

## **Abstract**

Public policy concern with the development of health care services in the Third World has changed dramatically since the 1978 Alma Ata Conference and its focus on primary health care. In Bangladesh the primary health care emphasis shares the stage with an expressed concern to provide for basic health needs and to change family planning implementation schemes. Drawing on data collected between 1980 and 1983, this paper examines the gendered political economy of health policy in Bangladesh as it is reflected in the type and implementation of health services available to women. Particular attention is given to resource allocations within and to the health sector and to the national health priorities of government. Through an examination of specific health sector initiatives, the paper concludes that women's health care needs are narrowly defined within a view of women as child bearers. This view has framed sector planning, delimited the kinds of resources available to provide health care services to women, and resulted in the fragmented delivery of maternal and child health services.

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## **Sometimes Available but Not Always What the Patient Needs: Gendered Health Policy in Bangladesh**

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SOMETIMES AVAILABLE BUT NOT ALWAYS WHAT THE  
PATIENT NEEDS: GENDERED HEALTH POLICY IN BANGLADESH

Introduction

It is accepted wisdom that health services in Asian countries are used differently by women and men. Women and men also perceive the availability of health resources in quite different ways. In the context of an analysis of the implementation of a Health for All strategy in Bangladesh, this paper argues that a gendered political economy of health care structures the set of policy and program choices the Government has supported. The argument rests on the assumption that the gendered political economy of health policy caricatures women as child bearers.

The paper contends that a policy environment premised on women's reproductive capacity, and a set of family planning projects and programs which are diffused throughout the bureaucratic sectors of government (see Figure 1), shape the health services that are made available to the rural population. The paper avers that the choices women make for particular health services are premised, not on their reproductive interests alone but on their ability to meet the labor demands of the family (Feldman 1983b; Feldman et al. 1981). In other words, women's receptivity toward, involvement in, and acceptance of specific health and family planning interventions are premised on a broader interpretation of their health care needs than that which typically characterizes a conception of women that underlies international and national policy and planning initiatives. This broadened view indicates a basic contradiction between the kind of health services made available to rural dwellers and the demand for services which are thought to meet the needs of the vast majority. Additionally, the paper asserts that the perceptions people hold about illness and the treatment they seek are complicated by factors of gender, class and age, as well as by the quality and availability of existing health services.

The 1978 Alma Ata Conference sponsored by the World Health Organization recognized the importance of primary health care (PHC) as a strategy for improving the lives of the vast majority of Third World populations. As an outcome of the Conference a number of specific objectives were proposed as a means of strengthening a country's commitment to improving primary health care services. These objectives include: (1) a community-based maternal and child health care (MCH) and family planning service delivered in coordination with other elements of PHC; (2) a hierarchical institutional structure to facilitate a coordinated system of health resources to the countryside;<sup>1</sup> (3) the strengthening of epidemiological surveillance and the control of all communicable diseases; (4) the expansion of immunization coverage; (5) self-reliance in the production of basic pharmaceuticals;<sup>2</sup> (6) collaboration in the provision of clean water and the disposal of wastes, and of biomedical and health services research; and (7) systematic improvement in the practice of indigenous medicine and the evaluation of indigenous drugs.

Bangladesh has supported the primary objectives of the Conference and in accepting these objectives has outlined four major areas of intervention: health status concerns, health care delivery, quality of life issues, and an improvement in the coverage and accessibility of health services.

Under each major area of intervention a number of specific objectives were framed. Health status objectives include a reduction in infant, child, and maternal mortality, a reduction in disease-specific and overall death rates, reductions in morbidity in various diseases and in population growth as well as improvements in nutritional status. Health care delivery includes the following objectives: the immunization of infants and children through an expanded program of immunization (EPI) against tuberculosis, diphtheria, pertussis, tetanus, measles, and polio; the provision of antenatal, natal, and postnatal care, and the control of preventable diseases with particular emphasis on communicable diseases.

Included under the heading of improved health care delivery is a commitment to establish a surveillance mechanism in the disease control program, to focus institutional changes on the development of health facilities of the treatment of minor and common diseases, and to institutionalize a comprehensive program for health information and health education; the ensuring of community involvement in strengthening supportive and auxiliary services; the adequate provision of essential drugs and vaccine including contraceptives and other family planning services; and the development and integration of indigenous and homeopathic systems of medicine into health care service. This would include the establishment of comprehensive referral services for ensuring better quality health care for the rural population (GOB 1981).

A national commitment to primary health care as defined by the Alma Ata Conference implies a broad view of the factors which influence health care access and utilization and implies the acceptance of poverty as the main determinant of ill-health in the world today (UNICEF/WHO 1981). In this respect a commitment to primary health care has superseded the narrow, technocratic approach which had been the primary thrust of the "basic health services" approach in the past to the provisioning of rural health services (UNICEF/WHO 1981:29). The primary health care objectives as outlined by the Government of Bangladesh (GOB), therefore, imply a commitment to improved quality of life. Improvements in quality of life indicators are anticipated to include the expansion of employment opportunities, particularly for the most disadvantaged and vulnerable groups, a commitment to increase and more equitably distribute per capita GNP, the provision of safe water and improved environmental sanitation and housing, compulsory primary education and the complete removal of illiteracy, and the integration of these efforts so as to realize increased life expectancy and ensure the full participation of women in socioeconomic activities. Under the fourth major area of intervention, coverage, and accessibility, there is a commitment to provide free medical services at least to the disadvantaged (GOB 1981:3-5).

Given the range and institutional commitments that must be met in order to provide the services outlined above, the Bangladesh Government would need to significantly alter resource allocations between sectors of the economy. It would also need to raise sufficient revenues for, and commit increased resources and personnel to the health sector as well as reorient its present understanding of the causes of poverty and inequality in the country. Given the country's economic and political history since independence it is difficult to imagine that it will be able to realize these objectives in the next two decades.

For Bangladesh, much of the difficulty in realizing the objectives of the Alma Ata Conference lies in the organization of existing health care services. These services remain urban biased and include an emphasis on curative rather than promotive or preventive care. Any reorganization of services requires a financial and intellectual commitment by the government to reorient its health sector strategy. It will also require a commitment to develop a rural infrastructure able to provide decentralized services to meet the needs of the rural majority.

A reformed health strategy will undoubtedly encounter implementation difficulties because of the constraints imposed by the international priorities which characterize aid flows to Bangladesh. International priorities emphasize the increase and privatization of agricultural and industrial productive capacity, but they neither adequately address nor fully integrate the need for an expansion in the public social services sector including health, education, and welfare resources. To the extent that attention is directed at providing social services, there is a growing commitment toward privatization and self-reliance. This is articulated in terms of "fees for service" whereby it is assumed that people who pay for services are more likely to actually use them appropriately. This is also indicated in skills training programs which are designed to increase employment and income-generating opportunities through an expanded commitment to individual initiative and self-reliance.

In the move away from public sector initiatives, a rethinking of health sector policy must confront the nature of national policy priorities and state practices which assume that the primary cause of rural poverty is high population growth. As will be elaborated upon below, health policy priorities are contextualized by a number of assumptions regarding women's reproductive responsibilities and expectations regarding child rearing. They are also embedded within an ideology, shared by the donor community and urban elite policy planners, that the social and cultural expectations of purdah, or women's seclusion, shape valuations of women's behavior and deportment and serve to constrain their participation in social programs, particularly health and family planning programs.

Two additional constraints to realizing the objectives of a Health for All strategy concerns the aid-dependent character of the Bangladesh state and the particular relationship of national policy formation and implementation to the structure of the rural bureaucracy and the nature of decentralized decision making. Aid dependency is indicative of an extremely limited national resource base upon which health care services rely for financial support. In effect a minimal tax base and stagnant agricultural and industrial production provide only limited funds for public sector activity such as health care. The degree of aid dependence is epitomized by the fact that foreign assistance presently supports 80 percent of the national budget. This dependency on foreign funding to support government operations has also served to constrain autonomous sector planning. This is because the donor community may tie aid agreement to particular policy reforms or operational strategies.

Another aspect of dependency is that investment in health sector activities are shaped and supported by international assistance which often reflect the priorities of lending countries. This has been most visible, for example, in the shifting assistance the U.S. government provides to family planning programs which support menstrual regulation or abortion.

The second constraint to health sector reform, also a derivative of limited revenues, affects national policy and government operations. Financial constraints limit decentralized program development and engender competition among ministries for the scarce resources available in the revenue budget. Factors of scarcity and competition shape relations among ministries and between policymakers and planners at the national level as well as at the regional level. This array of financial and structural constraints conditions the nature of health policy and program implementation in the urban and rural areas and sets the context for patterns of health care availability, access, and utilization.

### The Political Economy of the Bangladesh Health Service

In the context of the current situation in Bangladesh the leadership as well as members of the donor community argue that the primary problem in the country is population. This emphasis is encapsulated by General Ershad in a 1983 address to the nation where he notes that:

We must keep one thing in mind...the process of socio-economic progress is being hindered time and again...(because of the increase)...in the country's population (cited in Donors' Community 1983:1).

The donor community in a document to the Government has echoed this argument:

An improvement in the general standard of living because of significant economic and social development in Bangladesh can begin only after population growth has been brought under control [emphasis added] (Donors' Community 1983:13).

It is in this cultural and ideological environment that national policy and planning as well as all social and technical programs take shape.

One can argue, therefore, that understanding underdevelopment and growing impoverishment in Bangladesh as caused by population pressure provides the arena for understanding health policy options and program intervention strategies. Population-reducing interventions also provide the criteria against which indicators of social improvement are assessed and serves to legitimize the tying of health interventions to population-reducing objectives. The choice of indicators employed to assess changes in the health status of a population shape the objectives set forth in health programs. Health care initiatives, in other words, are structured within a "population as crisis" framework (Feldman 1987). One indication of the way this framework is assumed to effect policy assumptions is in the linking of maternal and child health initiatives to the government's family planning program and the "functional integration" of the health and family planning ministries at the regional and sub-regional levels. The purpose of this integration, according to the Minister of Health and Family Planning, has been

- (1) to improve the delivery of family planning, MCH, and primary health care services but particularly those of family planning,
- (2) to provide medical support to help implement clinical family planning services,
- (3) to assist in the difficulties encountered by

the population program in recruiting medical personnel, and (4) to improve "the acceptance of family planning workers and their program among the masses" (Mostafa 1983).

A "population as crisis" framework also structures women's access to technical resources, credit, and training opportunities, and shapes resource distribution strategies. A brief examination of the special Integrated Rural Development Program for women, titled the "Women's Programme in Population Planning and Rural Women's Cooperatives" (IRDP), provides an interesting example of how a "population as crisis" framework is embedded in the assumptions held about Bangladeshi women. Since 1975 this program has been funded under the population initiative of the World Bank and operates in concert with a number of other population planning initiatives supported by the Bank. These include programs under the Social Welfare Ministry entitled "Rural Social Services" and "Mother's Clubs" which are specially targeted for Bangladeshi women. Each program is assumed to provide a vehicle for reducing population: the latter two within the context of welfare and training opportunities for women. The underlying premise of the third initiative, the IRDP, is that access to credit, skills training, and income-generating opportunities will increase women's autonomy and will encourage their participation to reduce the number of children they desire and decide to have. The criteria used to assess program success emphasize contraceptive prevalence rates and IUD and sterilization acceptance rates (Feldman et al. 1980).<sup>3</sup> Improved rates of acceptance are compared across the various program strategies within the World Bank's overall population program to assess the strategic effectiveness of the different program approaches.

Among health sector initiatives, maternal and child health (MCH) services have been given priority over a range of other possible health interventions. MCH services are critical in Bangladesh since the maternal mortality rate is 600 per 100,000 and the infant mortality rate, while supposedly down from 153 to 121 per 100,000 represents relatively high rates among Third World countries. Despite the recognized need for international support and national policy priority to facilitate the delivery of MCH services to rural Bangladeshis, it is instructive to examine the assumptions and operational strategies employed in strengthening MCH services.

The choice of MCH services, from among a selection of primary health care interventions, corresponds to the approach used by the Ministry of Health and Population Control to integrate services. As the Minister noted, the purpose of focusing on MCH services is to help implement family planning services. The new institutional arrangement being implemented reflects a new ideological connection between improved health services and reductions in family size. Previously, family planning programs which were concerned with a cafeteria approach to the delivery of contraceptives and strategies for birth spacing had, by the mid-1970s, become associated primarily with the national sterilization program and its incentive schemes. In order to break the negative association of family planning with population control, although the latter remains the primary concern of government, efforts are now made to strengthen the population control infrastructure through a provisioning of MCH services. The integration of MCH and family planning services is an attempt to neutralize the negative history of family planning efforts to date. The MCH program, in other words, is partially premised on the incentive effect of low infant and child mortality on fertility.

The rationale for a policy or program emphasis on maternal and child health services has been the result of the choice to emphasize a particular set of interventions and a particular target population. These include those MCH services that are most closely tied to family planning initiatives and a target population of women of childbearing age. One could argue persuasively that attention and resources should be focused on improving women's general access to health services or on providing resources to improve women's overall health status rather than to emphasize the targeted approach.<sup>4</sup>

A more generalized health care intervention strategy corresponds to the finding that measures of Bangladeshi women's social status rank them among the lowest in the world. In a recent publication, the Population Crisis Committee (1988) noted that Bangladesh scored lowest of 99 countries on a 20 indicator scale measuring women's status. Only one in three school-age girls attend primary school, some 24 percent more women are illiterate than men, and female university enrollment is less than two percent of women aged 20 to 24. Only one in 15 women is in the paid labor force, of which women represent only 14 percent. Moreover, female life expectancy remains at 49 years, and Bangladesh remains one of the few countries where women die on the average, two years earlier than men. More striking is the fact that one in six female fifteen year olds will not survive childbearing years, and about one-third of these deaths relate to pregnancy and childbirth (Population Crisis Committee 1988).

In this context one could argue that a primary health care emphasis on MCH services and a focus on women in their child-bearing years represent a gendered political economy of health care and a policy priority to reduce the national population growth rate. This is quite distinct from a national strategy to improve women's overall health status.<sup>5</sup> Said another way, it can be argued that the government and international lending institutions have been selective in the resources they allocate to the Health and Population Control Ministry and that they have targeted their lending to realize quite particular goals. These goals are premised on the assumption that the primary cause of social and economic underdevelopment is overpopulation. Given this assumption, and its operational acceptance by both the government and donor community, it is not surprising that the primary health care objectives as outlined by the Bangladesh Government are shaped within the national agenda of reducing fertility. The Bangladeshi health care infrastructure, in other words, can best be understood in relation to the population control objectives of international agencies concerned with Third World population reduction. Moreover, most women's programs in the country must be understood as a commitment to tying the kind of resources and services offered to women to their direct or indirect impact on overall declines in the population growth rate.

So far we have examined the choices made among a variety of Health for All objectives selected by the Bangladesh Government to meet their commitment to an overall improvement in primary health care as outlined by the Alma Ata Declaration. We have indicated how these objectives are shaped by specific international donor objectives to reduce population growth rates in the Third World. We have also suggested the ways in which international lending during the decade for women has emphasized a particular set of concerns which work from two assumptions: (1) that women are primarily child bearers whose fertility choices need to emphasize declines in family size, and (2) that these choices reflect specific socioeconomic and demographic characteristics

which, if altered, could have a positive impact on fertility declines. Project interventions which include credit, skills training, and other inputs to facilitate income generation and potential employment have been envisioned as mechanisms to transform demographic profiles and create conditions likely to have a positive impact on fertility declines.

These two themes complement a third area of interest which is concerned with resource allocations between the health and population control wings of the integrated Ministry. In other words, in addition to understanding the functional integration of health and family planning objectives in facilitating MCH activities under the umbrella of primary health care, it is also important to note how resource distribution is negotiated within the combined Ministry. The health sector, for example, relies primarily on the national revenue budget for financial support whereas the population control wing of the ministry is largely financed through the credit and lending programs of the bilateral and multilateral aid community. Financial support from the international community constitutes what is referred to as the development budget. This means that local resources finance health sector inputs, personnel, and administration, while development aid finances a significant proportion of the population control initiative of the government.

The dependence of the health sector on domestically mobilized resources highlights the financial vulnerability of the sector. It also highlights constraints imposed on resource allocations, institutional expansion and consolidation, and program and project expansion. For example, funding for health programs represents fixed allocations, generally equally divided among upazilas (counties), rather than disbursed on a per capita basis. This means that health inputs are distributed on an "as available" basis through a Dhaka based distribution center. No money is available to have supplies distributed to the rural areas. Instead, representatives from each upazila must come to the capital to pick up medical supplies and transport them to their respective communities. This resource allocation strategy often generates a national or regional supply constraint on inputs.

Health funds, however, while generally limited to national revenue sources, may be supplemented by foreign assistance, which has two institutional forms: direct assistance to the health sector or project, or program support via nongovernmental agencies (NGOs) or semi-autonomous national agencies. UNICEF, for instance, supports oral rehydration therapy programs for distribution through government-operated rural health centers, while Swedish International Development Cooperation supports a similar effort through the Bangladesh Rural Advancement Committee, an internationally recognized nongovernmental organization.

Resources available to population control efforts in the Ministry of Health and Population Control, on the other hand, operate on a created demand basis. This means that supplies are distributed to reach a predetermined target population. To help realize sterilization or contraceptive use objectives, targets are often set higher than expected achievements and resources are allocated against these targets. This indicates the extent to which there is generally an overabundance of contraception and sterilization supplies on the domestic market. Moreover, unlike the distribution system established for medical supplies, the technical infrastructure of the population control sector includes the financing of a transportation and

delivery service. Thus, Dhaka-based decisions regarding population control resource distribution include resource delivery to the rural areas.

Discussions with regional officers reveal that the relationship between the medical and family planning cadres posted in the rural health centers are both formal and operational and are generally conflictual. The Civil Surgeon who is a member of the health service of the Ministry, for example must accompany the upazila family planning officer to special sterilization camps or participate in mobilization efforts carried out to support the realization of Government IUD or sterilization targets. The purpose of these efforts are focused solely on population control activities. If, or when, health programs are implemented, they are dependent solely on the efforts of the Civil Surgeon and other medical officers and as such do not receive active participation from family planning workers. Upazila family planning officers are neither directly obligated to nor responsible for implementing MCH efforts.

Under conditions which differentially weigh health and population control objectives, there is a decreased likelihood of operational integration between the two wings of the Ministry. These conditions are also more likely to ensure that the Ministry's primary commitment will meet the targets set for mobilizing vasectomy and tubectomy clients. Complicating this is the fact that neither targets nor indicators are set for assessing the extension of MCH services. In effect, health objectives get subsumed under the family planning agenda within the integrated Ministry.<sup>6</sup>

An overview of development allocations by sector suggests the commitment to the Health for All objectives of the Alma Ata Declaration, rhetoric to the contrary. It is noteworthy to point out, for example, that despite support for the objectives of the Declaration, no significant proportional rise in development resources accrued to the health sector between 1973-74 and 1985 (see Table 1).

The data in Table 1 indicate a declining proportion of government resources allocated to the health sector: an overall decline of 2.9 percent of the budget allocation to health between 1973-1974 and 1980-85. An examination of within-sector expenditure reveals that a significant proportion has been allocated to physical infrastructure including the construction of hospitals and clinics. According to Gish (1981), of the total cost of new schemes approved between 1973 and 1975, half was for teaching hospitals and only 15 percent for rural health centers; one-third was allocated to training and only 2 percent was disbursed for other activities including public health schemes and the development of a rural health infrastructure. In addition to the gap between construction and operational costs, there are unequal resource allocations between Dhaka and other smaller cities and towns and the rural areas, since allocations to teaching hospitals and for training are generally limited to the development of the Dhaka-based infrastructure.

An examination of public expenditure outlays for human resource development programs suggests the location of health allocations within the overall human resources budget. This information is summarized in Table 2. As is clearly noted in the table, allocations to health and population as a proportion of total development expenditure have declined between the average for the five year period prior to 1980 and for the 1987 fiscal year. The table also indicates an increase in recurrent budget expenditure, from 4.6

percent to 6.4 percent, allocated to health during this same period. As mentioned earlier, given the distribution of revenue and development budget expenditures between health and population, an overall decline in resources in this sector is likely to be realized in disproportionate declines in the resources available for health care services. Moreover, while average per capita human resource expenditures are estimated at US\$4 per capita, this figure masks the fact that the poor are likely to suffer disproportionately from such limited financing.

In short, while both development and revenue expenditures have increased since the late 1970s,<sup>7</sup> it is probable that health sector expenditure did not grow proportionately among human resource investments. Moreover, it is well accepted that despite declines in the population growth rate and the infant and child mortality rates, health indicators in Bangladesh continue to compare unfavorably with those of countries at a similar stage of development. Child and infant mortality rates are twice the average rates in low income countries, and malnutrition remains a pervasive and widespread problem (World Bank 1987). A broad-based primary health care initiative would need to emphasize improvements in services to meet these particular needs. The limited attention focused on these concerns, as compared with those focused on MCH, suggest the implicit commitment to women as child bearers and the ways in which gendered assumptions shape health and nutrition policy.

Other statistics are also suggestive in illuminating biases in health sector allocations. The urban bias within the sector is noteworthy. For example, of 8,500 doctors, less than 10 percent hold posts in the rural areas; of the available hospital beds, only 24.5 percent are located in rural health facilities and of those available, utilization rates remain at only 30 percent. Such rates indicate both the lack of client confidence in the rural health care system and the way in which health care choices are made by rural villages (Feldman 1983a). This urban bias, however, does not presume that urban health and MCH services are adequate. Rather, while differences between the urban and rural areas remain, the poor in both locations are likely to be disproportionately disadvantaged regarding access to adequate health care services.

Two administrative and training constraints to adequate urban and rural health care service delivery have been identified. One concerns the lack of fit between the available skill base of the health, nutrition, and family planning cadres, and the second is the inadequacy of facilities and supplies in the health sector. Available personnel are neither prepared to offer preventive and promotive services to rural dwellers nor willing to locate in rural health centers. Drug allocations to the upazila health centers have been estimated at only Tk 1 (US\$.03) per person annually so that medical supplies are extremely limited and often require the purchase of drugs from a local pharmacist. In addition, health sectors are understaffed and result in trained personnel having a demand of between 50 to 250 patients per day (Feldman et al. 1981). This means that access to trained medical staff is often garnered at a fee for service rate, sometimes as private patients. For those requiring both diagnosis and treatment, these constraints indicate likely reasons for low utilization rates.

The government's present commitment to the decentralization of resource allocations and services to the upazila includes the support given to the development and stabilization of a rural health infrastructure.<sup>8</sup> In principle, this follows the Alma Ata prescription of a hierarchy of services to meet the promotive and preventive health care needs of local villagers. It is anticipated that such a hierarchy would also be expected to provide easy access to urban based services which offer more curative and specialized treatment. In the context of limited resources, including trained physicians and nurses, it is anticipated that this decentralized approach would limit redundancy and link resource availability to the particular needs of the rural populace. However, without financial redress, it is unlikely that this reorganization will significantly alter the effect of existing constraints on service availability and delivery.

Moreover, the extent to which health sector initiatives are couched in terms of a gendered understanding of women's health care needs matches the extent to which population control priorities will continue to shape the available health care resources for women. For instance, the national decentralization effort has not challenged the assumptions upon which the present primary health care program is organized, nor has the reorganization of the administrative structure generated opportunities for reintegrating or reorganizing ministerial and sectorial programs. These programs and national policy questions remain issues addressed at the center. Additionally, despite the commitment to improving MCH services and the recognition of a poorly trained cadre of health service workers, population control efforts remain the focus of the combined ministry. For instance, there are more than 40,000 family planning but only 15,000 health workers operating in more than 2,000 rural centers. An interesting balance: for every health worker there are almost three family planning workers.

Interestingly, however, the generally accepted reason for the limited presence of doctors in the rural health clinics has been that doctors are unwilling to accept a rural post and are increasingly likely to accept instead employment overseas, in Dhaka, or the major secondary cities. This individualized interpretation of a structural problem markedly contrasts with discussions with ministry officials which reveal that the government's budget is so depleted that it is unable to fill sanctioned posts even when there are interested staff willing to work in a rural health center. Alternatively, for medical personnel on leave for study or long-term consultancies and who may retain their salaries, the government is unable to fill these posts with temporary employees. This too is indicative of a shortage of resources in the revenue budget. These are indications of the relative position of health sector resources vis-a-vis those of family planning which may include subsidies for salaries through allocations from the development budget.

Field visits to Comilla District<sup>9</sup> confirm that in none of 26 upazila health centers or 23 rural health and family welfare centers visited were the full complement of medical staff available (Feldman 1983). What is distressing about this finding is the disproportionate location of filled posts. In some cases, such as in Debidwar with its relatively small population, seven posts were filled, whereas in Nabinagar, a more populated upazila, only two of the seven medical officer posts were filled. That is, within district differences in population density, desirability of service, and proximity to Dhaka shape the hiring and placement of medical staff. Here

practical patronage shapes the distribution of resources that might be more appropriately allocated on a per capita basis.

According to information from medical school personnel and recent graduates there appears no shortage of medical graduates to fill existing posts at the upazila health centers. This assumption gains credibility since the government recently allowed medical school graduates to seek overseas appointments and removed the requirement for them to serve at last three years in the rural areas upon graduation. Given this, the medical "brain drain" may again become a problem for the rural health sector, thus creating an opportunity to explain the health care crisis in terms of individual choice and characteristics rather than as a consequence of health care policy and sectorial resource allocation choices.

### Expanded Program for Immunization

A major component of primary health care and rural health extension services identified by the Alma Ata Declaration was a commitment to expand immunization coverage. In Bangladesh this has been organized under the Expanded Program for Immunization (EPI) supported by WHO. An examination of the coverage of EPI services in Comilla District provides an illuminating example of the role that poor planning of health sector initiatives plays in the dissemination of existing, if limited, resources. Moreover, the example highlights the narrow assumptive basis of women's health care needs. Table 3 summarizes this information and reveals the sharp decline in EPI service delivery after an initial intervention.

National figures indicate a loss of between 34 and 36 percent of the population receiving a second DT, DPT, or polio injection and a 46 percent decline between the first and third immunization.<sup>10</sup> The data also suggest that persons accepting a second injection were more likely to receive a third one. Given the location of Comilla District, and its relatively good access to services and resources compared to other outlying districts, one would assume that declines in immunization services would be above average. District level statistics, which are likely to be more accurate than national figures, reveal poorer rates of immunization services over the course of a particular intervention. Moreover, for a particular upazila the declines are even greater: between first and second, and second and third injections of DPT and polio there has been a decline of 38 percent and 71 percent, respectively.

A number of reasons explain these declines. First, the EPI staff exert little extension or communication effort to generate a local information base and information exchange regarding the importance of immunization to good health. This is critical in a context where there is a general ignorance about allopathy. Second, mobilization efforts, including effective education regarding the importance of receiving a complete cycle of a particular immunization are weak. Third, there is an inconsistency in the available supply of vaccine; therefore, outreach services can only be erratic and unplanned. Fourth, insignificant attention is given to extending the program so as to include village visits and specialized village-based campaigns to encourage rural participation. Unfortunately, village-based campaigns are not even considered to be an important and appropriate mobilization strategy in

extending health services, despite the fact that such a strategy has been a popular approach of the population control program. Fifth, the EPI is not administratively integrated within the MCH/PHC program; instead, services are offered at a separate facility located in regional towns.

Discussions with EPI officers in Dhaka, at district headquarters, and at each center, suggest that there is no program or policy relationship between the immunization program and MCH services. Rather, the EPI is envisaged as an autonomous input in the health care network and as such is not part of the antenatal and post natal services offered at the centers. Interest in maintaining accurate records of recipients, especially on the relationship between pregnant women's acceptance of EPI services and the use of these services for their children, therefore, is not important because assessments of program success are made on aggregate figures of those vaccinated rather than on measures of program effectiveness in terms of the link between pregnant women's use of vaccine and the use of the program for their children. A question such as does a TT injection to a pregnant woman increase the likelihood that she will bring her children for TT, DPT, or other program inputs, is irrelevant. Given the importance of primary health care efforts to increase TT immunization in order to reduce both infant and maternal mortality, this kind of recordkeeping and monitoring should be included in new program design and could readily become part of an integrated primary health care program. In addition, this strategy for program extension can be easily tied to the MCH services provided at the rural health centers if such interests were actually held by government or donor. This example highlights the rather narrow view of MCH services provided to women. And, to the extent that a broad MCH program would embrace the range of health care needs of women, such as child rearers, this is absent from a service primarily committed to diffusing the negative experience many women had with earlier family planning initiatives.

Before turning our attention to the demand for health services and the differential use of rural health care facilities by men and women, it is worthwhile to indicate the physical infrastructural conditions which represent rural health services. First, only 9 of 23 health facilities for which we have specific information in Comilla District have running water or a tubewell. Given the availability of hand tubewells in the country, it is unimaginable that an infrastructure which is charged with promoting the importance of clean drinking water and those practices which help realize improved living standards at minimal cost can operate without access to a clean water supply. In Bangladesh, in particular, where water-borne diseases are a major cause of death, the absence of a clean water supply contradicts any rhetoric offered for promotive and preventive health care.

What has been interesting about the medical supplies at the centers is the general availability of infant and adult scales, stethoscopes, sphygmomanometers, thermometers, and kerosene or electric stoves. These supplies were usually located in a locked steel closet in a relatively new cement building. Moreover, in three of the four health centers visited, no bedsheets, blankets, or pillows were found nor were kerosene stoves available so that needles and other supplies could be sterilized before use. What this finding confirms is the extensive building and technical supply effort of the major donors but the limited financing of medical supplies, other support resources such as kerosene, and an operating budget to meet training,

monitoring, and extension needs. More critically, this example indicates the policy and donor lending choices that were made to favor construction at the cost of offering rural people access to information, sanitary facilities, and low cost promotive health services.

### The Utilization of Rural Health Centers

Rural health centers are open six days a week and emergency services are supposed to be available for 24 hours a day, 7 days a week. The centers generally open at 8:30 a.m. and close out-patient services at 3 p.m. A review of patient records at two centers in Comilla District reveal that for the 11-month period beginning in January 1983, only .002 percent of the population used in-patient services in either center. Discussions with in-patients at the various centers indicate that male patients usually are admitted to the clinic because of a fight in which they sustained injuries or as a result of being robbed or molested. Women usually entered the hospital for pregnancy complications. Only 18 children were admitted to the center and were diagnosed as having malaria or severe diarrhea (Feldman et al. 1981).

These general rates tell us little about the duration of stay and reason for entering the clinic. This information is not monitored by the center nor are figures usually collected on the age and gender of patients. In the few cases where this information was available, it showed that men tend to stay at the health center for more than five days, while women generally stay one or two days after a sterilization operation (Feldman et al. 1981).

Out-patient use of health services at Comilla averages between 90 and 206 patients per day. General utilization rates for outpatient care for this same period range between 14 percent of the total population for a 10-month period and 16 percent of the population for an 11-month period. Interestingly, the monitoring of services offered at the centers are not a requirement of the staff and thus depend upon the personal commitment and quality of each upazila officer. A mid-year shift in officers at one center, for example, meant that recordkeeping efforts of the predecessor were discontinued in midyear by the new officer. These rates represent quite different proportions of the potential user population. Interviews with patients confirm that satisfaction with existing services and the center's reputation makes a difference in a patient's willingness to use a facility, including traveling whatever distance is necessary for treatment.

At union-based Family Welfare Centers (FWC) health care practitioners are generally non-degree staff, that is, two year certificate Medical Assistants who tend to see more patients than medical doctors at upazila health centers. In Comilla District one FWC averaged 83 patients per day while another only saw a handful each day. For one union center, the number of patients visiting per day for the month of November ranged from a low of 52 to a high of 165. These rates appear to depend on the reputation of the staff but also change in response to the availability of free medical supplies such as the Vitamin A tablets distributed by UNICEF or in response to the availability of special health services such as the Under 5 Clinic. Interestingly, more women than men use the FWCs, as the name is assumed to be a place where women and children seek medical treatment. Thus, few men seek these services since they can and do travel farther than women and are more

likely to seek allopathic treatment from professionally trained doctors (Feldman 1983b).

### Gender Disaggregated Use of Health Care Services

In an examination of records kept at one upazila health center in Comilla, it was found that no distinction was made between a woman visiting the center for the treatment of diarrhea or a common cold and a specific visit for antenatal or postnatal care. Supplies at the Center were also not disbursed against their specified allocation but distributed according to demand from medical officers at the center. Discussions with Family Welfare Visitors (FWVs),<sup>11</sup> for example, indicate that medical supplies allocated to the MCH program are often distributed among male patients visiting the out-patient clinic, since out-patient supplies are often unavailable. In instances where males are the recipients of the MCH inputs, the male patient may give his wife's name to the medical staff so that a female name is placed in the center's medical ledger. An examination of data from Comilla District on the utilization of MCH and child care services is both illuminating and disturbing. Table 4 summarizes utilization rates of health services for different health facilities in Comilla District.

Assuming the above figures suggest rather than represent actual utilization rates, it is appropriate to conclude that services vary significantly by upazila. In Faridganj Health Center, for instance, 665 women utilized antenatal services, whereas in Laksam only 21 women utilized these services. One reason for these differences may be the differential availability of resources for particular services such that the medical supplies allocated for antenatal care in Laksam were significantly less than those available in Faridganj. For those centers where no service provision was indicated, it is likely that no supplies were available to dispense at the center. In situations where the reporting rates were quite high, it is likely that some misreporting of users explains the high utilization rates. For example, during one two-hour visit to one health center, male patients accounted for approximately 40 percent of those who engaged MCH services. That is, men were given the medicines allocated for antenatal and postnatal care or distributed by UNICEF for its special Under 5 Clinic. These would reduce actual rates and distribution of resources quite markedly.

While the lack of sufficient resources may encourage the misuse of medical supplies, this type of constraint can be overcome by a technical solution: increased supplies would likely alleviate the tendency to misreport and incorrectly allocate drug distribution and service delivery. What is of greater concern than the misreporting of users are the policy and planning strategies that are employed to promote and provide MCH services to women. At the level of program development and program planning, for instance, there is no real attempt to implement integrated health services available to women and children. Instead, each intervention is envisioned as a discrete input. For example, during our two-hour health center visits, it was found that no efforts were made by the FWV to offer health or nutrition education to mothers utilizing the health service. Or, when children were brought in for health care, none of the available technical resources such as baby scales were used to help women learn about the importance of good feeding habits to child growth.

Moreover, among the women who used the MCH facilities, no questions were asked regarding the number of previous visits they had made to the center and for what purpose, the benefits they felt accrued to them because of their use of the center, or the extent to which they participated in the EPI. This lack of any extension program to provide information to users undermines the basic thrust of the primary health care initiative promoted by the Alma Ata Declaration.

Also of interest in understanding how health services are utilized by different clientele is the finding that women who bring children to an upazila health center or to a rural dispensary for treatment will use this opportunity to seek treatment for their own illnesses. More than 4 out of 5 women interviewed at the health centers had infants with them, and when asked why they had come to the Center, treatment of the child was the first reason mentioned. When these women were then specifically asked about their own health status, they often mentioned that they hoped to receive treatment for their own illnesses. Their interest in bringing their children to the Center, in other words, was also seen as a vehicle for receiving treatment for themselves. This suggests an important opportunity to offer health education to women and to highlight the important relationship between maternal and child health. Here too, monitoring of women and children would enable people to keep track of their health history and to learn to request services for which they know there is a need. However, as has been suggested throughout this paper, an implementation scheme which would address the specific needs of women's health has not been the primary focus on the MCH program in Bangladesh, nor has the health service taught women how to demand services which they should increasingly control.

### Conclusion

This paper has examined the policy commitment Bangladesh has made to the implementation of the Alma Ata Declaration as outlined in 1978. It has specifically explored the implementation of the country's primary health care initiative as it has developed within the context of a joint health and population control ministry and as it has introduced maternal and child health care and an expanded program for immunization into the service. Findings reveal that these programs are poorly implemented, do not adequately serve their anticipated clientele, and have not led to the development of a technical and social infrastructure sufficient to realize their expressed goals.

At the level of policy and program implementation, planning and promoting health care initiatives would need to be more effectively grounded in the conditions and practices of social life if they are to meet the needs of the majority of Bangladeshis. For example, an assessment of differential health service utilization rates indicates that more effective planning, based on actual population figures, should be used to determine staff or resource needs rather than providing standard allocations to health centers or upazilas. Such an allocation system would increase the likelihood that the demand for supplies more closely corresponds to supply availability. Furthermore, in the effort to decentralize the health care network and reduce redundancies, greater attention should be focused on diffusing the political and personal patronage that have come to characterize rural class relations. This would

serve to improve equitable resource and personnel allocation among health centers.

While a number of technical constraints need attention before an adequate health service program can prove beneficial for the vast majority, a number of these constraints can be overcome with the availability of increased resources. Structural and conceptual constraints, however, would require a reorganization of the health care service in the country. If programs are to reflect and meet the needs of a gender and class differentiated population, it would also require a new set of assumptions about the clientele to be served. More specifically, the goals which underlie the Bangladesh commitment to maternal and child health services and primary health care would need to be transformed if they are to help realize improved health for women.

Such a reconceptualization of clientele and a differentiated set of client needs also means that the focus on maternal mortality and reproductive health would need to be broadened to include a number of issues which continue to remain unaddressed or which are not well integrated into the present health service: female malnutrition, limited access to promotive, preventive, and emergency medical care, and a better understanding of traditional practices that affect women's health over their lifespan. Women's health, in other words, should be tied to an understanding of their social status and their differential control of resources including social services. This new conceptualization would better enable one to explore why, in times of debt crisis or budgetary austerity, the consequences of the present health service system are more costly for women than for men. These differential costs may shape women's future status and affect their productive capacity as income earners, employers and employees, as well as their effects on women as mothers and child bearers.

In sum, until the assumption of women as child bearers is broadened to include women as health care users, and a commitment is made to improve the overall health status of women, the objectives of the Alma Ata Declaration are not likely to be realized. Moreover, to the extent that the primary constraint to economic development is assumed to be overpopulation or a too rapid population growth rate, efforts to generate broad based development policies will continue to include health service provisioning focused on women as child bearers and as gatekeepers for children's health. Unless a commitment to population control is replaced by a set of assumptions which recognizes the need for family planning but inbeds this need in the commitment to improve the standard of living and quality of life of the majority of the country's population, the primary health care program of the Bangladesh Government, and the donor agencies which support it, are not likely to improve the terms and conditions under which Bangladeshi women live.

### Acknowledgments and Notes

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1. This hierarchical structure is to include preventive and promotive services at the village and union level, curative care at the upazila or county level, and specialized care at the subdistrict and district level.
2. The drug policy of 1982 ranks Bangladesh among only a few countries which offer political support for a strengthened and indigenously based pharmaceutical industry. This is an interesting and important contribution made by the Ershad regime, but a critical reading of its significance is beyond the scope of this paper.
3. This project identified the important link between women's employment, mobility and increased autonomy, and fertility choices--a major breakthrough in understanding family size choices in the mid-1970s.
4. It should not be assumed that initiatives in the Ministries of Education, Welfare, or Labor are unconcerned about improving women's economic and political status. The point to be emphasized in this discussion is that the health and population control strategy employed by the Ministry of Health and Population Control has a particular focus which is not adequately integrated with other social welfare initiatives. Moreover, our point is not to criticize these efforts but rather to understand their rootedness in the development assumptions that characterize aid and technical assistance in Bangladesh.
5. The setting of targets for both IUD insertions and sterilizations, committing earlier financial incentives to clients and doctors who accept or perform sterilization operations, and the withholding of salary for family planning workers who are unable to meet targeted goals, has made it difficult for family planning workers to seriously invest their time and effort in meeting primary health care or specific MCH objectives.
6. There is also a persuasive argument to support MCH, though it is important to understand why this strategy was assumed to be the best short-term initiative.
7. The declines for FY86 should not be overlooked but changes within the year need not be elaborated for this particular argument.
8. While not appropriate to elaborate here, the abuse associated with upazila resource distribution, and the commitment to the building of infrastructure as opposed to the providing of services, suggests that health care services are unlikely to improve without a national organizational effort to assess effective health service delivery.

9. Comilla District is the home of the now famous Bangladesh Academy for Rural Development, an early cooperative program that has served as the basis for cooperative efforts around the world. The District is highly urbanized, the center of education in the country, and envisioned as a desirable post for any civil servant. Resources to the district are above average and it is only a three-hour drive between Dhaka and Comilla. Findings from research in this district are likely to be magnified for more remote districts.
10. These data should be considered suggestive since data collection is not well coordinated and is recognized to be quite faulty.
11. Family Welfare Visitors (FWVs) are medical technicians who are administratively subordinate to Medical Officers. This means that FWVs have difficulty refusing a Medical Officer's request.

**Table I**  
**Sectorial Allocation of Development Expenditures, 1973-74 to 1979-80 (in %).**

Sector/Year	73-74	74-75	75-76	76-77	77-78	78-79	79-80	80-85
Health	5.5	4.1	3.4	3.2	3.6	3.0	3.0	2.6
Agriculture	12.4	12.2	13.5	15.2	12.8	14.6	12.6	13.4
Rural instns	6.6	5.4	3.9	4.2	4.2	3.9	3.2	7.1 <sup>d</sup>
Flood control & water resources	15.0	16.4	13.9	11.9	11.9	10.8	12.8	16.8
Industries	11.3	12.4	12.1	14.2	15.8	19.0	15.6	12.7
Power & STR <sup>a</sup>	11.6	13.6	15.7	13.1	14.0	15.8	17.1	19.6
Transport	20.8	15.5	15.4	19.5	14.7	13.3	17.3	11.3
Communications	2.8	3.5	3.2	3.1	4.2	2.7	3.4	2.1
Physical Planng & housing	5.0	6.5	7.2	6.3	6.7	6.0	6.2	5.1
Education & training <sup>b</sup>	6.6	5.5	6.2	4.7	4.8	4.3	3.1	4.4
Family planng	-	1.5	2.0	2.2	2.6	2.9	2.5	2.3
Social welfare <sup>c</sup>	0.4	0.4	0.4	0.3	0.4	0.4	0.9	1.7
Labor & training	0.1	0.2	0.2	0.2	0.3	0.4	0.4	0.6
Cyclone recon-struction	1.7	2.9	2.9	0.8	1.1	1.0	0.2	na
Others	-	-	0.1	1.3	2.7	1.9	1.3	-
Reserves	-	-	-	-	0.2	0.1	0.3	-
<b>Totals</b>	<b>100</b>	<b>99.7</b>						

Source: The Second Five Year Plan 1980-85, Planning Commission, Government of the People's Republic of Bangladesh, Dacca, May 1980, pp.I-22-23. For the 1980-85 figures see The Third Five Year Plan, p.I-37.

<sup>a</sup>STR = Scientific and technological research. In the Third Five Year Plan this category was expanded to include natural resources.

<sup>b</sup>In 1980-85 includes religious affairs.

<sup>c</sup>In 1980-85 includes sports and women's affairs.

<sup>d</sup>Includes upazila infrastructure and development assistance.

**Table 2**  
**Public Expenditures in Human Resource Development\* (in %).**

Expenditures	FY76-80	FY81	FY83	FY85	FY86	FY87
<u>Share of Public Expenditure</u>						
Health and Population						
Development	5.8	4.6	5.4	6.1	4.4	5.1
Recurrent	4.6	5.2	4.7	5.2	3.3	6.4
Public Expenditure	5.3	4.8	5.1	5.7	3.9	5.9
Education and Training						
Development	4.2	4.1	3.9	4.3	3.5	5.3
Recurrent	14.1	13.9	13.7	16.8	17.5	18.6
Public Expenditure	8.4	7.9	8.3	10.2	10.2	11.2
Human Resource Development (1+2)						
Development	10.0	9.8	9.3	10.5	8.0	10.4
Recurrent	18.7	19.1	18.4	21.9	20.8	25.0
Public Expenditure	13.7	12.7	13.4	15.9	14.1	14.1
<u>Share of Human Resource Expenditures in GDP</u>						
Development	1.0	0.9	0.9	0.8	0.6	0.9
Recurrent	1.4	1.2	1.4	1.5	1.5	1.8
Public Expenditure	2.4	2.1	2.2	2.3	2.1	2.7

\*Public expenditures are those funded under the ADB Budget (Development) and the Revenue Budget (Recurrent).

FY76-FY80: Both development and recurrent expenditures are revised budget estimates.  
 FY81-FY86: Development expenditures are actual figures, recurrent expenditures are revised figures for FY81-FY84 and actuals for FY85-FY86.  
 FY87: Budget figures.

**Table 3**  
**Summary of Selected EPI Services in Comilla District (as percent change).**

	Type of Intervention						
	DPT		Polio		DT	Tetanus	Toxoid
	1-2	2-3*	1-2	2-3	1-2	Pregnant	Others
National**	-34	-19	-36	-16	-34	-28	-36
Comilla	-39	-20	-36	-29	-46	-35	-51
<i>Selected upazilas</i>							
Choddogram	-53	-38	-62	-71	-38	-05	-51
Laksam***	-54	-31	-45	-54	-53	-21	-65

Source: Feldman, 1983 (discussion with Dr. Talukdar, EPI Project Director, TB Clinic, Comilla).

\*1-2 and 2-3 refers to the loss between a first and second injection or a second and third.

\*\*Figures include data for February, July and August, 1983.

\*\*\*Figures from January through November, 1983.

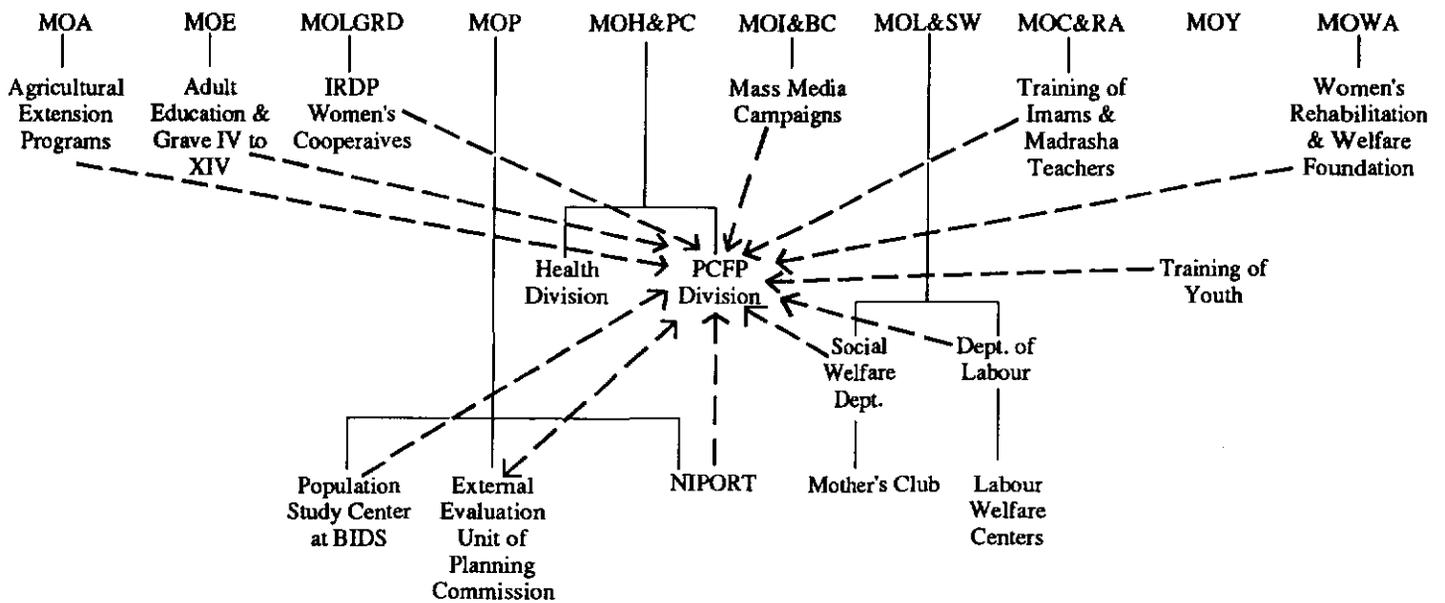
**Table 4**  
**Utilization of MCH and Child Care Services for Different Health Facilities**  
**in Comilla District (six month figures for number of patients seen).**

Health facility	Natal Care		Immunization		Under 5 Clinic
	Ante	Post	MCH	Child	
<i>Upazila Health Centers*</i>					
Daudkandi	350	220	197	3160	150
Faridganj	665	495	-	-	3258
Laksam	21	11	-	7840	70
Kasba	374	616	-	-	-
Choddogram	22	1	-	-	NA
<i>Family Welfare Centers</i>					
Rampur, Hajiganj	41	17	-	-	254
Meher (S), Sharasti	22	76	-	-	692
Bagmara, Laksam	31	12	7	139	559
Kila, Sharasti	26	45	-	-	570
Barasalgar, Debidwar	6	43	-	-	355
Saidabad, Kasba	12	-	-	-	1044
Khila, Laksam	102	227	-	-	575
Tamta, Sharasti	21	11	-	-	352
<i>Maternal Child Welfare Centers</i>					
Karaitali, Faridganj	14	34	-	-	367
Chandpur, Chandpur	697	516	-	-	1436

Source: Feldman, 1983

\*No information is available from Homna *Upazila*.

FIGURE I: MULTI-SECTIONAL PROGRAM STRATEGY FOR POPULATION CONTROL



- MOA = Ministry of Agriculture
- MOE = Ministry of Education
- MOLGRD = Ministry of Local Government, Rural Development & Cooperatives
- MOP = Ministry of Planning
- MOH&PC = Ministry of Health & Population Control
- MOI&BC = Ministry of Information & Broadcasting
- MOL&SW = Ministry of Labour & Social Welfare
- MOC&RA = Ministry of Cultural & Religious Affairs
- MOY = Ministry of Youth
- MOWA = Ministry of Women's Affairs

x — broken line refers to required information exchanges  
 — non-broken line refers to administrative linkages

Source: abstracted from Second Five Year Plan, Chapter XVII-27, May 1980.

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