

# **CHALLENGES OF ACHIEVING**

**The State of Health  
in Bangladesh 2006**

**Challenges of Achieving Equity in Health**

# **EQUITY IN HEALTH**

**Bangladesh Health Watch**

December 2007

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James P Grant School of Public Health  
Centre for Health Systems Studies  
BRAC University  
66 Mohakhali C/A, Dhaka 1212, Bangladesh  
Email: [bhw@bracuniversity.ac.bd](mailto:bhw@bracuniversity.ac.bd)  
Tel: 880-2-8824051 ext. 4041

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## FOREWORD

Bangladesh has made spectacular progress in some of its social development indicators. Since independence in 1971, both the infant mortality and total fertility rates have been more than halved. Life expectancy has risen by over 50%. The excess female mortality that historically characterized this part of the world has disappeared; women now live longer lives than men. Gender parity in primary schooling has been achieved and the net enrolment ratio has reached 85 percent.

In spite of these positive developments, the country continues to face numerous challenges – in particular how do we take such pace of development further? The maternal mortality ratio, which has shown some decline in the past decade, still continues to be one of the highest in the world. With improvement in post-neonatal and child mortality, newborn health poses a new and daunting challenge. The total fertility rate has plateaued at about 3 per woman for the past decade and is reported to be increasing for the very poor group. The question of inequalities in health is all pervasive. The difference between the rich and poor, between the urban and rural, between urban middle and higher classes and urban slums, between men and women, between the dominant Bangalees and ethnic minorities is disturbing. In addition, there are new scourges such as arsenicosis that is threatening the health of 30 million Bangladeshis.

The country is committed to attaining the Millennium Development Goals (MDG). A review of the achievement thus far reveals that we are probably on course for a few of the goals but not for many others. The Health, Population and Nutrition Sector Programme (HNPSP) of the Government of Bangladesh (and also its predecessor the Health, and Population Sector Programme, or HPSP) are landmark commitments of the government and its development partners towards improving the health of the population of the country, particularly the poor and other disadvantaged groups. One of the salient features of these two programmes is the importance attached to the need for civil society and communities' monitoring of their performance. The Task Force on Child health and Maternal health set up by UN under the Millennium Project has also recommended in its report the need for systematic monitoring of the progress towards the goals at the country level.

In Bangladesh, progress in health and other development indicators is gauged in many different ways. The Census and other systematic surveys conducted by the government through the Bangladesh Bureau of Statistics provide longitudinal information. The donors employ surveys to study selected indicators which are of interest to them (such as the Bangladesh Demographic and Health Survey). The small area intensive studies done by various agencies also provide valuable and credible information (such as by ICDDR,B in Matlab). A few non-governmental organizations (NGOs) have also developed capacities to undertake research (such as the Research and Evaluation Division of BRAC). The Bangladesh Health Equity Watch (BHEW) provides a forum for discourse and debate on equity issues through publication of newsletters and occasional reports. However, these efforts have had limited impact in influencing policies and programmes towards achieving good health for all.

Civil society in Bangladesh has been active in monitoring the country's progress in various sectors. A case in point is the Education Watch. Set up in 1998, the Education Watch has been publishing a State of Bangladesh's Education report every year since 1999 and is a credible source of information quoted widely in and outside Bangladesh. The BRAC University Centre for Governance Studies has also recently launched its first Governance Watch report. I am very happy to see that the Bangladesh Health Watch has now made its debut. With such a tradition of civil society activism, I am confident that this effort will go a long way in establishing accountability in the health sector.

I am delighted to see that the Health Watch group has selected equity as the theme of their first report. Equity is very close to my heart and ensuring this is the cornerstone of all our efforts at BRAC. The report has brought to light, once again, the importance of ensuring good health for all the citizens of Bangladesh. Although much progress has been made we cannot wait any longer to see that the poor and other disadvantaged groups enjoy a similarly long and healthy life as the rich and other privileged section of the population. We are mortified to find that the access of poor women to safe delivery is about one-fifteenth that of the well-to-do groups, and that some disadvantaged groups in Bangladesh have immunization coverage as low as 10%.

The past decade has seen enormous new evidence on the existence of inequities in health all over the world. However, what is disturbing is the fact that we have not yet adopted effective scaled up measures to minimise these inequities. Fortunately, this report has produced evidence from Bangladesh that this can, in fact be done. We need many such analyses of programmes and replication of best practices.

I congratulate the Bangladesh Health Watch group for this timely effort, particularly the authors of this report. I am indeed greatly honoured to have been part of this effort, albeit, from a distance, and am grateful to the Health Watch for selecting the BRAC University James P Grant School of Public Health as its secretariat. I wish the Watch all success.

Dhaka, December 2007



F H Abed

Founder & Chairperson, BRAC

## CONTRIBUTING AUTHORS

1. **Kaosar Afsana**, MBBS, MPH, PhD, Programme Coordinator, BRAC Health Programme, BRAC
2. **Ahmed Al-Sabir**, MA, PhD, Director, Research, National Institute of Population Research and Training (NIPORT) and Co-chair, Bangladesh Health Equity Watch (BHEW)
3. **Abbas Bhuiya, MA**, PhD, Senior Scientist and Head, Poverty and Health, ICDDR,B and Co-chair, Bangladesh Health Equity Watch (BHEW)
4. **A Mushtaque R Chowdhury**, MSc, PhD, Deputy Executive Director, BRAC, Dean, BRAC University James P Grant School of Public Health, and Professor of Population and Family Health, Columbia University, New York, Co-chair, Bangladesh Health Equity Watch (BHEW)
5. **Tehmina Ghafur**, MSS, Assistant Professor, Department of Population Sciences, Dhaka University
6. **A M Zakir Hussain**, MBBS, MPH, PhD, Staff Consultant, Urban Health, Asian Development Bank. Former Director, Primary Health Care & Disease Control, Government of Bangladesh and Former Short Term Professional, WHO, New Delhi
7. **Rounaq Jahan**, PhD, Member, Board of Directors, Research Initiative Bangladesh and Senior Research Scholar and Adjunct Professor, Columbia University, New York
8. **Naila Z Khan**, MBBS, FCPS, PhD, Professor, Child Development and Neurology Bangladesh Institute of Child Health, Dhaka Shishu (Children's) Hospital
9. **Shehrin S Mahmood**, MA, Research Investigator, ICDDR,B
10. **Simeen Mahmud**, MSc, Research Director, Bangladesh Institute of Development Studies and Co-chair, Bangladesh Health Equity Watch (BHEW)
11. **Sabina Faiz Rashid**, MA, PhD, Assistant Professor, James P. Grant School of Public Health, BRAC University
12. **Ubaidur Rob**, MS, PhD, Country Director, Population Council, Dhaka
13. **Md. Noorunnabi Talukder**, MSS, Research Officer, Population Council, Dhaka

## Bangladesh Health Watch Advisory Committee and Working Group Members

### The Advisory Committee:

**Dr. Rounaq Jahan**, Member, Board of Directors, Research Initiatives Bangladesh (RIB) and Adjunct Professor, Columbia University, New York (Chair)

**Dr. Halida Akhter**, Director General, Family Planning Association of Bangladesh

**Mr. Mahfuz Anam**, Editor, The Daily Star

**Dr. Maleka Banu**, General Secretary, Bangladesh Mahila Parishad

**Prof J R Choudhury**, Vice Chancellor, BRAC University

**Dr. Zafarullah Chowdhury**, Coordinator, Gonoshasthya Kendra

**Dr Syed Jahangir Haider**, Executive Director, Research Evaluation Associates for Development (READ)

**Dr Zakir Hussain**, formerly of World Health Organization

**Ms. Khushi Kabir**, Coordinator, Nijera Kori

**Dr. M Kabir**, Professor of Statistics, Jahangirnagar University

**Dr. A K Azad Khan**, General Secretary, BIRDEM/Bangladesh Diabetic Association

**Dr. M R Khan**, National Professor

**Dr. Sadeqa Tahera Khanum**, Formerly Director, National Institute of Preventive and Social Medicine (NIPSOM)

**Dr. Wahiduddin Mahmud**, Professor of Economics, Dhaka University

**Dr Mahmudur Rahman**, Chairman Board of Trustees, Dhaka Community Hospital

**Mr. Moti ur Rahman**, Editor, Prothom Alo

**Prof. Rehman Sobhan**, Chairman, Centre for Policy Dialogue

**Dr. M Q K Talukder**, Chairman, Centre for Women and Children Health

**Dr. A M R Chowdhury**, Deputy Executive Director, BRAC and Dean, James P. Grant School of Public Health, BRAC University (Member Secretary)

### The Working Group:

**Dr. Abbas Bhuiya**, Senior Scientist and Head, Social and Behavioural Sciences Unit & Poverty and Health Programme, ICDDR,B (Coordinator)

**Dr. Ahmed Al-Sabir** Director (Research), National Institute of Population, Research and Training (NIPORT)

**Dr. Rafiqul Huda Chaudhury**, Director, Center for Research and Training, East West University, Dhaka

**Dr. A M R Chowdhury**, Deputy Executive Director, BRAC and Dean, James P. Grant School of Public Health, BRAC University

**Dr. A J Faisel**, Director, Engender Health, Dhaka

**Dr. Yasmine Ahmed**, Director, Marie Stopes Clinic Society, Dhaka

**Dr. A M Zakir Hussain**, Public Health Specialist, PSO, Ministry of Health and Family Welfare, Government of Bangladesh

**Dr. Naila Z Khan**, Professor, Child Development and Neurology, Bangladesh Institute of child Health, Dhaka Shishu Hospital

**Ms. Simeen Mahmud**, Research Director, Bangladesh Institute of Development Studies (BIDS)

**Dr. Ubaidur Rob**, Country Director, Population Council, Dhaka

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While the Watch acknowledges its debts to many, the final responsibility for the contents of the report lies with the authors of the report.

## Acronyms

ANC	Ante-natal Care
BDHS	Bangladesh Demographic & Health Survey
BIDS	Bangladesh Institute of Development Studies
BIRDEM	Bangladesh Institute of Research and Rehabilitation in Diabetics, Endocrine and Metabolic Disorder
CCC	Committee of Concerned Citizens
CPR	Contraceptive Prevalence Rate
EmOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FYP	Five Year Plan
GK	Gonoshasthya Kendra
GoB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HPSP	Health and Population Sector Programme
HPSS	Health and Population Sector Strategy
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MR	Menstrual Regulation
NGO	Non-governmental Organization
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive & Social Medicine
ORT	Oral Rehydration Therapy
PNC	Post-natal Care
PPP	Public-Private Partnership
READ	Research Evaluation Associates for Development
RIB	Research Initiative Bangladesh
SES	Socio-economic Status
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UHC	Upazila (Thana) Health Complex
USC	Union Stakeholder Committee
WB	World Bank

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### INTRODUCTION AND OVERVIEW: HEALTH AT THE CROSSROADS

#### Health at the crossroads

Bangladesh is the ninth largest country in the world with a population of nearly 140 millions. Although it is predominantly rural, the urban population is increasing very fast constituting around 20 percent of the population currently. Although Bangladesh has not made a significant dent in eradicating poverty, which severely touches nearly a half of the population, the country has made spectacular progress in some of its social development indicators, particularly in terms of health outcomes. In the thirty-five years since independence infant and child mortality rates have been markedly reduced. Life expectancy has risen steadily. Reversing past trends, women now live longer than men. The total fertility rate has been more than halved. Maternal mortality and under-nutrition rates, though still very high, are registering decline.

In spite of these positive trends, numerous challenges remain. First, despite aggregate gains inequities in health continue to be pervasive. There are major differences in health status and health care consumption between different groups. The difference between the rich and poor, between urban and rural residents, between urban middle and higher classes and urban slums, between men and women, between the dominant Bangalees and ethnic minorities are disturbing. Some of these inequities are stark and persistent and are holding the country back from making

further gains at the aggregate level. Thus, while the first round challenge was one of improving overall health outcomes by expanding aggregate access to health care, the second round challenge is one of more fine tuned policy and interventions to reach the 'hard to reach' and excluded groups. In addition, there are new scourges such as arsenicosis that is threatening the health of 30 million Bangladeshis; the threat of HIV that is hovering on our borders; the rise of incidence of non-communicable disease, and the rise in the frequency of road accidents and violence.

Second, improvements in some areas are relatively more difficult to sustain while there are indications of stagnation in others. The maternal mortality rate, which has shown some progress in the past decade, continues to be one of the highest in the world with a maternal mortality ratio of between 320 and 400 per 1000 live births. With improvement in post-neonatal and child mortality, newborn health poses a new and daunting challenge. The total fertility rate is hovering around 3 per woman for the past decade and has not reduced any further substantially. Ironically, even as Bangladesh has achieved food self-sufficiency, food security remains elusive to many and the level of under-nutrition appears to be quite insensitive to programme interventions.

*The maternal mortality rate, which has shown some progress in the past decade, continues to be one of the highest in the world with a maternal mortality ratio of between 320 and 400 per 1000 live births.*

Third, in the context of economic liberalization and the general trend toward a more market-based economy health care provision has been no exception. If anything, health sector reform (at least on paper) has been more efficiency driven and health care delivery has become more market based than other social service delivery (education for example), particularly in view of the growing demand for curative care. Since the quality of curative care at public facilities falls below

even what poor people are willing to accept , the poor have no option but to rely on the market to access curative health care. This in itself is not a problem, except that the market for health care is quite segmented, with the poor having access to only very low standard market services. Thus, attempts to shift to a more market based health service delivery may actually end up hurting the poor by contracting their access to good quality health care.

The Constitution of Bangladesh puts the obligation on the state to ensure the provision of basic necessities including food, education, and health care for all its citizens (Article 15). Following this constitutional guidance, the Government of Bangladesh (GOB), through its various policies, plans and programmes, has attempted to improve the health conditions of all citizens, particularly vulnerable groups, defined as the poor, women and children. Initially, the most important policy challenge was to move from a narrow, urban, and elite-based health care delivery system with preference for curative services to a more broad-based and rural delivery system with a focus on preventive services. Starting with the first Five-Year Plan in 1973, successive Five-Year Plans

*Bangladesh can be proud of some of her health innovations and achievements: the doorstep service and the family planning programme; the campaign for ORT; immunization; the essential drug policy; the national Menstrual Regulation (MR) programme and so on.*

have adopted primary health care as the key approach for the improvement of the health of the poor people. The country developed a health infrastructure for the rural areas to deliver integrated and comprehensive health services.

Bangladesh can be proud of some of her health innovations and achievements: the doorstep service and the family planning programme; the campaign for ORT; immunization; the essential drug policy; the national Menstrual Regulation (MR) programme and so on. Effective partnership between the government and non-government organizations (NGOs) contributed to these successes. NGOs on their own have also played an important role in initiating innovations, delivering services and in advocacy.

Though the government has established a nationwide infrastructure to deliver health care, the quality of services remains poor. A variety of problems, such as lack of medicine, absence of doctors, and other providers; unofficial fees; lack of cleanliness, hygiene and privacy; neglect and maltreatment of patients; and so on bedevil the public sector services. Since the mid 1990's the government has attempted to introduce reforms to improve governance and efficiency in the public sector but implementation has been slow and ineffective. In several instances reforms faced opposition from powerful groups and could not move forward.

Health policy and programming is at the cross-roads in Bangladesh. The government has to make some tough choices in deciding what services to deliver to whom, where, through what channels (public, NGO, private) and with what amount of payment by whom. It has to pay attention not only to service delivery but also to the

challenge of fostering demand for services. It has to maintain momentum in areas of success, but at the same time it has to move forward with new sets of interventions where past policies have not yielded results. Above all, it has to improve the health system's governance and accountability, which will require consultation and participation by all stakeholders including the disadvantaged service users.

The policy environment is not insensitive to these challenges and has also undergone significant transformation. Since the late 1990s Bangladesh has adopted a sector wide approach to health care delivery addressing particularly the needs of the most vulnerable population groups. The Health, Population and Nutrition Sector Programme (HNPSP) of the Government of Bangladesh (and also its predecessor the Health, and Population Sector Programme or HPSP) are landmark commitment of the government and its development partners towards improving the health of the population of the country. Both of the programmes also underscored the need for civil society or grass-roots monitoring of the achievement by the programme in the context of Bangladesh. Currently the PRS (Poverty Reduction Strategy), which proposes a strategy to halve poverty by 2015, is committed to attaining a number of the MDGs (Millennium Development Goals). Out of ten MDG targets set for 2015 four are health related targets (infant and child mortality, under-nutrition, maternal mortality and reproductive health), some quite ambitious<sup>1</sup> and admittedly requiring huge additional resources<sup>2</sup>. A review of the achievement thus far reveals that we are probably in course for a few but not for many others. The Task Force on Child health and Maternal health set up by UN under the Millennium Project

recommended in its report the need for systematic monitoring of the progress towards the goals at country level (Freedman et al. 2005).

### **Monitoring progress in health: *The Bangladesh Health Watch***

During 2005-2006 a number of professional and civil society organizations came together to discuss the possibility of creating a civil society network to regularly and systematically measure and monitor our progress and performance in health. It was felt that health is a critical national concern and citizens' groups ought to take an active interest in health policy formulation, implementation, monitoring and oversight. Further, it was argued that creating a broader citizens' understanding of the challenges and choices we face, would contribute to a more democratic discussion and debate about our policy/programme options. As a result *Bangladesh Health Watch* was launched in April 2006. It was decided that the Watch would publish an annual report on State of Health in Bangladesh focusing on different themes every year and also, report on the performance of key indicators on a continuing basis.

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In Bangladesh, progress in health and other development indicators is gauged in many different ways. The Census and other systematic surveys conducted by the government through the

<sup>1</sup> Reduce maternal mortality rate by 75 percent and reduce infant mortality by 65 percent.

<sup>2</sup> The WHO Commission on Macroeconomics of Health estimated the average cost of the set of essential interventions at \$34 per person per year.

Bangladesh Bureau of Statistics provide longitudinal information. The donors employ surveys to study selected indicators which are of interest to particular donors (such as the Bangladesh Demographic and Health Survey). The small area intensive studies done by selected agencies also

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provide valuable and credible information (such as by ICDDR,B in Matlab). Selected non-governmental organizations (NGOs) have also developed capacities to undertake research (such as the Research and Evaluation Division of BRAC). The Bangladesh Health Equity Watch provides a forum for discourse and debate on equity issues through publication of newsletters and occasional reports. However, most of these suffer from various deficiencies and are not able to provide a credible,

systematic and nationally representative and holistic picture of the progress towards good health for all.

The Bangladesh Health Watch is not a unique attempt, however, and draws upon the experience of The Education Watch (EW) set up in 1998 as a joint effort of several individuals and civil society organizations. EW has been publishing a State of Bangladesh's Education report every year since 1999 with its secretariat at Campaign for Popular Education (CAMPE). They have now become a credible source of information on the education sector, and is quoted widely inside and outside Bangladesh. Every year, the EW picks up a (new) theme and carries out field level surveys using both quantitative and qualitative methods. The Research and Evaluation Division of BRAC do most of the field studies with inputs and

supervision of the EW Advisory Board and Working group. Other institutions, which have done field level studies for Education Watch, are Bangladesh Institute of Development Studies (BIDS) and the Institute of Education & Research (IER) at the University of Dhaka. An assessment done by a researcher of New York's Columbia University acclaimed the effort of the EW and identified reasons for its apparent success (Chatterji 2005). There are also other such civil society initiatives including the ones done by BRAC University Centre for Governance Studies and Transparency International Bangladesh. The *Bangladesh Paribesh Andolan* (BAPA), civil society group also does informal monitoring and movement on environmental issues.

The Bangladesh Health Watch is governed by an *Advisory Board* consisting of eminent personalities in the field of development, particularly health. A *Working Group* consisting of researchers and activists from different organizations carry out the different activities for the Watch (Annex). The Secretariat for the Watch is located at the BRAC University James P. Grant School of Public Health.

## **Bangladesh Health Watch Report 2006**

This is the first report of the Bangladesh Health Watch and the theme of the first report is the *Challenge of Achieving Health Equity*. This theme was chosen because in recent years health inequities have emerged as a major challenge for Bangladesh. The persistent health divides are contributing to persistence of poverty thus creating a vicious circle. And a divided health system, one serving the rich and the other serving the poor, cannot be an acceptable norm in a democracy.

In this report we underscore the principle of social justice in defining equity. While inequalities in health describe differences between groups independent of any assessment of their fairness, inequities refer to a subset of inequalities that are deemed unfair because they are avoidable and can be redressed by redistributive justice.

Through analysis of published data, studies and documents, this report attempts to identify the main fault lines of inequity: income, gender, and place of residence. It tries to assess which inequities are the most persistent and hence require the greatest policy attention. It looks at the policy commitments and describes both the achievements and the limitations. It draws lessons for wider application from selected successful initiatives in delivering services as well as holding the health system accountable.

### Health equity in context

As defined by World Health Organization, health is not merely an absence of disease and as Benjamin Disraeli said, 'the health of the people is really the foundation upon which all their happiness and all their powers as a state depend.' However, not everybody enjoys the same benefit of good health. The question of inequities in health has been a matter of concern for ages, but it is not until recently that a systematic literature on the subject has begun to emerge. These have discoursed on inequities between and within countries.

While inequality is an empirical concept equity is a normative one and associated with social justice. Evans et al. (2001) have distinguished the two in the following way:

*Inequalities in health describe the differences in health between groups independent of any assessment of their fairness. Inequities refer to a subset of inequalities that is deemed unfair. The unfairness qualification invokes assessments of whether the inequalities are avoidable as well as more complex ideas of distributive justice as applied to health.*

Although inequity in health status or outcome (such as infant or maternal mortality rates or nutritional status) is the most important marker of inequities in a society, the access to health care and the ability of different groups to avail it is an important determinant of the inequity. So is the importance and role of other sectors (the so-called *social determinants*) in mediating inequities in a society, as argued by Amartya Sen (2001). Diderichsen et al. (2001) have provided a framework for examining inequities in a society and its determinants. They argue that inequities happen through the interplay of several mechanisms: social stratification (a person's position in society defined by his/her occupation, education status, for example), differential exposure (the differential risks of contracting a disease by being in different social, geographic or occupational category), differential vulnerability (the different susceptibility to diseases due to different biological defense status such as poor or strong nutritional status) and differential social and economic consequences of ill health (consequences resulting from an accident or onset of a severe

*The most popular health equity proposal is one which reduces disparities through special efforts to improve the health of the disadvantaged. However, health equity can also mean ensuring that all groups have a basic minimum level of well being and services, and that any health gains among the rich and better off sections of the population in the course of implementing these special efforts are positive externalities.*

chronic illness, for example). Figure 1 gives a schematic representation of the ways inequities happen in society and the ways to address them. Needless to mention, this may be used effectively in monitoring progress in reducing health inequities in a society such as Bangladesh.

Thus health equity requires reducing and eliminating unfair disparities and unnecessary social gaps in health and health care. The most popular health equity proposal is one which reduces disparities through special efforts to improve the health of the disadvantaged. However, health equity can also mean ensuring that all groups have a basic minimum level of well being and services, and that any health gains among the rich and better off sections of the population in the course of implementing these special efforts are positive externalities. In countries like Bangladesh, where poverty is a major reason for inequalities in health and health care, it is expected that health equity is seen primarily in terms of reducing income inequalities in health and health care. However, there are also other sources of inequality, like sex, residence and ethnicity, that are also unfair and unnecessary and equally deserving of special attention.

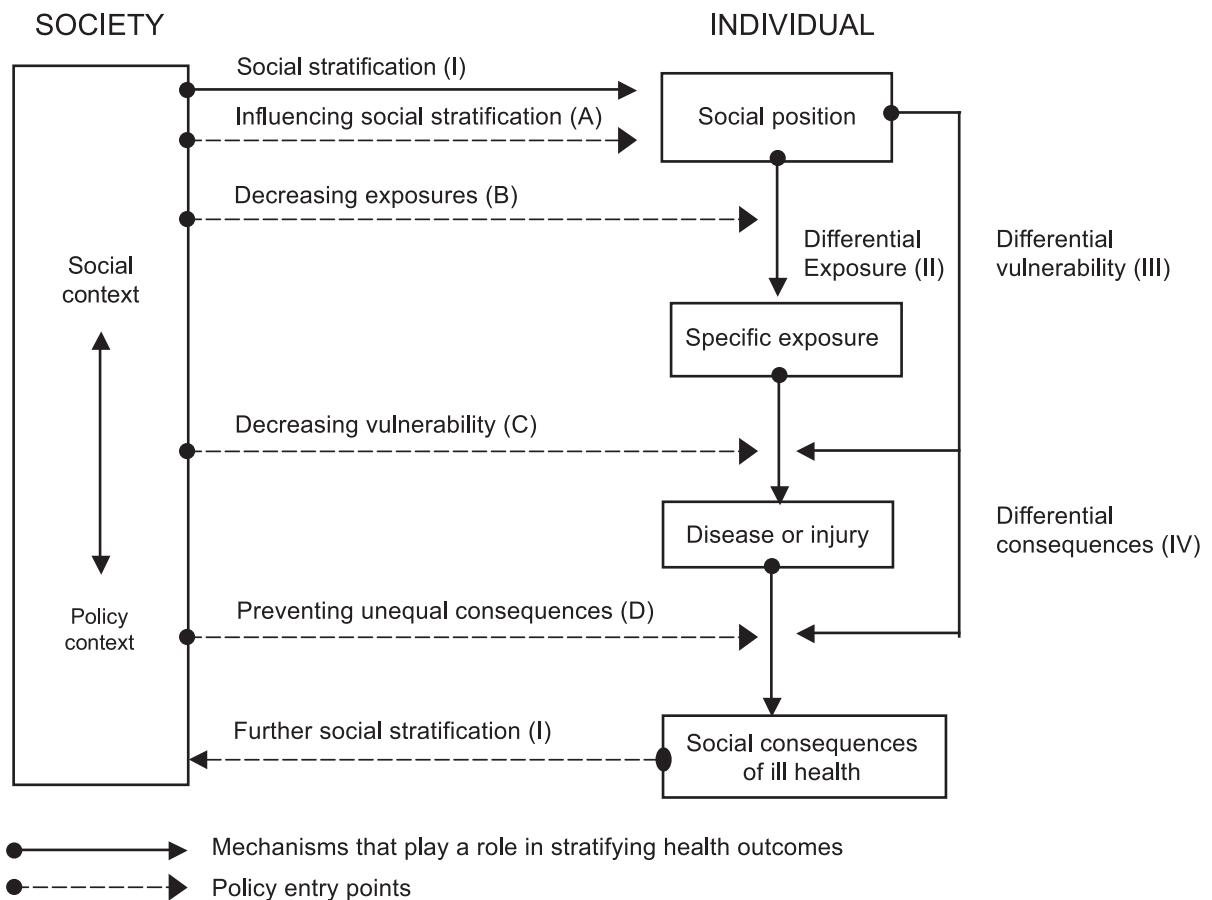
The attention in recent times on the equity dimensions of health can be viewed as the natural evolution of health sector development in Bangladesh. Initially, after independence the most important policy challenge was to move from a narrow urban elite based health care delivery system that we had inherited as a legacy from Pakistan, to a more broad based and rural delivery system under the slogan of "Health for All". The rationale of that policy shift was that the health service at that time was not reaching the vast

majority of the population who lived in the rural areas and constituted over 80% of the population. The goal of policy then was to provide free or low cost primary health care services at the community level, with a referral system to secondary and tertiary level services whenever necessary, by expanding the delivery system as far down as possible to reach as many people as possible.

In trying to expand coverage it became clear that there were pockets of hard to reach groups and subgroups that were unable to access services due to various demand constraints. With time these excluded and disadvantaged groups began to be identified with greater accuracy. At the same time vulnerable groups suffering from poorer health outcomes than average were identified and the socio economic gaps in health outcomes became visible, indicating severe demand constraints. The challenge was now to reach services to those left behind and to eliminate these gaps in both access to services and in health outcomes. It is in this respect that the special emphasis on equity and on reducing socio economic inequalities becomes crucial.

The more instrumental rationale for an equity focus is that without reduction in socio economic inequalities in health further gains at the aggregate level will be difficult if not impossible to achieve. The observed stagnation in some of the health outcomes noted earlier is precisely because inequalities are proving hard to reduce. Hence, an equity focus on health policy and health care delivery becomes essential for attaining further improvement in health outcomes and for attaining the health MDGs.

**Figure 1:** A framework for elucidating the pathways from the social context of health outcomes and for introducing policy interventions



Source: Adapted from Diderichsen & Hallqvist 1998

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# Health Status: Progress Yet Many Challenges

### Introduction

Bangladesh being one of the low-income countries may be perceived as a place mostly of poor and hence issues of social disparities especially in health may be considered not so important. Yet, studies conducted in the seventies and the eighties, when poverty and mortality levels were high, documented the existence of socioeconomic differentials in mortality (D'Souza & Bhuiya 1982).

It is also one of the few countries in the world where sex differentials in life expectancy and child survival contradicted expected patterns of female's biological superiority over male until the late eighties (D'Souza & Chen 1980; Bhuiya et al. 1986; Koenig & D'Souza 1986; Bhuiya et al. 1989; Sen 1990; GOB 1998). Many national and small-area-based surveys in the country have documented large male-bias in child survival after the first

five months of life, when the influence of social factors such as male preference in intra-household food distribution and sickness care become apparent (Chen et al. 1981; Bhuiya et al. 1987).

Over the last two decades, Bangladesh has witnessed a large decline in mortality. During the period 1981-1996, the crude death rate dropped from approximately 15 to 9 per 1,000 population (BBS 1990; BBS 1996). Child mortality rate has decreased from 50 per 1,000 children aged 1-4

*The Data collected in the recent years clearly indicates improvement in the area of nutrition, although malnutrition rates have been among the highest in the world, with more than one-third of infants born annually classified as being of low birth weight (<2.5 kilogram) (BBS 2005).*

years in 1993-94 to 24 in 2004 (NIPORT, Mitra & Associates, ORC Macro 2005; Mitra et al. 1994). Improvement has also been recorded in maternal mortality ratio— the rate has declined from 650 per 100,000 births in the eighties to 322 in the beginning of the new century. However, the level is still one of the highest in the South Asian countries (NIPORT, ORC Macro, Johns Hopkins University, ICDDR,B 2003; DFID Bangladesh Fact sheet 2006).

The Data collected in the recent years clearly indicates improvement in the area of nutrition, although malnutrition rates have been among the highest in the world, with more than one-third of infants born annually classified as being of low birth weight (<2.5 kilogram) (BBS 2005). Approximately two-thirds of children less than six years of age used to be underweight or stunted, and over 17% were moderately to severely wasted (BBS 1997). The proportion of low birth weight babies has reduced to 36% in 2004 from around 50% during the nineties and proportion of severely under-nourished children (below -3 standard deviation) measured by weight-for-age to 12.8% in 2004 from 20.6% in 1996-1997 (NIPORT, Mitra & Associates, ORC Macro 2005).

Thus, the situation seems to be getting better in terms of reducing gender and socioeconomic gaps in mortality in rural Bangladesh (Bhuiya et al. 2001).

While the decline in mortality and the reduction in socioeconomic and gender gaps are impressive and thought to be outcomes of past policies and programmes, it is not known whether these trends are continuing or if groups still exist that are not gaining as others. The situation in the urban slums or in the difficult to reach areas, usually inhabited by ethnic minorities, compared to the rest of the country also needs to be explored. Similar explorations are also required in the areas of morbidity, nutritional status, utilization and accessibility of the healthcare services. At the same time, it is important to know whether the large-scale public health and social and economic development programmes, such as, National Nutrition Programme (NNP), mitigation of arsenic contamination in underground water, micro-credit, HIV/AIDS awareness raising programme, are having equitable impacts on various socioeconomic groups and hard to reach areas.

It is against the above background that this chapter examines the trends in health outcomes and reveals the extent of inequities thereof. It is expected that interpretation of the findings in conjunction with the national policies and programmes will provide valuable insights to explain the prevailing health situation in general and of the socially disadvantaged in particular.

## Materials and methods

The analysis is based mainly on compiling and reanalysing existing nationally representative published and unpublished data. Data from small area based studies on important health issues were used where credible nationally representative data were unavailable.

The independent variables in the analysis included individual, household, rural-urban residence, and region (administrative divisions). The individual level variables included sex and age. The household level variables included socioeconomic status. The independent variables such as health outcomes and health related behaviour included life expectancy at birth, mortality rates at various ages, and prevalence of health conditions including nutritional status. The definition of most of the variables used in analyzing inequities, if not obvious, was made clear in the tables or in the text. The socioeconomic categories were derived from asset scores obtained by using principle component analysis<sup>1</sup>.

Analysis of health outcomes and other related variables was carried out using rates/ratios by socioeconomic and other independent variables.

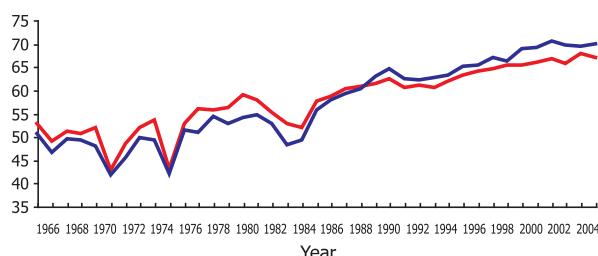
## Status of health

The life expectancy at birth has improved significantly during the last two decades. A newborn in 2004 could expect to live between 67 and 70 years as opposed to 49 to 52 years for a newborn in 1984 (Figure 1). The rate of increase in life expectancy per calendar year is almost a year, signifying a tremendous health gain during the last 20 or so years<sup>2</sup>.

<sup>1</sup> Details of such methods can be obtained from many published literature (Filmer & Pritchett 1998; Filmer & Pritchett 2001; Gwatkin et al. 2003b; Gwatkin et al. 2003a; Hotelling 1933).

<sup>2</sup> Quality national mortality data are rare in Bangladesh. Life expectancy figures presented in this chapter are based on ICDDR,B data from Matlab. Data from other ICDDR,B field sites (Chittagong, Cox's Bazar, Jessore) also present a similar level of life expectancy at birth.

**Figure 1:** Life expectancy at birth in Matlab, 1966-2004



Source: ICDDR,B 2006

This was possible because of the improvement in health status at various stages of life cycle, especially during the early stages of life. Recent

In the field of immunization, the country achieved 'near miracle' by increasing immunization coverage among children from 2% in 1986 to around 62% in the early nineties

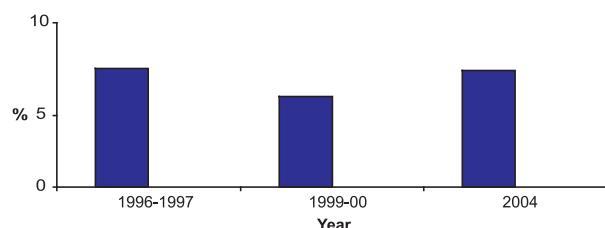
data from the Bangladesh Demographic and Health Survey (BDHS) depict a sharp decline in under-five mortality in the country since the early nineties. The 1993-1994 BDHS reported under-five mortality of 133 per 1,000 live births, which has declined to 88 per 1,000 live births as per the 2004 BDHS report.

Data on birth weight has been historically lacking in Bangladesh. Small area studies conducted in the nineties reported a prevalence of 51% low birth weight (less than 2.5 kilogram) in rural areas (Goodburn et al. 1994) and 46% in the slums of Dhaka (Arifeen et al. 2000). A recent nationwide survey carried out during 2003-2004 reported 37% prevalence of low birth weight for rural areas and 29% for urban areas (BBS 2005). The data are indicative of a decline in the prevalence of low birth weight in the country.

Improvement of life expectancy has also been achieved at later stage of life. A person of age 50 can now expect to live an additional 26 years compared to 20 years in 1984 (ICDDR,B, 2006;

ICDDR,B 1991). The health gain has not only been in life expectancy but also in quality of health in terms of decreasing under nutrition. Morbidity, on the other hand, has remained somewhat static. Data on population-based nationwide morbidity have been very rare. BDHS collected information on prevalence of diarrhoea among the under-five children in all the surveys. The prevalence remained somewhat static during the period 1996-2004 (Figure 2).

**Figure 2:** Prevalence of diarrhoea, 1996-2004



Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

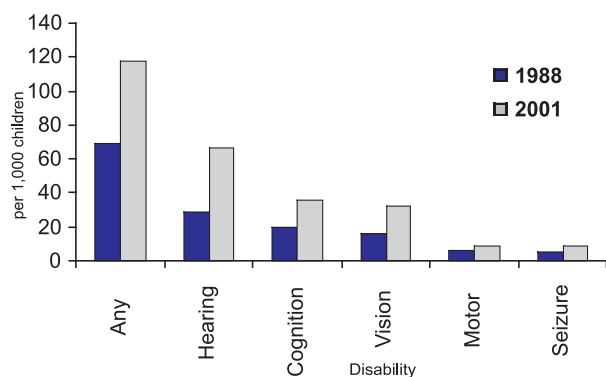
There has been a significant improvement in nutritional status of children although the level of under-nutrition is still quite high. The 1996-1997 BDHS reported 20.6% of under-five children to be severely malnourished (less than 3 standard deviation) in terms of weight-for-age, which went down to 13% during the subsequent years (NIPORT, Mitra and Associates, ORC Macro 2005).

In the field of immunization, the country achieved 'near miracle' by increasing immunization coverage among children from 2% in 1986 to around 62% in the early nineties (Silva et al. 1991; Chowdhury et al. 1999). The availability and utilization of oral rehydration therapy for the

treatment of dehydration from diarrhoeal diseases also increased during the last two decades. A similar progress has been made in the field of family planning- the contraceptive prevalence rate was raised from mere 25% in the mid eighties to 58% in 2004 (NIPORT, Mitra and Associates, ORC Macro 2005). In the field of maternal health, the maternal mortality ratio has declined from 850 to 500 per 100,000 live births in the 1970s and 1980s (WHO 1996) to 322 per 100,000 live births during 1999-2001 (NIPORT, ORC Macro, Johns Hopkins University, ICDDR,B 2003).

However, these progresses in health status need to be matched with improved quality of life. Disability is an important measure of the quality of life during childhood. ‘Overt’ disabilities such as nutritional blindness, post-polio paresis and serious mental retardation have been replaced with mild hearing and cognitive disabilities, which hamper learning. The prevalence of various disabilities may have increased over time (Figure 3). These findings have grave implications for over 11% of the present generation of children aged 2-9 years.

**Figure 3:** Prevalence of childhood disabilities in population-based surveys in Bangladesh, 1988 and 2001



Source: Khan N and Durkin M 1995; Bangladesh Protibondhi Foundation and Columbia University 2001

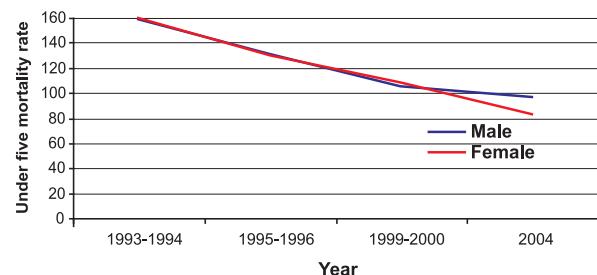
## Gender-based inequalities

How equitable has been the gain in life expectancy between men and women? Figure 1, presents the life expectancy at birth by sex from Matlab, a rural area in Bangladesh. It was clear that as the gain continued, the females’ biological superiority started to prevail since 1988 and continued to maintain so.

With reference to birth weight, the BBS survey reported 38% low birth weight among the girls compared to 33% among boys using 2.5 kilogram as a cut off point for both boys and girls. In fact girls tend of have lower birth weight than boys in general, so if a lower cut off point for girls is used then the observed difference may become insignificant.

Figure 4 presents under-five mortality rates by sex from the four BDHS surveys carried out so far. The rate for male has declined from 149 per 1,000 live births, as estimated in 1993-1994 BDHS, to 102 in the 2002-2003 BDHS. During the same period the decline for girls was from 150 to 91. The sex differential was however absent in all the BDHS figures except in the 2004 BDHS. This is an indication that the female disadvantage in survival during the first five years of life is either disappearing or taking a turn in favour of females.

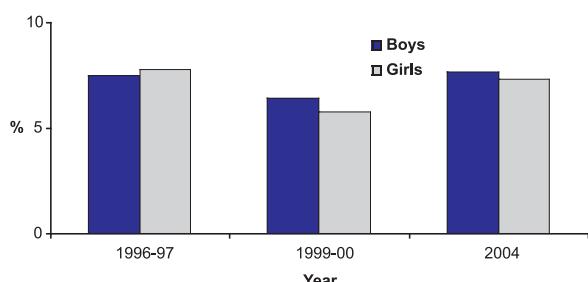
**Figure 4:** Under-five mortality rates by sex, 1993-2004



Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1994; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

In terms of morbidity, the prevalence of diarrhoea among children aged less than five years have been almost similar for boys and girls in every survey (Figure 5).

**Figure 5:** Prevalence of diarrhoea by sex, 1996-2004

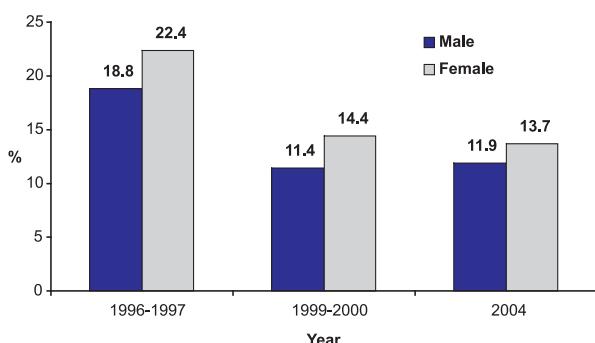


Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

*The gain in mortality situation as reflected in the under-five mortality rates has been as inequitable as they were ten years ago.*

Although the proportion of severe under nutrition has declined over the years the female disadvantage persisted even with a decreasing trend in gender gap (Figure 6).

**Figure 6:** Proportion of severe under-nutrition by sex, 1996-2004



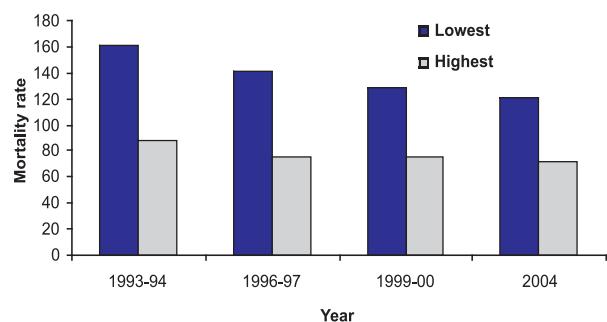
Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

### Socioeconomic inequalities

The improvement in under-five mortality situation over the years as depicted earlier was not matched by the improvement in reduction in the

gap between the rich and the poor. In fact the gap between the rich and the poor has been maintained almost at the same level as reflected in the mortality rates examined by asset quintiles from the four BDHS surveys. Although the absolute reduction in under-five mortality for the poorest quintile was 40 per 1,000 live births compared to 16 per 1,000 live births for the richest quintiles during 1993-2004, the under-five mortality rate for the poorest quintile in 2004 was high at 121 per 1,000 live births compared to 72 per 1,000 among the richest quintile. In fact the under-five mortality rate among the poorest quintile in 2004 was much higher than the rate experienced by the richest quintile almost 10 years ago. Thus, the mortality situation as reflected in the under-five mortality rates remains inequitable as they were ten years ago (Figure 7).

**Figure 7:** Under-five mortality among children from lowest and highest asset quintiles, 1993-2004



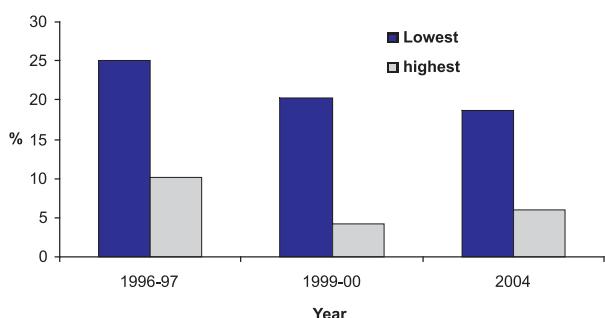
Source: Bangladesh Demographic and Health Survey 1993-94; 1996-97; 1999-00; 2004

Although the prevalence of diarrhoea among under-five children did not show any gender differential, it did seem to vary across different socio-economic status groups in recent years. In 2004, prevalence of diarrhoea in the poorest quintile was

8.7% and for the richest quintile this percentage was to 6% (NIPORT, Mitra and Associates, ORC Macro 2005).

The rich-poor gap in severe under-nutrition; even with a decreasing trend over the years is still at an alarming stage (Figure 8).

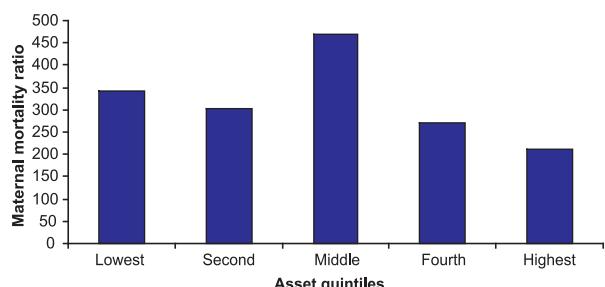
**Figure 8:** Severe malnutrition among under-five children from lowest and highest quintiles, 1996-2004



Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

Maternal mortality ratio also varied by socioeconomic status of the household. The mortality ratio in 2001 was least among women from the highest asset quintiles followed by the women from the 4th quintiles. The ratios in the other three quintiles were higher than that of 4th and 5th quintiles; however, it is surprising to note that the women from the 3rd quintile had much higher ratio than poorer women followed by the lowest and 2nd lowest quintiles (Figure 9).

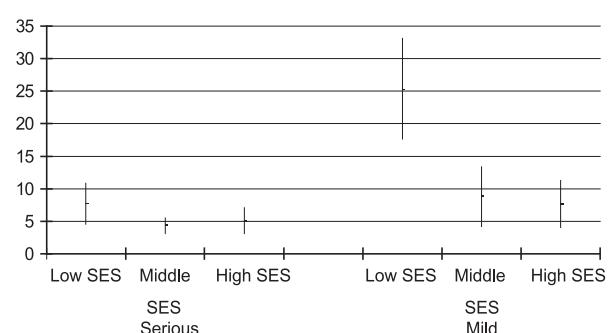
**Figure 9:** Differentials in maternal mortality ratio, 2001



Source: NIPORT, ORC Macro, Johns Hopkins University, ICDDR,B 2003

The prevalence of disability in childhood also varies across various socioeconomic groups. Figure 10 shows that children from the lowest SES group suffer from both serious and mild mental retardation more than the children from the highest SES group. The difference is more explicit in case of mild retardation (Islam et al. 1993).

**Figure 10:** Prevalence (95% CI) of serious and mild mental retardation (per 1,000 Children) aged 2-9 years, by socioeconomic status, Bangladesh.



Source: Islam S et al. 1993

## Rural-urban differences

The under-five mortality rates in the urban areas have always been lower than that of the rural areas. Over the years, the under-five mortality rates reduced in both urban and rural areas and so did the rural-urban gaps. The rural-urban gap in under-five mortality was 38.9 in 1993-1994 and it reduced to 6 in 2004 (NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1994). One of the interesting features of the rural-urban difference is that under-five mortality rates in the lowest two asset quintiles in the urban area have always been higher than that of the lowest two quintiles in the rural area. On the other hand, the under-five mortality rates in the highest quintiles in the urban area have always been lower than that of the children in the highest quintiles in rural area. These imply that the rich-poor gap is much higher in the urban area than in the rural area.

The rural-urban difference in the prevalence of diarrhoeal morbidity has always been small and it has continued to be so in all the BDHS.

The proportion of severely undernourished children in the 1996-1997 BDHS was reported to be 14.2% in the urban area compared to 21.3% in the rural area. By 2004, the proportion of severely undernourished children decreased to 12% and 13% in the urban and rural area respectively (NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997).

During 1999-2001, the maternal mortality ratio in the rural area was lower (326 per 100,000 live births) than the non-metropolitan urban area that had a maternal mortality ratio of 344 per 100,000 live births. Women from the metropolitan area had the lowest maternal mortality ratio of 262 per 100,000 live births during the same time (NIPORT, ORC Macro, John Hopkins University, ICDDR,B 2003).

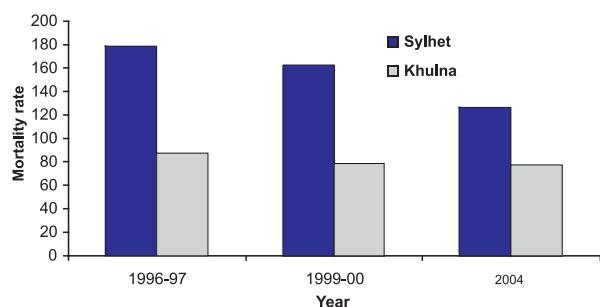
The country is making economic progress and urbanization is taking place rapidly. Two of the relevant questions in our search for the nature of inequity are: Do economic well-being and urbanization reduce gender gap? And, does urbanization reduce socioeconomic differentials in health? It can be seen from all the BDHS surveys that in the urban area boys always had slightly higher under-five mortality rates compared to girls. However, for the lowest two quintiles in the urban area girls always had higher mortality rates than boys and in the richest quintiles boys always had higher mortality than girls. The pattern is almost similar in the rural area. This implies that under economic hardship females are worse sufferers.

## Region

Bangladesh now has six administrative divisions, namely Barisal, Chittagong, Dhaka, Khulna,

Rajshahi and Sylhet. Sylhet is the newest division and data on all the six divisions are only available since the 1999-2000 BDHS. The highest under-five mortality was always experienced by the children in Sylhet and the lowest by the children from Khulna. In the 1996-1997 BDHS the under-five mortality rate was 179 per 1,000 live births for Sylhet and 87 for Khulna. In the latest BDHS the rate for Sylhet was 126 compared to 78 in Khulna (Figure 11).

**Figure 11:** Under-five mortality rate in the two divisions with highest and lowest rates, 1996-2004



Source: NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997; NIPORT, Mitra and Associates, ORC Macro 2001

Prevalence of diarrhoea among the under-five children in various divisions did not show any clear pattern of variation. The rates varied in between 3.1% and 8.7% in the 1996-1997 BDHS and 5.2% and 7.8% in the 2004 BDHS.

The prevalence of severe under-nutrition varied among the divisions from 15.7% to 25.2% in the 1996-1997 BDHS with Chittagong having the highest prevalence followed by Sylhet, Dhaka, Barisal, Rajshahi and Khulna. Over the years, the prevalence of severe under-nutrition declined in all the divisions. In 2004 BDHS the highest prevalence was in Chittagong (16.2%) and the lowest in Khulna (8.3%) (NIPORT, Mitra and Associates, ORC Macro 2005; Mitra et al. 1997)

The variation in maternal mortality ratio by the administrative divisions also put Sylhet on top of

the list with a maternal mortality ratio of 471 per 100,000 live births. Rajshahi had the lowest mortality ratio of 223. (NIPORT, ORC Macro, Johns Hopkins University, ICDDR,B 2003)

## Conclusion

The rise in life expectancy, decline in mortality, and improvement in nutritional status indicates a steady progress in health outcomes for Bangladesh. However, the progress has been uneven: some areas have seen major gains, while others have lagged behind. Prospects of survival have improved but the quality of survival remains a concern with childhood disability showing an increasing trend over the last decade. Although some inequities in some outcomes have reduced over the years, others have shown resilience.

*The rich-poor gap in rates has reduced in magnitude but the ratio of rich-poor rates has been maintained almost at a constant level.*

*Gender gaps have been closed in life expectancy, under-five mortality and certain types of morbidity, but it still remains in under-nutrition.*

There still exist significant rich-poor gaps in under-five mortality, severe malnutrition and maternal mortality. The rich-poor gap in rates has reduced in magnitude but the ratio of rich-poor rates has been maintained almost at a constant level. Gender gaps have been closed in life expectancy, under-five mortality and certain types of morbidity, but it still remains in under-nutrition.

Besides these health outcomes, there are other health issues with concerns of inequities. Examples of these include vector borne diseases, such as, malaria, kalazar, iodine deficiency, and rickets among children. Some of these problems are localized and are likely to create regional inequity unless specifically addressed.

Additionally, there are issues such as unsafe abortion and violence against women that have uneven consequences only for women. Despite having serious human rights and public health concerns,

preventive efforts to deal with these issues have so far been limited.

Focused policies and programmes are required to address these inequities in health, for instance targeting vulnerable areas and vulnerable population groups, and problems faced by the vulnerable and disadvantaged. Supply side initiatives alone may not be effective unless accompanied by programmes enabling the disadvantaged to avail the benefit of the programmes and policies. Regarding the prevention of childhood disability specific programmes targeted towards stopping early marriage and avoiding consanguineous marriages, ensuring use of antenatal care and safe delivery, ensuring improved nutrition of women through intake of balanced diet, programmes for economic emancipation of the lowest income families need to be put in place.

*Supply side initiatives alone may not be effective unless accompanied by programmes enabling the disadvantaged to avail the benefit of the programmes and policies.*

The success of these programmes can be ensured through monitoring health outcomes and utilization of services with equity focus on a regular basis. However, available data permit examination of inequities in health by individual and household characteristics. Data are quite often inadequate to map area-based inequities beyond divisions. For example, adequate data are not available to examine the extent of inequities in health of the population in areas having exposure to malaria, kalazar, iodine deficiency and rickets. Data are also lacking to examine the health status of the population living in slums compared to other urban areas and rest of the country. Assessment of socioeconomic inequities so far either was limited to rural, and between rural and urban areas. It is largely unknown how the country as a whole has been doing in terms of reducing socioeconomic inequities in health.

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# Health Care Consumption and Utilization: Persistent Inequities

## Introduction

Given the situation of endemic poverty and deprivation experienced by the majority of the population, the constitution of Bangladesh lays down basic principles of state policy, putting the obligation on the state to ensure the availability of food, shelter, employment, health and education for all its citizens. Thus there is strong constitutional commitment and obligation on the state to take on the responsibility of ensuring "Health for all" through the provision of affordable and good quality health care. In view of government's commitment to halve poverty by 2015 the right to affordable, accessible and good quality health care achieves greater significance because of the crucial link between health and poverty: poor health is both a cause and a consequence of poverty.

Government is also committed to reduce infant, child and maternal mortality and eliminate gender differences. Unfortunately, there is glaring inequality in consumption of health care (by income, sex, ethnicity, region, urban/ rural) and, in addition, good quality health care is beyond the reach of the majority of the population because of inability to pay for private curative health care, undermining the constitutional promise of affordable and accessible health care.

The plurality of health care provision in Bangladesh means that people who fall ill have a

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'choice' of health seeking options ranging from no treatment, self care (home remedies), traditional care, unqualified allopathic care from pharmacies and drug stores, care from health workers and paramedics to qualified allopathic care from doctors at chambers, clinics and hospitals<sup>1</sup>. If the decision is to seek health care there is also a 'choice' with respect to where to go for treatment: public providers, private for profit providers or private NGO not for profit providers.

The chapter is divided in three sections. The first section examines the equity aspects of health care consumption, focusing on the consumption of primary health care and curative health care separately. This is because primary health care is largely provided through community based public facilities (with some provision through NGO facilities), while curative health care is increasingly being provided by the market. The second section discusses affordability of health care by the poor. The concluding section highlights the main findings and some policy implications.

## Changing morbidity pattern and implications for health care consumption

The continuing demographic transition (falling birth rates, rising life expectancy, shrinking proportion under age 15, growing proportion of

<sup>1</sup> This 'choice' however is constrained by significant socio economic differentials in access to health care that falls outside the purview of this discussion.

elderly) and health transition (rise in non communicable diseases) has led to a change in the disease profile of the population. With decline in death rates from communicable diseases, especially in infancy and childhood, the incidence of non communicable diseases (hypertension, heart disease, diabetes, rheumatism, cancer) has increased, which now account for 37 percent of illnesses that result in death, much higher than a decade ago (Mahmud and Begum 2004).

The change in disease pattern has resulted in an increase in the propensity to seek allopathic care, whether from qualified or unqualified providers, across the board, i.e. for the nonpoor as well as for the poor. According to the nationally representative household expenditure survey of 2000 allopathic care represented two thirds of all recent illnesses (last 30 days) that had been treated. More than one third got treatment from qualified allopathic providers (37%), with a considerably higher proportion in urban (44%) compared to rural areas (35%)<sup>2</sup>.

*Although the proportion of illness is similar among the poor and the non-poor, the poor are less likely than the non-poor to seek treatment for a recent illness.*

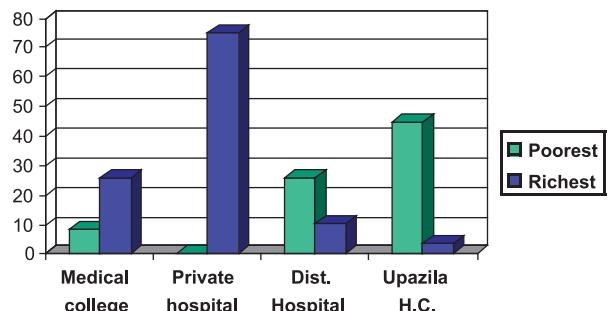
The morbidity burden in Bangladesh is fairly high with one fifth of the population reporting an illness in the last month (HIES 2000). The proportions of illnesses that received treatment were 83% and 72% respectively for the non-poor and poor, and the gap was more pronounced in the case of 6-10 year old children (WB, 2003a). Wealth or income gaps in health care consumption are the most pronounced, but there are other constraints on consumption as well, such as sex, age, residence, region, ethnicity.

Utilization of tertiary level health service, both publicly and privately provided, is dominated by the non-poor (see annex Table 1). At tertiary level

public hospitals one fifth (22%) of patients belonged to the poorest 40 percent of households (bottom two income quintiles) while one fourth (26%) were from the richest one fifth of households (top quintile); utilization of private hospital services was even more unequal, with only 3% of patients from the poorest two quintiles and 75% from the richest quintile group. At district level hospitals utilization by income level was quite balanced, maybe even slightly favouring the poor in public hospitals, possibly because of proximity and relatively lower transport costs from villages. At the upazila level the pattern of utilization of public facilities was reversed, with poor patients being in the majority. Thus, the poor dominate consumption of public health care at the primary level while the rich dominate consumption of private and public care at the tertiary level.

*Utilization of health services provided at primary, secondary and tertiary levels vary considerably by household income: the higher the level of service provision the greater the income inequality in utilization.*

**Figure 1:** Patients by income quintile (Source Annex, Table 1)



In terms of supply of services there is substantial regional variation in population coverage of public health facilities at the community (union), upazila,

<sup>2</sup> Data from 1995 in rural areas (Matlab) show that only 14% of recent (last 15 days) illnesses received care from qualified allopathic doctors (See Table 14, Ahmed 2005, pp38).

district and tertiary levels. The unequal population pressure on public services according to region (division) demonstrates that despite policy commitment to reach services to underserved areas and in accordance with need, provision of services and financial allocations are not based on any assessment of need or demand.

## Primary health care consumption

Since 1998 primary health care in Bangladesh is delivered through the essential services package (ESP) from public facilities at upazila level and

below and from NGO community based health centres. Private ESP provision is extremely limited. Primary health care on an outpatient basis (vaccination, antenatal care, infectious and childhood disease care) is also available in a limited fashion from tertiary and district level public facilities.

*Although there has been expansion in use of primary health care, nevertheless large proportions of women and children, particularly among the poor and in rural areas, remain excluded.*

Consumption of primary health care is examined by looking at use of selected ESP components, namely maternal and child health services, and family planning services. The rising consumption of primary health care is evident from significant declines in maternal, infant and child mortality during the 1990s (see Chapter 2). On average, use of antenatal care (ANC), particularly tetanus toxoid (TT) acceptance, increased visibly, while expansion in the use of postnatal care (PNC) has been much less and the use of trained delivery care has hardly changed at all. Child immunization coverage has also increased considerably.

### Sources of obtaining primary health care

Over three fourths of mothers received ANC from public facilities at upazila and below, 6% at public

hospitals, 8% from private clinics and only 3% from NGO services (see Annex, Table 2). About 5% of mothers received traditional ANC. Urban women were more likely than rural women to use public hospitals and private/NGO clinics for ANC since these are more available in cities and district/upazila towns, while as expected rural women were more likely to use government primary health facilities. Compared to ANC, however, public primary health facilities were less likely to be used for PNC (49% of mothers); in contrast use of public hospitals for PNC (12%) was greater especially in urban areas (21%). For obtaining PNC there was also greater reliance on private clinics (14%) particularly in urban areas, and on private doctors at home (11%) in rural areas. For child immunization the most preferred source was public primary health care in both rural and urban areas, while NGO not for profit services were also used quite frequently (15%). Use of private services for child immunization was negligible in rural areas but around 3% in urban areas.

*The poor and the non-poor access reproductive health care from different sources. However, both the poor and the non-poor use government immunization services the most frequently.*

While public facilities were the preferred choice for ANC by all women, non-poor women were more likely to use private clinics and NGO clinics compared to poor women (see Annex, Table 3). The income effect on use of private/NGO clinics for ANC and PNC was more pronounced in urban areas, suggesting that rural non-poor women would use private facilities more if these were available in rural areas. When available, such as in urban areas, poor women's use of public hospitals for ANC and PNC increased visibly. Poor women also used private hospitals to a much greater extent in urban compared to rural areas,

suggesting the increased dependence of the urban poor on the market even for accessing primary health care. Although most women deliver at home (over 90% of births in the preceding five years), non-poor women are more likely to avail health facilities during delivery than poor women (8% of births compared to 2%). In urban areas these proportions are slightly higher (15% and 5% respectively). Both the poor and non-poor used government immunization services the most frequently, except that the poor relied on government community health workers slightly more while the non poor relied on district hospitals somewhat more. In urban areas the non-poor were found to rely on NGO and private sources relatively more.

### Differential consumption of family planning services

*There is increasing reliance on the market for the consumption of family planning services with declining importance of government fieldworkers as a source of contraceptives.*

Family planning services are considered part of primary health service and the ESP. The public sector is still the major provider of family planning services. Nearly six out of ten modern contraceptive method users obtained contraceptives from a public source: 34% from a public facility and 23% from a government field worker (BDHS 2004).

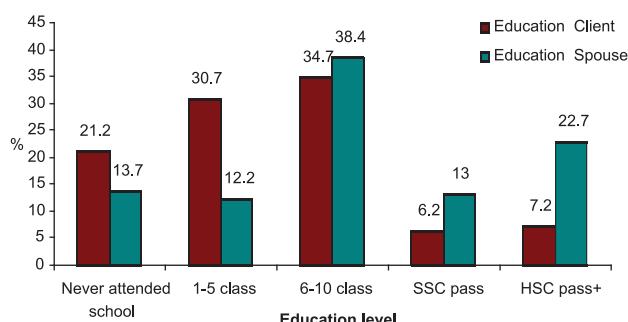
One third (31%) obtained contraceptives methods from pharmacies, private doctors and clinics, 5% from shops, friends and relatives, and 6% from NGO sources. Reliance on the market for the consumption of family planning services has been increasing as well, indicated by declining importance of government fieldworkers as a source of contraceptives (42% in 1992-94 to 23% in 2004) and rising importance of pharmacies (21% in 1999-2000 to 29% in 2004), particularly for pill users.

Consumption of family planning services is indicated by contraceptive use patterns for currently married women shown in Table 4. The contraceptive prevalence rate (CPR), which indicates the uptake of family planning services, increased slowly but steadily since the mid 1970s, from 5% of eligible couples in 1975 to 58% in 2004. However, there are visible differences in the use of family planning methods by residence and division, and also by the education level of women and household wealth. Women in Sylhet and Chittagong and those living in rural areas were less likely to use a birth control method compared to women in other regions and women living in urban areas. Poor women and less educated women were less likely to use contraceptives than non-poor and more educated women. This same consumption pattern holds for modern methods, and poor women were more likely to rely upon less effective traditional methods. There is also visible difference in reported unmet need for family planning, suggesting both differences in supply as well as demand constraints related to income and non income (awareness) factors.

While the use pattern for oral pills is not differentiated by either education or household wealth, poor and less educated women are more likely to use injectables compared to non poor and more educated women, while the reverse is true for condom use. In fact, methods requiring male participation are much more likely to be used by well off and educated women compared to poor and little or not educated women: this proportion is as high as 31% for women who have secondary or higher education and is 24% for women in the richest households.

*The burden of fertility regulation is much greater on poor and less educated women, while the burden is more likely to be shared by husband and wife when the woman is more educated or in wealthy households.*

**Figure 2:** Education status of the MR clients and their spouse at BAPSA's health care centers, 2004-2005



Source: Annual report of BAPSA 2004-2005

Utilization of menstrual regulation services appears to have increased, but reliable national data are not available<sup>3</sup>. There is not much details available on socio economic differences in use of MR, but the service statistics suggest that women with less than SSC level education are more likely to rely upon MR than more educated women. The vast majority are also housewives (81%) and the remaining in service occupations.

*Despite increase in consumption differentials in ANC use by socio economic characteristics are quite large. Income and education gaps in PNC use are even starker.*

Nearly half of all contraceptive users in Bangladesh stop using their method within 12 months of starting, with 18% discontinuing as a result of health side effects. The proportion is even higher (34%) when the reference period is the last five years. The family planning bias is also seen in field level service provision: 18% of currently married women had been visited by a field worker for family planning services (whether government or NGO) in the last six months compared to 10% of women visited by field worker for health service (BDHS 2004).

#### Differential consumption of pregnancy related health care

Antenatal care use from a medically trained provider increased sharply in the recent past from

only one third of all women having a birth in the five years in 1999-2000 to 49% in 2004 (BDHS 2004). PNC use did not increase very much in the recent past, only rising from 14% in 1999-2000 to 18% in 2004. Use of facility based delivery care, which is still very limited, hardly changed since 1999-2000 with only 9% of live births in the last five years taking place at a health facility (BDHS 2004). The proportion of births attended by a medically qualified person was slightly higher at 13% while trained birth attendants assisted in another 14% (BDHS 2004). These proportions have also remained static.

In 2004 on average 56% of women who had a live birth in the last five years received some form of antenatal care, with 49% from medically trained providers (see annex Table 4). In urban areas ANC use by pregnant women was 75% compared to 51% in rural areas, while use was lower than average in Barisal and Sylhet and higher than average in Khulna and Rajshahi. The differences were much starker with respect to education and household wealth. Women with secondary or higher education were three times more likely to use ANC from a medically trained provider compared to women with no education (90% versus 30%), while the richest women were two and a half time more likely to use ANC compared to the poorest women. The wealth and education related differences were more pronounced for ANC from a qualified doctor, and the gaps were seen for all the various ANC components (height, weight, blood pressure, blood and urine samples, ultrasonic test). The education and wealth gaps

<sup>3</sup> The number of MRs performed during July 2004-June 2005 in four health centers of BAPSA was 6,743, from 2026 performed during 1991-92 from one centre (BAPSA Annual report 2005).

were particularly striking for use of ultrasonic test and blood sample, while the gaps were least for tetanus toxoid.

The use of trained assistance during delivery was generally very low at 13% of live births in the last five years in 2000, but education and wealth gaps were quite severe: 55% of births to women with secondary or higher education compared to 4% of births to women with no education, and 40% of births to women in the richest wealth quintile compared to 3% of births to women in the lowest wealth quintile (BDHS 2004). Education and wealth differences in use of PNC and propensity for receiving medical care for pregnancy complications were equally large. Smaller differences in the use of trained delivery care and PNC were seen by birth order, rural urban residence and region. Khulna division stood out by having twice the reported level of trained delivery assistance compared to other divisions. The other noteworthy feature is that while pregnant women in Sylhet were less likely than average to receive ANC or trained delivery assistance, they were more likely to receive Vitamin A, trained medical care for complications and PNC than average. The propensity to receive PNC and trained delivery care was greater for women who received ANC<sup>4</sup>.

Inequalities in caesarian sections appear particularly large (Anwar et al 2005). According to the WHO and UNICEF the population based rate for caesarian sections should range between 5 and 15 percent of all births<sup>5</sup>, so that the national average 1.6 percent (NIPORT 2001) indicates very poor maternal situation. The rich-poor disparity for caesarian section is the highest (it is 9.2 in the ICDDR,B area) since the intervention is costly and requires referral to public and private district level facilities.

The resilience of inequalities in consumption of maternal health care is seen from the fact that even in areas that have specialized community based interventions, such as in the Matlab villages covered by the ICDDR,B maternity care programme, the rich-poor gap has been persistent. Thus, while such programmes have increased consumption they have not been able to adequately address equity or reach services to all who need them. Inequality in utilization of trained delivery care even among a seemingly homogenous group of poor mothers in a rural area even when services were provided free of charge are indicative of the persistent inequity in consumption (Anwar et al 2005). The rich-poor ratio for trained delivery care in Matlab was as high as 11.6. The likely reasons include indirect money costs associated with use, such as transportation, referral and lost wages or income for attendants. Distance is another factor that curtails consumption. Women who had received any ANC were much more likely to have trained care during delivery even after controlling for socio economic status and mothers' education, indicating that lack of knowledge and awareness of services also dampens consumption. All these barriers affect poor women more than the non-poor. Thus providing free services does not ensure equity.

### Differential consumption of child health care

The proportion of fully vaccinated children 12-23 months increased by 14 points between 1993-1994 to 2004, from 59% to 73% (BDHS 2004, pp.151). Together with rise in coverage the

<sup>4</sup> Among mothers who delivered at home the proportion receiving PNC was only 8% compared to 18% on average (2004 BDHS)

<sup>5</sup> Anything below 5 percent indicates that a substantial proportion of women do not have access to potentially life-saving surgical obstetric care and may die as a result.

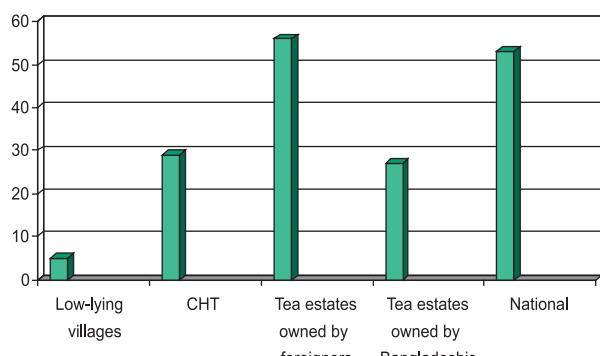
gaps in coverage between rural and urban areas and by income class have diminished. Although

*The use of qualified health care for childhood diseases remains extremely limited, and income and gender inequalities are severe. However, the importance of non income constraints on consumption remain as evident from the lower immunization coverage in Sylhet accompanied by the higher than average use of qualified provider for childhood diseases.*

improvements are noted for all, vaccinations coverage varies by type of vaccination: BCG has the highest coverage (93%) compared to measles with the lowest (76%)<sup>6</sup>. Even with improvement in coverage over time this variation has persisted, indicating that access to different vaccinations are constrained differently, which again has implications for how immunization services are provided. Since immunization levels are fairly high, socio economic differences were relatively small (table 5). However,

inequalities by residence and region remain, while differences by mothers' education and household wealth are in fact quite large.

**Figure 3:** Immunization coverage for special vulnerable groups (1995-99)



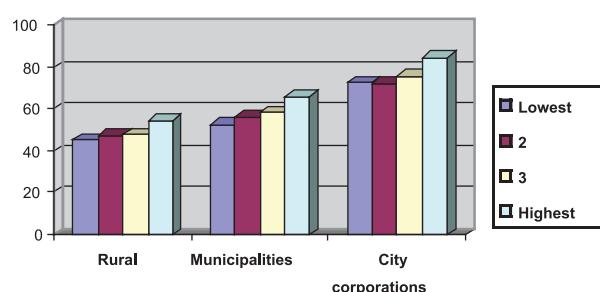
Source: BHEW 2002

Socio economic differences are the least for BCG coverage and the largest for measles coverage. Differential access to immunization is also evident from differences in the proportion of children who had health cards. Use of oral rehydration therapy (ORT) for diarrhea was also quite common with

83% of children under 5 who had diarrhea receiving some form of hydration, and socio economic differences are relatively small.

But even use of ORT in case of diarrhea among children is far from equitable. Children living in rural areas get ORS for around 50% of the cases, followed by urban municipalities (58%), urban city corporation slums (71%), and urban city corporation non-slums (81%) (Larson et al 2006). The socioeconomic inequities in receiving ORS are also very striking. Children from the lowest asset quintiles in rural areas receive ORS for 45% of the cases compared to 85% by the children from the highest asset quintiles living in the urban city corporations.

**Figure 4:** Use of ORS by location of residence and asset quartiles, Bangladesh 2003-2004



Source: Larson et al. 2006

By contrast the average consumption of qualified medical care for childhood disease is still extremely low (ranging from 16-20% of children suffering an illness), and income and other inequalities are much starker. While on average 20% of children under 5 who received treatment

<sup>6</sup> BCG is given immediately after birth while measles shot is at nine months after birth, so different delivery mechanisms are needed.

for ARI (in two weeks preceding the survey) were taken to a health facility or medically trained person, the proportion was 45% in the highest wealth quintile compared to 11% in the lowest; 23% for boys compared to 17% for girls; 35% in urban areas compared to 17% in rural areas; and 30% in Sylhet division compared to 13% in Barisal (BDHS 2004). Similar patterns of health care consumption are seen for childhood fever and diarrhea. The existence of cultural non income constraints to consumption of primary health care is re-confirmed by the fact that while Sylhet region has lagged behind in the use of immunization services, in the case of using qualified medical care for childhood diseases Sylhet region surpassed the average.

### **Curative health care consumption**

*Service statistics show that although on average more women (54%) than men use public facilities, women are increasingly over represented the lower the facility level.*

In this paper treatment for a recent or current illness is seen as curative care. Curative care is provided in a very limited manner from public facilities at upazila and below. One study estimated that among patients who visited public health facilities only 17% sought treatment for curative care or non ESP diseases, while the majority (53%) went for limited curative care, one fifth (19%) went to seek care for childhood diseases, 7% for reproductive health care and 3% for communicable diseases (Mannan et al. 2003).

Among recent illnesses that received treatment, only 10% were treated at a public facility, with relatively higher use in urban areas (13%) compared to rural areas (10%)<sup>7</sup> (Table 6, Annex). Nearly three fourths (73%) of treated recent illnesses obtained health care from the market, with the majority going for qualified allopathic care from doctors or unqualified allopathic care from

pharmacists in drug stores rather than traditional care<sup>8</sup>. A fairly large proportion (15%) got health care from public doctors who practice privately, or the so called 'mixed' source, and this proportion is also much higher in urban areas, because of greater availability of government doctors in district and medical college hospitals. Use of NGO services for recent illness is negligible. Male female patterns in obtaining curative health care from different sources are not very differentiated.

There are visible income differences by source of care with implications for care quality (see Annex, Table 7). Although pharmacies were the most common source of obtaining curative care, they accounted for nearly half of all visits for the poor but less than one third of visits for the non poor. The use of government doctor in private practice was twice as common among the non poor (21%) compared to the poor (10%), while use of private doctors (whether qualified or unqualified) was of similar level (24%). The poor were less likely to use government facilities and more likely to seek private traditional providers for curative care compared to the non poor.

*The huge demand among all socio economic classes for fee based services of government doctors in urban areas and among the non poor in rural areas means that public doctors have high opportunity cost of providing services in government facilities, especially in rural areas, resulting in high doctor absenteeism in public facilities.*

The urban poor are more likely to use public hospitals for curative care compared to the rural poor<sup>9</sup>. They were also relatively more likely to use government doctor in private practice and less likely to use

<sup>7</sup> The relatively lower consumption of health care from public sources was confirmed in small village based studies (See Mahmud 2006). In urban areas the presence of public hospitals explain the slightly higher use of public facilities.

<sup>8</sup> Private traditional health care is used for treating 11% of recent illnesses.

<sup>9</sup> There is a wide range of private providers of curative allopathic care, including unqualified practitioners like pharmacies, with varying quality of treatment.

private doctors and pharmacies than the rural poor. On the other hand, because of greater availability of government doctors in urban areas the urban non poor used government doctor in private practice relatively more and pharmacies relatively less than the rural non poor.

There are also important gender dimensions in the consumption of curative care. At district hospitals men patients outnumbered women patients, but the female proportion was 55% at upazila level,

64% at union level and as high as 75% at community level. This gender pattern of utilization partly reflects the type of services provided at lower level public facilities (maternal and child health care and family planning). It is interesting to note, however, that out

patients were more likely to be men for all ages except for the reproductive ages (15-49 years), particularly at ages over 65 years. In patients were also more likely to be men (55%) than women (Mannan et al.2003, pp.27).

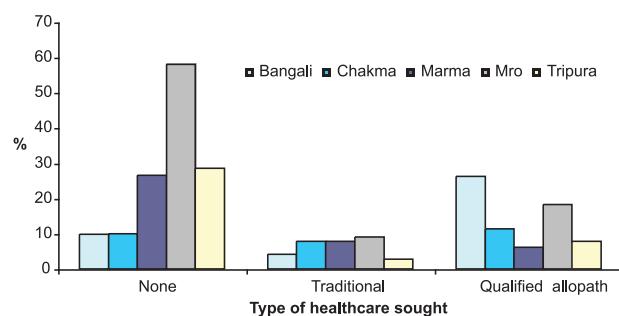
Propensity to receive qualified curative health care varies both by income and by sex. Among the poorest (lowest 40% of households by income quintile) women were much less likely to receive qualified allopathic care than men, and much more likely to get traditional care or unqualified care (from pharmacy/drug store). These sex differences are not seen among the richest households and are negligible in urban areas (Mahmud 2006).

While the evidence suggests that indeed more women, particularly poor women, are consuming health services than before, they are receiving services that are of lower quality than those that

*The rise in curative health care consumption by the poor and by poor women particularly has been more in terms of quantity than quality of health care.*

men use. The income gap in quality of services consumed by women is also quite stark. Access to good quality market based services is necessarily more restricted for the poor and for women, since private expenditure on health and other services are more unequal than total household expenditure. Women also have less access to incomes that are used to pay for private services. Ethnicity is another factor associated with differential use of health care for a recent illness (see Figure-5 below).

**Figure 5:** Health seeking behaviour by ethnic group (%)



### Affordability of health care

In Bangladesh government pays for primary health care and ESP targeted at the most vulnerable groups, as well as curative care to a limited extent by subsidizing the cost of services at district and national level public hospitals. But by and large, the bulk of health expenditure is incurred by people themselves either by purchasing health care from the market or by paying unofficial fees while accessing 'free' and subsidized public services. As expected household expenditure on health declines visibly with fall in household income level, but the poor spend roughly the same proportion (2-3%) of their income on health as the non poor, indicating the heavy burden of health care cost on the poor (Mahmud 2006).

Average expenditures hide the fact that the poor are less able to pay for health care costs compared to the non poor, although they are equally likely to fall sick and need health care. The poorest households (lowest quintile group) spent only 7.5% of total health expenditure incurred by households compared to 42% by the richest (highest quintile group), indicating the huge inequality in health expenditure (Table 6). The most unequal was hospitalization expenditure while expenditure on medicine was relatively less unequal.

The poor are also less able to afford primary health care and ESP even though costs of these services are subsidized by the government. This is indicated by large differences between the rich and the poor (according to wealth status) in the proportion of children with ARI taken to a medical facility (rich/poor ratio 2.2:1), in the proportion of births attended by a medically trained person (15:1) and in the proportion of women who received at least one antenatal care consultation from a medically trained person (4.2:1) (WB 2003, Table 2.2, pp.25). Wealth differences in consumption of less costly services like child immunization, childhood diarrhoea and family planning were relatively smaller, confirming the severe income constraint on even primary health care utilization. Subsidies received by the poor are actually not very large, and are further undermined by related costs of utilization of public health care services, such as unofficial user fees and tips, and because public personnel, equipment and supplies are diverted to the private practice of government doctors.

## Key findings

The key findings that emerge from the preceding analysis are summarized in this section.

- Overall the proportion of illness is similar among the poor and the non poor, but the poor are less likely than the non poor to seek treatment for a recent illness. The income gap in receiving treatment was more pronounced in the case of children.
- The poor dominate consumption of public health care at the primary level while the rich dominate consumption of private and public care at the tertiary level.
- In general women primarily rely upon public primary health services provided at upazila and below for accessing pregnancy related health care and for child immunization. Public primary health facilities are less used for PNC than for ANC, possibly because of the poor quality of clinical care provided at upazila health complexes, while the reverse is true for public hospitals especially in urban areas. For obtaining PNC there is also greater reliance on private clinics and on private doctors at home.
- There are visible income differences in accessing reproductive health care from different sources. Non poor women use private clinics and NGO clinics more frequently compared to poor women. The income effect on use of private/NGO clinics for ANC and PNC is more pronounced in urban areas.
- The public sector is still the major provider of family planning services, but reliance on the market for the consumption of family planning services has been rising, particularly for pill users.
- There is differential access to modern methods of birth control according to income,

education, region and residence. Part of the geographic variation in use could be related to differences in supply, but there are also demand constraints that are both non income (cultural norms, awareness) and income related.

- The burden of using contraceptives, including health costs (pills, injectables), is much greater on poor and less educated women, while the burden is more likely to be shared by husband and wife when the woman is more educated or in wealthy households.
- There is dearth of provision of health care for contraception related health problems.
- Although consumption of RH care increased significantly in the last decade, the increase was not the same for all components. ANC use from a medically trained provider increased by 16 points in the recent past, but PNC use increased only 4 points in the same period. The proportion of births attended by a medically qualified person and the proportion born in a health facility remained static.
- Despite expansion in overall use, differentials in ANC use are quite large. Income and education differences were the most stark, especially for services from a qualified provider or that required a payment or had to be purchased. Regional and residence differences indicate that there are also important non income constraints on obtaining ANC linked to cultural and religious practices and norms. Non income constraints are also important for obtaining PNC and trained delivery care as indicated by the use pattern of RH services in Sylhet region.

- Immunization coverage against all six of the childhood communicable diseases increased in recent years, but coverage varies by type of vaccination and this variation has persisted, indicating that access to different vaccinations are constrained differently, which again has implications for how immunization services are provided. Socio economic differences by mothers' education and household wealth are still quite large, and differences were more pronounced when overall coverage was smaller, for example measles.
- Socio economic differences in use of ORH for diarrhea have been almost eliminated, but income differences are still visible.
- The use of qualified health care for childhood diseases remains extremely limited, and income and gender inequalities are severe. The importance of non income constraints on consumption emerges again as evident from the lower immunization coverage in Sylhet accompanied by the higher than average use of qualified provider for childhood diseases.
- The main feature of curative health care consumption is overall low use of public health services and primary reliance on the market for health care, including public doctors who practice privately, a proportion that is much higher in urban areas, because of greater availability of government doctors in district and medical college hospitals.
- Both the poor and the non poor generally rely on private health services for getting curative care but there are visible income differences: the poor use private care of lower quality

(pharmacy and traditional providers) while the non poor use private care of relatively better quality (government doctor in private practice).

- The likelihood of receiving qualified health care for a recent illness rises significantly with household income level for both women and men. But the income gap is more pronounced for women. Thus growing reliance on the market for curative care tends to increase gender inequality in the consumption of good quality services and eventually in health outcomes.

### Conclusions and policy implications

Demand constraints related to both income and non income factors are the most important determinants of health care consumption. Reduction in the wealth gap in consumption of many primary health care components represents a sort of catching up by the poor who have lagged behind. Generating demand for services that are free or subsidized and can be provided close to peoples' homes through health workers and satellite clinics (such as ANC) has been relatively easy. But this will be more difficult when demand for services is weak because of the high money cost of qualified obstetric care and social cost of going against cultural norms, such as for PNC and delivery care. Similarly demand for health care for childhood diseases is severely income constrained, but there are also resilient non income constraints as well. Policy will need to address both income and non income demand constraints.

The other issue that determines consumption of primary health care is the quality of care. So long as a minimum acceptable quality of care is

maintained and services are 'free' or subsidized poor people are willing to use public sources, such as for ANC and immunization. However, when care quality matters, such as for PNC, trained delivery care or qualified care for childhood diseases, even the poor are unwilling to avail 'free' services. While the non poor have the option of accessing these services from the market the poor are unable to pay for them. Thus, if ESP coverage of the poor and other excluded groups is to be expanded, demand for primary and preventive care must be generated at the community level by improving the quality of existing care at public facilities and by going into partnerships with NGOs for the provision of not for profit (cost recovery) community based services that are difficult to reach through the public delivery system (EOC, delivery care, childhood diseases). Policy will have to deal with constraints related to the delivery of more sophisticated technology that is more expensive and entail greater governance problems.

There are severe income constraints on utilization of good quality curative health care services from the market. The market for private health care is quite segmented along lines of treatment quality, so that relatively low quality treatment is accessed by the poor (unqualified providers and pharmacies) while relatively high quality treatment is accessed by the non poor (government doctors in private practice and private clinics). The absence of third party payments in total health expenditure suggests that there is a role for health insurance in expanding access of the poor to good quality curative care from the market. Another policy option is to bring the unqualified practitioners providing services from drug stores, by far the most commonly used private provider, into the fold of the formal health system through some training and regulation.

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### Annex to Chapter 3

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**Table 1:** Distribution of patients (inpatient and outdoor) by income quintile **and source of care (%)**

Income group	Tertiary Level Care		Secondary Level care		Primary level care at public facility (upazila health complex)
	Public facility medical college hospital	Private hospital	Public facility District Hospital	Private clinic	
First quintile	8.3 (19)	-	26.1(47)	12.5 (5)	44.6 (49)
Second quintile	13.9 (32)	2.9 (1)	30.0 (54)	20.0 (8)	22.7 (25)
Third quintile	23.9 (55)	10.0 (4)	16.7 (30)	30.0 (12)	17.3 (19)
Forth quintile	27.8 (64)	12.5 (5)	16.7 (30)	20.0 (8)	11.8 (13)
Fifth quintile	26.1 (60)	75.0 (30)	10.5 (19)	17.5 (7)	3.6 (4)
Total	100 (230)	100 (40)	100 (180)	100 (40)	100 (110)

Source: Jahan et al 2002, pp10 (HEU)

Figures in brackets are numbers of patients.

**Table 2:** Choice of provider for primary health care according to residence (% mothers received ANC and PNC for most recent birth in past 5 years and % children under 5 who received at least one dose), 2000

Type of provider	Mothers received ANC.			Mothers received PNC			Children received Vaccine		
	National	Rural	Urban	National	Urban	Rural	National	Urban	Rural
Public: upazila and below	77.75	83.66	57.98	49.13	56.80	31.22	81.83	83.24	74.92
Public Hospital	6.24	3.91	14.06	11.57	7.40	21.30	1.31	0.56	5.03
Private Clinic	7.56	4.20	18.80	15.53	9.17	30.37	0.58	0.14	2.77
NGO	3.04	2.34	5.41	4.13	3.09	6.54	14.58	14.26	16.19
Home	-	-	-	11.23	13.43	6.10	-	-	-
Other	5.40	5.89	3.74	8.42	10.11	4.46	1.68	1.80	1.10
Total	100	100	100	100	100	100	100	100	100

Source: Report of the Household Income & Expenditure Survey, 2000. BBS.

**Note:** Public: upazila and below=satellite clinic, union sub-center, family welfare center, upazila health complex and government health worker

Public hospital = district hospital and medical college hospital.

NGO=NGO health center and NGO health worker

**Table 3:** Choice of provider for ANC, delivery and PNC according to residence and poverty status (percent of visits to different providers)

Type of care	Urban		Rural		Bangladesh	
	Poor	Non poor	Poor	Non poor	Poor	Non poor
<b>Antenatal care<sup>1</sup></b>						
Public: upazila and lower	77	50	87	80	86	71
Public hospital	11	15	3	5	4	8
Private or NGO	12	35	10	15	10	21
<b>Delivery<sup>1</sup></b>						
Home	95	82	98	96	98	92
Public: upazila and lower	2	3	1.5	2	1.4	2
Public hospital	2	7	0.4	1	0.6	3
Private or NGO	1	8	0.3	1	0.5	3
<b>Postnatal care<sup>1</sup></b>						
Home	9	5	14	13	13	10
Public: upazila and lower	52	27	61	54	59	44
Public hospital	18	22	4	10	7	14
Private or NGO	21	46	21	23	21	32
<b>Child immunization<sup>2</sup></b>						
% children received all vaccinations	65	81	63	66	64	69
% children received at least 1 vaccine	92	97	92	94	92	95
<b>% immunized from different sources</b>						
Public: upazila and lower	77	71	82	84	81	81
Government health worker	14	11	14	11	14	11
District hospital	3	7	0	1	1	3
NGO health centre or worker	5	6	2	2	2	2
Private	2	6	2	2	2	3

Source: 2000 WB 2003a, tab 3.5, pp52, calculated from HIES 2000.

**Note:** 1=for most recent birth in last 5 years for ever married women; 2=for children under 5 who received at least one dose

**Table 4:** Consumption of reproductive health services by currently married women for family planning services and by women who had at least one live birth in the last five years for anc and other services

	Family planning services						ANC						
background	any method	Mod-ern meth	Inj-ect-aible	Con-dom	Male meth <sup>1</sup>	FP Unmet need	Any anc	TT <sup>2</sup>	Info on comp <sup>3</sup>	Trained delivery assistance	Vit A <sup>4</sup>	Treat-ment for comp <sup>5</sup>	pnc
<b>Residence</b>													
Rural	56.7	46.0	9.8	3.0	13.7	11.9	50.9	62.8	27.3	9.4	12.9	24.6	13.5
Urban	62.9	51.6	9.1	8.3	18.4	9.4	74.8	66.6	42.2	29.6	20.9	45.2	34.1
<b>Division</b>													
Barisal	54.2	42.7	12.8	1.9	13.2	12.7	46.8	72.2	27.9	11.4	17.2	28.4	15.0
Chittagong	47.1	37.4	8.3	4.8	13.8	17.0	54.3	62.5	31.1	11.7	20.5	27.7	17.4
Dhaka	59.3	48.5	8.0	4.9	15.4	10.7	56.1	63.3	29.4	14.9	12.0	25.2	17.6
Khulna	63.8	50.7	11.5	4.9	18.4	8.3	61.4	60.1	32.7	21.2	10.9	35.5	25.6
Rajshahi	68.3	57.8	12.2	3.4	14.6	7.2	59.1	66.9	32.7	10.6	11.5	30.5	14.5
Sylhet	31.8	22.0	4.1	2.5	12.0	20.6	48.2	55.4	23.8	11.1	21.6	32.0	20.4
<b>Education</b>													
No eduction	58.8	48.3	12.2	1.5	12.0	11.6	37.6	56.5	17.8	4.4	10.2	14.9	6.7
Pri incomplete	56.8	45.4	11.0	2.5	14.1	12.2	52.9	62.5	26.9	8.7	11.5	25.0	13.4
Pri complete	58.9	47.4	7.1	4.1	15.9	12.0	59.2	65.4	31.3	12.4	15.1	34.8	15.4
Sec incomplete	56.3	46.7	7.0	5.9	15.5	11.7	75.2	71.7	41.8	20.7	18.2	41.0	26.8
Sec or higher	62.0	49.1	3.9	17.8	30.7	7.9	93.8	71.9	62.6	55.2	31.4	62.6	56.9
<b>Wealth index</b>													
Lowest	53.6	44.7	11.9	1.2	10.4	13.0	33.7	56.0	18.8	3.4	8.5	14.0	5.1
Second	57.6	47.7	11.8	1.7	11.8	11.7	46.0	61.2	21.9	4.5	8.9	17.6	8.6
Middle	57.8	46.6	9.0	2.5	13.6	11.7	58.3	63.5	30.5	10.5	14.7	25.8	12.7
Fourth	58.5	47.4	9.0	3.8	14.8	11.3	66.5	69.6	35.2	17.4	17.9	42.8	22.3
Highest	62.5	50.0	6.7	11.4	23.8	8.6	84.1	70.7	51.2	39.6	25.9	55.8	46.9
<b>Total</b>	<b>58.1</b>	<b>47.3</b>	<b>9.7</b>	<b>4.2</b>	<b>14.9</b>	<b>11.3</b>	<b>55.9</b>	<b>63.6</b>	<b>30.4</b>	<b>13.4</b>	<b>14.5</b>	<b>28.7</b>	<b>17.8</b>

Source: BDHS 2004

**Note:** 1=methods requiring male cooperation (condom, male sterilization, periodic abstinence, withdrawal); 2=two or more doses; 3=information on pregnancy complications provided; 4=within 2 months after delivery; 5=% of births in the last five years who had at least one complication who received qualified medical care

**Table 5:** Consumption of health care for childhood disease

	% children <sup>1</sup> immunized with				% children <sup>2</sup> with illness taken to trained provider <sup>3</sup> for				
Background	All <sup>4</sup>	BCG	Measles	% with health card	ARI <sup>5</sup>	fever	diarrhea	ORT <sup>6</sup>	Vit A <sup>7</sup>
<b>Residence</b>									
rural	71.1	93.2	73.9	47.3	16.8	14.7	12.3	82.7	80.9
urban	80.9	94.2	82.8	58.1	35.4	33.7	31.4	87	85.2
<b>Sex</b>									
male	73.4	93.4	75.6	46.8	23.3	19.8	16.3	83.3	82.1
female	72.8	93.4	75.7	51.7	16.8	17.2	15.1	83.5	81.4
<b>Division</b>									
Barisal	72.5	96.2	77.3	49.6	13.3	11.7	6.9	70.6	73.7
Chittagong	75.1	93.1	77.1	48.9	22.2	22.6	13.5	88.8	83.8
Dhaka	68.8	95.5	72.0	43.0	17.0	16.3	15.7	83.7	83.9
Khulna	82.8	96.9	86.6	58.2	23.7	23.6	17.2	86.5	83.5
Rajshahi	76.4	91.1	77.0	53.4	19.1	14.7	19.8	83.9	81.5
Sylhet	61.5	87.1	66.3	50.9	30.3	25.8	16.7	72.8	72.9
<b>Mother's Education</b>									
No eduction	60.3	89.0	62.3	43.4	12.5	12.0	8.9	81.4	79.0
Pri incomplete	72.5	94.0	76.3	53.4	21.6	17.6	12.6	75.7	81.6
Pri complete	80.3	95.4	81.1	41.1	20.1	16.5	18.1*	84.1*	83.0
Sec incomplete	82.2	96.3	85.4	53.4	27.4	25.9	25.9	92.8	83.9
Sec or higher	92.2	98.8	94.2	62.1	43.9	35.9	33.9*	96.6*	89.4
<b>Wealth index</b>									
Lowest	57.4	87.1	59.5	43.9	10.8	9.2	6.9	74.9	77.2
Second	76.0	95.5	79.2	46.4	15.5	12.7	17.2	82.0	82.1
Middle	74.1	94.9	76.3	47.9	18.7	17.6	17.8	83.9	81.2
Fourth	78.7	94.2	80.5	52.3	27.4	21.6	14.8	90.7	83.2
Highest	86.7	97.9	90.5	60.7	45.3	40.7	30.6	94.4	87.6
<b>Total</b>	<b>73.1</b>	<b>93.4</b>	<b>75.7</b>	<b>49.4</b>	<b>20.3</b>	<b>18.5</b>	<b>15.7</b>	<b>83.4</b>	<b>81.8</b>

Source: BDHS 2004

**Note:** 1=children 12-23 months; 2=children under 5; 3=excludes pharmacy, shop and traditional provider; 4=all 6 doses; 5=refers to cough with either rapid or difficult breathing or chest indrawing; 6=includes ORS packets, recommended home fluids and increased fluids;

\*=based on less than 50 unweighted cases

**Table 6:** Choice of provider for curative health care according to residence and sex (% of illnesses in last 30 days), 2000

Source/ sector	National			Urban			Rural		
	Both sex	Male	Female	Both sex	Male	Female	Both sex	Male	Female
Public Allopathic	10.38	10.22	10.55	13.02	11.84	14.10	9.80	9.88	9.73
Private allopathic	62.33	63.24	61.43	54.68	55.93	53.54	64.01	64.76	63.25
NGO	0.93	0.73	1.12	1.28	0.96	1.57	0.85	0.68	1.02
Mixed	15.73	15.45	16.00	23.08	23.42	22.77	14.12	13.80	14.43
Private traditional	10.63	10.36	10.90	7.94	7.85	8.02	11.22	10.88	11.57
Total Number in Million	100	100	100	100	100	100	100	100	100
	20.67	10.34	10.33	3.72	1.78	1.94	16.95	8.59	8.39

Source: Calculated from Report of HIES 2000, BBS.

**Note:** Public=government doctor, government health worker.

Private allopathic=private doctor, pharmacy/drug store

NGO= NGO health worker, NGO doctor.

Mixed=Government doctor in private practice.

Private traditional= homeopathy, kabiraj, ayurbadic, peer, fakir, tantric, ojha and other

**Table 7:** Choice of provider for curative care according to residence and poverty status (% of visits to different providers among those who sought curative care), 2000

Provider	Urban		Rural		Bangladesh	
	poor	non poor	poor	non poor	poor	non poor
Government facility	16	11	8	12	9	12
Government doctor						
In private practice	14	29	9	19	10	21
Private doctor	20	24	25	24	24	24
Pharmacy/drug store	39	28	45	35	44	33
Private traditional and NGO	11	8	13	10	13	10

Source: WB 2003a, table 3.7, pp53

**Table 8:** Total household payments by income quintiles

Quintile	fees %	hospita- lization %	medicine %	tests %	transport %	tips %	other %	Total monthly household payment	
								million Tk	%
Poorest	5.9	2.5	9.4	3.6	5.2	4.0	4.7	562	7.5
Second	10.4	2.1	16.0	5.5	9.7	22.2	8.1	958	12.8
Third	13.2	7.8	19.3	14.1	18.3	5.3	14.2	1274	17
Fourth	23.3	9.8	22.2	16.3	24.1	26.8	17.3	1550	20.7
Richest	47.2	77.7	33.1	60.5	42.7	41.7	55.6	3126	41.9
Total monthly household payment (million Tk)	680	524	4712	681	419	50	405	7476	100
%	9.1	7.0	63.0	9.1	5.6	0.7	5.4	100	100

Source: WB 2003, Table 2.3, pp28

# Health Policies: Pledges and Implementation

### Introduction

Increasing access to health services to disadvantaged people and closing the health gap between socio-economic groups has been the major goal of the health policies and programmes in Bangladesh. In addition, ensuring access to free family planning services to rural populations, particularly women, has been emphasized in

*Changes were made in the policies and programmes to ensure greater efficiency, and responsiveness to the expectations of the people, but yet to make any significant efforts to reach the poor with affordable health care services.*

government plans and policies. Initially, the health policies and programmes prioritised the establishment of national health systems, including the establishment of infrastructure facilities and institutional facility of education and training. Significant emphasis was placed on basic and preventive services meeting the needs of vulnerable groups through the

provision of comprehensive primary health care and universal family planning services.

Successful implementation of some of these policies and programmes ensured the poor access to certain primary health care services in rural areas, improving equity in the use of services like expanded programmes on immunization (EPI) and family planning. Although the poor dominate the consumption of public health care at the primary level, the rich benefit more from public sector subsidies to health care (Rob et al. 2005). Even though health services provided at the public facilities are free, there are hidden costs associated with seeking treatments.<sup>1</sup>

In the past, some changes in policy have been prompted by perceived failures in the service delivery system. In recent years, in line with the changes in the global policy, the government has redefined the programme objectives and adopted new approaches. The implementation of these policies and programmes has not been simple. There are both optimism and pessimism as to successes and failures in implementing the policies and programmes.

It is important to examine what plans and programmes the government has adopted to improve the health status of its poor and disadvantaged population. It is also important to know what policies and programmes have been successfully implemented and which have not.

### Policies: Goals and strategies

The Government of Bangladesh (GOB) has adopted two population policies, drafted one health policy, and implemented five Five-Year Plans and two sector strategies. Although the health policy was approved in 2000, it is yet to be implemented. Historically, the most powerful 'policy instrument' in Bangladesh has been the five-year development plans prepared by the Planning Commission, which outlined the health and population sector priorities for the country.

<sup>1</sup> It was observed that one has to pay for consultation in local level public facilities in rural areas (Rob et al. 2006).

The following sections examine the impact of the five-year plans, policies and sector strategies in reaching poor and disadvantaged section of populations.

### **Reducing population growth**

Since independence, the government's population policy focused on the need to reduce population growth. The first population policy, adopted in 1976, was specifically directed towards population control. However, the policy did not clearly explain a strategy that would link population control and

socio-economic development. Each of the successive policy plans as well as the five-year plans and annual development programmes were developed and expanded upon the 1976 policy.

*The most powerful 'policy instrument' in Bangladesh has not been the health policy but the five year development plans.*

The key strategy of the population policy was to provide comprehensive health and family planning services through the use of clinics and female field workers. As part of developing a comprehensive service delivery structure, facilities were constructed and expanded, recruiting and training of programme personnel took place, institutions for administration, research and training were developed, and a multi-sectoral approach was employed including the active involvement of non-government organizations (NGOs). All these activities were directed towards increasing access to the family planning services for the rural populations. Besides, there was a strong emphasis on doorstep (domiciliary) family planning services to rural women in efforts to ensure universal coverage of services. This was in the context of restricted mobility of village women, and the realization that visiting clinic or service providers was quite often inconvenient or difficult

in terms of time and transportation cost. Eligible couples were provided family planning methods free-of-cost.

The population policy and the population sections of the Five-Year Plans recognized the need for making family planning programmes an integral part of social mobilization and national development efforts and suggested introduction of various social and legal measures for keeping the family small and a system of incentives and disincentives for accepting permanent contraceptive methods. Social measures included preferential treatment in all government facilities and incentives were largely directed towards the rich and educated segments of population, not to the poor and illiterate population who adopted family planning methods. The only social incentive intended to benefit poor families was the provision of free education and stipend for girls attending schools. In addition, monetary incentive for accepting permanent contraceptive methods claimed to have helped poor by compensating for loss of wages and related expenses incurred by the couples. However, such policies and measures had been criticized for not serving the client's best interest. The incentive and disincentive system was also contradictory with respect to safe and ethical provisioning of fertility regulating methods (Ghafur 2000). Women's health is jeopardized if the family planning method is provided to them ignoring its potential health hazards. Thus the policy of introducing incentive and disincentives, and promotion of certain contraceptive methods, was seen as directed towards population control rather than increasing access. The 1976 Population Policy and the population sections of the Five-Year Plans

*The key strategy of the population policy was to provide comprehensive family planning services mainly through clinics and female field workers, with a strong emphasis on doorstep services to rural women.*

identified several demographic targets that would need to be reached in specific years in order to decrease rapid population growth. The information presented in the following tables illustrates a comparison between the demographic targets and actual achievements.

It is believed that the domiciliary service has enabled the system to achieve programme effectiveness. Evidence suggests that programme

performance had sharply increased. The contraceptive prevalence rate increased from 9 percent in 1975 to 58 percent in 2005. Consequently TFR has also decreased from 6.3 in 1975 to 3.0 in 2005.

Thus, family planning programme earned a worldwide reputation and much of the credit should go to pro-poor service delivery system in rural areas.

**Table 1:** Demographic Target in Five-Year Development Plans

Development plan	Growth rate	TFR	CPR	CBR	CDR	MMR	IMR
1976 Population Policy	2.4	5.6	12.0	39.8	14.5	-	-
First Five-Year Plan (1973-1978)	2.8	-	-	43.0	15.0	-	-
Second Five-Year Plan (1980-1985)	1.8	4.1	37.5	31.6	14.0	4.0	100
Third Five-Year Plan (1985-1990)	1.8	-	40.0	31.0	13.4	4.0	100
Fourth Five-Year Plan (1990-1995)	1.8	4.0	50.0	28.9	10.7	4.5	80
Fifth Five-Year Plan (1997-2002)	1.3	2.6	60.0	21.0	7.8	-	55

Source: Five-Year Plans, Planning Commission, Government of People's Republic of Bangladesh

**Table 2:** Actual Achievements of the Population Programme 1975-2005

Indicator	1975	1985	1989-90	1996-97	2005
Growth rate	2.8	2.3	2.2	1.8	1.5
TFR	6.3	5.5	4.9	3.3	3.0
CPR	8.5	25.0	39.0	48.0	58.0
CBR	46	36	34	27	20
CDR	18	13	12	9	5
MMR	7.0	6.3	6.0	4.5	3.2
IMR	140	112	94	77	65

Source: Fifth Five-Year Plan (1997-2002)

Bangladesh Demographic and Health Survey 2004  
Bangladesh Bureau of Statistics 2006

Since the mid-nineties, in line with the global consensus achieved at the International Conference on Population and Development (ICPD), Bangladesh has shifted its programme approach from target-driven to client-centred, dealing with a broader range of reproductive health issues targeted at a larger number of population groups. Unlike the earlier plans, the Fifth Five-Year Plan did not clearly state the need for drastic reduction of population growth rate and continuity of incentive and disincentive system for family planning activities. The Fifth Plan proposed to provide reproductive health care through an

Bangladesh family planning programme earned a worldwide reputation and much of the credit goes to the system of doorstep and pro-poor service delivery system.

integrated, multi-sectoral maternal and child health-based service delivery approach to decrease the population growth rate. The second population policy, adopted in 2004, again endorsed the ICPD approach and has a much wider perspective than that of the first population policy. It made a similar shift from narrowly designed family planning services towards broader reproductive health services and also intends to improve the delivery of family planning, and maternal and child health, including reproductive health services. Through striking a desired balance between population and development in the context of the Millennium Development Goals (MDGs) and a Poverty Reduction Strategy, this second policy intends to improve the country's living standards.

### **Increasing access to primary health care**

Reducing inequalities in the access to health services has been emphasized in all Five-Year Plans and policy documents. Bangladesh had inherited a system of urban-based health care with emphasis given to curative services rather than

preventive services (Planning Commission 1973). However, immediately after the independence, government realized that major health problems in the country had been associated with nutrition and communicable diseases and health systems had never been able to deliver even the most basic services to people living in rural areas.

Moreover, the new country had tremendous resource constraints in terms of both capital and skilled manpower. Therefore, the First Five-Year Plan had adopted the policy of preventable morbidity and mortality reduction while providing basic curative care. This would require comparatively less resources and less highly trained personnel. Hence, the First Five-Year Plan had emphatically stated the necessity of a prevention based health programme for Bangladesh. Successive Five-Year Plans have adopted primary health care as the key approach to achieving affordable universal coverage as well as for the improvement of the health of the poor people.

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*Successive Five-Year Plans have adopted primary health care as the key approach towards the improvement of the health of the poor people.*

The government commitment to extend health facilities to the community level, reflecting its intention to improve equity in access to primary health care services, was expedited by the international commitment made in Alma Ata Conference in 1978 to ensure 'Health for All' through comprehensive primary health care. Thus, the health sector in Bangladesh has achieved a progressive resource shift in favour of basic and preventive services meeting the needs of vulnerable groups.

The First Five-Year Plan set out the objective of creating health infrastructure in the rural areas for

delivering integrated and comprehensive health services through Thana Health Complexes (THCs) and Union Sub-Centres (Planning Commission 1973). Although the First Plan emphasized the establishment of infrastructure facilities and recruiting and training of primary health care providers, it did not emphasize developing a referral mechanism from the community to the health facility. The non-availability of health facilities at the union level was an important missing link in the health system.

During the Second Five-Year Plan period, institutional development continued in respect of education, training, and service dispensation, and more health facilities at the primary level were constructed. The Second Plan particularly focused

on extending health care facilities to the rural poor by building up a network of infrastructure i.e., Thana Health Complexes at the sub-district, and Health and Family Welfare Centres (HFWCs) at the union level (Planning Commission 1980). The plan document emphasized the production of health manpower at the mid and grassroots level. To ensure treatment of poor people from the rural area, the Second Plan had urged the need for a clear-cut linkage between the specialized

institutes and regional medical colleges, and the district and sub-district hospitals. These activities were aimed at ensuring availability of skilled and motivated service providers at the local level as well as appropriate referral, all with the goal of increasing access to health services in rural areas.

In addition to expanding the coverage, the Third Plan focused on the quality of the primary health care services in hopes to increase utilization of

*Initially, priority had been given on building and expanding infrastructure facility and increasing the number of skilled health manpower to provide primary health care service at the grassroots level. Gradually, emphasis had been shifted to quality and coverage.*

these services in rural areas (Planning Commission 1985). Establishment of health facilities at the sub-district and union level continued. Specialized services were introduced in the THC and cold chain was instituted in each THC and EPI service was extended to remote areas. Special efforts were taken for the expansion and modernization of 'district hospitals' in order to serve as referral centres for primary health care. Through establishing the 'satellite clinic', services of HFWC had been taken to the doorstep of the clients. The introduction of EPI and satellite clinic services has been an effective innovation of the government health service delivery system, reaching poor people at their doorstep, and providing disease prevention.

The Fourth Five-Year Plan laid emphasis on improving the quality and quantity of health services and promoted adequate production and distribution of essential drugs, vaccines and other diagnostic and therapeutic agents (Planning Commission 1990). Unlike the preceding plans, the Fifth Five-Year Plan was directed towards changing the health service delivery system to improve health outcomes among the disadvantaged populations. It was intended to ensure universal access to essential care services of acceptable quality. To facilitate delivery of essential health services, it has categorically mentioned the introduction of integrated service delivery in the rural area (Planning Commission 1997). The integration of essential services provided additional potential for the delivery of a range of maternal and child health interventions both at health facilities and at the community level.

The Fifth Plan focused on strengthening urban primary health care services, which the earlier

plans did not address. Primary health care, including maternal and child health and family planning services, is equitably distributed in the rural areas to reach the poor women and children. However, in urban areas there are limited government facilities to provide primary health care for the poor.

Development partners are supporting some NGO clinics to provide integrated primary health care to the urban poor, yet these initiatives are not adequate to ensure equity in the access to services and other concerns remain with the sustainability of these programmes.

### **Reaching women and children with services**

An important focus of all policy and programmes was reaching the women and children living in rural areas. The 1976 Population Policy proposed strengthening maternal and child health (MCH) care services as a strategy towards improving the acceptance of family planning methods (Mabud and Akhter 2000). Upon realizing that effective control of infant and child mortality is a prerequisite for achieving fertility reduction, the government integrated MCH services with family planning services. This integration was specifically directed towards equity in access to the health services for the poor women and children in rural areas.

The family planning programme adopted the MCH-based approach in 1978 and since then MCH-based family planning has been the key feature of the family planning programme (Mabud and Akhter 2000). The Second Five-Year Plan proposed the integration of health and family planning service delivery structure at the grassroots level. By establishing HFWCs, the

family planning and MCH services were extended from the sub-district level to rural areas and large numbers of female field workers were deployed at that time for doorstep service delivery of health and family planning services.

Another important strategy of the population policy was the inclusion of family planning activities in the women's development programmes, envisioned under the Third Five-Year Plan. These programmes successfully engaged more than 1.5 million rural women in women's cooperatives and mothers' clubs through vocational training, credit programmes, functional literacy, and maternal and child health and family planning education. These development programmes created opportunities for women to earn income, which was considered one of the major ways to contribute to fertility regulation and health status improvement. Existing women's development programmes were expanded and efforts were made to encourage girls to enrol in school, including financial incentive to girls living in rural areas. This initiative contributed to the fertility reduction in rural areas.

*The family planning programme adopted the policy of MCH-based family planning in 1978. The Second Five-Year Plan had advocated for integrated health and family planning services at the community level. The Third Five-Year Plan emphasized integrating family planning activities into women's development programs. The Fourth Five-Year Plan encouraged NGO involvement in health and family planning activities, particularly in rural areas.*

The Fourth Five-Year Plan encouraged NGO involvement in health and family planning activities, particularly in rural areas. NGOs were involved to supplement government health and family planning services in rural areas and urban slums. The government provided drugs, contraceptives and other supplies to the NGOs at a subsidised price. The collaboration between the government and NGOs has been found to be

effective in expansion of access, coverage, and sustainability of health services, including family planning for underserved women and children.

An important feature of the national family planning programme was the adoption of the menstrual regulation (MR) policy in 1979. The government considers menstrual regulation to be

*The immunization programme has been successful in reaching the poorest and most remote populations, ensuring equity in immunization services.*

an “interim method of establishing non-pregnancy for a woman at risk of being pregnant, whether or not she actually is pregnant” (Ali, Zahir, and Hasan 1978). Safe MR services are widely available throughout the country. To ensure equity in access to

safe menstrual regulation services, more than 15,000 physicians and female paramedics were trained to provide MR services in more than 5,000 government health facilities. In addition, private and NGO service providers were trained to provide MR services mainly in urban areas (Piet-Pelon 1998). MR services substantially contributed to the reduction of maternal mortality and mitigation of the number of abortion-related complications (Ministry of Finance, Bangladesh 2005).

The GOB has fostered several successful partnerships with development agencies to improve the quality and availability of MCH health services throughout the country. Vertical interventions have had a notable impact on MCH-related outcomes in Bangladesh. Immunization services with cold chain facilities have been established throughout the country to combat child morbidity and mortality. Immunization is a free service and inherently pro-poor in terms of its capacity to prevent disease. It has proved to be particularly cost-effective and has saved the lives

of millions of children under the age of five. There has been a substantial decline in infant mortality rate from 110 per 1000 live births in the mid-eighties to 65 per 1000 live births in 2004 (NIPORT, Mitra and Associates, and ORC Macro 2005), which is largely attributed to the success of the EPI programme.

Until the late nineties, the government trained more than 20,000 traditional birth attendants. After this point, the government introduced a six-month competency based skilled birth attendant (SBA) training. Skilled birth attendants were trained following international policy opinion change. Existing government field staff, FWAs and female HAs, receive SBA training. However, the current training plan will not be able to ensure the universal coverage of home delivery by SBAs in near future.

To provide the facility-based maternal and child health services including emergency obstetric care (EmOC) services in rural areas, Maternal and Child Welfare Centres (MCWCs) were established. In recent years, the government has strengthened its reproductive health and EmOC services, with specific attention given to improving MCWCs. Accordingly, these facilities have been upgraded to provide comprehensive EmOC services to rural women. There has been an increase in utilization of EmOC services since the staff training and facilities of the MCWCs were upgraded (GOB 2003). However, this increase in the utilization of EmOC services from upgraded MCWCs is not to its maximum potential. There still exist infrastructure, human resource and programmatic barriers that prevent many women from accessing service (GOB 2006). Other government facilities in rural areas do not meet the needs of women with respect to EmOC.

Despite the sincere efforts of government and NGOs, the impact of the expansion of health services has been much less than was expected because these services do not reach the disadvantaged people who constitute a large segment of the population. The level of maternal mortality ratio is one of the most important indicators for measuring the impact of health and family planning programmes. Further, maternal mortality is a particularly sensitive indicator of inequity, which displays the status of women, their access to health care system in responding to their needs. In Bangladesh, high rates of maternal mortality and morbidity continue to be important challenges for health systems. Disparities in maternal mortality ratio and differentials in the utilization of maternal health care services across different wealth groups persist in the country (see chapters 2 and 3).

## Reorganization of service delivery

Bangladesh has witnessed a major shift in the health and population plans in the mid-nineties.

The first phase was marked by the implementation of a MCH-based target-driven family planning programme. The second phase started in 1998 and has continued to the present, which has been characterized by a transition from a target-driven to a client-centred approach. These policy shifts have led to considerable reorganisation of service delivery, which is described in this section.

### The reproductive health approach for primary health care

In the wake of ICPD, Health and Population Sector Strategy (HPSS) had been adopted in 1997 to

accommodate the concept of reproductive health within the service delivery system, with three major objectives:

- maintenance of the momentum of efforts to lower fertility and mortality
- reduction of maternal mortality and morbidity
- reduction in the burden of communicable diseases.

The HPSS broadened the scope of services from primary health care to reproductive health care, in line with ICPD recommendations. It proposed delivery of an “essential services package” (ESP) through the primary health care system. With reproductive health being its centrepiece, components of ESP also included child health, communicable disease control, simple curative care, and behaviour change communication. ESP was considered important to satisfy the basic health needs of the most vulnerable in society i.e., women, children and the poor. HPSS also suggested a gradual shift from domiciliary-based services to the fixed-centre based services at the community level.

*HPSP introduced major structural reforms to facilitate delivery of the ESP. A decision was taken to unify health and family planning services and it was agreed that ‘community clinics’ will be established to deliver one-stop ESP services free-of-cost and will replace domiciliary doorstep services.*

Following HPSS, the government formulated a five-year (1998-2003) Health and Population Sector Programme (HPSP), targeting the improvement of the health status of the most vulnerable women, children, andlt was contemplated that both the family planning and health programmes should be merged into one sector. The primary focus ofthe programme implementation plan had been the reorganization of the service delivery, making it compatible with

*HPSS had marked a major shift from achieving demographic targets to dealing with a broader range of reproductive health issues targeted at a larger number of population groups.*

the ESP. It was stated that at the sub-district level and below, the ESP would be delivered through a unified structure comprising of health and family planning workers under a single manager. The HPSP introduced the concept of integrating health and family planning services and personnel to provide an essential services package.

Replacing the doorstep service by family planning and health workers, HPSP introduced one-stop service delivery system, by establishing

'community clinics' at the village level to deliver the ESP. One community clinic was to serve a population of about 6,000 people. Under the plan, community clinics were to be the first level for delivery of a standard package of integrated health and family planning services free-of-cost (MOHFW, Bangladesh 1998). Additionally, in order to ensure coverage of clients who might not have

access to fixed service delivery points, the existing mobile services were planned to continue for some time.

### **Expanding the scope of services**

In order to address the limitations of HPSP, government started a new programme in 2003 titled Health, Nutrition and Population Sector Programme (HNPS). The old doorstep service delivery model in rural areas has been reintroduced to reach underserved, poor populations. HNPS (2003-2006) has been directed towards increasing availability and utilization of client-centred, effective, efficient, equitable, affordable and accessible quality services for a defined 'essential services package' along with other selected services (MOHFW,

*In order to address the limitations of HPSP, government has started a new programme HNPS in 2003. The old system of doorstep service delivery model in rural areas has been reintroduced to reach underserved, poor populations particularly women and children.*

Bangladesh 2003). In the context of the Poverty Reduction Strategy Paper, HNPS emphasizes reducing severe malnutrition, preventing mortality, reducing fertility, promoting healthy life styles, and reducing environmental, economic, social, behavioural and other risk factors for human health, with a focus on improving the health of the poor, in particular, poor women, children and elderly. Major strategies undertaken under HNPS to improve maternal and child health are: strengthening basic EmOC services at the primary level health facilities, increasing the utilization of comprehensive EmOC provided at the secondary level health facilities, and the provision of essential newborn care. These strategies are expected to result in reduced infant, child and maternal mortality, and improved nutritional status among children and women, especially among the poor.

### **Progress towards delivery of health services for the disadvantaged**

The health system witnessed considerable progress in institutional development both in respect of education and training as well as for service delivery. The government has been committed to equity of access. Maternal and child health services have been given highest priority in the health system. The government attempted to increase the number of health facilities to reach the majority of people who live in rural areas. As a result, facilities became available in rural areas, which indicates improvement in equity. In rural areas, THCs with minimum 30 beds were established at the sub-district level and HFWCs were constructed at the union level with appropriate staff strength. In addition, the number of beds at the district hospitals was significantly increased.

The health service delivery system promotes gender equity through targeted interventions like recruitment of female field workers (family welfare assistants, female health assistants) and improvements in maternal health care through linkages between different level facilities. These workers are covering the underserved population to ensure family planning and primary health care at the doorstep through an integrated community-based approach. During the period of First through Third Five-Year Plans, the government had recruited 23,500 female field workers for providing doorstep preventive health care and family planning services (Rob et al. 2004). They were provided with back up services from doctors and paramedics throughout the country. Deployment of large numbers of female workers at the community level has certainly brought a revolutionary effect in the contraceptive behaviour of the rural population.

The government has an extensive network of health facilities and services to provide maternal and child health services from grassroots to higher levels. At the community level, family welfare assistants primarily provide family planning and some maternal health services to households. Male health assistants also provide domiciliary services, including distribution of vitamin A capsules, immunization, detection of malaria, and prevention and treatment of diarrhoea diseases, among others. Family welfare assistants and health assistants serve approximately 6,000 populations. Also at the community level, there are 'satellite clinics' where female paramedics, with assistance from family welfare assistants, provide family planning, antenatal care and immunization services. At this level, primary health care services including maternal and child health services are integrated with family planning services.

In rural areas, first fixed-facility service is provided at the union level through HFWCs, each covering a population of about 30,000. The staff of HFWCs is comprised of female paramedics who provide family planning and maternal and child health services, and male paramedics or medical assistants who provide general health services, simple curative services and health education. These services are provided free-of-cost.

The THC, the heart of the public health system in the rural areas, is designed to serve a population of around 250,000-300,000 at the sub-district level. It operates a 31- 50 bed full hospital with doctors and medical staff including nurses, paramedics, and lab technicians to provide in-patient and outpatient health services including family planning and maternal and child health services. Drugs and health and family planning services are provided free-of-cost.

*Improvement has been made in the physical infrastructure to deliver health service in primary, secondary and tertiary levels, however, the accessibility of the poor people to healthcare is often constrained, and the services they receive are low in quality and do not respond to their needs.*

Above the THC, there are the district hospitals, regional teaching hospitals and national specialized institutions. There are also MCWCs established at the district level to deliver all services for women and children, including assisted delivery and EmOC services. Each MCWC serves a population of approximately 1.5 million. These facilities are equipped to provide comprehensive EmOC services and also serve as the first referral hospital for health facilities located at rural areas. Fees for the health services are set at a minimum level to enable the poor people to utilize the services from district hospitals and MCWCs.

Clearly, improvement has been made in the physical infrastructure to deliver health service in primary, secondary and tertiary levels, however, the accessibility of the poor people to healthcare is often constrained, and the services they receive are low in quality and do not respond to their needs. They also get less respect and time from doctors and nurses (UNFPA 2002). Their economic condition is a major determinant for the quality of services they receive at the facility. Non-availability of service providers at public facilities located at rural areas is a persistent

*Non-availability of service providers at government facilities located at rural areas is a persistent problem, which badly influences the health seeking behaviour. In addition, there is an absence of proper referral chain to secondary and tertiary facilities.*

problem, which has adverse influences on the health seeking behaviour. In addition, there is an absence of proper referral chain to secondary and tertiary facilities. Findings from a recent study reveal that the poor women mostly turn to governmental health facilities and rural medical practitioners in case of complications during pregnancy and delivery but there are evidence that absence of proper referral system, especially where to go for which problem, causes women to suffer even when they seek care from the public facility (Rob et al. 2006).

Although the public health system provides free primary health care, family planning and reproductive health services in rural areas, utilization of maternal health care during pregnancy, childbirth and after delivery is low. Low utilization of maternal health care services from government facilities raises the question of effective service delivery.

The problem is the availability of information – on time, reliably – to those who need them. Lack of

knowledge on necessity of the service is another important reason for low utilization of maternal health care services (Rob et al. 2006). Additionally, women in rural areas do not have adequate knowledge on how and where to go for services.

Cost has been found to be the most commonly cited reason for not seeking treatment for reproductive health problems including delivery complications care. Economic status has a strong bearing on seeking services from skilled providers (Rob et al. 2006). In rural Bangladesh, health care cost is arranged from a variety of sources. Distress sale of assets or incurring loan is more common among the poorest households than the wealthiest households. Among the wealthiest households, family savings is found to be the dominant source of paying the cost of treatment for reproductive health problems including maternal health care (Rob et al. 2006). Socio-economic status is found to be a strong determinant of service utilization (see Chapter 3). In urban areas, while some NGO clinics are providing subsidised primary health care including MCH-FP services to poor population living in slums, the poor are not protected by pricing structure in public tertiary hospitals and the private health system. There is a need to introduce risk-pooling mechanism to improve the access of poor population, who are in most need, to receive services from qualified providers.

## Discussions and conclusions

Since independence, Bangladesh's health and population policy has evolved in two distinct phases. The first phase lasted through 1997 and was guided by objectives and strategies outlined

in the First Five-Year Plan and first population policy. Successive plans considered family planning as a national priority. The population control programme was treated as a model to achieve development goals through an assertive maternal and child health based family planning programme marked by the implementation of a target-driven family planning programme focused on reducing population growth. The second phase, started in 1998, was influenced by the ICPD and has been characterized by a transition from a target-driven to a client-centred approach, which is reflected in the HPSP, the HNPSP and the 2004 Population Policy. The population and health programmes were broadened to include

*The recent policy focus is on quality and coverage of essential services. The change in policy was intended to ensure more appropriate strategies toward equities through the provision of high quality delivery of essential care rather than universal comprehensive care, or only the simplest and most basic care for the poor.*

reproductive health, eventually integrated with essential service package. Programmes were redesigned to meet clients' needs rather than to achieve demographic targets. Thus changes in government policies were influenced by the shifts in global policies. All five-year development plans and first population policy pledged to reduce inequalities in the access to health and family planning services. The government embraced the primary health care

approach as a route to achieving affordable universal coverage. Emphasis was placed on establishment of health infrastructure in the rural areas for delivering integrated and comprehensive health services. In accordance with the commitment, the government established an extensive network of health facilities from grassroots to higher levels. In addition, health and family planning services were extended to the rural poor through doorstep services as well as satellite clinics at the community level. Another

major commitment of the policies was to produce health manpower at the mid and grassroots level with the goal of increasing access to health services in rural areas. Comprehensive programme efforts have been made to recruit and train primary health care providers.

As a whole, the government was successful in building and expanding health infrastructure in the rural areas and developing skilled primary health workforce, and the health sector has, thus, achieved a progressive resource shift in favour of basic and preventive services meeting the needs of vulnerable groups through the provision of comprehensive primary health care. The implementation was mostly in line with the commitments in the policy documents.

Currently, the policy focus is on quality and coverage of essential services. The change in policy was intended to ensure more equitable access through the provision of high quality delivery of essential care rather than universal comprehensive care, or only the simplest and most basic care for the poor. Emphasis has been shifted towards restructuring the health service delivery system to improve health outcomes among the disadvantaged populations. Integrated service delivery in the rural area has been emphasized to facilitate delivery of essential health services of acceptable quality. However, there was a big gap between the design and implementation in recent past policy document.

The practical experiences of implementation of community clinics under HPSP were significantly different from the expected programme outcomes. With the introduction of integrated service delivery at the community clinic, the field staff became dysfunctional. Moreover, the shift from doorstep

service to community clinic service was considered premature in a society where people are not accustomed to visiting clinic or hospital to receive family planning services. The change in service delivery was seen as immensely damaging for the family planning activities, which can be partly reflected in the plateauing in total fertility rate from 1997 to 2003. Access to ESP was not as easy as expected due to discontinuing doorstep service. Community clinics were established without ensuring community involvement although the plan document emphasized to establish 'community groups' consisting of government field workers, members of local government and representatives of primary stakeholders as management committees for the community clinics. Consequently, this measure became contested, and decisions to unify health and family planning services and to deliver one-stop services through 'community clinics' were later reversed when a new government came into power in 2001.

Reaching the women and children living in rural areas with necessary services was emphasised in all policies and programmes. The family planning programme adopted the policy of MCH-based family planning service delivery in 1978. A network of government health facilities to provide maternal and child health services from grassroots to higher levels has been established. Activities undertaken to improve health outcomes of women and children include strengthening primary health care, community-based maternal and child health and family planning programme, immunization services, developing adequate field workers to provide services at clients' homes, and safe menstrual regulation services in more than 5,000 government health facilities throughout the

country. The Maternal and Child Welfare Centres were established. Recently, these facilities have been strengthened and equipped to provide comprehensive emergency obstetric care services to rural women. For safe home delivery in rural areas, government trained more than 20,000 traditional birth attendants until the late nineties. After this point 'skilled birth attendants' were trained following international policy opinion change.

Despite sincere efforts of the government, the health systems cannot provide quality maternal health care services in rural areas primarily due to lack of adequate and appropriately trained human resources. Particularly, there is the lack of trained providers for obstetric care and safe abortion services, and limited availability of trained midwives or skilled birth attendants. Infrastructure difficulties also contribute to the high rate of maternal deaths in rural areas – there is limited availability of comprehensive obstetric care services in rural areas.

There is also gap between the design and implementation in some recent programmes. While some policies and programmes have been successfully implemented, others were halted in midway. The gaps between pledges and implementations of policies need to be minimized to increase equity in the utilization of services. Despite health policies and programmes of the government having a pro-poor approach, chapters two and three have shown that the poor are the most disadvantaged, both in terms of health outcomes and access to health services. The impact of expansion of health services has been much less than expected because these services do not reach the poor who constitute a large

segment of the population. In addition, the extensive network of primary health care facilities is not wide enough to cover the urban poor. Even though health services provided at most of the public health facilities are free, there are problems related to accessibility, quality of care, non-availability of services providers, and costs associated with seeking treatments.

### **Lessons learned**

- Expanding the infrastructure facility for health care at the grassroots level and increasing the number of trained health personnel in rural areas has improved equity in access to health services.
- Increased access to primary health care and family planning services contributed to the reduction in mortality and fertility rates. In other words, equity in terms of access to

health services needs to be ensured first to achieve equity in terms of health outcomes.

- The process of restructuring the service delivery system cannot be implemented without necessary piloting.
- Successful targeted programmes might lose their impetus while being integrated with the larger programme.
- In addition to upgrading the rural health infrastructure, there is a need to establish sustainable health care delivery system for the urban poor under the purview of integrated public health services.
- Health policy and programmes must be designed recognizing that financial burden of the poor needs to be reduced to enable them to have access to quality health care services.

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# Equity-Sensitive Services: Lessons from Four Case Studies

## Introduction

This chapter presents case studies of four initiatives undertaken in Bangladesh to increase access to health care and describes how they have or not been able to address their respective goals, with particular reference to the issue of equity. Over the years since independence, many development projects have been implemented in the country. Their success (or failure) is largely unknown mainly due to poor documentation and a general lack of interest in evaluating impact. The four projects are distinct and different in many ways. Two are public sector programmes while the

*Since independence, many development projects have been implemented in the country. Their success (or failure) is largely unknown mainly due to poor documentation and a general lack of interest in evaluating impact.*

other two are run by two preeminent NGOs. The Maternal and Child Welfare Centres (MCWCs), the first case, is implemented by the government and addresses one of the critical health issues in the country, viz., maternal and reproductive health. Unlike many other public sector programmes, the MCWCs have been

studied quite extensively, thanks to its donor the United Nations Population Fund (UNFPA). The Expanded Programme on Immunization (EPI) is a high profile public sector programme with good success. The other two cases are NGO programmes on health care provision, namely the programmes implemented by Gonoshasthya Kendra (GK) and BRAC. The Gonoshasthya Kendra has recently been studied in some depth and this paper includes their impact on maternal mortality. BRAC has been investing in research

and evaluation of its interventions for a long time since 1975. The BRAC study has convincingly shown that given the right approach and proper targeting, inequities in health status between different population groups can be reduced.

## Case I

### The Maternal & Child Welfare Centres: Extending maternal health services

Until recently Bangladesh had one of the highest reported rate of maternal mortality in the world. The 2001 Bangladesh Maternal Health Services and Maternal Mortality Survey (BMMS) found a maternal mortality rate of 320 to 400 per 100,000 live births (NIPORT and ORC Macro 2002). Given the slow or insignificant improvements in available 'effective' maternal health services, experts are confused about the real cause of this apparent reduction<sup>1</sup>.

Two of the effective services for maternal mortality reduction are the availability of skilled birth attendants (SBA) and Emergency Obstetric Care (EmOC), which together are sometimes referred to as 'skilled birth attendance' (Graham et al. 2001; Chowdhury et al. 2003). The Millennium Development Goals (MDG) has the former as one of the indicators for Goal 5 ('Improving maternal

<sup>1</sup> Previous studies done in the 1980s and 1990s had estimated a rate of above 600 deaths per 100,000 births

health'). The UN previously had recommended EmOC as an effective indicator of maternal health services (number of facilities per 500,000 population) (UNICEF, WHO and UNFPA 1997). Let us now consider the situation in Bangladesh in terms of these two indicators.

### Skilled birth attendance in Bangladesh

Bangladesh has one of the lowest rates of deliveries being conducted by skilled birth attendants. In 1993-94, doctors or nurse/midwives delivered 9.7% births, which increased to 14.2% in 1999-2000. Similarly, proportion of births conducted in a facility is also very low (10.1%) (BDHS 2004). The equity situation in maternal

health services is even worse. According to data available from BBS and UNICEF women living in rural areas, living in dilapidated dwelling houses, illiterate or poorest in wealth terms have both the lowest rates of attendance in delivery by skilled attendance and delivery being conducted in a health facility (Table 1).

*Women living in rural areas, living in dilapidated dwelling houses, illiterate or poorest in wealth terms have both the lowest rates of attendance in delivery by skilled attendance and delivery being conducted in a health facility.*

To increase access to skilled attendance in delivery, the government has been undertaking different projects by training new cadres and creating or improving delivery facilities including emergency obstetric care (EmOC).

**Table 1:** Percent of deliveries by trained personnel (medically trained personnel and trained birth attendants) and in health facilities by different equity groups (1999-2000)

Equity indicator	Group	Attendance by Doctors/nurse/midwives	Delivery in health facility
Residence	Rural Urban	20.9 47.7	5.4 29.0
Education	Illiterate Higher education	4.0 50.3	2.8 40.7
Dwelling house	Squatter Brick-built	2.4 63.5	2.5 52.7
Wealth	Poorest quintile Richest quintile	3.4 37.3	2.1 29.6

Source: Salam, Alam and Choudhury (2003) (based on BBS/UNICEF data)

### The MCWC project

Bangladesh has a relatively long history of investment in family planning and MCH-based family planning services (see Chapter 4). As a major intervention the MCH services in all 90 of the country's Maternal and Child Welfare Centres (MCWCs) were transferred from the Health Division of the Ministry of Health and Family Welfare to its

Population Control Division. To provide better services to the family planning clients; providing comprehensive reproductive health services was probably a secondary concern. Of the 90 MCWCs 55 were located at district level, 12 at Upazila level and 23 at Union level.

With UNFPA support, the ‘Strengthening of Reproductive Health Service Delivery at MCWCs in Bangladesh’ was launched in 1993. In the first phase 11 MCWCs were included, all in Rajshahi Division. According to the Project Final Report for the years 2003-2005 (Government of Bangladesh, undated), the goal of the project was to ‘contribute to improving the reproductive health status of the people of Bangladesh thereby leading to sustainable social development and reduction of poverty’. The purposes of the project as stated in the above report are:

- Increased access and use of quality reproductive health (RH) services
- Contribute to gender equity and equality through male participation, the reduction of gender based violence and increased women decision-makers in politics and civil administration
- Positive behaviour changes among youth and men in sexual and reproductive health (SRH)
- Increased national capacity and RH and population policies and programmes in line with ICPD.

The project identified two outputs and a series of services to offer as follows:

**Output 1:** Increased accessibility and availability to clinical contraception, RTI/STI case management, EOC, and safe motherhood services, particularly for the most vulnerable population and youth at MCWCs.

Services:

1. Provision of emergency obstetric care (EmOC) in most facilities
2. Deliveries at selected UH&FWC
3. Delivery by skilled birth attendants (SBA)
4. Adolescents and youths receiving reproductive health services at selected MCWCs

5. Clients receiving syndromic approach for RTI/STI treatment
6. Provision of clinical contraception services
7. Provision of services for males
8. Provision of ANC including TT
9. Provision of PNC
10. Counseling for female victims of gender-based violence

**Output 2:** Strengthened capacity in service provision, referral and networking to address the three delays in safe motherhood and informed family planning choices.

Services:

1. Provision of sterilization services
2. Provision of IUDs
3. Training of service providers on counseling for spacing methods
4. Educate attending women on warning signs in childbirth
5. Offer Visual Inspection of Acetic Acid (VIA) for cervical cancer screening
6. Offer treatment for fistulae in selected MCWCs

## Achievements

A major achievement of the project was the upgrading of services with comprehensive EmOC<sup>2</sup> at the MCWCs from 64 of 67. This, however, did not include safe blood transfusion and screening, an essential element of comprehensive EmOC services, which are yet to be integrated.

<sup>2</sup> Comprehensive EmOC includes the following facilities/services:

- Administration of parenteral antibiotics;
- Administration of parenteral oxytocic drugs
- Administration of parenteral anticonvulsants for pre-eclampsia and eclampsia
- Performance of manual removal of retained products (e.g., manual vacuum aspiration)
- Performance of assisted vaginal delivery
- Performance of caesarean section and
- Performance of blood transfusion

Service statistics provided by the project indicate that performance in terms of provision of various services in the MCWCs improved over the period

*Service statistics provided by the project indicate that performance in terms of provision of various services in the MCWCs improved over the period 2002 and 2005.*

*However, the improvement has been uneven.*

2002 and 2005. However, the improvement has been uneven. For Tubectomy and Norplant, the improvement was impressive (over 100%), much higher than what was achieved nationally through the routine programme. For others, the improvements have been modest. For example, there was an increase of only 15% in ANC services, or about 4% per year.

Similarly, the 25% increase in delivery over the period could have improved further. As the 'command area' of a MCWC is not known it is not possible to estimate what proportion of the deliveries are actually being done in these centres. However, an earlier report indicated that of all institutional deliveries, 13% took place in the MCWCs (Government of Bangladesh 2003). The negative impact on oral pill and condoms could well have been due to the change of service delivery mechanism of the MoHFW which reverted back to home delivery (from fixed centre model) following the change of government in 2001.

**Table 2:** Performance of MCWCs in selected indicators, 2002 to 2005

Indicators	2002	2005	% increase
ANC provided	250,211	286,627	15
Delivery done	33,528	41,870	25
PNC provided	52,002	71,103	37
C-Section done	4,437	6,545	48
RTI/STI treated	25,456	37,240	46
Tubectomy performed	5,020	10,050	100
Vasectomy performed	3,270	6,360	94
Norplant inserted	8,274	17,539	112
IUD inserted	5,955	8,347	40
Injectable provided	121,929	150,044	23
Oral pill provided	166,368	96,950	-42
Condom provided	22,291	18,819	-16

Source: Government of Bangladesh (undated)

In terms of other services the official documents speak of success with 15 MCWCs providing adolescent health care services and all MCWCs providing clinical contraceptive services. Also staff in all MCWCs has been trained in IPC on RTI/STI/HIV/AIDS counseling. Another significant achievement has been the establishment of a fistulae centre at Dhaka Medical College

(Government of Bangladesh 2006). Besides, the project has invested in developing human resources for sexual and reproductive health services delivery through short and long-term trainings. These include training and continuing medical education of medical officers on obstetrics/gynaecology, anaesthesiology, syndromic approach to RTI/STI case management, etc.

## Evaluations and Challenges

In 2005, ACNielsen Bangladesh, a consulting firm carried out an end of project evaluation of the project. Based on a sample of 20 MCWCs it tried

*The project invested in developing human resources for sexual and reproductive health services delivery through short and long-term trainings including training and continuing medical education of medical officers.*

to determine whether the project met its objectives by interviewing providers and their clients. Interestingly none in the community was interviewed which was a general limitation of the evaluation. Most providers retained much of the trainings, particularly those that are common knowledge such as hand decontamination; but not others such as syndromic approach for RTI/STI. Almost all providers correctly

mentioned the physical and psychological consequences of violence against women.

Almost all clients visiting the centres knew that family planning services were provided there. An overwhelming majority (85%) considered the providers' behaviour friendly but a third of the respondents felt that their privacy was not maintained. Many doctors and FWVs were found competent in performing some of the difficult surgical procedures. It concluded, 'considering the overall volume of service it can be inferred that the clinics have been functioning very efficiently'.

It also noted some of the challenges, particularly the shortage of providers. As was mentioned in a report (GoB 2003):

"The main problem of the MCWCs concerns staffing. All the MCWCs are quite loaded with clients – some are close to an overload. .... there is a need for additional staff. ..This effectively eliminate the ability to perform

cesarean section and these MCWCs can only refer clients to other centers."

It appears that shortage of human resources to run the centres is the most important challenge facing the sustainability of the MCWCs.

Another issue not dealt with by the evaluations is the question of coordination with other available services, particularly the District Hospitals run by the Directorate General of Health Services. Some reports of the project point to 'less cooperative relationship' as a problem without giving any further details on the nature of the problem (GoB 2003).

## The Question of Equity in MCWCs

The issue of equity in the services provided by MCWCs was not dealt with particularly in the evaluations. However, some qualitative information suggests that doctors' behaviours at these centres were likely to be biased in favour of better-off patients (see Annex 2).

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## Case II

### The Expanded Programme on Immunization (EPI)

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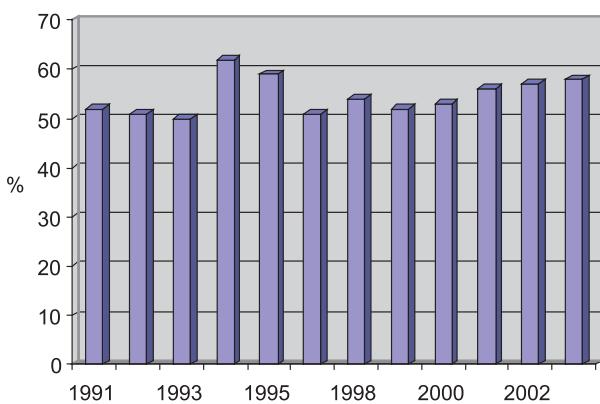
Vaccination against some of the most fatal and debilitating diseases is one of the most cost-effective interventions of modern times. Smallpox, which historically caused so many death and suffering, is now a phenomenon of the past. Poliomyelitis, another disabling disease, is now set to be eradicated. The single intervention that has made these to happen is vaccination. Bangladesh has a long history of vaccinating its population. British colonial papers suggest that variolation or inoculation, the predecessors of

*The coverage in terms of children fully immunized under 12 months of age increased from 2% in 1986 to 62% in 1994. Unfortunately, the rate that reached its peak in 1994 has remained plateaued.*

vaccination, was in practice in this part of the Indian Sub-continent as far back as 1731; Tikadars, a group of professional inoculators, provided inoculation against smallpox for a fee (Dasgupta 1998). The modern Expanded Programme on Immunization (EPI) in Bangladesh was launched in 1979 but intensified in 1986. With government commitment, donor support, and involvement of NGOs and the civil society, the programme attained quick success.

Within a few years, the coverage in terms of children fully immunized under 12 months of age increased from 2% in 1986 to 62% in 1994. In Rajshahi, one of the six administrative divisions of the country, the coverage reached 80%. This feat, however, was not unique for Bangladesh as similarly rapid improvements were experienced in several other countries in the developing world. Unfortunately, the rate that reached its peak in 1994 has remained plateaued (Chowdhury et al. 2003). The following figure shows the trends in immunization rates since the early 1990s.

**Figure 1:** National trends in coverage of fully immunized children under 12 months of age by year of survey, 1991-2004



Source: Government of Bangladesh 2002.

Although the plateauing is discomforting, the government is trying hard to increase the coverage, and that the country has been able to hold on to this level is encouraging. However, one may ask if there is an equity issue in the coverage? Are there groups in the population who are covered less than other groups? A study published in 2003 synthesized the findings of several studies that looked at the question of inequities in immunization coverage (Chowdhury et al. 2003).

The study concluded that there is very little difference documented in coverage between boys and girls. However, socioeconomic differences remain.

It was found that children whose mothers had attended secondary schools or higher had nearly 40% higher coverage rates than those whose mothers had not attended school. The occupation of the major breadwinners of the households also played a significant role. It was found that children whose fathers had salaried jobs were two-and-a-half times more likely to be immunized than those whose fathers were day labourers. In terms of 'self-rated food security status' (a proxy for economic status), children belonging to 'surplus' households had nearly 50% more coverage than chronically 'deficit' households.

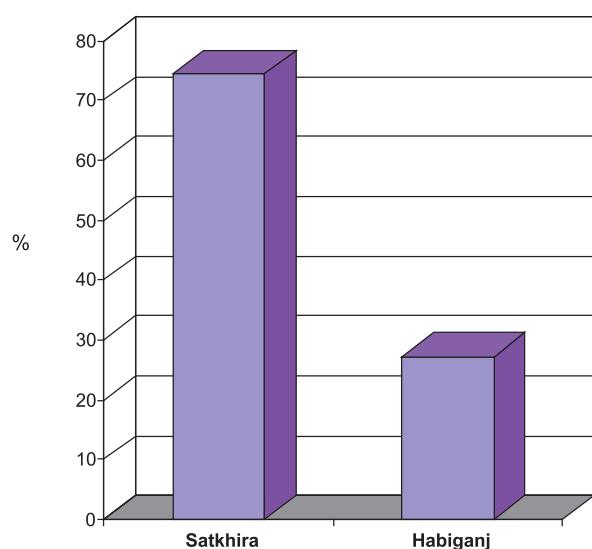
*In terms of 'self-rated food security status' (a proxy for economic status), children belonging to 'surplus' households had nearly 50% more coverage than chronically 'deficit' households.*

Some studies documented differential behaviours of health workers as meted out to different wealth groups. As one noted, 'the health workers behaved differently with different people... A health worker gave a syringe and a measles vaccine vial to the porter, just before closing the

session. The porter and the health worker then went to a house on the other side of the road. To explain this, the vaccinator said that they went to vaccinate a child in that house. The house owner was a rich man and the parents did not want to come to the field clinic' (Aziz et al., 1999).

Urban children were found to be more likely to complete the immunization schedule successfully than rural children. However, the situation in urban slums is even worse than the rural areas. There is also wide difference in coverage levels between different districts. According to the BBS/UNICEF study, the lowest rate for 2002 of 27% was for Habiganj and highest of 75% for Satkhira (see Figure 2). A small in-depth study also found wide intra-district difference in coverage rate. In Kishoreganj district, for example, while the district average in 1997 was 28%, there were pockets of small villages isolated by rivers which had coverage as low as 5%.

**Figure 2:** Lowest & highest coverage districts by EPI (2002)



Source: Government of Bangladesh (2002)

The coverage among some of the country's ethnic minorities was one of the lowest. Bangladesh has a large number of tea estates and their workers are ethnically different from the majority Bengalees. Bangladeshis now own a majority of the estates although some are still owned by British companies. It was found that while the coverage of children living in British company estates was similar to the national average (56%), the coverage in Bangladeshi owned estates was dismally low (27%). A similar picture emerged for Chittagong Hill Tracts (CHT). While the dominant CHT ethnic group Chakmas had a higher rate, some of the ethnic minority groups such as the Mros had a rate as low as 9%.

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### Case III The Gonoshasthya Kendra's impact on maternal mortality

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The Gonoshasthya Kendra (GK) was founded in 1972 soon after the liberation of Bangladesh. The founders of GK ran hospitals in the liberated areas to help the freedom fighters during the liberation war. One of their first pioneering works was in setting up a major health programme in Savar near Dhaka with a population of about a million, supported by a hospital. In the 1970s the GK earned fame by training local paramedics to do tubectomy. The innovation continued unabated and now it has trained paramedics to do more serious procedures such as conducting caesarean sections. Recent studies show that the organization has already achieved some of health MDGs such as reducing the maternal mortality ratio by two-thirds in its project areas. As it maintains, GK is a supplement and not a substitute for government (GK 2006).

Although GK runs programmes on education and women's development, the real thrust still remains on health. The GK starts work in a new village by establishing a Village Development Committee (VDC), usually headed by a female member of the Union Parishad. This "automatically" ensures local community participation. The main force behind the GK programmes is the local health worker whom it trains to do a series of activities. She is trained through an extended and specialized immersion into the field. Another set of workers are the trained Traditional Birth Attendants (TBAs) whom they train for prolonged periods. Initially they tried fielding skilled birth attendants from outside the

village but it did not work after which they switched to local TBAs. By training them extensively GK was able to remove the bad traditional practices effectively. As mentioned above, GK also trained village women on how to do caesarean sections in its hospitals thereby practically eliminating the need for formally trained doctors and specialists/ obstetricians, who are difficult to retain in rural settings.

*GK trained village women on how to do caesarean sections in its hospitals thereby practically eliminating the need for formally trained doctors and specialists/ obstetricians, who are difficult to retain in rural settings.*

The services offered by GK includes (i) registration and follow-up of pregnant women and offering them various ANC related services such as: (a) measuring height and weight, including measuring circumference of lower leg 2-3 inches (5-8 centimeters) above ankle, (b) checking of edema, blood pressure, jaundice and anaemia, (c) testing of urine, and albumin, (d) examining eyes, ear and teeth, and abdomen for fundal height, fetal movement and fetal heart sound; (ii) distribution of iron and calcium tablets amongst pregnant women; (iii) immunization of pregnant women against tetanus, and children under age one against six major killers: Diphtheria and Whooping

Cough (DPT), Polio, BCG, Measles and TT; (iv) identification and regular follow-up of high risk mothers and ensuring their timely treatment including referral; (v) promotion of additional nutrients and a balanced diet for pregnant and/or lactating women and newborns with family members; (vi) organization of follow-up meetings with the family members and villagers on the possible cause(s) of maternal death and how this death could have been prevented; (vii) promotion and delivery of family planning services; and (v) organization of camps to treat pregnant women.

Reproductive Health (RH) services are provided as an integrated package with other basic primary health care services to cater to overall basic health care needs of men and women of all ages in the community, irrespective of whether they have health insurance or not (GK 2006).

*Some of the unique innovations introduced by GK include cost recovery through health insurance with a pro-poor focus, and local level accountability.*

Another innovation it has made is in the cost recovery through health insurance with a pro-poor focus. They group the villagers according to socio-economic categories: Destitute, Very poor, Poor and Middle class. Premiums are charged on a sliding scale with the destitute paying the least and rich/middle class highest thus subsidizing the poorer groups. Also, the co-payments for the poorest two groups are waived and the smokers are expected to pay higher premiums irrespective of their socio-economic status. As of mid-2006, about half of households in the Savar project areas have been brought under the insurance scheme, with variable rates for different socio-economic categories. As it appears the destitute have the highest rate of enrolment (100%), followed by very poor (70%), poor (19%) and middle/rich class (3%). It is mentioned that insurance fees and co-payments generate about 70% of GK's annual income (World Bank 2006).

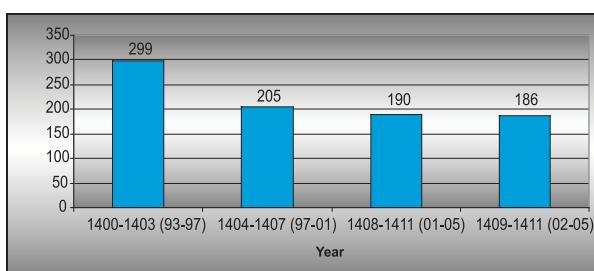
Another significant innovation is the local level accountability that it has ensured through its work: for its own workers as well as for government health workers. The VDC, as mentioned before, ensures local participation in GK affairs. Whenever a death occurs in a village, a social 'post mortem' is done to assign responsibility for the event. The

*An example of innovation is the local level accountability that is ensured by a social postmortem done to assign responsibility for an event.*

cause of death and the mistakes done by staff, if any in managing the event, is thoroughly discussed in such post mortem. Such a practice creates a kind of a 'creative tension' that ultimately helps to improve performance of all (World Bank 2006).

Chaudhury et al. (2006) have recently analyzed data from GK's rich repository of field level information. They found a huge impact of GK's work on maternal mortality. As the following figure suggests, there has been a significant reduction in maternal mortality in the Savar area during the period 1993 and 2005. In fact, Savar has reached the MDG goal of reducing such mortality by two thirds during this period (from 299 to 186).

**Figure 5:** Maternal mortality rates in GK programme area for the period 1993-1997, 1997-2001 and (2001-2005).



Source: Gonoshasthya Kendra 2006

The GK programme is targeted towards the poorer sections of the society as evidenced from the

premium payments schedule mentioned above. Although the available documents do not provide analysis of the reduction in maternal mortality by socio-economic group, it is likely that the impact will be at a higher rate for the poorer groups. More research is, however, needed to confirm this.

## Case IV Role of BRAC in Reducing Inequities

BRAC is one of the largest NGOs (non-governmental organization) in Bangladesh. The twin goals of BRAC are poverty alleviation and empowerment of women. Poverty is looked at from a wider perspective; it is not only insufficient income or an absence of employment opportunities but is a complex syndrome which manifests itself in many different forms.<sup>3</sup>

Although BRAC works all over Bangladesh, the data for the present analysis came mostly from Matlab upazila, the field station of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), reputed for its reliable demographic and health related data<sup>4</sup>. In 1992, BRAC started VO formation and organization of the poor, micro-credit, training of VO members on human and legal rights, and skills, and non-formal primary education for children. Evaluations have shown that BRAC VO members have been able to increase the survival chances of their children (Chowdhury & Chowdhury 1978; Chen 1983; Lovell 1992; Chowdhury & Cash 1996; Abed & Chowdhury 1998).

<sup>3</sup> In the words of Amartya Sen (1995): "The point is not the irrelevance of economic variables such as personal incomes, but their severe inadequacy in capturing many of the causal influences on the quality of life and the survival chances of people."

<sup>4</sup> More details on study methodology are available in Chowdhury & Bhuiya (2001).

*The survival advantage associated with BRAC membership among the poor was largely the result of mortality differences in the first few months of life, particularly in the neonatal period.*

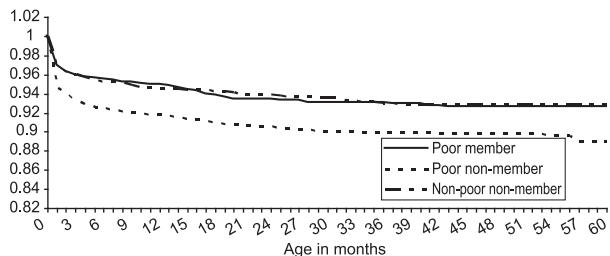
*Impact on nutritional status of children:* The BRAC - ICDDR,B project collected mid upper arm circumference (MUAC) information at two points of time: 1992 before the BRAC intervention started and 1995 when the intervention was about three years old. The prevalence of severe protein-energy malnutrition (PEM) significantly declined among the children of BRAC member households but there was no such change among the children of non-members (Annex 1, Table 1).

The same information when analysed by sex showed a significantly higher prevalence of severe PEM in females among both BRAC members and poor non-members, but not among non-poor non-members.

*Impact on child survival:* Survival rates of children belonging to BRAC member households in comparison to poor non-member and non-poor non-member households is seen in Figure 2. It shows that survival of children belonging to BRAC households is better than that for children from poor non-member households, and is in fact rather similar to survival of children from non-poor households. The pronounced survival advantage of children of poor members compared to poor non-members is seen for girls as well as boys (not shown in figure). It is striking that the survival advantage associated with BRAC membership among the poor was largely the result of mortality differences in the first few months of life, particularly in the neonatal period.

*Food and family expenditure:* The pattern in intra-family food distribution was explored through observations of a small sample of 25 households having both girls and boys. Among BRAC member

**Figure 2:** Life table probability of survival of children belonging to households of BRAC members, poor non-members and non-poor non-members



Source : Bhuiya et al., 2001

households, girls more commonly received equal treatment; boys were more favoured in terms of being given culturally preferred/superior parts of the fish, chicken, meat, etc. (Roy et al. 1998).

In a separate assessment conducted in a larger geographic area, BRAC member households spent more overall and spent significantly more on consumption of food items than poor non-members (See Annex 1, Table 2). Proportion of non-food expenditures, indicating the capacity of households to spend money beyond food, was also greater among BRAC member households. Finally, the per-capita calorie intake was also significantly higher in BRAC households.

*Violence against women:* The prevalence of self-reported violence against women was studied by interviewing 2,038 currently married women aged 15-55 years. A higher incidence of violence among BRAC members than among non-member households was found. When the incidence figures were analysed according to length and 'depth' of membership (Chen & Mahmud 1995), however, the prevalence decreased with increasing membership length. The peak in

violence is reached when credit is introduced, but tapers off when other inputs, such as 'training' are offered (Annex 4).

## Discussion

This chapter presented four case studies, two each from public and NGO sectors. For various reasons as indicated in the text, these are considered 'success cases'.

The Government of Bangladesh in 1993 launched the 'Strengthening of Reproductive Health & Emergency Obstetric Care Services at MCWCs' with a view to improving the sexual and reproductive health status of Bangladeshi women. The project started with the premise that 'all women, once pregnant are at serious risk of developing complications and that mortality due to these complications cannot be reduced unless Emergency Obstetric Care (EmOC) services are available at hand' (GOB 2003). Of 90 MCWCs in different districts and upazilas, 64 were upgraded to provide the EmOC and other reproductive health services. Since the MCWC project was launched in 1993, almost all of the centres have been adequately equipped and many of the staff have been trained on a range of subjects including obstetrics and gynaecology, anaesthesiology, and other reproductive health issues such as emergency and clinical contraceptives, violence against women, cervical cancer, etc. As reported in this paper a large number of women are taking advantage of these facilities. It is clear that without these upgraded centres many of these women would have faced death and disabilities. The number of deaths reported in these centres was very insignificant.

In a project like this many challenges are faced. One may also ask questions on how much of the potential gains have been reaped. The utilization of the centres increased over time but not to its maximum potentials. For example, the ANC clients increased only at a rate of 4% per annum between 2002 and 2004 and the number deliveries at 6% per annum. In the absence of information on the 'command area' population served by an MCWC it is not possible to estimate the utilization rate accurately. The Averting Maternal Death and Disability (AMDD) estimates that there should be at least one comprehensive EmOC for every 500,000 population. If we consider this as the 'command area' for a typical MCWC, then there should be about 12,000 births per year. This means that probably about 5% births were delivered in MCWCs. Obviously there are opportunities for improvement.

Why is utilization low? The culture and tradition (the 'demand' side) obviously had a role as it takes time for people to get used to new opportunities<sup>5</sup>. But there may be other 'supply' related factors, which, unfortunately we have very little clue about. Three issues have been identified in this paper, based on whatever secondary materials available from project reports and evaluations. One is the question of human resource. It is true that the project trained a large number of health functionaries. Unfortunately it could not do as good to keep them. This is particularly true for medical officers. This problem has been mentioned in a number of project reports and as one of the reports lamented, this (drop-out of

<sup>5</sup> ICDDR,B has been promoting institutional delivery in its Matlab project for the past few years. Interestingly there has been a noticeable increase in such as about 40% deliveries are now said to be conducted in the ICDDR,B facilities.

doctors) ‘effectively eliminates the ability to perform cesarean section’ (GOB 2003).

The second issue is the broad question of quality of care and equity. As the case study indicated the service quality in the MCWCs is questionable. The staffs are less motivated and make use of the facility for personal gains (such as promoting private practice). The special attention given to the well off and the powerful and passing of derogatory remarks against some others are sources for hurting the dignity of many clients. The last is the question of coordination with other providers of similar services such as the District hospitals and the facilities created out of the AMDD project. The schism and sometimes overt conflict between the health and family planning directorates of the Ministry of Health and Family Welfare is well known (Chowdhury 1990).

The Expanded Programme on Immunization is another success story. Within five years of intensifying the programme the coverage rose from 2% in 1986 to 70% in 1991. A significant aspect of the success is the partnership between the government and other sectors such as NGOs, the private sector and the civil society. However, even in a highly successful programme such as this, there were inequities. Some groups in the population lagged behind substantially from the more dominant groups.

The Gonoshasthya Kendra has been working for improvement of health since 1973. Over the years, a lot has been learned from its numerous experiments in developing an equity-focused health intervention for Bangladesh. While the country as a whole struggles to be on track for MDG 5, the million population served by GK has already put itself on track for achieving the MDG. The challenge for GK now is how to replicate and scale up its efforts to reach a larger section of the population than they have been reaching so far.

The stated objectives of BRAC are the alleviation of poverty and empowerment of the poor, particularly women, so as to reduce inequities between the rich and the poor, and between men and women.

Impact of BRAC programmes presented in this chapter suggest three things: (a) there was a measurable improvement in terms of nutrition for the BRAC household members in comparison to a ‘comparable’ non-member group; and (b) child survival is better in BRAC households in comparison to that in poor households that did not belong to BRAC; (c) these differences in nutritional status and child survival were equally discernible for male and female members of BRAC households.

An important question is whether these impacts are the result of the BRAC programmes or could they be artefacts due to selection bias in the recruitment process, whereby the “poor” who become BRAC members are better off in a number of important ways at entry. Answers to this question are available in other papers (Husain 1998; Zaman 1998; Evans et al. 1999; Bhuiya et al. 2002), which confirm that the impact is real. The mortality data presented here showed that the survival chances of BRAC beneficiary children were much more than a comparable non-BRAC group. BRAC members were actually very close to the elites, meaning that inequity between the poor and non-poor has indeed been removed.

In BRAC households, the intra-family allocation of food is more equitable, although there is still the tendency to favour boys. The average calorie consumption is higher among BRAC participants. The per capita monthly expenditure is greater as is the proportion of the expenditure spent on food. BRAC women were greater users of family planning methods which may have given them a longer time between pregnancies and opportunity to participate in micro-credit financed

income-generating activities. The increased violence against women that occurs at the time of introduction of microcredit was reduced over time when credit was accompanied by other inputs such as human development and skill training. When a woman receives a loan, a new transaction and relationship emerges in her own and extended family. A small amount of money works as a miracle in a cash-hungry society and significantly raises the woman's power in the family (Zaman 1998; Hashemi et al. 1996). Not all men are ready to accept this new power relationship and some may resort to violence to express their anger. The changes in women's economic role within the family may initially be met with resistance/resentment and in extreme cases with violence (Khan et al. 1998).

## Conclusion

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Based on the above observations the following conclusions can be drawn:

1. Both the government and NGOs are capable of initiating and setting up development programmes and scaling them up thereby serving the needs of many. Several of them have demonstrated impact. The EPI reached the whole country and achieved impressive results. The other public sector programme and the Maternal and Child Welfare Centres also have been quite successful in reaching a large population, although there is need for further and fast expansion. The two NGO programmes examined in the chapter also have been quite successful in achieving their objectives. The GK programme although carried out in a relatively small population, has been able to reduce maternal mortality, a major challenge for the country. The BRAC programme has reached a huge population

and has been shown to have had great impact on the lives of the population it serves including reducing inequities in health status between the rich and the poor.

2. Without specific attention given ('targeting'), the programmes run the risk of bypassing the poor and other disadvantaged sections of the community. This is particularly true in case of the MCWCs. Programmes attain good results in reaching the poor if they are well targeted as is the case with BRAC and GK.
3. Quality of care is a major issue that needs to be addressed, particularly when scaling up. Particular attention may be drawn to the MCWCs. Although it was designed to provide both maternal and child health services, these were found to emphasize more the family planning aspects of reproductive health.
4. Targeted, pro-poor, women-centred programme can reduce inequities in health. This has been particularly shown in case of GK and BRAC. One of the reasons is the holistic approach that the two NGOs took in addressing the problem. For example, BRAC provides multiple services including financial services such as micro-finance, educational services through the BRAC primary schools and health services through the community health workers.
5. Public-NGO partnership can work very well if both sides are committed to the concerned issue. The EPI is an example where the public-NGO partnership brought good results. There are other examples where such a partnership has been working very effectively and these include the TB-DOTS and Malaria programme being implemented with Global Fund assistance.

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## Annex to Chapter 5

### Annex 1

**Table 1**

Prevalence of severe PEM of children by BRAC membership status during pre (1992) and post (1995) intervention period.

Malnutrition	Year of survey				1 vs. 2	1 vs. 3
	1992 baseline Poor individuals (n=827)	1995 BRAC Member (n=273)	1995 Poor Non Member (n=707)	1995 Non-poor non- members (n=538)		
Severe PEM (MUAC<125 mm)	23.2	12.1	21.2	11.5	p<0.01	NS

Source : Khatun et al (1998)

**Table 2**

Expenditure pattern of BRAC and non-BRAC sample households

Expenditure pattern	BRAC Length of membership (in months)				arison vs Comp.	BRAC vs Comp.
	1-11 (n=360)	12-47 (n=417)	48+ (n=295)	Total (n=1,072)	(n=223)	(t value)
Per capita monthly expenditure (Taka)	686	686	689	687	540	3.43***
% cereal to total food expenditure	45.9	45.0	46.4	45.7	46.1	-0.26
% non food to total expenditure	37.9	35.4	34.2	35.9	32.4	3.57***
Per capita calorie consumption	2,279	2,304	2,342	2,306	2,182	3.37***

\*\*\* p <0.01

Source : Husain (1998).

**Table 3**

Distribution of children (11-15 years) achieving 'basic education' by membership status in 1992 and 1995.

Sex	1992 baseline poor individuals	1995 BRAC members	1995 poor non- members	1995 non-poor non- members
Girl	9.6 (188)	23.7 (152)	12.6 (340)	33.5 (337)
Boy	14.9 (215)	30.7 (163)	15.5 (330)	41.2 (381)
All	12.4 (403)	27.3 (315)	14.0 (670)	37.6 (718)

Figures within parentheses indicate the number of children.

**Table 4**

Occurrence of physical violence during last four months by BRAC membership, membership length and membership depth, Matlab 1995.

	Physical violence %
<b>BRAC membership</b>	
BRAC member (n=438)	8.9
Poor non-member (n=1550)	5.8
$\chi^2$ Significance	$p<.05$
<b>Length of BRAC membership</b>	
< 2 year (n=185)	10.8
2+ year (n=260)	7.3
$\chi^2$ Significance	NS
<b>Depth of BRAC membership</b>	
Poor non-member (n=1595)	5.6
Only savings (n=56)	5.4
Savings+credit (n=268)	11.2
Savings+credit+training (n=119)	3.4
$\chi^2$ Significance	$p<.01$

Source : Khan et al (1998)

## Annex 2

### MCWC Case Studies

"A female client arrived at the MCWC at 8.30 AM in the morning. The corridor of the centre was gradually filled with many patients. The staff of the centre informed the patients that the doctor will not see any patient today. But after 10 AM, the doctor arrived at the Centre and there was serial number for the patients so the patients were very happy to see the doctor. The staff let the well-off patients enter the doctor's chamber breaking the serial, so some pregnant women got upset because they were at the beginning of the serial and also came early in the morning. Nobody paid any heed to their complaints. The staff was repeatedly making excuses that the lady doctor does not have time now and informed them that if they go to her house in the afternoon, they would get quality services. All patients cannot afford to go to her but some of them were discussing that once a patient goes to

the doctor's residence, she behaves very well with them and gives the lots of medicine during their next visit.

Another case: One lady came with her 8/10 year old daughter, who was probably suffering from vaginal itching. The staff at the centre immediately let them in without registering her name. The client then offered some money to the staff and then he pushed them in. When one of them told the doctor her symptoms, she was furious and scolded the client badly. When the doctor heard that the patient was unmarried she immediately jumped into conclusions and scolded her saying bad words like she does not have any religion, she should do business in the society not here etc."

Source: AC Nielson

### Voice and Accountability

#### Introduction

This chapter presents “voices” of the socially disadvantaged in seeking health care as well as experience of multiple voice mechanisms in establishing accountability of the health system in Bangladesh. People’s participation and voice in health care is crucial for improving access of disadvantaged populations to quality health services and thus, enhancement of their health. As Rifkin (2003) argues, a focus on the poor and community participation in health care contributes to positive health outcomes. The Alma-Ata

Declaration highlighted the fact that people have a right to participate individually or collectively in planning and implementing their programs (WHO 1978). The International Conference on Population and Development in Cairo in 1994 and the Fourth UN Conference in Beijing in 1995 emphasized the rights to and

needs for health services, particularly, for women where people’s participation in planning, monitoring and evaluation is deemed essential (ICPD 1994; Beijing Platform for Action 1995). Bangladesh has endorsed the strategies ratified in all those most important conventions to secure health as human rights and to foster people’s participation in health care.

Community participation as a human right of citizens is regarded as a strategy to strengthen accountability of public sectors to be more

*To strengthen support to the functioning of local health system, people-centered approach is underscored in Alma Ata Declaration to involve people actively in defining health priorities and allocating scarce resources.*

responsive to needs of people (Malena 2004). To strengthen support to the functioning of local health system, people-centered approach is underscored in Alma Ata Declaration to involve people actively in defining health priorities and allocating scarce resources (WHO 1978). Successful people centered approach has been observed in Comprehensive Rural Health Project of Jamkhed in India where communities were empowered to take health actions especially under the leadership of village health workers (Arole & Arole 1994). Users of health services can be very effectively used to monitor performance of health providers, but, inclusive participation is essential to a people centered approach emphasizing people’s rights to health care and meeting health demands through democratic process (Mahmud 2004).

We have seen that despite remarkable progress in health status particularly in mortality and fertility declines and increase in life expectancy, Bangladesh still suffers from inequitable health status (Streatfield et al. 2003). Health inequity is complicated not only by socio-economic inequality, but also by disparity in gender, age, ethnicity, geographic location, citizenship to the State and many more issues (Streatfield et al. 2003; Ahmed 2005). Public health facilities are not truly accountable to meeting health care needs of the disadvantaged, marginalized people (Afsana 2004). Inadequate resources and health service

facilities, widespread corruptions, lack of professionalism, absenteeism of health providers and lack of knowledge about health and rights to health care have resulted in a weakly functioning and inequitable health system in Bangladesh (BIDS 2006). Both public and private health sectors suffer from poor quality of care and non-accountability of health providers.

*Inadequate resources and health service facilities, widespread corruptions, lack of professionalism, absenteeism of health providers and lack of knowledge about health and rights to health care have resulted in a weakly functioning and*

For the last few decades, some efforts of the Governments and NGOs have been observed in improving governance and ensuring accountability in order to enhance health services for the disadvantaged populations. Many of the partnering initiatives showed achievements in improving service sectors by endorsing people's participation and incorporating voice mechanism. But, on the other hand, it was also observed that progresses were challenged by factors that hinder or slow down the processes.

Moreover, many of the committees were reported to be existing on paper, but remained non-functional due to lack of vision and future plan of action (Jasimuddin et al. 2001). The aim of this chapter is to examine the processes through which local health initiatives facilitate improvement of quality of health care for the disadvantaged populations and bring to light the successes and challenges faced during the course of action.

## Voice of the grassroots: Is health equity addressed?

Disadvantaged populations because of their social vulnerability suffer from multiple health problems, and face challenges while seeking health care. As defined, disadvantaged populations are, "groups

with diminished capacity to take advantage of opportunities for better health and who are often denied those opportunities, whether due to internal or external factors" (UNI-SOL (Universities in Solidarity for the Health of the Disadvantaged), 1999). It is observed that poverty, illiteracy, gender, old age, ethnicity, geographic distance, citizenship status and any more issues make people at the grassroots disadvantaged and powerless.

Case studies of people's experiences at the grassroots are presented below, specially selected from Salma Sobhan Fellows<sup>1</sup> journalistic reports published in national newspapers. In addition, some case studies from review of research documents are also presented. Newspaper reports often give voices to the disadvantaged groups. These real life stories illustrate the various ways these groups are vulnerable to discrimination and exploitation, and demonstrate the sheer invisibility of various sections of the population. They also bring to light the inadequacy, corruption and lack of accountability of the health services. The stories are typical of the silent sufferings and exclusion of thousands of women and their families.

*Newspaper reports often give voices to the disadvantaged groups. These real life stories illustrate the various ways these groups are vulnerable to discrimination and exploitation.*

### Case 1

Uterine prolapse: Sufferings from reproductive morbidity

Nazma is 32 years old. She was married off at the age of 15. She became pregnant within a

<sup>1</sup> Young, bright woman aspiring to journalism are recruited and trained by BRAC Training Division under a programme called Salma Sobhan Fellowship in Journalism for Women. It is a year long training aiming to improve grassroots journalism and create platform to hear voices of the disadvantaged populations. This project is financed by Pratichi Trust where the Nobel Laureate Amartya Sen contributed from his Nobel Award.

year and gave birth to a child after two days of prolonged labor pain. At that time the TBA put her hands into Nazma's uterus several times to expedite delivery. Nazma usually had to deal with all household chores of the family. Eight days after giving birth she had to drag a one-maud (40 kg) bag of rice into the house. She suddenly experienced some pain in her abdomen. Later, Nazma realized that her uterus had come down a little. At first when she revealed the matter to her husband, he did not pay much attention. After that when she told the TBA about the matter, she was advised to drink warm water. Despite all this, her uterus kept descending. She could not work for any length of time and faced difficulty in walking. She went to her father's place and was told by women family members, relatives and neighbours to keep her condition a secret. They considered it to be a curse. She began to seek treatment from a quack but it did not help. After this she was taken to a doctor by her mother. He advised Nazma to have an immediate surgical operation but they did not have money. After five years of suffering, Nazma has still not had her surgery. She lives with a uterine prolapse and continually suffers from lower abdominal pain and fever.

Source: Layli Begum, Salma Sobhan Fellow, The Daily Banglar Manush Kurigram, Wednesday June 21, 2006.

### **Case 2**

Poor services at an NGO Clinic in an Urban Slum

A woman at her late 20s became furious after waiting for a long time to see the paramedic. She suddenly screamed out, 'How long will we have to sit and wait? We have work at home and then they just keep us sitting and sitting. All the time it is the same thing either there are no medicines available or the doctor is away. How long can we wait like

this?' Her baby was clearly sick and crying and she was rocking him back and forth. The paramedic had been away for the entire week on training and personal leave. When she arrived this particular morning, she was busy sorting out her files in her room. It was 10.00 a.m. and most of the women and their children had been waiting for services since 9 a.m. One of the health workers got annoyed with the woman's outburst and replied, 'Listen you, the government doesn't care about you, has the government given anything in this slum? It is the NGOs who have come and helped you all! ...Go where you want to go! We can't do anymore...'

Source: Rashid, 2005.

### **Case 3**

Rural woman arriving for delivery in a tertiary hospital

Shahanara, a young girl of 18 lived in remote village in a sub-district. This was her first pregnancy. She started labor pain in the evening. As time went off, she gradually developed stronger pain, but the baby's head was not coming down. The birth attendant known locally as daini diagnosed her fetal position as transverse lie. In the morning along with her families she arrived at Thana Health Complex. They had to wait long for the doctor. At noon, one doctor came in and referred her to the nearest private tertiary hospital located in a rural area. They traveled to the hospital by bus. However, the hospital emergency refused to admit her as the obstetrician was not available. Shahanara along with two women - mother and mother-in-law decided to go to a big tertiary medical college hospital located in a district city. This was their first in a town and in that

hospital. When I met them, she was on a trolley pushed by hospital staff in hospital corridor. Her mother and mother-in-law were accompanying her. They faced many predicaments in getting hospital care including doctors' condescending behavior, financial crisis, paying money for each service, running in an unfamiliar environment and so on. Shanarara later said: I thought, once we reached hospital, some arrangements would be made. But, that's not true. Doctors do not do anything. You need money for treatment. Doctors do not want to listen, but become irritated. The government has made this hospital to suck money from the patients. If patients do not come to the hospital, do you think it will run? Hospitals run on people's money, but people do not get any treatment.

Source: Afsana, 2005

#### **Case 4**

High fertility and inadequate family planning services

Women of Sridharkhila of Kishorganj district are still outside the reach of family planning methods. They do not get any services from Government health workers in their village nor have they seen any health worker for nearly 10 to 12 years. Helena, a young woman lives in Sridharkhila. Since her marriage, she has been giving birth with an interval of one to one and a half years. At present she is the mother of six and is waiting for the birth of seventh child. Helena says "There is no one here to teach us about birth control pills." She is also ignorant of the fact that at union levels, public health facilities provide free health care services. She sometimes stops taking pills because of money constraints and remains unclear of the effectiveness of the method.

Source: Mahrufa Khatun, Salma Sobhan Fellows, Sexual and Reproductive Health Research Project Working Paper, BRAC School of Public Health, 2006

#### **Case 5**

Looking after the needs of the mentally challenged

Chanda (pseudonym) is mentally challenged. She is a down-syndrome child because of a head injury during her birth. Her mother blames the doctor for this injury. Chanda's mother says with grief, "Chanda's father does not want to spend the money from his pension." This is why there is no interest to send her to an autistic school. Her mother worries about some of the behaviors by Chanda, such as, sudden sitting on boys' laps and different types of over-excitement. She does not understand anything about her menstruation cycle and does not know how to take care of herself, often soiling herself. Chanda's mother wishes that there was a free of charge private or government training centre to assist or advise her with how to look after mentally challenged needs. She says, 'How will the mother of a mentally challenged girl tackle the problems of reproductive health and sexuality? How do we take the initiative of making the mentally challenged understood by others? And if there such training centers they need to be publicized. Many people do not even know that autistic training centers exist."

Source: Sharmin Farzana Nahid, Salma Sobhan Fellow, Amar Desh, Tuesday June 6, 2006

#### **Case 6**

Garment factory violates maternity/pregnancy laws<sup>2</sup>

Kulsum Begum works at one of the garments factories in town. She rejoined the garments factory three months after her pregnancy but did

<sup>2</sup> Section 4 of the 1939 Pregnancy Leave Act highlights the rights and responsibilities of women during their labor period. According to this law, all the women eligible are allowed a leave of six weeks before delivery and six weeks after delivery, which is inclusive of the holidays and working days.

not get her salary for those three months, even after working at the same factory for the past five years. Like this, several other garments factories in the country are not following by the regulations, set fourth by the Pregnancy Leave Act of 1939, which was specifically made for working women. Majority of the garments workers are completely unaware of the various regulations and benefits that are present regarding pregnancy leave. A number of young women did not receive any pregnancy leave allowance. There are several garment factories in some specific regions, which do not pay pregnancy leave allowance to their workers. When Chittagong BGMEA officials were contacted to address the issue of the miserable conditions of the garments workers and the irregularities of the garments officials, they refused to comment on the matter.

Source: Ismot Morjida Eti, Salma Sobhan Fellows, The Dainik Shomokal, Dhaka, Sunday May 28, 2006

### **Case 7**

Brokers control in Patuakhali Hospital:  
Violation of patients' rights

The Patuakhali general hospital has been virtually taken over by a powerful syndicate of brokers, who in collusion with a section of employees lure patients to private clinics. Though the 100 bed hospital was upgraded to 250 beds in February, this has made little difference to the situation. In one scene, the broker was overheard telling the patient: 'Here treatment will take more than a month and you have to spend Taka 500 per day. I can arrange everything in a private clinic at the same cost, where you will get better treatment and go home within 7 to 10 days.' It is reported by a number of employees that the brokers have free

access to all the doctors, departments and office rooms. According to hospital sources, 5 to 10 patients leave the office everyday without completing their treatment, taken away by brokers to private clinics. In addition, a number of the doctors, who practice in the hospital run or work in other private clinics in town. Hospital authorities declined to talk about these challenges facing the government hospital.

Source: Staff reporter, The Daily Star, Dhaka, Tuesday October 25, 2005.

### **Case 8**

Bribery at 10 different levels: Health care in Government Hospitals

A patient at Rajshahi (district) city has to pay up to Taka 5000 (US \$71) on bribes for obtaining their fundamental rights to medical care at government hospitals in the city, including Rajshahi Medical College Hospital. According to a report by Transparency International, patients have to pay up to 10 different levels, including the doctors and nurses, for x-rays and pathological tests, for surgeries and injections and for intravenous devices and fluids. It was calculated that every outdoor patient pays taka 20 each time they visit the hospitals. A patient usually visits a hospital 5.31 times on average per year and 7% of the patients end up paying bribes of Taka 1,159 (US \$ 16) a year. There are additional costs if one requires a stretcher or for different pathological tests. These are in clear violation of patients' rights, who are not required to pay according to the policies of the government.

Source: Staff reporter, The Daily Star, Dhaka, Tuesday October 26, 2005.

### **Case 9**

Denial of sex worker's treatment in health facilities

A fellow sex worker recounts: Nargis was like a sister to me at this place (brothel). One day she ate some fish and started crying out in pain and began to bleed. We had heard that the fishermen were mixing poison in the water to catch fish and selling fish at a very cheap price. After eating this fish, she became very ill. The leaders of the brothel took Nargis to the local government health clinic, but the doctor and nurse refused to treat her because she was a commercial sex worker. Then we had to take her to a private clinic in the district town, which was 30 minutes away and she died on the way...

Source: Voices of the Unheard. Testimonies from the People's Health Assembly. Dhaka: Gonoshasthya Kendra, Bangladesh 2000.

*Many lessons have been learnt from their innovative models, experimental health systems and community based programmes, which are people-centered and begin with people's needs. NGOs have the capacity to reach out to the poorest through strong grassroots networks at community levels.*

workers, unmarried adolescents, mentally challenged, indigenous communities and so on, and as a consequence, their access to and utilization of health services are inequitable. Poverty, social class, illiteracy, ethnicity, gender, age, geographical location and lack of knowledge about rights and demands impact on the kinds of care and services received.

### **Grassroots speaking out for health equity: What difference can be made when we include the excluded and marginalized?**

Enhancing participation and making health services more responsive to the poor and the disadvantaged are essential for creating an impact on the community. Citizen participation is a complementary and alternative strategy to government led health reforms (Thomas et al. 2003). Although, the government has initiated many efforts to encourage participation of people in improving health service provision, many NGOs, grassroots organizations and advocacy groups have been important contributors to the delivery of health services in the country. A number of these organizations have stepped in either with encouragement from the government or independently to provide various kinds of support and services.

Many lessons have been learnt from their innovative models, experimental health systems and community based programmes, which are people-centered and begin with people's needs (Upham 2004). NGOs have the capacity to reach out to the poorest through strong grassroots networks at community levels. Social mobilization and communications activities attempt to give voice in different ways for the socially excluded (poorest, women, elderly, widows, sex workers, garment workers and so on) to access services and challenge existing power structures (Perry 2000; Antuono et al. 2004). The government has utilized NGOs capacities in many aspects, more recently, in planning, monitoring and implementing health service provision at union and upazila levels.

In this section, we present a number of cases of a diverse range of citizen initiatives within and beyond government health structures to accentuate the participation of people in improving governance and accountability issues in health care system with a view to identifying successes and challenges of the different initiatives.

### **Voice for the poor: Stakeholders' committees**

The Ministry of Health and Family Welfare (MoHFW) emphasizes that the participation of

stakeholder committees are critical for improving governance and health service delivery focusing on client centre approach, quality of care, social and gender equity, and decentralization (Ministry of Health and Family Welfare, 1998). The participation of stakeholders and users of health services in planning, implementation, monitoring and evaluation of the project is considered important for improving health service quality and service utilization, which will eventually impact on health and development of the community (Ministry of Health and Family Welfare, 1998; 2005).

#### **Stakeholder Committee**

The activities of the stakeholders committees began in nine thanas with the involvement of four NGOs, such as Voluntary Health Services Society (VHSS), Bangladesh Mahila Parishad (BMP), Nijera Kori (NK), and BRAC. These four NGOs were given the task of facilitating the preparatory activities and subsequent implementation of committee activities in their respective working areas of nine thanas.

To build a partnership between the government and the people, it is observed that the process of involving stakeholders was initiated in the inception phase of the HPSP. As part of the process, a National Stakeholder Committee (NSC) was formed with Joint Chief (Planning) of MoHFW as its chairman and GoB officials and representatives from different stakeholder groups including users of health services as members. Under the guidance of NSC, nine Thana Stakeholder Committees (TSCs) and 16 Union Stakeholder Committees (USCs) were formed: to ensure participation of users and stakeholders; to broaden understanding of HPSP concept and its support for implementation; and to facilitate transparency and accountability to users.

The stakeholders committees emphasize representation from users of services, particularly women and the poor and different stakeholders, such as, school teachers, lawyers, journalists, and representatives of the local government and NGOs. The facilitating NGOs organized workshops for the TSC and USC members to devise work plan through participatory approach. The work plan essentially included monitoring of activities in health facilities, organizing monthly meetings, holding dialogue with community and generating demand for quality services, helping poor and women to access health services, collecting health related data and communicating with NSC about their activities and concerns.

It is documented that activities of these NGOs vary considerably in their areas of concentrations and mode of operation. Although there is little coordination between NSC and local committees, most meetings were regularly held with more than 90 percent attendance of the members. The selected members of the committees represented women and the poor from the community, but did not represent the whole geographic areas of upazila or union. The committees were found to monitor and supervise the activities of health facilities. Most health users reported improvements in cleanliness, waiting arrangement, waiting time and consultation time.

Source: Nycander 2004; Barkat et al. 2003.

Given the short span of operation, the stakeholders' committees achieved some success in addressing quality issues in health facilities. Changing negative attitudes of service providers even to poor and female patients, enhancing regular presence of service providers, improving poor patients-providers interactions and maintaining continual flow of essential drugs and other supplies were observed. This led to client satisfaction and thereby, enhanced patient attendance at health facilities. Contrarily, it was observed that the stakeholders committees did not follow any standard procedures to monitor activities, because most were neither aware of their actual monitoring role nor there were any government guidelines for executing the tasks. Unfortunately, the Thana Health Administrators were also not cognizant of the stakeholders' roles and responsibilities due to lack of any formal guidelines from the government. Moreover, the linkage between NSC and local committees was not established which created a gap in information flow and structuring of activities. Apart from these, lack of financial resources also impeded the implementation of activities. The stakeholders committees that could be successfully acted as a

forum for grassroots voice was by and large overlooked due to lack of commitment and negligence of the government.

### **The Public-Private Partnership and the Community Health Scheme**

The public-private partnership (PPP) was established to enforce responsiveness of health providers to render quality services.

The aim of PPP is to combine healthcare through community based schemes with the involvement of local people in developing and implementing the scheme (Barkat et al. 2003). The Community Health Scheme of PPP, an experimental project, is also part of the Ministry of Health and Family Welfare (MoHFW) programme under the HPSP establishing a structure for Government participation at upazila and policy levels. The Government interest and commitment was fostered through experimental approaches, as referred to in the box next page.

*The linkage between NSC and local committees was not established creating a vacuity in information flow and structuring of activities. The stakeholders committees that could be successfully acted as a forum for grassroots voice was by and large overlooked due to lack of commitment and negligence of the State.*

### **Public-private partnership and community health scheme: A Case of Brahmanpara**

The first pilot test of the community health scheme (CHS) is in Brahmanpara. The community clinic employs a Clinic Facilitator, part time Medical Assistant and part-time Community Physician to supplement government employed paramedics posted to the clinic. The community employed staff of the PPP are under the supervision of the CHS management committee, comprised of local authorities, NGOs and other providers. In response to community demands, the clinic is open from morning to 8 pm and the CHS employed staffs only work in the evening. To ensure punctuality and deter absences the community staff introduced a logbook to record attendance and regularly monitor the logbook, and kept informed of leave plans (both government and CHS staff). In North Shidhai, the government paramedics coordinated and worked with CHS management committee, but ensured that they were reportable to Upazila Health and Family Welfare Officers. While this scheme operated, absenteeism of government staff drastically reduced. It suggests that the combined pressures of monitoring, community demands, congenial working partnership and local level Upazila management's commitment to the PPP approach have led to the change in staff behavior and attitudes. Moreover, a service improvement action plan for the Upazila Health Complex was developed by the hospital staff in a participatory process facilitated by PPP. Using this action plan service provision at Health Complex was improved enhancing client satisfaction as well as their utilization of health services. As of 2003, there were currently five CHSs operating with plans to eventually scale up.

Source: Barkat et al. 2003; Thomas et al. 2003

The PPP experience at Brahmanpara has brought into light some positive changes. The participation of stakeholders with dialogue among themselves was increased and the dialogue was directed more towards improvement of service provision and accountability of health providers. A participatory process in developing action plan for Upazila Health Complex has improved service quality and client satisfaction and utilization of health services. It was also observed that the frequent turnover of upazila managers and senior MoHFW officers, and the political appointments of staff have discouraged the process of continuing the activities. Here, the newly appointed officers lacked exposure, skills and commitment and thus,

were not able to respond to lessons and policy implications of the project. Moreover, lack of commitment and persuasion also makes policy influencing difficult in such an unstable situation.

### **Advocacy for Better Services: Committee of Concerned Citizens and the Transparency International**

People of Bangladesh are deprived of their rights to health and health care. 'Health for all' is far beyond the reach of the people, particularly of the poor and women. Public health sectors suffer from poverty of health services, and health care facilities are immersed with paucity of supplies and

corruptions. To examine quality of care and create accountability in the health sectors, the Transparency International, Bangladesh (TIB) works with the Committee of Concerned Citizens (CCC) in Rajshahi. CCC usually arranges workshops and meetings with different stakeholders

at district and upazila levels to create awareness and build network with local Health and organizations. In health sectors, CCC has participated in problem explorations and managed to bring about improvement in services provided at public health facilities (see below).

### **The Committee of Concerned Citizens (CCC) creates change and lobbies for better services**

The Committee of Concerned Citizens (CCC) was formed in many districts of Bangladesh under the auspices of the Transparency International, Bangladesh. This committee works for curbing corruption and establishing good governance through increasing transparency, accountability and people's participation in various service providing government and private organizations at local level.

In Rajshahi division, the CCC collects information from public health facilities with the support of TIB. The whole intent is to lobby hospital managers for specific improvements of service quality. Information was collected through report card surveys to investigate the quality of health services, the extent of corruptions and client satisfaction. It was reported that more than one third of the patients did not receive any medicines from the hospitals and out of pocket expenditures were incurred for 13 types of hospital services, such as, paying doctor's consultation fees, bribing for hospital admissions, paying tips and so on. Besides, many patients complained of long waiting time, non-availability of doctors, low quality of hospital meals and unclean wards and toilets.

Source: Transparency International Report 2005.

It was observed that the credibility of TIB facilitates access of CCC members to hospital administrators and doctors. The dialogue between health providers and CCC made some immediate changes in hospitals. Many instructions were publicly displayed in health facilities: a) list of available medicines; b) without receipt, no transaction will be made; c) menu of daily hospital meals; d) names of attendant doctors and nurses; e) government fixed fees for different services; f) responsibilities of nurses; g) enhancing supervision of doctor's and nurse's duties; h) cleaning of toilets, wards and corridors twice a day; i) damaged hospital beds repaired and more

issues. As a result of the CCC's monitoring and dialogue with health providers, there has been some improvement in service quality including reduction in staff taking bribes from patients. This has led to client satisfaction and enhancement of service utilization.

### **Voice and responsiveness initiatives**

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Voice and responsiveness initiatives are critical for improving access of disadvantaged populations to public health services. Performance of the health system can be enhanced by including people's

voice in and influences over health sectors and making the system accountable to their needs and wants (Mahmud 2004). People's participation in local health initiatives, thus, acts as means to advance health service quality and accessibility for the disadvantaged. In 1998, the Ministry of Family Welfare set off many projects on 'citizen participation' to empower people through acquisition of skills, abilities and knowledge and enable one to voice for the better efficiency of the

health system. Nijera Kori participated in the citizen participation project, but took different approaches to make health services more responsive and accountable to the poor. There is also a citizen's oversight committee at the upazila level to monitor the public health facilities. Naripokkho has been working to activate such committees. These two case studies are presented below.

### **Ensuring accountability: Upazila Health Advisory Committee (UHAC)**

In 1999 Naripokkho working to establish women's rights as citizen undertook the reactivation of the Upazila Health Advisory Committee in Patharghata upazila with the active involvement of Sankalpa, a local NGO. The project aims to improve health services for women through reactivating upazila government instituted accountability mechanism.

The UHAC included the Member of Parliament being the convener of the committee. The other members were local administrators, elected leaders, hospital representatives, police and local leaders as specified by the government and nominated by the MP. During the process, Naripokkho was engaged in developing capacity of and providing technical assistance to Sankalpa. Community mobilization was done by Sankalpa by organizing workshops with different stakeholders, women's groups, local health practitioners, service providers from the local health facility, college students and so on.

The NGO workers of Sankalpa arranged meetings with UHAC to improve health services in government health facilities. At the beginning, the meetings of the committee were regularly held at the behest of Sankalpa and the committee functioned quite well when the implementation of decisions were followed up. Under supervision and direct orders from the MP, the hospital administrators were influenced to implement decisions. However, in reality, to bring changes in negative attitudes and irregular practices of doctors proved difficult. The workers of Sankalpa visited hospitals, but not the members of the UHAC. As the members of the committee were elites and hardly used government health facilities, they had little interests in resolving problems faced by the poor users. As a result, the meetings became irregular as well as the follow up of health services in public health facilities.

Source: Sen Gupta, n/d; BIDS, 2003.

Naripokkho, a women's organization has earned reputations as an advocacy group to secure women's health and rights. It works at grassroots level and also at government level to facilitate communications and bring to light the challenges and the gaps in health service provision. Naripokkho has built up partnership with a grassroots organization, Sankalpa, in Pathorghata upazila in the Southern part of Bangladesh, to ensure accountability of the public health providers to local needs, particularly, of women for rendering appropriate, adequate health services.

Naripokkho acted as a catalyst to create a sense of urgency about problems in public health

facilities and Sankalpa facilitated the process of activating the role of UHAC. However, the initial improvement in health service provision gradually faded away due to lack of interest of the members of UHAC in resolving problems of the poor users. As a matter of fact, the voice mechanisms did not include the actual users of health facilities who include the poor and women, nor was there any mechanism to communicate problems faced by the users. The lesson from this project was that health users, services providers and local elites should equally participate in the management and implementation of health initiatives to make health providers accountable to public.

### **Ensuring citizen participation: Health Watch Committee (HWC)**

In order to ensure accountability of health service providers and improve quality, affordable health services, in 1998 NK started to work in nine upazilas by encouraging citizen's participation through Health Watch Committee (HWC). The HWC was formed at upazila and union levels as a part of MoHFW's pilot stakeholder participation project with the guidelines provided by the Ministry to ensure community representation. A nine member committee included professionals, service users, members of landless groups and NGO representatives. The Committee purposefully excluded Government staff from the committee, but included active and vocal female members, and people from very poor backgrounds. NK insisted on 50% representation of women members in the committee and union committees to be headed by women to ensure gender equity.

The HWC meetings were held regularly with reports to NK. More women members attended the meeting regularly, but did not actively participate especially in Upazila HWC meetings because they lacked confidence to speak before educated ones. On the other hand, Union HWC meetings were more participatory than the Upazila meetings because of homogenous group representation in the former. Women members were more active in advocacy, informing community, mobilizing women and children for health related activities, monitoring the health facilities and noting problems faced by the service users. The committee was not able to create a platform to dialogue with local public health managers, and the satirical folksongs and drama organized for raising public awareness were considered annoying to health providers. Implementation of decisions taken at the committee was attempted by the members, but difficulties were faced regularly, for example, not being taken seriously or ignored by the health facility personnel.

Source: BIDS, 2006.

Nijera Kori (NK) is a rights-based grassroots membership organization emphasizing social mobilization of the poor. Their ideology is to build up capacities of the vulnerable groups so that their voice, individually or collectively will lead to changes in structural inequality that continually reproduces poverty (Hobley, 2004). This organization is engaged in a range of activities by including both men and women from poor rural communities and also works at local and the central government level to facilitate a just system for the disadvantaged. NK's long-term activities for social mobilization have allowed 'voices of vulnerable groups to be heard', while taking a watch-dog approach to monitor public health provision.

Improving accountability of health services has been tried through the platform of NK's committees. It was observed that exclusion of service providers from the committee and exposing their failures rendered the health providers to be even more unsupportive. As the committees lacked representation of health service providers, elected political representatives and policy influencers, decisions of the meetings failed to draw adequate attention from these particular classes. Women were active in providing information and doing advocacy at community level. But, unfortunately, their voice was totally ignored by the mainstream health system due to their subordinate position in society. These initiatives could not make the public health facilities accountable to the users due to lack of effective mechanism for communication and the government commitment.

### **Lessons learned from health initiatives**

The key findings that emerge from the above case studies are as follows:

- Poor and marginalized people faced predicaments in public health facilities
- The grassroots people spoke the same language of frustrations, deprivations and humiliations in seeking care from health facilities.
- Lack of accountability of public health facilities to people was observed.
- Voice of the disadvantaged remained silent.
- In local health initiatives, people participation was observed. However, representation from all sectors of populations was not equal.
- Local health initiatives tried to bring about affirmative changes.
- Quality of service and service utilization were reported to be improved to a certain extent when NGO partners acted actively in grassroots mobilization and as a bridge between community and government health facilities
- Lack of communications between government and stakeholders of local public health facilities failed to bring interests of the health providers in local health initiatives.
- Local health initiatives were short-term donor-driven project, thus, commitment and continual flow of resources both lacked.

Although many initiatives were taken and are still in place, people of the grassroots largely remain disadvantaged. Voices we heard of the grassroots still speak of the same language of frustrations, deprivations and humiliations while seeking care from health facilities. Even then, the initiatives presented here have brought about some positive changes in health facilities, in terms of improving service

*To bring about health equity and eventual development for wider populations, a long-term strategy is required to scale-up and sustain the successful approaches of health initiatives given that transparency, accountability and people's participation are ensured.*

quality and utilization rate. As the initiatives are usually short-term projects or done on a small scale, these benefits are limited to localized specific communities. In this socially stratified society, despite some encouraging experiences, implementing such initiatives is not easy. Moreover, due to project-based, short-term nature, the initiatives also lack continual flow of financial resources, which is not conducive to the sustainability of such efforts.

The role of NGOs as a catalyst is very important to bridge the gap between the government and the community. Due to intimate grassroots network, the NGOs are reported to work better in mobilizing people, raising awareness, involving people in local health initiatives to voice their rights and needs and communicating messages from local to central levels. This, to a certain extent, enhances accountability of public health care providers. It is, thus, critical to acknowledge and ensure the inclusion of NGOs in local health initiatives to address health inequity.

## Recommendations

To bring about changes in health policy and practice in Bangladesh, a people-centered approach discussed in the Ottawa Charter in 1986 is essential. This defines health promotion as the process of 'enabling people to increase control over, and to improve, their health' (WHO 1986). A people-centered dimension implies a bottom-up grassroots perspective, that is, the perspective and experiences of the ordinary person in his or her life, social-cultural context and community. A people-centered approach creates an enabling environment for poorer and socially excluded communities to have more control over their health and its determinants (Montgomery n.d). To ensure

people's participation and health equity, the first and foremost issue is the political commitment of the government. The inclusion of people-centered approach in health policy will ensure people's participation in practice, but significant political and institutional changes are necessary to facilitate health sector reforms in Bangladesh. On the basis of the key lessons from the case studies presented in this chapter, the following recommendations are made:

- Implement policies that have already been adopted regarding people's participation in health policy formulation, implementation, and monitoring.
- Involve NGOs to work as a catalyst between the government and the communities.
- Create a culture of and a demand for accountability through sensitization of government health providers, local elites, NGO officials and common people including women, poor and other disadvantaged.
- Create an enabling environment for the voice mechanisms at different levels to work actively in planning, monitoring, and oversight.
- Involve people from different socio-economic groups with strong consideration of gender balance in voice mechanisms.
- Create transparent communications between citizens' voice mechanisms and the local health providers working in public health facilities.
- Reward the facilities that maintain quality of care and attract clients.
- Reward the health providers, who actively cooperate with citizens' voice initiatives.
- Bring citizens' voices from the local to the national level.

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## Key findings and recommendations

### Key findings

*Persistent wealth based inequalities in maternal mortality and child survival are especially disturbing. Although the rich-poor gap has reduced in magnitude the ratio of rich poor rates in maternal and child mortality has been maintained almost at a constant level, indicating that inequality has not declined.*

Over the years there has been steady progress towards more equitable health outcomes, but progress has been uneven. Overall prospects of survival have improved but quality of survival is threatened by the rising prevalence of childhood disabilities, especially in economically disadvantaged populations (Chapter 2). Socioeconomic status, sex and place of residence are three major determinants of health inequities. Income and regional inequities in survival and disadvantage in nutritional status especially in females, children and the poorest populations continue. Persistent wealth based inequalities in maternal mortality and child survival are especially disturbing. Although the rich-poor gap has reduced in magnitude the ratio of rich poor rates in maternal and child mortality has been maintained almost at a constant level, indicating that inequality has not declined.

A large part of unequal health outcomes is explained by inequitable access to and consumption of health care. Continuing demographic and health transitions have increased demand for curative care, allopathic medicine and market-based services, and it is here that access is most inequitable, particularly with respect to income, sex and place of residence (Chapter 3). Thus the pattern of health care

consumption is quite distinct: the poor dominate consumption of public health care at the primary level and low quality private curative care while the rich dominate the consumption of public care at the tertiary level and relatively better quality private care. The gender dimension of health care consumption also remains striking: regardless of household income women are much more likely to rely upon unqualified care, particularly those residing in rural areas and urban slums. However, income constraints are particularly strong in limiting the access of poor women and children to life saving allopathic care.

Accessing allopathic health care from the market has been increasing. However, the market for allopathic health care is quite segmented in terms of care standard and training of health care providers. Reliance on private health care increases inequality in access to qualified health care, since private expenditure on health is more unequal than total health expenditure. Continued differentials in the use of low cost services (immunization, ante natal care, ORS) means that the availability of 'free' public services does not ensure equity because of non income demand constraints. Larger differentials in the use of higher cost public services, such as qualified care for childhood diseases and emergency obstetric care and PNC, indicates that both income and non income constraints operate leading to weak demand.

Increasing access of disadvantaged people to affordable health care and closing the health gap between socio-economic groups has been the major stated goal of public action in the health sector in Bangladesh since the late 1970s (Chapter 4). Since the mid-nineties, in line with the global consensus achieved at the International Conference on Population and Development (ICPD), Bangladesh has shifted its programme approach from target-driven to client-centred, dealing with a broader range of reproductive health issues targeted at a larger number of population groups. Currently, the Poverty Reduction Strategy, which intends to improve the country's living standards and halve poverty by 2015, has set three health related Millennium Development Goals (MDGs), reaffirming government's commitment to improve health outcomes and reduce inequalities in outcomes. Initially, priority was given to building health infrastructure to reach rural populations and expand coverage. Later, services were targeted to the most vulnerable groups: the poor, women and children, particularly in rural areas. However, the lack of sustainable integrated primary health care services in urban areas restricts access of poor people in urban areas.

Historically, the most powerful 'policy instrument' in Bangladesh has been the five-year development plans prepared by the Planning Commission, which outlined the health and population sector priorities for the country. Although increasing access to primary health care has been emphasized since the late 1970s reduction of population growth rate has been an overriding goal of all five-year plan documents. The weakness of policy is evident from poor implementation: strategic decisions on structural

reorganization, decentralization of management authority and alternative financial modalities were not implemented, while some pilots were abandoned on political considerations. Strengthening of management for efficient and effective planning, budgeting, financing, program implementation and project cycle management fell flat, because of lack of understanding and support from the policy makers from the highest echelon. Strategic directions towards enhancing the skill of the public sector managers through management training did not materialize. Equity based allocations to neglected programs and marginal population was forgotten in the national plans.

*The weakness of policy is evident from poor implementation: strategic decisions on structural reorganization, decentralization of management authority and alternative financial modalities were not implemented, while some pilots were abandoned on political considerations.*

Government and NGO initiatives to provide more responsive services and increase coverage of services have shown mixed results (Chapter 5). For example, despite strengthening of government reproductive health and emergency obstetric care services to reduce maternal mortality utilization is low because there is a lack of qualified personnel since public facilities cannot hold on to health care provider they have trained; quality of care is inadequate and poor patients are not accorded the same treatment as better off patients. There is also lack of coordination between health and family planning personnel. On the other hand, the EPI demonstrates that focused public sector programmes can also be successful if a good working partnership can be built between government, NGOs and other civil society actors. The GK and BRAC programmes show how a low cost community based delivery system with good referral can ensure both accountability of

providers and better health outcomes. Quality of care is a major issue to be faced when such initiatives are to be scaled up.

However, despite pro poor targeting the health system has been generally non-responsive and non-accountable to the service user's concerns, especially in the case of the poor, women, elderly and children, and marginalized groups. Voices from the grassroots reveal that inadequate service, mistreatment of patients, doctor absenteeism, unofficial user fees, endemic corruption are the common problems in public health facilities (Chapter 6).

For the last few years the government and NGOs have made efforts to improve governance and enhance accountability. Initiatives to engage communities and citizen groups in monitoring and oversight activities have resulted in improvement

of service quality and utilization but these initiatives are not sustained due to funding constraint and lack of cooperation and support from the service providers and the government. Impact of these citizen initiatives to demand and monitor better health services is localized and unable to make an impact at the national level.

## Policy recommendations

### 1. Improve the coverage and depth of official statistics and survey data

a) Although available data permit examination of inequities in health outcome and access by individual and household characteristics, assessment of socioeconomic inequities is now limited to aggregate comparisons between rural

and urban areas. More disaggregated data are needed to map area-based inequities beyond divisions and rural urban distinctions. For example, adequate data are not available to examine socio economic and other inequities in health status of the population in areas having exposure to malaria, kalazar, iodine deficiency, arsenicosis, rickets, and so on. Data are also lacking to examine inequities in the health status of the population living in slums compared to other urban areas and rest of the country, or populations living in remote areas like the hill tracts and the rest of the country. Thus, data are needed to identify more specifically areas and groups lagging behind with respect to health outcomes.

b) Disaggregated data on health care utilization are also needed to identify disparities more accurately so that services may be fine tuned and better targeted to meet the specific needs and address the special constraints faced by disadvantaged and marginalized groups, like poor women and children, slum populations, remote pockets, and so on.

c) Utilization of health care services must be monitored with an equity focus. Hence service statistics are essential at disaggregated levels (union, upazila, district) to monitor utilization of services at both public and private facilities.

### 2. Generate effective demand for services where demand is weak, such as reproductive health care and childhood diseases

Demand generation has to receive as much attention as expanding supply of services since demand for certain types of health care (post natal care, trained delivery care, child health, nutrition)

is quite weak. Special measures must be taken to address specific income and non-income demand constraints among the poor and women, paying special attention to income costs of qualified obstetric care and child health care, and social costs of obtaining PNC and qualified delivery care.

### **3. Improve standard of curative public health services**

The extremely low standard of curative care at public facilities (for PNC, delivery care or care for childhood diseases) forces people to rely on the market especially in rural areas, but since there are severe income constraints on utilization of good quality private curative health care services, the quality of curative health care at public facilities must be improved if access of poor people and women to curative care is to be expanded. One option that has potential is partnership with NGOs and the private sector for the provision of subsidized low priced (cost recovery) community based services (EOC, delivery care, childhood diseases) that are difficult to deliver through the public health care system with its weak accountability mechanism because it requires more sophisticated technology and trained personnel that is more expensive and entails greater monitoring and supervision. The capacity of NGOs like GK and BRAC to train community based health workers to provide maternal and child health care and for referral should be examined for possible replication and scaling up.

### **4. Reduce cost of accessing good quality health care in urban and rural areas**

a) Good quality health care must be made more affordable for the poor. The absence of third party

payments in total health expenditure suggests that there is a possible role for micro health insurance in expanding access of the poor to good quality curative care from the market. The experiments of NGOs (Grameen Kalyan, Brac, GK) in the area of micro health insurance based on risk pooling at the community level could provide important lessons for scaling up.

b) Another policy option is to bring the rural medical practitioners (RMP: unqualified providers working out of drug stores), usually the first source of getting allopathic care and one that is affordable by the poor, into the fold of the formal health system through some training and regulation. RMPs can be linked with formal health system and within this network their role could be limited to counseling and prescribing general illnesses and referral. The lessons from NGO health programmes that utilize community based health workers (with short basic and then monthly refresher training) in the treatment of common illnesses and infectious diseases like TB and childhood pneumonia, and in pregnancy and childbirth related complications would be very useful in this regard.

c) Policy must be oriented to minimize hidden cost of public service utilization at secondary and tertiary level. Despite a pro-poor approach to health policies and programmes public services do not actually reach the poor because of hidden costs (such as unofficial fees, provider behaviour, payments for unavailable medicine, poor quality or lack of diagnostic tests, etc) associated with seeking 'free' treatment at public health facilities. The challenge for the government is to address the hidden costs associated with utilization of free public services that constrain access by the poor.

Creation of public accountability and civil society actions through local level monitoring may be helpful in this regard.

**5. Introduce explicit target oriented programmes to reduce unequal outcomes and make public health service more equity focussed**

Addressing social inequities in health needs programmes targeted towards the disadvantaged. A general expansion in services may not be effective unless accompanied by programmes enabling the disadvantaged to avail those services. Experience suggests that targets are also useful for monitoring progress and provider performance. Examples of such targeting would be vulnerable areas and vulnerable population groups.

The experience of successful interventions by both government and NGOs indicates that pro-poor and women-centred services can reduce inequities in health and reduce the risk of bypassing disadvantaged groups. Community ownership of health care delivery and accountability also promotes equity. This includes training and fielding of community health workers from the disadvantaged groups such as BRAC's Shasthaya Shebika Political will and support is essential to sustain equity oriented actions.

**6. Create a culture of accountability in health service delivery**

a) Involve NGOs to work as a catalyst between the government and communities to create transparent communications between citizens' voice mechanisms and the local health providers

working in public health facilities. These mechanisms can help people articulate their needs and complaints at different levels and participate actively in planning, monitoring, and oversight of local health service delivery to emerge. NGOs can also be involved in sensitizing government health providers, local elites, NGO officials and common people including women, poor and other disadvantaged groups about the role and value of these mechanisms. However, involving NGOs may be resisted by government health care providers.

b) Accountability will be improved by rewarding the health facilities that maintain quality of care and attract clients. Similarly, health providers who actively cooperate with citizens' voice initiatives should be recognized and supported.

**7. Initiate social campaigns to create awareness and help change unfavourable practices.**

Primary prevention of childhood disability is possible by reducing the incidence of early marriage, ensuring use of antenatal care during pregnancy, improving nutrition of women and using safe delivery services. Increasing maternal literacy, ensuring intake of balanced diet, inclusion of iodized salt, and avoiding consanguineous marriages are other urgently needed steps. These factors fall somewhat outside the direct purview of policy intervention, but social awareness through government slogans and media campaigns can have visible impact on practice as evidenced by the changed norms of child immunization, use of antenatal care, use of ORS, and so on.

## **8. Re think the role of government in service provision and regulation to enhance equity**

- a) Due to the expanding market for health care and greater cost effectiveness of NGO service provision, the key functions of the Ministry of Health will increasingly be policy management, budget management, the management of contracts, commissions and service agreements, the management of information about the activities of all HNP service providers and the regulation of service quality and price. Thus, government future capacities need to be built up in that light with training in contract management, budget management, planning and devising pro poor and equity focused programmes,
- b) To achieve equity goals budget allocation has to be shifted towards areas in the country with the greatest health, nutrition and population needs

over the next 10 years. This is also a strategy of PRSP. However, this necessitates the construction of an allocative norm. Criteria for identification of the recipients of service subsidies will also be necessary. The present piloting on the demand side financing may help in this regard.

c) Strategies for ensuring accountability in the system with respect to policy directions on equity, quality and coverage of service, human resource development and resource management including health care financing and budgeting and logistics management must be developed, including ways and means of making provision for the service recipients locally to participate in planning, review and monitoring of the services for quality and coverage and fiduciary arrangements. This will mean capacity enhancement of providers as well as service users committees who will have oversight roles.