Policy Discourse and the Paradigm Shift in Reproductive Health in Bangladesh

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By

Tehmina Ghafur

Cambridge Scholars Publishing

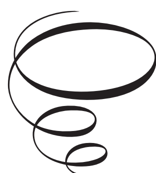

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TABLE OF CONTENTS

Preface vii

Abbreviations ix

Chapter One 1
Introduction
- 1.1 Background and Rationale 1
- 1.2 Research Questions 5
- 1.3 Objectives and Scope of the Study 6
- 1.4 Significance of the Study 8
- 1.5 Research Methods 8
- 1.6 Theoretical Framework of the Study 13
- 1.7 Conceptual Framework of the Study 21
- 1.8 Study Outline 23

Chapter Two 26
Health System and Reproductive Health Issues in Bangladesh
- 2.1 Delineating the Health System 26
- 2.2 Logistic Management System of the Government 34
- 2.3 Regulatory and Statutory Bodies for Health Services 35
- 2.4 Major Reproductive Health Care Issues 36
- 2.5 Reproductive Health Issues 40
- 2.6 Summary and Assessment 40

Chapter Three 42
Policy Discourse in the Family Planning and Maternal Child Health (FP-MCH) Regime
- 3.1 Contextualizing Policy Development in the Family Planning and Maternal Child Health-Based Regime 42
- 3.2 Legacy of FP-MCH Program 46
- 3.3 Policy Framework in the FP-MCH Regime 48
- 3.4 Summary and Assessment 80

Chapter Four 85
Policy Discourse in the Reproductive Health Regime:
The Reformist Approach
4.1 Contextualizing Policy Development in the Reformist Reproductive Health Regime 85
4.2 Policy Framework in the Reproductive Health Regime with a Reformist Approach 89
4.3 Policy Framework *vis-à-vis* the Implementation Scenario of Reproductive Health Program.. 102
4.4 Reproductive Health Policies and Programs: Issues, Gaps and Challenges 105
4.5 Summary and Assessment 112

Chapter Five 116
Policy Discourse in the Reproductive Health Regime:
The Conformist Approach
5.1 Contextualizing Policy Development in the Reproductive Health Regime with Conformist Framework 116
5.2 Policy Framework in the Conformist Reproductive Health Regime ... 119
5.3 Policy Framework *vis-à-vis* Scenario of Health, Nutrition and Population Sector Program (HNPSP)................................... 129
5.4 Reproductive Health Policy and Program Issues, Gaps and Challenges 131
5.5 Summary and Assessment 142

Chapter Six 146
Contemporary Policy Issues and Program Implementation Challenges:
An Analysis of Views and Opinions of the Policy Actors
6.1 Major Policy Issues 147
6.2 Strengths and Weaknesses of the Reproductive Health Program... 172
6.3 Future Directions 173
6.4 Synopsis of the Opinions of the Policy Actors 176
6.5 Summary and Assessment 179

Chapter Seven.. 183
Conclusion
7.1 Summary of Study Findings 183
7.2 Revisiting Research Questions.. 185
7.3 Relevance to the Conceptual Framework of the Study 194
7.4 Epilogue 196

References 197

PREFACE

Health and population policies and programs in Bangladesh have evolved in the context of global discourses and the “national mood” on health and population issues. Policy processes have involved the political process at different levels. The donor-dependent health and population sector has mostly relied on policy prescriptions from donors. It was claimed that major policy ideas and changes in the health and family planning sector had been introduced by external sources. Often the changes were incremental in nature and built on the previous policies, and were often radical.

This study aims at mapping and analyzing the development of policy discourses relating to reproductive health care in Bangladesh with a view to examining if there has been a paradigm shift in the policy frameworks and assessing complementarities and inconsistencies within the policy framework for addressing reproductive health.

The analysis of policy discourses has been made along three policy regimes identified by the study: a) the Family Planning-Maternal and Child Health (FP-MCH) policy regime; b) the reproductive health policy regime with a reformist approach; and c) the reproductive health policy regime with a conformist approach. It has analyzed the policy frameworks of the three regimes through the lens of a rights-based approach to health in terms of freedom and entitlement. Policy frameworks have been analyzed with a view to examining how policies, strategies and interventions evolved under the influence of major actors and factors promoting “freedom” in terms of self-determination, i.e., the state of being free from coercion, restraint and discrimination; and ensuring “entitlement” through affecting the availability of, accessibility to, and quality of maternal health and family planning services.

This book has its origin in a Ph.D. thesis submitted to the University of Dhaka in July 2012. I am indebted to my Ph.D. examiners, who all made helpful, acute and provocative suggestions and comments.

I am grateful to many individuals and institutions for their assistance and cooperation at various stages of this research. To my supervisors, Professor Dr. Salahuddin M. Aminuzzaman and Dr. Ubaidur Rob, I owe a special word of thanks for the instrumental role they played in encouraging me to complete this thesis. Without their guidance, critical

comments, insights and advice at different stages of my study, it would not have been possible to complete this thesis. Further, I am indebted to those who have read and commented on all or part of the thesis.

I am very grateful to all those who so kindly consented to be interviewed and give their precious time for the lengthy interviews. The information and valued opinions they communicated have immensely aided in building the argument of the thesis.

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I especially owe my husband Professor Dr. Borhan Uddin Khan for his constructive suggestions, sincere support and continuous encouragement during the entire period of the study. My son deserves special thanks for the sacrifice he made by sparing me for the work. His curiosity and inquisitiveness about my study have been a constant source of inspiration and encouragement for me.

I would like to express special gratitude to my parents and all other family members for the moral support they have extended during the course of the study. The support and encouragement of my family members have been a great source of inspiration for my work, and a simple acknowledgment can hardly express my feelings.

ABBREVIATIONS

ABCN	Area-Based Community Nutrition
ADB	Asian Development Bank
AFPOs	Assistant Family Planning Officers
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic Health Survey
BHW	Bangladesh Health Watch
BINP	Bangladesh Integrated Nutrition Project
BMDC	Bangladesh Medical and Dental Council
BMMS	Bangladesh Maternal Mortality Survey
BNC	Bangladesh Nursing Council
BNP	Bangladesh Nationalist Party
BPC	Bangladesh Pharmacy Council
BWHC	Bangladesh Women Health Coalition
CDD	Control of Diarrheal Diseases
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CIDA	Canadian International Development Agency
CMSD	Central Medical Store Department
CPR	Contraceptive Prevalence Rate
CRHCC	Comprehensive Reproductive Health Care Centers
CRC	Convention on the Child Rights
DD-FP	Deputy Director Family Planning
DFID	Department for International Development
DFMHVS	Demand-side Financing Maternal Health Voucher Scheme
DGFP	Directorate General Family Planning
DGHS	Directorate General Health Services
DPT	Diphtheria, Pertussis and Tetanus
ECNEC	Executive Committee of the National Economic Council
EmOC	Emergency Obstetric Care

EPI	Expanded Program on Immunization
ESD	Essential Services Delivery
ESP	Essential Service Package
FP	Family Planning
FPIs	Family Planning Inspectors
FP-MCH	Family Planning Maternal Child Health
FWAs	Family Welfare Assistants
FWVs	Family Welfare Visitors
FWVTIs	Family Welfare Visitors Training Institutes
GAD	Gender and Development
HACs	Health Advisory Committees
HAPP V	Health and Population Project V
Has	Health Assistants
HEB	Health Education Bureau
His	Health Inspectors
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HNP	Health Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Program
HPSP	Health Population Sector Program
HPSS	Health and Population Sector Strategy
HUFs	Health Users' Forums
ICCPR	International Covenants on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IEM	Information Education and Motivation
IFA	Iron Folic Acid
IMF	Monetary Fund
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
i-PRSP	Interim Poverty Reduction Strategy Paper
IUD	Intra Uterine Device
Mas	Medical Assistants
MCH	Maternal Child Health
MCWCs	Maternal and Child Welfare Centers
MDGs	Millennium Development Goals
MHVS	Maternal Health Voucher Scheme
MIS	Management Information System

MMR	Maternal Mortality Rate
Mos	Medical Officers
MO-CC-MCH	Medical Officer for Clinical Contraception and Maternal Health
MoHFW	Ministry of Health and Family Welfare
MoHPC	Ministry of Health and Population Control
MoLGRD	Ministry of Local Government and Rural Development
MO-MST	Mobile Sterilization Team
MR	Menstrual Regulation
MTP	Medical Termination of Pregnancy
MTR	Mid-Term Review
NGOs	Non-Government Organizations
NHP	National Health Policy
NIPORT	National Institute of Research and Training
NNP	National Nutrition Program
NPC	National Population Council
NRR	Net Reproduction Rate
OGSB	Obstetric and Gynecological Society of Bangladesh
Ops	Operational Plans
PCFPD	Population Control and Family Planning Division
PIP	Program Implementation Plan
PNC	Postnatal Care
PRSP	Poverty Reduction Strategy Paper
PSTC	Population Services and Training Center
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SBAs	Skilled Birth Attendants
SCs	Satellite Clinics
SIP	Strategic Investment Plan
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THCs	Thana Health Complexes
TT	Tetanus Toxoid
UDHR	Universal Declaration of Human Rights
UFPO	Upazila Family Planning Officer
UHCs	Upazila Health Complexes
UHFPOs	Upazila Health and Family Planning Officers
UHFWCs	Union Health and Family Welfare Centers

UMIS	Unified Management Information System
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNO	Upazila Nirbahi Officer
UPHCP	Urban Primary Health Care Project
USA	United States of America
USAID	US Agency for International Development
VDP	Village Defense Party
WHO	World Health Organization
WID	Women in Development

CHAPTER ONE

INTRODUCTION

This study aims at mapping and analyzing the evolution of policy discourses relating to reproductive health services in Bangladesh. The study examines how far the policy frameworks have reflected a paradigm shift toward a rights-based reproductive health program. It also investigates the complementarities and inconsistencies within the policy frameworks for addressing reproductive health of the population.

The following sections give an account of the justification for the study, place the research questions, objectives and scope, highlight the significance, present the research methodology, draw the theoretical and conceptual framework and lay down the outline of the study.

1.1 Background and Rationale

The prioritization and allocation of value are embedded in the policy process because policies are founded on goals and objectives. Policy process always involves choosing between and among competing alternatives. Public policies deal with the allocation of public resources, and have to set their priorities to reducing the inequities in provisioning goods and services. The stakes are much higher, and thus public policies not only invoke debates and arguments but also involve a complex political process (Blank and Burau 2004). Responsive public policies embody democratic values like participation, transparency and accountability in order to resolve the competing and often conflicting claims about the use of public resources (Roberts et al. 2004).

Health care is considered one of the most controversial public policy issues (Roberts and Reich 2002; Barker 1996; Blank and Burau 2004; Lawn et al. 2006; 2008). Controversies centering on health care largely stem from the differential valuing of health care by societies at large. Many argue that health care is a right and some see it as expenditure while others consider it an investment (Barker 1996). Conflicts emerge when resources are to be allocated among contending groups of health services i.e., a particular type of health service, a specific type of disease, etc.

(Roberts and Reich 2002: 1055–56; Blank and Burau 2004: 17; 107; Lawn et al. 2006: 1474–75; 2008: 919–20). Frequently sought ideas and values like efficiency, human rights, cultural respect, equity and individual choice lead to different policy outcomes (Roberts and Reich 2002: 1055). Governments struggle over issues like coverage, access, equity, etc. in health services but at the same time are confronted with the challenge of cutting down on health care expenses and allocating resources to other valued social sectors.

Health care policies have been defined as "the network of interrelated decisions which together form an approach or strategy in relation to practical issues concerning health care delivery" (Barker 1996: 6). This network has also been referred to as the "course of action proposed or taken by governments that impact on the financing and/or provision of health services" (Blank and Burau 2004: 16). Non-action by the government in any area of health care or the health system has also been claimed to be a part of government policy (Blank and Burau 2004: 16).

Health and population policies and programs in Bangladesh have evolved in the context of global discourses and the national mood on health and population issues. Policy processes have involved the political process at different levels. The donor-dependent health and population sector has mostly relied on policy prescriptions from donors. It has been claimed that major policy ideas and changes in the health and family planning sector were introduced by external sources (Buse and Gwin 1998; Rob et al. 2005; World Bank 2005a; Chowdhury and Osmani 2010). Often the changes were incremental in nature and built on the previous policies, and were at times radical (Jahan 2003; MoHFWa 1998).

The reproductive health program of Bangladesh, as in many other developing countries, has its legacy in the family planning program of the past, the only program intervention of the population policy in Bangladesh. Other elements of population policy, i.e., migration, health and urbanization, have not been adequately integrated into its implementation strategy.

The prime objective of the family planning program as directed by the policy documents has been fertility reduction. The range of activities and strategies within the family planning program of Bangladesh were intensified and also varied over time, and the program has been evaluated only in terms of its impact on fertility reduction. Monitoring has been primarily done on the basis of the increase in contraception users. Many have lauded the family planning program of Bangladesh for its commendable success in fertility reduction, without it being accompanied by a substantial improvement in the socioeconomic condition of the

country (Cleland et al. 1994; Carty, Yinger and Rosov 1993). Again, many of the activities and strategies, particularly the method-specific targets and incentives-disincentives within the family planning program, have raised serious controversy among different groups (Sen et al. 1994; Dixon-Mueller 1993; Hartmann 1987; Hartmann and Standing 1989).

In the mid-seventies, the government integrated the maternal child health (MCH) services with the family planning services. Since then the family planning program in Bangladesh has changed from a uni-purpose program into a family planning and maternal child health program (FP-MCH) (World Bank 1979: 6). The neglect of maternal health had been a long-standing issue in the realm of the FP-MCH program (Gill and Ahmed 2004; Simmons, Koening and Huque 1990). Maternal mortality remained very high even after the start of the "reproductive revolution" in the early nineties.

After the International Conference on Population and Development (ICPD) in 1994, along with the global shift in the area of health and population, there was a major policy shift in Bangladesh from FP-MCH to reproductive health (Jahan 2003). Such a major shift from a target-driven family planning program to broad-based reproductive health called for massive changes in the policy focus, program design and strategic interventions. Like in many other countries, this shift has not been very smooth; many of the policy shifts done only on paper; and many were thwarted with implementation challenges. Reproductive health is conceptually and qualitatively different from the previous stand-alone vertical programs and requires a complete change in the policy orientation, program design and management system, including monitoring and evaluation. Thus, the provisioning of reproductive health services in a resource-poor setting like Bangladesh has thrown big challenges before the government, such as the addition of new services, up-gradation of facilities, training of service providers, introduction of appropriate program design including monitoring system, etc.

The move toward reproductive health has necessitated changes in the program direction more than ever before. Under the new realm of reproductive health, the government has introduced various new programs, arrangements and measures to address the reproductive health program challenges of the country (MoHFW 1998). While some of these changes have been hailed for broadening and strengthening the program, some changes have been blamed for causing disruption in its implementation (Jahan 2003; Islam 2003). Some have claimed that this disruption resulted in the plateauing of the total fertility rate at the level of 3.3 for several years (Mabud, 2007; Islam 2003).

Against this backdrop, some fear that family planning efforts will be diluted if broader reproductive health services are provided. On the other hand, advocates of reproductive health claim that good family planning services cannot be provided without due attention to reproductive health needs. For example, reproductive tract infections (RTIs) are very common among women and the management of these infections is critical for the safe and effective provision of contraceptives. Further, it has also been argued that while providing comprehensive reproductive health services is a desirable goal, the extent to which it can be delivered without compromising the quality and effectiveness of the services must be considered. Therefore, some have argued for prioritizing and developing a phased approach with an incremental addition of health intervention that requires greater skills and resources (Pachuri 1999). The real challenge is to design an available and accessible cost-effective package of good quality services in the context of the respective countries.

The reproductive health program of Bangladesh is yet to address the very basic reproductive health issues of its people. Reproductive health services are still confronted with the issue of availability of services. Equality issues like accessibility and quality are far-reaching demands. Good progress has been made in curbing maternal mortality in the last decade, from 322 in 2001 to 194 in 2010 per 100,000 live births (NIPORT et al. 2011: 19), and this is reflective of the government's commitment toward reducing maternal mortality. However, maternal health care needs to be significantly improved for a further improvement in the maternal health situation. Differentials in maternal health status and maternal health need to be lessened.

Even though the determinants of health are broad-based and not located only within the health sector, it is argued that a good policy even in a resource-poor setting can contribute greatly to promoting the health of the people and *vice versa*. Again, sound policies on paper without effective implementation do not have any practical utility. Successful policy reforms demand a set of interdependent and mutually reinforcing interventions, especially when the policy is making a major shift from past practice in one go. While the operation of the health sector plays the most vital role in affecting the health of the population, health status is also very much affected by forces in other sectors (WHO 1986). Therefore, a comprehensive approach to the health sector requires cross-sectoral coordination.

Given this context, it is important to examine: a) whether adequate policy attention was given to increase the availability of and accessibility in, and the quality of reproductive health services; and b) whether policy

frameworks have been appropriately designed to address the reproductive health needs of the population.

A comprehensive study on reproductive health policies and programs in the context of Bangladesh has been lacking, particularly a systematic academic work on reproductive health policies and programs through application of a specific framework or concepts relevant for the study of reproductive health care policies and programs. Most of the works so far done on reproductive health policies and programs in Bangladesh have been confined to a particular policy or program at a given time (Sundewall, Forsberg and Tomson 2006; Jahan 2003; 2007; White 2007; Mridha, Anwar and Koblinsky 2009; Chowdhury and Osmani 2010). Some studies were too broad to engage in academic discourse. Most of the studies on population policies and family planning programs in Bangladesh have been conducted from demographic perspective. However, the most common deficiency of most of these studies has been that they did not use any theoretical framework or concepts for examining the policies and programs.

This study intends to contribute in the knowledge of reproductive health policies and programs in Bangladesh through a systematic examination of its reproductive health policies and programs with particular reference to family planning and maternal health services through application of the concepts of a rights based approach to health policies and programs. The study for the first time in Bangladesh attempted to examine reproductive health services in general and family planning and maternal health care services in particular in the context of the respective policy frameworks and policy environment through the lens of the concepts of "freedom" and "entitlement" as they are applied by the rights based approach to health policies and programs. This study has segmented the policy regimes on the basis of their philosophical notions to allow a better comparison between and among various policies and programs along broader timelines and major policy shifts. Further, the stakeholders' opinions obtained on various policy and program issues are a unique feature of this study.

1.2 Research Questions

In view of the above context, this study attempts to address the following questions.

1) How have the policy frameworks[1] of various policy regimes[2] affected the "availability of, accessibility to, and the quality of reproductive health services"[3] in Bangladesh?
2) How far has there been a paradigm shift relating to reproductive health services in Bangladesh?
3) How have major policy actors[4] and factors[5] influenced the policy frameworks, changes and shifts?
4) Have the policy frameworks been appropriately interconnected to achieve the policy objectives?

1.3 Objectives and Scope of the Study

This study aims to examine the changes and shifts in policies relating to reproductive health services in Bangladesh. The objective has been to explore whether such changes were directed to respond to the reproductive health challenges of the country. This study intends to give an account of the development of the policy regime relating to reproductive health from the country's independence in 1971 to 2011. It aims to reveal and examine the complementarities and inconsistencies within the policies, and between and among the policies, strategies and program interventions. Further, the scope of the contemporary policies and programs to address reproductive health challenges in Bangladesh has been analyzed.

The study analyzes the policies and programs relating to the family planning and maternal health components of the reproductive health care services from independence in 1971 up to 2011. Thus, an analysis of policies or programs relating to other reproductive health services or after

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[1] "Policy framework" in this study refers to a set of policies, strategies and interventions to form an approach for guiding and directing the program.

[2] "Policy regime" in this study refers to policy periods with similar content, focus, approach and incremental changes. The study has categorized three major policy regimes: a) FP-MCH based policy regime; b) reproductive health policy regime with a "reformist approach"; and c) a reproductive health policy regime with a "conformist approach".

[3] For a detailed account on the availability of, accessibility to and quality of reproductive health services, see the conceptual framework of this chapter.

[4] "Policy actors" in this study refer to individuals, groups or networks, agencies that influence the policy process either by giving input or by bargaining in the policy process. They include both state actors and non-state actors.

[5] "Policy factors" in this study refer to the situation or circumstances at the national and international levels, including political, economic, social and cultural influences.

2011 is beyond the scope of the study.[6] The study confines itself to examining policies relating to the family planning and maternal health component of reproductive health care services. The study discusses and analyzes policies relating to child health services to the extent deemed relevant for analyzing maternal health services. It addresses its questions through an analysis of policy discourses and the opinions of the policy actors. Thus, beneficiary or impact assessment is beyond the scope of the study.

The study further investigates how policy framework affects entitlement to services in terms of availability of and accessibility to, and quality of reproductive health services, and thus it brings in the implementation scenario of the respective policy regime to the extent deemed necessary for analyzing how policy framework affects the implementation of the program. The purpose of the study is not to examine how implementation achievement or failure affects the availability of the services. As the study examines the policy framework in terms of "freedom" and "entitlement" as per the rights based approach to health policies, it brings in governance issues relating to rights based approach to policies like accountability to the extent it is connected to the freedom and entitlement issues.

Finally, the study examines how complementarities and inconsistencies between and among policies, strategies and interventions affect the achievement of policy objectives through affecting the availability of, accessibility to, and quality of care of reproductive health services. Thus, other factors affecting the availability of, accessibility to, and quality of care of reproductive health services are beyond the scope of the study.

[6] The study is time-bound like most other studies. Since the completion of this study, new policies, plans and programs relating to reproductive health have been reinstated. The subsequent policies and plans (health policy, population policy, sector plans) for reproductive health care in general and family planning services in particular have the similar features (i.e., focus, content, strategy, design, management structure for program implementation) and similar issues as those of the last policy regime of this study. Thus, the policy and program issues raised, observations made and inferences drawn in this study are very much relevant for the present day situations and contemporary policies, plans and programs relating to reproductive health in general and family planning and maternal health in particular. Therefore, this study is very much relevant to the present day policy and program issues and environment.

1.4 Significance of the Study

The rights-based approach is gaining currency in contemporary policy frameworks. This study, in light of its analysis of different policy regimes relating to reproductive health, shows how the rights-based approach promotes reproductive health in a better and sustained way. This study will add critical insight into the entire gamut of policy changes in reproductive health from the rights-based approach to health. The study will also contribute to the finding of inconsistencies between and among policy frameworks with respect to rights-based reproductive health, and thus will be helpful in giving future directions for rights-based reproductive health care policy making.

1.5 Research Methods

The study, based on its conceptual framework, investigates its research questions at two levels using two different methods. It has primarily used content analysis and the in-depth interview method to gather data and information.

1.5.1 Content Analysis

Content analysis was done for: i) mapping the policies; ii) analyzing policy discourses in the context of broader policy environment; and iii) examining the policies in terms of "freedom" and "entitlement" and the complementarities and inconsistencies within and among the policy frameworks.

For the examination of the policy discourses, the entire period was divided into three policy regimes. These policy regimes were categorized according to the time lines of major policy documents and the major policy shifts.

The contents of the documents reviewed, among others, include the following:

a. Long-term plans of the government, i.e., i) Five-Year Plans;[7] (the First Five-Year Plan (1973–78) to the Fourth Five-Year Plan (1990–

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[7] The five-year plan is the macro-level plan prepared by the Planning Commission of Bangladesh. It is based on various input, output and projection models. All development activities, programs and project interventions of the government and private sector are guided by the plan. It provides broad outlines of all the sectors within which concerned ministries operate. Annual development programs are implemented in accordance with the five-year plans.

95) ii) the Two-Year Plan (1978–80); iii) Millennium Development Goals (MDGs); and iv) the Poverty Reduction Strategy Paper.

b. Policy documents, strategic plans and program implementation plans of the concerned ministries or sectors like the : i) Bangladesh Population Policy, 1976; ii) National Drug Policy, 1982; iii) Health and Population Sector Strategy (HPSS), 1997; iv) National Health Policy, 2000; v) Health and Population Sector Program 1998–2003: Program Implementation Plan; vi) Health Population Nutrition Sector Program (HNPSP), July 2003–June 2006; vii) HNPSP revised 2003–2010; Bangladesh Population Policy, 2004; viii) National Strategy for Maternal Health, 2001; and ix) National Communication Strategy for Family Planning and Reproductive Health, 2008.
c. Reports of the concerned ministries; mid-term reviews and annual performance reviews of the government; independent review reports, project appraisal reports, project evaluation reports, policy briefs and notes produced by different international donor agencies, i.e., the World Bank, UN bodies and specialized research institutions.

The contents of other secondary sources that have been reviewed include published research articles, review articles, research monographs and conference papers relating to reproductive health programs and policies.

1.5.2 In-depth Interview

To supplement the analysis and findings through the content analysis of all the available literature, this study has conducted in-depth interviews with two categories of policy actors, to gather their views and opinions on major policy issues that have emerged through an analysis of policy discourse in the three policy regimes.

The purpose was twofold: i) to examine how the views and opinions of the policy actors, i.e., state actors and non-state actors, reflect on the contemporary policy frameworks; and ii) to find a common thread to resolve conflicting claims on various policy issues and contribute to future policy directions. The interviews were conducted between April 2011 and December 2011.

The state actors were drawn from the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). They included top to mid-ranking officials responsible for guiding, directing, monitoring and implementing the government reproductive health program. The state actors consisted of: a) the policy makers [i.e., executive heads of the Ministry of Health and Family Welfare (MoHFW), the joint chief of the MoHFW, chiefs of the DGHS and the DGFP]; b) senior officials

(i.e., respective line directors, divisional and district-level chiefs of DGHS and DGFP); and c) mid-level officials [i.e., mid-level program managers assigned with the operation, management and implementation of the relevant operational plans, and district-level program managers and medical officers (MOs) of the DGHS and the DGFP at district hospitals and Maternal and Child Welfare Centers (MCWCs), respectively].

However, some alterations had to be made in the original list of interviewees from among the state policy actors because of their non-availability i.e. refused to give interviews and could not be reached for seeking appointment for interviews. This also included a few top level policy makers.

Ten districts were chosen from four out of the seven divisions of the country. These four divisions are Dhaka, Chittagong, Khulna and Sylhet. Of these, Khulna is a high-performing division, Chittagong and Sylhet are low-performing divisions and Dhaka is an average performer. Four districts were chosen from Khulna, two from Chittagong, two from Sylhet and two from Dhaka. Of the total ten districts, six are old districts and four are new districts. These districts are: Jessore, Jhenidah, Magura, Khuna, Sylhet, Maulavibazar, Chittagong, Noakhali, Narayanganj and Comilla.

In-depth interviews were held with a total of 65 state policy actors.[8] They are: 8 policy makers (executive heads of MoHFW, the joint chief, chiefs of DGHS and the DGFP, including the former ones); 6 line directors of the operational plans of reproductive health services; 4 divisional directors of health and family planning; 20 district-level heads of the DGHS and the DGFP, i.e., civil surgeons (10) and deputy directors (10); 10 mid-level program managers at the national level; and 17 mid-level program managers and MOs at the district level (7 from MCWCs and 10 from district hospitals).

More district-level heads and mid-level managers were interviewed because the rights-based approach calls for a bottom-up policy process.

Political heads of the ministry were not interviewed as state actors because major political parties do not exhibit major ideological differences regarding health and population policy and program issues. Moreover, the policy process in developing countries like Bangladesh is largely dominated by bureaucrats.

Non-state actors included academia, researchers and professionals contributing to the area of reproductive health outside the state machinery. They were drawn from a range of external stakeholders of the policies and programs relating to reproductive health. They are not employed in or do not directly work for the government's health sector. They are key persons who

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[8] For policy actors, see above, section 1.2 Research Questions.

have been actively involved in providing input and support for policy processes or have been involved in bargaining with the government in the policy process in various capacities. This group excludes representatives from donors. Policy actors under this category were identified in consultation with a pool of experts in this field. However, some alterations had to be made because of the non-availability of some persons i.e. refused to give interviews and could not be reached for seeking appointment for interviews. In-depth interviews were held with a total number of 25 non-state policy actors. Among them, 7 were academicians with wide teaching and research experience in the field of health and population, 8 were the chiefs (former and current) of population and health-related national and international organizations, 5 were researchers in the field of health and population and 5 were consultants. All of them had contributed in various capacities to the policy process.

1.5.3 Interview Technique

Interviewees were clearly informed of the research objectives. They were also briefed on the implications of their views and opinions for the study. They were pledged of maintaining anonymity and confidentiality about their personal identifier, i.e. name, specific designation, service delivery point, etc. They were also informed that they could withdraw at any point in time during the interview.

An approximate number of various categories of policy actors were prefixed for the study before the onset of the interviews of the policy actors. However as and when policy actors of a particular category begun repeating similar views and opinions on various policy and program issues no more interviews were taken from that category because data saturation reached on that particular issue.

In-depth interviews were held on thematic issues and concerns. Interviews were held in a conversational style. Policy issues were discussed with the policy actors as they came up in the flow of conversation without following any preset sequencing. The interviewees were allowed to move from one issue to another without any interruption so that the natural flow of conversation was not obstructed. Many interviewees moved from one issue to another, creating a link between and among the issues without any probing. This technique added to the depth of the opinions of the interviewees. Some probing was employed to get more in-depth perspectives on some policy issues. Further, sometimes other policy actors' opinions on some of the issues were discussed with the interviewees to help them formulate their opinions more clearly. It also

helped to grasp their opinion more clearly and to make comparisons between and among the opinions given by different categories of policy actors.

1.5.4 Recording of Responses

Opinions and observations were recorded according to the category of the policy actors and policy issues. Most of the policy actors did not consent to the use of audio recorder and thus hand written notes were taken in paper layouts made for taking issue based notes. The hand notes were expanded on the very day the interviews were held. Interesting comments, statements and claims were immediately noted down for quotes in the appropriate section. Interviewees were sometimes requested to repeat some of their statements and comments for facilitating this process of noting down quotes. Each interviews lasted for forty-five to sixty minutes. Opinions of all categories of policy actors were filtered to fit into the policy issues identified through policy discourse. This process required repeated readings of the transcripts. This was done on a one-by-one basis and was completed on the very day the interview was held. In some of the cases, interviewees were contacted again to verify that their opinions had been grasped appropriately.

1.5.5 Analysis of Interview Transcripts

Patterns and themes were sought in the interview transcripts to locate meaningful categories or themes in the body of information. Patterns and themes emerged through repeated readings of the transcripts and developing logical associations between and among the issues. The perspective for a logical association between and among various issues was developed through analysis of the policy discourse. Thus, some commonalities and differences in opinion on different policy issues were identified by the category of policy actors.

1.5.6 Validation Techniques

The study used the triangulation method for ensuring the validity of the information obtained. Information obtained from one source was cross-checked through another source.

1.6 Theoretical Framework of the Study

The study is premised upon the discourses on justice relating to health and health care and the rights-based approach to health. The following sections elaborate on the theoretical discourses.

1.6.1 Discourses on the Notion of Justice Relating to Health and Health Care

"Ethical doctrines" occupy and merit a special place in the analysis of public policy, especially in policies pertaining to health. Ethical analysis provides important insight to guide policy action in the health sector. "Utilitarianism" has been one of the most dominant theories of justice for over a century, and public policy was dominated by this approach for quite a long time (Sen 2000: 58). It has been one of the leading analytical models of health economics and has occupied a significant space in health policy discourse as a framework of analysis (Ruger 2006: 280). English philosopher Jeremy Bentham is credited for developing utilitarianism as a specific school of thought. He believed that the rightness of any action can be measured by calculating the pains and pleasures it produces. The action that produces the greatest happiness of the greatest number is right (Bentham 1789, cited in Roberts et al. 2004: 42; Roberts and Reich 2002: 1055). John Stuart Mill was one of the greatest proponents of Bentham's philosophy of utilitarianism.

Utilitarianism is embedded in the concept of absolute utility and therefore rationalizes resource allocation and social or institutional arrangements that maximize net social utility. The right to health is justified only if it contributes to the overall maximum of net social utility. Health care would be composed of those factors that maximize net social utility. With the change in utility, it too would change (Ruger 2006: 280–81).

Utilitarianism justifies any action, choice, rule and institution in terms of its consequences. It upholds the value "the end justifies the means" (Roberts et al. 2004: 41). It is also called a consequentialist theory because it is primarily concerned with the consequence of any action or decision. Bentham values each individual's judgment for his or her own happiness. In his philosophy of utilitarianism, all individuals matter equally, thus Bentham's concept of utilitarianism requires adding up everyone's utility level for each policy option and then choosing the policy that leads to the greatest happiness for the greatest number (Roberts et al. 2004: 41; Roberts and Reich 2002: 1055).

According to this theory, an unjust society is the one in which people are significantly less happy together than they need be (Sen 2000: 59). In utilitarianism, policies are evaluated by examining the effects on the total wellbeing of the society. Hence, it does not question the rightness of the means employed to reach a goal and is of the opinion that some individuals can be sacrificed for the sake of others (Roberts et al. 2004: 42-48). However, utilitarian reformers, who question the validity and reliability of arbitrary individual choices, argue for founding policy decisions on objectively defined individual wellbeing by a pool of experts (Roberts et al. 2004: 44). Objective utilitarians rely on expert-determined indexes of health status like the Quality Adjusted Life Years or Disability-Adjusted Life Years for policy decisions on alternative choices (Roberts and Reich 2002:1055).

The utilitarian framework is concerned with the total gain and thus disregards the negative consequences of any action or decision on a particular group or individual, and it is not sensitive to the actual distribution of justice (Sen 2000: 62). It ignores large inequalities in exchange for higher total or average social utility (Ruger 2006: 281).

As opposed to utilitarianism, 'liberalism" focuses on individual rights and the equality of opportunities. Different schools of liberalism focus on different forms of rights but all liberals support some rights, including right to life, liberty and property. They are of the opinion that these rights would guarantee individual liberty and allow people to exercise their own choice without infringing on the state. Liberalism emphasizes an extensive freedom of thought and speech, a limited role and control of government, the rule of law, a market or mixed economy and a transparent system of government. Libertarians are the proponents of a limited role of the state in the protection of individual property rights and individual liberty (Roberts et al. 2004: 49). Thus, they perceive liberty in its absolute form. Libertarians like Robert Nozik deny any social obligation to protect or promote health because increased taxation for provisioning health care by the society or state would violate the principle of individual liberty. Health is not considered as a special good or service. The libertarian approach endorses the fulfillment of civil and political life but not social, economic and cultural rights, with the argument that increased taxation on the wealthy infringes on their liberty (Ruger 2006: 282). Thus, the liberalist notion of the right to life and liberty is incomplete in the sense that it is not founded on the right to health.

"Egalitarian liberals" questioned the notions of liberty and choice propagated by the libertarians for not being able to see the link between making meaningful choices and having resources and power. Egalitarian

liberals argue that the right to choose is meaningless without adequate resources and power. Making meaningful choices is less likely for those who do not have a minimum resource base or other sources of power. The right to access or choose health care becomes meaningless without adequate resources, i.e., money, information, power, etc. Therefore, it has been argued that every individual needs the minimum level of services and resources required to assure fair equality of opportunity. Extremely poor, ill, uneducated or uninformed people do not have the scope to make meaningful choices (Roberts et al. 2004: 49). Rawls' *A Theory of Justice* known as "Justice as Fairness" is built on the notion that primary goods that are natural to want are to be allotted on the basis of fair equality of opportunity (Rawls 1971). Natural goods like health, intelligence and imagination are not on Rawls' list of primary goods, and he argues that no society can guarantee health to its individuals (Ruger 2006: 283). However, in his later work *The Law of Peoples*, Rawls included health care as one of the primary goods (Rawls 1993).

On this point some egalitarians are of the opinion that there should be fair equality in the distribution of resources, and then individuals could buy health care like they do other goods and services (Drowkin 1993). Other egalitarians claim that the state has a special obligation to protect health. Daniels (2008) argues that the "fair equality of opportunity" demands the protection of opportunity. Everyone has a positive right to the minimum level of services needed to assure fair equality of opportunity. Health is different from other goods and services. It has an intrinsic value and therefore is an end itself. It also has instrumental value because good health is a precondition of the normal functioning of people. Health and health care have been claimed to have special moral importance because meeting health needs is necessary for normal functioning. Thus, health protects opportunity or capability, and meeting health care needs safeguards the protection of that opportunity or capability. The fair protection of opportunity or capability requires meeting health demands fairly. Health inequalities are called unjust when they are the consequence of an unjust distribution of the socially controllable factors affecting the health of a population (Daniels 2008: 27–31).

Amartya Sen argues that capability to function should be the central concern of ethical evaluation, not health, wealth, etc. Wealth, health, etc. are instrumental to the capability of people to function. Sen's capability approach is rooted in the freedom of individual. Capability is referred to as the freedom to achieve alternative functioning and this approach to health takes into account both wellbeing and the freedom to pursue wellbeing (Ruger 2006: 274). Capability to function is an indicator of wellbeing, and

the capability to achieving functions is an indicator of the individuals' freedom to pursuing wellbeing.

Thus, Sen makes a distinction between health achievement and the capability to achieve good health. Individuals may or may not exercise their capability to achieve good health. He therefore argues that preventable and treatable illnesses resulting from controllable social factors have a bearing on social justice (Sen 2004 in eds. Anand et al. 2004: 23). Sen opines that society or the state should only be held responsible for health achievements which he calls "capabilities" through the creation of health facilities, and not for individual choices that also have a bearing on health achievements (Roberts et al. 2004: 50). From this perspective, the state is obliged to make health care available to its citizens. This perspective does not deny the state's responsibility to educate its citizens on health issues but rather limits its role to education and information access. For example, education provided on the ill-effects of smoking on health is considered appropriate and falls within the responsibility of the state; however, the state should not go beyond this educational and informational role and should not take more aggressive means to control smoking. In Sen's capability perspective, the aim is to maximize the set of capabilities available to each individual but the level of functioning achieved by individuals should be their choice (Roberts and Reich 2002: 1057).

These scholarly thoughts have founded a claim that a good health system does not only maintain or improve the average health of the population but also has the responsibility to reduce inequalities by giving preference over improving the health of the worse-off. Hence, the objective of a good health system is both goodness and fairness. Goodness implies the best attainable average health of population and fairness implies the smallest differences among different individuals and groups (WHO 2000: 25). Thus, "health as a right" is premised on these notions of social justice, fairness and equality.

1.6.2 Rights-Based Approach to Health

The rights-based approach to health is built upon the international human rights conventions and declarations adopted within the United Nations system. Nevertheless, the Universal Declaration of Human Rights, 1948 (UDHR); the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1965; the International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR); the Convention on the Elimination of All Forms of Discrimination Against Women, 1979

(CEDAW); and the Convention on the Rights of Child 1989 (CRC) are of utmost significance. Article 25(1) of UDHR states:

> Everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care, and necessary social services.

The ICESCR came into force in 1976, making it binding upon the ratifying states to ensure the satisfaction of at least the minimum level of the rights mentioned therein. Article 12 (1) of ICESCR recognizes the right of everyone to the highest attainable standard of physical and mental health. Article 12 (2) elaborates on the measures needed by the state parties for the reduction of stillbirths and infant mortality, and the healthy development of the child; improvement of environmental and industrial hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the provision of all medical services in the event of sickness. The CEDAW and the CRC of 1989 were landmarks in the international legal framework of the human right to health for women and children, respectively.

The Committee on the Economic, Social and Cultural Rights of the United Nations adopted *General Comment No. 14* in 2000, which elaborates on the right to health. It identifies two fundamental dimensions of this right – on the one hand, it entails freedom, i.e., to make decisions about one's health, and on the other hand, it entails entitlement to a system of health care. The freedom dimension of health in *General Comment No. 14* includes the right to be free from non-consensual treatment, such as medical experiments and research or forced sterilization, and from torture and other cruel, inhuman or degrading treatment or punishment. Entitlements include the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and the control of diseases; access to essential medicines; maternal, child and reproductive health; equal and timely access to basic health services; the provision of health-related education and information; and participation of the population in health-related decision making at the national and community levels.

The Committee in *General Comment No. 14* worked out four interrelated and essential elements of the right to health, i.e., availability, accessibility, acceptability and quality. The precise application of these elements depends on the conditions prevailing in a particular state. Availability means and includes functioning public health and health care facilities, goods and services as well as programs in sufficient quantity.

The nature of the facilities, goods and services vary depending on the respective country's developmental level.

Accessibility includes four overlapping dimensions: *non-discrimination, physical accessibility, economic accessibility* and *information accessibility*.[9] Non-discrimination means health facilities, goods and services must be accessible to all, especially to the most vulnerable or marginalized sections of the population without any discrimination on the ground of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation or civic, political, social or other status. Acceptability means all health facilities, goods and services must be respectful of medical ethics and be culturally appropriate, i.e., respectful of the culture of individual, minorities, peoples and communities, and sensitive to gender and life-cycle requirements as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality means health facilities, goods and services must be scientifically and medically appropriate and of good quality, and thus requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. However, quality of care has varying connotations. Quality can be used to mean the quantity of health care services provided. The providers' perspective of quality of care is markedly different from the users' perspective. Health professionals generally perceive quality of care in terms of clinical quality, which refers to the skill of the caregivers, correct diagnosis and treatment decisions and the availability of the right input, i.e., drugs, equipment to carry out appropriate care, existence of appropriate referral systems, etc. The providers' perspective of quality of care has been increasingly integrated with the users' perspective. The utilization of health services is very much influenced by the users' perception of quality of care, which has two dimensions, i.e., convenience of the users and interpersonal dimensions between the providers and users. Users' perspective of convenience generally refers to travel time, waiting time, opening hours, and time needed to get an appointment. Interpersonal dimensions of quality of care include providers' behavioral aspects (Roberts et al. 2004: 116 –17). Social and cultural beliefs, economic constraints and gender also influence users' perception of the quality of care.

Measuring quality of care requires detailed data. Patient's reports are an important mechanism with which to locate quality gaps. Further, outcome indicators like infection rates, operative mortality, etc. are also used as indicators for measuring quality of care (Roberts et al. 2004: 116 –

[9] Italics for emphasis.