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BANGLADESH RURAL ADVANCEMENT COMMITTEE (BRAC): ORGANIZATIONAL INNOVATION IN POPULATION, HEALTH AND DEVELOPMENT IN BANGLADESH IN THE CONTEXT OF THE MILLENNIUM DEVELOPMENT GOALS

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ABSTRACT

Bangladesh has marked strides to make in reaching the Millennium Development Goals (MDGs) for child mortality and maternal health by 2015. Progress and achievements that have been made to date are recognized. However, challenges remain that may impede steady progress towards the realization of the goals, including social inequality, largely defined by the low status of women, and the rich-poor divide. BRAC's innovative organizational approach in Bangladesh serves to fill in the gaps left by the public sector, and brings a comprehensive approach to addressing these challenges and encouraging advances in health and development.

Keywords: BRAC, Millennium Development Goals (MDGs), Southeast Asia, Bangladesh, Health

Introduction

Bangladesh is a country with a unique history consisting of colonization by the British, partition from India, and then again from Pakistan. The majority of the Bangladeshi population speaks the Bengali language and practices Islam. Historical and geographical factors combined with traditional culture contribute to disparity among Bangladesh's citizens, and to Bangladesh's status as a developing country. This paper focuses on two Millennium Development Goals in relation to Bangladesh: the reduction of child mortality (goal four) and the improvement of maternal health (goal five) and how BRAC, an NGO, serves to fill the large gap left by the Government in furthering these goals through their current initiatives.

Millennium Development Goals

The Millennium Assembly took place in September of 2000 at the United Nations in New York, and was the largest gathering of world leaders in history. At this event, Secretary-General Kofi Annan presented a document, *We the Peoples: The Role of the United Nations in the 21st Century,* which illustrated the multitude of challenges faced by global society. The document not only discussed these issues of extreme poverty, environmental harm, pandemic disease, civil strife and war, but also offered recommendations and possible solutions for alleviating some of the problems which could be launched through global efforts. The Millennium Declaration, a global statement adopted by the assembled leaders of the Millennium Assembly, was subsequently based on Annan's document. This declaration specifically outlines out a series of quantified goals with specific time-restrictions and deadlines, dedicated to reducing problems faced by the world today. These goals became known as the eight Millennium Development Goals or MDG's [1]. Of these eight goals, five are health-related, and of these five, two are particularly relevant to Bangladesh from both an epidemiological and demographic point of view. These two goals include reducing child mortality and improving maternal health.

Goal 4:

The target of reducing child mortality includes:

- Reducing the mortality rate by 2/3 for children under the age of five between 1990 and 2015

The specific indicators for this goal include:

- Under-five mortality rate

- Infant mortality rate
- Proportion of one-year-old children who are immunized against measles

To meet these target goals, the main causes of childhood mortality must be addressed. Seventy three percent of deaths that occur in children under the age of five are caused by pneumonia, diarrhea, malaria, neonatal pneumonia, preterm delivery or asphyxia at birth. Twenty percent of deaths in children under five occur during the first week of life, largely due to malnourishment of the mother which leads to low birth weights. Poor antenatal care and the lack of skilled birth attendants exacerbate the situation [2]. Technical intervention should focus on malnutrition, infectious and parasitic diseases as well as immunizations delivered through a strengthened basic healthcare system. Malnutrition contributes to over half of child deaths in Bangladesh and low birth rate is estimated to affect 30-50% of infants. In Bangladesh, while there has been an appreciable drop in under-five death rates in the past 15 years, the rate has slowed considerably, and still remains high [2].

Goal 5:

The target goal in terms of improving maternal health includes:

- Decreasing the maternal mortality ratio (the number of women who die during pregnancy and childbirth per 100,000 live births) by ¾ between 1990 and 2015

The specific indicators for this goal include:

- Maternal mortality ratio
- The proportion of births attended by skilled health staff

In spite of the fact that maternal mortality has declined in Bangladesh since 1990, the maternal mortality ratio remains one of the highest in the world. Therefore, in order to achieve the above goals, a number of changes must occur. Access to skilled birth attendants must be increased. Complications occurring during pregnancy and childbirth account for the leading cause of death and disability among women in developing countries of reproductive age, and thus, emergency obstetric services and reproductive health care services must be made available, and existing services must be improved. These services should be united within a functioning health and referral system. In addition, broad social and cultural issues that inhibit women from seeking health care must be addressed, family planning knowledge must be increased, and women must become empowered. The Government of Bangladesh in synergy with aid from NGOs have taken many steps toward the continued reach of the MDGs.

Ministry of Health and Family Welfare

Bangladesh is unique in that its government has successfully built a rather extensive infrastructure and an innovative health sector –led by the Ministry of Health and Family Welfare (MOHFW) - compared to many other developing countries, especially in the aspect of their health and family planning services. However, it is the quality, efficiency, and effectiveness of services that are to be questioned and further examined. The principles of self-sustainability, quality leadership and management, comprehensiveness, and reach of programs and services must be examined. It is important to note that Bangladesh is a large recipient of foreign aid and is the largest recipient of assistance in the population sector, hence self-sustainability is a problem, and increased support are necessary factors [3].

The extensive organizational structure of the MOHFW does not lend to effectiveness in services provided. In fact, the highly centralized management system which is divided into district, sub-district (thana), and union levels, results in limited flexibility and decreased efficiency and effectiveness in services delivered. This essentially transfers into less available service, if any service at all. Many service sites are not providing what they claim to provide. This has led to a loss of faith and confidence in government health care services on all levels. The problems are numerous as clinics are found to not be in operation with staff that are frequently absent from their posts, supplies and medicines that are misappropriated, and additional payments from patients which are often sought for what should be free services. Poor management in conjunction with the corruption and lack of transparency associated with government health services has hampered their success. Few patients seek services at these health centers, the ones that do utilize services come disproportionately from the village elite. Many women, who are the caregivers of their family, are not even aware of the presence of these government facilities [3].

This is not to say that Bangladesh's health delivery system has failed, because it has been upheld by its attempts to launch a community-based promotion of family planning services. Due to the Government's strong commitment to reducing the population's growth, it has developed a system in bringing essential family planning services to the population where female family welfare assistants visit the homes of married women of reproductive age promoting utilization of family planning mainly through the distribution of condoms and birth control pills. This method of health promotion and outreach has been successful in promoting family planning as well as other MCH activities including immunization, breast feeding, and ORT for diarrhea. Moreover, these community field workers have managed to reach more women in all the villages than the whole system and networks of clinics and health centers combined.

Several studies have shown a strong association between the number of personal contact between a client and field worker and the utilization of immunization services, particularly among the most uneducated female population [3]. Through this success, the sustainability of this program again arises, as it is noted that much of the support for the field workers come from external donors and NGOs.

Furthermore, with the sheer number of the country's population, Government health services alone are inadequate to meet the needs of its population and have often bypassed those who are in most need, the ultra-poor. There is a lack of comprehensive programs to not only meet the needs of, but to sustain and build the capacity of two important groups in Bangladesh's population: women and the ultra-poor. These two disproportionately affected groups must be addressed in order to make marked strides towards achieving MDG goals.

As a developing country, Bangladesh is unique in the existence of an extended public sector infrastructure through which to implement family services. Furthermore, it acknowledges health and service delivery problems that need to be addressed, and works alongside the private sector and NGOs, both local and global, to address these problems. One such local NGO through which a large amount of development and capacity building is accomplished is the Bangladesh Rural Advancement Committee (BRAC).

Bangladesh Rural Advancement Committee (BRAC)

Bangladesh has one of the most dynamic NGO sectors in the developing world. The NGO sector works through a strong working partnership with the Government, and greatly serves to fill the gap left void by Government services. BRAC is the largest non-sectarian national private development agency in the world and is unique and innovative in its approach to development in three particular aspects.

1) **BRAC uses the approach of operating a comprehensive program of multi-sectoral development activities in all 64 districts in the country [3].** That is, it has institutional intelligence in its ability to work effectively across all sectors including the commercial sector/private sector and government/public sector and combine all the aspects together in order to drive the development of the population, without being a threat to the current government system, but providing complementary and supporting services instead. Its innovative approach to development includes a decentralization of its management system and a flexibility that allows for constant expansion, evolution, and growing through experiential learning [4]. Unlike the Government, BRAC has proven itself to be self-sustainable as more than half of its annual budget is generated locally from its own activities and programs which include its own commercial enterprises.

2) **BRAC recognizes and puts an emphasis on women and the ultra-poor and their empowerment.** As the primary caregivers of the family who ensure the health and education of their children and thus the sustainability of future generations, women's empowerment plays a significant role in BRAC's focus on development. In a region where gender equity is an evolving state and women are starting to explore a certain newfound freedom, creating an enabling environment is crucial to allowing women to have the information to make their own choices and decisions for themselves as well as for their families. As one of the world's poorest countries, 49.8% of the country's population lives below the poverty line, and of that 49.8% [3, 4], 20% to 34% percent are considered to be the extremely

poor, or ultra-poor [2]. This group of people is often bypassed by standard development programs including microfinance and health programs, and is therefore left in their state of poverty without the opportunity for advancement or improved health status. BRAC recognizes this disparity in development capacity and seeks to bridge the gap.

3) **Through recognizing the multidimensional nature of poverty, BRAC seeks a holistic approach to its programs.** The comprehensiveness of programs acknowledges that improving the health of the people of Bangladesh cannot occur without development in all essential areas including education, economic, and social spheres in a strategic approach to counteract poverty through livelihood generation and sustainability. As the second largest employer in Bangladesh next to the Government, BRAC creates opportunities for the people of Bangladesh, especially the marginally poor women who often are not able to connect into the current market system and lack knowledge and education, thus forcing them to continue in the cycle of poverty and poor health.

Current Achievements

Bangladesh has made strides in reaching the targeted MDGs, and BRAC's multidimensional initiatives are helping women to achieve the more optimal health status sought by the MDGs.

MDG 4 – Reduce Childhood Mortality[1]

Prevention of diseases such as measles, poliomyelitis, and diphtheria--concurrent with widespread use of ORS for diarrheal diseases--has significantly reduced childhood mortality and morbidity [5, 15]. From 1990 to 2004, the under-five mortality rate[2] decreased from 149.0 to 77.0 per 1,000, and the infant mortality rate decreased from 100.0 to 56.0 per 1,000 live births [6, 15]. This success is also due in part to the slight increase in the number of births attended by trained health personnel from 5% in 1990 to 13.2% in 2004 [7, 15]. During the same time period, immunization against measles increased from 65 percent to 77 percent for children one year of age, though since among diseases that can be eradicated through immunization, measles is the leading cause of child deaths, this improvement is still below expectations [8, 15]. A few of the challenging factors that must continue to be addressed include neonatal and perinatal care, malnutrition, as well as special targeting of un-reached and underserved populations. Though progress has been made, there is still much work to be done to reach the under-five mortality rate goal of 50 per 1,000 live births by 2015 and this future progress is also dependent upon the social, cultural, and economic progress in the country [7].

MDG 5 – Improve Maternal Health[1]

To achieve this MDG, Bangladesh must drastically reduce its maternal mortality ratio (MMR) which stood at 574-850 deaths per 100,000 live births in 1990.[3] Recent data has shown that progress has been made in the reduction to 320-400 in 2000 [6, 7]. Despite this progress, MMR in Bangladesh remains one of the highest in the world [2]. In order to reach the goal of 143-213[4] deaths per 100,000 live births by 2015, the decrease will have to occur at substantial rates, and to address this, Bangladesh seeks to increase the proportion of births attended by skilled health personnel to 50%, and reduce the total fertility rate (TFR) to 2.2 per woman by 2010.[5] As indicated earlier, the proportion of births attended by medically trained personnel has increased to 14%,[6] and so increased efforts on this point must be made to reach the 50% national goal.

[1] Most recent data as of April 2005

[2] The under-five mortality rate markedly differs according to socioeconomic status and disproportionately affects the poorest. As of 2000, the rate of the poorest fifth of the population was 140 per 100,000 live births, 106 for the middle fifth, and 72 for the richest fifth (DHS Survey Year 1999/2000).

[3] There is a discrepancy between numbers recorded by WHO, UNICEF, UNFPA on the UN millennium indicator statistical database and the Bangladesh Maternal Mortality Survey (BMMS), NIPORT, 2001.

[4] Numbers based upon the initial 1990 discrepancy as noted above.

[5] These are Bangladesh national goals as articulated in the Bangladesh National Strategy for Maternal Health, 2001.

[6] Births attended by Medically Trained Personnel by percentage according to socioeconomic status is 4% for the poorest fifth, 7% for the middle fifth, and 42% for the richest fifth.

The benefits of reducing the TFR are numerous, and Bangladesh has made marked strides in this area. The Bangladesh TFR dropped from 6.3 births per woman in the 1970's to 3.4 births per woman in 1993-1994, and by the late 1990s was at 3.3.[7] This drop is consistent with a rise in contraceptive use. From an initial rate of less than 10 percent in the mid- 1970's, contraceptive prevalence rate rose from 30.8% to 53.8% percent between 1989 and 1999 and stands at 58% in 2004. It is noted, however that the TFR may not be completely accurate due to reporting errors, recall lapse errors, displacement of births, and the fact that male births tend to be reported more than female births. There are also indications that mothers often systematically overstated their children's ages, which would cause discrepancy in TFR [9].

BRAC's Comprehensive Approach

When families have fewer children, they are able to invest more in health care, nutrition, and education per child. This affects the next generation by lifting the standards of living for the future by promoting the importance of good nutrition, health care and education. When the population rises at a rapid pace, it places massive amounts of stress on environmental resources and farm sizes, which has the effect of only exacerbating poverty levels. "High fertility rates in one generation, therefore, tend to lead to impoverishment of the children and to high fertility rates in the following generation as well" [1].

For rural women in Bangladesh, health status marked, in this case, by MDG indicators, is not an isolated entity defined entirely by access to health care, but instead, is also linked to other factors including knowledge of basic sanitary precautions, access to income-generating opportunities, education, social development, and knowledge of legal and human rights [4]. BRAC provides the support needed in all of the following areas of health, education, economic development, and social development. A central component of BRAC's development program is village organizations (VOs), which are associations of the village rural poor with the common goal to improve their socioeconomic position, with a special emphasis on the participation of women [4]. This forum is also the venue through which a lot of information for each development component is disseminated and issues are discussed as it is a crucial link between the people and BRAC.

Health

Essential health care services (EHC) is provided through village health workers or *Shastho Shebikas (SS)*, members of the VOs who are trained to provide a comprehensive package of health care through critical health services in reproductive health and disease control. Furthermore, SS provide health education, treat basic ailments, collect basic health information, and refer the patient to a secondary health center if needed. These SS provide primary health care at the individual and community level to all, even the most poor. These health volunteers are allowed the opportunity to generate income through the selling of essential health commodities that they purchase from BRAC [4]. SS form the basis of essential health care delivered through BRAC, and additional services are built upon that for more specialized and focused care, which include health, nutrition, and immunization education often in conjunction with Government supported programs.

Unlike usual development programs, BRAC seeks to reach the extreme-poor or the ultra-poor, to whom most funding and programs are inaccessible in standardized approaches. The provision of EHC to the specially targeted ultra-poor (STUP) go beyond basic EHC to provide care to all STUP regardless of their health status and additionally provides financial assistance to STUP who are diagnosed with mild to severe morbidity. By ensuring this form of care, personal interaction, and education is provided to all women regardless of status guarantees a greater form of compliance and understanding of family planning measures and MCH measures which in turn make progress in meeting child and maternal health needs. Analyses suggest that empowered women are aware and concerned about the health and well-being of their children and try to promote better health and social outcomes in the next generation, but are faced with many cultural constraints and social pressures in doing so [10].

[7] The poorest again suffer from the highest TFR when TFR is observed according to socioeconomic levels. As of 2000, the TFR for the poorest fifth was 4.6 lifetime births per women, 3.3 for the middle fifth, and 2.2 for the richest fifth. (DHS Survey year 1999/2000).

Education

Non-Formal Primary Education has successfully contributed to the reduction of illiteracy, and has ensured that a significant proportion of the country's children, especially the poor and hard-to-reach (ie. females) were educated. With an approach different from the national system, by 2003, nearly 1.1 million children, 66% of whom were girls, attended BRAC schools, and of the 2.1 million who had graduated from a BRAC school, 91% had moved on to attend formal schooling at higher grade levels. Without BRAC, parents would typically invest in their child's education through the annual cost of $18 per child. This investment was made to equip this future generation with the knowledge, literacy, numeracy, and life skills needed to sustain themselves and their families more successfully in the future. For women, education plays an important role in empowerment as it increases their agency, capacity, and resources to improve their health and life status.

Economic Development

This foundational core of BRAC's development program allows women to participate in the opportunity with the support of peers to achieve self-sustainable livelihoods and improvement in their lives and thus empowering themselves through the attainment of an income. Under the economic development core of BRAC's initiative, the areas covered include microfinance, institution building, income generating activities, and program support enterprises. This element of BRAC's work provides a firm basis for the self-sustainability of the participants in the development process. By making credit available to the poor, especially women, at a reasonable price, and involving them in income-generating activities outside of the home, promotes economic development of the country as a whole in addition to promoting the livelihood of the individual to make headway out of poverty.

Social Development

In promoting awareness of social, political, and economic issues, and building local-level social institutions, women and the poor are empowered to develop a voice and leadership to take action when their basic rights are being infringed upon and violated. By helping women obtain access to appropriate resources, protection can be sought and the challenges faced by women and the poor can be more greatly understood.

Current Challenges

The positive steps and achievements made for improvement and development are not without challenges. Although the successes made with BRAC towards the improvement of the quality of life and health within the context of the MDGs and the different development cores have been great, at the macro-level, the gains are modest in comparison to the overall magnitude of the problem. Steps towards social change are met with cultural resistance at all levels, and these barriers are ones which must be overcome in order to see true progress. Despite economic achievements, Bangladesh remains one of the world's poorest countries. Poverty rates continue as 50% of the country's 135 million people live below the poverty line, giving Bangladesh the dubious distinction of having the highest incidence of poverty in South Asia. After India and China, Bangladesh has the third highest number of poor people living in a single country [11].

Bangladesh's maternal mortality rate remains at an unacceptably high level, even though the country has a relatively strong national policy regarding maternal health care. Considering that maternal mortality figures vary widely by source and are greatly controversial, estimates for Bangladesh suggest that approximately 25,800 women and girls still die each year from complications related to pregnancy. Additionally, each year another 516,000 to 774,000 Bangladeshi women and girls suffer from disabilities caused by complications during pregnancy and childbirth. The traditional practice of early marriage impacts the maternal and infant mortality rate as well; the younger the mother, the greater the risk of negative health consequences for both mother and infant. The average age for female marriage is 14 years, and 11 percent of women aged 15-19 years give birth each year [12].

Despite improvement in nutritional status of women and children, further progress is still needed as the rate of malnutrition is highest in the world. Malnutrition is a major cause of death and debility in children in Bangladesh. Micro-nutrient deficiency is quite common; nearly 75 percent of children's life is spent in illness mostly due to malnutrition-related debility and infections. Low

birth weight and malnourished children are susceptible to infections; roughly two-thirds of under-five deaths are attributed to malnutrition. About 25 percent of maternal deaths are associated with anemia and hemorrhage. Women and adolescent girls mostly suffer from anemia owing to iron deficiency [12].

In spite of a dramatic decrease in the total fertility rate (TFR) in the early nineties, TFR has remained constant at 3.3 births per woman since 1994, even while contraception prevalence rate (CPR) has increased. One possible explanation for the stagnation of the TFR is that desired family size culturally has a bigger impact on TFR than use of contraceptives. Another explanation is gender preference. Fertility research shows us that the expected desired fertility is much higher than the desired fertility in the presence of sex preference, which is a continuing problem in Bangladesh. However, in Bangladesh, sex preference only explains a small portion of the present differences between family size and the TFR [9]. Therefore, further explanations must be sought and addressed. Also, the quality of all maternal and child health (MCH) and family planning (FP) services are not on the same throughout the nation and differs greatly in rural versus urban areas.

Corruption is another major factor inhibiting the progress in Bangladesh. Its presence is detrimental to progress as funding allocated to health care and poverty often fail to benefit those in need. Transparency Coalition International ranks countries in terms of the degree to which corruption is perceived to exist among public officials and politicians. Among 146 countries surveyed, Bangladesh's Corruption Perception index (CPI) in 2004 was 1.5 and ranked 145. Globally, 60 countries score less than 3 out of 10, indicating rampant corruption. With a score of less than two, Bangladesh is considered one of the most corrupt nations in the world, second only to Haiti [13]. However, in recent months and with the aid and support from NGOs, the government of Bangladesh has begun to address the problem of corruption by the development of the Caretaker Government. If this is successful, Bangladesh will see an ushering of a new era.

The progress being made with BRAC represents a positive, albeit slow trend towards economic, social, educational, and health development, where women and the ultra-poor are more empowered. BRAC emphasizes making the partners of the programs true collaborators in the development effort by listening, observing, encouraging, and having them participate and contribute to development efforts and together use epidemiology to determine needs. Their holistic approach to health outcomes includes increasing the value of girls and women in society, thus effectively and directly addressing the issues which affect maternal health and child mortality. BRAC's approach aligns with the people's needs in order to have them see the essentialness of health care. Therefore, by placing an emphasis on livelihood and equipping them with the means to assure the necessities of life, BRAC provides standard services geared specifically towards the poor and women, and creates an accountability among the poor for their lives [14]. BRAC's innovative and participatory approach engages youth, women, and the ultra-poor directly in improving their own status and strives to create social change towards self-sustainability and capacity and seeks to bridge the existing gap between provided government services and the women and ultra-poor. Only when this is done can there be true progress towards meeting the MDGs.

Conclusion

BRAC brings organizational innovation and program design to Bangladesh. Its contributions in the areas of program implementation in education and health, technical assistance in bringing microfinance to the ultra-poor, and capacity building of women and the ultra-poor represent a comprehensive approach to bringing sustainability and health to the population of Bangladesh. With the realization and accomplishment of these objectives, true progress towards child and maternal health can be attained. BRAC involves specific change agents to this innovation. These include the *focused behavior* in improving maternal and infant health; an *organizational* structure, a unique decentralized *management* system that constantly evolves as the people's needs change and shape the services delivered, a broader *environment* that connects different ministries and sectors of government and beyond, informal *networks* of women's groups, and the appropriate use of *technology*. Through the collective use of these change agents, BRAC is able to *foment* or excite the growth and development of Bangladesh and contribute to sustainable progress towards the Millennium Development Goals.

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