

Bangladesh context analysis for accountability interventions to support the delivery of FP2020 commitments

This country brief is part of a series of briefs produced by Action2020, a consortium led by Christian Aid and implemented by Christian Aid, Plan International UK and the HIV/AIDS Alliance. It follows an in-depth investigation into the context and opportunities for civil society-led accountability on family planning in 10 countries, with a focus on the commitments made by Governments as part of FP2020's global initiative to meet the need of an additional 120 million new contraceptive users by 2020. Each brief provides a country-specific overview of the context for family planning commitments - the power, politics and potential for accountability interventions related to these commitments – and proposes recommendations for accountability interventions related to these commitmentsⁱ. A general note on Lessons Learned in FP Accountability accompanies this seriesⁱⁱ.

The right to enjoy full, free and informed access to contraceptive information, services and supplies is central to sexual and reproductive health and rights, as well as to the right to the highest attainable standard of health. These rights are universal, inalienable and indivisible, and States have a duty to respect, protect and fulfil these rights to the maximum of their available resources. There are a range of barriers and opportunities that either prevent or enable access to FP. Power, governance and accountability and women's participation and leadership all influence the outcomes and capacity of key actors to deliver for FP.

The Government of Bangladesh has made commitments to increase access to Family Planning (FP) as part of FP2020 and to take the measures within their remit to address some of these barriers.

Implementation of FP2020 commitments has the potential to transform family planning provision, extending high quality services at scale and reaching the most marginalised. However, insufficient leadership, financing and attention to excluded groups means that Bangladesh may struggle to meet all aspects of its commitments.



Family planning context in Bangladesh

- Unmet Family Planning need: 14% (2012 - 2013 MICS)
 - Contraceptive Prevalence Rate: 62.4% (DHS Key Indicators 2014)
 - Total Fertility Rate: 2.3 – DHS 2014
 - Maternal Mortality Ratio: 176 per 100,000 (2015 modelled estimate)
 - GINI Index: 32.0 (2010, Consumption based)
- Source:

- <http://data.worldbank.org/indicator/SH.STA.MMRT>
- <http://wdi.worldbank.org/table/2.9>

Accountability interventions can alter this trend by working with a range of actors so that governments and service providers are better able to meet the commitments they have made, leveraging a scale of impact which would be unachievable by alternative interventions.

FP2020 commitment:

Reduce total fertility rate (TFR) to 2.0 by 2021; Increase contraceptive prevalence rate (CPR) to 75% by 2021; Increase share of LAPM to 20% by 2021; Reduce unmet need to 10% by 2021 and reduce discontinuation rate of FP method to 20% by 2021. Policy commitments are to adopt the policy of provision of clinical contraceptive methods by trained/skilled nurses, midwives, and paramedics by 2016; to promote policies to eliminate geographical disparity, inequity between urban and rural, and rich and poor, ensuring rights and addressing the high rate of adolescent pregnancies.

Progress to date:

Unmet need among the age group 15-19 years and 20-24 years remain higher than the national average at 17.1% and 14.1%. Across divisions, unmet need is highest in Sylhet (18%) and Chittagong (17%), and lowest in Rangpur (7 percent). The all-method discontinuation rate is 30 % in 2014. Discontinuation rates are much higher for more temporary methods like condoms (40 percent) and the pill (34 percent) than for longer-term methods like implants (7 percent).

[For further information](#)

To achieve this, social accountability programmes must be 'strategic': pursuing multiple pathways to change, creating an enabling environment for collective action and linking citizen mobilisation to agents within governments with similar incentives³. Interventions must link citizens to authorities with the necessary capacity to enforce agreements in order to achieve substantial outcomes^{4 5}. When applied in tandem, these strategies may increase political incentives to act, and facilitate oversight and reflexive evaluation of barriers, gaps and opportunities for FP by all stakeholders.

Strategic accountability interventions in Bangladesh

Effective accountability rests on an enabling governance environment where the state has both the capacity and incentives to respond, and where citizens are able to mobilise collectively^{6 7 8}.

While there is nominally a good accountability context in Bangladesh actual collaborative spaces

for dialogue are limited. Progress has been patchy with some good progress on providing more clinical delivery but little evidence of progress on others. Key challenges include quality of service provision, socio-cultural norms that result in legal and policy restrictions and limited attention to the needs of marginalized groups, as well as limited demand for long-term methods, linked to poor service quality, perceptions, and cultural reluctance. These combine with issues of leadership of FP services, financing, coordination, infrastructure and skilled human resources for providing the required services, especially for the poor.

The key pathways to effective FP accountability in Bangladesh can be conceptualised as three overlapping components, outlined below. For interventions to be successful, they must start by identifying the prevailing drivers and political incentives/disincentives to develop smart, context specific strategies for securing change^{9 10}. It is likely that informal and technical channels will be most effective, alongside supporting nascent vertical accountability efforts.



Figure 1: Key Pathways to Effective FP Accountability

The following section explores the context and opportunities for action in Ethiopia using these three pathways as a framework for analysis.

Enhanced citizens' voice and agency - problem analysis:

Though the constitution formally provides equal rights to women, in reality, patriarchal traditions still dominate. Patriarchal traditions prevent women and girls from participating in familial decision making processes, and create barriers to communication about FP. Partner preferences influence women's level of unmet need, which is higher where the male partner wants more children or is undecided¹¹. Buddhist women have the highest level of unmet need, although Muslim women make up the highest proportion based on religion¹². Muslim women have less mobility and empowerment than women in communities practicing other religions. Rural women generally have limited exposure to media messages on family planning and less mobility to go to health centres.

Early childbearing is common, linked most strongly to levels of education and wealth. Women over 45 years are more able to take decisions than younger women. Data is limited, but studies suggest that unmarried women face additional barriers and have far higher unmet need than their married counterparts¹³. Unmet need is particularly high among women who have never used contraception¹⁴. Married adolescents are treated as adults and can access limited services, but if they are unmarried they have very little autonomy to seek help or information. Legally, government policy only supports the provision of contraception to married couples. Although contraception is available for purchase at pharmacies, social taboos on pre-marital sex limit access for unmarried young people. This situation is worse in the hard-to-reach area such as the coastal belt, hill areas, Char and Haor areas. Religious and cultural barriers deter open discussion about sexual and reproductive health services for unmarried youth and there is limited political appetite to address these barriers.

Bangladesh was one of the first developing countries to strongly endorse a national family planning programme, which resulted in higher uptake of contraception. However, concerns were raised about whether these changes were brought about in a sufficiently rights-based manner, particularly in relation to service provider incentives¹⁵. Rights based provision based on free and informed consent for all remains an issue, alongside addressing socio-cultural norms and

related legal barriers to access for others such as unmarried women.

At the local level, laws are in place to provide specific opportunities for citizen engagement and participation, but these opportunities for citizen participation are only useful if citizens are motivated and empowered to engage with services. Social and cultural norms undermine the incentives that would naturally motivate women and girls to demand better services, and social hierarchies define who participates in public meetings, discouraging participation by the uneducated, the poor, women and girls.

Recommendations for action:

- Strategies that seek accountability for FP services will need to take cultural realities that limit participation by women and girls into account, and find ways to mitigate or overcome them. Framing FP accountability as part of a wider health dialogue may lessen the additional barriers related to discussing FP.
- If the government is to meet its commitments to FP, it will need to find creative ways to reach all sectors of the population including unmarried women. Civil society and religious leaders may be valuable partners in opening the debate and identifying narratives that can be supportive and also co-exist with broader socio-cultural norms.

Increased political space for state-citizen engagement - problem analysis:

Two laws form the foundation of transparency, accountability and citizen participation in Bangladesh. The Right to Information Act of 2009 is designed to increase transparency and accountability, decrease corruption and establish good governance. It requires that government officials catalogue and preserve all information on decisions, procurements and activities executed or proposed. This law provides an entry point for tracking key FP commodities and identifying staffing shortages directly linked to Bangladesh's FP2020 commitments. The Local Government Act defines specific opportunities for citizen engagement and participation at the local level. "Ward Shava" meetings convene all registered voters and can propose projects and examine local government performance. "Standing

Committees” exist for 22 themes, including family planning. The analysis demonstrated some interest in the possibility of aligning pro-reform local government officials with traditionally disempowered constituencies in order to advance FP services.

Corruption in Bangladesh remains rife, however, Bangladesh outperforms its peers in South Asia with respect to budget openness, which may offer limited opportunities. If properly leveraged, Bangladesh’s \$400M commitment to FP2020 objectives offers an opportunity for civil society to hold the government accountable for a specific benchmark. In particular, Bangladesh civil society has decades of experience implementing localized social accountability interventions with a focus on health that could be linked, consolidated, and vertically integrated to influence the broader policy environment. By linking local monitoring and accountability to national and international commitments, civil society can help ensure that reality is matched to ambition.

Bangladesh has a rich, sometimes contentious history of political participation, a lively media, and widespread political awareness among the people at large. Although recent electoral violence has closed some space for collaborative political dialogue, civil society has been active to date in producing shadow human rights reports, for example on the situation of child marriage¹⁶; participating in the consultation for the Mid-Term Review of the Bangladesh Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011-2016¹⁷; campaigning to include the right to access healthcare within Bangladesh’s constitution¹⁸ and including young peoples’ voices in the post2015 agenda¹⁹. Notwithstanding this, the chief focus of civil society work in Bangladesh is service delivery, with accountability programming still an emerging area. Given their history of service provision, the role of civil society in accountability raises questions about conflicts of interest. Accountability initiatives would need to consider how to negotiate this without undermining civil society’s role in pressing for more structural, sustainable change²⁰.

The media in Bangladesh is influential but does not routinely prioritise FP issues. The government has recently made greater use of the media to disseminate information on maternal, newborn and child health; family planning; nutrition; adolescent

reproductive health and HIV/AIDS. This increased attention by the media could be matched with efforts to encourage investigative reporting on performance and delivery of services, as well as following through on government commitments including tracking budget allocations and spending. To secure interest, it may be necessary to consider how best to frame these issues in ways that will appeal to media outlets- bearing in mind the lack of interest attached to FP when considered a ‘women’s issue’. This need to consider the frame for FP exists at all levels of government, with social norms and political apathy towards FP resulting in few champions for FP.

A critical space for state-citizen engagement on FP would be through the Country Strategic Working Group for FP2020, a collaboration between Government, International & National NGOs and Development Partners. Guided by the Health ministry and facilitated by UNFPA, this forum has both potential and interest and facilitating the government and CSOs to ensure efforts to make progress towards FP2020 commitments.

Recommendations for action:

- Support the incorporation of FP elements into health-focused social accountability and campaign interventions, including the Right to Information Act and existing Grievance Redress Mechanisms.
- Address the lack of leadership for FP at the national level, through fostering a community of “believers” - specifically within the DGFP and within women parliamentarians. Identify and promote “champions” at all levels. Generate attention by convening media-heavy events with large FP donors and DGFP leadership and leverage the FP2020 platform to cultivate international relationships and put pressure on national level officials.
- Support could be complemented by the creation of an FP professional society, similar to those that exist for other medical professions. This society could conceivably play an important role in catalysing support for FP at the political level in districts and Dhaka. By combining moderate popular demand, the interests of the private sector, and pressure from a professional society, the consortium might be able to foster sufficient political pressure to advance FP accountability at the policy level.

- Foster a less divisive environment for accountability by deploying social accountability processes to measure civil society as well as private and public provider performance.

Open, inclusive, responsive and accountable institutions - problem analysis:

FP in Bangladesh sits within the Ministry of Health and Family Welfare (MOHFW). Under this, the Directorate General of Family Planning (DGFP) is responsible for providing family planning and MNCH services nationally in rural areas. The Ministry of Local Government, Rural Development & Co-operatives (MOLGRDC) has the primary responsibility for urban health care. The DGFP sets its own budget in consultation with local authorities, with yearly budgetary allocation ultimately determined by the MOHFW and fund availability. Demand for FP commodities is projected by local authorities and distribution is managed via DGFP central and divisional level warehouses. Bulk purchases are made by respective central units of DGFP and allocations are provided to the local level to meet specific needs. Complex commodity systems may in part contribute to the chronic commodity security and supply chain challenges.

Leadership on FP is lacking and recruitment processes within the Directorates have led to a lower prioritisation of FP through reliance on civil servants without an FP background, short periods of office amongst key decision makers and limited opportunities for career advancement. At the local level this is replicated in a high level of staff vacancies, delays in recruitment and insufficient resources for adequate supervision. Increasingly, urban areas have more localised control through Local Level Planning processes which can provide greater space for communities to influence service delivery and FP budgets directly.

Currently, poor prioritisation of FP by local governments and a lack of coordination and alignment with the MOHFW limits the success of this model and undermines citizen attempts to seek accountability. Some of this lack of clarity could be ameliorated by the DGFG's Citizen Charter but in practice this Charter has been underutilised. Many of these problems are

traceable to poor practices of decentralized planning, and could be improved by strengthening clear, accountable local government structures and processes.

Given the weaknesses of the democratic institutions, there are few effective oversight mechanisms to ensure the accountability of the government's fiscal operations and other economic functions. Bangladesh's FP Costed Implementation Plan commits to a total of US\$ 1.495 billion in order to reach 39.4 million eligible couples by 2021 and to halving the resource gap for FP services by 2021, including resources from donors. The total allocated budget for FP has increased yearly since 2012 however the overall commitment has not yet been met. Bangladesh spends less on health from all sources than the average for other low income countries globally, and within this the DGFP proportion of the budget is low. Budgets are both highly centralised and split across two budgets nationally and over 32 different Operational Plans, with little or no flexibility to reallocate as needed. Lengthy and complex commodity procurement processes and dependency on foreign procurement create further barriers.

Bangladesh made commitments at the London Family Planning Summit in 2012 to provide clinical contraceptives by trained/ skilled nurses, midwives and paramedics by 2016; to promote policies to eliminate geographical disparity, and inequity between urban and rural, rich and poor; and to ensure rights and address high rate of adolescent pregnancies. To date, significant progress has been made towards increasing the number of staff and clinics that can provide FP commodities and services, including increased recruitment and training of Family Welfare Visitors and Family Welfare Assistants (FWAs), allowing FWAs to administer oral contraceptives, condoms and injectable contraceptives after the first dose in the community six days a week, and allowing staff nurses to insert IUDs. Two child restrictions on sterilisation and the use of implants by nulliparous married women have been relaxed. However, it is less clear to what extent these changes have addressed commitments to tackle FP disparities or targeting adolescents, and evaluations of the changes are not publicly available.

Challenges in service provision include lack of financing, infrastructure and skilled human resources for providing the required services, especially for the poor. The quality of FP services tends to be low. FP service providers tend to be poorly motivated and are typically not highly remunerated or respected. To some degree, recent government initiatives have increased the workload on local level workers without expanding the incentives to perform, and it is unclear how effective the training has been. The resultant gap in service provision is largely filled by the private sector. While 49% of modern contraceptive users, and nearly all sterilization, IUDs and implants are obtained from the public sector, the role of the private sector coverage is growing by about 15% per year. Business interests have also gradually gained influence over politics. Therefore, the private sector is a critical partner in efforts to ensure the accountability for FP. In particular, formal providers are regulated by a joint governing board, and have networks of teaching colleges that might serve as instruments of accountability. Professional associations like these can provide valuable political leverage in Bangladesh.

Recommendations for action:

- To address the critical lack of leadership on FP, long term strategies could include pressing for the appointment of more technically sound leadership within the DGFP. Short term strategies could include incentivizing current leadership through high-profile events and targeted support to strengthen the capacity and leadership of individual allies within the DGFP.
- Help convene coordinating committee for FP at the district level to ensure clarity of mandates, budgets, and accountabilities. In particular, leverage DGFP's "Citizen Charter" as a starting point for accountability and rigorously baseline and evaluate change to generate lessons and provide a model for other communities.
- Press DGFP to evaluate the effectiveness of its training programme and explore an independent evaluation of FP knowledge among trained staff. Increase motivation and dialogue with service providers, for example through creating an "FP Service" award.

- Track FP budgets from national to local level to identify bottlenecks and publish yearly briefings.
- Make briefings simple and accessible to media.

Conclusion and general recommendations

Accountability for FP at the local level will require new approaches that do not necessarily reflect traditional social accountability practice. Unlike traditional social accountability targets in health and education, FP is taboo. Cultural norms and confidentiality concerns can undermine candid discussion of FP service delivery performance, particularly with regard to the full free and informed access by marginalized groups. Thus, semi-private approaches like citizen report cards and social audits might be more appropriate than deliberative approaches like community score cards. Added to the challenges of taboos are the challenges presented by the relatively low political power of citizens (especially youth) who need FP services the most. Local actors might be able to mitigate this dynamic by incorporating FP service monitoring into regular health service monitoring, thereby enlisting the support of a broader segment of society.

Shared responsibility across numerous departments currently results in limited and unclear accountability channels. The DGFP's Citizen Charter could, if revitalised, be a useful focal point to mobilise citizens in collaboration with the Directorate. CSOs can encourage government service providers to participate in FP monitoring by opening social accountability processes that measure CSO performance as well. By participating in FP accountability as equal partners, CSOs can help create a constructive enabling environment, and encourage reluctant (often underpaid and overworked) FP health workers to participate. In other fields (health, education), frontline workers often serve as useful public allies when addressing larger structural accountability issues²¹.

Of course, these positive measures must be accompanied by interventions that supply “teeth” Independent evaluation of health worker capacity, interventions to test performance management approaches and use of existing grievance redress mechanisms and Bangladesh’s Right to Information Act may compel government action.

Ministry-level and parliamentary leadership will help ensure that the Government of Bangladesh fulfils its (currently lagging) financial commitments. Since health in general is grossly underfunded, it may be strategic to seek to leverage existing health campaigns and supply an FP angle. Smart, targeted FP budget tracking could provide a sophisticated angle to such campaigns. By focusing on the fundamental, structural leadership and budgetary restraints on FP failures, FP accountability efforts can promote a more sustainable environment for overall progress towards meeting the unmet need for FP.

ⁱ This brief is based on a full Country Context Analysis, available on request from Christian Aid and Plan International UK.

ⁱⁱ Also available on request from Christian Aid and Plan International UK.

³ Fox, J.A. (2007) The Uncertain Relationship Between Transparency and Accountability. *Development in Practice* 17(4): 663-671; and Fox, J.A. (2014) Social accountability: What does the evidence really say? GPSA Working Paper No. 1

⁴ Mansuri, G., & Rao, V. (2012). *Localizing Development: Does Participation Work?* Washington, DC: World Bank

⁵ World Bank (WDR) (2014) *World Development Report: Making Services Work for the Poor*. Washington, DC: World Bank

⁶ Wales J. and F. Smith (December 2014) Initial review – Evidence on social accountability in fragile states

⁷ Fox, J.A. (2007) The Uncertain Relationship Between Transparency and Accountability. *Development in Practice* 17(4): 663-671

⁸ Mansuri, G., & Rao, V. (2012). *Localizing Development: Does Participation Work?* Washington, DC: World Bank

⁹ O’Meally, S. C. (2013). *Mapping context for social accountability*. Washington DC: Social Development Department, World Bank

¹⁰ World Bank (WDR) (2014) *World Development Report: Making Services Work for the Poor*. Washington, DC: World Bank

¹¹ <http://www.omicsgroup.org/journals/why-unmet-need-for-family-planning-remains-high-in-bangladesh-a-community-level-analysis-2167-0420-1000290.php?aid=65248>

¹² <http://www.omicsgroup.org/journals/why-unmet-need-for-family-planning-remains-high-in-bangladesh-a-community-level-analysis-2167-0420-1000290.php?aid=65248>

¹³ Casterline JB, Sinding SW (2000) Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. *Population and Development Review* 26: 4 691–723.

New Estimates of Unmet Need and the Demand for Family Planning. DHS (Demographic and Health Surveys) Comparative Reports No.

14. Calverton, MD: Macro International Inc

¹⁴ <http://www.omicsgroup.org/journals/why-unmet-need-for-family-planning-remains-high-in-bangladesh-a-community-level-analysis-2167-0420-1000290.php?aid=65248>

¹⁵ Hardee et al 2014

<https://www.gutmacher.org/pubs/journals/4020614.html>

¹⁶ <https://www.hrw.org/report/2015/06/09/marry-your-house-swept-away/child-marriage-bangladesh>

¹⁷ <http://www.manniondaniels.co.uk/2014/09/18/advocating-for-more-attention-to-srhr-in-bangladesh/>

¹⁸ <http://serac-bd.org/health-rights-advocacy/>

¹⁹ <http://serac-bd.org/can-you-hear-me-raising-the-voices-of-young-key-populations-in-the-post-2015-agenda/>

²⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928100/>

²¹ Marta Schaaf et al, Social accountability and health system performance in Zambia, forthcoming (2016).