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Strengthening Health and Family Planning Services in Low Performing and Hard-to-reach Areas of Bangladesh

Workshop Report

Population Council

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Workshop Report

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April 2008

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AHI	Assistant Health Inspector
BCC	Behavior Change Communication
BRAC	Bangladesh Rural Advancement Committee
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
DD-FP	Deputy Director-Family Planning
DG	Director General
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
EPI	Expanded Program on Immunization
ESP	Essential Services Package
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant
HFWC	Health and Family Welfare Center
HIV	Human Immuno-deficiency Virus
HNPSP	Health, Nutrition and Population Sector Program
IUD	Intra-uterine Device
MDG	Millennium Development Goal
MOHFW	Ministry of Health and Family Welfare
MTR	Mid Term Review
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NGO	Non-Governmental Organization
PLTM	Permanent and Long-term Method
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UHFPO	Upazilla Health and Family Planning Officer
UFPO	Upazilla Family Planning Officer
VDP	Village Defense Party

EXECUTIVE SUMMARY

Although Bangladesh has established a comprehensive physical infrastructure to deliver health and family planning services with a vast network of primary health care facilities in rural areas, the impact of extensive health service network has been much less than expected because these services do not reach all regions effectively. Two divisions, Sylhet and Chittagong, remain the most disadvantaged both in terms of health and population outcomes and access to services, compounded by the poor utilization of facilities in these areas. Moreover, the current health and population sector programs are beset with human resources and infrastructural problems. Against this backdrop, the Population Council organized a workshop to find answers to a key question: how to improve the service delivery in low performing and hard-to-reach areas. The objectives of the workshop were to: (i) review the current and emerging health and family planning issues particularly in low performing and hard-to-reach areas; (ii) identify areas of deficiency in the service delivery; and (iii) develop strategies for improving the performance of the health and population sectors in low performing and hard-to-reach areas. Deliberations and discussions at the workshop were centered on three broad areas: (i) human resources and infrastructure; (ii) BCC and advocacy; and (iii) supplies and logistics.

Current and emerging health and family planning issues

Bangladesh has made significant progress in reducing fertility and population growth as well as reducing infant and child mortality. Bangladesh is performing well in several of the targets of health-related MDGs. However, there remain principal health development challenges which include:

- Attaining the replacement level fertility
- Reducing maternal and neonatal deaths.

Although Bangladesh is yet to reach replacement level fertility at the national level, there is some satisfactory performance at the regional level. Khulna division has reached the replacement level fertility (TFR: 2.2) and in Rajshahi the TFR is 2.4. Sylhet and Chittagong divisions are lagging far behind than other divisions in reducing fertility with concomitant increase in the contraceptive use. In both Chittagong and Sylhet, couples have nearly four children. Similarly, the contraceptive prevalence rate remains substantially low in both the divisions. Furthermore, unmet need for family planning in Sylhet and Chittagong is almost double of Khulna and Rajshahi.

Delay in reaching replacement level fertility will stabilize the population at a larger size and at a later time due to population momentum inherent in the young age structure, creating insurmountable problems in socio-economic development. A major concern is that half of the women become mothers by age 19, which heightens the risk of maternal morbidity and mortality. This group contributes approximately one-fifth of the TFR. There are several compelling demographic reasons for addressing this particular group. The most important one is the size of young population. Approximately 30 million adolescents and youth age 10 to 24 are living in Bangladesh. The size of this age group will continue to grow in the years ahead due to the population momentum. By the year 2020, Bangladesh's population is likely to grow up to 180 million and approximately half of the country's population is expected to

live in urban areas. This shift from rural to urban areas will have significant impact on food production, resource allocation, existing social services and infrastructure. Nevertheless, it is to be noted that the government has been committed to achieve the replacement level fertility and attain the stable population at the earliest possible time.

Improvements over maternal and neonatal mortality are two key issues of health development, which are still unacceptably high. To achieve the Millennium Development Goal of reducing maternal mortality to 143 by the year 2015, the government has introduced an innovative demand-side financing scheme for maternal health care, which is expected to increase the utilization of health facilities for maternity services. Moreover, the government has the sincere intention to expand emergency obstetric care and essential newborn care services throughout the country to improve health outcomes among mothers and infants in the country.

Areas of deficiency in the service delivery

Human resources and infrastructure

Several human resources issues were identified at the workshop, which are considered as barriers to providing quality health and family planning services in rural areas. The key problem identified was the inadequate number of service providers and field workers. Large number of vacant posts at the field level has been identified as the major weakness in the service delivery. There is also the problem of absenteeism, and poor accountability of service providers. Even the available human resources are not distributed equally across regions. Thus, people living in low performing and hard-to-reach areas are yet to have equitable access to services. The government's inability to retain trained providers in the designated position is also apparent. Discontinuation in the training of field-level functionaries and attrition of government field-level staff are jointly likely to pose a formidable challenge for the health system in the coming years.

Service delivery at the community level provides a dismal picture – field workers are not making home visits on a regular basis. These field workers are not routinely supervised and monitored due to lack of officials at the district and sub-district levels. In addition, satellite sessions are not held regularly, a common phenomenon in low performing and hard-to-reach areas.

Several infrastructural problems in service delivery have also been raised at the workshop. There are limited health facilities in remote, hard-to-reach areas. Physical infrastructure in many areas is not in a good condition. Some facilities are found in run down condition, which require renovation. Some are abandoned which need to be made functional. In addition, there are several other infrastructural problems which need immediate attention: lack of electricity, shortage of running water, filthy toilets and no separate toilet for female clients, inadequate cleanliness, lack of waste management, and absence of separate waiting place for females and adolescents.

BCC and advocacy

Insufficient BCC meetings, lack of staff, lack in skills of service providers to use BCC materials, low visitation by field workers, lack of health education session, inadequate local participation, and low utilization of local media were the major problems identified in the areas of BCC and advocacy.

Supplies and logistics

Among the problems identified on supplies and logistics related issues, first and foremost concern was chronic shortage of drugs, contraceptives and equipment. Weakness in the procurement and logistics at the local level was also observed. Other problems identified at the workshop are: supply of uniform pre-packed kits of drugs irrespective of the differences in geography, health outcomes and disease patterns; problem of worn out and insufficient furniture and equipment; limited supply of record keeping materials; absence of proper security system; lack of proper storage facilities at the local level; and difficulty in recovering fund for health and family planning activities from Upazilla Parishad. Targeted BCC materials are not widely available at the upazilla level facility and below. Supply procedure is very lengthy and carrying cost provided is not sufficient.

Recommendations

As a way forward to improve the performance of health and family planning services in low performing and hard-to-reach areas, a special program for two years should be undertaken to address the issues of immediate concern. Strengthening the public health and family planning sectors should be the foremost priority, as public sector makes cheaper services available across the country. Specific recommendations as prioritized at the workshop are as follows:

a) Human resource situation can be improved by filling up the vacant posts of service providers and field workers like FWVs, FPIs, FWAs, AHIs and HAs. Competency and skill development of field workers and other technical staff through refresher training, and reviving the training program for FWVs are important areas of immediate attention too. Most importantly, remuneration can be revised as way to improve field workers' performance and efficiency.

b) Where there is no field worker or there are difficulties in recruitment, volunteers with some incentives should be recruited after being trained. In the areas where qualified individuals are not available for recruitment, private sector including NGOs can be involved with the program. Special attention should be given to *char* areas with special incentives to the workers.

c) Inadequate maintenance of facilities is considered as one of the reasons for underutilization of Community Clinics, Health and Family Welfare Centers and Upazilla Health Complexes. There could be outsourcing for the maintenance of facilities, especially for hard-to-reach areas. Abandoned or run down facilities can be contracted out to private sector or NGOs.

d) Absenteeism at service delivery points should be strictly dealt with. There should be strategies to retain trained providers in designated service delivery points. On the other hand, withdrawal of any service providers working in low performing and hard-to-reach areas in the name of deputation should be discouraged.

e) Infrastructure in low performing and hard-to-reach areas should be renovated or reactivated through the use of local government and active involvement of community members. Revitalization of outreach centers with appropriate field workers can be an alternative in places where there is no Health and Family Welfare Centers.

f) Adequate supply of contraceptives, drugs and logistics should be ensured for providing pro-poor and quality services in low performing areas. The government has to introduce demand-based supply system replacing the standard kit system, which will enable health facilities to receive essential drugs in line with their needs. Other strategies to improve supplies are: addressing the pilferage of supplies and logistics; and local production of contraceptives.

g) In remote and hard-to-reach areas, a medical team with necessary transport system can be employed in order to strengthen the health and family planning service delivery.

h) A special BCC program to cater local needs in low performing and hard-to-reach areas should be undertaken. In the BCC campaign, community volunteers, women groups, satisfied clients, Ansar and VDP can be involved.

i) In line with social norms, demand and expectation, special BCC materials for men and youth should be developed. Satellite sessions and home visits with special campaign to motivate newlywed couples, mothers-in-law, adolescents and youth should be strengthened. For effective BCC activities in the community, courtyard group meetings and health education sessions at the youth club and forum can be organized regularly. Local BCC activities (e.g., theme-based folk songs) can be widely used.

j) Inadequate, irregular home visits by field workers was identified as one of the reasons for low performance in hard-to-reach areas. The system of accountability, monitoring, and supervision is not functioning, which should be strengthened along with the frequent visits of senior officials of concerned departments. In this connection, it is necessary to ensure regular monitoring at the district, upazilla and field levels.

k) There should be delegation of financial and administrative authority to the upazilla level and below to meet the emergency needs. Functionaries in these areas should be allowed to make necessary expenditure for travel to *char* and hard-to-reach areas, hiring of transport and emergency procurement of essential drugs, if the situation demands so. Smooth release/transfer of fund from Upazilla Parishad to health and family planning activities needs to be ensured. Reactivating local level committee will help devolve health and family planning service management.

l) It is necessary to conduct mapping in order to identify requirements of hard-to-reach areas and to consider the distance factor in implementing health and family planning programs. In addition, there should be continuous operations research to identify

constraints and opportunities in low performing and hard-to-reach areas for improving program performance.

m) Adequate fund to ensure safety net for poor women to utilize maternal health care needs to be mobilized through voucher scheme. Experience of some successful interventions should be replicated in low performing and hard-to-reach areas.

It is expected that the Ministry of Health and Family Welfare will continue the momentum of the current program efforts and incorporate low performing and hard-to-reach areas in the "Health Policy" that is being finalized. In addition, there is an urgent need to provide health and family planning services to low performing and hard-to-reach areas by ensuring the safety net to the poor and mobilizing manpower and logistics in these areas. Implementation of these commitments will require huge investment in the health and population sectors. It is imperative that development partners will come forward with assistance and the government will make increased allocation to the health and family planning programs.

SECTION I: BACKGROUND

Making required health care services available to the people of all strata is the main goal of the health policies and programs in Bangladesh. The national policies provide a strong framework for programs in the health and family planning sectors. The government has developed a comprehensive service delivery infrastructure from grassroots to higher levels and created skilled primary health workforce to ensure universal access to health and family planning services. Significant emphasis has been placed on basic and preventive services meeting the needs of vulnerable groups through the provision of comprehensive primary health care and family planning services. Successful implementation of the policies and programs has improved the equity in the use of services like expanded program on immunization (EPI) and family planning. As a result, substantial progress has been made in reducing fertility and mortality resulting in lower population growth.

Although child health in general has improved, neonatal mortality rate remains high contributing to overall infant mortality. The mid-term review (MTR) of Health, Nutrition and Population Sector Program (HNPSP) indicates that progress towards Millennium Development Goal (MDG) 4 (reduction in infant and under-5 mortality rate) has been impressive, most likely due to a combination of health related interventions like EPI coverage, vitamin-A distribution and diarrhea management. Related developments like improved primary education of girls, water and sanitation have also contributed to the reduction in infant and child mortality.

Maternal mortality remains unacceptably high, despite sincere intention of the government. Maternal mortality and morbidity has continued to remain a great concern without making any substantial improvements in safe motherhood initiatives. Bangladesh is struggling to achieve MDG 5: reducing maternal deaths by two-thirds. According to the MTR report, slow progress towards MDG 5 has been due to lack of strong support system to operate effectively for significant improvement. Yet, a high 85 percent of births continue to occur in the home managed by unqualified persons. Pregnant women who arrive at facilities often experience catastrophic costs, having to pay out-of-pocket, informally, for drugs, materials, services and referral transport. To provide financial assistance for transport and maternity care, the Ministry of Health and Family Welfare (MOHFW) is piloting a voucher scheme for pregnant women to receive delivery care from facilities. It is expected that the demand for maternal health services will increase significantly in the coming years once the voucher scheme is mainstreamed in the whole country. The MTR report defined this as a positive development, but advised the MOHFW to prepare itself by taking adequate measures in the areas of the human resources and infrastructure.

During 1975 to 1994, total fertility rate (TFR) in Bangladesh decreased significantly from 6.3 to 3.3 followed by a period of small negligible decline of only 0.6 from 1994 to date. Slow pace in fertility decline is causing serious concern in reaching replacement level fertility by 2010. Delay in reaching replacement level fertility will stabilize the population at larger size, that is, the challenges of the population momentum will be more intense.

Despite health policies and programs of the government having a strong equity approach, two divisions, Sylhet and Chittagong, remain the most disadvantaged both in terms of health

outcomes and access to services. The impact of extensive health service network has been much less than expected because services do not reach these two divisions effectively. These populations are still inconsistent with the country's resources. Less accessibility to health and family planning facilities and quality primary health care services in low performing and hard-to-reach areas still remains to be a major challenge. In these areas, a large proportion of primary health care services is met by untrained and unskilled health care providers, which often results in unwanted morbidity and mortality and also makes people susceptible to various illnesses.

During the past decade, Bangladesh has been facing a major health system challenge – the poor utilization of facilities particularly in low performing areas. Moreover, the current health and population sector programs are beset with infrastructural and human resources problems. The government has several management problems with facilities in upazilla and lower levels, particularly Health and Family Welfare Centers (HFWCs). Improvement of facilities in upazilla and lower levels with appropriate equipment and drugs is required to increase the utilization of services from these facilities. Practical experiences of implementation of 'Community Clinics' under Health and Population Sector Program were not satisfactory. Decisions to unify health and family planning services and to deliver one-stop services through the Community Clinic made the field staff dysfunctional. In 2001, service delivery through these clinics was stopped. A large amount of government resources was wasted as the MOHFW completed the construction of nearly eight thousand Community Clinics with furniture, equipment and medicines.

Although large numbers of medical graduates are produced each year, it is not easy to retain those doctors in rural areas, particularly in low performing and hard-to-reach areas. There is also a great imbalance in the mix of health workforce. For example, Bangladesh has more doctors than nurses. Yet, increasing the number of nurses, technicians and paramedics is a longstanding issue in health service delivery. Furthermore, the urban concentration of physicians and nurses is a persistent problem in the health system – only 16 percent of the doctors are practicing in rural areas. Geographic imbalance in the distribution of human resources has worsened the health care delivery in the rural areas, particularly in the hard-to-reach areas.

According to the MTR report, human resources in maternal, neonatal and child health are suffering from high number of vacancies in key posts. Although training of obstetricians and anaesthetists has made progress, it is yet to make teams available in low performing areas. Health facilities at upazilla, district and tertiary levels do not have sufficient midwifery trained nursing staff to provide 24-hour maternity services of acceptable quality. Moreover, the current "skilled birth attendant" training plan will not be able to ensure the universal coverage of home delivery by trained Family Welfare Assistants (FWAs) and female Health Assistants (HAs) in near future. Where there is no FWA, the situation is expected to be much worse as the government abandoned the training program for traditional birth attendants (TBAs).

Bangladesh may confront another big challenge in mobilizing human resources in near future as large number of government field-level workforce in the family planning sector will be retiring soon. There is an apprehension that shortage of well trained, skilled and competent service providers and field workers at the local level will slow down the family

planning program performance across the country, more intensely in low performing and hard-to-reach areas.

To improve the performance of health and family planning services in low performing and hard-to-reach areas, the government needs to act immediately. Against this backdrop, the Population Council organized a workshop to find answers to a key question: how to improve the service delivery in low performing and hard-to-reach areas.

SECTION II: PURPOSE OF THE WORKSHOP

The goal of the workshop was to identify issues and develop strategies for improving the performance of the health and population sectors in low performing and hard-to-reach areas. Specific objectives of the workshop were to:

- Review the health and family planning services in low performing and hard-to-reach areas
- Identify areas of deficiency in the service delivery
- Formulate recommendations and action-oriented future programs to improve the service delivery in low performing and hard-to-reach areas.

SECTION III: ORGANIZATION AND METHODOLOGY OF THE WORKSHOP

This report is the outcome of the workshop on "Strengthening Health and Family Planning Services in Low Performing and Hard-to-reach Areas of Bangladesh" held on 12 April 2008 in Dhaka.

The workshop was day-long and divided into four sessions: Inaugural, Business, Group Discussion, and Concluding (see detail program of the workshop in Annex 1). Mr. A.K.M. Zafar Ullah Khan, Secretary, Ministry of Health and Family Welfare, inaugurated the workshop as the Chief Guest. Mr. Dhiraj Kumar Nath, former Adviser, Non-party Caretaker Government of Bangladesh chaired the inaugural session of the workshop. Professor Md. Abul Faiz, Director General (DG) of Health Services, Ms. Quomaran Nessa Khanam, DG of Family Planning, and Dr. Rajani Alexander, Head of Development Co-operation, Canadian International Development Agency (CIDA) were present as special guests.

In the business session, Dr. Ahmed Al-Sabir, Director (Research), National Institute of Population Research and Training (NIPORT) and Dr. Jahiruddin Ahmed, Additional Director General, Family Planning Association of Bangladesh presented keynote papers, followed by the open discussion moderated by Dr. Ubaidur Rob, Country Director, Population Council, Bangladesh. This session was chaired by the DG of Family Planning. The third session was dedicated to group discussion. Three groups were formed and given specific topics to identify problems related to these topics and to compile their understanding on how to resolve these issues.

In the concluding session, three groups presented their recommendations on the issues assigned to them. Mr. Nasimul Ghani, DG, NIPORT, chaired the concluding session with Professor A. Mushtaque R. Chowdhury, Dean, James P. Grant School of Public Health, BRAC University as the moderator. After an interactive discussion, Mr. Dhiraj Kumar Nath suggested some future strategies.

A total of 101 participants attended the workshop. Participants were mostly from the MOHFW, Department of Health Services, Department of Family Planning, and NIPORT. In addition, participants from other public organizations like Planning Commission, National Institute of Preventive and Social Medicine (NIPSOM) joined the workshop. Civil Surgeons, Deputy Directors-Family Planning and several government field-level officials like Upazilla Health and Family Planning Officers and Upazilla Family Planning Officers participated at the workshop as well, which proved to be useful since during group discussion they effectively contributed in identifying problems in health and family planning service delivery as well as in formulating strategies. Among others, representatives from development partners, international organizations and NGOs were present at the workshop (see participant list of the workshop in Annex 2).

The sitting arrangement of the workshop was U-shaped, which enabled interactive and lively discussions among the presenters and participants. Presentations were made using multi-media, and workshop proceedings were tape recorded for ensuring better documentation.

SECTION IV: PRIORITIES AND CHALLENGES OF THE HEALTH AND FAMILY PLANNING SERVICES IN BANGLADESH

The discussion of the inaugural session is summarized in this section. The inaugural session started with the deliberation of Dr. Ubaidur Rob, Country Director, Population Council, Bangladesh, who presented an overview of the current and emerging demographic challenges in Bangladesh. Director Generals of Health Services and Family Planning discussed on current and emerging challenges of health and family services respectively, and highlighted on current programs as well as feasible options on how to improve the service delivery in low performing and hard-to-reach areas. The representative from CIDA highlighted Canadian government's priorities and commitments in the health sector of Bangladesh. The Secretary of MOHFW reiterated the government commitments and identified priorities in health and family planning services. The last speaker of the inaugural session, Mr. Dhiraj Kumar Nath, former Adviser, Non-party Caretaker Government of Bangladesh suggested revisiting the policies and programs in order to improve the service delivery in low performing and hard-to-reach areas.

Overview of the demographic situation

Dr. Rob provided an overview of the population situation in Bangladesh. The country has made significant progress in reducing fertility and population growth as well as infant and child mortality. Dr. Rob informed that approximately 16 million eligible couples are using family planning methods currently. Bangladesh is a small country, but there are regional variations in TFR. Khulna has reached replacement level fertility (TFR: 2.2) and in Rajshahi the TFR is 2.4. In both Chittagong and Sylhet, couples have nearly four children. Similarly, significant regional variation in the contraceptive prevalence rate (CPR) is also observed. The contraceptive prevalence rates remain substantially low in Sylhet and Chittagong divisions. For example, contraceptive use in Sylhet is half of Khulna (32 percent vs. 63 percent).

Dr. Rob expressed his concerns that minimum legal age at marriage is not observed in the country. It is observed that by age 19 half of the women become mothers. This group contributes approximately one-fifth of the TFR. There are several compelling demographic reasons for addressing this particular group. The most important one is the size of young population. Approximately 30 million adolescents and youth age 10 to 24 are living in Bangladesh. The size of this age group will continue to grow in the years ahead due to the population momentum.

Another area of concern is the low level of awareness on sexually transmitted infections (STIs) among Bangladeshi women. Although more than two-thirds of the women of reproductive age know about HIV/AIDS, only seven percent are aware of STIs. Utilization of professional maternity care is alarmingly low in Bangladesh – less than 15 percent of the deliveries are attended by trained personnel.

While highlighting the impressive success achieved in the population sector during 1975 to present, Dr. Rob cautioned that Bangladesh is going to confront two critical demographic problems: attaining replacement level fertility and population stabilization, and the population momentum. Bangladesh's population is likely to grow up to 180 million by the

year 2020. Future demographic scenario of the country will be determined in the next ten years. Depending on the rate at which the country reaches the replacement level of fertility, the total population size can be expected to reach between 230 and 250 million in 2050. In addition, by the year 2020 approximately half of the country's population is expected to live in urban areas. This shift from rural to urban areas will have significant impact on food production, resource allocation, existing social services and infrastructure. This would place severe stress on the national resources and constrain the efforts to improve the living standards of the people. Finally, Dr. Rob emphasized that the government should act now to address some of these issues urgently; otherwise the population would have to live in an unhealthy and chaotic situation.

Current and emerging challenges in the population sector

Special Guest, Ms. Quomaran Nessa Khanam, DG of Family Planning, highlighted on family planning achievements, pointed out obstacles to reaching the demographic goals and highlighted government initiatives in addressing the problems.

The DG, Family Planning stated that the country achieved remarkable successes in the population sector during last three decades. Implementation of a strong family planning program has slowed down the population growth. The contraceptive prevalence rate was 8 percent in 1975 and it increased to 56 percent in 2007. Similarly, total fertility rate was 6.3 in 1975, which decreased to 2.7 in 2007. The national program has several key strengths which contributed to the remarkable success in family planning. Factors contributing to the success of family planning program are:

- Continuous commitment of the government
- Dedication of field-level functionaries
- Domiciliary service and service delivery network
- GO-NGO collaboration
- Strong information, education and communication program
- Maternal and child health based strategy
- Cafeteria approach for family planning program
- Involvement of community, stakeholders and civil society
- Increased cooperation of development partners
- Use of research in policy making.

According to the DG of family planning, the major concern of the family planning program is the delay in reaching replacement level fertility. In spite of continuous emphasis on increasing the use of contraceptive methods, the national family planning program is lagging behind to reach replacement level fertility, which is largely due to low use of contraceptive methods in Sylhet and Chittagong divisions and imbalance in the use of effective methods. There are problems of low quality health care and less accessibility to health and family planning services in low performing and hard-to-reach areas. Moreover, there is little evidence that contraceptive method mix will change in future despite the government's continued efforts to increase male sterilization and permanent methods.

The population of Bangladesh is likely to grow up to 180 million by the year 2020 and stabilize at 250 million by the year 2060, if replacement level fertility is achieved by the year 2010. The DG, Family Planning expressed her concern that each year the population increases by three million and delay in reaching replacement level fertility is likely to stabilize the population at a larger size and at a later time due to population momentum inherent in the young age structure, creating insurmountable problems in socio-economic development. In addition, high maternal and infant mortality and morbidity will continue as a big challenge to the health service delivery system in Bangladesh.

The DG, Family Planning emphasized continued commitments of the government to maintain the momentum of efforts in order to reduce fertility and maternal and infant mortality and morbidity. She highlighted several recent government commitments directed towards attaining the replacement level fertility and achieving the MDG target of reducing maternal deaths. These are:

- Increase acceptance of long acting and clinical family planning methods with male participation
- Reduce discontinuation of contraceptives
- Encourage delayed marriage, delayed pregnancy and delayed first birth
- Ensure safe motherhood including emergency obstetric care services with provision of skilled birth attendants
- Increase health seeking behavior
- Ensure client friendly behavior of service providers
- Implement special program for low performing areas including urban slums.

Achievements and challenges in the health sector

Professor Md. Abul Faiz, DG of Health Services, was present as a Special Guest and outlined key achievements and major problems in the health sector, with some directions for improving the health system service delivery in low performing areas.

The DG, Health Services stated that there was substantial improvement in the health outcomes in the country and some of them had recently been highlighted by the MTR report. Also, Bangladesh has been performing well in several of the targets of health-related MDGs, and there are some progresses in the health service delivery, but there remain many areas of concern over health development. Improvements over maternal and neonatal mortality are two key issues. Regarding maternal health, the DG mentioned an important policy reform – the government is piloting a "demand side financing" option in the form of maternal health voucher scheme in 33 upazillas with the aim of providing support to poor pregnant women. The DG suggested to expand the program as soon as possible.

The DG, Health Services mentioned the shortage of manpower to implement the current policies down to the village level, and identified increasing workforce to the expected level as a big challenge for the government. The DG, however, mentioned that the number of medical graduates was increasing and enough number of graduates would be produced in future. The DG emphasized the necessity to increase the number of nurses and paramedics in large number at the community level.

Although there have been improvements in the health infrastructure, the DG of Health Services sketched out some strategies to improve service delivery and to increase the utilization of health facilities in rural areas. First, the government has to increase number of workforce and ensure functional service delivery system at the community level. At the same time, it is necessary to ensure the availability of field workers. As there is an inappropriate distribution of health workforce across the country centering on the cities, balance in the geographic distribution of health care providers needs to be ensured.

To overcome the challenges in the health sector, the DG called for a concerted effort by the government and development partners. He rightly identified the main issue: the government needs greater investment in the health sector. Currently, the total health expenditure is well below the level needed to scale up essential health interventions. Along with emphasizing to maintain the current program efforts, the DG advised some pressing interventions:

- The government is required to implement integrated, comprehensive health service delivery at the community level in hard-to-reach areas since facilities do not exist in these areas, and access to health services is poor as well.
- Medical education and training needs to be updated with the goal of providing health care services at the local level.
- Health sector requires wide participation of NGOs and private sector because there is evidence that NGOs play a contributory and complementary role to the public sector.

Finally, the DG of Health Services acknowledged the urgency to improve the existing service delivery in low performing and hard-to-reach areas and to make necessary ways and means for the people to ensure optimum use of available opportunities in government hospitals and health service delivery system particularly in those areas.

Priorities and commitments of development partners

Dr. Rajani Alexander, Counselor and Head of Development Co-operation of CIDA, highlighted Canadian government's priorities and commitments to improve the health system service delivery in Bangladesh, while delivering her speech as a Special Guest.

CIDA has been in Bangladesh since 1972 and health has been an important focus area for the Canadian government. Dr. Alexander informed that Bangladesh is one of the fifteen focus countries of the Canadian government to receive additional assistance. In addition, Canadian government is the fifth largest bi-lateral donor in Bangladesh.

Dr. Alexander observed that women irrespective of socio-economic status were likely to be affected if married earlier. Low age at marriage initiates early childbearing, exposes married women to a long reproductive life and more number of children, and heightens the risk of maternal morbidity and mortality. Dr. Alexander expressed her concern on figures and facts about women given by previous speakers, e.g., only seven percent women knowing about STIs and its impact on their reproductive health.

Dr. Alexander stressed the urgency to address the pressing issues in health, reproductive health and population as pointed out by previous speakers. She commented that money was not the main problem in the health and family planning sectors. It is important what the policymakers and program managers do and how they implement.

Dr. Alexander found recent government initiatives like the mid-term review of health sector program particularly useful in underlining regional variances in service delivery and outcomes as well as in identifying some of the priorities and obstacles and designing future direction. She commended the Population Council for organizing such workshop aimed at identifying issues and giving recommendations to implement appropriate approaches effectively.

Referring to previous speakers, Dr. Alexander stated that the key issue was how to move forward, and policymakers and program managers would need to collect information and design policies and strategies to address the issues. She expected that the government and development partners should move forward according to the urgency of the situation. In particular, she wanted to know how the Canadian government could co-operate with Bangladesh, especially in the areas of human resources and health service delivery. She noted that one-fourth of the positions of field workers remains vacant particularly in low performing areas. Regarding private sector involvement, she expected complementary role of civil society and the private sector including NGOs.

Dr. Alexander mentioned an operations research project, the results of which might have the relevance for use in efforts to improve service delivery in low performing areas. The project is testing innovative and effective service delivery models for increased use of family planning and reproductive health services in low performing areas.

Dr. Alexander said that the issues of discussions at the workshop were both important and technical. With high hope, she said that recommendations of the workshop would form policy development in the health sector in Bangladesh.

Commitments and issues in the health and family planning services

Mr. A.K.M. Zafar Ullah Khan, Secretary, MOHFW inaugurated the workshop as the Chief Guest. He highlighted on government commitments to improve health and family planning services and identified pressing issues that hinder the improvement of health and family planning services.

At the beginning, the Secretary briefly described government commitments and achievements in the health and population sector. He said that to ensure universal access to reproductive health services, the MOHFW developed a comprehensive service delivery infrastructure from grassroots to higher levels, with necessary program personnel and heath workforce. Upon considering the restricted mobility of village women, the government has given strong emphasis on doorstep services to rural women in efforts to ensure universal coverage of services. Because of these concerted efforts, there has been a substantial decline in TFR from 6.3 in mid-seventies to 2.7 in 2007.

The Secretary was not complacent with the success so far in reducing fertility. Rather, he cautioned that there is one major work to be accomplished: reaching the replacement level fertility. He expressed doubts that the government would be able to reach replacement level fertility by 2010 – the target year. The Secretary emphasized to attain the replacement level fertility sooner than 2015.

The Secretary observed that performance of two divisions in attaining replacement level fertility was satisfactory. Khulna has already achieved replacement level fertility and Rajshahi is close. Sylhet and Chittagong divisions are lagging far behind than other regions in reducing fertility with concomitant increase in the contraceptive use. Moreover, utilization of reproductive health services from facilities is low in Bangladesh. To increase the use of contraceptive methods in these low performing and hard-to-reach areas, innovative service delivery models are needed to identify successful interventions for these regions. Prior to designing the program it is necessary to identify the determinants of low use of contraceptive methods. In particular, the Secretary felt it necessary to know whether low utilization of facilities led to low use of contraceptive methods in low performing areas.

The Secretary expressed deep concern with the large unmet need for family planning. He pointed out that if unmet need for family planning was fulfilled, contraceptive prevalence rate would increase enough to attain replacement level fertility. Sylhet and Chittagong divisions have the highest unmet need for family planning, which is almost double of Khulna and Rajshahi.

The Secretary put emphasis on several non-programmatic issues that need special attention. One of the key non-programmatic issues for low use of contraceptive methods is the desired number of children. Adolescent fertility and non-enforcement of legal age at marriage are two other contributing factors for high fertility. These factors are responsible for the maternal mortality too.

The Secretary presented an overview on the maternal health situation in Bangladesh and related recent policies. Utilization of maternity care provided by trained professionals is alarmingly low in Bangladesh. To achieve the MDG of reducing maternal mortality to 143 by the year 2015, the government has introduced innovative approaches to create demand and enhance awareness to receive maternal care from skilled providers, and at the same time to institute a financial assistance scheme for poor women for managing pregnancy and delivery-related complications. This demand-side financing scheme for maternal health care is expected to increase the utilization of health facilities for maternity services.

The Secretary stated that although the government has well-devised policies and programs to ensure the availability of services, it is yet to ensure smooth implementation of the strategies in low performing areas. There are some structural problems that the government needs to overcome to improve the health and population situation. The Secretary identified human resources and health care financing issues as matters of immediate concern in low performing areas. He underlined the need to involve local level government and community to improve program performance. Private sector can be encouraged to enhance service coverage in these areas. The Secretary felt it necessary to seriously consider the current health and family planning situation of low performing areas and to attach priority to these

areas. In this connection, he highlighted four policy issues that need to be addressed while implementing the programs:

- Health Policy will be finalized soon. There is ample scope to add some new areas in this policy to address pressing issues of low performing and hard-to-reach areas.
- A significant portion of the HNPSP pool fund remains unutilized. An agreement should be made between the government and development partners that these unutilized funds can be used in the pro-poor program in rural areas.
- There is a need to revise Program Implementation Plan and Operational Plans to address pressing issues.
- In addition to pool fund, there are some other sources of funding for neonatal and maternal health care. These funds can be used for addressing family planning and reproductive health activities in low performing and hard-to-reach areas.

The Secretary emphasized the need for cooperation among public, NGO and private sectors for the successful completion of the HNPSP program. He expected that development partners would continue their cooperation to improve health and family planning activities in Bangladesh with special attention to low performing and hard-to-reach areas.

The Secretary expressed thanks to the Population Council for arranging the workshop at the appropriate time with the participation of relevant government, NGO and development partner representatives. He expected that recommendations of the workshop would be submitted to the MOHFW as soon as possible for necessary action.

Revisiting the policies and programs

Mr. Dhiraj Kumar Nath delivered his speech as the Chair of the inaugural session. Mr. Nath conveyed his thanks to the Population Council for arranging the workshop at the right time, identifying appropriate areas of interventions. He also expressed his heartfelt thanks to Mr. A. K. M. Zafar Ullah Khan, Secretary, MOHFW since this workshop was arranged on Secretary's instructions.

Mr. Nath appreciated the Secretary for reiterating the government commitment to achieve the replacement level fertility and attain the stable population as quickly as possible. He also mentioned the Secretary's intention to expand health care services to remote areas to support poverty alleviation programs and improve health outcomes in the country. Similarly, Mr. Nath gave sincere thanks to Dr. Rajani Alexander for reiterating CIDA's promise to assist Bangladesh in the health and family planning sectors. He highly appreciated Dr. Alexander for her comments that money should not be a problem for improving health and family planning programs in Bangladesh.

Mr. Nath also appreciated the DG of Family Planning, by pointing out that family planning program of Bangladesh made a success under a challenging environment. He, however, cautioned that the reduction of TFR from 2.7 to 2.0 along with the increase in CPR from 56 to 70 is a stupendous task. Massive efforts and strategic approaches must be taken to address unmet need and desire for male child, and to ensure appropriate method mix.

Pointing out outstanding innovations and interventions in the health sector, Mr. Nath mentioned that environmental health with climatic changes, global health hazards like HIV/AIDS, re-rolling malaria and dengue hemorrhage fever emerged as challenges to be addressed with firm commitment. Mr. Nath also mentioned innovations like gene mapping, medical transcription, tele-medicine, laser treatment etc. in the health sector. The country must be accustomed with those modern technologies.

Mr. Nath mentioned that the revision and revisit of "Health Policy" is a must. He noted that Health Adviser to the Caretaker Government of Bangladesh expressed his desire that the government would finalize the Health Policy soon. This opportunity should be availed in cooperation with GO, NGO and the private sector in order to formulate a pragmatic policy consistent with the expectation of the people. The Health Policy of 2000 should be revised to achieve the targets of health-related MDGs by 2015. Mr. Nath also advised that Population Policy should be revisited to make it consistent with the current and future priorities.

Mr. Nath, the Chair of the inaugural session, offered a few suggestions to improve the performance of health and family planning services in low performing areas:

- Undertaking special program to address low performing and hard-to-reach areas with special interventions in Chittagong and Sylhet divisions
- Mobilization of manpower
- Involvement of local government in health and family planning campaign and infrastructure management
- Outsourcing of human resources, employment of volunteers
- More budgetary allocation to health and family planning programs
- Devolution of financial and administrative power to Civil Surgeon and Deputy Director-Family Planning
- Delegation of authority to government administrative unit at the local level
- Strengthening BCC and advocacy programs, and formulating a strategy incorporating the interpersonal communication and women group
- Utilization of infrastructure through outsourcing and private operation of Upazilla Health Complexes, HFWCs and Community Clinics.

Mr. Nath emphasized that "Health for All" should be called as "All for Health". He also made a clarion call inviting all entrepreneurs to "Invest in Health: Build a Safer Future".

SECTION V: PRESENTATIONS OF KEYNOTE PAPERS AND OPEN DISCUSSION

This section summarizes the keynote papers presented in the business session, followed by open discussion. Keynote presentations focused on determinants of low use of contraception and health care utilization in hard-to-reach areas in Bangladesh.

Determinants of low use of contraception in Bangladesh

In his presentation, Dr. Ahmed Al Sabir, Director, Research, NIPORT reviewed the findings of Demographic and Health Surveys and indentified some key determinants of low use of contraception in Bangladesh.

While discussing the fertility situation in Bangladesh, Dr. Sabir suggested that TFR was stagnant at 3.3 in the 1990s, and since 2000 it declined by 18 percent. At present, TFR is 2.7, which is 0.5 above the replacement level fertility. Dr. Sabir mentioned that the population would stabilize at 210 million by 2060, if the replacement level of fertility is reached by 2010. He also informed that if the existing growth rate continues, the current population of 144 million would grow double (282 million) by 2051.

Dr. Sabir described the relationship between fertility and several socio-economic and geographic variables. Fertility is negatively related with wealth. Richest people are more likely to have less number of children than the poor people. Recent data shows that TFR of the women in the poorest quintile is 3.2 whereas it is 2.2 among the richest quintile. TFR is also closely associated with the education of women. TFR is higher among women with no education than women with secondary or higher education (3.0 vs. 2.3). Dr. Sabir also noted substantial variations in TFR between regions. Sylhet division has the highest fertility rate followed by Chittagong division, 3.7 and 3.2 respectively. In contrast, Khulna division has achieved replacement level fertility (TFR: 2.2) and TFR in Rajshahi division is 2.4, which is close to replacement level fertility.

Dr. Sabir acclaimed the family planning program of Bangladesh, which has contributed to the remarkable decline in fertility. At present, fifty-six percent of the eligible couples are using family planning methods. Forty-eight percent of the eligible couples use modern contraceptive methods and the remaining eight percent use traditional methods. Although CPR has decreased slightly in the past four years, the share of the modern contraceptive methods remains the same. Dr. Sabir mentioned that the likelihood of using modern contraceptive methods in Sylhet and Chittagong divisions was substantially low. He reported that couples in Rajshahi were five times likely to use modern contraceptive methods compared with Sylhet.

Dr. Sabir informed that pill is the most widely used contraceptive method (28.5 percent), followed by injection (7 percent), female sterilization (5 percent), and condom (4.5 percent). Long term methods such as implants, IUD and male sterilization are hardly used – use of any of these methods is less than one percent. Dr. Sabir explained the trend in the use of modern contraceptive methods. The use of oral pills continued to rise from 17 percent in 1993-94 to 29 percent in 2007. Injectable use has a mixed trend – its use increased from 5

percent in 1993-94 to 10 percent in 2004 but declined to 7 percent in 2007. The proportion of condom users increased from 3.0 percent to 4.5 percent during this period. Continuous decreasing trend of permanent and long-term method (PLTM) is observed – the use of PLTM reduced from 11.4 percent in 1993-94 to 7.3 percent in 2007. Dr. Sabir also mentioned that the poorest people are twice as likely to accept injectables and PLTM as the richest people. Conversely, likelihood of using condoms is six times higher among the richest people compared with the poorest people.

Dr. Sabir informed that the largest source of contraceptive supply in Bangladesh is the public sector (50 percent) followed by the private sector (45 percent). NGOs provide the remaining five percent of the contraceptive supply. The contribution of the private sector in contraceptive supply increased from 29 percent in 1999 and to 45 percent in 2007. On the other hand, the contribution of the public sector in contraceptive supply decreased from 69 percent in 1999 to 50 percent in 2007, while NGOs' contribution has been static over this period.

Dr. Sabir highlighted changes in the sources of modern contraceptive methods. The source of pill has been changing rapidly. Public sector contribution in pill supply was 62 percent in 1996-97 which decreased to 30 percent in 2007. Decrease in the public sector contribution in pill supply has been complemented by the increase in the private sector contribution, e.g., pharmacy's contribution increased from 21 percent to 45 percent during 1996 to 2007 period. Similarly, in case of condom supply, people are becoming increasingly dependent on pharmacy. Pharmacy's contribution to condom supply increased from 36 to 66 percent during 1996 to 2007 period.

Dr. Sabir examined trends in field workers' visits in family planning services. Field workers visited more frequently in 1993 than in 2007. In 1993, 43 percent of the married women of reproductive age were visited in last six months by field workers compared with 21 percent in 1999. The important thing is that there is no change in the fieldworker visitation since 1999. Dr. Sabir observed that visit of field workers varied by divisions. Low performing and hard-to-reach areas (Sylhet and Chittagong divisions) have experienced less number of visits.

Dr. Sabir considered contraceptive discontinuation as a major obstacle in the family planning program. Approximately 40 percent of injection and pill users discontinue in the first twelve months of use. The scenario is much worse in case of condom use – 71 percent of condom users discontinue in the first twelve months of use. The reasons identified for discontinuation of contraceptive methods are side effects or health problems, and desire to become pregnant. Dr. Sabir provided an interesting finding that the level of education that women have attained is positively associated with discontinuation level. Similarly, discontinuation increases as the household's wealth index increases.

While discussing desire for additional children, Dr. Sabir said that 62 percent women wanted no more children suggesting a strong demand for family planning. One-third of the women wanted more children whereas 12 percent wanted soon and the remaining 21 percent wanted later. Dr. Sabir observed an alarming situation for Sylhet and Chittagong divisions where more than half of the women desire for three or more children. While the desire for three or more children in Khulna and Rajshahi are 22 and 26 percent respectively, it is 51 percent in Chittagong, and 56 percent in Sylhet division. Difference between wanted fertility and actual

fertility is much higher in these two divisions too. In these two divisions, the gap between wanted fertility and actual fertility is more than one child.

Dr. Sabir provided an alarming statistics on unmet need for family planning, which has increased from 11 to 18 percent during the past four years. Unmet need for family planning is the highest in Sylhet division (26 percent) followed by Chittagong (21 percent) compared with 12 percent in Rajshahi division. Dr. Sabir expressed his optimism while mentioning that if all women who had an intention to space births or limit their children were to use methods, the CPR in Bangladesh could be increased enough to reach replacement level fertility.

Dr. Sabir mentioned another important determinant of fertility – early age at marriage and child birth. There is no substantial change in trends in the proportion of women marrying by age 18. Currently, 66 percent of women marry before their eighteenth birthday and median age at first birth is 19 years.

Finally, Dr. Sabir highlighted some of the major issues related to the family planning program:

- Factors that distinguish low performing regions from high performing regions most clearly are programmatic and cultural in nature.
- The profile in high performing regions appeared to be modern, with a higher status of women. Low performing districts suffer from low level of community development or women empowerment.
- Lower field-worker visitation and limited exposure to family planning message are a clear indication of program weaknesses. People living in low performing areas have poorer access to counseling and family planning services.
- Lower contraceptive use in Sylhet and Chittagong is likely to be associated with the two divisions' higher demand for children and poor performance of health and family planning programs.
- Although the program has worked hard to cover all strata of populations, there remain significant groups of the population who are socially and economically more deprived and who have lower rates of contraceptive use.
- Demand for services can be increased by making people more aware of the need for services, along with ensuring the availability of quality services. Programs should also remain ready to deliver services asked for, by improving quality of services and efficiency of the program.

Health care utilization in hard-to-reach areas in Bangladesh

Dr. Jahiruddin Ahmed, Additional Director General, Family Planning Association of Bangladesh elaborated on the government initiatives in providing essential health services, identified problems associated with the public sector health service delivery and provided some insights to address these problems.

Dr. Ahmed briefly described essential services package (ESP) interventions/services while describing the health care delivery system in rural Bangladesh. The major ESP service areas are: child health; reproductive health which include maternal health, adolescent health and family planning; communicable disease control; and limited curative care. These ESP services cover 80 percent of the national population.

Dr. Ahmed commended the MOHFW for providing comprehensive services with limited resources. He highlighted some key observations of the MTR of HNPSP. The MTR states that there has been good progress in extending already high coverage of interventions for reducing under-5 mortality, and modest progress in maternal health and nutrition, despite significant reduction in progress in addressing chronic shortages of staff, drugs and equipment.

The MTR 2008 concludes that the poor have benefited more than the rich, as public health interventions such as immunization and vitamin-A distribution have been expanded. Dr. Ahmed, however, pointed out that there is little of a concerted pro-poor health policy, besides the limited scale introduction of the voucher scheme for the rural poor women.

Dr. Ahmed emphasized that the MTR report identified some issues which need special attention:

- Services most used by the poor have declined from 51 percent in 2003/04 to 42 percent in 2005/06, as money for the tertiary hospitals and the administration of the MOHFW has increased.
- Throughout the life of HNPSP, human resource issues have not received the attention despite their principal importance for expanding health services.
- The pool of existing FWAs and FWVs is ageing compounded by the shortage of candidates for training.
- There is little progress in addressing chronic shortages of staff, drugs and equipment, and weaknesses in procurement and logistics.
- A high 85 percent of births continue to occur in the home managed by unqualified persons who cannot recognize childbirth complications or deliver the effective interventions.
- Pregnant women those who seek care at facilities often experience catastrophic costs, having to pay out-of-pocket, informally, for drugs, materials, services and referral transport.
- Urban poor population is increasing rapidly, but currently there is no strategy to cater for their maternal health needs.

Dr. Ahmed highlighted several key deficiencies in the area of human resources as identified by the MTR report: shortage of trained human resources (both public and private sectors); mal-distribution of available resources (both public and private sectors) between urban and rural, and between districts; insufficient posts; vacancies; absenteeism; and poor accountability of service providers. Dr. Ahmed classified the shortage of health workforce as a serious issue, because of (i) inadequate number of doctors, paramedics, medical technologists, (ii) diminishing health and family planning workforce, (iii) lack of community involvement activities, and (iv) halt in the training activities of Medical Assistant Training School and Family Welfare Visitor Training Institute for a decade.

Dr. Ahmed has made some recommendations to address the problem of utilization of health and family planning services in low performing and hard-to-reach areas:

- Map out hard-to-reach, disadvantaged areas with location of houses, populations (segregated), facilities, manpower, logistics channel, communication etc.
- Recruit and train local youths who will complement services of field-level staff
- Make HFWC as referral center at the union, and establish linkages between Upazilla Health Complex, Maternal and Child Welfare Center, District Hospital, private/NGO clinics (Ganoshashthaya Kendra, BRAC and others)
- Devolve or transfer resources and authority to lower level government units
- Contract out to private sector/NGOs that can manage, maintain and deliver services
- Introduce mobile team/roving team or strengthen mobile clinic/satellite clinics for delivering specialized services.

According to the MTR report, utilization of service delivery at district and upazila levels has increased, but without an equivalent increase in staffing and medicines, leading to decrease in quality of care. Areas that need improvement to ensure quality of care of services being provided at the government health facilities are: training, supply, constellation of services, privacy, counseling, waiting time, follow- up, and infection prevention.

Dr. Ahmed made several specific recommendations to improve the service delivery:

- Implement pro-poor and population-based resource allocation
- Consider non-formal providers and link them with the health system
- Focus on illiterate and poor population because of their unmet need
- Address adolescent population groups as they need most urgent services
- Reduce high unmet need for family planning
- Put special attention to family planning services in Chittagong and Sylhet divisions
- Address health workforce shortage in low performing areas like Chittagong and Sylhet
- Introduce cost recovery or user fee
- Reduce the hidden cost on consultation, services and supplies.

Open discussion

After the presentation of two keynote papers, there was an open discussion where the following comments were made by different individuals:

Professor Abdur Rahman, Head, Maternal and Child Health, NIPSOM classified the current family planning situation as a chance and not as a challenge, by citing that the determinants for delay in reaching replacement level fertility had already been identified. While commenting on the sources of contraception, Professor Rahman said that public sector supplies decreased and private sector supplies increased. He strongly advocated for sufficient supply of contraceptive methods for the poor people, as the poor people are producing more children and depend on the public sector supply. In addition, Professor Rahman felt it urgent to reduce discontinuation rate which was primarily due to heath concern. He believed that quality and informed counseling would make the clients aware of the side-effects of contraceptive methods and its management which would eventually increase the client satisfaction and ensure continued use of contraception.

Professor Rahman pointed out that high TFR in Sylhet and Chittagong divisions is largely due to large unmet need in these divisions. He was optimistic that if the demand for contraception was met, the national goal of replacement level fertility would be attained.

Dr. Barkat E Khuda, Professor of Economics, Dhaka University expressed his worries about the national program both on health and population and suggested revamping of these programs. Professor Khuda spotted out several important statistics which needs special attention in designing program in low performing areas. Between 2004 and 2007, CPR declined markedly among women age over 30. It declined both in urban and rural areas, but more in rural areas.

Like other speakers at the workshop, Professor Khuda felt it urgent for the population program to put emphasis in low performing and hard-to-reach areas. He noted that the performance in Sylhet and Chittagong has increased over the last years, but these two regions still remain below the national level. Professor Khuda said that there were opportunities like better literacy and wealth in Sylhet and Chittagong divisions than the other four divisions, which was conducive to propel the performance in these regions.

Professor Khuda provided an alarming statistics that 30 percent of Dhaka city population live either in slums or are floating population. He portrayed a miserable picture of the people living in slums and the floating people, and insisted that the MOHFW should be in charge of providing primary health care and family planning services for these population groups not the Local Government Ministry. As the "Health Policy" is being drafted or revisited, there is scope to include this issue in the Health Policy. Professor Khuda identified several issues which need attention:

- Developing urban health strategy
- Reducing maternal and neonatal health
- Increasing the use of long-acting method
- Reducing unmet need

- Addressing the reproductive health of adolescents in slums
- Providing targeted services to floating population in cities.

Professor Khuda was of the opinion that integration of health, nutrition and population would help to achieve greater synergies over duplication. He concluded with the statement: "Patient is still in critical condition, the health services need to listen and respond."

Mr. Md. Younus Fakir, Director, MIS, DGFP believed that vicious cycle of poverty and early marriage caused most of the problems. Early marriage results in more number of children and hence increases the burden. The poor cannot afford to buy modern contraceptive methods. Moreover, illiteracy, ignorance, and faith on religion or wrong interpretation of religion are barriers to the increase in use of modern contraceptive methods. Mr. Fakir stated the failure of the national program to reach hard-to-reach and slum areas. There are hurdles like lack of health workers and lack of awareness among the population living in these areas.

Dr. Zakir Hussain, Public Health Specialist, Program Support Office, MOHFW made comments on the presentation of Dr. Jahiruddin Ahmed. Like Professor Barkat E Khuda, Dr. Hussain pointed out an unusual relationship between high literacy/wealth and use of contraception. He wanted to know why Sylhet and Chittagong were not performing to the expectation despite these two regions being the richest in terms of literacy and wealth. He was skeptical with the idea of putting entire emphasis in Sylhet and Chittagong divisions without selecting actual low performing areas or unions. Furthermore, he expressed doubts about the effectiveness of recruiting more people. Dr. Hussain advocated for reviewing and rethinking about the deployment of TBAs. The reason is that the government abandoned the idea of sponsoring TBAs, but in remote areas there is no other alternative but TBAs.

Dr. Hussain appreciated some of the strategies for local level planning and pro-poor services as mentioned by Dr. Ahmed: mapping of the houses in remote areas; transport service; recruiting local youth; and mobile team. Regarding allocation of resources, Dr. Hussain argued that population-based allocation could not be the solution for remote areas. He stated that devolution could not be a panacea either. According to him, the government is yet to develop the environment for devolution.

Dr. S. M. Sirajul Islam, UHFPO, Charfeshon, Bhola informed that there was no health and family planning activities in Charfeshon for the last four years – women were not getting TT, children not getting vaccination but polio. Currently, vaccines are supplied, but network of family planning activities is not strong. Outreach activities cannot be done by current staff strength. Justifiably, Dr. Islam made a request to employ volunteers in the *char* area. He devised a plan that if a volunteer worked two or three days per week, s/he could cover all the work.

Dr. Shafiqur Rahman, UHFPO, Nabiganj, Habiganj shared some of his field experiences. Dr. Rahman mentioned the problem of logistics and medicine. He justified having a medical team in order to strengthen the health system service delivery in remote and hard-to-reach areas. On several grounds, he suggested to activate Community Clinics. Dr. Rahman emphasized that there should be separate budget for health sector at the upazilla level, which

the Upazilla Health Complex would receive directly from the central level not through the existing committee headed by Upazilla Nirbahi Officer. He complained that there was five percent allocation for the health sector but Upazilla Health Complex at Nabiganj was not getting a single penny. Dr. Rahman cited a pilot project of the Population Council at Habiganj, which is experimenting several interventions to improve services and to increase the use of contraceptive methods among poor, illiterate persons living in rural areas.

Mr. S. M. Anwar Hossain, DD-FP, Habiganj put forward some recommendations, which have the worth of being considered in national programs. The prime one is to improve communication facilities in hard-to-reach areas. Some incentives should be given to volunteers for delivering communication services. For making a large impact of BCC, involvement of community leaders, women groups, Ansar and VDP is necessary. In the hard-to-reach areas where there is no HFWC, low cost HFWC should be constructed and one depot holder can be employed for a population of one thousand, who will distribute contraceptive methods and other health commodities and refer clients to appropriate facilities.

Professor Abdul Hannan, Executive Director, Institute of Child and Mother Health put emphasis to redesign the policy by reviewing existing policies of the Ministry and programs of DGHS and DGFP, with the goal of allocating adequate budget for hard-to-reach areas. He expressed his conviction that making HFWC functional with necessary staff, activating the Community Clinics, and regular supply of logistics to these facilities would provide easy access to people living in hard-to-reach areas. Professor Hannan recommended introducing a provision of incentive for volunteers. He also suggested empowering the UHFPO regarding decisions on the development and improvement of the health and family infrastructure at the upazilla level and below, which would increase the efficiency of the health system.

Dr. Mohammad Alauddin, Independent Consultant in Public Health, wanted to know what programmatic interventions the government implemented in Chittagong and Sylhet. He also made an inquiry: whether health service utilization has increased or remains static in low performing areas. He made recommendations on BCC, financing and human resources. Dr. Alauddin suggested that satellite sessions could cover more people (e.g., adolescents, youth, and mothers-in-law) and teach them family planning, EPI and others as part of BCC strategies. He felt that utilization of health services and performance of the facilities would have been better if demand-side financing was implemented in low performing areas. Dr. Alauddin's special recommendation was to gradually replace TBAs with midwifery services. He strongly recommended introducing a new cadre of midwifery services into the health structure or special cadre of people to provide maternal and neonatal health services in the rural area.

Dr. Alauddin suggested implementing special interventions only in low performing upazillas in Sylhet and Chittagong divisions. In this connection, he emphasized on identifying the constraints prevailing in these low performing upazillas and on addressing these constraints not on a generic basis.

Concluding remarks by the chair of the business session

Ms. Quomaran Nessa Khanam, DG of Family Planning, appreciated the presentations, and the ensuing discussion. She felt that recommendations made in this session by the government and development partners would form policy for the low performing and hard-to-reach areas in Bangladesh. She highlighted on the supply, human resources, urban health and BCC.

The DG, Family Planning explained the supply situation. She informed that there is sufficient supply of contraceptives in the public sector. She exemplified that low-income women mostly use pills, which they do not buy, rather get from the public sector free-of-cost. The DG noted the shortage of field workers in the service delivery system. In the family planning sector, there is no recruitment after mid-1980s. As a result, many posts remain vacant and the health and family planning field staff are getting old. Ms. Khanam made a call for recruitment of field-level functionaries on an emergency basis. She also agreed that there should be a structured urban health service network for slum and floating people. In conclusion, she called for concerted actions to address the priorities and challenges identified by the speakers and participants.

SECTION VI: GROUP PRESENTATIONS, DISCUSSIONS, AND FUTURE STRATEGIES

The following discussion highlights on major points made in the concluding session. The concluding session consisted of group presentations and open discussion followed by future directions.

Group presentations

a) Mobilization of human resources and use of infrastructure facilities

Group A discussed on human resources and infrastructure situation in the public sector. The group was consisted of fifteen members. Among them Dr. Jafar Ahmed Hakim, Deputy Director-Family Planning, Comilla was the team leader and Dr. Shafiqur Rahman, UHFPO, Habiganj was the presenter.

At the beginning of the presentation, Dr. Rahman mentioned several human resources issues that are considered as barriers to providing quality health and family planning services in rural areas. The key problem identified was the inadequate number of service providers and field workers. Even the available human resources are not distributed equally across areas. Thus, people living in low performing and hard-to-reach areas are yet to have equitable access to services. There is also the problem of absenteeism and accountability of service providers. Dr. Rahman also raised the issue of the government's inability to retain trained providers in the designated position. Moreover, vacancy of service providers is another health system problem in low performing areas.

Dr. Rahman provided a dismal picture of the service delivery at the community level. He noted that field workers were not making home visits on a regular basis. These field workers are not supervised and monitored routinely because of lack of officials at the district and sub-district levels. Satellite sessions are not held regularly – a common phenomenon in low performing and hard-to-reach areas.

Dr. Rahman also raised several infrastructural problems in the service delivery. He mentioned the lack of health facilities in remote, hard-to-reach areas. Physical infrastructure in many areas is not in a good condition. Some facilities are found in run down condition, which require renovation. Some are abandoned which need to be made functional. Dr. Rahman identified several other infrastructural problems which need immediate attention: lack of electricity, shortage of running water, filthy toilets and no separate toilet for female clients, inadequate cleanliness, lack of waste management, and absence of separate waiting place for females and adolescents.

Dr. Rahman pointed out some recommendations, emerged from the discussion of group members. Recruitment of health workforce where needed was cited as the prime and foremost recommendation, because human resources is the central element of any health system. In addition, volunteers can be recruited to complement services of field workers. It is necessary to ensure regular supportive supervision and monitoring at all levels in order to provide quality services. To encourage and retain service providers and volunteers in low

performing and hard-to-reach areas, incentives can be given. Other recommendations put forward include:

- Effectively involve community leaders in health and family planning services/ activities
- Encourage and involve NGOs to work in low performing areas
- Use local government to repair and strengthen health facilities
- Reactive health and family planning committees
- Involve community in the maintenance of physical infrastructure
- Allocate fund for repairing.

b) BCC and advocacy

Group B presented on BCC and advocacy issues and the group discussion was led and presented by Dr. Alauddin, Public Health Consultant. The group consisted of nineteen members and identified some BCC and advocacy related problems and suggestions in strengthening health and family planning services. Insufficient BCC meetings, lack of staff, lack of health education sessions, inadequate local participation, low utilization of local media, lack of service providers' skills, inadequate home visitations were the major problems identified by Group B.

During presentation, Dr. Alauddin mentioned the inadequacy of motivational activities. Only one motivational workshop is generally held annually at the upazilla level. He added that home visit was inadequate and current staff strength was not sufficient. School health education sessions are not organized routinely. On the other hand, service providers and volunteers have lacks in skills to use BCC materials.

Many low performing and hard-to-reach areas are not covered by electricity, upon which the development of an area largely depends. According to Dr. Alauddin, health education and interpersonal communication activities are directly related to electricity. Unavailability of electricity is a barrier to conduct BCC activities. Another big issue is the absence of local participation in BCC activities.

On the basis of the discussion among members at the group session, Dr. Alauddin presented several recommendations which include:

- At least two motivational meetings will be organized annually at the upazilla level, and also in low performing unions.
- Volunteers should be recruited where there is no field worker. Volunteers will serve as depot holder, conduct interpersonal communication, and provide referral services. Here, it is necessary to develop effective communication skills among them.
- Travel allowance and other allowance will be provided to health workers for the school health education session. Most importantly, remuneration can be revised as way to improve field workers' performance and efficiency.

- As electricity is not available in low performing areas, regular courtyard group meetings can be organized to develop strong communication, education, and interpersonal communication. These meetings will increase people's understanding on major health problems and provide a platform for community participation. To this end, religious leaders, school teachers, Union Council members, and members of youth club can be involved.
- As folk songs are popular among the local people, this local media can contribute to strong BCC and advocacy.
- Increase in the number of home visits by field workers will help to strengthen BCC in health and family planning services.

c) Supplies and logistics

By identifying problems on supplies and logistics related issues, Group C came up with some recommendations. The group consisted of seventeen members. Professor Abdur Rahman, Head of Department of Maternal and Child Health, NIPSOM was the team leader and Dr. S. M. Sirajul Islam, UHFPO, Charfeshon, Bhola presented the findings accumulated through group discussion.

Group C identified several important supply related problems. First and foremost concern is inadequate and irregular drug supply. Observed also is the shortage of supply in contraceptives. Health facilities across the country receive standardized pre-packed kits of drugs. This uniform kit does not necessarily meet the requirements of all health facilities particularly in low performing and hard-to-reach areas which differ in geography, socio-economic status, health outcomes and disease patterns. When needed drugs and contraceptives are not available to the clients. This issue is particularly important because clients may lose trust on the clinics when they do not get the required medicines or contraceptive methods. Moreover, there is the risk of less utilization of these facilities by clients in future. Targeted BCC materials are not widely available at the upazilla level facility and below. Service delivery system at the local level lacks proper storage facilities. Supply procedure is very lengthy and carrying cost provided is not sufficient.

While focusing on logistics related issues, the presenter mentioned scarcity of surgical instruments, medical supplies (e.g., weight measure machine and spot light), registers, stationeries, and toiletries. Local authority is not empowered to procure drugs and medical and surgical requisites during emergency.

Problem of worn out and insufficient furniture and equipment is not uncommon at the union level health facilities. The presenter stated that it was very difficult to recover fund from Upazilla Parishad allotted by the government. It is to be noted that only five percent of the fund allocated to Upazilla Parishad is budgeted for health and family planning activities. Supply of record keeping materials is very limited. Moreover, there is no proper security system for the facility.

At the end of the presentation some recommendations were put forward for consideration by Group C. To ensure pro-poor service delivery in low performing areas, drugs should be made available at the facility. Adequate supply of contraceptives and logistics are required for

providing continuous quality services. Improving service delivery also requires necessary supply of surgical instruments, weight machine, BCC materials, and other equipment. An additional requirement is separate storeroom with adequate space for health and family planning at the upazilla level.

The presenter said that vacant posts of storekeepers should be filled up immediately at the upazilla level and below. Sufficient guards have to be employed to maintain the security and regulation at the facility. Supply of logistics and equipment must be demand oriented. The government has to introduce demand-based supply system replacing the standard kit system, which will enable health facilities to receive essential drugs in line with their needs. Group C also suggested that government fund for health and family planning activities at the upazilla level should be given directly to the UHFPO and UFPO instead of Upazilla Parishad. These managers need more financial authority for procurement of logistics.

Open discussion

After the three groups had presented their recommendations, there was an open discussion where the following individuals shared their views:

Professor A. Mushtaque R. Chowdhury, Dean, James P. Grant School of Public Health, BRAC University highlighted on private sector contribution to the health system and equity in access to services. He noted that although government is an important factor in the health sector, 80 percent of the population do not go to public sector facilities rather they go to traditional system or private health care providers. Professor Chowdhury suggested improving the health system across the country by involving private sector including NGOs like BRAC. Earlier BRAC's program, as he informed, had been concentrated in the North Bengal which was considered as poor region. But in doing this, a portion of the country (e.g., Sylhet) has been neglected. On the basis of this lesson learned, BRAC is currently implementing its program with the goal of providing services in an equitable way with emphasis on neglected areas.

According to **Dr. Tofayel Ahmed**, Consultant, Japanese International Cooperative Agency, public sector is the major catalyst to make services available across the country. In hard-to-reach and remote areas, poor people are getting health services largely from the public sector. He argued that although private sector reached all people, cost was a vital factor for receiving services from this sector.

Professor Md. Abul Faiz, Director General of Health Services was of the opinion that there were some contradictions regarding primary health care management. The government has spent huge resources to develop infrastructure for primary health care in rural areas, but there is no structured government primary health care infrastructure in urban areas. With the expectation of improving health of urban poor, the government has put emphasis on NGO sector development and thus conferred the responsibility of urban primary health care to the local government.

Professor Faiz highlighted mixed successes and failures of primary health care services. He appreciated the group presentations, which identified current priorities and challenges of

health services at the local level. By referring to the group presentations, he identified major weaknesses in primary health care infrastructure, particularly in the areas of human resources and logistics. He suggested improving the human resource condition by addressing vacancies and appropriate staff mix. In this connection, he requested to give more priority in hard-to-reach areas where there were limited human resources. He advised to conduct mapping in order to assess the requirements for hard-to-reach areas and also to consider the distance factor in implementing renewed program.

While commenting on BCC, Professor Faiz acknowledged the relevance of suggestions made by Group B, and explicitly advised to involve the large pool of satisfied clients to motivate those who do not utilize services from facilities. He heightened the necessity to ensure continuous availability of supplies and logistics in hard-to-reach areas. Professor Faiz concluded by stating that strengthening the public health sector should be the priority.

Future strategies

Mr. Dhiraj Kumar Nath, Former Advisor to Non-party Caretaker Government of Bangladesh summarized the key points of the three sessions and suggested strategies to improve the health and family planning services in low performing and hard-to-reach areas.

Mr. Nath reiterated Secretary's commitment to incorporate low performing and hard-to-reach areas in the "Health Policy" that is being finalized. He was optimistic that the government would provide health and family planning services to low performing and hard-to-reach areas by ensuring the safety net to the poor, and mobilizing manpower and logistics in these areas. He noted that DGs of Health Services and Family Planning also reaffirmed the same view in the inaugural session. Implementation of these commitments will require huge investment in the health sector. He expressed optimism that development partners like CIDA would come forward with assistance and the government would make increased allocation to the health and family planning programs.

While summarizing the two keynote papers presented in the business session, Mr. Nath highlighted problems of health and family planning services in low performing and hard-to-reach areas. Problems of health and family planning services as prioritized are:

- High fertility among poor but limited access to contraceptives
- High unmet need for family planning
- High discontinuation rate due to side effects or complications
- Low visitation by field worker
- Large-scale unsafe home delivery
- Chronic shortage of health workforce
- Vacancy, absenteeism, and poor accountability
- Attrition of government field level staff e.g., FWAs and FWVs
- Chronic shortage of drugs and equipment
- Weakness in the procurement and logistics
- Inadequate quality of care
- Health care financing.

Mr. Nath reviewed the strategies put forward by keynote speakers and three groups, and identified several strategies to mobilize manpower, improve supplies, and strengthen BCC activities (shown in Table 1).

Table 1 Strategies to mobilize manpower, improve supplies, and strengthen BCC activities

Category	Strategies
Manpower	• Recruitment in vacant posts • Addressing absenteeism through strengthening the system of accountability, monitoring, and supervision as well as introducing incentives • Competency and skill development of field workers and other technical staff through refresher training • Reviving the training program for FWVs • Mobilizing volunteers in hard-to-reach areas
Supplies	• Empowering local level facility for procurement of logistics • Regular supply of medicines, contraceptive methods and equipment • Addressing the pilferage of supplies and logistics • Local production of contraceptives
BCC activities	• Developing BCC materials appropriate to local needs • Ensuring home visit by field workers • Innovative interpersonal communication activities by involving community • Involvement of local government for advocacy and information dissemination • Strengthening regular school health education • Involving satisfied contraceptive users to motivate non-users

In addition, there are several key strategies to improve health and family planning service delivery, which are:

- Devolution of power
- Reactivating upazilla and union family planning committees
- Ensuring smooth release/transfer of fund from Upazilla Parishad to health and family planning activities
- User fee as cost recovery
- Maximizing resources by involving NGOs
- Contracting out services to private sector or NGOs
- Pro-poor health policy e.g., introducing financial incentives for poor pregnant women for safe motherhood
- Mapping of hard-to-reach areas and populations

- Operations research activity to identify problems and provide solutions
- Strengthening program monitoring
- Special crash program in low performing and hard-to-reach areas.

Remarks by the chair of the concluding session

Mr. Nasimul Ghani, DG of NIPORT congratulated the Population Council for successfully organizing the workshop at the appropriate time. He greatly appreciated the presence of distinguished participants and the contribution made by them. He extended his sincere thanks to the speakers who particularly provided a platform for useful discussion. Mr. Ghani highlighted several issues on the deliberation of the workshop. He emphasized to improve human resources situation in health and family planning programs. Mr. Ghani advocated for decentralization in service delivery. He advised to reactivate local level committee for devolution of health and family planning services management.

Finally, Mr. Ghani requested the Population Council to present the workshop recommendations in a structured way to the MOHFW for further improvement of the health and family planning program.

SECTION VII: WAY FORWARD

As a way forward to improve the performance of health and family planning services in low performing and hard-to-reach areas, a special program for two years should be undertaken to address the issues of immediate concern. Strengthening the public health and family planning sectors should be the priority, since public sector makes cheaper services available across the country. In hard-to-reach and remote areas, poor people avail health services largely from the public sector while cost is exorbitant for the poor in getting services from the private sector. Specific recommendations as prioritized at the workshop are as follows:

a) **Large number of vacant posts at the field level** has been identified as the major weakness. Human resource situation can be improved by filling up the vacant posts of service providers and field workers like FWVs, FPIs, FWAs, AHIs and HAs. If there are difficulties in the recruitment, **community volunteers** with some incentives can be deployed. The experience of community police or other experimental projects can be shared. In the areas where qualified individuals are not available for recruitment, **private sector including NGOs can be involved** with the program. Special attention should be given to *char* areas with special incentives to the workers.

b) One of the reasons for underutilization of Community Clinics, HFWCs and Upazilla Health Complexes is inadequate maintenance of facilities as revealed from the discussion in the workshop. There could be **outsourcing for the maintenance of facilities** through the open bid especially for hard-to-reach areas.

c) **Absenteeism** at service delivery points should be strictly dealt with. There should be **strategies to retain trained providers** in designated service delivery points. On the other hand, withdrawal of any service providers working in low performing and hard-to-reach areas in the name of **deputation** should be discouraged.

d) Infrastructure in low performing and hard-to-reach areas should be **renovated or reactivated** through the use of local government and active involvement of community members. Where there is no HFWC, revitalization of **outreach centers** with appropriate field workers can be an alternative.

e) In remote and hard-to-reach areas, **a medical team with necessary transport system** can be employed in order to strengthen the health and family planning service delivery.

f) **Regular supply of drugs, medicines, and equipment** will provide an enabling environment for the service providers to deliver quality services.

g) A special **BCC program** to cater local needs in low performing and hard-to-reach areas should be undertaken. In the BCC campaign, community volunteers, women groups, satisfied clients, Ansar and VDP can be involved.

h) **Participation of local government authority** (e.g., members of Union Parishad especially female members) will enhance the program performance. BCC activities tested in experimental projects could be adopted as a part of this strategy.

i) In line with social norms, demand and expectation, **special BCC materials for men and youth** should be developed. **Satellite sessions and home visits** with special campaign to motivate newlywed couples, mothers-in-law, adolescents and youth should be strengthened. For effective BCC activities, some **other strategies** could be implemented such as:
    - Strengthen school health education session
    - Organize regular courtyard group meetings
    - Organize health education session at youth club and forum.

j) **Inadequate, irregular home visits** by field workers was identified as one of the reasons for low performance in hard-to-reach areas. The system of accountability, monitoring, and supervision is not functioning, which should be strengthened with frequent visits of senior officials of concerned departments. In this connection, it is necessary to ensure **regular monitoring** at the district, upazilla and field levels.

k) There should be **delegation of financial and administrative authority** to the upazilla level and below in order to manage any emergencies caused by disaster, epidemic, climatic change situation in *char* and hard-to-reach areas. Functionaries in these areas should be allowed to make necessary expenditure for travel to *char* and hard-to-reach areas, hiring of transport, and emergency procurement of essential drugs, if the situation demands so.

l) It is necessary to **conduct mapping** to identify the requirements of hard-to-reach areas and to consider the distance factor in implementing health and family planning program. In addition, there should be continuous **operations research** to identify constraints and opportunities in low performing and hard-to-reach areas for improving program performance.

m) Adequate fund to ensure **safety net for poor women** to utilize maternal health care needs to be mobilized through **voucher scheme**. **Experience of some successful interventions** should be replicated in low performing and hard-to-reach areas.

ANNEXURE 1

PROGRAM

Workshop on Strengthening Health and Family Planning Services in Low Performing and Hard-to-reach Areas of Bangladesh

Date: April 12, 2008 (Saturday)
Venue: Lake Shore Hotel

9:30am – 10:00am	**Registration**	
10:00am – 11:00am	**Inaugural Session**	
	Overview of the situation:	Dr. Ubaidur Rob, Country Director, Population Council
	Speech by Special Guest:	Ms. Quomaran Nessa Khanam, Director General, DGFP
	Speech by Special Guest:	Prof. Md. Abul Faiz, Director General, DGHS
	Speech by Special Guest:	Dr. Rajani Alexander Head of Development Co-operation, CIDA
	Speech by Chief Guest:	Mr. A.K.M. Zafar Ullah Khan, Secretary, MOHFW
	Speech by Chairperson:	Mr. Dhiraj Kumar Nath Former Adviser Non-party Caretaker Government of Bangladesh
11:00am – 11:30am	**Tea**	
11:30am – 1:00pm	**Business Session**	
	Chair: Moderator:	Ms. Quomaran Nessa Khanam, Director General, DGFP Dr. Ubaidur Rob, Country Director, Population Council
	Presentation 1:	Determinants of Low Use of Contraception in Bangladesh Dr. Ahmed Al Sabir, Director (Research), NIPORT
	Presentation 2:	Health Care Utilization in Hard-to-Reach Areas in Bangladesh Dr. Jahiruddin Ahmed, Additional Director General Family Planning Association of Bangladesh
	Open Discussion	
	Remarks by Chairperson	

1:00pm – 2:00pm	**Lunch**
2:00pm – 3:00pm	**Group Discussion**
	(Participants will be divided into 3 groups and formulate strategic recommendations) Group A: Mobilization of Human Resource and Use of Infrastructure Facilities in Low-Performing Areas Group B: BCC and Advocacy Group C: Supply and Logistics
3:00pm – 4:30pm	**Concluding Session**
	Chair: Mr. Nasimul Ghani, Director General, NIPORT Moderator: Dr. A. Mushtaque R. Chowdhury Dean, James P. Grant School of Public Health BRAC University Presentation: Group Recommendation Looking Forward– Future Strategies: Mr. Dhiraj Kumar Nath Former Adviser Non-party Caretaker Government of Bangladesh Vote of Thanks: Dr. Ubaidur Rob Country Director, Population Council

ANNEXURE 2

LIST OF PARTICIPANTS

Mr. Dhiraj Kumar Nath
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Mr. A. K. M. Zafar Ullah Khan
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Ministry of Health and Family Welfare

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ANNEXURE 3

PRESS COVERAGE AND PICTURES

THE DAILY ITTEFAQ ■ প্রতিষ্ঠাতা তফাজ্জল হোসেন মানিক মিয়া

রেজি-ডিএ ৮৪ : ৫৬তম বর্ষ : ১১০তম সংখ্যা : রবিবার, ৩০শে চৈত্র ১৪১৪ : ৬ই রবিঃ সানিঃ, ১৪২৯ হিজরি, SUNDAY, 13 APRIL 2008 : মূল্য ৮.০০ টাকা

সাফল্য অর্জনে পরিবার পরিকল্পনা সেবাকে নাগালে আনতে হবে

॥ ইত্তেফাক রিপোর্ট ॥

দুর্গম অঞ্চলের স্বাস্থ্যসেবা সম্পর্কিত কর্মশালায় বক্তারা স্বাস্থ্য ও পরিবার পরিকল্পনায় সাফল্য অর্জনের জন্য ব্যাপক প্রশিক্ষণ ও জনসচেতনতা সৃষ্টির মাধ্যমে স্থানীয় জনগণের আচরণ পরিবর্তনের ওপর জোর দিয়েছেন। এজন্য গণমাধ্যমকে সম্পৃক্ত করে মানবিক যোগাযোগ কার্যক্রমকে আরো শক্তিশালী করতে হবে বলেও তারা অভিমত দেন। গতকাল শনিবার রাজধানীর একটি হোটেলে পপুলেশন কাউন্সিল আয়োজিত 'পিছিয়ে পড়া ও দুর্গম এলাকায় স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা শক্তিশালীকরণ বিষয়ক কর্মশালায় বক্তারা বলেন, পরিবার পরিকল্পনা সেবাকে সাধারণ মানুষের চাহিদা ও নাগালের মধ্যে নিয়ে যেতে না পারলে সফলতা আসবে না। তত্ত্বাবধায়ক সরকারের সাবেক উপদেষ্টা ধীরাজ কুমার নাথের সভাপতিত্বে কর্মশালায় বক্তব্য রাখেন স্বাস্থ্য ও পরিবার কল্যাণ সচিব একেএম. জাফর উল্লাহ খান, স্বাস্থ্য অধিদপ্তরের মহাপরিচালক প্রফেসর আবুল ফায়েজ, পরিবার কল্যাণ অধিদপ্তরের মহাপরিচালক কামরুন্নেসা খানম, নিপোর্ট-এর মহাপরিচালক নাসিমুল গণি, কানাডীয় উন্নয়ন সংস্থা-সিডার প্রধান উন্নয়ন সমন্বয়ক ড. রজনী আলেকজান্ডার, পপুলেশন কাউন্সিলের আবাসিক পরিচালক ড. ওবায়েদুর রব প্রমুখ।

রাজধানীতে কর্মশালা

তারা বলেন, স্বাস্থ্য ও পরিবার কল্যাণ খাতে পিছিয়ে পড়া এলাকাগুলোতে বিশেষ কর্মসূচি গ্রহণ করে স্বাস্থ্য ও পরিবার কল্যাণ খাতে উন্নতি করা না গেলে দেশ পিছিয়ে পড়বে। কাঙ্ক্ষিত সফলতার জন্য স্বাস্থ্য ও পরিবার কল্যাণ সেবার গুণগত মানোন্নয়ন, জনসাধারণ, এনজিও, বেসরকারিখাত ও স্থানীয় সরকার ব্যবস্থাকে এর সঙ্গে সম্পৃক্ত করতে হবে। বক্তারা দেশের স্বাস্থ্য এবং পরিবার কল্যাণ সেবার চ্যালেঞ্জগুলো তুলে ধরে বলেন, মাতৃমৃত্যু হ্রাস ও প্রতি নারীর সন্তান জন্মহার আরো কমাতে হবে। অনুষ্ঠানে জানানো হয়, সিলেট এবং চট্টগ্রাম অঞ্চল পরিবার কল্যাণ কার্যক্রমে লক্ষমাত্রা অর্জনে পিছিয়ে আছে। মাঠকর্মীর অভাব ও প্রশিক্ষণ কার্যক্রমে স্থবিরতা এর মূল কারণ। পিছিয়ে পড়া ও দুর্গম এলাকাগুলোতে স্বাস্থ্যসেবা ব্যবস্থা শক্তিশালীকরণে বেশকিছু সুপারিশ পেশ করা হয়।

ঢাকা, রোববার, ১৩ এপ্রিল ২০০৮
৩০ চৈত্র ১৪১৪, ৬ রবিউস সানি ১৪২৯
রেজি. নং ডিএ ১৮৮০, বর্ষ ১০, সংখ্যা ১৫৭

প্রথম আলো

প্রতিবছর জনসংখ্যায় যোগ হচ্ছে ২৫ লাখ

নিজস্ব প্রতিবেদক

বাংলাদেশের জনসংখ্যা প্রায় ১৫ কোটি। এর সঙ্গে প্রতিবছর নতুন করে ২৫ লাখ মানুষ যোগ হচ্ছে। দুর্গম এবং কর্মসূচির বাইরে থাকা এলাকায় জনসংখ্যা কার্যক্রম সফল হচ্ছে না। এ ছাড়া সিলেট ও চট্টগ্রাম বিভাগে কার্যক্রম পিছিয়ে আছে। বর্তমান ধারা চলতে থাকলে ২০৫১ সালে বাংলাদেশের জনসংখ্যা দাঁড়াবে ২৮ কোটির ওপরে।

গতকাল রাজধানীর একটি অভিজাত হোটেলে 'দুর্গম ও পিছিয়ে পড়া অঞ্চলে জনসংখ্যা কার্যক্রম শক্তিশালী করার উপায়' শীর্ষক কর্মশালায় অংশগ্রহণকারীরা এসব কথা বলেন। যুক্তরাষ্ট্রভিত্তিক প্রতিষ্ঠান পপুলেশন কাউন্সিল এই কর্মশালার আয়োজন করে।

বাংলাদেশ পরিবার পরিকল্পনা সমিতির অতিরিক্ত মহাপরিচালক ড. জহির উদ্দীন আহমেদ বলেন, পাহাড়, হাওর, চর ও উপকূলীয় এলাকায় অবকাঠামো অনুপযুক্ত এবং বাড়ি বাড়ি গিয়ে সেবা দেওয়ায় তুলনামূলকভাবে বেশি সমস্যা হয়।

জাতীয় জনসংখ্যা গবেষণা ও প্রশিক্ষণ ইনস্টিটিউটের পরিচালক (গবেষণা) ড. আহমেদ আল-সাবির উপস্থাপিত প্রবন্ধে বলেন, সিলেট ও চট্টগ্রাম বিভাগে টিএফআর যথাক্রমে ৩ দশমিক ৭ ও ৩ দশমিক ২। জাতীয় পর্যায়ে এই হার ২ দশমিক ৭। (একজন নারী প্রজনন বয়সে মোট যত সন্তান জন্ম দেয়, সেটাই মোট প্রজনন হার)। এই দুই বিভাগে জন্ম নিরোধ পদ্ধতি গ্রহণের হারও কম।

অনুষ্ঠানের সভাপতি তত্ত্বাবধায়ক সরকারের সাবেক উপদেষ্টা ধীরাজ কুমার নাথ বলেন, ২০০৪ সালের জনসংখ্যানীতিতে কিছু পরিবর্তন আনা এরপর পৃষ্ঠা ১৯ কলাম ৩

প্রতিবছর জনসংখ্যায় ২৫ লাখ

শেষ পৃষ্ঠার পর

দরকার। তিনি আরও বলেন, মাঠপর্যায়ে জনসংখ্যা কার্যক্রমে গতি আনতে হলে স্থানীয় সরকার এবং স্বেচ্ছাসেবী ব্যক্তি ও সংগঠনকে এই প্রক্রিয়ার সঙ্গে সম্পৃক্ত করতে হবে।

স্বাস্থ্যসচিব জাফর উল্লাহ চৌধুরী বলেন, জনসংখ্যা কার্যক্রমে সৃজনশীল কিছু কৌশল যুক্ত করার সময় এসেছে। তিনি বলেন, স্বাস্থ্য খাতে বিপুল পরিমাণ অর্থ অব্যয়িত থেকে যাচ্ছে। সঠিকভাবে অর্থ ব্যয় করতে পারলে জনসংখ্যা কার্যক্রম আরও গতি পেত।

স্বাস্থ্য অধিদপ্তরের মহাপরিচালক অধ্যাপক আবুল ফয়েজ বলেন, জনসংখ্যা কার্যক্রমকে সফল করতে হলে জনবলের ঘাটতি দূর করার পাশাপাশি সেবা কাঠামো ও সেবা সরবরাহের ধরনে পরিবর্তন আনতে হবে।

কানাডার দাতা সংস্থা সিডার প্রতিনিধি ড. রজনী আলেকজান্ডার বলেন, স্বাস্থ্য বা জনসংখ্যা কার্যক্রমের জন্য তহবিলের কোনো ঘাটতি নেই। প্রয়োজন মাঠপর্যায়ে কর্মসূচি সঠিকভাবে বাস্তবায়ন করা।

অনুষ্ঠানে আরও বক্তব্য দেন পপুলেশন কাউন্সিলের এ দেশীয় পরিচালক ড. আবদুর রব, পরিবার পরিকল্পনা অধিদপ্তরের মহাপরিচালক কামরুন্নেসা খানম, ঢাকা বিশ্ববিদ্যালয়ের শিক্ষক অধ্যাপক বরকত-ই-খুদা প্রমুখ।

Mr. Dhiraj Kumar Nath, former Adviser, Non-party Caretaker Government of Bangladesh delivering his speech as the Chair of the inaugural session of the workshop

Mr. A.K.M. Zafar Ullah Khan, Secretary, Ministry of Health and Family Welfare delivering his speech as the Chief Guest of the workshop

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