

Chapter Eight

CHALLENGES AND FUTURE DIRECTIONS

The reproductive health of the population of Bangladesh stands at an important threshold as the tenth anniversary of the ICPD draws near. While some progress has been achieved in increasing the attention to and scope of women's health needs in the country, there is still a great deal that remains to be done.

Challenges and gaps

The disadvantaged “resource-population” equation in Bangladesh suggests that sustainable development cannot be achieved without targeted efforts in the population field. The hard fact of life in this country is that population pressure is creating additional demands on the already scarce land, water, and other non-renewable resources, thereby making it difficult to support the increasing number of human beings.

The high level of fertility will be a major contributor to the growth of population around 2005. After that population momentum will cause the growth of population at an increasingly rapid pace. If fertility of 2.2 is reached by 2005, the population will continue to grow and will stabilize at 211 million by 2059. And if replacement level of fertility is not reached by 2023, the population size will stabilize in 2109 at 300 million (MOHFW, February 1999). This is a real challenge for Bangladesh.

Some of the important challenges currently faced in the field of reproductive health in Bangladesh are:

- **Programmatic:** how to integrate health and family planning services;
- **Definitional:** lack of consensus about the definition of reproductive health and what is included in it;
- **Ethical:** how to address issues related to sexuality and reproductive rights in societies which are mostly conservative;
- **Policy related:** how to foster public-private relationships;
- **Political:** politicization of reproductive health issues such as abortion and reproductive rights;
- **Resource related:** decreasing resources both from the donors as well as from the Government making it difficult to ensure quality of care.

The term 'reproductive health' emerged from the 1994 United Nations International Conference on Population and Development (ICPD) held in Cairo. ICPD was a watershed event that significantly altered the policies and programs related to women's health around the world by broadening the more traditional women's health agenda of family planning and maternal and child health (MCH) to include issues like safe motherhood, STDs/HIV/AIDS, post-abortion care, adolescent health, violence against women and sexual and reproductive rights. ICPD presents major challenges and raises important questions for policy makers, program personnel and health care providers.

Specifically, at least five major challenges need consideration; (MOHFW 1999)

- Motivation of current non-users of contraceptive to become users; particularly those who have indicated that they intend to limit or space their children;
- Strengthening of the delivery system to provide quality services to increasing number of family planning users;
- Improvement of the quality of family planning services to meet the needs of increasing number of users;
- Efficient use of limited resources; and
- Improvement of the sustainability of the FP program, including financial, organizational and management sustainability.

Under the HPSP the major service delivery issue at the community level has been the shift away from domiciliary (doorstep) services to static clinic services. This mainly affected the functioning of the FWAs and HAs. Even where Community Clinics (CCs) were constructed, there was widespread uncertainty among the (FWA/HA) staff about their roles as service providers in the CCs versus households. Fears were expressed that such changes in the delivery system would adversely affect use of contraceptives and many women would drop out from home delivery to the private clinic (Khan M E et al., 2000).

The stalling of the declining TFR has proven such fears to be a reality. Establishing a community center is no guarantee with regard to its utilization. Bangladesh clearly demonstrates under utilization of various health facilities in rural areas and dependence of women on private sources for health care services (Population Council study). Therefore, unless the community clinics provide good quality integrated reproductive health services women may continue to depend on private sources and may not utilize the CCs for family planning services. Those unable to get services from the private sector may face difficulty in achieving their reproductive goals leading to unplanned pregnancies and demand for MR.

Upon assessing the perceived problems by women themselves, the BDH survey 1999-2000 showed that 80% of the women felt that lack of adequate healthcare facility nearby is an obstacle to accessing care. (NIPORT, Mitra and Associates, and ORC Macro, 2001). Half of the women mentioned that lack of confidence in the services and going to the health center as the main problems in accessing care. Another factor mentioned by about 70% women was arranging

the money required for treatment while 44% mentioned difficulty in getting permission to go to the facilities as the main problem. About two thirds said that their lack of knowledge about where to go is the major obstacle to accessing care.

The 'free' maternity care provided at urban hospitals involved considerable hidden costs that may have been a major contributor to low utilization (<15%) of maternity services among low income groups. The mean cost of normal delivery at these facilities was Tk.1275 (US\$ 31.9) and for caesarean section Tk. 4933 (US\$ 117.5) (Nahar S, Costello A, 1998).

Despite progress in many other areas, the maternal mortality and morbidity situation in the country is unacceptable. This is the main reason as to why the safe motherhood has been defined and accepted as the first of the seven sub-areas under the reproductive health care element of ESP. (Safe motherhood encompasses antenatal care including vaccination, detection and management of pregnancy complications and screening of high-risk pregnancies, attendance at normal delivery by trained personnel, obstetric first aid and referral services for complicated delivery by post-natal care).

GoB response to the situation

The reproductive health agenda is a multi-sectoral issue. Reducing maternal mortality, morbidity and violence against women cannot be achieved through health sector interventions alone. While this sector will concentrate on increasing availability and utilization of essential quality services, intense sectoral involvement will also be needed along with incorporation of different activities into existing programs (MOHFW, Oct 2001).

The government is fully aware of the fact that any further increment in the contraceptive use rate – in the short-run, and population stabilization-in the long-run, cannot be brought about by family planning program efforts alone. In this connection it is well recognized that investments in human capital, especially those which ensure equity, equality and empowerment of women and accelerate the process of mortality rate decline, especially infant and child mortality, are quite effective. These have been reflected in the official social investment policies, various legislation and newly created organizational structures.

Following the policy outlines of the ICPD reproductive agenda, the GoB had already taken a policy decision that family planning delivery systems at thana level will be restructured and services offered by them will be targeted with increased attention to maternal and adolescent health care provided as part of ESP.

Future directions

The GoB envisions fulfillment of every woman's right to safe motherhood. The mission is to nurture a socio-cultural movement that reduces mortality and morbidity as a woman's right as well as enhances her self-esteem and status. The experience in Bangladesh shows that reducing maternal mortality and morbidity is both an output and an entry point for addressing key strategic issues associated with women's rights, such as violence. Efforts will also reduce morbidity and the long-term suffering of the millions of women who survive obstetric complications. However, strategies and interventions will require focus on efforts to enhance women's status, dignity and self-esteem, if effective results are to be obtained (ibid.).

Besides the challenges that Bangladesh faces in the field of Sexual and Reproductive Health there are also some opportunities which could be explored and harnessed towards planning and implementations of future programs. Some of these opportunities identified by ICDDR,B in their strategic plan for 2010 are:

- Although deliveries generally take place at home, women are willing to use delivery facilities, especially for emergencies. ICDDR,B projects have demonstrated how to improve basic obstetric facilities and to make them acceptable and effective at low cost;
- Most families are now using contraceptives, but they need assistance in using them appropriately. There is opportunity for improving the method mix to more closely adapt to the changing needs of families (e.g., long acting methods for those who have completed their families);
- STI's will require behavior changes and increased use of condoms, but the treatment of current infections will also be required. Antenatal clinics will need to begin screening women for STI's in order to prevent complications (pelvic infections and transmission of infection to the newborn);
- Adolescents are eager to learn about reproductive health and the rising awareness of the need to educate the younger generation provides a new opportunity to improve the lives of the next generation.
- Regarding HIV/AIDS, Bangladesh has an opportunity to avoid the epidemic if the issue can be addressed rapidly. The nation already has a good surveillance system in place, and through coordinated interventions, the HIV epidemic might be avoided, but the window of opportunity is rapidly closing.

Development strategies

Based on the challenges and gaps that have been identified in the policies, programs and on-ground reality, strategies and priorities must address the reproductive health issues with major emphasis on safe motherhood, reduction in MMR, improvement in family planning acceptance and performance rate, and prevention and treatment of sexually transmitted infections. The major emphasis is given on including adolescents and men into reproductive health programs. Continued efforts to improve family planning programs with appropriate targeting of services are likely to be effective. The education level of both husband and wife has a direct impact on reproductive health. Research and studies have repeatedly identified educational background as a key determinant in issues like reproductive behavior, fertility, maternal mortality, infant and child mortality, etc.

The Government has made major strides in making primary education compulsory for girls and providing stipend at secondary and higher levels. These initiatives are also yielding tangible results in empowering women and in increasing the age of marriage and childbearing. The GoB has introduced a quota system in public administration under which 10% of gazette and 15% non-gazette posts are kept reserved for women. Sixty percent of the primary school teacher posts are reserved for women (Barkat, Abul, et al., 1999).

In the field of population control the main approaches and policies that will result in delaying marriage revolve around education and employment. Increase of average age at female marriage is likely to be the most productive intervention to reduce the future impact on population momentum. The issue of child survival also needs to be given a very high priority. The most immediate determinants of further fertility decline are contraceptive practice, abortion use, breastfeeding, and marriage or cohabitation patterns. Regarding contraceptive practice, a greater variety of methods are needed in Bangladesh, ideally with at least one long-term method and one short-term method being provided to at least half of the population. Furthermore, a better understanding of the reasons for reluctance of clients to use any clinical methods is needed.

In determining where their efforts should be focused, planners should make more use of information on the unmet need for and intention to use family planning. This should be seen not only in relation to the clients but also as a reflection of coverage and quality of family planning services. This would be a productive approach to bridging the gap between desired family size and actual fertility.

Education gives women a sense of confidence and status to think, discuss and reach decisions on matters pertaining to themselves within the family. The BDH Survey 1999-2000 shows that women who have no formal education have an average of 4.1 children, while women with at least some secondary education have an average of 2.4 children. Despite the modest achievements in the education sector, a big gap still remains between the number of educated males and females in this country. The BDH Survey also shows that a substantial gap exists between urban and rural education status. The proportion of urban men and women with some secondary education is almost twice that of rural men and women. However, it is encouraging to note that the male-female and urban-rural gap in school attendance of children (6-15) has become virtually non-existent.

As the plateauing TFR is a big concern for Bangladesh, the long term policy and strategy of HNPSP will emphasis a more appropriate method mix and increasing proportion of clinical and terminal methods. HNPSP also envisages to improve the quality of FP services through the revival of the doorstep services and increasing social awareness on FP services. HNPSP plans to improve access clinical services by offering high quality services in major hospitals in addition to Upazila, MCWC and UHFWC (MOHFW, May 2003).

Though much information is available on the experience and situation of maternal health in Bangladesh there is a need for some specific investigation. These will help in clarifying issues and contribute to policy and strategy implementation. Research is particularly needed (MOHFW, Oct 2001) to define:

- Modalities for improving Quality of Care and retention of trained personnel in the remote districts and in Upazila Health Complexes;
- Factors that will enhance utilization of antenatal care (ANC) and skilled attendance at delivery;
- Modalities for encouraging un-employed nurses to take up midwifery as a profession and link to referral facilities;
- Issues and options related to zero tolerance on VAW;
- The GoB has laid down matrices for strategy development with clear objectives up to 2010 and priority actions to strengthen the provision of essential (including emergency) obstetric care and improve utilization of services and ensure accessibility of appropriate and safe maternal health services by skilled providers at all levels of service delivery (ibid.) including the community/household level.

The priority action areas in the field of improving reproductive health as identified by ICDDR,B are:

- Improving emergency and essential obstetric care and ensuring safe motherhood;
- Improving family planning services including developing services for men as well as women;
- Meeting the needs of adolescent reproductive health;
- Prevention and treatment of STI/RTI/HIV/AIDS;
- Minimizing the need for and improving post-abortion care;

- Developing programs to increase male involvement in reproductive health;
- Improving newborn care;
- Understanding the issue of violence against women in the social context and developing public health strategies to reduce it.

To set priorities in addressing the population problem more research and investigations will be required along with a good understanding of issues that affect population science, i.e.:

- Investigations into fertility decline rate in Bangladesh, understanding how to reduce fertility rates to replacement level or below, and how to minimize the impact of population momentum through social interventions;
- Understanding adult health problems, including non-communicable diseases including how families provide the necessary resources, both in terms of financial and social support, to deal with the growing health demands of an ageing population;
- Understanding the economic and social forces motivating out-migration from rural areas. This understanding is linked to monitoring of changes in the family structure, especially in terms of social and financial support for family members remaining behind in the rural communities;
- Collaborating with other surveillance systems through a network to improve the capacity of such systems to develop and monitor interventions for better management of health and population challenges in other countries;
- Understanding the relation between family planning programs and abortion in order to minimize the latter;
- Understanding as well as developing tools for monitoring health equity, especially in relation to rapid population growth and urbanization.

As a multi-sectoral concern, population stabilization requires integration of population factors into the activities of health, education, women's development, urbanization, housing, environment, poverty alleviation, elimination of social and economic disparities, etc. Policies and strategies of these sectors have to be consistent with the goal of population stabilization and socio-economic development. GoB services need to integrate population variables in the development plans and policies of all relevant ministries in order to make public policies more population focused.

The population and development strategies will emphasize the following four areas:

- Migration and urbanization
- Coordinated collection and use of data
- Population and environment
- Welfare services for the elderly and poor

Policy Reforms

In the evaluation report of the MoHFW about HPSP 1998-2003 (Status of Performance Indicators 2002) published in January 2003, the GoB addressed the major policy issues with a view to decide the role of the Government as to whether it should primarily be a regulator and maker of policy, or mainly be a service provider. This issue is particularly relevant at the upazila level and below where many alternative service providers exist, and NGOs in particular collaborate with the Government in joint service delivery activities. This is happening without any formal GoB-NGO strategy or policy, although the development of such a strategy was anticipated under HPSP.

The Bangladesh Family Planning Program is at the initial stage of a big structural change. However, as policy decisions have not been implemented so far nor has the revised roles and responsibilities been clearly defined and communicated to all staff, certain amount of confusion and uncertainty prevails among the staff at thana level. This has led to a slowing down in promotional efforts and decline in program performances, particularly in clinical services.

Conclusion

Like most developing countries, Bangladesh faces difficult challenges caused by poverty, malnutrition, and poor health, poor performance of health system, and inadequate and/or unsustainable health care financing.

Bangladesh is the eighth most populous country in the world with a population of around 130 million and the highest population density in the world. It is one of poorest countries with a per capita income of around US\$380. The costs incurred by families in seeking critical health services acts as a deterrent to seeking care. As a result of overcrowding, poverty, and poor access to health services, infectious diseases and malnutrition are common (ICDDR,B., 2002).

Reproductive healthcare encompasses a wide variety of issues like safe motherhood, family planning, and adolescent health, STI/RTI, HIV/AIDS, maternal nutrition, abortion care and violence against women.

Unless a coordinated programmatic action is implemented and monitored for evaluation of the ground level success, no real achievement is possible in the field of reproductive health. While the country's achievement in this field has been reasonably successful against the backdrop of financial, social, bureaucratic and other constraints, previous programs have yielded visible results. Women's ability to come out of the home to avail services from community centers is quite encouraging.

A Population Council study (Khan M.E et al., 2000) indicates that Bangladeshi women are relatively more empowered today than 10 year ago and are in a better position to take decisions about their reproductive goals and contraception than their sisters in India or Pakistan. The study also indicates that discontinuation of home visits by FWAs could adversely affect motivation and provision of contraceptive services to younger couples (newly married and low parity women). Lack of access to contraceptive could become a serious bottleneck in the acceptance of contraception. The study also indicates that prevalence of domestic and sexual violence is of a fairly large magnitude. Such gender-based violence not only has serious consequences for women's health but also reduces their ability to avail services from clinics located outside the villages. With regard to family planning, the use of long acting, low cost clinical methods of contraception are declining, and temporary methods have high discontinuation rates. Better systems are needed to increase long acting methods and to improve continuation of temporary methods.

In the context of Bangladesh one negative aspect of service delivery in general is the growing inequality among certain important services. When the rich use these services more than the poor, it indicates that the system is not working as intended. This socio-economic inequity is particularly prominent where higher-level medical staffs are involved. Health and population activities have matured in Bangladesh and families are less reliant on household delivery of services. Increased mobility of women and greater awareness of available services has created a demand, and clients manage to obtain services from one source or another when their usual source is removed or restricted. Greater attention and research are required with regard to clients' needs in future programs. A number of examples of service delivery activities have continued to improve because of the existence of committed staff at the MOHFW, including at the Line Director level, and continued technical support from collaborating agencies.