on the occasion was *Professor (Dr) M S Akbar*, Honourable Member of Parliament (MP). Participants attended the dialogue from a range of sectors and professional groups including academia, NGOs, donor agencies, politics, bureaucracy and civil society. A list of participants is annexed.

Professor Rehman Sobhan, Chairman of CPD, moderated the dialogue. He started the event by welcoming the participants to the dialogue and acknowledging the long-standing relationship between Columbia University and CPD on the *Health Sector Reforms Project.*

2. Keynote Presentation

Professor Jahan opened her presentation by describing her research project on *Health Sector Reforms* in Bangladesh, in which there is a specific focus on issues of gender equity and participation in health. The research project was initiated in 2001 and in July 2002, a policy dialogue was organised in collaboration with CPD where both stakeholder participation and gender equity issues were highlighted. *Professor Jahan* noted that one of the participants of the earlier dialogue, *Dr Makhduma Nargis*, had pointed out that gender issues appeared to have received low priority in the discussion. Based on this valuable earlier comment, the present dialogue was tailored to focus specifically on gender issues.

Professor Jahan noted the contribution of the International Women's Health Coalition (IWHC), for supporting the Health Sector Reforms Project in Bangladesh. She stressed that MPs should remain involved in policy and programme issues, stating that the two

important functions of parliament are to formulate policy and ensure the accountability of the executive branch.

Professor Jahan then began her keynote presentation by restating the objectives of the dialogue. These objectives are: to provide a forum for civil society, particularly women's organisations where they are able to express their views on what the priorities should be for the next health programme; and, to raise public awareness through open dialogue and debate. Her presentation centred on three issues:

- why women's health is a matter of great concern in Bangladesh;
- what causes death and disability in women;
- what actions the next health programme needs to take to improve women's health.

2.1 Why Women's Health is a Matter of Concern?

Women's health continues to be a matter of great concern in Bangladesh. Despite the fact that women constitute half our citizenry, they continue to face persistent disadvantages and exclusion, evident in gender differentials for various indicators of health. One of the most telling indicators of the disparity between males and females can be found in child mortality. Though following global norms in Bangladesh, infant mortality is higher for males than females, soon after birth the mortality rates start to reverse. For example, post neonatal mortality among males is 27 per 1,000 births versus 31 among females, and child mortality among males is 28 per 1,000 births versus 38 among females. These disparities clearly indicate the neglect of girl children in terms of nutrition and access to health care. Surveys show that females are more likely than males to suffer from malnutrition, which is evident from stunting and underweight figures. Similarly, females are less likely to receive basic health care in the form of immunisation since only 57% of females as compared to 63% of males receive full vaccination.

According to *Professor Jahan*, the data indicates that wide gaps exist between policy and programme intentions and implementation. Successive Five Year Plans and health programmes have adopted improvements of women's health as a major goal of the government's health policy and programmes, yet progress has been slow. This gap between policy/programme objectives and results calls for a reassessment of strategic

interventions and allocation of adequate resources. One needs to ask whether the policy/programme interventions have been appropriate and whether sufficient resources have been allocated to meet the policy/programme objectives. Thus, questions remain as to the nature and range required of future interventions including the budget, in order to implement effective change in women's health indicators. Professor Jahan also warned of the risk posed by the recent concerns expressed in the media by the Ministry of Health and Family Welfare (MOHFW) about the stagnating Total Fertility Rate (TFR). She felt that these concerns indicate that the population control agenda is gaining priority and in future only family planning services will be pushed while other aspects of reproductive health, most importantly safe motherhood, will be neglected.

2.3 Causes of Death and Disability in Women

Malnutrition, pregnancy and childbirth-related problems and violence account for most deaths and disabilities among women, not diseases as some may assume. *Professor Jahan* illustrated this point by citing some current statistics. For example, the majority of women (52%) are malnourished (BMI below 18.5), which creates additional problems during pregnancy and childbirth and in the use of certain contraceptive methods. Maternal deaths account for 37% of all deaths. Twenty percent of these are caused by unsafe abortions while 14% are due to violence. In the age group of 10-45 years, 22% of deaths are due to violence, half of which are brought about by women committing suicide.

Data on morbidity is more limited, indicating low prioritisation of the issue. Available data, however, shows high maternal morbidity. Childbirth-related chronic or residual morbidity is experienced by 39% of women, at the same time, 15% of mothers' report prolapsed uterus. In the reproductive age group (14-45 years), women's morbidity rate is 38% more than men.

Not surprisingly given the many indicators that show the lower status of women's health especially when compared to that of men, only 40% of households' health budgets are spent on women. This despite the fact that the morbidity rates for women is 14% higher than that of men. The main reason for this gender disparity in household spending is the fact that women are excluded from making decisions regarding their bodies and health, which quite naturally contributes to women's mortality and morbidity. This lack of

decision-making power is evident in the statistics that show that 17% of women report having the last say with regards to their own health, while 40% report their husbands having the last say.

Even when a woman earns an income, she does not control her earnings. An example of this can be seen in the garment industry, which is a major export industry of Bangladesh and employs mostly women. Even among this prominently female group of workers, only 34% control their own income. Similarly, micro credit programmes are seen as Bangladesh's showcase example of a successful development strategy, particularly in terms of contributing to the socio-economic empowerment of women. Yet only 30% of women in micro credit programmes, control their income. The need for increased participation of women in decision-making and the control of their own income is all the more clearer when one looks at research findings that show that when women make decisions and control income, their own nutrition and health as well as that of their families' improve. Data shows that although women are decision-makers in only 5% households with pre school children, these 5% of households have been found to be making better choices in what they eat and thus enjoy better nutritional status compared to households with male decision-makers.

Women face discrimination not only within households, but also outside. Service providers do not prioritise women's nutrition and antenatal, safe delivery, and post-delivery care. They are generally insensitive to women's complaints about health problems such as the side effects of contraceptives, postpartum disabilities, and violence against women. Seventeen per cent of women compared to 10% of men report not using government health services because of the unsympathetic often non-cooperative behaviour of the staff.

Women's lack of access to health services is evident in the fact that only 34% of women receive antenatal care, and only 2% of women receive post-delivery care. Skilled personnel attend only 15% of births and only 7% of high-risk pregnancies get health care. In addition, it has been found that 29% of women discontinue contraceptive use because of side effects. Low prioritisation of maternal health is evident from the fact that more women know about the availability of family planning services (47%) from Union Health and Family Welfare Centres, than antenatal care (4%) and delivery care (1%).

Poor and rural women are particularly disadvantaged. For example, 49% of female children belonging to the lowest wealth quintile and 26% of female children belonging to the highest income quintile are stunted. Similarly, 35% of rural women and 16% of urban women deliver their babies in health facilities. Adolescent girls are even more vulnerable. They suffer greater risk of maternal mortality and morbidity, of STDs, and larger risk of violence. Of female students, for example, 46% do not know the name of any STDs versus 33% of male students.

2.3 Ways in Which the Next Health Programme Can Respond

Professor Jahan stressed the need for the next health programme to respond to these issues in a number of ways. First, clear priorities should be established keeping in mind resource constraints. The target groups for public sector services are children, adolescents, women of reproductive age, and the poor. Investing in the health of these particularly disadvantaged groups has great potential for economic growth.

Although the Health and Population Sector Programme (HPSP) adopted several well thought-out objectives and developed excellent strategies, there was a large disparity between the design and implementation of HPSP. *Professor Jahan* said that the next programme needs to carry forward the unfinished agenda of the HPSP in areas such as reproductive health. In the next programme, the ESP package, for example, should include all the elements of reproductive health defined by the International Conference on Population and Development (ICPD) and also HPSP. These are safe motherhood, neonatal care, maternal nutrition, infertility, family planning, safe abortion, prevention and control of RTI/STD/AIDS and adolescent care. Integrated reproductive health services should be provided and within reproductive health, maternal health should continue to be a priority.

Professor Jahan also argued out that while the maternal health and gender equity strategies of HPSP were excellent plans in theory, their implementation was inadequate. Therefore, in the next programme, operational plans should be developed and resources allocated for the implementation of gender equity and maternal health strategies, which were approved by MOHFW in 2001. The next programme should focus on selected strategic interventions to improve maternal health. For example, skilled birth attendants should be trained at an accelerated pace. The current number of 25,000 trained birth

attendants is inadequate and need to be tripled for nationwide coverage (at present the coverage is only15%). She stressed that investment in the training of community midwives should receive priority instead of the building of new hospitals. Moreover, outreach workers should be trained to provide comprehensive messages on women's health to both women and men. In this regard, a nation-wide information campaign 0should be launched, similar to past family planning campaigns through the radio and television media about nutrition, safe delivery, pre and post delivery care and RTI, STD and HIV/AIDS.

Professor Jahan highlighted the need for the next programme to continue and strengthen services for victims of violence against women. HPSP has initiated services only on a pilot basis in selected facilities. The coverage needs to expand given the enormity of the problem. She then went on to stress that HPSP's commitments to health sector reforms should be carried forward and implementation bottlenecks of different reform elements should be addressed by the next programme. In particular, the contested issue of the unification of health and family planning services should be resolved by using the criteria of serving the interests of service users rather than those of service providers. *Professor Jahan* clarified that the current contestation over unification of services is mainly over the control of staff and funds. The contestants are not concerned about improving quality of service or service outreach. The interests of service users who need one-stop comprehensive reproductive health services are getting lost in the current controversy.

She also stressed that the next programme should move ahead with decentralisation of administrative and financial authority to lower levels of services as conceived under HPSP. The next programme should attempt to unburden the already overloaded public sectors by outsourcing certain services to the private and NGO sectors where they have competence and comparative advantage. Examples from pilot projects such as the Bangladesh Integrated Nutrition Programme (BINP) demonstrates the effectiveness of outsourcing services for improving maternal and child nutrition and the utilisation of reproductive health services. Additionally, incentives should be provided to the private and NGO sectors to expand their health services, provide training and undertake advocacy. Bangladesh needs thousands of additional doctors, nurses and trained midwives. Public sector training facilities are not providing the required numbers.

Private sector medical colleges are training doctors but so far, the private sector has not shown interest in training nurses and midwives. In the next programme, the government can consider providing incentives to the private sector to start training of nurses and midwives.

Furthermore, *Professor Jahan* emphasised the need for the next programme to develop accountability of services through both internal and external checks. On an internal level, service providers should undergo effective monitoring by their supervisors to check for absenteeism and corruption. Externally, accountability to users of services must be established by forming local level accountability structures such as community clinic groups, stakeholder committees, hospital boards, etc. These accountability structures should ensure representation of women's organisations and women users of services. Awareness must be raised regarding the recently adopted Patient and Provider Charter of Rights. This will facilitate better communication between providers and users of services; it will particularly help the process of informed consent.

Before going on to concluding remarks, *Professor Jahan* described her recent trips to government health centers in Bogra shortly after Eid-ul-Azha, which exemplified the problems faced by users of public health services. She visited a Thana Health Complex (THC) where she found that the majority of male patients were injury cases from the Upazila elections and the female patients were delivery cases. It seemed that very little if any counseling was given to patients. For example, a delivery case had been brought to the complex the previous night and the mother had already been sent home after delivery because her relatives wanted to take her home. This without any further advice as to required bed rest or supplementary care, even though she had excessive bleeding due to obstructed labour, and the child had difficulty breathing. Another delivery case was waiting – she was suffering from eclemtia, and had to rely heavily on the assistance of her relatives because there was a lack of attention being given to her by attending nurses and doctors.

A further point that was brought out was that although Essential Obstetric Care (EOC) equipment was available at the THC, there was no-one available to operate the equipment since the doctor trained in EOC refused to join the THC. In addition, *Professor Jahan* was informed by the resident Medical Officer (MO) that patients seeking Menstrual Regulation (MR) services are generally referred to private providers

rather than having the complex provide this service. In fact, for a long time public sector providers have been providing this service to clients in their private facilities for a fee. She added that the general lack of cleanliness in the complex was deplorable.

Professor Jahan also found that doctors were not using the housing intended for their use and preferred to live in Bogra town where their children went to school. Regardless of this, however, she did observe that the resident MO was on duty for 24 hours even though it was a public holiday (Eid ul Azha) and the community members were able to make use of his services.

At the Union Health Centre, she was told that the centre generally remains closed, and she found it closed during her visit. Regardless of its inactivity, however, a 31-bed clinic was being built next to it. *Professor Jahan* pointed out that the presence of stronger local women's organisations or other civil society advocacy groups who could monitor the health complexes would allow service users to voice their complaints.

2.4 Conclusion

Professor Jahan concluded her presentation by stating that women's health cannot be improved by the efforts of the health sector alone. Multi-sector efforts such as increasing women's education, income, and social status would contribute significantly to improving women's health. She also said that citizen's pro-activism such as health watch groups and media scrutiny would improve the quality of health services. And finally, women's organisations should play an important role in raising awareness about women's health needs, demanding the allocation of appropriate resources and holding service providers accountable.

3. Floor Discussion

Professor Sobhan thanked *Professor Jahan* for her insightful keynote presentation and asked for general comments on health sector reforms and women's health. He then asked participants to address the following three questions that emerged from the presentation:

- What particular delivery interventions should be prioritised by the health system?
- What systemic reforms are necessary, particularly how effective is the newly instituted unification of Family Planning (FP) and Health Services?
- How can accountability of the system be improved?

In the ensuing discussion, several participants talked about the gaps between the objectives of reforms as contained in HPSP versus their implementation. The evidence provided by participants, when discussing examples of successes in HPSP design as well as some of the implementation bottlenecks, further strengthened this discussion. Several participants pointed out factors such as lack of experience, and still others highlighted the lack of political will as major constraints in implementation. The contestation over the unification of Family Planning (FP) and Health Services was a topic that was highlighted in discussions. Participants also discussed gender equity and women's health. The discussion on this topic included issues such as the difference in access and provision of health care between women and men, the acute need for targeted health services for women and the crying need for increased civil society participation in health policy formulation; especially in the realm of FP, maternal health care and other women's health issues. The discussion is presented here under the two broad headings of 'Health System Reforms' and 'Gender Equity and Women's Health'.

3.1 Health System Reforms

The integration of family planning and health featured as a particularly important issue in the discussion. *Dr. Halida Hanum Akhter*, Managing Director of Health Promotion Limited, observed that the Government of Bangladesh has incorporated the strategies discussed in the Beijing Conference and other international forums for women's issues with a great deal of care and articulation in HPSP. *Dr. Halida Akhter* drew on her experience of FP and Health Services as a provider, researcher, and women's health advocate, particularly as a past Director of Bangladesh Institute of Research for Promotion of Essential Reproductive Health and Technologies (BIRPERHT), to conclude that the FP and Health services should be integrated. She did caution, however, that while the principle of unification was an excellent one, several aspects of unification were not being effectively implemented. This was due to a number of reasons. The first is that there is a difference between FP workers and Health workers.

The orientation of a FP worker, according to *Dr. Halida*, is similar to that of a salesperson rather than that of a health care provider. Secondly, there was only a brief transition period in which time FP workers were retrained for the purposes of unification and in all likelihood, FP staff did not receive adequate training or time for the psychological adjustment that was required of their changing roles. They were not, therefore, able to accept and understand the changes that were implemented as part of integration. It is clear though, that despite the resistance to unification among providers, the overlapping family planning and health needs of users justify integration. For example, when a FP patient needs to cope with a reproductive health problem that requires a medical diagnosis, she would automatically turn to the health sector. The private sector in fact, already provides one-stop services and their popularity amongst users indicates that the government would do well in providing one-stop services for the public health sector.

Dr. A.K.M. Masihur Rahman, former ERD Secretary, agreed with the arguments for unification presented by Dr. *Halida*. *Mr Alamgir Farrouk Chowdhury* former Secretary of the MOHFW mentioned the fruitlessness of FP and Health being integrated only up to the Thana level. He felt that the services should either be fully integrated or things should return to the way they had been under previous system of separate services. *Dr. Enamul Karim*, Technical Director of HLSP said that other priorities such as a strategy to improve maternal health, which was not adequately implemented in the HPSP, should be given equal importance to the contested issue of unification in the next programme. He also said that the overall administration of the health system must be made more efficient and the quality of health care improved.

Human resources training was another theme that was commented upon by several participants**.** *Dr. Abu Jamil Faisel*, Country Representative of Engender Health, observed that interventions are generally discussed in relation to available facilities rather than human resources. He talked about birth attendants as well, reiterating *Professor Jahan's* point that increasing the number of skilled birth attendants was important. *Professor Dr. Amanullah*, a Member of Parliament and a former state minister for MOHFW, observed that the most important aspect of the health sector is human resources and that the need to deliver doctors and nurses in addition to goods should be emphasised.

Dr. Morshed Chowdhury, Director of Gonoshasthya Kendra (GSK), also argued that medical intervention alone was inadequate to improve reproductive health. He pointed out that the FP campaign had motivated teachers and other community members until everyone was involved in the programme. Similarly, training for Emergency Obstetric Care (EOC) should not be limited to doctors alone but some basic EOC information should also be disseminated amongst community members. Moreover, he pointed out that the standards should be raised for medical training in Bangladesh so that resources are not needed to train doctors abroad. Referring to the context of rapid population growth and increased maternal mortality Dr Chowdhury urged for extensive training facilities to generate more skilled birth attendants. He stressed that for the purpose of implementing a strategy, motivation is more important than funding. On a different point, he observed that one of the main problems of the health sector was that the policies were being determined by the donors. He stressed that civil society in Bangladesh should be more involved in order to prevent this trend from continuing.

Ms. Afroza Parvin, Executive Director of Nari Unnayan Shakti, expanded on *Dr. Morshed Chowdhury's* point on the issue of donor involvement in health sector policy making. She argued that donors are dictating health strategies and Bangladeshis are not included in formulating relevant policies. She said that the politicisation of the sector and frequent shifts in the health policies and strategies should be stopped .

On the issue of gaps between policy and implementation, *Professor Amanullah*, commented that HPSP had been envisaged to bring about a complete overhaul in terms of implementing gender-sensitive strategies and other reforms. However, due to the floods of 1998 and the political situation prevailing at that time, the programme could not be launched on time and it lost almost a full year of implementation. He pointed out that the lack of trained and committed professionals was a major constraint. He felt that staff in the MOHFW was moved around from one post to another too frequently and therefore constantly required retraining. He also cited "cultural problems" within the country, referring to rampant corruption and the consequent inability to deliver services equitably and efficiently. However *Professor Amanullah* emphasised that despite these challenges, the Essential Services Package (ESP) was provided effectively.

On a different note, *Dr. Jahangeer Haider*, Executive Director of READ**,** argued that it was very difficult to assess HPSP because the programme has only been half-heartedly implemented in the last two years. By 2002, there were attacks on the HPSP from top policy makers of MOHFW, which created the overall impression that the programme has been abandoned. He highlighted one of the failures of HPSP's implementation, which is that only 4% of community clinics were operational. Although monitoring of these clinics by community groups is an excellent idea, he felt that these groups remained ineffectual. *Dr. Haider* however acknowledged that despite many problems, there has nevertheless been a remarkable change in people's attitude towards maternal care in recent years—clear successes have been achieved towards improving the status of safe motherhood. Additionally, more and more family planning services are being offered according to user demand rather than providers' interests. Service towards the poor has also been improved. He concluded that it may not be possible in the foreseeable future to make a dent in the attitude of the Ministry but the health system can be changed at the grassroots level and that is where the priority should lie.

Dr. Mahmudur Rahman, from the Initiative for People's Development reiterated that the delay in the launching of the five-year HPSP programme was caused by numerous problems. His view was that the two major problems that needed to be addressed in the health sector were poverty and gender. He felt that the lack of decision-making power among lower levels of administration was a major constraint hampering reforms.

Dr Masihur Rahman delineated some key points in the area of resources and resource management in the health sector. He said that he had worked for the government in the area of resources and knew from his experience, that resources for the health sector were not used efficiently. He emphasised three strategies for improvement. The first is that auditing standards need to be raised, as there are currently no standards for compliance. His second point had to do with the development of a managerial structure. He observed that since 1980s, due to structural failures and lack of coordination, there had been a problem of provision of services and supplies. He pointed out that incentives should be provided, such as promotions and performance-based bonuses, for the purpose of encouraging management to take increased interest in improving the state of services. And lastly, *Dr Rahman* said that there should be provisions for fully funded outsourcing of the delivery of goods.

Expanding on *Dr Masihur Rahman's* point on outsourcing, *Dr Debalok Singhe*, Executive Director of Dustha Shasthya Kendra, felt that priority should be given to incorporating NGOs in the health sector. He also commented on micro health insurance, stating that such approaches should be given full support. Micro credit groups have been linked to issues such as health insurance for some time and ten million people were participating in the micro credit system already. He observed that this large section of the population is a built-in user group for such health insurance. In terms of improving human resources, he said that there was a need for training of skilled Birth Attendants. He pointed out that it was very difficult to keep doctors in rural and urban slum areas. Therefore, he suggested that ESP be delivered instead through medical assistants to compensate for this doctor absenteeism. *Dr. Singhe* also reiterated the need for continuing civil society participation, but questioned whether parliament would ever discuss issues like reproductive health.

Mr S A F Chowdhury observed that management system in the health sector should be revamped for more efficient use of existing funds rather than simply increasing allocations for the sector. At this he referred the over arching issue of lack of coordination. He pointed out that EOC activities in many cases have been unsuccessful due to a severe lack of coordination amongst the actors involved.

From the donor perspective, *Ms. Margaret Verwijk*, First Secretary of the Royal Netherlands Embassy stressed the need for commitment and accountability not only from the government, but also from civil society and international Development Partners (DPs), through the process of consultation. Moreover, she emphasised the need to translate words into action.

3.2 Gender Equity and Women's Health

On the topic of gender disparities, *Mr S A F Chowdhury* pointed out that in the upcoming Health Nutrition Population Sector Programme (HNPSP), very specific interventions would be necessary to address gender issues. He said that the next programme should focus particularly on providing maternal health services. He also said however, that it was not feasible to provide women-focused services as this would lead to discriminatory health care provision. *Dr Masihur Rahman* added that the social status of women has an important impact on access to health as women are not independently mobile. He then refuted *Mr S A F Chowdhury's* point on targeted

services and said that it was important to provide facilities focused on women, quipping that not too many male patients could be found in the Ajimpur Maternity Health Center.

Dr Nazneen Akhter, Deputy Executive Director of the Bangladesh Women Health Coalition expanded on the theme of women's status by observing that barriers to alleviating gender-related problems often lie with men. This makes it all the more important to include men and adolescent boys in the process. Reforms should also be sensitive to the issues of physical distance, the lack of financial resources among much of the population, and the lack of decision-making power amongst women in most households. She commented that ESP should prioritise the issue of violence against women. She added that women's psychological health should be considered in addition to reproductive health because there is a need to provide counseling in order to, among other things, improve the decision-making powers of women. Finally, she said that education of women is the most important factor in gender equity in the health sector. In this regard, *Dr. Nazneen* suggested that women come together to define the agenda of the next round of reforms and assess the progress of the previous strategy prescribed by HPSP. She said that improvements in the system would require commitments from both the government and women's groups.

Dr Abu Jamel Faisel stressed the need for interventions such as safe motherhood and suggested that clinical contraception be linked with safe motherhood. Continuing on the issue of contraception, *Dr Enamul Karim* pointed out that stagnation of the TFR began in 1990 according to the Demographic Health Survey (DHS), which coincided with an 82% reduction in permanent methods of contraception. He stressed that TFR and permanent methods are issues that must be dealt with in the next programme. He also talked about the budget in relation to women's health care by observing that, while 67% of the resources available to the health system were out-of-pocket, 33% came from the public sector. This 33% should be prioritised towards improving maternal health. He then pointed out that public sector allocations for maternal health had been on the increase during the initial stages of HPSP but was now decreasing again. He questioned the need for EOC in all facilities in light of this decrease. *Dr Karim* then emphasised the need for incorporating the views of users of public health services through grassroots level consultations. In terms of civil society involvement, *Dr Enamul Karim* also suggested that the MOHFW Secretariat should be held accountable for

incorporating civil society consultation and implementing policies based on such active discourse.

Ms Sophia Robineault, First Secretary in Development of the Canadian High Commission, agreed with *Dr Karim* in asking for a gender-sensitive budget. *Ms Robineault* also said that strengthening women's issues within HPSP with respect to health would involve a difficult consultation process and reiterated the point that some process of consultation with users at the grassroots level should be included in the formulation of the upcoming HNPSP. In regards to civil society participation, she also said that the time is ripe for civil society involvement.

Ms Adrienne Germain made her comments on gender and women's health in five key points. Firstly, if one looked at the age and demographic structure of the Bangladeshi population, the most important group to focus on would be those who were young and those who marry young. Secondly, young couples should be encouraged to delay first births as first births at a young age dramatically affect younger women's health not to mention limiting future opportunities. Thirdly, NGOs and other organisations should help ensure safe delivery of babies. Progress has already been made in the area of EOC, but this should be seen as merely the beginning. To stop encouraging such services further, Ms Germain felt, would be a foolish waste of resources. Fourthly, the ability to make informed and effective decisions must be encouraged, particularly in relation to clinical methods of contraception. Finally, she observed that future discourse should focus more on incorporating the views of women users.

Ms. Tahera Jabeen, National Social Development Advisor of the British Council underscored the importance of mainstreaming gender issues. She pointed out that the current Annual Operational Plan (AOP) takes into account gender only in vague terms. She likewise stressed the need for policy makers to take civil society dialogues into consideration when implementing changes, but questioned the value of conducting such dialogues if MPs failed to participate actively in the discourse.

Dr. Yasmine Huq, UNICEF Project Officer, put a more positive tone into the discussion when she pointed out that according to general indicators, life is in fact improving for all strata of society. Bangladesh is in a better state than many developing countries in terms of the health sector. She pointed out that in 1999, she would have had a one in

twenty chance of receiving lifesaving services as a woman in Bangladesh. By 2003, her chances of such services have already improved to one in four. *Dr. Yasmine Huq* also posed some valuable questions in relation to the participation of civil society and translating such dialogues into strategies that can be implemented: How can rhetoric be put into action? How committed is civil society to making changes in the area of prioritizing the two issues of providing life-saving services such as safe prevention of unwanted pregnancies and providing services to alleviate morbidity? When suggested changes are not taking place, who should raise their voices? Who is going to listen and bring those changes? What formal mechanism is there for addressing such issues, and where is the safe space for this discourse? How can impunity be addressed?

Dr. A.S.M. Mushior Rahman, Programme Coordinator for the World Health Organisation (WHO), cited a WHO document highlighting women's health. In this document the following health problems specific to women were prioritised: malaria, hepatitis, and tuberculosis during pregnancy, anemia, osteoporosis, the greater frequency of diabetes, hypertension, and obesity in women than in men, sexual abuse, violence, and the tendency of women to outlive their husbands and face various social disadvantages as widows. He added to *Dr. Nazneen Akhter's* comment on women's psychological health and said that all of these diseases should be addressed in the next health programme.

Dr. Dina Siddiqi, CPD Fellow, expanded the discussion by attempting at a broader definition of women's health. She posed the question as to why generally, women's health is only discussed in terms of reproductive or maternal health and commented that there was a need to move away from this traditional focus on women only as reproductive beings. Dr. *Siddiqi* felt that the definition of women's health should be expanded to issues such as violence against women and occupational hazards for female labourers such as garment workers.

4. Comments by the Special Guest Professor Akbar, MP

Professor Dr. M S AkbarMP responded to the comments of the participants by saying that politicians cannot always be blamed for failures of implementation, as they often have to accept policies without being involved in their formulation. He then told a story of how he had very recently come across a mother with four daughters and a four-year-old boy who was the youngest of her children. All her children had been cesarean

section babies and he had asked her why she had had so many children when she could have died from the number of cesarean sections she had undergone. Her response was that despite the risks, she was happy due to the final outcome of a boy. He regretted that this was the inherently sexist attitude to be dealt with when alleviating gender-related problems in the health sector.

Professor Akbar also emphasised the need to analyze all outcomes of any given strategy before implementing it. He cited the example of outlawing rickshaws in some roads saying that they had been abandoned without any further plan as to what to do with them and stressed that such lack of foresight must be avoided in the health sector. He conceded *Ms. Parvin's* point that strategies were changed too quickly and called for an in-depth analysis of the causes for the shortfalls of HPSP. He concluded by pointing out that countries like Sri Lanka had the same GDP as Bangladesh and yet their maternal mortality figures were better and therefore funding is not the main issue. Similarly, cities like Madras, despite cultural similarities, also had lower maternal mortality. His main argument was that there are examples of better health status for women in places with similar contexts to Bangladesh. These require scrutiny and analysis so that newer and more effective interventions can be implemented in the Bangladesh context.

5. Response by The Keynote Speaker

Professor Rounaq Jahan responded to the discussion and some of the comments made by participants in five key points. On *Dr. Siddiqi's* comment on expanding the definition of women's health, Professor Jahan pointed to the existence of other elements in the definition and referred to resource constraints. Therefore, in the short term, prioritising reproductive health may be the most effective strategy. She also responded to the comment of *Mr. Mushior Rahman* from WHO who had said that several emerging diseases should be included in the next programme. *Professor Jahan* argued against this saying that free services are available to the poorest of the poor only to a limited extent due to financial constraints. In the HPSP under ESP, they are not treated for problems such as osteoporosis, for example, because an attempt to incorporate too many diseases and conditions will make ESP unmanageable and costly.

Professor Jahan responded to *Professor Akbar's* comment on politicians often being unable to formulate policy. She said that if politicians themselves are using the

argument that they lack the ability to formulate policy, it is a sad commentary on the thirteen years of representative government that Bangladesh has so far experienced. She reiterated her earlier point on the role of the legislative branch in monitoring the executive branch of government and work as a public accountability mechanism. *Professor Jahan* continued on the earlier theme of civil society participation by stressing that it is the government's responsibility to invite civil society to participate in the process of policy formulation. But, if the government fails to do so, civil society should take a pro-active role and set up autonomous groups to monitor government policy and process of strategy formulation and implementation of policies. *Professor Jahan* also stressed the importance of information being placed in the public domain. She said that civil society should take the extra initiative required to pursue current information on the health sector. Finally, she emphasised that women's groups should work together to strengthen networking and focus their efforts further on keeping a watch on the government's policies and actions to address gender disparity issues in the health sector.

6. Concluding Remarks by the Chairman

In his concluding remarks, *Professor Sobhan* regretted the absence of participants from the government. He called for the continued and active presence of civil society to scrutinise every policy under analysis. Both the public and private sectors, he said, should be closely studied and monitored; and civil society must stay proactive in this process. He pointed out that it was inadequate to blame the government when the efforts of all sectors of society are required to progress effectively. He concluded the dialogue by thanking the participants for their active participation.

Annex

List of Participants (in alphabetical order)

Prof. (Dr.) M. S. Akbar (Special Guest)	Honourable Member of Parliament
Mr. Faruque Ahmed	Director, Health Nutrition & Population Programme BRAC
Dr. Manzur Kadir Ahmed	Director, Health Gonoshasthya Kendra
Mr. Sayed Khaled Ahsan	Programme Officer SIDA
Dr. Halida Hanum Akhter	Managing Director Health Promotion Limited
Dr. Nazneen Akhter	Deputy Executive Director Bangladesh Women Health Coalition
Ms. Arifa Akther Anu	Kormojibi Nari
Ms. Hasina Akther	Trainer Nijera Kori
Prof. Dr. M. Amanullah, MP	Former State Minister Ministry of Health & Family Welfare
Dr. Selina Amin	Programme Manager, Health Save the Children (UK)
Ms. Hosne Ara Begum	Deputy Register Bangladesh Nurses Association
Dr. Debapriya Bhattacharya	Executive Director Centre for Policy Dialogue
Dr. Morshed Chowdhury	Director Gonoshasthya Kendra
Mr. Sayed Alamgir Farrouk Chowdhury	Former Secretary Ministry of Health and Family Welfare
Md. Shahidullah Chowdhury	Noman Group

Ms. Tapati Das	Programme Officer Royal Netherlands Embassy
Dr. Abu Jamil Faisel	Country Representative Engender Health
Dr. Ladly Faiz	Chief Executive Population Research and Development
Ms. Adrienne Germain	President Inter'l Women's Health Coalition
Ms. Gitasree Ghosh	Nursing Instructor Nursing Institute, DMCH and Vice President, Bangladesh Nurses Association
Dr. Jahangeer Haider	Executive Director READ
Dr. Yasmin Ali Haque	Project Officer UNICEF
Mr. Abdullah - Al – Harun	Programme Officer Save the Children (UK)
Dr. Akram Hossain	Senior Programme Monitor TAU –CIDA
Dr. Khondoker Bazlul Hoque	Professor, Dhaka University
Ms. Tahera Jabeen	National Social Development Advisor British Council
Professor Rounaq Jahan	Southern Asian Institute Columbia University, USA
Ms. Roushan Jahan	Member, Women for Women
Dr. Enamul Karim	Technical Director, HLSP
Ms. Mahmuda Rahman Khan	Social Development Advisor, DFID
Dr Fahmida Akter Khatun	Research Fellow, CPD
Dr. John Leigh	Sector Manager, Health & Population, DFID

Ms Simeen Mahmud	Senior Research Fellow Bangladesh Institute of Development Studies
Ms. Afroja Parvin	Executive Director Nari Unnayan Shakti
Mr. Frank Paulin	Senior Health Advisor SIDA
Mr. Gordon Peters	Programme Director Nicare
Dr. Lailun Nahar	Assistant Chief Ministry of Health and Family Welfare
Dr. Nazmoon Nahar	Programme Officer Naripokkho
Md. Abdur Rahman	Student, Department of Women Studies Dhaka University
Dr. A K M Masihur Rahman	Former Secretary, ERD Government of Bangladesh
Dr. A. S. M. Mushior Rahman	Programme Coordinator WHO
Dr. Mahmudur Rahman	Secretary General Initiative for People's Development
Prof. Mustafizur Rahman	Research Director Centre For Policy Dialogue
Ms. Sophia Robineault	First Secretary (Development) Canadian High Commission
Mr. M. A. Sabur	Joint Convenor Forum on Health Care Financing & Organisation
Mr. Bernd Schulz	Team Leader, Human Resource Development GTZ (German Technical Cooperation)
Mrs. Priti Dev Sen	Associate Economist, Health Economics Unit Ministry of Health & Family Welfare

Ms. Tahrat Shahid	Research Assistant Professor Rounaq Jahan
Ms. Farida Shaikh	Department of Public Health and Engineering WHO Programme
Md. Abu Syed	Department of Women Studies University of Dhaka
Dr. Dina Siddiqi	Fellow Centre for Policy Dialogue
Ms. Najma Siddiqui	Vice President Women for Women
Professor Rehman Sobhan	Chairman Centre for Policy Dialogue
Dr. Dibalok Singha	Executive Director Dustha Shasthya Kendra
Dr. Birte H Sorensen	Senior Health Specialist World Bank
Dr. Neil Squires	First Secretary, Human Development, DFID
Ms. Bina Valaydon	HPSO World Bank
Ms. Margret Verwijk	First Secretary Royal Netherlands Embassy
Dr. Nashid Kamal Waiz	Professor, Population Environment Independent University
Dr. Reena Yasmin	General Manager Programme Resource Development Marie Stopes Clinic Society