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Sustaining Menstrual Regulation Policy:

A Case Study of the Policy Process in Bangladesh

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Abstract

Bangladesh introduced menstrual regulation (early abortion) into its national family planning program in 1979, and for more than 20 years women with unwanted pregnancies have been able to avail themselves of a relatively safe and accessible service. Over the years, however, concern has been expressed about deficiencies in the implementation of the policy, and by the mid-1990s, the menstrual regulation (MR) policy was approaching a critical juncture. The introduction of health sector reforms and the waning of international and domestic support raised questions regarding the sustainability of the policy. This study was conducted to determine the factors that influenced the development of and support for the MR policy in Bangladesh, in order to explore how far those factors might influence future sustainability.

The study used an analytic framework based on literature from the policy field to test what factors were important in the policy process in Bangladesh. Qualitative data was gathered from interviews and documents in an inductive approach to determine the development of the MR policy, which was then subjected to a retrospective analysis of the entire life cycle of the MR policy—how it came to be placed on the policy agenda, how and why it was formulated the way it was, and why it was not implemented as well as it could have been. Data gathered from interviews and document reviews were then used in a political mapping exercise undertaken in a prospective analysis for the policy, providing insights in relation to the future sustainability of the MR policy.

The research suggested that the analytic framework used was helpful in providing a systematic analysis of contextual conditions, agenda-setting circumstances, and policy characteristics that could explain much of the variability in the policy process. The role of international donors and attitudes toward religion were found to be particularly relevant to explaining the policy process. The study concluded that the MR policy would likely not be sustained in the future unless purposeful action were taken to mobilise additional bureaucratic and political resources in support of the policy.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BBS	Bangladesh Bureau of Statistics
BILIA	Bangladesh Institute of Law and International Affairs
BWHC	Bangladesh Women's Health Coalition
CWFP	Concerned Women for Family Planning
D&C	Dilation and Curettage
FP	Family Planning
FWV	Family Welfare Visitor
HPSP	Health and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Inter Uterine Device
MCH	Maternal Child Health
MFSTC	Mohammadpur Fertility Research and Training Center
MOHFW	Ministry of Health and Family Welfare
MOHPC	Ministry of Health and Population Control
MMR	Maternal Mortality Ratio
MR	Menstrual Regulation
MRTSP	Menstrual Regulation Training and Service Program
MTP	Medical Termination of Pregnancy
NGO	Non Governmental Organization
NIPORT	National Institute of Population Research and Training
PATH	Program for Appropriate Technology in Health
PCFPD	Population Control and Family Planning Division
RTI	Reproductive Tract Infection
SIDA	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Disease
UBINIG	Policy Research for Development Alternatives
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

1.0 Introduction

Of the 600,000 maternal deaths that occur in the developing world annually, an estimated 13 percent are the result of complications from unsafe abortion[1] (World Health Organization, 1998). Of the 40 to 60 million abortions that are performed every year, as many as 20 million are unsafe (World Health Organization, 1994), and up to 95 percent of these occur in developing countries (Germain and Kim, 1998). The World Health Organization estimated that approximately 80,000 women die from complications of induced abortion in the developing world every year, and countless others suffer from lifelong physical and mental health problems (1998).

The international health field has recognized the public health significance of unsafe abortion and there appears to be widespread agreement that unlike many other causes of maternal mortality and morbidity, death and disabilities resulting from unsafe abortion are largely preventable (Germain and Kim, 1998, Mclaurin, 1995). The vice-president of the International Women's Health Coalition maintains that causes of abortion-related deaths and disabilities are "punitive laws, narrowly defined health policies, and failure to provide adequate health and family planning services" (Germain and Kim, 1998:1). What advocates have maintained is that the technology for performing early abortion has been available since the 1970s, and because it is simple, inexpensive and safe in the hands of mid-level providers, it is a feasible option for developing countries, and could in theory replace unsafe abortion.

According to a global review of laws on induced abortion nearly one third of the population of the developing world live in countries whose policies prohibit abortion in all circumstances, or permit it only to save a woman's life or in cases of rape or incest, and in many countries with liberal laws, policy implementation is characterized by bureaucratic obstacles and a lack of services which limits access to a small minority of women (Rahman, et al., 1998). Nonetheless, nearly two thirds of the population of the developing world lives in countries whose policies permit abortion in cases of rape, incest, or endangerment of the life or health of the mother, or on broad socio-economic grounds. Despite restrictive laws, abortion is available,

[1] According to a WHO definition, unsafe abortion is a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal technical standards (World Health Organization, 1992).

even with government knowledge in several countries. Moreover, since 1985 several more countries have decided to liberalize their abortion laws, including Albania, Botswana, Cambodia, Ghana, Romania, and South Africa, and a few others—Brazil, Nepal and the Philippines—are considering liberalizing their laws (Cohen, 2000).

With the exception of several studies there is very little knowledge and information derived from systematic policy analysis about why and how abortion policy reform in developing countries occurred.[2] What lessons have been learned? How can these lessons be applied, if at all, to other countries seeking abortion policy reform? Other researchers have drawn similar conclusions about the lack of research on abortion policy in developing countries (Githens and McBride-Stetson, 1996, Lane, 1994).

This research used a policy analysis approach to examine abortion policy in the case of Bangladesh where the government introduced menstrual regulation into its national family planning program in 1979 as "an interim method of establishing non-pregnancy" (Population Control and Family Planning Division, 1979:3). This was done despite highly restrictive legislation, which prohibited abortion except to save a woman's life, and a patriarchal and relatively conservative religious society. This case study examined the political dimensions of how abortion got on to the policy agenda and how it fared once there.

1.1 Research Questions

When it was introduced in the early 1970s the term *menstrual regulation* (MR) referred to the induction of uterine bleeding that had been delayed up to 14 days beyond its expected onset, or up to 42 days from the beginning of the last menstrual period by manual vacuum aspiration using a hand-held, non-electric syringe and flexible plastic cannula.[3] At that time, conventional pregnancy tests were not reliable in the first several weeks following a missed menstrual period and MR was frequently performed without a pregnancy test (Van der Vlugt and Piotrow, 1973, Watson, 1977). The fact that MR could be performed without confirmation of

[2] For studies on abortion policy, see (Bradley, et al., 1991, Gursoy, 1996, Hull, et al., 1993, Klugman and Budlender, 2001, Nunes and Delphe, 1995, 1997, Phadke, n.d.).

[3] This definition of MR was used by (1982, Akhter and Rider, 1983, Bhatia, et al., 1980, Hodgson, 1977, Khan, et al., 1977, Laufe, 1974, Paxman and Barberis, 1980, Tietze and Murstein, 1975, Watson, 1977).

pregnancy distinguished it from conventional early abortion using dilation and curettage, and held important "psychological, semantic, legal, medical, and programmatic implications (as well as in some cases, social-cultural, religious, and economic ones)" (Watson, 1977:250).

Bangladesh, however, was the only country in the world with a restrictive abortion law where MR was actually introduced on a large-scale basis as a matter of government policy. In Indonesia, Fiji, the Philippines, and Malaysia, which also had restrictive abortion laws, some private agencies offered menstrual regulation in the 1970s and 1980s (Henshaw, 1990, Lee and Paxman, 1977). In other countries where abortion was legal, such as China, Cuba, South Korea, Taiwan, India, Turkey, and Vietnam, the government permitted early abortion, and in some cases (South Korea and Taiwan) referred to it as menstrual regulation (Lee and Paxman, 1977) although apparently not for the purpose of circumventing the law, as was the case in Bangladesh, where abortion was, and still is, illegal. Another unique feature about the introduction of MR in Bangladesh was that it was one of a few countries in which non-physicians were permitted to perform MR. To date, with the exception of Bangladesh, South Africa, Vietnam, Sweden, Mozambique, Malawi, and the United States, the provision of legal abortion services including MR has been restricted to physicians (Ipas and IHCAR (Division of International Health; Departiment of Public Health Sciences; Karolinska Institutet), 2000). The features of abortion policy in Bangladesh argued for a case study of how the government's policy was formulated—a subject about which the literature was silent. Accordingly, a fundamental question formulated for this research was:

> What were the critical factors that enabled the Government of Bangladesh to formulate its MR policy in the late 1970s?

In the two decades following the introduction of the MR policy in Bangladesh, a number of unpublished reports as well as several published documents including an article by Dr. Ruth Dixon-Mueller (1988) which appeared in the widely read *Studies in Family Planning* generally described a success story in terms of how the Government of Bangladesh was able to expand women's access to early abortion services in a resource-poor setting, by using paramedics to deliver safe, high quality services (Begum, 1993, Kabir, 1986, Kay and Kabir, 1988). Research and evaluation reports in Bangladesh, however, appeared to indicate that the policy was not

implemented as well as it could have been, either in terms of access to MR services or in terms of the quality of the MR services that were delivered.[4] The studies were repetitious. They documented the same kinds of deficiencies time and again, and repeated recommendations for adopting the same technical solutions, focusing on *what* needed to be fixed and technically *how* to do it. They ignored the more difficult question as to *why* the government failed to address the known implementation deficiencies in spite of the known technical solutions and in spite of repeated indications from government officials that the deficiencies would be addressed. Accordingly, a second research question formulated during the research design was:

> Why was the Government of Bangladesh unable or unwilling to address known deficiencies in the implementation of its MR policy during the implementation period 1979-1997?

The two research questions posed above were related roughly to the past and present of the MR policy. However, in the mid-1990s, I was personally concerned about the future of the policy. I worked in the field of women's reproductive health in Bangladesh in the early 1990s, and from my first-hand observations, I judged that the MR program was not being implemented as well as it could have been. I also observed that the original advocates of the MR policy were nearing retirement, and that former champions and financial supporters of the policy such as the Ford Foundation and the International Women's Health Coalition were closing their programs in Bangladesh. In addition, I learned of major reforms that were being proposed for the health sector in Bangladesh which, together with the previously mentioned factors, led me to believe the MR policy was approaching a critical juncture, for which the following research question seemed relevant:

> Is the Government of Bangladesh likely to sustain its MR policy in the future?

My research documents the story of how the MR policy came to be placed on the health policy agenda of the Government of Bangladesh, how and why the policy was formulated the way it was, and why the policy was not implemented as well as it

[4] See (Akhter, 2000, 1996, Amin, et al., 1989, Barua, et al., 1981, Begum, et al., 1984, 1987, 1986, Dixon-Mueller, 1987, Dixon-Mueller, 1996, Hossain, et al., 1997, International Women's Health Coalition, 1994, Rochat, et al., 1981, Ross and Chowdhury, 1997).

could have been. I believe this is an important story to research and to document, particularly because many of the early advocates and decision makers involved in the MR policy have already retired or passed away. The research will be used to apply the analytical framework and to test the propositions inherent in a relatively new theoretical model of policy reform in developing countries as advanced by Grindle and Thomas and as explained more fully below. Finally, I hope that this research will provide insights to better enable future supporters of the policy to assist the Government in sustaining its policy. I strongly believe that the MR policy is one of the most important policies affecting the women of Bangladesh, and I declare my bias in advocating for sustaining and effectively implementing it in future. Because I was no longer a player in the health policy environment in Bangladesh when I undertook my fieldwork, I also believed that there was no tension between my partisanship and my commitment to obtaining as thorough and as objective an understanding of reality as feasible.

The remainder of this chapter covers a review of the policy analysis literature, an explanation of the theoretical perspective employed by this research, and a description of the research approach, strategy, methods, and limitations. Chapter 2 provides background information including a political history and a description of the policy environment in Bangladesh during the time the MR policy was formulated and implemented, as well as a description of the health care system and of gender issues in Bangladesh. The findings to my three research questions are presented in chapters 3, 4, and 5 respectively. Chapter 3 covers the agenda setting stage from approximately 1971 to 1973. Chapter 4, which covers the formulation stage from roughly 1974 to 1979, is aimed at identifying and analysing the critical factors that enabled decision makers in Bangladesh to formulate the MR policy. Chapter 5 analyses the factors that constrained or enabled decision makers in the implementation of the policy from 1979 to 1997. Chapter 6 is concerned with the ability of the Ministry of Health and Family Welfare (formerly called the Ministry of Health and Population Control) to sustain the policy in the future, which is defined as beginning with the Health and Population Sector Program of the Government's Fifth Five-Year Development Plan (1998 to 2003), and assesses the extent to which the key actors were likely to contribute toward or frustrate opportunities to improve the policy provided by the Health and Population Sector Program. The final chapter presents overall conclusions with respect to analyses of the policy and the usefulness of the

theoretical approach adopted, and states the contribution to knowledge made by this research.

1.2 The Policy Analysis Literature

The research questions correspond to three stages of the policy process—agenda setting, formulation and implementation—each of which are explained by various theoretical frameworks contained in the policy analysis literature. This review begins with a broad overview of these theoretical frameworks. What does the agenda setting literature suggest in respect of how issues come to the attention of government policy makers and make it onto the policy agenda? How, according to the literature on decision making, do policy makers select and decide on enacting into policy acceptable courses of action for dealing with a particular policy problem that has come to their attention? What do the various implementation models contribute to understanding the factors that influence whether a policy is successfully implemented?

The role of actors—just who sets the agenda, who decides on policy, and who influences implementation—constitutes the central concern of other theoretical frameworks that cut across theoretical frameworks of individual stages in the policy process. Accordingly the review also examines the major theoretical frameworks that are primarily interested in the role of actors in the policy process. The review concludes by arguing that none of these frameworks can readily be used on their own to explain the development and implementation of the MR policy in Bangladesh, and turns to a review of alternative analytical frameworks.

1.2.1 Agenda-Setting Models

The work of Cobb and Elder distinguished between two types of agendas: the systemic agenda and the institutional agenda (1972). The systemic agenda refers to the universe of issues under consideration by the public and by professionals and experts, but not yet on the formal government agenda, as well as those issues already being addressed by government. The institutional agenda refers to those issues that are under serious and active consideration by decision making bodies. Agenda setting theorists proposed several models to explain how issues got onto the systemic agenda, and how issues moved from the systemic agenda to the institutional agenda.

Cobb and Elder maintained that the larger the audience to which an issue may be appealed, the more likely it would be to move from a matter of popular concern to a matter of government concern. Issues with the following characteristics were likely to have wide appeal: specificity, social significance, temporal relevance, complexity, and categorical precedence. According to this argument, issues were more likely to have mass appeal if they are concretely defined, widely relevant, far-reaching, easy to understand, and new rather than routine. For an issue to move from the systemic agenda to the institutional agenda, they hypothesized that a critical mass must judge that something needs to be done to address it, and that it falls under the jurisdiction of a particular government agency. Similarly, Hall et al. identified legitimacy, feasibility, and support as critical factors in predicting whether an issue was likely to become a public agenda item (1975). Legitimacy referred to those issues that the government feels it has a legitimate right and responsibility to address. Feasibility referred to the potential for implementing the policy, and support referred to public support for the government's role in policymaking. An issue with high feasibility, legitimacy, and support, according to Hall et al. was likely to become an agenda item and to fare well once enacted into official policy.

Davies proposed an alternative model that viewed agenda setting as a process entailing initiation, diffusion and processing (1967). Initiation referred to a demand for action. Diffusion involved the process by which demands are turned into matters of government concern, and processing involved converting the issue into an agenda item. Davies claimed that the type of issue was the most critical factor in determining whether an issue got onto the government agenda. He also maintained that government initiates many issues itself.

Cobb, Ross and Ross proposed three other models of agenda setting: the outside initiative, the mobilization model, and the inside initiative (1976). The outside initiative was similar to the model that Cobb and Elder proposed earlier, with issues moving from the systemic to the institutional agendas. The mobilization model was very similar to the model proposed by Davies whereby issues that were initiated by government eventually got onto the agenda. The inside initiative represented instances when issues initiated by government were not expanded to the public arena.

Nelson contributed to agenda setting theory by differentiating the process even further, and introducing new distinctions about the process. She suggested that agenda setting consisted of 4 stages:

- Issue recognition: the point at which an issue is recognized as deserving government attention and involvement;
- Issue adoption: when a decision to respond or not to respond is made. Government decides it has a responsibility to act, and can find a feasible and acceptable solution;
- Issue prioritisation: the government agenda is reordered to accommodate the new issue; and
- Issue maintenance: the issue advances to the decision making arena, and government interest is sustained. (1984)

The last three stages were new. Nelson argued that for an issue to get onto the agenda, there had to be a shared sense that the government had a legitimate responsibility to deal with the issue, for which a feasible and acceptable solution existed.

Kingdon's work on agenda setting is viewed as the most extensive and comprehensive work on the agenda setting stage of the policy process. Kingdon defined agenda setting as "the list of subjects or problems to which government officials [. . .] are paying some serious attention at any given time" (Kingdon, 1984:35). His conceptual model suggested that problems come to the attention of policy makers through three streams: the problem stream, the policy stream, and political stream.

The problem stream has to do with the origins and definition of the policy problem to be addressed, and includes "focusing events" that draw the attention of policy makers to the problem, such as crisis events, indicators, or feedback on the achievements and failures of existing policies and programs. The policy stream is concerned with the technical feasibility of addressing the problem, including among other things, the availability of technology, and public acceptance of and receptivity to the proposed solution The political stream has to do with the politics surrounding the solution to the problem, including the national mood, public opinion, electoral

politics, and organized interest group activity. According to this model, "policy windows" of opportunities occur when the three streams come together. "Policy entrepreneurs," Kingdon suggests, "are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems, and for coupling both problems and solutions to politics" (:21). Kingdon's conceptual model implies that agenda setting is not a rational process that consists of a series of neat and discrete steps. "Societal predispositions" (values, political culture, etc.) set the context for issues getting on the agenda, in addition to "spillovers" from other policy areas.

1.2.2 Decision Making Models

Not all agenda items result in the formulation of new government policies. Why do policy makers choose some items and discard others? The rational approach has been advanced as an ideal model to describe how policy makers should arrive at decisions involved in the selection of alternatives for dealing with a policy problem. This approach has been widely criticized as lacking empirical validity, and challenged by the incremental approach. The latter is an empirical model that seeks not to describe the ideal, but the reality of what actually happens in the policy process. The third leading explanation for how decisions are made in the policy process is another empirical model that focuses on the role and influence of bureaucratic interests in the decision making process.

1.2.2.1 The Rational Decision Making Model

The rational decision making model represents an ideal stemming from economic and sociological theories of rationality (Parsons, 1995). It focuses on decision makers and the decision process, and in its purest form it involves a series of steps in which goals are determined, translated into objectives, and prioritised. All courses of action are evaluated, and the optimal solution is chosen. A rational policy is one that produces the greatest benefits over cost.[5] Indeed, this approach suggests that governments should desist from policies that produce greater costs than benefits. It is an ideal or normative model in the sense that it assumes that decision makers have limitless access to information about policy alternatives, the ability to foresee

[5] Dye suggests "One should *not* view rationalism in a narrow dollar-and-cents framework, in which basic social values are sacrificed for dollar savings. Rationalism involves the calculation of *all* social, political, and economic values sacrifices or achieved by a public policy, not just those that can be measured in dollars" (1998:25).

the consequences of all alternatives, and the intelligence to calculate the ratio of costs to benefits (Dye, 1998).

In contrast, theorists in other social science disciplines, namely psychology, have asserted that human behaviour is driven not by reason and rationality, but by instincts, passions, emotions, and anxieties (Parsons, 1995). In describing decision making in the real world, Simon advanced the notion of "bounded rationality" to describe the limits of psychological motivations on rational decision making (1976). Simon's theory that decision making was indeed rational but bounded by psychological and organizational factors, particularly the near impossibility of analysing all the information and options when considering a problem, led him to the theory that individuals within organizations look for courses of action which are "satisficing" rather than maximizing. Simon also suggested that the rationality of decision making could be enhanced through knowledge and the tools and techniques of managerialism.

1.2.2.2 Incrementalism

Like Simon, Lindblom believed that decision making could never be purely rational because of the complex and changing nature of the policy environment and limitations in terms of time, information, and cost (1959). Instead of searching for the best policy possible, he suggested decision makers followed a process of "successive limited comparisons" or the "science" of "muddling through." Lindblom's incrementalism as it became widely referred to involved "continually building out from the current situation, step-by-step and by small degrees" in contrast to the process advocated by Simon which Lindblom suggested started from "fundamentals anew each time, building on the past only as experience embodied in theory, and always prepared to start from the ground up" (:81).

As a model of decision making, incrementalism has been criticized on the grounds that it proceeds to a conservative agreement not far from the status quo and does not help to explain how or under what circumstances decision makers are likely to adopt more far reaching and innovative initiatives (Bunce, 1981). Dror acknowledges the empirical validity of incrementalism, but in order to render decision making less conservative he proposes an ideal model for decision makers which incorporates "extra rational" dimensions, including value judgements, creative thinking, intuition, feelings, and impressions (1989).

Another alternative to rationality and incrementalism was proposed by Etzoni who advocated a description and model for better decision making called "mixed scanning" which draws an analogy to weather forecasting and observation techniques to involve a broad sweep of the problem as well as a detailed examination of particular aspects depending on the nature of the decision (1967).

The barriers to rational decision making are well established, and it is widely recognized that rational decision making rarely takes place in practise. However, the model, argues Dye, "remains important for analytic purposes because it helps to identify barriers to rationality" (1998:25).

1.2.2.3 Bureaucratic Politics Model

This model holds that policy is an outcome of power relationships and bargaining between bureaucratic actors. These actors are considered to have their own interests including policy preferences and more power. They are able to operate in pursuit of these goals with considerable autonomy, and are constrained only by their organizational roles and capacity—hierarchical position, political skill, personal and bureaucratic resources. Grindle and Thomas suggest that in this competition to achieve certain goals "losing can threaten even greater losses, including those of power, access and budgetary resources. For this reason, players are encouraged to negotiate and compromise with one another in order to minimize the impact of losing" (1991: 29).

The bureaucratic politics model was developed by Allison as one perspective to view foreign policy decision making in the United States (1971). Grindle and Thomas argued that it was not widely applicable to other policy areas because foreign policy is dominated by executive decision makers and often takes place in secrecy. They acknowledge the usefulness of the model in highlighting state interests and autonomy, but they suggest it "provides little insight into the ways societal pressures, historical contexts and constitutional processes shape and influence policy outcomes. Indeed societal actors appear only in the guise of resources to be used by bureaucratic players in their efforts to influence policy, as pawns to be used in bureaucratic 'games'"(1991:30).

1.2.3 Implementation Models

"Implementation research has been concerned with acquiring a better understanding of the political, economic, organizational, and attitudinal factors that influence how well (or how poorly) a policy or program has been implemented" (Lester and Stewart Jr., 2000:109). The need for such research and understanding has been underlined by the difficulties encountered in turning decisions to alter policies into reality. According to Lester and Stewart, implementation research from 1970 to 1975 consisted of case studies detailing accounts of how particular policy decisions were carried out. This effort did not result in the development of useful theory about success or failure of implementation. The latter part of the 1970s, however, saw the development of analytical frameworks that identified factors that contributed to the success or failure of policy, and to the achievement or lack of achievement of policy objectives. These early theories applied a top-down approach that implied a linear model for the policy process, as described below (2000:109).

1.2.3.1 Top Down Approaches

Many analyses perceived policymaking as occurring in successive stages, with a clear distinction between formulation and implementation. The formulation stage was perceived as a political activity that mainly took place at the national level between national policy makers and, in the case of developing countries, donors. Implementation was perceived as a more administrative or managerial set of activities, carried out by administrative agencies at the national or sub national levels. Top down approaches to understanding implementation began with policy decisions taken at the national level and then asked the following types of questions:

1. To what degree were the actions of implementing officials and target groups consistent with (the objectives and procedures outlined in) that policy decision?

2. To what degree were the objectives attained over time (i.e., to what extent were the impacts consistent with the objectives)?

3. What were the key factors affecting policy outputs and impacts, both those relevant to the official policy as well as other politically significant ones?

4. How was the policy reformulated over time on the basis of experience? (Van Meter and Van Horn, 1975)

Influenced by an ideal model of perfect implementation advanced by Hogwood and Gunn that identified 10 preconditions that were thought to shape the linkage between policy and performance (1984), several top down frameworks were developed to explain the factors that affected implementation.

Van Meter and Van Horn proposed a model with six variables that they hypothesized shaped the relationship between policy and performance. These included: 1) policy standards and objectives; 2) policy resources (e.g., funds and other incentives); 3) interorganizational communication and enforcement activities; 4) characteristics of implementing agencies (e.g., staff size, degree of hierarchical control, organizational vitality); 5) economic, social and political conditions (e.g., economic resources within the implementing jurisdiction, public opinion, interest group support; and 6) the disposition of the implementers (1975). Mazmanian and Sabatier advanced another top down model. Their model included 16 variables that were thought to affect implementation. They fall into 3 broad categories: 1) the tractability of the problem; 2) the ability of the statute to structure implementation; and 3) non-statutory variables affecting implementation (1983).

Ingram criticized the top down models of policy implementation for failing to specify which variables were likely to be the most influential and under what circumstances (1987). Sabatier criticized them for assuming "that the framers of the policy decision (i.e., the people who drafted the statute) are the key actors and that others are basically impediments. This, in turn, leads the top-downers to neglect strategic initiatives coming from the private sector, from street level bureaucrats or local implementing officials, and from other policy subsystems" (1986:30). These criticisms led to the development of bottom up approaches.

1.2.3.2 Bottom Up Approaches

Bottom up approaches begin by identifying the network of actors involved in service delivery in one or more local areas, and asking them about their goals, strategies, activities, and contacts (Sabatier, 1986). According to Walt, the bottom up view holds that "implementers may change the way a policy is implemented, or even re-define the objectives of the policy because they are closer to the problem and the

local situation. Rather than seeing implementation as a stage in the sequential transmission of policy from formulation to implementation, it should be seen as a much more interactive process, and just as policy formulation may be characterized by bargaining, so may implementation be characterized by negotiation and conflict" (Walt, 1994:155). Elmore (1979), Lipsky (1971), and Hjern et al. (1981) advanced bottom up models to explain the implementation of policy. In the early 1980s, these models were subjected to empirical testing that according to Van Horn resulted in four broad lessons learned:

1. The frameworks were found to be useful in constructing general explanations for policy implementation success and failure.

2. Researchers showed that timing was important in implementation research (in other words, results varied depending on whether they were limited to only a few years of investigation or longer time frames).

3. Some programs were successfully implemented, compared to the case studies of the 1970s that emphasized failure.

4. Analysts concluded that even simple, modest programs can fail to be successfully implemented. (1987)

Lester and Stewart criticized bottom up approaches for "assuming that policy implementation occurs (or should occur) in a decentralized policymaking environment. Thus, the bottom-up approach was somewhat flawed by a rather limited explanation of implementation behaviour as both a desirable form of implementation and the only analytical approach for a complex organizational and political problem" (2000:113). According to Lester and Stewart, the research conducted during the early 1980s "added much to the knowledge of what implementation is, and how and why it varies as it does. However, the research has been much less helpful in differentiating among types of implementation outcomes, or in specifying the explanations associated with these outcomes. Also the research has not helped explain the frequency with which these patterns occur and the relative importance and unique effects of each of the various independent variables that are part of any adequate analysis of implementation performance" (2000:113). These critiques led to a synthesis and revision of the implementation

literature, to develop new frameworks that incorporated features of both the top down and bottom up approaches.

1.2.3.3 Combination Approaches

Elmore was one of the first to combine top down and bottom up concepts. He held that policy makers need to consider both the policy instruments and other resources at their disposal with the incentive structure of ultimate target groups, and that success depends on combining both of these aspects (1985). Similarly, Sabatier combined bottom up units of analysis (e.g., network of public and private actors involved with policy problem) with the top downers' concerns over the way in which socio-economic conditions and legal instruments constrained behaviour (1986). In applying his model to policy changes over period of ten or more years, Sabatier was admittedly more concerned with the development of theory rather than with prescription.

Goggin et al. focused on intergovernmental policy implementation (1990). Goggin et al. argued that state-level implementation is a function of enabling and constraining factors imposed on or provided by other levels of the government, as well as a function of the state's own propensity to act and its capacity to realize its preferences. Moreover he suggested that state decisions were not the result of a single rational actor, but the result of bargaining among parties at the national and local levels.

In another combination of top down and bottom up approaches, Grindle and Thomas view implementation as an explicitly political process in which top down and bottom up actors engage in conflict and negotiation over the goals of the policy and the allocation of resources. The degree of participation by various actors depends on the strength of their interest in the policy, and their organizational capacity, among other factors. Analysis begins with assessing the characteristics of the policy and the level of support or opposition that it is likely to generate. Next, policy makers must assess their resources (e.g., political, financial, managerial, and technical) and how these can be mobilized to ensure successful implementation (1990).

1.2.4 Policy Actors

Concurrent with agenda setting and decision making models, a number of explanations about who sets the agenda and who is involved in policy formulation

and implementation have been advanced. The extent to which different institutional and individual actors have access to and are able to influence the policy process depends largely on the broader policy context or environment within which they operate (Walt, 1994). The policy environment differs from one country to another, and depends largely on the country's political system (e.g., parliamentary democracy, presidential democracy, one-party state, or a dictatorship). The major actors in the policy environment are collectively referred to as policy makers, policy elites or decision makers, and may also include other actors such as organized interest groups and the citizenry. The leading explanations in the policy field are based on experience from the U.S. and Europe where societal actors play a relatively more important role than they do in more closed political systems characteristic of many developing countries. Precisely what roles they play and how they exert power in the policy process has been explained by pluralist, elitist, Marxist, and public choice approaches.

1.2.4.1 The Pluralist Argument

The original versions of pluralism advanced by Dahl (1961), Polsby (1963), and Truman (1951) hold that that power is distributed pluralistically among a large number of groups organized around common interests and ideas who through a process of competition—conflict, bargaining, and the formation of coalitions—influence the policy process. The government plays the role of neutral arbiter mediating between conflicting and competing groups. It is assumed that policy outcomes arrived at through this process have been endorsed by the majority and thus represent the public's best interest. In his well-known study of politics in the American city of New Haven where Dahl showed that policy-making in several different sectors was determined by a series of minorities rather than a single elite he argued:

> In the United States the political system does not constitute a homogeneous class with well-defined interests. In New Haven, in fact, the political system is easily penetrated by anyone whose interests and concerns attract him to the distinctive political culture of the stratum...The independence, penetrability and heterogeneity of the various segments of the political stratum all but guarantee that any dissatisfied group will find a spokesman. (:91-3)

Lester and Stewart summarized the pluralist model as follows:

1. Power is an attribute of individuals in their relationship with other individuals in the process of decision making.

2. Power relationships do not necessarily persist; rather they are formed for a particular decision. After this decision is made they disappear, to be replaced by a different set of power relationships when the next decision is made.

3. No permanent distinction exists between "elites" and "masses." Individuals who participate in decision making at one time are not necessarily the same individuals who participate at another time. Individuals move in and out of the ranks of decision makers simply by becoming active or inactive in politics.

4. Leadership is fluid and highly mobile. Wealth is an asset in politics, but is only one of many kinds of assets.

5. There are multiple centres and bases of power within a community. No single group dominates decision making in all issue areas.

6. Considerable competition exists among leaders. Public policy thus reflects bargains or compromises reached between competing leadership groups. (2000:55-56)

For pluralists, the concept of power is one that is manifest and measured through observable behaviour in decision making on issues where there is an actual and observable conflict of subjective interests (viewed as policy preferences) that come to light through political participation (Lukes, 1974). According to Dahl, power is defined as "a successful attempt by A to get *a* to do something he would not otherwise do" (1961:82). Dahl's method of determining the relative power of competing groups was to "determine for each decision which participants had initiated alternatives that were finally adopted, had vetoed alternatives initiated by others, or had proposed alternatives that were turned down. These actions were then tabulated as individual 'successes' or 'defeats.' The participants with the greatest proportion of successes out of the total number of successes were then considered to be the most influential" (1961: 336). According to the pluralist model, other interests could neutralize the power of the most influential groups, and interests would balance (Parsons, 1995).

1.2.4.2 Neo-Pluralist Theory and Non-Decision Making

Reflecting on the failures of policymaking in American society in the 1970s, and incorporating the criticisms levelled at pluralism by Marxist and elite theorists, Lindblom who had earlier advanced the pluralist model became the main proponent

of the neo-pluralist model.[6] Dahl (1982) also changed his views in the same way as Lindblom. Decision making they concluded was dominated by the more powerful groups in society and led to policy outcomes that were biased against the less powerful. The power of the most influential groups, such as corporate business interests, could not be checked or held in balance by other major interests as the original pluralist model supposed (Dahl and Lindblom, 1976, Gailbraith, 1969, Harrington, 1962).

Agenda setting theorist Schattshneider introduced the idea that a predominant set of values, beliefs, rituals, and institutional procedures operated systematically and consistently in favour of some groups and against others, a process that he described as "the mobilization of bias"[7] (Schattschneider, 1960). According to Shattschneider, "all forms of political organization have a bias in the exploitation of some kinds of conflict and the suppression of others because *organization is the mobilization of bias*. Some issues are organized into politics while others are organized out" (Schattschneider, 1960: 30).

Bachrach and Baratz instead of viewing power as "totally embodied and fully reflected in concrete decisions" (1962:7), as the pluralists model held, shifted the discussion about power by arguing that Schattschneider's theory pointed to a second face of power. In their words:

> Of course power is exercised when *A* participates in the making of decisions that affect *B*. Power is also exercised when *A* devotes his energies to creating or reinforcing social and political values and institutional practises that limit the scope of the political process to public consideration on only those issues which are comparatively innocuous to *A*. To the extent that *A* succeeds in doing this, *B* is prevented, for all practical purposes, from bringing to the fore any issues that might in their resolution be seriously detrimental to *A's* set of preferences. (1962:7)

Building on Schattshneider's "mobilization of bias" theory Bachratz and Baratz argued that power might be exercised by "confining the scope of decision

[6] Lindblom's pluralist views are presented in (Dahl and Lindblom, 1953, Lindblom, 1959).

[7] Bachrach and Baratz suggested that those who benefit form the mobilization of bias, "the status quo defenders' in other words, could be an elite group or a minority. Elitism they argued was not "foreordained or omnipresent...the mobilisation of bias can and frequently does benefit a clear majority" (Bachrach and Baratz, 1962: 43-44).

making to 'safe' issues" (1962:6) as well as through "non-decisions" which they define as follows:

> A non-decision, as we define it, is a decision that results in the suppression or thwarting of a latent or manifest challenge to the values and interests of the decision-maker. To be more clearly explicit, non decision making is a means by which demands for change in the existing allocation of benefits and privileges in the community can be suffocated before they are even voiced; or kept covert; or killed to gain access to the relevant decision making arena; or failing all these things, maimed or destroyed in the decision-implementing stage of the policy process. (1970:7)

Critics suggested that the theory of non-decision making could not be empirically demonstrated. How, they questioned could a person study a non-decision or in other words an event that never took place? (Merelman, 1968, Polsby, 1963, Wolfinger, 1971)[8] Bachrach and Baratz defended their view that a non-decision can be observed even though it may not be overt. Notwithstanding this methodological debate, the theory of non-decisional power became a widely applied model and the processes by which policy makers controlled the agenda were further elaborated. In a study of race relations in Baltimore Bachrach and Baratz showed how business leaders and politicians kept the demands of black people out of the decision making process through various forms of power, including force, sanctions, and manipulation (1970). Crenson argued that non-decision making could be studied by analysing the way in which an issue gets on to the agenda in one context and not in another (1971).

1.2.4.3 Bounded Pluralism

Arguing that neither pluralist nor elitist models of societal power are adequate descriptions of the policy process, Hall et al. advanced the idea of "bounded pluralism" (1975). In their alternative model of power, particular issues, namely systemic or "high politics" issues such as economic policy and national security, are decided with the predominant involvement of policy elites, whereas "low politics"[9] or more routine sector specific policy matters, such as healthcare, education, and

[8] Critics argued that if *B* fails to act because he anticipates *A*'s reaction, nothing has transpired and one has a 'non-event' that is impossible to test empirically (Lukes, 1974).

[9] Evans and Newman define 'high politics' as: "The maintenance of core values—including national self-preservation—and the long-term objectives of the state." "Low politics' they suggest are "not seen as involving fundamental or key question relating to a state's national interests, or those of important and significant groups within the state" (Walt, 1994:42).

housing, are open to a more pluralistic process of decision making. Walt argues that the concept of bounded pluralism can be more readily applied to the policy process in developing countries than either pure elitist or pluralist approaches (1994). She points out however that the process of globalisation[10] has begun to limit the extent to which the policy agenda is set and defined by bounded pluralism or by any other model that takes place with purely national boundaries.

1.2.4.4 Policy Networks and Communities

In response to the growth in the size of government and the number of participants in the policy process over the last several decades, as well as in the number of policy programmes focused on specific targets and functions, theorists have advanced several new metaphors for exploring the way policy is made within the context of a network of actors and organizations that exist in some modern societies. The metaphors were developed as an alternative to traditional approaches, but have also been examined within the context of traditional approaches.[11] Among the most important of these are the concepts of policy networks and communities, and policy streams.

In contrast to the analysis of the dynamics between formal policymaking institutions, network and community analysis focuses on the formal and informal relationships between actors and organizations. It is concerned with how these relationships influence policy agendas and decision making, and how ideas impact on policy or not. Networks or communities including politicians, civil servants, policy

[10] Walt's point echoes a growing body of literature on globalisation and its implications for public policy making in industrialized countries and the developing world (1998:25). With increasing interconnectedness between nations in the form of transnational corporations, growing economic integration, and the globalisation of communications and media the policy making process can no longer be viewed within purely national boundaries (Parsons, 1995). Within the context of three theoretical approaches, Giddens suggests that globalism is the product of 1) the expansion of capitalism, 2) uneven development and the domination of the underdeveloped world by the industrialized world, and 3) the expansion of the world economy leading to centralization around a core, semi periphery, and periphery of system of relationships (1988).

[11] Smith argued that the idea of communities and networks might be viewed within the context of several theoretical approaches. He suggests "For Marxists the networks would be closed and dominated by the interests that represent capital. For elitists, networks would be closed and dominated by a small number of interest groups and state actors...For state theorists, networks could take different forms but would exist in order to pursue the interests of state actors. For pluralists, networks are continually breaking down into issue networks which makes its increasingly difficult for a small number of groups to dominate policy sectors" (Smith, 1983:74).

analysts, experts, and interests groups are involved with advocating ideas and impacting policy through a constant flow of ideas and information (Walt, 1994). The difference between networks and communities has been described in terms of the degree to which they are cohesive and have access to the policymaking process. Rhodes suggested that communities, on one end of the spectrum, were tightly knit, like-minded, restricted, and had strong access to the policy process. On the other end of the spectrum, networks were looser, less stable, non-exclusive, issue-focused, and had weaker access to the policy process (1981).

Sabatier proposed that policy communities included a number of coalitions which he called advocacy coalitions—like-minded actors with similar policy goals—competing for influence in the decision making process (1991). Compromise between advocacy coalitions according to Sabatier's model is negotiated by "policy brokers" such as civil servants, politicians, special commissions or courts, who are more concerned with maintaining overall stability than with reaching particular policy goals. Benson proposed that networks included different structural interests at different times and across policy sectors. These interests include demand groups, support groups, administrative groups, provider groups and coordinating groups (1982). "Epistemic communities" have been defined as made up of professionals who, according to Haas, "share a commitment to a common causal model and a common set of political values. They are united by a belief in the truth of their model and by a commitment to translate this truth into public policy, in the conviction that human welfare will be enhanced" (1990: 41).

Richardson suggested that the way networks function varied according to the "policy style" of the government, mainly in terms of whether its style could be described as proactive or reactive, and consensual or dictatorial (1982). Richardson noted that a government's policy style could vary over time and from policy to policy. For instance, a government that normally seeks broad participation may, in the case of national security, behave in a closed and furtive manner.

1.2.4.5 Professionalism

Professionals are viewed as having power by virtue of their knowledge. This view holds that professionals and experts are frequently considered the producers and disseminators of knowledge and thus play a critical role in agenda setting, decision making, and implementation, especially in sectors where professional knowledge is

found, such as health or education. Wilding suggests that the power of social workers and doctors, for example, extends beyond the policymaking process itself, to the allocation of resources, command over people, and control over their work (1982).

How professionals have used and maintained power has been the subject of numerous policy studies across sectors, notably in America and Britain (Parsons, 1995). Pluralist models hold that professional power is fragmented while elite theorists suggest that it is concentrated. During the 1970s and 1980s, however, the power of professionals was undermined by a forceful academic critique: a decline in public trust (Parsons, 1995:156-157). This can be attributed to three major factors: scepticism about the ability of science and technology to solve complex social problems (Nelkin, 1992); a conflict of interests between the policy aims of professionals that called for greater spending against the need to reduce and contain costs felt by government (Laffin and Young, 1990); and thirdly, a sense that professionals were more interested in serving their own power than the public's interests (Illich, 1975a, 1975b, 1977).

Although this criticism undermined the role of professionals, Parsons suggests that professionalism would continue "in a much adapted discourse in which professional knowledge, expertise and standing will have to be negotiated for, rather than accepted as in the past" (1995: 265). Indeed, he notes that professionals became more pluralistic and diverse in terms of expert opinion and knowledge, and suggested that they "should not be seen as a distinct separate class or structure within the policy-making process, but inextricably enmeshed with power and politics. They are not "non-political" or neutral participants in the process: they advance class and business interests as well as professional values and beliefs" (1995:158).

1.2.4.6 The Elitist Argument

Elitists argue that agenda setting and decision making operate in favour of the preferences and values of a governing elite (Dye, 1998). According to Laswell, "The influential are those who get the most of what there is to get [...] Those who get the most are elite, the rest are mass" (1936:13). He suggested that elite power and influence derived from "skills" as well as class dominance.[12]

[12] Laswell defined skills as the use of violence as in the military or police forces, the use of communication and propaganda, the use of business and commercial skills, and the use of

Dye summarized the ruling elite model as follows:

1. Society is divided into the few who have power and the many who do not. Only a small number of persons allocate values for society; the masses do not decide public policy.

2. The few who govern are not typical of the masses who are governed. Elites are drawn disproportionately from the upper socio-economic strata of society.

3. The movement of nonelites to elite positions must be slow and continuous to maintain stability and avoid revolution. Only nonelites who have accepted the basic elite consensus can be admitted to governing circles.

4. Elites share consensus in behalf of the basic values of the social system and the preservation of the system.

5. Public policy does not reflect the demands of masses but rather the prevailing values of the elite. Changes in public policy will be incremental rather than revolutionary.

6. Active elites are subject to relatively little direct influence from apathetic masses. Elites influence masses more than masses influence elites. (1998:22-23)

Modern elite theorists such as Hunter concluded on the basis of extensive interviews with members of the business community in an American city that a power elite controlled decision making in democratic society (1953). Similarly, Mills argued, that a "power elite" made up of persons who run the major institutions such as the military establishment, corporations, and the political bureaucracy make all the important decisions in the U.S. political system (1956). He concluded on the basis of his research the following: "Not all power [. . .] is anchored in and exercised by means of such institutions, but only within and through them can power be more or less continuous and important" (1956:).

According to elite theory, policy thus reflects the interests and values of a ruling elite rather than the masses, yet according to Dye, "the value of elites may be very 'public regarding'. A sense of noblesse oblige may permeate elite values, and the welfare of the masses may be an important element in elite decision-making.

organizational and administrative skills, such as those held by bureaucrats (Laswell, 1935, 1936, 1965).

Elitism does not mean that public policy will be against mass welfare but only that the responsibility for mass welfare rests of the shoulders of elites, not masses" (1998:24).

Elite theory was influenced by pluralist critics such as Schattschneider and Bachrach and Baratz, whose ideas were taken a step further by Lukes who maintained that the concept of power involved elite control over decision making and the political agenda (1974). Lukes argued, "the bias of the system is not sustained simply by a series of individually chosen acts, but also, most importantly, by the socially structured and culturally patterned behaviour of groups, and practises of institutions, which may indeed be manifested by the 'inaction' of individuals (1974:22).

According to Dye, "elites share in a consensus about fundamental norms underlying the social system, that elites agree on the basic rules of the game, as well as the continuation of the social system itself. The stability of the system, and even its survival, depends on elite consensus in behalf of the fundamental values of the system, and only policy alternatives that fall within the shared consensus will be given serious consideration" (1998:24).

Luke contended that the absence of conflict does not necessarily mean that consensus exists, as the pluralists would suppose. As he puts it, "A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants. Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have—that is, to secure their compliance by controlling their thoughts and desires?" (1974:23)

According to elite theory, the democratic system—elections and political parties—are important for their symbolic value, but do not do not enable the masses to influence the policy process. Elitists contend that the masses have if anything a very indirect influence over policy.

1.2.4.7 Marxism

Sharing the same theoretical base as elitism, the classical Marxist approach holds that policy is the outcome of conflicts between social classes. The state functions as an instrument of domination used by the ruling class to reproduce

inequitable societal relations that exist within a capitalist system. In this instrumentalist view, the state does little more than provide "the legal, institutional and ideological hegemony of the dominant class or class alliance over subordinate classes" (Grindle and Thomas, 1991: 21). In the words of Engels, the state functions as an "organization of the possessing class for its protection over the non-possessing class" (1968: 291).

This model has been adapted over time mainly to account for instances where the state has demonstrated its own initiative and autonomy in promoting capitalism as a system and capitalist interests (Grindle and Thomas, 1991). For example, Engels argued that during periods when no one class dominates, the state is afforded some degree of independence to pursue policies, even those with the potential to conflict with the interests of the dominant class (1968). Poulanzas claimed that the "structural" power of capital determines decision making, and in some instances the state acts like a neutral arbiter between classes or factions rather than as an instrument of the dominant class in order to protect the long-run interests of capital and the capitalist class (1973). Further, Cawson and Saunders argued that issues of interest and priority to the capitalist system and the capitalist class are tightly controlled by the state whereas, in the interests of maintaining legitimacy, less important areas of decision making are open to a more pluralistic political process (1983).

1.2.4.8 Public Choice Approach

Grindle and Thomas suggest that neoclassical economists have adopted the public choice approach because it offers "a coherent and relatively parsimonious explanation for seemingly nonrational decision making by governments" (1991:25). Parsons suggests that approach has not been substantiated by solid evidence, and that its main appeal is more normative than empirical in that it appeals to a widespread anti-bureaucratic sentiment (1995).

Dating back to Tullock's observations of the U.S. State Department in the 1970s the public choice approach holds that elected and non-elected government decision makers, like profit maximizing firms and consumers, are fundamentally self-interested rather than being concerned with the public's interest. Politicians make promises to secure votes, and then once in power, provide favours and benefits to powerful interest groups to remain there (Anderson and Hayami, 1986, Bates, 1981, Tullock, 1965). Similarly, non-elected officials are motivated by self-interest and

power which according to Niksanen finds expression in the desire of those who work in bureaucracies to increase the size of their institutions and budgets (1971). They also seek to derive rents by responding to the demands of powerful interest groups in the form of granting favoured access to public resources (Colander, 1984, Krueger, 1974). According to the public choice approach, decisions motivated by the self-interests of elected and non-elected officials result in policies that have negative or harmful consequences for the public (Grindle and Thomas, 1991). Tullock maintained that traditional democratic structures and processes were not strong enough to contain the growth of political and bureaucratic power, and that market forces were needed, such as contracting-out services, privatisation, and incentives to stimulate competition between government departments (1965). In developing countries, public choice theory has been used to explain the political behaviour of politicians towards other state agencies such as the military and the bureaucracy, whose support, like that of powerful interest groups in western liberal democracies, is perceived as a critical source of power (Ames, 1987).

The public choice approach views political society as comprised of organized interests. It views people as rational, self-interested, opportunistic actors who seek to maximise their own self interest rather than the public's interest. Interest groups are concerned with acquiring access to public resources, and preferential treatment such as an import license or exclusive rights in a particular industry. Not all interests have equal access to the policy process. Less powerful groups are at a disadvantage unless they can organize and articulate their interests. According to Turner and Hulme, "the difference between pluralist and public choice approaches is in the perception of politics. The former sees wise policy resulting from competing interest groups while the latter has no illusions about politics, characterizing it negatively as an often cynical and always self-interested struggle for resource" (1997:67).

1.2.5 Alternative Approaches to Explaining the Policy Process

All of the literature reviewed above contains important explanatory elements. However, there were significant difficulties in using these theoretical frameworks to explain the MR policy process in Bangladesh. Firstly, the approaches concentrating primarily on one of the three stages in the policy process could not be extended to explain the processes followed in the other stages. Further, many of these approaches tend to view policy as a linear process, with implementation especially perceived as

being an "utterly simple and automatic" stage following a policy decision, rather than as a highly political process, which was the case in Bangladesh (Lane, 1993:93).

Secondly, most of the analytical frameworks reviewed above were developed in the context of the liberal democratic systems of western industrialized countries, and were not easily applied to developing country policy environments such as Bangladesh. The main difference between the policy environments of the developed and developing countries in general, contend Grindle and Thomas is the relative centrality of government officials—policy elites—in the policy process in Southern countries (1991:44). This they argue is due to the political environment, specifically the closed nature of the political system, which excludes other actors, as well as factors such as uncertain information, poverty, pervasive state influence in the economy, and centralization of decision making. While policymaking may look superficially similar in developing and developed countries, especially where countries have derived their formal institutions from Western models, Grindle and Thomas suggest, "a finely tuned understanding of the environment and the factors that influence the interactions among the principal players and institutions is critical" (Grindle and Thomas, 1991:44). Grindle and Thomas suggest that what they categorize as society-centred models, such as Marxist approaches, pluralist approaches, and public choice approaches, grant too little initiative to policy elites in developing countries, instead focusing on the interplay between social actors such as classes or interest groups as the source of policy choice and change. Similarly, Grindle and Thomas criticize state-centred approaches that emphasize the interactions of policy makers involved in the decision making of the policy process on the grounds that they tend to reduce policymaking to a set of highly controlled interactions between policy elites who are unencumbered by classes or interest groups.

Finally, no one of the above approaches is capable of being used on its own to comprehensively explain the health policy process. Parsons (1995) suggests that given the complexity of health policy, it may be particularly difficult to use a single theoretical approach. Harrison et al. (Harrison, et al., 1990) cited in (Parsons, 1995) applied six of the traditional policy analysis frameworks to the health policy process in Britain. While Harrison et al. concluded that health policy in Britain could best be explained by a combination of neo-elite and neo-Marxist models, they also concluded that health policy could not be explained by one theory. The origins, formulation and

implementation of the MR policy in Bangladesh spanned a more than twenty-year time period, during which time the policymaking environment, processes and actors did not remain static and amenable to a single model. Moreover, it can be said that at any given time the policy process fit the general characterizations of one or more of the models described above, but by and large, defied the explanatory power of a single model. Policymaking as a construct is poorly suited to many of the traditional analytic approaches above because of its variability and its complex and interactive relationship to a multiplicity of factors that affect the policy process and its outcomes.

Of particular relevance to this research, therefore, was the review of analytical frameworks and methods that were comprehensive enough to explain the complex nature of the entire policy process under examination, that paid due weight to the role of policy elites in developing countries, and that contained parts which were neither completely independent nor rigidly interconnected. Instead of focusing on linear approximations of relationships among fairly discrete factors, these models are similar in their search for patterns and meaning to look for connections, interactions, instability and disorder. They are further motivated by a desire that their findings should contribute to improving policy as opposed solely to objectively contributing to knowledge.

Walt and Gilson suggest that the policy process can be best understood using a political economy approach focused on actors, context, and process, yet they noted that with a few exceptions, political economy approaches have not been used to examine health policy (1994). They also noted however that there is a dearth of literature on actors and their roles in health policymaking, including professionals and donors, and political economy approaches to analysing health policy more generally. In order to begin to generate broader frameworks Walt and Gilson proposed "a simple analytical model which incorporates the concepts of context, process, and actors as well as content" for exploring policy in the health sector (1994:354).

The Walt and Gilson framework is useful in that it incorporates important elements from several approaches and disciplines. For example, "context" in the Walt and Gilson framework includes Leichter's policy analysis model (Lee and Walt, 1995) which posits that the content and direction of policy are a function of

situational, structural, cultural, and environmental factors.[13] Although they appear rather one dimensional, these factors represent complex and dynamic political variables such as for example, state-society relations, political participation, globalisation, and the process of policy transfer. Leichter applied this framework to the comparative analysis of health care policy in four countries. According to Leichter, a situational factor "is a more or less transient, impermanent, or idiosyncratic condition or event that has an impact on policy making" (1979:39). Situational factors may last a short or a long time, and may, if they persist, become structural factors. For example, war would be considered a situational factor that is likely to have an impact on public policy. Structural factors "include more permanent and persistent features of a system, such as its economic base, political institutions, or demographic structure" (1979: 39). Cultural factors refer to political and general culture (such as religion) and involve the values and norms of the society. Lastly, environmental factors are "events, structures, and values that exist outside the boundaries of the political system but that influence decisions within the system" (1979:40). Leichter suggests, "the policy context usually involves a simultaneous interplay of more than one situational, structural, cultural or environmental influence," and the influence of these factors varies over time, and by policy (1979:40).

Similarly, the Walt and Gilson framework draws on theories from both state-centred and society-centred approaches, and specifically recognises the importance of analysing the relative power exerted by national and international actors. It is a neat heuristic device for the wide exploration of the concepts of actors, power and process, for inquiring about the causes, or determinants of public policy, and for building new conceptual models. Because of the comprehensiveness of this model, and because it is particularly well-suited to assessing qualitative data gathered in an inductive manner, it was used extensively during the fact-gathering stage of this research. While it is useful as a broad conceptual framework, however, the Walt and Gilson model does not attempt to explain the causal relationships between context, process, actors and content. It does not contain specific propositions or hypotheses that could be tested specifically to explain the policy process in Bangladesh.

[13] Leichter's model is based on a similar framework proposed by Robert Alford in which "Decisions, policies and government roles can be explained by a combination of situational, structural, cultural and environmental factors" (1975, n.p.).

Grindle and Thomas proposed an alternative framework for policy analysis specifically relating to policy reform in developing countries. This model suggests that government policy makers are affected by three main factors in their efforts to effect policy change: contextual conditions, agenda-setting circumstances, and policy characteristics. Based on extensive research including case study development by mid-career officials from developing countries with personal involvement in the reform cases, the authors formulated a number of generalized hypotheses to predict whether and under what conditions a reform initiative would fare at each of three specific critical junctures in the reform cycle. They contended that by exploring a series of questions at each juncture, they could explain the subsequent course of agenda setting, decision making, and implementation. The authors explicitly rejected "theoretical approaches that view policy elites as cogs in the wheels of large structures and systems which they have no capacity to influence or alter" (Grindle and Thomas, 1991:183) and in fact presented a central argument that policy elites can take "purposive action" to alter the "policy space" for introducing reforms (Grindle and Thomas, 1991:183).

As with the frameworks proposed by Walt and Gilson and by Leichter, context is important to the Grindle and Thomas framework, primarily because contextual factors define the "embedded orientations" of policy elites. In addition, the circumstances of policy reform—whether one of crisis or one of politics-as-usual—have a critical effect on the policy process that is followed according to the Grindle and Thomas model. In turn, the specific characteristics of a particular policy reform will determine what types of conflict are likely to follow, and therefore whether the policy decision is likely to be successfully implemented and sustained. Like the framework proposed by Walt and Gilson, the Grindle and Thomas framework is not designed to predict what technical solutions will be crafted or how successful they may be in resolving particular public problems. Rather, "it systemizes thinking about how context influences particular solutions, how circumstances shape options, how options are sorted out in terms of their political, technical, bureaucratic and international implications, and how policy characteristics affect conflict and the resources needed to manage it in the introduction of reform." Analytically, according to Grindle and Thomas, "these are important sets of relationships to map out" (1991: 187).

Like Folz Grindle and Thomas consider policy elites to be the critical actor in the policy process. In an analysis of 16 population case studies, they found the chief executive to be the principal actor. Ministers of health as well as their technical corps were often acknowledged as important because they served as filters through which population initiatives flowed. In addition, domestic and international interest groups often attempted to influence the perceptions of the chief executive. However, as noted by Walt and Gilson the role of vested interests and interest groups is somewhat neglected in this model.

1.3 Analytical Framework

This research applies the theoretical framework proposed by Grindle and Thomas to attempt to explain the MR policy process in Bangladesh, for three main reasons. First, the model was explicitly developed to explain public choices and policy change in developing countries. As such, it recognizes that concepts of pluralism, for example, and other society-centred explanations that may have greater applicability in Western societies, cannot readily be applied in developing country settings. At the same time, it specifically recognizes that state-centred explanations cannot be strictly applied either, because policy elites in developing countries are always constrained by economic realities, societal pressures and interests, international contexts, and bureaucratic capacity and compliance. Similarly, Grindle and Thomas observed that public officials in developing countries play relatively larger roles in policy-making and implementation than their counterparts in Western industrialized countries, and they developed their model accordingly. The Grindle and Thomas model for explaining how policy choices are made and applied in developing countries was thus felt to be relevant to the policy environment in Bangladesh throughout the lifecycle of the MR policy. This environment was very different from the settings in which health policies are typically framed in Western societies.

A second reason for applying the model proposed by Grindle and Thomas is that the framework attempts to explain the entire life cycle of policy reform. The framework requires a series of questions to be explored at three critical junctures in the policy process, the responses to which can be used to predict or explain the subsequent course of agenda setting, decision making, and implementation. More specifically, the framework requires an assessment of two sets of *contextual*

conditions—the "embedded orientations" of policy elites and the broader historical, political and cultural factors—to help understand how reform initiatives emerge and are placed on the policy agenda. The framework then requires a distinction to be made as to whether the *agenda-setting circumstances* are those of crisis or of politics-as-usual, in order to understand or predict the decision making dynamics during the policy formulation phase. Grindle and Thomas argue that the perception of whether a crisis exists or not will alter the timing of the reform (with a compelling urgency to "do something" when a crisis situation is perceived), the magnitude or nature of the reform (with innovation rather than incrementalism more likely to result when a perception of crisis exists), the status of decision makers (with conditions of crisis tending strongly to move the level of concern upward in the decision making hierarchy of government), and the stakes involved (with stakes in a crisis situation involving macropolitical issues such as the survival of the regime, unlike the stakes in a noncrisis situation which would tend to involve bureaucratic power relationships and micropolitical concerns). In addition, Grindle and Thomas argue that the agenda-setting circumstances affect which of four "lenses" through which policy elites filter options will take on greater or lesser importance during the policy formulation phase. These predictions are set out in the following three relatively specific hypotheses:

> Hypothesis 1:
>
> In crisis-ridden reforms, decision making tends to be dominated by concern about major issues of political stability and control. Technical analysis, bureaucratic interactions, and international pressures often assume importance in these decisions but usually remain subordinate to concerns about the stability or survival of the regime in power or the longevity of its incumbent leadership.
>
> Hypothesis 2:
>
> When noncrisis-ridden reforms concern policy issues, decisional outcomes tend to be dominated by micropolitical and bureaucratic concerns. Technical input and international pressure are important, but not decisive, in explaining policy choice under these conditions. Major issues of political survival and support building are usually not salient to decision makers.
>
> Hypothesis 3:
>
> When noncrisis-ridden reforms concern issues of organizational change, decision making tends to be dominated by bureaucratic concerns. International pressures often emerge as part of bureaucratic interactions in these reforms. Technical input and concern for political survival are usually not salient to reform decision makers. (1991:106)

The Grindle and Thomas framework also attempts to explain the process of implementing policy reforms. Unlike a linear model of the policy process that is implicit in many of the implementation models mentioned above, however, Grindle and Thomas propose an interactive model that anticipates some response or reaction to any reform initiative that may be felt at many points in the implementation process. The nature, intensity and location of those reactions determine whether the reform will be successfully implemented. Grindle and Thomas assert that the *policy characteristics* determine whether there will be a strong public reaction to the initiative, or whether the response to implementation efforts will primarily be played out in the bureaucratic arena. The costs of some reforms, such as a commodity price increase, will be more broadly and immediately felt than the costs of others, such as the reorganization of a government ministry. Similarly, the benefits of some reforms may not be widely understood or valued. Certain reforms, such as currency devaluation, may be self-implementing, whereas others may require extensive technical or administrative efforts in order to see that they are carried out. In addition, reforms may require extensive cooperation and participation in order for a vaccination program, for example, to work, while others such as the granting of licenses require participation on an individual or case-by-case basis only. Finally, some reforms may be implemented overnight, whereas others require years to be implemented.

Boneparth and Stoper similarly proposed that an assessment of policy characteristics could be useful to anticipate likely reactions to the policy (1988). They proposed visibility, degree of controversy, and scope as the salient characteristics. Lowi suggested an examination of the policy's effect on society to predict reactions to the policy, and for this purpose he proposed a typology of three kinds of policy: distributive, regulatory, and redistributive (1964). This research will use the policy characteristics suggested by Grindle and Thomas, as outlined in the preceding paragraph.

An analysis of the characteristics of a policy can lead to a determination of where the resistance to the implementation will be felt. The "arena of conflict", in turn, affects the stakes involved and resources required to implement the reform. Grindle and Thomas contend that when a public reaction is anticipated in a high stakes "game" of reform, the critical implementation actor is the decision maker,

whose primary role is to assess the political resources available to implement and sustain the reform, to mobilise support, and to counteract opposition. On the other hand, the public manager is the key actor in a lower stakes bureaucratic arena. The manager's critical role in this case is to mobilise financial, managerial and technical resources to implement the reform.

Table 1.1

Three Critical Junctures in the Grindle and Thomas Framework

Phase	Variable	Evidenced by	Predicts/ Explains
Agenda setting	Contextual conditions • Embedded orientations of policy elites • Broader factors	• Personal attributes and goals Ideological predispositions Professional training and expertise Memories of similar policy experiences Position and power resources Political and institutional commitments • Societal pressures and interests Historical context International context Economic conditions Administrative capacity Other policies	What gets placed on the policy agenda
Policy Formulation	Agenda-setting circumstances • Crisis • Politics-as-usual	• Timing • Innovation vs. incrementalism • Status of decision makers • Stakes	Relative importance of "lenses"
Policy Implementation	Policy characteristics	• Costs and benefits • Administrative or technical content • Participation • Duration	• Arena of conflict • Stakes • Resources

Because this research is concerned with the entire life cycle of the MR policy in Bangladesh—how it came to be placed on the policy agenda in the first instance, how and why it was formulated the way it was, and why it did not appear to be implemented as well as it could have been—the Grindle and Thomas framework was felt to be particularly relevant to the research. That is, the model could be applied retrospectively in an analysis *of* the policy process that was followed in the past. This is done when examining the story of the menstrual regulation policy over the agenda-setting, policy formulation and implementation phases in chapters 3, 4 and 5, respectively, by applying the model as described above and as summarised in Table 1.1 above.

A third reason for choosing the political economy model of policy reform in developing countries as the analytical model for my research, was that the framework could be used prospectively in an analysis *for* policy. The framework is explicitly intended to be used by those who would wish to promote particular reform initiatives in order to alter policy outcomes. One of the main justifications for the research as indicated above was to provide insights to better enable future supporters of the MR policy to assist the Government of Bangladesh in sustaining its policy. The Grindle and Thomas framework can be used to generate those insights. Indeed, a central assertion in the Grindle and Thomas model is that policy elites can, by assessing the possibilities for manoeuvring within the critical policy process variables and through purposeful action, alter the "policy space" for the introduction of reform initiatives.

In chapter 6 we apply the framework to identify room for manoeuvring within constraints in order to expand the space for sustaining the policy in future. In particular, we draw on the proposition that all reform initiatives—but particularly those where the arena of response is anticipated in the public rather than in the bureaucratic arena—require political resources in order to be implemented as intended. In this part of the framework, the Grindle and Thomas model draws on the work of Lindberg and Crosby (1981) to go beyond simply identifying potential supporters and opponents of a reform measure, to assessing the degree to which support or opposition can be mobilized, how powerful each group is likely to be, and the sequence in which information reaches people. "Maps" of political support in the event of a bureaucratic response, in the event of a public response, and following possible "purposive action" to mobilise additional resources in support of the future implementation of the MR policy, are presented in chapter 6 when we assess the prospects for sustaining the MR policy in future.

Grindle and Thomas developed their model inductively, based on twelve instances of economic reform initiatives that were documented in case studies written by persons inside the government decision making processes. Subsequently, the model was assessed in light of 16 cases of population policy reform in developing countries. This research will provide a 17th population policy reform case study that can be used to assess the model of public choices and policy change advanced by Grindle and Thomas.

1.4 Research Approach

My research employed a single case study design wherein information relating to the formulation and implementation of the MR policy in Bangladesh from 1974 to 1997 was obtained following an inductive approach.

A case study has been defined as an inquiry that investigates a contemporary set of events within their real-life context particularly "when the boundaries between phenomenon and context are not clearly evident" (Yin, 1994:13). According to Yin, "you would use the case study method because you deliberately wanted to cover contextual conditions—believing that they might be highly pertinent to your phenomenon of study" (1994:13). Further, a case study is thought to have distinct advantages when a "how" or "why" question is posed about contemporary phenomena over which the researcher expects to have little or no control (Yin, 1994), and when the problem area is not well defined and the potential for rival interpretations exists (Keen and Packwood, 1995). In essence, my research questions are all "how" and "why" questions: how the Government of the People's Republic of Bangladesh (GOB) formulated its MR policy, why it seemed unable or unwilling to respond to known deficiencies in implementation, and how the policy can be sustained in the future. Also, the contextual factors discussed by Grindle and Thomas were believed to be extremely pertinent to answering the research questions, and the "problem area"—or the political economy of the MR policy process—was certainly not well defined and was open to rival interpretations.

Foltz has argued that in-depth case studies are "the only way to illuminate the policy process itself and to help construct the cases that in the long run will permit the building of theory about the policy environment in developing countries" (:220). Foltz calls for researchers to abandon prescriptive approaches and to gather data about policy environments in order to generate hypotheses and theories inductively. "At present," says Foltz, "we do not know enough about the policy processes of developing countries, particularly in the health sector, to move immediately to hypothesis testing on the policy process" (:220). For this study, I proposed to conduct an inductive enquiry as urged by Foltz, for much the same reasons. I indicated that I did not believe enough was known about the relationships between the stakeholders and the health policy process in Bangladesh to permit a deductive approach. I therefore proposed to follow an inductive approach that did not prematurely exclude any lines of enquiry and that was better suited, in my view, to

understanding the policy process and ultimately to discerning the principles and theories involved.

Yin maintains, however, that there is an important difference between case study design and related methods such as grounded theory, in that the latter deliberately avoids specifying any theoretical propositions at the outset of the enquiry (1994). He suggested that the study's propositions are an essential element of case study design. The study's "how" and "why" questions themselves, according to Yin, do not set sufficient direction for an explanatory or descriptive case study. "Only if you are forced to state some propositions," claims Yin, "will you move in the right direction" (1994:21). Initially, I did state a number of propositions that served to focus my lines of enquiry based on an initial review of the policy process as it pertained to MR and some experience of the sector. Based on a cursory review of the interrelationships between the MR policy content, context, and actors, and some experiences of the sector, I proposed that the MR policy was formulated by a small, male-dominated policy elite with encouragement from the international donor community, and with deliberate ambiguity about the nature and intent of the intervention so as not to arouse religious and moral opposition to abortion in a conservative Islamic society where abortion was, and is, illegal and socially unacceptable. I suggested that the way in which the policy was formulated led to ambivalence during the implementation of the policy, as manifest by the government's seemingly unresponsiveness to known deficiencies in the implementation of the policy. I proposed that this ambivalence grew during the implementation period because of changes in other factors since the time the policy had been formulated, including a change in the stated objective of the policy from population control to improving maternal health, a shift in the position of certain international donors from support to opposition, and a growth in religious and political conservatism. My research was designed to gather data to address the validity or otherwise of each of the propositions that I explicitly made at the outset of my study. My study was inductive and precluded no lines of enquiry only insofar as I attempted to remain alert throughout the fact-gathering and analysis phases of my research to additional factors that could contribute to understanding the research questions.

I employed a case study design to inductively explore the way MR made it onto the policy agenda in Bangladesh and how it fared once there. I believe this

approach was appropriate given that one of the three main reasons for doing the research was to document the story of the MR policy. Had I wished only to test a theoretical model, a deductive research design would have been more efficient, and the risk of being left at the end of the field research with insufficient data in relation to one or more of the critical variables contained in the model could have been reduced or eliminated. A deductive approach, however, would have focused the research on those variables defined by or contained within the model. This would have raised the risk that research into the story of the MR policy may have missed other pertinent variables.

1.5 Methods

I conducted focused and open-ended interviews with 80 persons in the United States and Bangladesh from July to December 1998, including representatives from all important stakeholder groups. (A full list of respondents is contained in Annex 2.) To protect the anonymity of the persons interviewed, I did not attribute specific points to individuals. Unfortunately, my fieldwork coincided with what many Bangladeshis and newspapers reported were the worst floods in living memory. The floods, which took place from July to October 1998, covered two-thirds of the country, caused over 1,100 deaths, and affected 30 million people. They severely damaged an estimated 15,000 kilometres of roads, including many in and around the capital city of Dhaka, 14,000 schools, hundreds of bridges and culverts, and close to 500,000 homes. During the period of my fieldwork, many government agencies and NGOs working in health and other sectors had suspended normal functions and were extremely busy with arranging and managing emergency assistance and relief. I made every effort to complete my fieldwork quickly, taking up as little time as possible for each interview, and asking for a second interview only when I considered it absolutely necessary.

Three quarters of the interviews were focused or semi-structured interviews that lasted about one hour each and that were guided by a set of questions but conducted in a conversational manner. The purpose of the interviews was to establish the facts of the matter to the best of the respondent's knowledge and belief, and to corroborate other information that had already been obtained. The remaining, open-ended, interviews lasted from 1 to 4 hours each, and did not follow a strict set of questions. In these interviews, I asked not only for the facts of the matter, but also for

the respondent's opinions about events and insights into certain occurrences, which I then used as a basis for further investigation.

I was planning to tape and transcribe all of the interviews, but for two reasons, I abandoned this idea early on. First, many of my respondents were uncomfortable with the idea of being recorded, especially current and retired government officials, and secondly, after spending a long time transcribing the first several interviews, I judged that the outcome was not worth the time and effort involved. Generally, each interview yielded less than a handful of new or important facts, opinions, and insights, and I felt that I was adequately able to capture these in my notes without the need for verbatim transcripts. Data analysis began in the field. I summarized each set of interview notes on a face sheet that listed the major points obtained during the interview and that listed follow-up reminder points for me, such as documents to obtain, additional persons to interview, or additional lines of enquiry to pursue. Throughout my fieldwork, I continually reviewed these face sheets, often referring to the full notes, to help focus my remaining interviews on gathering data on those aspects of the policy process where I felt I still had an inadequate understanding.

The analysis of actors in chapter 6 was guided by several approaches to stakeholder analysis and political mapping, drawing on the work of Lindberg and Crosby (1981), Reich (1996), and the United Kingdom's Overseas Development Administration (1995). The analysis focused on stakeholders' interest and position on the issue, as well as an assessment of their power in terms of resources, capacity to mobilize their resources, and their potential policy impact. This research analysed the position of the key actors on a continuum from high support to strong opposition over the life of the policy.

In addition to interviews of the major stakeholder groups, I conducted a systematic and exhaustive search for documents related to MR and abortion in Bangladesh from governmental and non-governmental sources in Bangladesh, London, and the United States. I was granted access to examine the files of several non-governmental organizations (NGOs) in Bangladesh and the United States, and searched several other organizational libraries in Bangladesh. I reviewed, synthesized, and interpreted a range of published and unpublished documents related

to MR and abortion in Bangladesh from governmental and non-governmental sources, including:

- Official government publications including five successive Five-Year Plans of the GOB, the Health and Population Sector Strategy of the Fifth Five-Year Plan, and all MR policy documents with the exception of one circular;
- Internal files including letters, memoranda, proposals, progress reports, and other internal documents from the Pathfinder Fund, the Ford Foundation, International Women's Health Coalition, the Swedish International Development Cooperation Agency, the Menstrual Regulation Training and Service Program, the Bangladesh Association for Prevention of Septic Abortion, and the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies;
- Agendas and minutes of meetings held by the Technical Advisory Committee (for MR) and by the Coordination Committee for MR, Bangladesh;
- Formal studies and evaluations of the MR program conducted by the Pathfinder Fund and by the Bangladesh Association for Prevention of Septic Abortion; and
- Newspaper clippings from four English-language daily newspapers in Bangladesh from 1974 to 1997.

The Government's files were not well preserved, and proved difficult to access. For the most part, government files were retained in various sections of the relevant ministries, and retrieval depended upon an individual remembering where a particular file was placed. Government files were not organized by section, subject or even alphabetically. The government documents that I was able to obtain primarily came from donor or NGO files, and from the Government's Planning Commission Library.

I found that the four English-language daily newspapers in Bangladesh from 1974 to 1997 were not properly indexed. In order to review them thoroughly, I would have had to scan more than 32,000 newspapers for relevant articles. In the end I reviewed a collection of articles that had been compiled by one of my respondents who had systematically collected articles from the mass media on MR and abortion from the mid-1980s onward for his organization, and from the files of another

respondent who conducted research on abortion in the late 1970s. In addition, I reviewed articles from U.S. newspapers on rape and abortion during Bangladesh's war of 1971 that I obtained from Boston University Library.

1.6 Limitations

In my research proposal, I highlighted two potential limitations to my research plan, one of which was that my search for data could have had the effect of arousing potential opponents of the MR policy who might be mobilized by the triggers tripped by my questions. I proposed to evaluate that risk on a case-by-case basis with a view to obtaining the necessary information without arousing any potential opponents.

However, after discussions with my academic advisors and with Bangladeshi researchers and activists, I deliberately chose not to request interviews with the many religious leaders in Bangladesh who might have been expected to influence public policy. In contrast to suggestions received from some of my academic advisors in London, the Bangladeshis whom I consulted unequivocally opposed my initial idea of interviewing religious leaders, including the director of the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies, a respected social scientist and head of the quasi-governmental research organization with which I held an official association throughout my fieldwork. She questioned why I would risk rousing "the sleeping tiger of religion" by interviewing religious leaders on a topic about which they had not spoken out to date, but about which they could only be expected to speak negatively. She emphasized her belief that such an action quite likely could result in "bringing harm to the MR program," and that it simply was not worth it "for the sake of an individual Ph.D."(Akhter, 1998).

The need for caution is not unusual in applied policy analysis. Robson in his book on real world research stresses the importance of "having a nose for situations where an enquiry is likely to be counter-productive" (1993:24). Similarly, Reich warns that his political mapping technique entails the risk of generating controversy (1994), and Foltz acknowledged that the politically sensitive nature of policy research in some circumstances poses important constraints for the researcher (1995). Despite this constraint, I believe that I was able to gather sufficient information about the role of religion through alternative means, specifically through interviews of the

other actors as to their perceptions of religion as a constraining factor in the formulation and implementation of the MR policy. Religious attitudes were perhaps the single most important constraining factor affecting the MR policy. This was not because of the actions or words of religious leaders, or because of the official position of religious institutions, however, or because of any other explicit messages delivered to the people of Bangladesh. Nonetheless, they were attitudes and values generally held by the broad spectrum of actors involved in the MR policy. It was not necessary to interview religious leaders in order to ascertain the religious values and beliefs held by those actors.

The second limitation that I highlighted at the outset was that my research was likely to depend heavily on verbal reports, and the information that I received from my respondents might be unreliable, partisan, inaccurately or selectively recalled, or otherwise rewritten over time. Moreover, chain sampling could have led me to interview more like-minded individuals such that corroboration by more than one interview source could have reinforced bias while at the same time appearing to have added credibility and objectivity. I found that among like-minded respondents—NGOs, Ministry officials, and women's right advocates—there was little variation in the portrayal of personalities, events, situations, and decisions. Some respondents exaggerated the importance of their personal roles in the past, but that was a minor source of subjectivity that was readily identified through triangulation in the sense of obtaining information about the same situation from several informants (Robson, 1993). In addition, I attempted to reduce the risk of bias associated with my own interpretation of the data by sharing many of my preliminary findings with a small number of key informants throughout the period of my fieldwork to check for accuracy, and to probe for alternative interpretations. I also triangulated the data by using two methods wherever possible—interviews and documents—and by collecting information from several informants. In some cases there was a discrepancy, especially between what government officials said and what was written in relevant or official documents. For example, government officials recalled that the objective of the policy when it was formulated was to improve maternal health while government documents clearly indicated that the main policy objective was population control (Planning Commission, 1973). Again, triangulation helped to reveal discrepancies, which in turn, helped to explain the phenomenon of interest. Accordingly, I believe the limitations inherent with verbal evidence were adequately considered during this research. Moreover, in retrospect I believe the

richness and depth of information that I was able to gather through interviews justified the use of interviews as the primary source of evidence gathering, precisely because the answers to the "how" and "why" questions of the research have never been documented.

Critics of the interpretive approach would argue that the results are not objective, however, one must think of this approach according to Cryer as reaching a verdict in a court of law. While the evidence, she maintains, "can be circumstantial [. . .] and doubt can always be cast on the veracity or reliability of the observers. A verdict must be reached on what is reasonable, i.e., the weight of the evidence one way or the other and the power of the argument" (1996:56).

A third limitation that was not explicitly stated in my research proposal had to do with the historical nature of the research. I indicated that the original advocates of the MR program were ageing, which implied a risk that some of the key actors would have died or retired to another country by the time of my research. In fact, one of the most important governmental actors, the director of MCH Services who was in charge of the MR Program during almost the entire period examined by this research had retired to New Zealand and was unreachable, and several other key actors within the government and NGO community had died or retired. I was honoured, however, to have recorded the recollections of three key actors and brave pioneers in the abortion field, Ms. Merle Goldberg, Dr. Feroza Begum and Dr. Shameem Ahmed, all of whom died shortly after I completed my fieldwork.

2.0 Background

2.1 Introduction

Bangladesh is one of the poorest, most densely populated and least developed countries in the world, with an estimated population of 124 million and a gross national product per capita of $273 (Bangladesh Bureau of Statistics, 1998). The economy is largely agricultural and centred around rice production with approximately sixty-five percent of the population engaged in the agricultural sector (United Nations Children's Fund, 1999). More than eighty percent of the population live in rural areas, and estimates of the percentage of the population that live in absolute poverty range from 60 to 85 percent (Ross, et al., 1995). Only 31 percent of rural households own more than one acre of land, and 28 percent of households own no cultivable land at all (Bangladesh Bureau of Statistics, 1997). Sixty-five percent of the total adult population is illiterate, including 78 percent of adult women (World Bank, 1993).

The Grindle and Thomas framework for understanding the policy process begins with two sets of contextual factors. One set, which shall be explored in subsequent chapters, focuses on the background characteristics of policy elites. The other set represents the broader context within which policy issues emerge, are formulated, and are implemented and sustained. This chapter describes the latter contextual factors that presented constraints and opportunities at all stages of the process of the MR policy in Bangladesh. The chapter begins with a description of the country's religious values and cultural norms, includes a brief political history of the country, and describes the policy environment particularly over the period during which the abortion policy was formulated and initially implemented. It also includes information about the reproductive health care system and background information on gender issues and attitudes in the country, which are important to understanding the need for an abortion policy.

2.2 Religion and Culture

When the British left India in 1947, India was partitioned on the basis of religion, whereby the eastern wing of the large Indian province of Bengal became the eastern wing of the newly created homeland for Muslims, the state of Pakistan

(Kabeer, 1989). The eastern and western wings of Pakistan were separated by 1000 miles of Indian territory, and were culturally and ethnically distinct from each other. According to Kabeer and Sobhan these differences could be traced back to the 13th century, when the process by which Bengalis were converted to Islam led to two parallel belief systems. While the Punjabis of West Pakistan practised an orthodox Islam, the Bengalis of East Pakistan held a combination of Hindu and Muslim beliefs with fundamentally different interpretations of Islam (Kabeer, 1989, Sobhan,).

The eastern wing's cultural and linguistic affinity to Hindu Bengal was "profoundly threatening to a state which had only Islam to hold together a geographically and culturally divided nation" (Kabeer, 1989:7). Consequently, the dominant west Pakistanis embarked on "a strategy of forcible cultural assimilation towards the Bengalis" (Kabeer, 1989:7). The Bengali Muslims of East Pakistan responded by becoming defensive as Muslims and by asserting their Bengali identity (Sobhan,). Kabeer suggests, "the Bengali middle class was forced to confront more clearly the dilemmas of identity: were they Muslim first or Bengalis first? Resistance to Pakistani cultural hegemony helped to crystallise what was exclusive to the Bengali Muslim community: its shared common history and distinct way of life, reaffirmed continuously through shared cultural symbols, rituals and modes of communication" (1989:8). This led to a mass movement for Bengali nationalism culminating in the war in 1971.

West Pakistanis allegedly portrayed the war as a *jihad* (holy war against the infidel) thus calling into question the Islamic faith of Muslim Bengalis (Sobhan,) The people of Bangladesh, claim Sobhan, came out of their shared history with Pakistan and their experience of the war feeling disillusioned with the notion of Islamic unity and "determined that religion should never again be a political determinant" (:71). Consequently, Bangladesh deliberately adopted a position of strict secularism in its Constitution, and banned all religious political parties. While it holds the third largest Muslim population in the world, "official attempts to give a more Islamic interpretation to national identity in Bangladesh have been altogether more muted and cautious" (Kabeer, 1989:1).

Kabeer suggests, the "changing interactions between religion and culture in defining national identity in Bangladesh" have affected state policy to a great extent (1989:1). Further, she argues that Islam and Bengali values have never been unified

into a coherent and stable national identity, and that this has led to contradictions and tensions in state policy (1989).

2.3 Political History

Shortly after becoming independent from Pakistan in 1971 until 1990, the People's Republic of Bangladesh was ruled by two authoritarian military regimes, and genuine democracy has been elusive (Ahmed, 1995). The first Government of Bangladesh was formed by the Awami League and headed by Sheikh Mujibur Rahman (Sheikh Mujib), leader of the Bengali nationalist movement that fought for liberation from Pakistan. Sheikh Mujib had strong populist support, but his government was unable to restore the old colonial order or to create a new one based on the Awami League's socialist ideals (Ahmed, 1995). It has been suggested that Sheikh Mujib's own party members placed party and self-interest above public interest, and ultimately stymied his reform initiatives (Jahan, 1980), and that the Awami League alienated the administrative structure of the country—the bureaucracy (Zafrullah, 1995). In 1975, Sheikh Mujib decided to seize power to carry out his programs directly. He amended the Constitution to ban all political parties including his own Awami League, to suspend fundamental rights, to curtail the freedom of the press, and to make the judiciary subservient to the executive branch of government (Khanna and Sudarshan,). These unpopular measures, as well as the Awami League's failure to fulfil the social, political, and economic aspirations of a country that had undergone tremendous sacrifices during the war, led to a military intervention in which Sheikh Mujib and forty-six members of his family were brutally killed by a group of Army officers in August 1975 (Ahmed, 1995). Sheikh Mujib's assassination was followed by a series of coups and counter coups led by different factions of the military vying over one another for power and that ended 3 months later with the installation of the Chief of Army and former leader of the resistance movement during the war, General Ziaur Rahman (Zia), as the Chief of Staff and leader of the country (Zaman, 1987).

In the period following Sheikh Mujib's assassination, martial law was established, Parliament was dissolved, four of the Awami League's five former cabinet ministers were killed, and the military and the people were ready to revolt (Ahmed, 1995). This state of political chaos formed the policy backdrop against which MR was introduced in 1974 as described in the next chapter.

Zia led the country as the Deputy Chief Martial Law Administrator and later as Chief Martial Law Administrator. Although there was a figurehead civilian president, Zia had supreme authority over the executive and the legislature. His early years were occupied with stabilizing the government and restoring its credibility nationally and internationally (Ahmed, 1995). He was also concerned with containing aggression by India, and restoring peace in the streets (Ahmed, 1995). He was attributed with restoring the old order—a functioning administration and a mostly civilian government—and with introducing a pro-Islamic bias (Ahmed, 1995). Purportedly, in order to maintain support among the people, Zia allied himself with pro-Islamic rightist forces that he allowed to operate in the political arena by lifting the ban on political parties that had been put into place by Sheikh Mujib (Ahmed, 1995, Kabeer, 1989). While this was as a step towards democratising the policy environment, it was done under the cover of martial law, and the government maintained control over the political parties through various regulations. Zia's decision to introduce a pro-Islamic bias had implications for the implementation of the MR policy that are discussed in chapter 4.

In 1977, Zia assumed the presidency, not through a general election, but by holding a referendum to "ascertain the confidence of the people in him and in the policies and programs enunciated by him" (Ahmed, 1995:56). After thus becoming president, he formed a new political party called the Bangladesh National Party with himself as the leader, and secured a two-thirds majority in the parliamentary elections held in 1979. In the first week of the first session of the new Parliament, an Act was introduced to ratify and confirm all actions of the Martial Law regime from 1975 to 1979, including constitutional amendments to restore the multi-party system and to re-establish the independence of the judiciary (Ahmed, 1995) and freedom of the press (Khanna and Sudarshan,). On the day this Act was passed, Martial Law was lifted, thus returning the country to a multi-party parliamentary form of democracy.

Zia's most important challenge following Sheikh Mujib's assassination was to regain control of the military. He was relatively successful at doing so, primarily by taking swift and ruthless action. He summarily tried and executed about 488 army personnel (Ahmed, 1995), and constantly reshuffled the army hierarchy. Nonetheless, he faced approximately 18 attempted military coups in 6 years, and in the final one in 1981, he was assassinated by a band of military officers. In a

subsequent election, Zia's vice-president, Justice Abdus Sattar, was elected president, but four months into his rule, Chief of Army, General H.M. Ershad seized power in a bloodless coup, established martial rule, and declared himself Chief Martial Law Administrator. Like Zia, General Ershad assumed the title of president, established a political party, the Jatiyo Party, and contested parliamentary elections in 1986. Following the election of his government, which was widely alleged to be characterized by violence and vote-rigging, Parliament passed a ratification bill legalizing Ershad's regime, lifting Martial Law, and establishing General Ershad as the constitutional ruler of the country. General Ershad held the presidency until 1990 when a massive popular uprising that had been fomenting since he took power forced him to resign.

The decade since 1990 represented a shift towards a more representative government, but confrontational politics between the government and the major opposition party has impeded Bangladesh's movement towards democracy. After the popular uprising that overthrew President Ershad, a caretaker government was established, which organised national parliamentary elections in 1991 that were contested by all the major political parties, and that were declared "free and fair" by outside observers (Riaz, 1998). The Bangladesh National Party established by former President Zia won the majority of seats in Parliament, and its leader, Khaleda Zia, the widow of the former president, became prime minister.[14] Shortly thereafter, allegations by the main opposition party, the Awami League, of vote rigging by the government in a by-election held in 1994 led to a demand for fresh national elections under a caretaker government. All opposition members of the Parliament resigned, and, stymied by parliamentary gridlock, Khaleda Zia acceded to the opposition's demand for fresh elections. Because the government did not resign to allow the elections to be held by a caretaker government, however, the major political opposition parties urged their supporters to stay away from the polls, and actively discouraged the people from voting. The Bangladesh National Party won the 1994 election, but there was less than a 10 percent voter turnout and the opposition parties claimed the elections were not "free and fair," causing the Awami League to resume its demand for free and fair elections under a caretaker government. After a 25-month long stalemate between the government and the opposition parties punctuated

[14] In the most recent Constitutional amendment in 1991, the Bangladesh National Party-led Parliament changed the form of government from a presidential to a parliamentary system with the prime minister as its chief executive, and the president as head of state (World Bank, 1996).

by Parliamentary boycotts and opposition-led general strikes called *hartal*, a caretaker government was sworn in and elections were held in June 1996. This election, which was considered free and fair, attracted 70 percent of eligible voters and was won by the Awami League by a narrow margin. Sheikh Hasina, the daughter of the first Prime Minister of Bangladesh, Sheikh Mujib, became prime minister. Not long after the elections, the Bangladesh National Party, in opposition, adopted the Awami League's tactics and a renewed period of agitation in the Parliament, the press, and the streets began, and had become increasingly active at the time of this research in 1998.

2.4 The Policy Environment

Through a Constitutional amendment in 1991, Bangladesh returned to a Parliamentary form of government similar to the one it began with in 1971 with the prime minister as its chief executive, and the president as the head of state. The virtually absolute levels of control previously enjoyed by the president as described above were simply transferred, without significant modification, to the prime minister by virtue of this amendment, and the president was left with largely ceremonial duties.[15] After 1990, the country's executive powers have thus been exercised by the prime minister, who heads the cabinet of ministers, which in turn is responsible to Parliament, the supreme legislative authority and the repository of public accountability. In Bangladesh, the collection of Ministries and Divisions forms the Central Secretariat in Dhaka which has policy and clearing house functions, while general administration, delivery of public services, and implementation of development programs is carried out by sub-national levels representing the central level ministries. Local government authorities with some elected representatives and diverse administrative and development functions exist at the sub-national levels as well, but decision making has been highly centralized at the national level, and local government authorities have had very little economic or political autonomy (Westergaard and Alam, 1995).

Ministries and Divisions are responsible for policy formulation and for monitoring programs and projects under the political leadership of a minister or state

[15] The 13th amendment to the Constitution (Caretaker Government Amendment) made the president's role more important. Under this amendment, if Parliament is dissolved, the president is responsible for directing the installation of a caretaker government to oversee fresh elections (U.S. Central Intelligence Agency, 2000).

minister, and the administrative leadership of a secretary or joint secretary (also the chief accounting officer). The responsibility for policy implementation rests with the departments and directorates within the Ministry, which are staffed by non-elected civil servants collectively referred to as the bureaucracy. The elected members of Parliament are supposed to be responsive to the needs of the electorate, whereas the bureaucracy is supposed to be a technical and politically neutral instrument of administration. Civil servants are expected to execute the policy decisions of the Government in an efficient and effective manner, irrespective of their personal views and preferences, or of the broader social, political and economic context within which they work.

In Bangladesh, a parliamentary system of government was not allowed to function for much of the country's history. Military leaders ruled for 15 years, including 8 years under martial law. Throughout the first two and a half decades of its existence, political power in Bangladesh was centralised in the executive, Parliament was weak or non-existent, and the political system was unstable. Between 1971 and 1997, the Cabinet of Ministers was reshuffled approximately 97 times, and from 1992 to 1996, the Ministry of Health and Family Welfare for example, changed its secretary four times (World Bank, 1996). In this political context, the Bangladesh Civil Service which by 1997 had reached about one million civil servants working in 36 separate Ministries and in over 200 departments and directorates (World Bank, 1996), was arguably one of the most pervasive and influential groups of civilians in the policy process.

Khan and Zafrullah argued that because of the absence of an effective, accountable and stable democratic parliamentary system, bureaucrats went beyond mere implementation of policies to take "upon themselves the responsibility of public decision making" (Khan and Zafrullah, 1991: 651-61). According to the Joint Chief (Planning) who had worked in the Ministry of Health and Family Welfare from 1976 to 1996, civil servants wielded considerable influence and control over not only implementation, but the formulation of policy as well. This was mainly due to the fact that civil servants were familiar with the technical issues and the process of policymaking within the Ministry, and had established close relations with the donors (Karim, 1998). These administrators were not, however, viewed by critics as responsive to public sensitivities (World Bank, 1996) or efficient or effective, and the bureaucracy was characterised by an inadequate "delegation of authority and

responsibility down the hierarchy, superfluous paperesserie, archaic record management, procrastinated decision making, intricate communication patterns, non-familiarity with rules and procedures and other stumbling blocks" (Zafrullah, 1995:11). Moreover, Khan and Zafrullah noted "there is no efficacious means of holding them accountable for their actions" (Khan and Zafrullah, 1991:651-61).

The policy process in Bangladesh has been described as a "very secretive affair, except for the well connected" (World Bank, 1996:107). Organised interest groups existed among only a small proportion of the population based in urban areas, primarily including political parties, student groups, trade unions, businessmen, middle-class professionals, and more recently special interest NGOs. According to Kochanek, the influence of interest groups "has been individual and fragmented," and "modern associations representing divergent social forces have been rudimentary and insufficiently mobilised, organised, and coherent to do more than sporadically intervene in the political process" (1996:704). While informed observers, surveys and anecdotal evidence suggest that citizens are dissatisfied with public policies and programs; there is surprisingly little public protest, or mention of this issue in the political platforms of the major political parties (World Bank, 1996). This lack of mobilization has been explained by several factors, including citizen's fear of antagonizing the monopoly power of the state by demanding better services, the availability of alternative services in the private or NGO sector to which people may turn to when government fails, especially the most wealthy, leaving the poorest and least likely to demand better services dependent on government, a sense that the money government wastes is foreign aid rather than public tax dollars, so why bother, as well as a "fatalism and despondency" about the prospects for ever effecting change in government performance (World Bank, 1996). Thus, theories of pluralism that explain how policies are formulated and implemented in other countries in terms of the activities of organized interests in society cannot readily be applied to the policy environment in Bangladesh from 1971 to 1997.

Although special interest groups have not had much influence in the policy arena in Bangladesh, foreign donors have (Sobhan, 1982). From 1971 to 1990, Bangladesh received 20.8 billion U.S. dollars in foreign aid from various bilateral and multilateral donors (External Relations Division, 1991). Bilateral aid increased from $232 million in 1972 to $912 million in 1990, and multilateral aid over the same period increased from $39 million to $898 million (Islam, 1994). Islam notes that

foreign aid financed about 70 percent of all investments in 1990 (compared to 5.3 percent in India in 1982), and 96 percent of the development budget (compared to 17 percent in India in 1982) (1994). Because of this heavy dependence on foreign aid and donors wielding influence over how their funds were spent, donors have had an influence on the overall policy process, the extent of which has been extensively documented by leading economists and other academics inside and outside of Bangladesh.[16] According to Taslim, the power and influence of International Financial Institutions such as the International Monetary Fund and the World Bank "are often greater" than that of the ministerial cabinet or the Parliament (1994:293). Further, he contends, "since aid is a major source of employment of the educated people and of aggregate demand, a drying up of aid could cause serious resentment and dislocation in the economy. The resulting turmoil could easily unseat the ruling government" (1994:292). As a result, the bargaining power of the government in relation to the donors is limited, giving the latter immense power to influence the policy process through preconditions and stipulations attached to its aid (Taslim, 1994).

2.5 The Family Planning and Health System

The implementation of the MR policy was the responsibility of the Directorate of Family Planning (formerly called the Population Control and Family Planning Division) within the Ministry of Health and Family Welfare. Since 1975, the Directorate together with financial and policy assistance from international and multilateral donors has implemented a succession of five-year plans that have focused predominantly on delivering family planning services. Support for maternal and child health and disease control increased with the Third Five-Year Plan (1985-1990) and Fourth Five-Year Plan (1990-1995), but the national health and population policies of the Ministry of Health and Family Welfare have been dominated by family planning (Research Evaluation Associates for Development, et al., 1995). According to critics, the success of the national family planning program is viewed as "coming at the expense of meeting a broader range of health needs through an integrated primary health care system" (Ross, et al., 1995:14).

[16] For a discussion of the Government of Bangladesh's dependence on external aid, see (Billetoft and Malmdorf, 1993, Buse, 1999, Islam, 1994, Islam, 1977, Sobhan, 1981, 1982, 1990, Thomson, 1991).

Administratively, Bangladesh was divided into six major divisions, 64 districts, 489 sub-districts, 4,422 unions, and 68,00 villages. Whereas modern primary health services other than immunizations were available to less than 40 percent of the rural population (Abedin, 1997), family planning services have been made available to most of the rural population (Larson and Mitra, 1992). Family planning services were distributed through clinics, community-based distribution, and retail outlets. At the village level, paid female workers were responsible for motivating women to use contraception, and for supplying pills and condoms through house to house visits, and for referring or accompanying women to clinics for clinical methods of contraception. The field workers were considered the single most important feature of the government's family planning program largely because they reached women who because of poverty and isolation were unable to access clinic-based services (Larson and Mitra, 1992). Clinical contraceptive services and other outpatient services, including MR, were provided at the union and sub-district levels. The *thana* (sub-district) health complex was a 31-bed centre serving a population of 200,000 and that was equipped to perform sterilizations, insert IUDs, and perform MR. Most rural families lived closer to a union-level health and family welfare centre, however, which served a population of approximately 25,000 and was staffed by a male medical assistant and a female paramedic, known as a Family Welfare Visitor, who inserted IUDs, performed MR, provided follow-up to family planning clients, and referred complicated cases to the *thana* health complex. Family welfare visitors also conducted fortnightly outreach clinics known as satellite clinics for IUDs and injectable contraceptives, advice and follow-up care. The *thana* health complexes and union health and family welfare centres were grossly under-utilised because of a shortage of medicines and supplies, and a cultural proscription that prohibited women from travelling alone (Larson and Mitra, 1992). In addition to the Government's delivery system, approximately 400 local, national, and international NGOs were involved in health and family planning services, and men and women have been able to obtain pills and condoms from pharmacies and shops in the private sector (Larson and Mitra, 1992).

2.6 The Demand for Abortion

The precise number of abortions performed by government providers using MR or by private and traditional practitioners using MR or other techniques is unknown. While government statistics suggest that the number of women using MR

has increased steadily from its introduction in the mid-1970s until present, it is widely accepted that government workers have not reported many MR procedures. Data from a nationally representative survey conducted in 1986 found that government workers reported less than a third of all MR procedures (Amin, et al., 1989).

Since 1981, there have been only a few studies that have tried to estimate the number of abortions carried out in Bangladesh. In 1978, Measham et al. estimated that approximately 780,000 abortions were induced by government service providers and by private and traditional practitioners in that year (1981). More recent studies estimated that 241,442 abortions were performed in 1985 (Begum, et al., 1987) and 261,894 in 1985 (Kamal, et al., 1993), however, both studies considered abortions induced by government service providers only, and did not address abortions induced by private and traditional practitioners.

The total fertility rate in Bangladesh declined from about 7 births per woman in the early 1970s when the national family planning program began, to an estimated 5 births per woman in the late 1980s and 3.3 births per woman in 1996-97 (National Institute for Population Research and Training, et al., 1997). Demographers have attributed the decline in total fertility rate primarily to an increase in contraceptive use brought about by heavy program inputs (Cleland, et al., 1994). The percentage of married women using some form of modern contraception increased from 8 percent in 1975 to 39.5 percent in 1996-97 (Mitra, et al., 1997).

On the other hand, the 1996-97 Bangladesh Demographic and Health Survey suggested that approximately 15.7 percent of currently married women had an unmet need for contraception because of inadequate access to contraceptive services, poor quality of existing services, fear or distrust of methods, or conflicts between partners about childbearing goals[17] (Mitra, et al., 1997). The survey also showed that all the methods, but especially the pill which was used by the majority of contraceptive users, were associated with high rates of discontinuation within the first year, which left many women at risk of unwanted pregnancy (National Institute for Population Research and Training, et al., 1997). Further, the survey estimated that 36 percent of adolescent women have begun childbearing (National Institute for Population

[17] Conventionally demographic surveys have calculated unmet need as the percentage of women who say that they either want no more children or would like to delay the next birth but are not using family planning methods to help them meet their stated goals.

Research and Training, et al., 1997) suggesting that they will complete their desired family size at an early age, and need safe and effective fertility regulation, including abortion, for the rest of their reproductive age, about 20 to 25 years (Piet-Pelon, 1998).

Although the total fertility rate declined significantly, it consistently exceeded the total wanted fertility rate reported by women (Mitra, et al., 1997). In addition to the desire to limit childbirths, women seeking abortion in Bangladesh most commonly cited health or economic reasons. Pregnancy and childbirth are hazardous in Bangladesh with official estimates suggesting that nearly 15,000 women die of pregnancy-related causes annually (Bangladesh Bureau of Statistics, 1997), while other estimates are as high as 28,000 deaths per year (De Francisco, 1997, World Health Organization and United Nations Children's Fund, 1996). As a result of early marriage and pregnancy, the United Nations Children's Fund (UNICEF) reported that 11 percent of women 10-15 years old (more than 850,000) are married and have a child (United Nations Children Fund, 1997). The average Bangladeshi mother at the end of the 1990s was only 147 centimetres tall and weighed only 40 kilograms (88 pounds) (Perry, n.d.). Ninety-five percent of all deliveries took place at home with less than 14 percent attended by someone with medical training, and every year less than 5 percent of women experiencing an obstetric emergency were able to reach a health care facility (United Nations Children Fund, 1997). Approximately one in every 40 women died of maternal-related causes (De Francisco, 1997). Women comprise about 47 percent of the population and constitute a majority of the poor (Chowdhury, 1994).

Many women in Bangladesh resolved their unwanted pregnancies through the government health system, which provided MR free of charge at all levels down to the union level. In addition, non-medical providers such as village doctors, homeopaths, and traditional healers provided abortion outside the government system. In addition, many women attempted to induce abortion themselves, most commonly by ingesting some type of oral preparation that they perceived would act as an abortifacient.[18] It is notoriously difficult to obtain information on clandestine

[18] For studies of clandestine abortion, see (Anowar-ul Azim, 1992, Caldwell, et al., 1997, Fauveau and Blanchet, 1989, Hossain, et al., 1997, Islam, 1992, 1999, Johnston and Akter, 1997, National Institute for Population Research and Training, et al., 1997).

abortion, and there are no reliable estimates of the true magnitude of the problem in Bangladesh.

UNICEF with technical assistance from the World Health Organization estimated a maternal mortality rate in Bangladesh of 850 per 100,000 women, with 33,000 maternal deaths per year (World Health Organization and United Nations Children's Fund, 1996), while the Government of Bangladesh and donors, without referring to UNICEF's figures, have used a lower rate of 450 per 100,000 in their official documents (Piet-Pelon, 1998). Regardless of which figure is used, most observers agree that the maternal mortality rate in Bangladesh has been unacceptably high (Piet-Pelon, 1998). These and other studies conducted over the past two decades estimated that deaths due to complications from induced abortion accounted for 25 to 30 percent of all maternal deaths (Ross, et al., 1995).

2.7 Gender

Families in Bangladesh typically prefer sons to daughters, and allocate scarce household income unevenly in favour of boys. A son is perceived as an asset whereas a girl is perceived as a liability. When a son reaches maturity, traditional society expects him to assume responsibility for his parents as well as his own household, whereas it expects a daughter to marry off, often at great cost to the family in the form of dowry (Baden, 1992). Discrimination against girl children is reflected in women's lower health status, literacy rates, and school enrolment figures. The literacy rate for females five and older is 21.8 percent compared to 36.1 percent for males (Chowdhury, 1994).

Approximately ninety percent of the population of Bangladesh is Muslim while the small remainder are Hindu and other religions. According to Chowdhury the predominant interpretation of Islam by religious opinion leaders "tend to gravitate toward a narrow and rigid interpretation of Islamic tenets, relegating women to a subordinate status, to the private sphere, to seclusion" (1994:95). In traditional Muslim Bengali society, women were valued as mothers, and as the personification of morals and traditional values (White, 1992).

The Constitution guarantees women equal rights with men, yet in practise, customary laws that coexist with civil codes discriminate against women in the areas

of marriage, divorce, and inheritance govern women's lives. Under customary laws, men inherit double that of their female counterparts, and have the unilateral right to divorce, polygamy, and guardianship over spouse and children, including the right to chastise their wives for "disobedience" (Baden, 1992, Jahan, 1995). Chowdhury noted that, "religious precepts guiding marriage, divorce, custody, and inheritance are taken to imply that by divine will girls are inferior to boys, and women occupy a status unequal to and subordinate to men's" (1994:95). Among the civil laws that have been enacted to "protect" women[19] are those that are at odds with prevailing customs, such as the Child Marriage Restraint Act and the Dowry Prohibition Act, which have been ignored (Ross, et al., 1995).

In Islam, women's sexuality is viewed as a potentially destructive force that must be controlled in order to prevent social breakdown (Mernissi, 1987) Patriarchal values such as female virginity and chastity, and a prohibition against sex outside of marriage, exert control over women's sexuality and are reinforced by the custom of *purdah*—the practise of veiling and secluding women—based on ideals of protecting women's modesty and controlling their interactions with men with whom contact is not permitted. In Bangladesh strict *purdah* was typically limited to the middle stratum of rural households, and has become less common due to poverty as women seek work outside the home. Nonetheless, "*purdah* values" continue to permeate Bangladeshi society (Chowdhury, 1994). According to Sarah White, "the power of *purdah* is the power of a myth, not in the sense of being unreal or untrue, but as a symbolic expression of relations between male and female, with simultaneous ideological and material dimensions" (1992:23). White suggests that ideologically *purdah* "is intermeshed with fear and distrust of women's powers of sexuality and fertility" while in material terms it, "legitimises and facilitates the use of female family labour and sexuality while also restricting control of what they produce" (1992:22). In Bangladesh, she suggests that historically it has "been associated with a system of family farms where crop storage and processing work within the homestead was a vital part of subsistence production" (1992:22).

[19] Laws intended to "protect" women include: The Muslim Marriages and Divorces (Registration) Act, 1974; Dowry Prohibition Act, 1980; Cruelty to Women (Deterrent Punishment Act), 1983; Child Marriage Restraint Act (Amended Ordinance), 1984; The Muslim Family Ordinance, 1961 (Amended 1985); The Penal Code (Second Amendment Ordinance); the Family Court Ordinance, 1985; Anti-Terrorism Ordinance, 1992; Women and Children Oppression (Special Provisions) Act, 1995 (Ross, et al., 1995), and the Suppression of Violence Against Women and Children Act 1998 (Hashmi, 2000).

Fear and distrust of women's sexuality has led conservative Bangladeshi society to view family planning and abortion as threatening to the social order. The need for a state-sponsored approach to population control has become accepted only insofar as it encompasses married women. While there is no explicit law or regulation restricting reproductive health services to married women, in practise unmarried women and adolescents have not had ready access to contraceptive services, counselling, or abortion services. In the past girls were married off early or sheltered by their families until married. Yet, more recently, with a slightly higher age at marriage, and more educational and employment opportunities, researchers have speculated that girls are more likely to engage in sex before marriage, either voluntarily or coercively. Without access to contraceptive services and counselling many of these women will become pregnant and seek abortion, frequently outside the government health system. Researchers in Bangladesh also found a correlation between unwanted pregnancy and high rates of suicide among unmarried adolescents (Fauveau and Blanchet, 1989).

2.8 Chapter Summary

This chapter has presented background contextual information that is crucial to understanding how the MR policy was formulated and implemented in Bangladesh. The country was formed in order to assert a unique religious and cultural identity that maintained the people of East Pakistan were Bengalis first, unlike the people of West Pakistan who considered themselves Muslim first. So strongly did the Bangladeshis feel about their identity that they would fight a protracted war—portrayed by the West Pakistanis as a holy war—and subsequently would ban all religious political parties and adopt a position of strict secularism in the Constitution of the new country. Far from the conditions inherently assumed in democratic and pluralistic models of the West, the first 20 years of the country's history were marked by a series of military coups and 15 years of rule by military leaders, including 8 years under Martial Law. Bangladesh has had a democracy only since around 1991, and the period since then has been characterised by highly polarised, confrontational politics. The policy environment, therefore, has been unstable, with a weak or non-existent Parliament and power very much centralised in the executive. The bureaucracy assumed a larger relative policymaking role in such an environment, although it has never been viewed as accountable or responsive to the public, nor efficient or

effective in discharging its duties. Special interest groups have not had any significant influence in the policy arena in Bangladesh. In contrast, because of the country's heavy dependence on foreign aid, international donor agencies have had a considerable influence on domestic policy in Bangladesh.

The chapter also briefly outlined the reproductive health care system, in order to present background information necessary to understanding the conditions under which the MR policy was implemented. Five-year plans operationalised national health and population policies, translating the policies to health services that were delivered in 68,000 villages in Bangladesh. Large numbers of women from those villages demanded abortion services, and partly as a result, the total fertility rate was cut in half in approximately 25 years. Nonetheless, the total fertility rate consistently exceeded the mean desired family size, which indicates there have consistently been a significant number of unresolved unwanted pregnancies. The relatively high maternal mortality and morbidity rates—coupled with studies estimating 25 to 30 percent of all maternal deaths were due to complications from induced abortion—strongly suggest that large numbers of women consistently resorted to unsafe, presumably illegal, abortion services. Women's sexuality has generally been viewed as a potentially destructive force that must be controlled in order to prevent social breakdown. Accordingly, unmarried women and adolescents have not had ready access to contraceptive services, counselling or abortion services, and, many may have therefore been forced to seek services outside the government health system.

3.0 Setting Abortion on the Policy Agenda

3.1 Introduction

Abortion was not on the policy agenda of pre-independent Bangladesh; yet it was featured in the government's first Five-Year Plan. Was abortion on a latent policy agenda? How did abortion come to the attention of policy makers? Why did decision makers choose to include abortion on the initial policy agenda? What were the agenda-setting circumstances at the time? These are the types of questions explored in this chapter, which begins with a discussion of the international policy agenda in respect of population policies in general and abortion policies in particular. The chapter then examines the first sanctioned abortions that were provided literally during the first months of the new country, for women raped during the war, and it assesses the impact of this experience on the policy process. The chapter also examines abortion in the First Five-Year Plan (1973-1978) of the Government of the People's Republic of Bangladesh, and reviews the experiences of policy makers with population policies in pre-independent Bangladesh, to better understand why abortion featured so prominently in the first official policy document of the new government. The chapter closes with a summary of the agenda-setting story, and an analysis of that story using the Grindle and Thomas theoretical model of policy choices in developing countries.

3.2 The International Population Control Agenda

Rapid population growth became a matter of global concern beginning in the 1950s.[20] Drawing on the argument of eighteenth century British clergyman and economist Thomas Malthus that rapid population growth would outstrip food production, neo-Malthusians reasoned that demographic increases in the developing world would eventually retard economic development and outstrip governments' efforts to supply social services. Based on the logic of Malthus, American and European scientists, policy makers, and birth control advocates promoted large-scale family planning services as the most effective way to reduce population growth in developing countries (Donaldson and Tsui, 1990).

[20] See (Donaldson and Tsui, 1990, Finkle and McIntosh, 1994, Lee and Walt, 1995, Warwick, 1982).

Following World War II, a number of large international organizations were established with the aim of reducing population growth and promoting family planning in the developing world. The International Planned Parenthood Federation (IPPF) quickly became the "most prominent and widely recognized private effort to support family planning internationally "(Donaldson and Tsui, 1990:10). IPPF, based in London, was conceived at an international conference in Stockholm in 1946, and its constitution was subsequently established at international conferences held in 1948 and 1952 by its original members from India, the United Kingdom, the United States, the Netherlands, Sweden, West Germany, Singapore, and Hong Kong. IPPF began with the aim of promoting family planning and population education, and stimulating and disseminating research on fertility control. By 1990, its membership included 107 family planning affiliates in developed and developing countries (Donaldson and Tsui, 1990). Secondly, the U.S.-based Population Council described by Warwick as "the world's most respected organization on questions of population policy in developing countries" (1982:57) was established by John D. Rockefeller III in 1952 in response to his personal concerns about population growth in the developing world. The Council was established "to promote knowledge and action leading to a reduction in fertility" (Warwick, 1982:58), and its main strategies included advancing knowledge, including demographic and biomedical research, and family planning program and policy related research; developing contraceptives; and technical assistance. Thirdly, the newly established United Nations set up a Population Commission, and within the UN Secretariat, a Population Division, to provide member governments with information on the causes and consequences of rapid population growth. Population control soon caught the imaginations of political leaders in the developing world, and by 1951, India became the first country to establish a national family planning program to control population growth, followed almost ten years later by Pakistan, the Republic of Korea, the People's Republic of China, and Fiji.

By the 1974 United Nations World Conference on Population in Bucharest, Donaldson suggested that rapid population growth in the developing world had been transformed from "an interest primarily of the United States and a few Asian countries to a legitimate political issue in a much wider circle of countries" (Donaldson and Tsui, 1990:10). The conference also marked the first "significant conflict" over population policy between the United States, who by then had become the single largest population donor, and the developing world. The United States

delegation to the conference argued that developing countries should set and work toward targets for lowering birth rates. In response, a large contingency of developing countries argued for the establishment of a new international economic order that would allow developing countries to participate in the global economy. The latter, they maintained, rather than the expansion of family planning programs by international donors, would address the underlying barriers to economic advancement and slow population growth. The U.S. and other international actors continued to support family planning as the best means to slow population growth, and by the late 1980s, 82 percent of the developing world lived in countries that had official policies to slow population growth through family planning programs (Donaldson and Tsui, 1990).

Finkle suggested that several factors were responsible for moving population control onto the agenda of developing country governments. First, many countries were discouraged by a decade or more of slow economic growth, and made anxious by the alarming neo-Malthusian forecasts of Western economic planners and population specialists. Secondly, better demographic data provided convincing evidence that rapid population growth was a problem. For instance, census data indicated that population growth was far greater than previously thought. Thirdly, the development of new fertility regulation technologies, such as the pill, the IUD, and early abortion techniques, provided affordable and technically feasible means for developing country governments to launch large-scale interventions to alter reproductive behaviour (Finkle and McIntosh, 1994). The most important innovation was the IUD, which was considered medically safe, effective, reversible, inexpensive, and easier to deliver than other methods of birth control, such as the pill, which required daily volition on the part of the user, or sterilisation, which was permanent, and involved a more complicated medical procedure (Donaldson and Tsui, 1990, Finkle and McIntosh, 1994, Lee and Walt, 1995).

Behind these factors lay the widespread and powerful influence of international donor agencies, mainly from the United States. Through their own activities, and through their support to other organizations, international donors had a substantial impact on all stages of the policy process. According to Warwick, of all the spheres of national development, population was the most donor driven. Donor impact on population problems began with the very "initial idea that the country had a population problem—something that was not evident to many governments" and

extended to include "the precise definition given to that problem; the broad strategies used for dealing with the problem, such as voluntary family planning programs; the number, location, and organizational structure of population agencies; the strategies they followed in pursuing their mission, including promotion of specific family planning methods or the use of targets; the kinds of personnel used at all levels; the level of commitment from top to bottom; the criteria used in judging programmatic success or failure; and the program's image in the country." (1982:44)

During the 1960s and 1970s the major donors for population assistance included the United States Agency for International Development (USAID), the World Bank, American philanthropic organizations such as the Ford and Rockefeller Foundations, the International Planned Parenthood Federation, and the United Nations Fund for Population Activities (UNFPA, an acronym that would continue to be used to refer to the agency even after it was renamed the United Nations Population Fund). These organizations provided funds and advice to support non-profit population research and family planning service delivery organizations such as the Population Council and the Pathfinder Fund, as well as organizations established to promote the perceived threats of rapid population growth, such as Zero Population Growth, the Population Crisis Committee, the Population Reference Bureau, and Population Institute.

In the late 1960s and 1970s, studies were published which drew international attention to the fertility impacts of abortion, as well as to the harmful consequences of clandestine abortion for women's health (1978, Tietze and Bongaarts, 1975). Studies from Japan, Eastern Europe and elsewhere suggested that abortion played a major role in the decline of the birth rate of those countries (Burhanuddin, 1972) and led population specialists such as Potts to argue that "no developed country has brought down its birth rate without considerable recourse to abortion and it appears unlikely that developing countries can ever hope to see any decline in their fertility without a massive resort to induced abortion—legal or illegal" (Potts, et al., 1977:526). Accordingly, the major population donors including USAID, International Planned Parenthood Federation, UNFPA, and the World Bank supported abortion in the 1970s as a method of fertility control, as did a number of other agencies including the Pathfinder Fund, the Population Crisis Committee, and the International Projects Assistance Service. To a very large extent, the strong support of international agencies for abortion to be adopted by developing countries as a method of fertility

control came about because of the development of a new safe and affordable method of early abortion called menstrual regulation, or MR. The international development of this procedure and of the underlying low-technology equipment used in MR is described below.

3.3 Advancements in Abortion Technology

Following the 1968 decision of the United States Congress to allocate foreign assistance appropriations to support population activities, USAID quickly became the largest single donor of population assistance, contributing approximately $4 million to population and family planning over the next twenty years (Donaldson and Tsui, 1990). In the early 1970s, its contributions comprised over 90 percent of the budget of the Pathfinder Fund, approximately half the operating funds of both the International Planned Parenthood Federation and the United Nations Fund for Population Activities, and a substantial portion of the budget of the Population Council (Warwick, 1982). According to Warwick, "AID was not timid about using its funding leverage to promote desired action by these recipients," and "if one had to pick the donor agency with the strongest total impact on population programs in the developing countries, the choice would be AID" (1982:45).

From its inception in the 1960s until 1973, USAID's Office of Population was perceived as "an ardent supporter of abortion" that actively supported the development of new and improved methods of first trimester abortion as a "post-conceptive" method of birth control (Warwick, 1980:31). The director of the office was a strong advocate of abortion, but AID did not directly invest substantial amounts of money in abortion programs overseas because, explains Warwick, "political leaders interested in family planning did not wish to jeopardize their other work. The prevailing sentiment was that contraception was sensitive enough without adding the complexities of abortion" (1980:31). Instead, USAID's focus on abortion was concentrated on the development of new technologies.

In 1971, USAID funded a U.S. company, Batelle Northwest Laboratories, to help develop a technique called manual vacuum aspiration, which was first used in the Soviet Union in 1927. Batelle researchers inspired by a California psychologist named Harvey Karman improved the two instruments—the cannula and the syringe—used in manual vacuum aspiration. Eventually, with other than USAID support, new

flexible plastic tubing materials were used to replace the previously rigid cannula, reducing the risks and discomfort associated with the procedure. In addition, the design of the syringe was enhanced by improving the handle and by adding a collar stop to avoid inadvertent withdrawal of the plunger. Locking valves were also added in single-valve and double-valve designs, to allow the practitioner to create a vacuum before inserting the cannula into the uterus (Van der Vlugt and Piotrow, 1973).

Because the syringe did not come into direct contact with the client, it could be used many times with only a low level disinfectant cleaning between uses (Greenslade, et al., 1993). The flexible plastic cannula, on the other hand, was designed to come into contact with the client and accordingly, it has been distributed as a disposable item to be discarded after a single use (Chowdhury, 1994). In an important finding for developing countries, however, providers found the cannulae could be reused safely so long as they were properly disinfected between uses. With proper care, providers found that a cannula could be used for up to 15-20 procedures so long as the side walls were intact and so long as there was no damage to either of the offsetting "whistle cut" apertures (Laufe, 1977).

Manual vacuum aspiration within 14 days of a missed menstrual period was referred to as menstrual regulation or menstrual extraction.[21] Laufe described the procedure as follows:

> Following a thorough pelvic examination, a speculum is introduced and the cervix made visible. An antiseptic swab (such as Betadine) is used to cleanse the external cervix and wipe away any discharge. The cervix is grasped with an atraumatic tenaculum [. . .] The cannula is inserted through the cervix [. . .] In the great majority of cases, constant, gentle pressure and a slight rotary motion allow easy passage of the cannula. Once the cannula is past the internal os, gentle pressure directs it to the fundus. ... The syringe is attached to the cannula, and the pinch valve released. Almost immediately a flow of blood and tissue appears. The operator then begins with a sideways rotation of the cannula, bringing it into contact with the major portion of the uterine walls. When the active flow diminishes in the cannula, a scraping motion is begun, which produces a curette-like effect. The operator knows that the procedure is nearing completion when the gritty texture of the myomentrium becomes evident and when uterine contractions begin, producing a clamping

[21] See (1982, Akhter and Rider, 1983, Bhatia, et al., 1980, Hodgson, 1977, Khan, et al., 1977, Laufe, 1974, Paxman and Barberis, 1980, Tietze and Murstein, 1975, Watson, 1977).

> around the cannula. It is during this phase of the procedure that the patient experiences the greatest discomfort. (Laufe, 1977:254)

The procedure does not require general anaesthesia, although paracervical anaesthesia or analgesia is often recommended. Trained paramedical staff at a first referral level hospital can perform it, or at a primary level health facility if trained paramedical staff, equipment, and supplies for aseptic procedures are available (McLaurin, et al., 1991, Rosenfield, 1992). The risks of side effects and complications are minimal. Since it was introduced in the 1970s manual vacuum aspiration up to 14 gestational weeks has been considered to be the safest and most effective method of early abortion (Cates Jr, et al., 1980, Stubblefield, 1986) and has been recommended by the World Health Organization for use in developing countries for first trimester abortion and for the treatment of incomplete abortions[22] (1990). It has been considered the method of choice for first trimester abortion in the U.S. (Grimes, 1977) and by 1985, was used for 95 percent of all early abortions (Kunins and Rosenfield, 1991).

Prior to the development of manual vacuum aspiration, the only method of first trimester abortion involved dilation followed by sharp curettage, commonly referred to as D&C. D&C could be performed from 6 to 14 weeks of pregnancy. The cervix is dilated to 10-12 mm, and a sharp surgical instrument (curette) is used to evacuate the uterus. Because dilation of the cervix is painful, D&C is frequently performed under general or paracervical anaesthesia. D&C is normally provided in a hospital setting where trained physicians and surgical resources are available, and an overnight stay is typically required. D&C poses greater risks than manual vacuum aspiration, requires more expensive surgical instruments, and must be performed in an operating theatre at a first level referral hospital by a physician and specialized gynaecological staff (Cates Jr, et al., 1980, Ladipo, 1989). Nonetheless D&C or sharp curettage without dilation is still the most commonly used methods for early pregnancy termination in developing countries (Sundstrom, 1993).

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[22] Either spontaneous (miscarriage) or induced abortion, especially unsafe abortion, can be incomplete and require medical attention. An unsafe abortion procedure is more likely to be incomplete than a safe procedure. Bleeding occurs following an incomplete abortion, and the risk of infection and other complications increases with the time a woman has to wait for treatment (Konje, et al., 1992). Manual vacuum aspiration is recommended for the treatment of uncomplicated incomplete abortion up to 15 weeks of pregnancy (Cates Jr, et al., 1980, Stubblefield, 1986). The outcome of treatment depends on the quality of services and health care providers available (Sundstrom, 1993).

3.4 Population Policy in Pre-Independent Bangladesh

Population control interventions began in the former East Pakistan in the early 1950s, following a pattern similar to other developing countries in which family planning NGOs—particularly chapters of the International Planned Parenthood Federation[23]—preceded and heavily influenced the subsequent establishment of government population policies and programs (Correa, 1994). Observing this pattern of intervention, Correa points out that "in many cases where local family planning initiatives pre-dated the neo-Malthusian wave of the 1960s, existing milder programs were adapted to the new demographically driven approach" adopted by states (Correa, 1994:17). The history of population control intervention in pre-independent Bangladesh was no exception.

Driven by a concern for the poor health of women caused by pregnancy, elite women in Pakistan established the Family Planning Association of Pakistan in Lahore in 1952 to provide women with birth control services (Khan, 1996). The government, concerned about the possible reaction of a conservative Muslim society to family planning in the 1950s, was unwilling to openly support the Association, but gave it a small amount of money, and tacit support (Gamble, 1998). It was not until the early 1960s that the Government of Pakistan felt that it could talk openly about family planning (Khan, 1996). Most likely, the open environment developed not because of any dramatic shift in the cultural context of Pakistan, but because as the literature of the time suggests family planning programs were gaining widespread international legitimacy as a major instrument of population control.

Khan suggests that by the mid-1960s, the imagination of president and military ruler, Ayub Khan "was captured by the problem of overpopulation, and the effect this would have on national development" (Khan, 1996:31). Ayub Khan established a National Board of Family Planning at the federal level with two subsidiary organizations in East and West Pakistan. The board advised the government on policy while the Ministry of Health implemented family planning programs. Among a number of other factors, Khan suggested that a disregard for religion by the western-educated military dictator, and donor support were critical to

[23] The International Planned Parenthood Federation grew out of the Planned Parenthood Federation of America in 1948 to oversee international operations.

transforming Khan's ideas into a national population program. Khan "did not seek a religious mandate for his rule," and was not concerned about the religious position on family planning (Khan, 1996:31). In 1959, President Khan visited the United States where he requested the Population Council to send an advisory mission to help his government design a family planning program. Following the Council's recommendations, Khan launched a large-scale government family planning program under its Third Five-Year Plan (1965-1970). This was the second national family planning program in the developing world after India. While the program suffered from major implementation problems, Khan's strong political backing brought a high level of credibility and publicity to family planning, and awareness and knowledge about contraceptive availability throughout Pakistan (Khan, 1996). By the time the first Government of Bangladesh was formed in 1971, therefore, its policy makers had been steeped in the importance of family planning as a major instrument of population control. Before those persons could articulate their policies for the new country, however, it would be necessary to fight for independence.

3.5 The First Sanctioned Abortions in Bangladesh

The nine-month war included rapes that ultimately resulted in unwanted pregnancies, and these led to the first sanctioned abortions in the country, in defiance of the laws of the land at the time. This section traces the history of these early abortions, and examines a hypothesis advanced by several observers that this early experience served, in Amin's (1996) words, to "desensitise" policy makers and the public to the issue of abortion, such that an MR policy could be formulated within the decade.

Approximately one million lives were lost and 20 million families were displaced during the war (Jahan, 1980). The U.S. press contained a handful of stories alluding to the mass rapes of Bangladeshi women by Pakistani army regulars and by Muslim Biharis hired by the Pakistani Army (Drummond, 1971, Fried, 1971, Menen, 1972). According to these articles, women were raped in their villages, and tens of thousands were abducted and held by force, sometimes stripped of their clothes to prevent them from escaping, in the Pakistani Army's military barracks (Brownmiller, 1975). By January 1972, these stories were corroborated by the Asian Relief Secretary for the World Council of Churches in a press conference held in Geneva following his two-week mission to Bangladesh (Brownmiller, 1975). The Secretary

reported that according to Bangladeshi authorities more than 200,000 women had been raped (Brownmiller, 1975). Over the next year, Brownmiller reported, the full extent of the rapes came out in the international press; estimates of the number of women raped ranged from 200,000 to 400,000.[24]

The newly installed Awami League Prime Minister, Sheikh Mujib, launched an effort to "rehabilitate" and reintegrate these women back into society. First, the prime minister formally declared that these women were victims and *Birangonas* (heroines of the war) (Drummond, 1971). Second, he tried to persuade husbands of the raped women to take them back, and to find bridegrooms among his freedom fighters for the unmarried women that had been raped. Few husbands agreed to take their wives back, however, and the small number of willing bridegrooms demanded that the Government present them with prohibitively large dowries before they would agree to marriage (Brownmiller, 1975).

A more urgent problem, however, was resolving the unwanted pregnancies of many of the women who had been raped which was by all accounts a source of great shame to the new nation despite Mujib's efforts to cast them as heroines. The prime minister created a National Board of Women's Rehabilitation in February 1972 with a goal of "rehabilitating" women affected by the war. This was to be done by providing abortions to women who had been raped and become pregnant, and by providing professional and vocational training and employment opportunities to women whose husbands or male earning members had been killed or stranded in Pakistan or whose family property had been looted or destroyed. A sitting Supreme Court Judge was appointed as chairman, and eleven other "eminent lady social and political workers" were appointed as the members of the board (Haider, 1972:536). Based on estimates in the local media and information collected by its sub-dstrict offices, the board judged that nearly 400,000 women had been raped, of whom at least 20 percent were "social outcasts with their property or male earning members lost," and another million women were left economically destitute (Haider, 1972:535). Accurate statistics on the number of women who became pregnant as a

[24] The Associated Press and UPI reported 200,000 women on January 17, 1972, the New York Times reported 50,000 on March 5, 1972, and the New York Times Magazine reported 400,000 (Brownmiller, 1975). The Women's Rehabilitation Program of the Government of Bangladesh reported 400,000 women were raped (Haider, 1972).

result of these rapes were difficult to determine, but 25,000 was the number generally accepted (Brownmiller, 1975, Haider, 1972).

Although mass rape during war was not unique to Bangladesh, the international attention accorded to the mass rapes in Bangladesh was unprecedented (Brownmiller, 1975). This Brownmiller attributed to Sheikh Mujib's need for aid and sympathy, a "new feminist consciousness" that encompassed rape as a political issue, and a practical acceptance of abortion as a solution to unwanted pregnancy (Brownmiller, 1975). The news stories led to an organized response from feminist and humanitarian groups in London, New York, Los Angeles, Stockholm, and elsewhere (Trumbull, 1972, Tweedie, 1972). Several interviewees recalled the far-reaching efforts of one feminist activist, former head of the New York-based National Women's Health Coalition (now the International Women's Health Coalition). The head of the Coalition, whose involvement with women's health in Bangladesh continued beyond her response to women raped during the war, was allegedly responsible for negotiating with officials of the Embassy of Bangladesh and the International Planned Parenthood Federation (IPPF) to send a small team of American, European, Indian, and Australian doctors to Bangladesh to provide abortions for women who were raped during the war (Goldberg, 1998, Potts, 1998).

The former IPPF medical director, who led the team, recalled being warmly received by government officials in Bangladesh, including the minister of health (Sheikh Mujib's personal physician) and other officials of the Ministry (Potts, 1998). According to an interview with the former head of the National Board of Women's Rehabilitation (Haider, 1972) the team's role was to provide abortion training to doctors of the Health and Family Planning Departments and services to women in approximately 16 district-level clinics which had been established by local level commissions set up by the board. The only documentary source of information about the board that could be found at the time of this research was a paper on the experiences of the board that the director of the board wrote for a 1972 conference on family planning sponsored by the Pathfinder Fund.

By the time the team reached women in the villages, they learned that many of them had already resorted to traditional village abortionists, self-induced abortion, infanticide, and even suicide to resolve their unwanted pregnancies (Potts, et al., 1977, Trumbull, 1972). Families who could afford to had already sent their daughters

to Calcutta for abortions (Brownmiller, 1975). Over the nine months that one member of the medical team worked in Bangladesh, stories of suicide and infanticide to resolve unwanted pregnancies were recounted numerous times, and according to the IPPF medical director, few babies were delivered and practically none survived (Brownmiller, 1975). For the few babies who did survive, the Directorate of Social Welfare and Mother Theresa's Home tried to arrange international adoptions (Haider, 1972). Like abortion, adoption was illegal, but the circumstances led the chief executive to permit a deviation from the law during this time. According to Brownmiller's book and interviews for this research, however, very few children were put up for adoption during this time (Brownmiller, 1975).

The former director of the board said that in order to encourage women to come to the district clinics, anonymously if they wished, the National Board of Women's Rehabilitation relied on publicity and the help of village-based family planning field workers. The board's efforts to reach women were limited by the lack of field staff and transportation at their disposal, as well as the program's late start. The majority of rapes occurred in September and October 1971, but the board was not established until February 1972 (Haider, 1972). Moreover, many women who were raped were reluctant to be come forward for fear of being ostracised by their communities (Haider, 1972). The IPPF medical director judged that the reason some women hesitated to come forward had to do with the illegal status of abortion and their fear of prosecution (Potts, et al., 1977). Of the women who did come to the district clinics, many were already well into their second or third trimesters of pregnancy, or were suffering from minor to severe gynaecological complications resulting from sexually transmitted diseases and incomplete abortions (Brownmiller, 1975, Haider, 1972). The team performed a considerable number of late abortions using complicated and risky techniques, which twenty-six years later, the IPPF medical director recalled were some of the most dramatic and worst abortions he had ever performed. One of the Bangladeshi physicians assigned to work with the international medical team recalled that while early abortions, mainly by dilation and curettage, were practised by medical professionals in East Pakistan before the war, either clandestinely or for treatment of spontaneous, incomplete abortion, or diagnostic purposes, neither he nor the international consultants were accustomed to the procedures required to induce abortion in late pregnancy (Bhiuyan, 1998). They fumbled through, said the physician, often trying more than one technique, with most of them completed by rupturing the placenta with a sharp object, and administering

oxcytocin to induce labour. There was no oxcytocin available in the country at that time, so one of the international consultants arranged to have it flown in on a small plane, and delivered to the more remote district clinics. Some cases did not respond to this procedure, and needed to be induced in other ways, including removing part of the placenta, thereby releasing prostaglandin that would stimulate the abortion, according to this physician. There were no emergency back-up resources or emergency blood supplies, and the physicians interviewed were aware that the risk of haemorrhage and infection from these procedures was high. One physician recalled that he and the international physicians were extremely anxious about performing these abortions. Two other Bangladeshi physicians involved with the international team remember that the foreign consultants taught them to use a rubber catheter to induce mid-trimester abortions, which was not a procedure that they had ever been taught in medical school, and although they might have come across a description of the procedure in a medical journal, it was certainly the first time that they were carrying it out.

The medical director recalled that many of the local doctors let the international medical team perform the later abortions because they were worried that these procedures might be considered illegal according to the letter of the law. Although the abortions did not have legal sanction, the decision to provide abortions had been taken in a meeting of representatives of the prime minister and the Parliament, with strong support from Sheikh Mujib (Haider, 1972). The appointment of the Supreme Court justice as chairman of the board acted as a public endorsement of this deviation from the law, and assured those involved that nobody would be penalized for obtaining or providing an abortion (Haider, 1972).

The Government provided abortions free of charge until approximately seven months after the end of the war at which point it was assumed that all the women who had been raped and become pregnant would have had a chance to seek an abortion. In total, the director of the board judged that of the estimated 25,000 who became pregnant from rape, the board's efforts to provide abortion reached about 2,000 women (Haider, 1972).

These 2,000 cases represent the first government-sanctioned—albeit illegal—abortions in Bangladesh. Some have speculated that this episode in Bangladesh's earliest history eased attitudes towards abortion in a society where

abortion had long been legally, socially, and culturally restricted, and that this desensitisation represented one of the critical contextual factors that would enable the Population Control and Family Planning Division to formulate a policy to provide early abortion services on demand seven years later (Amin, 1996, Khan, 2000, Piet-Pelon, 1998, Potts, et al., 1977). This contention is partly supported by attitudinal surveys. In the 1975 Bangladesh Fertility Survey of 6,513 married women, for example, 88.3% of the women surveyed indicated they approved of abortion in the case of rape, and 87.6% of the women approved of abortion to terminate a premarital pregnancy. When these conditions were not present, however, and the pregnancy endangered the woman's life, only 53% were in favour of abortion, and when pregnancy "could be dangerous to the woman's health," only 14% of the women approved (Ministry of Health and Population Control, 1978). Similarly, in 1975 and 1976, men and women representing 2,682 married couples were surveyed separately about their attitudes toward abortion. Again, the most common reason given by both men and women for approving of abortion was rape and premarital pregnancy (about 80% combined). Significantly fewer (62%) approved of abortion to save the woman's life, while only 20% approved if the woman's health alone was endangered (Rosenberg, et al., 1981). It is interesting to note that under the Bangladesh Penal Code, abortion is only legal to save the life of the mother. The respondents' favourable attitudes towards abortion in the case of rape or premarital pregnancy may have been influenced by the victimization of women during the war. However, it is clear that these more liberal attitudes did not extend to the same extent to approval of early abortion services as a method of family planning or as a medical or health procedure for women.

The desensitisation contention might be more applicable to physicians rather than to the general public. According to the physicians interviewed for this research, the international medical team that came to Bangladesh during the war transferred technology as well as ideologies and attitudes about abortion. The international team was made up of a handful of physicians who strongly believed in and practised abortion, unlike many of their peers and compatriots who were reluctant to practise or advocate abortion. Most of the international team members were outspoken advocates who had long been involved in providing abortions, liberalizing abortion laws in their own countries, and advancing the use of manual vacuum aspiration for early abortion (Potts, 1998). In addition to providing technical training and equipment, the international doctors imparted their liberal views on abortion to the

dozen or more local doctors during the long hours that they spent together in the board's remote district clinics. One of the international physicians remained in Bangladesh for nearly nine months after the end of the war, providing equipment and training to local physicians beyond the requirements of the board (Potts, 1998). The IPPF medical director was in and out of Bangladesh for several months after his initial visit to provide additional equipment and training (Potts, 1998). At least three of the team members were part of a relatively small circle of international abortion experts who would return to Bangladesh several years later to provide early abortion training (Ali, 1998, Potts, 1998). Accordingly, one could argue that attitudes toward abortion among physicians were eased during this early episode to facilitate the later formulation of the Population Control and Family Planning Division's MR policy. This argument was partially questioned, however, by the physicians themselves.

Recalling Sheikh Mujib's instructions to doctors to provide abortions to the war heroines, one interviewee suggested that in 1972, he felt that he was fulfilling his "religious duty" by doing so (Anowar-ul Azim, 1998). Talking about a colleague, another interviewee said that her colleague found helping women during the war to end women's unwanted pregnancies "personally fulfilling and rewarding." After the war, however, neither physician wanted to perform elective abortions (Ali, 1998). The first respondent judged that it was his duty as a physician to provide abortions to protect the health and life of the mother, but he refused to provide abortions that he considered unnecessary, because fundamentally he considered abortion against his religion (Anowar-ul Azim, 1998).

The attitudes shared by physicians and by married women and men in general as outlined above are not so much attitudes towards abortion as attitudes towards rape. In 1971, rape was perpetrated as a weapon of war by the occupying side, which some believe may have been organized by the top ranks of the Pakistan Army (Brownmiller, 1975). As Bangladeshi sociologist Guhathakurta points out, this weapon was understood as "robbing the honour of mothers and sisters" (1996:27), and the "bastard children with their fair Punjabi features" as Brownmiller referred to them would have been a tormenting reminder of the atrocities of the war and of the shame of stolen honour (1975:84). In addition, one of the local doctors interviewed indicated he believed that the demand for abortion continued long after the board closed its clinic doors because of "miscreant" freedom fighters that were involved in raping young girls. In his estimate, unruly factions of the freedom fighters raped

more women during and after the war than by Pakistani soldiers. The allegation that unruly freedom fighters played a part in the mass rapes was also reported in the U.S. press (Brownmiller, 1975). Attitudes towards abortion appear not to have been changed by the early experience with rape. In 1979 when the MR policy was introduced, rape was just as abhorrent as in 1971 and 1972. It does not follow that the concept of MR for reasons unrelated to rape were somehow eased because of the country's early experiences in dealing with rape victims.

One aspect of the desensitisation contention, however, bears further scrutiny. Grindle and Thomas argue, "historical memories [. . .] influence policy elites in terms of their perceptions of what works and what doesn't [. . .] Such concerns clearly influence the caution or enthusiasm with which policy elites approach discussions of new initiatives" (1991:36). Policy makers in Bangladesh found that in 1972, they were able to circumvent the law dealing with abortion. This early positive experience specifically dealing with the sanctioned provision of illegal abortion services may have been a contributing factor that would enable policy makers to formulate the MR policy in 1979.

3.6 Abortion in the First Five-Year Plan (1973-1978)

Given the high population density of the country and the experiences of policy makers with population control interventions in pre-independent Bangladesh, it is not surprising that population control featured so prominently in the First Five-Year Plan (1973-1978). The country occupied a land mass of approximately 147,570 square kilometres and consisted of over 70 million people, making it one of the most densely populated countries in the word. The First Five-Year Plan (1973-1978) stated that it is "difficult to visualize the present land space of Bangladesh comfortably supporting anything near twice its present population," and accordingly stated an objective of reaching zero population growth within 30 years (Planning Commission, 1973:538).

With the demographic momentum for population growth at the time, however, this was considered a highly ambitious plan both by outside observers and by the Government of Bangladesh itself. Bangladesh had a population of over 70 million, with 14 million women of reproductive age. Nearly half the population was below the age of 15, and the majority of the population was below the age of 17. In

other words, most of the population of Bangladesh was about to enter childbearing years, and the total fertility rate at the time was about 7 children per woman (Planning Commission, 1973). Nonetheless maintaining that rapid population growth "is not conducive to the growth of the economy as it neutralizes much of the gains obtained due to development efforts" (Planning Commission, 1973:537), the Government of Bangladesh resolutely stated that "no civilized measure would be too drastic to keep the population of Bangladesh on the smaller side of 15 crores for sheer ecological viability of the nation" [*sic*] (Planning Commission, 1973:538).

In 1972, following the war and almost immediately after coming to power, the first ever Government of Bangladesh held an international seminar on family planning. The conference, which was sponsored by the U.S.-based Pathfinder Fund, led to several policy directions for the new government, including one to relax the abortion law (Burhanuddin, 1972). During the conference, a retired colonel from the Pakistan Army Medical Service, and then director of the National Post-Partum Program under the Ministry of Health and Population Control, strongly advocated the need for abortion as "an interim means of birth control under adequate legal and medical safeguards" in Bangladesh's family planning program (Burhanuddin, 1972:326). Citing numerous examples of the role of abortion in reducing population growth in countries where abortion was legal, he recommended that the government consider sanctioning abortion as a means of birth control (Burhanuddin, 1972). The Planning Commission appears to have taken very seriously the retired colonel's recommendation, as well as the several other advocates of abortion who spoke at the conference, because abortion was clearly featured in the government's First Five-Year Plan (1973-1978). Under the "Population Planning Programme" section, the Planning Commission noted, "in all successful family planning programmes abortion played a central role. While keeping in mind the question of social acceptability all efforts must be made to allow this method to play its proper role in controlling the growth of population in Bangladesh" (Planning Commission, 1973:539). Moreover, "legalization of abortion," they stated "has been known as probably the best and most effective method for control of population growth. It should be seriously considered how this method can be adopted to control population growth in Bangladesh" (Planning Commission, 1973:545).

The very first Five-Year Plan of the new Government of the People's Republic of Bangladesh therefore clearly announced that abortion had very much

made it onto the policy agenda. The following chapters shall examine the process followed to formulate and implement the policy.

3.7 Chapter Summary and Analysis

This chapter was concerned with the agenda-setting phase of Bangladesh's abortion policy in the early 1970s. At that time, the international policy arena accorded high priority to control of population growth in developing countries, through measures specifically including abortion. Numerous references to such international literature in the earliest official documents of the Government of the People's Republic of Bangladesh revealed that policy makers were aware of the international agenda, and that they believed at the time that direct population growth interventions and the adoption of fertility rate targets were the best way to slow population growth, rather than through economic measures which some other developing countries believed could better address the underlying root causes of rapid population growth. The architects of the first Five-Year Plan had been steeped in over a decade of population control initiatives in pre-independent Bangladesh, and approximately 2,000 abortions were provided during the very first months of the country's existence, in defiance of the laws of the land. Further, the population growth targets adopted by the first government were extremely ambitious, indicating perhaps the severity of the population problem perceived by policy makers, but certainly providing a ripe environment for abortion to be "seriously considered" as a policy of the government. The international development of a new safe and affordable early abortion technology made it feasible to do so.

Thomas and Grindle noted in their review of 16 population policy case histories that population policy "rarely" becomes an agenda item "through social mobilization and pressure, although the involvement of domestic and international organizations is almost universal. Rather, decision makers' perspectives about the relationship between population growth and economic growth and about maintaining social stability significantly affect how issues of population growth and limitation are added to government agendas" (1994:53-56). In Bangladesh, there was no social mobilization or pressure for an abortion policy, although international organizations both inside and outside the country were actively advocating for one. Further, evidence suggests that decision makers perceived direct population growth interventions to be appropriate in addressing the challenges facing the new nation.

Viewed in this light, it appears abortion was not placed on the policy agenda in Bangladesh because of widespread public demand or solely or even primarily because of international pressures, but rather primarily because of the "embedded orientations" of policy elites whose backgrounds included favourable experiences with population control interventions in pre-independent Bangladesh and with abortion in the initial months of the country. This elite was provided with a unique opportunity to formulate new policies, since the country was brand new and therefore all policies were new. This is what Grindle and Thomas referred to as a "moment in national politics" when opportunities for pursuing reforms already on a latent agenda may be introduced (1991:93).

4.0 Formulating the MR Policy

4.1 Introduction

This section covers the policy formulation stage, which spans the period from when the first Five-Year Plan was prepared to the time when the Population Control Division of the Ministry of Health and Population Control included MR as a method of family planning in the national family planning program (1979). Throughout this period, abortion was illegal, and yet the Population Control Division was able to formally sanction MR as part of an official government program, using paramedics rather than physicians to provide the abortion services, in a relatively conservative Muslim country. My research into this early period of the country's existence is aimed at identifying and analysing the critical factors that enabled the Population Control Division to formulate its MR policy.

The chapter begins with a description of the international dissemination of MR, and goes on to present an analysis of the actors and process involved in introducing MR into the national family planning program in Bangladesh. It also includes an analysis of attempts by the Population Control Division to legalize abortion in the mid 1970s, and a review of the factors that contributed towards a change in the agenda item from abortion to MR. The chapter closes with a summary of the critical factors that enabled the Population Control Division to formulate its MR policy in 1979, and an analysis of whether the hypotheses contained in the Grindle and Thomas framework with respect to the policy formulation phase of the policy process were supported by the case study findings.

4.2 The International Dissemination of MR

Menstrual regulation was reportedly first used in Bangladesh by an international team of physicians sponsored by International Planned Parenthood Federation to treat women raped during the war in 1971 (Laufe, c.1978). Shortly afterwards, clinical trials of MR were conducted throughout the developing world by the U.S.-based International Fertility Research Program in the early 1970s, with funding from USAID. By 1973, however, political events in the United States dampened enthusiasm for abortion, and it can be surmised, given the leadership role played by the U.S. in the population field, that the international dissemination of

menstrual regulation proceeded more slowly than it would have had U.S. support continued. In an amendment to the Foreign Assistance Act initiated by North Carolina Senator Jesse Helms in 1973, most of USAID's abortion related activities were brought to a halt. The Helms Amendment restricted USAID from the direct support or promotion of abortion. Other large population donors such as the Ford and Rockefeller Foundations were reluctant to fill the void left by USAID's withdrawal from the field. According to Warwick, the foundations judged that association with abortion could "touch off controversies that would impair work in less volatile areas of higher priority," and secondly, "the illegal nature of abortion in many countries and the common use of clandestine techniques to promote abortion services would cause considerable squeamishness among professional staff members at the foundations" (1980:32).

Despite USAID's abrupt retreat from its earlier support of abortion, Laufe suggested that MR was nonetheless "propelled into the international arena" by an international conference of medical professionals at the University of Hawaii School of Public Health in 1973 (Laufe, c.1978). Medical professionals from over 50 countries reviewed clinical reports from approximately 3,500 procedures performed in clinics in the U.S., the U.K., India and Singapore, and determined that MR was medically safe within 7 to 14 days of a missed menstrual period (Laufe, c.1978).

By 1977, the International Fertility Research Program, which retained some USAID support for research, published the results of its clinical trials in a series of papers comparing various techniques and technical modifications, and demonstrating the widespread acceptability of the menstrual regulation procedure in a range of countries. Further, studies conducted around this time suggested that paramedics could perform MR as safely and effectively as physicians (Karman, 1972, Laufe, c.1978).

A number of international agencies were involved in disseminating menstrual regulation equipment, including Ipas (formerly the International Projects Assistance Service), which was described as "the most aggressive promoter of abortion services in the developing countries" (Warwick, 1980:35). Ipas was established by a group of health professionals in the early 1970s to continue the development, manufacturing, and distribution of menstrual regulation equipment when the Helms Amendment forced USAID to withdraw its earlier support for the development of post conceptive

methods of birth control, including abortion (Greenslade, et al., 1993). Ipas was involved in providing loans for the establishment of new abortion clinics, in manufacturing menstrual regulation equipment for sale to other organizations, and in providing direct abortion services (Warwick, 1982).

The London-based International Planned Parenthood Federation was considered another outspoken advocate of abortion although it spent very little of its total funds—one third of one percent—on abortion related activities (Warwick, 1980). As the headquarters for numerous national family planning associations around the world, it channelled international funds and supplies to its local affiliates, and helped to set local policies and standards, including those favouring abortion. As of 1978, International Planned Parenthood Federation was involved in ten projects related to abortion, mostly concerned with training, in various regional and global efforts (Warwick, 1980). Similarly, the Pathfinder Fund was involved in establishing clinics in countries where abortion services were illegal but tacitly approved by the government, and in distributing MR equipment to interested clinics and private doctors. Under the Helms Amendment, International Planned Parenthood Federation and the Pathfinder Fund, like all other recipients of USAID funds, were required to maintain detailed accounting records and supporting documentation to satisfy USAID auditors that USAID funds were used only for eligible expenditures, i.e., that no USAID funds were used for activities relating to abortion.

Important financial support for the abortion-related activities of international agencies came from the Population Crisis Committee, a lobbying group for family planning based in Washington. The United Nations Fund for Population Activities (UNFPA) and the World Bank were also active in supporting abortion-related activities in developing countries, but to a far lesser extent. UNFPA operated under the policy that it would "respond to country requests for assistance for all kinds of population programs, provided that they are within the organization's mandate and do not violate UN policies on human rights" (Warwick, 1980:32). UNFPA placed no restrictions on methods of fertility control, and provided assistance for abortion services in India, Thailand, and Tunisia, and funds for research on abortion through the Special Program of the World Health Organization, and university research programs (Warwick, 1980). In total however it spent less than one fourth of one percent of its total budget on abortion related assistance. The World Bank operated under a similar policy to UNFPA, but spent an even smaller amount on abortion

related assistance. Both UNFPA and the World Bank received large contributions from the U.S., but resisted "any attempts by contributors to impose a curb on abortion expenditures" (Warwick, 1980:32).

In addition to the international dissemination of MR and manual vacuum aspiration technology and equipment, important discussions were held internationally as to the legal nature of menstrual regulation. In particular, in 1976, the Pathfinder Fund and the Graduate School of the University of Pittsburgh held a conference for Latin American physicians that focused on new low-technology methods of surgical contraception and menstrual regulation. According to Laufe, "one of the primary efforts of the conference was to focus on the legal aspects of MR" (Laufe, c.1978). In a panel discussion, panellists from Bolivia, Brazil, and El Salvador unanimously concluded that a recommendation adopted by the Symposium on Law and Population held in Tunis in 1974 could be supported. That recommendation was that "M-R be treated as falling outside the scope of restricted abortion laws" (Laufe, c.1978:79). At the time, contemporary pregnancy tests within 14 days of a woman's missed period were unreliable in ascertaining whether that woman was in fact pregnant. Some argued that this meant MR would be legal in any country where abortion was illegal but where proof of pregnancy was required in order to obtain a conviction. Others argued that because MR had multiple purposes (e.g. endometrial biopsy), it might be difficult to prove intent to commit an abortion in those countries where such legal proof was required (Lee and Paxman, 1977). As shown later in this chapter, these arguments were also used during the MR policy dialogue in Bangladesh.

4.3 The Introduction of MR in Bangladesh

The international development and dissemination of MR technology was a necessary but insufficient prerequisite for the introduction of MR to the family planning program in Bangladesh. At the time that the first Five-Year Plan was announced, there were no concrete plans in place to as to how abortion was to play a "central role" in achieving the ambitious fertility growth rate targets mentioned in the Plan. There were obvious practical difficulties involved, in that there were no trained providers in the country. Approximately 2,000 abortions had been provided to women raped during the war, but the vast majority of those were late procedures performed by international physicians. The Population Control and Family Planning Division would later calculate that it needed at least 2 trained MR providers in each

of its 413 districts, but none existed at the time the First Five-Year Plan (1973-1978) was announced and, in fact, the technology had yet to be used in the country on anything but a very limited scale, if at all. The following section examines how the technology was introduced to Bangladesh, and how the Population Control Division was able to gear up to supply adequate numbers of trained MR providers to enable formulation of its MR policy.

4.3.1 *The Model Clinic*

During the 1972 conference on family planning held in Bangladesh, a representative of the Pathfinder Fund offered a small grant to be used for clinical contraceptive and menstrual regulation services to the director of the National Post-Partum Program (Rahman, 1997). The National Post-Partum Program, established by the central Government of East Pakistan, was a Project within the Ministry of Health and Population Control that employed motivators to provide family planning information and services to women in the maternity wards of government hospitals (Khan, 2000). The Post-Partum director, an official of the Ministry of Health and Population Control, accepted the Pathfinder Fund's financial support, but soon thereafter he left the country to join UNFPA, leaving the unspent funds with the secretary of health. It was not until 1974 that the subsequent director used the funds, handed over by the secretary of health, to establish MR services.

The successor to the first director had recently returned to Bangladesh to resume his government post, which he had held since 1961, after taking a leave of absence to complete his doctorate in public health. Having specialized in population dynamics at Johns Hopkins University in the United States, the new director had an interest in abortion as "the only retroactive method to take care of unwanted pregnancy" (Khan, 2001). Moreover, he was interested in technological innovation, specifically the development of manual vacuum aspiration. In one of his first official acts after returning to Bangladesh, he and his staff established a satellite clinic that was named the Family Planning Model Clinic and Research Centre, Mohammadpur (later renamed the Mohammadpur Fertility Services and Training Centre) and referred to as the Model Clinic.

The Model Clinic was a government facility where all personnel were government employees. Yet from the beginning, all costs were met by the Pathfinder Fund through a grant to the government, and according to its former Chief Executive

Officer, the Pathfinder Fund played a major role in establishing and running the clinic (Gamble, 1982). The Model Clinic provided "comprehensive fertility services" which included the provision of oral contraceptive pills, IUDs, condoms, and injectables, as well as sterilization and menstrual regulation. The Pathfinder Fund supplied the MR equipment, and helped to appoint a full time medical consultant. The Pathfinder Fund sent the medical consultant and several other Clinic staff to the "KK Hospital" in Singapore for training in menstrual regulation, and brought approximately 6 American medical consultants to Bangladesh between 1974 and 1983, to provide MR training to the physicians at the Model Clinic. Interestingly, at least two of these consultants were part of the international team that came to Bangladesh to provide abortions to women raped during the 1971 war.

According to the former director of the Model Clinic, he and others within the Population Control and Family Planning Division urged the Pathfinder Fund to fund a comprehensive clinic rather than an MR clinic to reduce the likelihood that it would become stigmatised. Although abortion figured prominently in the First Five-Year Plan, it was still controversial among certain Ministry of Health and Population Control officials. The secretary of health at the time the Model Clinic was established "remained non-committal until Dr. Ravenholt, the former director of the Office of Population in USAID, congratulated him, during one of his visits to Dhaka for successful initiatives on MR services" (Khan, 2001). Later, the Secretary of the Population wing of the Ministry of Health and Population Control was supportive of MR, while below him, the director general, and above him, the minister, were unsupportive. Looking back on this period, the former director suggested that part of his success in setting up the clinic was due to his having had a "great deal of autonomy, partly because administrative roles and functions were not clearly defined in a new country" and due to the lack of any "clear administrative directive" concerning MR (Khan, 2001).

The Pathfinder Fund used funds from the United States Agency for International Development to support contraception and sterilization, and other funds to support MR. As USAID's regulations regarding abortion became more restrictive, the Pathfinder Fund was no longer able to fund contraception and sterilization in the same facility in which it was also funding abortions, even though the abortion activities were supported by private funds. A former director of the Model Clinic recalled constructing a bamboo wall to separate abortion services from contraception

and sterilization in a first attempt to accommodate the requirements of USAID, but eventually he was compelled to move the MR services to an adjacent building. The Pathfinder Fund found that as a result of this arrangement, the MR services and the contraceptive and sterilization services deteriorated in quality, and fewer clients were interested in either aspect of the program. Prior to the separation of services, the clinic had been popular for all family planning services, in large part, "because unwanted pregnancies could be terminated. [. . .] Many women who came for sterilization proved already to be pregnant—but could receive terminations and ligations at the same time. Over 80% of those who received an MR left the clinic with an effective, modern method of contraception" (Gamble, 1980:3). To revive the quality of services, the Pathfinder Fund decided to reintegrate contraception and sterilization with abortion and to support the entire facility with funds from private sources.

In addition to providing MR services, the Model Clinic became a field site for the International Fertility Research Program's international clinical trials of MR. Using a standard research protocol developed by the International Fertility Research Program, Model Clinic staff recorded data on 1,068 MR clients between 1974 and 1976. Data collection was supervised by the Johns Hopkins Fertility Research Program in Bangladesh, and analysed by staff of the International Fertility Research Program in the U.S. (Khan, et al., 1977). The results of the International Fertility Research Program's clinical trials in Bangladesh and 20 other countries were published in the October 1977 issue of *Studies in Family Planning* (Laufe, 1977). It is claimed that this article was an important factor in stimulating the dissemination of MR services internationally (Laufe, c.1978). However, the article does not mention the countries in which the trials were conducted, and thus it seems unlikely it had an impact in influencing policy in Bangladesh except perhaps to promote a greater acceptance of the procedure generally.

In 1975, the director of the Model Clinic published a preliminary report of MR service delivery at the Model Clinic in the Bangladesh Medical Research Council Bulletin (Khan, et al., 1975), and two further technical reports under the auspices of the Bangladesh Fertility Research Program, one on the findings of the first 1,068 MR cases treated by the Model Clinic between 1974 and 1976 (Khan, et al., 1977), and the other on the results of a study entitled "Pregnancy Termination By Vacuum Aspiration and D&C For 344 patients at Model Clinic, Mohammadpur, Dhaka"

(Khan and Ali, 1977). In the introduction to the former, the director of the Model Clinic and two of his staff who participated in the research judged that "these cases represent one of the earliest series that has been scientifically monitored and analysed. Therefore this report carries significantly important implication with regard to the role of menstrual regulation in the national family planning programme in Bangladesh" (Khan, et al., 1977:153).

4.3.2 *Training Medical Officers*

In 1978, the Population Control Division asked the Pathfinder Fund to develop large-scale MR training for medical officers working in the government's service delivery system; the Population Control Division wanted two trained MR providers in each of the country's 413 sub-districts. In a memo recalling the history of this period, the Chief Executive Officer of the Pathfinder Fund said, "we agreed to cooperate and, in consultation with the PCFP (Population Control and Family Planning Division), developed an ambitious plan which called for the rapid development of training and clinical facilities at each of the eight medical colleges" (Gamble, 1982:3). The Pathfinder Fund brought in an American consultant to conduct a weeklong seminar to develop an MR training curriculum, and made a grant to the Population Control and Family Planning Division for support to each of the medical colleges. Under this agreement, a national committee headed by a high-level physician employed by a prominent government hospital coordinated the MR training program, which consisted of training and services at the Model Clinic and at the eight medical colleges. The Pathfinder Fund also established a local office in Dhaka in 1978 and hired a Country Representative, a move that appeared to some interviewees to shift authority over the program from the Ministry of Health and Population Control to the Pathfinder Fund.

The training got off to a slow start. According to the head of the national committee and a doctor trainer from one of the eight medical colleges at the time, the training program was not well organized, and the medical college doctors designated as menstrual regulation trainers were busy with other clinical work besides training. Moreover, some of the doctor trainers felt menstrual regulation was a potentially controversial subject, and did not actively promote the services. At least partly as a result, the volume of clients was much lower than expected, thus necessarily slowing down the training program.

The Pathfinder Fund in contrast judged that the training got off to a slow start for technical reasons, such as that the trainers and some of the trainees had inadequate backgrounds to teach or to learn the procedure (Gamble, 1980). Frustrated with the program's performance, the Pathfinder Fund asked two American consultants to conduct an evaluation that appears to have had far reaching consequences. The consultants recommended changing the management structure, specifically by having the Pathfinder Fund take over supervision from the national coordinator. More than one interviewee recalled that this decision was not pleasant, and that it created a rift between the Bangladeshi doctors involved, including the national coordinator, and the Pathfinder Fund. One Bangladeshi doctor felt that the recommendations of the evaluation had "cast aspersions" on the Bangladeshi doctors' sincerity (Bhiuyan, 1998).

Acting on the recommendations of its American consultants, the Pathfinder Fund terminated its grants to the medical colleges through the Population Control and Family Planning Division, and agreed with the Division to a revised program that included direct grants from the Pathfinder Fund to the medical colleges. The Pathfinder Fund also required each of the participating medical colleges to send two of their designated trainers to the Chittagong Medical College for an intensive month-long training-of-trainers course before resuming training at the respective medical colleges.

The national coordinator, who was essentially removed from his position by these actions, was then the director of the Institute of Post-Graduate Medical Research and today is one of the most politically powerful and renowned gynaecologists in Bangladesh. By taking control from him and deciding to fund the medical colleges directly, some interviewees argued that the Pathfinder Fund usurped the Population Control and Family Planning Division's control, ownership, and management of the MR program very early on, and alienated itself from the medical establishment in Dhaka. They suggested that this shift in power might have been the consequence of establishing an in-country office and hiring a competent and ambitious local director. The man appointed Country Representative of the Pathfinder Fund was a recently retired senior civil servant and a physician with strong connections to both the Ministry of Health and Population Control and the medical community, including senior physicians and professors of medicine as well as the directors and administrators of the medical college hospitals. He is remembered as a

person who enjoyed the power he derived from being the Country Representative of one of the few international donor and technical assistance organizations based in Dhaka at the time, and interested in furthering his career by promoting a new and highly promising technology. The Pathfinder Fund won the power struggle, and in the short term it found it was better able to achieve its MR training and service delivery goals. In the longer term, however, by reducing the Population Control and Family Planning Division's ownership of the process, the Pathfinder Fund may have jeopardized the sustainability of the program, especially after the Pathfinder Fund withdrew its financial support for MR as described in chapter 5.

4.3.3 Sanctioning Family Welfare Visitors to Perform MR

Like most developing countries, Bangladesh had inadequate numbers of qualified physicians to deliver health care services to its predominantly rural population. Therefore, as in pre-independent Bangladesh as mentioned above, the family planning program relied on the use of Family Welfare Visitors. Family Welfare Visitors were women with less than high school education and whose medical training consisted of 12 months of classroom instruction in family planning, and 6 months of loosely supervised practical training at a government clinic. Several interviewees suggested that *paramedic* is perhaps a generous term to apply to Family Welfare Visitors; they may more accurately be described as lay health workers.

There was little data or international precedent to indicate that non-physicians could safely and effectively perform MR procedures. Nonetheless, convinced of the practical need to do so, the Pathfinder Fund's Country Representative worked "long and hard to encourage (in fact he required) the training of Family Welfare Visitors at the medical schools" (Gamble, 1982:4). Not surprisingly, the Pathfinder Fund encountered resistance to the idea of training Family Welfare Visitors from the doctors and professors of obstetrics and gynaecology who oversaw MR training within the medical college hospitals. Their objections were based on the grounds that Family Welfare Visitors did not have sufficient medical skills to perform MR safely and effectively. At the same time, many physicians were aware that some desperate women would seek MR services from male physicians, and would be willing to pay a high price for such services. Some physicians held on to their reservations, but saw the use of paramedics as the lesser of two evils. Although the services would not be ideal, the types of complications that one would expect to see from a paramedic-induced abortion would more than likely be less serious than the complications of

unsafe abortion techniques widely practised outside the medical establishment. In addition, many physicians interviewed suggested that some physicians in Bangladesh were reluctant to perform MR procedures on religious grounds, or because they felt MR was medically unsophisticated. This reluctance may also have contributed to the agreement by the medical community to allow female paramedics to provide MR services. In any event, after several meetings between the Pathfinder Fund, Ministry of Health and Population Control officials, and physicians from the medical colleges, it was finally agreed that paramedics would be allowed to provide MR services. Further, the Ministry of Education sanctioned the issuance of official certificates to physicians and Family Welfare Visitors who successfully completed the MR training course, thereby providing an endorsement of the training program and an acknowledgement of the graduates as official, competent MR providers.

Many people attributed the ultimate acceptance of the use of female paramedics to the pioneering work of the Gonoshyashta Kendra (People's Health Centre), an NGO that pioneered the use of paramedics to provide mini-laparotomy and menstrual regulation in the late 1970s (Chowdhury, 1998). In 1977, the minister of health challenged Gonoshyashta Kendra's use of female paramedics to perform mini-laparotomy in Bangladesh and threatened to take it to court, a threat that Gonoshyashta Kendra welcomed in the belief that such a sensation could only further its cause. The case stayed out of the courts, but caught the attention of President Zia and the United States Agency for International Development, both of whom became convinced that using paramedics would be critical to the success of the family planning program, especially the sterilization program. The founder and director of Gonoshyashta Kendra recalled one USAID official saying to him that eventually paramedics should be able to perform sterilizations "as fast as a sausage cutting machine" (Chowdhury, 1998). While Gonoshyashta Kendra did not agree with compromising quality to achieve quantity, the United States Agency for International Development's support lent credibility to the concept of using paramedics to provide menstrual regulation procedures.

Having convinced the doctor/professors to allow the training of paramedics at all, the Country Representative of the Pathfinder Fund had two more ambitious goals. First, that the Family Welfare Visitors be trained alongside doctors in the same classrooms and operating rooms, and second, that there be a close relationship in the field between Family Welfare Visitors and doctors whereby doctors acted as back-up

or referrals for clients of Family Welfare Visitors in case of complications. He succeeded in having Family Welfare Visitors trained with physicians for a short time, but eventually the two cadres were trained separately. Similarly, for a variety of reasons explored in the next chapter, the potential relationship between doctors and Family Welfare Visitors in the field was never fully realized.

Clearly, the Pathfinder Fund played an important role in introducing MR into Bangladesh, and in fact many of the people interviewed for this research credit the Pathfinder Fund for doing so single-handedly. This view would appear to be overly generous, however. The Population Control and Family Planning Division also played an important role, especially in the beginning. The Pathfinder Fund's first expression of interest in 1972 might have been ignored had the first director of the National Post-Partum Clinic not been strongly committed to promoting safe and legal abortion. His presentation at the 1972 the Pathfinder Fund-sponsored conference on Family Planning as described in the previous chapter distinguished him as a strong proponent of abortion. Similarly, the Pathfinder Fund's first grant might never have been revived after being left unspent by the first director had his successor not had a similar interest in abortion research and services. Importantly, both directors were competent medical specialists, rather than generalists within the Ministry of Health and Population Control. They understood the demographic and health implications of introducing abortion, and the second director was skill full in advancing the issue within the Ministry of Health and Population Control. Consequently, and not surprisingly, both were eventually recruited by the United Nations for international positions outside of Bangladesh.

The combination of an aggressive donor with like-minded, technically competent and politically savvy champions in positions of power and influence within the Ministry of Health and Population Control proved to be successful in introducing the technology and in establishing a training program that could produce sufficient numbers of adequately trained providers to enable the Population Control and Family Planning Division realistically to propose its MR policy. The successful formulation of the MR policy, however, involved more than mere practical or logistical considerations. Policy makers also had to consider that abortion was still illegal in the country, and it had to consider whether public opinion, specifically including religious attitudes towards abortion, would support or oppose the policy. These important considerations are examined in the following sections of this chapter.

4.4 Government Attempts to Legalize Abortion

4.4.1 Penal Code Provisions

The Pathfinder Fund and the Population Control and Family Planning Division of the Ministry of Health and Population Control believed that they had the tacit agreement of President Zia to carry out MR activities. This agreement was indicated by "no more than a nod of his head" when the chief executive officer told the president of the initiatives in MR by the Population Control and Family Planning Division (Gamble, 1998). The Pathfinder Fund's local country representative interpreted this as meaning that while these initiatives had his assent, the president would not support them openly. In the same meeting, the president said that population control was one of his top three priorities, the others being improved nutrition and the eradication of illiteracy, and he expressed "disappointment, perhaps even disapproval, of the slow progress and effectiveness to date of his nation's family planning program" (Gamble, 1980:2).

The first MR training and service sites that were established by the Pathfinder Fund and the Population Control and Family Planning Division of the Ministry of Health and Population Control nonetheless operated in defiance of a restrictive abortion law that existed at the time and that is still in effect today (Rosenberg, et al., 1981). In Bangladesh, abortion is regulated under chapter xvii of the Penal Code of 1860 related to Offences Affecting the Human Body. Section 312 dealing with the causing of miscarriage, has made abortion a crime and provides penalties for it as follows:

> Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine. (Ministry of Law and Parliamentary, 1977)

Cook purports that in many Commonwealth countries where the abortion legislation has not been tested in case law, it is accepted that the 1939 English jury

direction in *R. v. Bourne*[25] is applicable (1992). The *Bourne* principle maintains that even where legislation prohibits abortion, "the procedure is nevertheless lawful when undertaken in good faith to save a woman's life or to save her physical or mental health" (Cook, 1992:75). In *R. v. Bourne* itself, the judge "recognized the legal justification of abortion when performed to save not only life itself, but the condition of continuing life, namely health" (Cook, 1992:75). On this basis, the judge acquitted a doctor who had performed an abortion to save the patient from becoming "a mental wreck" (Cook, 1992:75). In order to clarify whether the *Bourne* principle applied, according to Cook, the Legal Division of the Commonwealth Secretariat sent a questionnaire to the Attorneys-General of the Commonwealth. Over 48 Commonwealth countries including Bangladesh indicated that they applied the *Bourne* principle. The principle has yet to be tried or tested in case law, however, and only two of 80 persons interviewed were aware that the Bangladesh Government had agreed to apply it.

4.4.2 Early Legalization Attempts

Under the social and legislative measures required to support population planning in Bangladesh, the First Five-Year Plan (1973-1978) included a proposition to legalize abortion, and according to interviews conducted for this research, the Population Control and Family Planning Division made several attempts to liberalize the abortion law during the 1970s. "Legalization of abortion," reads the First Five-Year Plan (1973-1978) "has been known as probably the best and most effective method for control of population growth. It should be seriously considered how this method can be adopted to control population growth in Bangladesh" (Planning Commission, 1973:75).

In "the mid-1970s" according to one report, the Population Control and Family Planning Division initiated a "discussion focused on a plea for a presidential ordinance that would legalize abortion" (Amin, 1996:8). A presidential ordinance was the "preferred option" according to Amin; advocates specifically did not want to propose a bill that would be debated in Parliament. The plea for a presidential ordinance was rejected during "discussions at high levels of government" which concluded that "there was no point in attracting attention to the legal code since there have been no known prosecutions under this code" (Amin, 1996:8).

[25] *R. v. Bourne* [1939] 1 K.B. 687 (Central Criminal Court, London).

In 1976, before or after the above attempt, the Secretary of the Population Division of the Ministry of Health and Population Control proposed alternative legislation on abortion for inclusion in the government's first National Population Policy that was issued later in that year. The proposed wording was drafted by the director of the Model Clinic, and as he recalled, it was reviewed by the Ministry of Law and approved by the National Population Council, which was headed by the president (Khan, 2001). According to the head of Gonoshyashta Kendra, the NGO involved in health services and advocacy, however, the president was reluctant to draw attention to the law, and this was apparently the main reason the legislation was not amended.

The 1976 Population Policy included a statement in favour of abortion as follows:

> It would not be an offence if a qualified doctor does the medical termination of pregnancy (MTP) within 12 weeks of conception provided the woman had obtained necessary permission of doing MTP voluntarily for health, social or economic reasons either from her husband or, in his absence, from her legal guardian. (Piet-Pelon, 1998:3)

The legal weight of the above policy statement is questionable. With the exception of the Population Council's report, no other document concerning the MR program mentioned this statement, and only two of the persons interviewed referred to the 1976 Population Policy at all. Even after the 1976 Population Policy appeared, the Population Control and Family Planning Division made subsequent attempts to legalize abortion as described below, suggesting that the above statement was not perceived as a sufficient legal basis for the MR policy.

4.4.3 *BILIA Study and Recommendations*

In 1977, the Population Control and Family Planning Division commissioned the Bangladesh Institute of Law and International Affairs (BILIA) to review the laws and regulations in the country that had either direct or indirect bearings on population growth, and to recommend "new legislation wherever necessary to bring national laws in various fields to a level to support the Government's declared policy relating to population planning" (Ali, et al., 1978:i). With regard to abortion, which was considered the first of eight priority areas for the study, BILIA recommended that

appropriate sections of the penal code be amended or new legislation be drafted to permit abortion within the first 12 weeks of pregnancy by a licensed physician or by a trained paramedic under safe medical conditions, when in the best judgement of the physician or paramedic the abortion could be justified on one of the following grounds: humanitarian, medical, eugenic, socio-economic, or contraceptive failure. BILIA recommended that abortion after 12 weeks of pregnancy be allowed after medical consultation with two doctors on all the above grounds, except contraceptive failure. In all cases, BILIA recommended that abortion require spousal consent in the case of married women, and spousal or guardian consent in the case of women "incapable of giving consent due to age or insanity" (Ali, et al., 1978:58).

The Population Control and Family Planning Division chose not to act on the recommendations arising from the study that it had commissioned. It neither introduced new legislation nor amended the existing legislation to permit abortions. Allegedly, President Zia feared that such abortion legislation might arouse religious opposition and result in regressive action, including banning MR. According to the Founding director of the Model Clinic (who later became the Chief of the Population Section of the Planning Commission), "the Planning Commission reviewed five legal proposals and decided to process three of them: abortion, law of inheritance and a third one that I cannot recall. The proposals were submitted to the Cabinet of Ministers, where the law of inheritance was rejected on grounds of possible religious repercussion and the abortion issue was referred to a cabinet sub-committee. The cabinet sub-committee meeting...determined that, since MR was already available, it was unnecessary to take any further legal measure. As far as I recall, in the meeting, the proposal was supported by the then health minister and planning minister, but was opposed by the minister of Women's Affairs. Someone observed "let the sleeping dogs lay" (Khan, 2001).

As a result of this direction from Cabinet, the Population Control and Family Planning Division simply introduced MR into the national family planning program without any further attempt to legalize abortion. A circular issued in May 1979 "announced that by 1982 all headquarters of the country should be equipped with facilities to provide all types of family planning methods such as MR, sterilization, the IUD, and other contraceptive methods" (Akhter, 1988:209). Seven months later, the Population Control and Family Planning Division issued a memo to all deputy directors of Family Planning with a legal interpretation of the Bangladesh Institute of

Law and International Affairs to "dispel the prevailing doubts about the legality of the procedure" which read as follows:

> Many Family Planning Clinics are carrying out the post-conceptive method of "Menstrual Regulation" as a means of birth control which does not come under Section 312 of the Penal Code. Under statutery [*sic*] scheme, pregnancy is an essential element of the crime of abortion, but the use of menstrual regulations makes it virtually impossible for the prosecutor to meet the required proof. In our country menstrual regulation (M.R.) is being carried out till the tenth week following a missed menstrual period, and after that patients are referred as abortion cases. M.R. is now recognised as an interim method of establishing non-pregnancy for the women [*sic*] who is at risk of being pregnant. Whether or not she is, in fact, pregnant is no longer an issue. (Population Control and Family Planning Division, 1979:1-3)

The legal logic of this paragraph deserves a brief explanation. The Bangladesh Penal Code is derived from the Indian Penal Code of 1860, and the Indian Penal Code, in turn, is based on British common law traditions. There are two Commonwealth legal traditions—Scottish and English—and they differ regarding the issue of abortion. Under the Scottish tradition, the prosecuting side must prove both criminal intent and that the accused committed a criminal act, whereas under the English tradition, the prosecuting side need prove a criminal intention only (Bhiwandiwala, et al., 1982). With respect to abortion, a prosecuting authority may, for example, be able to prove an abortion was induced for a reason other than to preserve the woman's life, which would be a criminal intent. This would be sufficient for prosecution under the English tradition which considers an abortion offence to have been committed "whether a woman be or not be with child." However, the Scottish tradition applies widely in Asian Commonwealth jurisdictions, specifically including Bangladesh (Bhiwandiwala, et al., 1982). In Bangladesh, therefore, it is necessary for the prosecution to meet an additional burden of proof with respect to a criminal act or, in other words, to prove that the woman was in fact pregnant at the time of an abortion that was induced for a reason other than to preserve the woman's life. The BILIA report noted that because menstrual regulation "makes it virtually impossible for the prosecutor to meet the required proof" that the "crime of abortion" had occurred, menstrual regulation does not come under the Penal Code (Ali, et al., 1978:31).

While the legal logic of the quoted paragraph is sound, the medical information contained in it is not. The use of MR as defined in the international literature would indeed have made it virtually impossible for the prosecutor to meet the required proof with the pregnancy tests available at the time. The international literature, however, defined MR as "the induction of uterine bleeding that has been delayed up to 14 days beyond its expected onset, or up to 42 days from the beginning of the last menstrual period" (Watson, 1977:250). As noted in the paragraph quoted above, MR procedures—which in this case could have more accurately been referred to as abortions carried out using manual vacuum aspiration techniques—were being carried out in Bangladesh up to the tenth week following a missed menstrual period. It would therefore appear that in many cases in Bangladesh, a prosecutor could indeed have readily met the required proof.

It is clear that BILIA did not intend the above paragraph to be used as a legal interpretation. It is buried in the findings section of a 32-page chapter on abortion where the conclusions and recommendations are clearly labelled and described. The BILIA report urged the government to liberalize the abortion law; it never recommended undertaking abortion under the guise of MR based on the evidentiary difficulties prosecutors may face in bringing criminal charges. In a review of menstrual therapies in Commonwealth Asian law, Bhiwandiwala et. al. suggested that to do so would be "bad law and worse ethics" (1982:276). It seems likely that the BILIA lawyers would have concurred with this judgement. Nonetheless, the government chose to use the above-quoted paragraph to justify its contention that there was no need to legalize abortion to provide MR.

4.5 Abandoning Legal Abortion as an Agenda Item

The previous chapter noted that in the First Five-Year Plan the Planning Commission urged that the legalization of abortion be "seriously considered" in order to allow abortion to play a "central role" in the government's family planning programme. However, no legalization attempt was ever successfully mounted. Instead, the Government of Bangladesh adopted a policy to provide something that it maintained was specifically not abortion. This section pursues additional factors that decision makers may have evaluated before ultimately choosing to "let the sleeping dogs lay" rather than to pursue the original agenda item.

4.5.1 International Sentiments

It was said that laws lag behind but nonetheless reflect the values of the society in which those laws are set (Ali, et al., 1978). The British Penal Code of 1860, however, which is the statute adopted by Bangladesh, is a 19th century law that was adopted in Europe to curb the provision of unsafe abortion practises by untrained and even trained abortion providers, and that was transferred to other countries during the colonial period (Lee and Paxman, 1977, Population Crisis Committee, 1979). By the second half of the twentieth century, the introduction of modern medical procedures changed abortion from a clandestine practise into an accepted medical one (Tietze and Lewitt, 1977), and with this change in the fundamental rationale for the law, public health professionals in Europe and in the United States began to advocate the legalization of abortion (Population Crisis Committee, 1979). The abortion law in Britain was amended in 1967 to allow abortion in cases where continuation of a pregnancy involved a risk to the mother's life or health and in cases of suspected foetal abnormality. By that time, however, Pakistan (including the country that is now Bangladesh) and several other former British colonies were independent of Britain, and so the inherited section 312 of the 1860 British Penal Code outlawing abortion remained in effect in those countries.

India legalised abortion in 1971, allegedly to protect women's health but, according to one Indian author, primarily to address population control concerns (Phadke, n.d.). Hong Kong reformed its abortion law in 1972 because it felt that the old statute did not reflect indigenous Chinese values. However, except for Hong Kong (Ordinances of 30 March 1972), Singapore (The Abortion Act, Law No. 25 of 1969), India (Medical Termination of Pregnancy Bill, 1971) and Zambia (Termination of Pregnancy Act of 1972), the movement to reform abortion laws in Europe and in the United States did not influence the statutes of former British colonies (Paxman and Barberis, 1980). Most former colonies maintained the old laws. This was likely due more to inertia than because the laws reflected indigenous values. Certainly the original, medical, rationale behind the law as mentioned above had lost its validity in Bangladesh.

4.5.2 Medical Considerations

A few physicians in Bangladesh advanced similar arguments that had been put forward by health professionals in Europe and in the United States to liberalize the abortion laws in those countries, namely to protect women's health. Although

there was little research on the incidence and consequences of illegal abortion with which to support their arguments, a few public health specialists in Bangladesh felt that the law "has so far served to shield the private practise of medical doctors and quacks, rather than the cause of humanity or women for that matter" and argued that "we can give an abortion under absolutely safe conditions but the law of the country makes it illegal" (Hassan, 1976: N. pag.). According to medical sources "hundreds of unrecorded, unspecified and unmourned for women are dying because of an obsolete law" (Hassan, 1976: N. pag.). Interviewees suggested that these attitudes were shared by a majority of those who were making and influencing policy in Bangladesh in the 1970s. However, with the exception of a small survey of the attitude of male elites (university faculty members, government officials, research scholars, and owners of private firms) toward the introduction of abortion as a method of family planning conducted by the Bangladesh Institute of Development Studies in which slightly over half responded favourably (Chowdhury, 1975), there was no research to determine the public's reaction to the Ministry of Health and Population Control's proposal to legalize abortion (Hassan, 1976).

There was some research to document the medical problems with maintaining the existing abortion law. The director of the Government's National Post-Partum Program reported in 1972 that 20.1 percent of admissions to the obstetrics and gynaecology wards in two Dhaka hospitals were for incomplete abortions, the majority of which had been induced (Burhanuddin, 1972). Based on the findings of a study of reproduction in 2 rural villages, Chen et al. reported that approximately 2 percent of all pregnancies ended in induced abortion (1974). In 1975, another official of the Ministry of Health and Population Control estimated that 15-20 percent of pregnancies ended in induced abortion (Chowdhury and Chowdhury, 1975). The mass media, especially daily and weekly newspapers, published several articles on abortion in the late 1970s which highlighted the plight of women suffering from illegal abortion based mainly on anecdotal reports from physicians.[26] Research, however, together with developments outside the country and attitudes shared by the most influential members of Bangladeshi society, proved to be insufficient to outweigh the fear of evoking religious opposition.

[26] See (Akhter, 1988, Chowdhury and Chowdhury, 1975, 1976, Hassan, 1976).

4.5.3 Religious Attitudes

Religious leaders in Bangladesh voiced opposition to the family planning program on the grounds that it would promote promiscuity and undermine women's roles as mothers, and they had voiced opposition to sterilization in particular on the grounds that Islam forbids it (Amin and Hossain, 1995). On abortion, however, they were silent (Amin, 1996). One wonders, then, where this widely attributed speculation as to opposition from religious groups originated. Persons interviewed for this research confirmed that the Ministry of Health and Population Control had never raised the issue of abortion in its dialogues with religious leaders in forums such as that provided by the Islamic Foundation in Bangladesh, for example.

In 1971, the issue of abortion in the Muslim world was raised in Rabat at the first international conference on Islam and Family Planning. The conference was organized by the Middle East and North Africa Region of the International Planned Parenthood Federation, and the proceedings were published in two volumes (The International Planned Parenthood Federation, 1992). In 1977 the Ministry of Health and Population Control reprinted selected parts of the conference proceedings in a booklet aimed at sharing consensus of an Islamic point of view on family planning in Bangladesh (Information Education and Motivation Unit, 1977). By and large, the *fatwas* (religious opinions on points of law) reprinted in the booklet reflected the most permissive Islamic attitude towards family planning and abortion (Information Education and Motivation Unit, 1977). According to my interviewees, the reprinted *fatwas* resonated with attitudes in Bangladesh at the time, and did not generate significant debate or controversy.

As academic writings attest, there is no simple Islamic position on abortion (Musallam, 1983). Because the Koran does not mention contraception or abortion, and because there is nothing like the Christian concept of "the Church" in Islam, the Islamic attitude toward abortion consists only of the opinions of Muslim jurists, who belong to different schools of jurisprudence as explained below. This "variety of legal regulations blurred the exact religious attitude towards abortion" (Musallam, 1983:58).

The basis of Islamic legal theory is the example of the Prophet, called *sunna*, as incorporated in recognized reports of his words and actions, referred to as *hadith*. The *hadith* embody the earliest legal reasoning of different schools of legal

interpretation, and are often used by individual jurists to provide evidence for their independent judgements. The four main schools of jurisprudence include the Shafi`i, Hanafi, Maliki and Hanabali schools. Based on Koranic references, all four schools believe that the foetus becomes a human after the fourth month of pregnancy (120 days). In light of the attention they have received historically in Koranic exegesis and Islamic jurisprudence, Musallam suggests that the two most important passages are *Sura* xxii, 4 and *Sura* xxiii, 12-14. The first passage is from the chapter of the Pilgrimage[27]:

> O mankind! If you are in doubt as to the Resurrection,
> [consider] that we have created you of earth;
> then of semen;
> then of a blood-like clot;
> [which is] formed or not formed;
> so that we may demonstrate to you [our power];
> and we establish in the wombs what we will,
> till a stated term;
> then we bring you out as infants. (Musallam, 1983:52)

The second passage is from the chapter of the Believers:

> We created man of a quintessence of clay.
> Then we placed him as semen in a firm receptacle.
> Then we formed the semen into a blood-like clot;
> then we formed the clot into a lump of flesh;
> then we formed out of that lump bones
> and clothed the bones with flesh;
> then we made him another creation.
> So blessed be God the best Creator. (Musallam, 1983:52-53)

The passages describe the first three stages of the development of the foetus—semen, blood-like clot, and lump of flesh—each of which, according not to Koranic reference but to a *hadith*, are thought to last 40 days. It is only after the end of 120 days that the foetus is given a human soul. Before that the foetus has "only the life of plants and animals" (Musallam, 1983:54).

The majority of jurists prohibit abortion after the fourth month (120 days). The Hanafi jurists permitted abortion until the end of the fourth month but suggested that a woman not do so without reason. Most of the Maliki jurists prohibited abortion

[27] The brackets were contained in source, apparently added to original by Musallam.

absolutely, although a small minority permitted it until 40 days. While they agreed with the other jurists that a foetus is not an ensouled until the end of 120 days, the majority of Maliki jurists held that the semen, once settled in the womb, is destined for ensoulement, and should not be interrupted. Many Shafi`i and Hanbali jurists agreed with the Hanafis in their toleration of abortion, some putting an upper limit of forty days for a legal abortion, others eighty days or 120 days (Musallam, 1983). Musallam concludes that "given the fact that prohibition was not the dominant view by any standard, given the fact that Muslims believed in ensoulment as the crucial event before which the foetus was not a person, and given the fact that the sanction of contraception strengthened the view that abortion should be legalized before ensoulment, perhaps we can say that, on the whole, abortion was religiously tolerated" (1983:59).

The majority of people whom I interviewed judged that most people in Bangladesh, who generally follow the Hanafi school of legal interpretation believe that abortion until the foetus takes on human shape, marked by "quickening" or 120 days, is not against Islam (Macklin, 1995). Similarly, the BILIA report, discussed in the previous section, concluded that because Islam permits abortion until 120 days after conception "there is scope for modification of abortion law without hurting the religious sentiment" (Ali, et al., 1978:55).

4.5.4 *Political Considerations*

It appears, therefore, that public opinion in Bangladesh in the mid 1970s, specifically including religious attitudes, was in fact not opposed to abortion. Why then did the government hesitate to change the law? One possibility suggested was that the Zia administration may have become skittish about introducing measures such as abortion to curb population growth due to the situation in neighbouring India, where forced sterilization during emergency rule became one of the pivotal issues in the 1977 national election that led to the defeat of the Indira Gandhi government and to a reversal of population policies. President Zia was trying to establish the legitimacy of his regime, after coming to power in a military coup in 1977, and could not afford to alienate any potential sources of political support, including religious groups, by raising a controversial issue such as abortion.

A fundamental reason why public opinion was not opposed to abortion in the mid 1970s, in other words, was precisely because the issue had not been raised.

Policy makers may have been reminded by the Indian experience that opposition could readily be aroused if a controversial situation were not handled properly. Similarly, policy makers may have been concerned that public opinion could be mobilized by appealing to emotional religious sentiments that could not effectively be countered through an "objective" review of the most liberal religious interpretations. By not raising the issue, the government could avoid that controversy. Indeed, by maintaining that MR was not abortion, it may have hoped to pre-empt the debate.

4.5.5 Practical Considerations

At the same time, the Population Control and Family Planning Division probably realized it would be possible to achieve its population control objectives without any revisions to the existing legislation. As in 1972 when abortions were provided to women raped during the war, the government found it could ignore the abortion laws in Bangladesh, this time by quietly proceeding with the introduction of a countrywide program of abortion. There was no apparent need to risk public debate on controversial legislation to achieve those ends and, in fact, such public debate could conceivably threaten the entire program. The president made the logical choice of minimizing his regime's political risks by not introducing new legislation on abortion in the mid to late 1970's, without sacrificing or placing at risk any of its political objectives.

4.5.6 Results and Ramifications

Avoiding debate, semantics, ambiguities, and inaccurate definitions may have been convenient ways to sidestep the legal issues and to quietly introduce the MR policy in 1979. However, the failure to lay solid foundations for the MR policy would make it more difficult to implement and sustain the policy in future. This is unfortunate because in retrospect, it appears that conditions in Bangladesh would never be more favourable than at the time of the BILIA report for introducing new legislation on abortion. There was a strong recommendation to do so by the most prestigious legal organization in the country, based on extensive and well-documented research. There was strong governmental and public support for population control, which was a sentiment shared by international donors. Abortion reforms were being made around the world, including in neighbouring India and in some Muslim countries like Tunisia. The policy-making process was still relatively closed, with potential opposition groups being less well mobilized and having smaller

voices in the policy arena. The country was still very new, having been born on a wave of nationalism that could have been used to amend the law to better reflect indigenous values. All in all, although it is impossible to say whether a concerted legalization attempt would have been successful in the late 1970s, the Ministry of Health and Population Control may have missed its best opportunity for establishing a proper legal basis for its MR policy.

4.6 Announcing the MR Policy

Menstrual regulation was introduced to the national family planning program in Bangladesh over a period of several years, beginning with the establishment of the Model Clinic in 1974. However, the May 1979 circular and the December 1979 memorandum discussed above appear to represent the earliest official documentation that referred to MR as a government policy. It was not possible to locate a copy of the May 1979 circular to substantiate reports that it stated that MR was included in the national family planning program, and that MR was to be provided by doctors and paramedics in all government hospitals, and health and family planning complexes (Akhter, 1986). The December 1979 memorandum, however, clearly describes MR as an official government policy, as discussed below.

The circular and the memorandum were reportedly drafted by the founding director of the Model Clinic and issued by the director general of the Population Control and Family Planning Division to all deputy directors of Family Planning, with copies to all directors in the Division, various permanent secretaries in the Ministry of Health, Population Control and Family Planning, civil surgeons, superintendents of the medical college hospitals, professors of Obstetrics and Gynaecology at all the medical colleges, and others. The memorandum opened with an observation that there was "some amount of confusion" within Bangladesh "regarding the status of official policy regarding Menstrual Regulation (MR)" "It is therefore, categorically stated," the memo continued, "that MR is one of the methods of the official F: programme. It is included in the official policy, necessary budget provisions have been made for the methods and required equipments (MR syringes) are procured through the support of International agencies. Population Control and Family Planning Division also arranged training of medical and para-medical personnel through different projects supported by pathfinder fund" [*sic*] (Population

Control and Family Planning Division, 1979:1). The memo then went on to refer to the "legal interpretation" of the Institute of Law discussed in the preceding section.

The First Five-Year Plan (1973-1978) that was drafted in 1972 called for abortions to be provided as part of the family planning program. The 1979 memo indicated that MR was part of the family planning program, and quoted a reference that made a distinction between abortion and menstrual regulation. Some time in between, menstrual regulation clearly became official government policy. When that happened, it appears to have been done without a great deal of fanfare or documentation. In fact, it appears that the policy was never formally announced, and that it was simply stated after some time in order to recognise a practise that had begun with a few procedures in the Model Clinic, and that had been gradually scaled up to include all health facilities in the country. By December 1979, in any event, the menstrual regulation policy had been clearly articulated and formally adopted by the Ministry of Health and Population Control, as evidenced by the 1979 memo.

It is interesting to note, as pointed out by a former secretary of health, that the 1979 memo was never signed. No persons interviewed for this research offered an explanation as to why the director general did not actually sign the memorandum over his signature block. It could be that a signature by a Ministry of Health and Population Control official would be seen as unnecessary, since the memo purports to present a legal interpretation of the Institute of Law. BILIA at one time included virtually all the legal luminaries in Bangladesh. A formal legal interpretation by such an august institution would likely be seen as compelling by a deputy director of family planning within the Ministry of Health, who would then be relieved of "prevailing doubts about the legality" of MR, and thus be able to proceed with a clear conscience in administering the government's MR program.

4.7 Chapter Summary and Analysis

4.7.1 Chapter Summary

The item placed on the policy agenda in the first Five-Year Plan was legal abortion, but an early plea for a presidential ordinance to legalize abortion was dismissed because there was "no point" to such an executive order. Similarly, alternative draft legislation on abortion that was proposed in 1976 for inclusion in the government's National Population Policy did not result in any modification to the

law, in spite of strong advocates with access to the president. The government subsequently commissioned the Bangladesh Institute of Law and International Affairs to conduct an in-depth study of all laws with direct or indirect bearings on population growth, and to recommend new legislation wherever necessary to bring national laws in accordance with the government's declared population policies. The government's declared population policies specifically included abortion, which was considered the first of eight priority areas for the study. The strong recommendation for the legalization of abortion contained in the resultant 32-page chapter on abortion, however, was not seriously pursued because a cabinet subcommittee judged it "unnecessary". In all of these legalization attempts, technocrats and mid-level decision makers aggressively pursued the legalization option, but senior level decision makers chose not to act. In large part, this was because decision makers perceived it was "unnecessary" to legalize abortion in order to achieve the underlying goal of population growth. Menstrual regulation was available in the country, and there appeared to be legal arguments that could be used to distinguish that procedure from abortion, which was regulated by the Penal Code. There was therefore no benefit to be achieved by legalizing abortion. In addition, senior levels of government may have been concerned about the possible negative political ramifications of calling attention to the issue of abortion. In spite of the arguments in favour of abortion that could be found in the most liberal religious scripts, and in spite of the medical and other technical arguments that could be presented in a legalization debate, the issue was clearly perceived as a controversial one that could have had a detrimental impact on the political support enjoyed by the government. There was "no point" to weakening that support; rather it was better to "let the sleeping dogs lay."

The government was able to abandon its original agenda item of legalized abortion because MR became widely available in the country. The chapter examined how MR technology was disseminated internationally, and introduced to the national family planning program in Bangladesh. It examined the role of the Pathfinder Fund, in particular, in establishing and running the Model Clinic, in conducting large-scale MR training for medical officers, and in obtaining acceptance for the sanctioning of Family Welfare Visitors to perform MRs. It also examined the critical role played by the first directors of the Model Clinic, who were both strong proponents of abortion, in using their autonomy within the bureaucracy to run the clinic, building up compelling data to demonstrate that MR could be safely and effectively delivered in

Bangladesh. MR services were continually scaled up from a modest beginning in 1974 when the Model Clinic was established, to 1979 by which time MR training courses had been officially endorsed to provide training to government physicians and Family Welfare Visitors, with goals of establishing two trained MR providers in each of the country's 413 sub-districts. Importantly, throughout this period of scaling-up, the MR program did not attract any controversy, indicating a "tacit acceptance" of the procedure. In 1979, when the government declared that MR was one of the methods of the official family planning programme, it was merely giving public sanction to a policy that by that time had already been established in practise.

The MR policy ultimately adopted by the Government of Bangladesh included abortion procedures carried out using manual vacuum aspiration "till the tenth week following a missed menstrual period," whereas internationally, MR was defined as a procedure using manual vacuum aspiration within 14 days of a missed menstrual period. The director general of the Population Control and Family Planning Division of the Ministry of Health issued but did not sign a memorandum to "dispel the prevailing doubts about the legality" of menstrual regulation, citing a reference that indicated MR was not abortion. The policy ultimately adopted, in other words, contained inaccurate definitions and was deliberately ambiguous about the nature of the intervention. Decision makers apparently perceived this was desirable for the same reasons that they perceived it desirable to avoid the legalization debate.

4.7.2 *Analysis*

In this section, we assess the extent to which "the story" of the formulation of the MR policy as documented above can be explained by the Grindle and Thomas framework. That framework first requires a distinction to be made as to whether the agenda-setting circumstances were those of crisis or of politics-as-usual.

According to Grindle and Thomas, a crisis arises from two interrelated factors: (1) events and actors outside of government, such as pressure from international agencies, and (2) information made available to policy elites by their own staffs of technical experts or by the technocrats of international agencies pressing for changes. In chapter 3 we saw that events as well as actors outside government consistently and strongly attempted to influence the perception of decision makers that overpopulation was an urgent problem that could best be addressed through population growth interventions including abortion and that, if not addressed, would

lead to dire consequences. These efforts were supported by the proceedings of a 1972 international conference on family planning, when technocrats from the Ministry of Health and Population Control and others strongly advocated for abortion. The very fact that abortion featured so prominently in the first Five-Year Plan is evidence that policy makers may have felt compelled to act quickly and boldly with a major departure from pre-independence policies and from the laws of the land. All of this would suggest that decision makers perceived a crisis situation to exist with respect to the need for an abortion policy. On closer analysis of the way the issue was handled during the policy formulation phase, however, it appears that decision makers may have perceived the conditions to be more those of politics-as-usual rather than of crisis.

The timing of the reform indicates decision makers felt there was no urgent need to act. Seven years passed between the time that abortion was announced as a priority in the first Five-Year Plan and the time when the "central role" of abortion to the family planning programme was officially stated as a government policy. Decision makers had the time to commission and deliberate the results of a major study into whether to legalize abortion. There is no evidence to suggest decision makers felt pressured or forced by circumstances to adopt an abortion policy before they were ready to do so, as more likely would have been the case if they had perceived a crisis situation to exist.

Similarly, Grindle and Thomas contend that when a perception of crisis exists, decision makers are pushed in the direction of major reform initiatives, where innovation is more likely to result than incrementalism. Conversely, under noncrisis conditions, "change is often incremental, with considerable scope for trial and error or scaling up if initial efforts provide positive results" (Grindle and Thomas, 1991:88). The process followed to formulate the MR policy was very much characterised by incrementalism rather than innovation.

The definition of the underlying problem was also a chosen one, not one forced on policy makers through pressure from outside parties as Grindle and Thomas contend would be more likely in a crisis situation. Outside parties certainly were trying to press overpopulation as an urgent problem. However, those views coincided with those of technocrats within the government, who used the outside parties to

advance their own interests. They also importantly coincided with the embedded orientations of decision makers, as shown in the preceding chapter.

According to Grindle and Thomas, the status of decision makers is also affected by whether a crisis is perceived to exist or not, with conditions of crisis tending strongly to move the level of concern upward in the decision making hierarchy of government. In Bangladesh, high-level officials stymied efforts to promote legal abortion and gave tacit support for MR, but they were never actively involved in developing strategies or in making decisions about the scope or pace of change. The status of decision makers remained at lower hierarchical levels.

Finally, in perhaps the single-most critical feature of the process followed to formulate the MR policy, decision makers consistently manoeuvred to lower the political stakes. In a crisis situation, according to Grindle and Thomas, the stakes for policy elites involve macropolitical issues such as the survival of the regime, overall political stability, or the tenure of high-level politicians. By avoiding debate, publicity and clear language, the stakes in the case of the formulation of the MR policy were kept at a bureaucratic level, more characteristic of a non-crisis or politics-as-usual situation.

In conclusion it therefore appears that the abortion policy in Bangladesh emerged and was formulated under circumstances of politics-as-usual. Interestingly, this was also found to be the case in all 16 cases of population policy change reviewed by Grindle and Thomas, where advocates including foreign donors tried to convince decision makers that population growth constituted a crisis situation, but where detailed accounts of how the issue was handled belied that sense of urgency. In any event, because the menstrual regulation policy reform emerged and was formulated under conditions of politics-as-usual, and because the reform concerned policy rather than organisational change, hypothesis 2 advanced by Grindle and Thomas as quoted in chapter 1 and as repeated below was deemed relevant.

> Hypothesis 2:
>
> When noncrisis-ridden reforms concern policy issues, decisional outcomes tend to be dominated by micropolitical and bureaucratic concerns. Technical input and international pressure are important, but not decisive, in explaining policy choice under these conditions.

> Major issues of political survival and support building are usually not salient to decision makers. (Grindle and Thomas, 1991:106)

As discussed below, the hypothesis was found to hold true to some extent.

4.7.2.1 Bureaucratic Implications

The second hypothesis predicts that bureaucratic concerns will dominate the decision making process, and that all other concerns will be subordinate to the bureaucratic implications of the policy choice. The research found that bureaucratic concerns indeed appeared to be important to the formulation of the MR policy, but that they did not assume the overriding importance predicted by the hypothesis.

A major reason for the adoption of the MR policy was that by that time, it had been demonstrated that MR could be safely and effectively delivered on a countrywide basis, without attracting controversy or encountering resistance from any sector. Gearing up to deliver MR across the country was primarily a bureaucratic challenge. The second director of the Model Clinic, who himself was technically competent, politically savvy, and a strong proponent of abortion, was able to use the Pathfinder Fund to advance his own interests. The bureaucratic unit that he led was greatly enhanced by the policy and by the efforts of the Pathfinder Fund to upgrade the technical skills and status of Family Welfare Visitors. As a result, his career and national and international stature were enhanced. These were not, however, the primary driving forces that enabled the Population Control and Family Planning Division to effectively deliver MR on a countrywide basis. The efforts of the Pathfinder Fund appear to have been at least as important.

4.7.2.2 International Pressure

Pressure is too strong a word to use in describing the activities of the Pathfinder Fund to introduce MR into the government's national family planning program. However, its support and encouragement in terms of funding, training, and building support from physicians for the use of Family Welfare Visitors were all critical in enabling the government to ensure sufficient numbers of adequately trained providers would be on hand to allow the policy to be feasible. Support from international agencies was therefore found to be relatively more important to the formulation of the MR policy than was predicted by the hypothesis.

This finding is less surprising when one considers the state of the bureaucracy and of the policy environment in general in Bangladesh from 1971 to 1979, as described in the Background chapter to this thesis. The support and encouragement of international agencies could be expected to assume greater relative importance in such a context. Nonetheless, the finding is consistent with the findings of Grindle and Thomas themselves when they tested their original hypotheses against 14 cases of reform in the 1980s. In almost all of those cases, the salience of international actors was rated "very important" or "important," in some contrast to hypotheses 1 and 2.

4.7.2.3 Technical Advice

As predicted by the hypothesis, technical advice was important but not critically so in the formulation of the MR policy. The international development of a low cost, low technology early abortion technique was clearly necessary to the formulation of the MR policy. In addition, decision makers appear to have seized upon technical arguments that were advanced internationally and nationally suggesting that it would be impossible with then-current technologies to establish that a woman receiving MR was in fact pregnant at the time of the procedure. However, at other times, technical advice was ignored. When the Bangladesh Institute of Law and International Affairs was asked to provide recommendations with respect to abortion and other laws, those recommendations were not pursued or used except to quote an excerpt from them out of context for political purposes. In addition, decision makers used—or rather, deliberately misused—the internationally accepted term menstrual regulation to refer to the abortion services that it had integrated into its national family planning program.

4.7.2.4 Political Stability and Support

The hypothesis predicts that in non-crisis situations, major issues of political survival and support building will not be salient to decision makers when formulating policy. However, the original population policy placed on the policy agenda with the first Five-Year Plan was legal abortion, and the policy ultimately adopted was something that was held out to be specifically not abortion. The fear of losing political support appears to be the primary reason for the use of such ambiguity, and a primary reason for not attempting to legalize abortion. This decision criterion therefore appeared to take on much greater importance during the formulation of the

MR policy in Bangladesh than the "not salient" weight predicted by the second hypothesis.

In their review of 16 population policy case histories, Grindle and Thomas found that "a country's religious identities and cultural norms regularly limit policymakers' options" (1994:58). They also noted that in three of the cases reviewed, "the implicit threat of offending religious groups set boundaries on the speed of family planning policy change" (1994:59). These are precisely the constraints that were exerted in formulating the abortion policy in Bangladesh, and that are referred to in the preceding paragraph as concerns over political support building. Grindle and Thomas, however, included these concerns in their discussion of the context of policy choice. If religious identities and cultural norms are to be exclusively considered under the broad category of context and are therefore removed from any consideration of political support that could be gained or lost because of possible reactions to policy choices by religious groups, then the hypothesis would hold up much better in explaining how the MR policy was formulated in Bangladesh.

4.7.3 Revisiting Contextual Factors

In chapters 2 and 3, we saw that the broad contextual factors and the embedded orientations of policy elites, respectively, could explain how abortion made it onto the policy agenda in Bangladesh in the early 1970s. This is consistent with a fundamental assumption in the Grindle and Thomas model that specific policy choices "are shaped by policy elites who bring their own perceptions, commitments, and resources to bear on the content of reform initiatives, but who are also influenced by the actual or perceived power of social groups that have a stake in reform" (1994:56). The same contextual factors also explain much of the variability in the policy formulation phase.

Grindle and Thomas noted from their review of 16 population policy case histories that "the factors that appear most important in accounting for policy change are the ideological predispositions, the expertise and training, the positional resources, and personal attributes and goals of the decision makers" (1994:57). The key policy elites in the case of the Bangladesh MR policy were President Zia, and the two directors of the National Post-Partum Family Planning Program. Some people suggested that the president tacitly accepted the introduction of MR because he was a former Freedom Fighter and may have remembered with empathy the women raped

during the war, and because he placed population control among his top three priorities. His tacit support was essential to the formulation of the MR policy, just as support from the chief executives were essential to the introduction of new or revised population policies in the cases reviewed by Grindle and Thomas. The first two directors of the National Post-Partum Program were active proponents of abortion and competent specialist practitioners. With his Ph.D. from Johns Hopkins and strong interest in abortion research and services, the second director also proved skilful in advancing the issue within the Ministry of Health. Had the initial overtures of the Pathfinder Fund and other outsiders interested in initiating abortion services been met by generalist bureaucrats rather than by such a technically competent and ideologically predisposed individuals, it is unlikely that the MR policy could have been introduced in Bangladesh.

Thomas and Grindle observed that surprisingly little public discussion and debate accompanied new population control policies in many developing countries, and attributed this "absence of politics" to a closed and executive centred decision making process. Nonetheless, "decision makers were well aware of the constraints set by societal groups and interests. Indeed, they knew well the potential risks of introducing policies that offended religious and ethnic organizations or that conflicted with well-established cultural values. Such awareness often determined whether policy change should or could be introduced" (Thomas and Grindle, 1994:58). These characteristics were precisely mirrored in the case of the formulation of the Bangladesh MR policy. In Bangladesh in the mid to late 1970s, policy-making was a closed process limited to a small elite that could introduce new policies without widespread public discussion or debate, but that was at the same time well aware of cultural values and very conscious of potential opposition to MR and abortion from religious groups. This not only shaped the speed of the introduction of the policy, it shaped the policy itself, cloaking it in semantics, ambiguities and inaccurate definitions.

5.0 Implementing the MR Policy

5.1 Introduction

This chapter is concerned with the implementation phase of the MR policy, which spanned the period 1979-1997. During this time, at least 1.3 million and perhaps as many as 6 million MR procedures were performed in government clinics throughout Bangladesh. This is a significant, demonstrable, measure of success in terms of the population control policy objectives for which this policy appears to have originally been formulated, as discussed in chapters 3 and 4. It is evident from the literature during this period, however, that the MR policy was not implemented as well as it could have been. Several studies conducted by NGOs repeatedly highlighted a number of implementation deficiencies and, accordingly, the question formulated during the research design pertaining to this period was:

> Why has the Ministry of Health and Population Control been unable or unwilling to address known deficiencies in the implementation of the MR policy?

This chapter explores the factors that constrained or enabled the Ministry of Health and Family Welfare[1] in its implementation of the MR policy from 1979-1997. The chapter begins with a discussion and analysis of MR training and services provided during the period, and as a final background section, the research on MR and abortion conducted during this period is reviewed. The chapter then turns to a discussion of the research findings that suggested three primary reasons for the Ministry of Health's failure to better implement the MR policy. The chapter concludes with a summary of the key factors that contributed to the growth in the Ministry of Health's ambivalence towards its MR policy over the period of implementation, and an analysis of the extent to which the Grindle and Thomas model of policy choice in developing countries may be applied to explain the implementation of the MR policy in Bangladesh.

[1] During the 1980s, the Ministry of Health and Population Control was renamed the Ministry of Health and Family Welfare, and the Division of Population Control and Family Planning was re-named the Directorate of Family Planning.

5.2 Background

There is a "persistent myth or perhaps naïve assumption" in the policy literature, according to Turner and Hulme, "that politicians make policy and public servants implement it rationally" (1997:75). Much of the policy literature portrays policymaking as a linear process where implementation follows a decision "as if implementation was something utterly simple and automatic" (Lane, 1993:93). This theory has been refuted by others who suggest that in reality policy implementation is "not easy and straightforward and cannot be simply classified as a technical exercise involving calculated choices of appropriate techniques" (Turner and Hulme, 1997:75). Grindle and Thomas, for whom the politics of implementation is a special interest, assert "even after the decision to adopt a new policy is made, considerable evidence suggests that the real work of turning reform into reality is still ahead" (1990:1165). This section analyses the barriers to implementation identified by the persons interviewed, and attempts to explain the underlying reasons for the poor implementation of the MR policy.

Implementation of the MR policy firstly required that the training effort which began in 1978, a year before the policy was promulgated, be continued in order to ensure that sufficient numbers of adequately qualified providers would be available to provide the services. Secondly, and implicit in the training goal, was that trained MR providers had to perform MR services safely and effectively. Finally, MR services had to be monitored and evaluated, in order to provide the information necessary to take corrective action or to modify the policy as appropriate (Pathfinder Fund, 1983). In this background section to the implementation chapter, these three activities are examined in turn.

5.2.1 Training Providers

As discussed in chapter 4, the Pathfinder Fund established large-scale MR training programs in 1978, in 8 of the country's 13 medical colleges. By 1981, MR training was being provided in 12 medical colleges, and in 2 of the 64 district hospitals.[2] Within each of the MR training sites, the same model was employed

[2] In addition to the Menstrual Regulation Training and Services Program initiated by the Pathfinder Fund, MR training was provided by a second quasi-governmental organization, the Mohammadpur Fertility Services and Training Center (MFSTC), and an NGO, the Bangladesh Women's Health Coalition (BWHC). MFSTC was one of the original 8 MR training centers initiated by the Pathfinder Fund, but was not incorporated into MRTSP because it already had its own Governing Council. BWHC was initiated in 1980 as an affiliate of the International Women's Health Coalition

whereby the director of the hospital served as the project director for the training program, and the head of the Obstetrics and Gynaecology Department served as the project advisor. The project director and project advisor, in other words, were government employees who received a stipend from the project but who had broader duties and whose base salaries were paid by the government. In addition, each training site or project office directly employed 11 persons, including 2 medical doctors and 2 MR counsellors who provided the main training in MR and counselling, respectively. The training course itself consisted of lectures, observance of MR, and actual performance of MR for a period of two weeks for doctors, and three weeks for paramedics (Majumder, 1996).

The MR training program as described above and as established at the time of the formulation of the MR policy, was continued throughout the entire implementation period. While the MR training sites and program remained constant, however, the management of the training centres was assumed by very different actors over the period. The Pathfinder Fund continued to manage the training function until 1983, when the training program became a "Special Project" of the Ministry of Health.[3] In 1991, MR training became the responsibility of a national NGO. These changes in management of the MR training program and their ramifications for the implementation of the MR policy are discussed further below.

In 1978 the Pathfinder Fund began making grants directly to the Medical Colleges rather than through the Population Control and Family Planning Division, and at the same time took over supervision of the MR training program from the national coordinator under the Division. By assuming greater ownership and control over the MR training program, interviewees suggested that the Pathfinder Fund acted in a manner inconsistent with achieving any goal it may have had for the Directorate of Family Planning ultimately to institutionalise the MR training program.

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to provide MR services for the clients of USAID-funded family planning NGOs that were restricted from providing abortion services. BWHC also provides MR training to government health workers. This research focused on the largest of the three training organizations initiated by the Pathfinder Fund.

[3] A 'Special Project' of the Ministry of Health referred to a semi-autonomous project with an externally-financed project office and project staff that operated under a government steering committee. Until approximately 1989, the Ministry had four 'Special Projects', including MRTSP. In approximately 1989, the Ministry decided to eliminate its 'Special Projects' and all 4 eventually became fully autonomous, NGOs. Apparently, the Ministry proposed assuming MRTSP under its permanent direction, but the Planning Commission who felt that the proposed arrangement was too expensive and administratively complicated vetoed this.

Nonetheless, in 1983 the Pathfinder Fund was forced to withdraw its funding because of policy decisions of the United States Agency for International Development as discussed in detail below. This would have been an opportune time for the Directorate of Family Planning to institutionalise the MR training program, but it chose instead to run the program as a 'Special Project' of the Ministry of Health. According to some of the persons interviewed, this was a convenient way for the Ministry to maintain some distance from an initiative that ran the risk of evoking a negative public reaction. In any event, in 1983, the secretary of health incorporated the training program into a "Special Project" of the Ministry of Health and Population Control called the Menstrual Regulation Training and Services Program (MRTSP). Being a 'Special Project' meant that it was run by a steering committee chaired by the secretary of health, and that its office, routine operations, and staff were fully financed by international donor funds. Coincidentally or not, the first two staff of MRTSP were close relatives to the secretary of health, which led some interviewees to speculate that the Directorate might have let the MR training program collapse in 1983 had it not presented opportunities for attracting external grant funds and for distributing government patronage.

From 1983 to 1991, the central office staff of MRTSP judged that they operated autonomously in spite of the need to report to the governmental steering committee. The steering committee consisted largely of government administrators who deferred to the two special medical consultants on the committee, one of whom was the president of the Bangladesh Association for the Prevention of Septic Abortion, an NGO that is discussed further below, and neither of whom was a part of the Directorate of Family Planning. The Directorate certainly did not interfere in the routine day-to-day operations of the training program and, accordingly, even during this period when it was considered a 'Special Project' of the Ministry of Health, the Directorate of Family Planning did not play an important or active role in the management of the MR training program.

In 1991, following a decision by the Ministry of Health and Family Welfare to eliminate all of its Special Projects, MRTSP became a nationally registered NGO. Reportedly, some persons within the Directorate wanted MRTSP to become a government project at that time, but others specifically including the Planning Commission vetoed the idea, allegedly on the grounds that it would be too expensive and complicated to administer. After it became an NGO, MRTSP had no formal

relationship with any government agency other than the NGO Affairs Bureau, with whom all NGOs had to register.

The Planning Commission's decision in 1991 to change the status of MRTSP from a Special Project of the Ministry of Health and Family Welfare to a nationally registered NGO was consistent with the general trend in the 1980s when substantial amounts of donor funds were redirected from the government to the NGO sector (Turner and Hulme, 1997). This led to tensions between the two sectors, as reported by Turner and Hulme who noted, "in Bangladesh, many civil servants complain of NGOs being unfairly favoured by donors" (1997:212). The international donors who were specifically concerned with supporting the MR policy in Bangladesh appeared to favour NGOs over the government. In 1982, for example, the Pathfinder Fund catalysed the establishment of the Bangladesh Association for the Prevention of Septic Abortion (BAPSA), a national NGO, inspired by the National Abortion Federation in the United States. The Pathfinder Fund envisioned that BAPSA, like the National Abortion Federation, would demand public accountability from the bureaucracy by independently monitoring and evaluating the safety and quality of government's MR services. Ironically, BAPSA, encouraged by international donor agencies, ended up largely taking over the Directorate's activities rather than holding it accountable for them. The Pathfinder Fund's vision of BAPSA's role was based on a U.S. model of pluralism, which simply did not exist in Bangladesh. Through tight control by the NGO Affairs Bureau of all NGO activities, the government discouraged the formation of active and diverse interest groups, and there were, in any case, no formal channels within the political framework for interest groups to influence policy. As a result, BAPSA, observers suggested, quickly evolved into more of a service contractor driven in large part by donor interests, than an advocacy agency concerned with exacting accountability from the government as it was originally envisioned.

The Ford Foundation, which funded MR activities from 1984 to 1990, also appeared to favour NGOs over the government. For example, rather than providing grants to the Directorate of Family Planning to recruit trainees, the Ford Foundation funded BAPSA to recruit government providers for MR training, and even helped it to hire two staff from the Directorate to do this. Similarly, the Ford Foundation supported BAPSA rather than the Directorate in research and evaluation activities. The Ford Foundation was also influential in encouraging MRTSP, BAPSA and two

other NGOs that provided MR training to establish a coalition that they named the MR Coordination Committee, Bangladesh, in order to, according to a former staff of the Ford Foundation, increase their strength vis-à-vis the government.

After the Ford Foundation, the Swedish International Development Cooperation Agency continued to focus on building the capacity of the MR NGOs. The national M.R program became synonymous with the activities of four NGOs. With support from the Ford Foundation and from the Swedish International Development Cooperation Agency, the U.S.-based International Women's Health Coalition conducted several technical assistance missions and at least four major reviews of "The National MR Program," all of which focused predominantly on the activities of the NGOs, rather than on government services. The donors tried to improve MR services by focusing on the training input provided by the NGOs, and by encouraging them to play a broader role in assisting the director of MCH Services. This strategy proved to be unrealistic.

While BAPSA's research helped to surface problems in the field, BAPSA's program staff did not have the authority to remedy them, nor sufficient influence over the Directorate to ensure that it addressed the problems. Ironically, BAPSA's president was a highly influential individual who may have been able to influence the Directorate, yet according to her staff she spread herself thinly across many different activities, and did not have the time to focus on BAPSA alone. In addition to serving as the president of BAPSA, she ran a busy private practise, served as president of the Bangladesh Association for Maternal and Neonatal Health, was a member of the Coordination Committee of the Family Planning Association of Bangladesh, sat as a director of the Bangladesh Women's Health Coalition, served as chair of the Board of Directors of the Dhaka Shishu Hospital, and was a member of the Health Policy, Health Manpower Committee and Medical Technical Committee of the Directorate of Family Planning. Moreover, she served as the president of the Women's Reproductive Health Forum from 1989 to 1997, president of the Regional Medical Committee of the International Planned Parenthood Federation from 1992 to 1996, and president of the Bangladesh Medical Association from 1971 to 1986.

MRTSP's central office lacked the capacity and vision to play a broader role. MRTSP's executive director was an accountant by training, and while he was a highly competent manager for MRTSP, interviewees judged that neither he nor his

staff had the background or vision to address the problems of implementing a national program. MRTSP employed two part-time Medical Advisors, but was criticized by several interviewees for never hiring a medical person to work full time in its central office. Neither MRTSP nor BAPSA regularly participated in the formal committees established for NGOs to cooperate with the Ministry of Health and Family Welfare, and the leaders of several family planning NGOs commented on the lack of initiative and skills displayed by both MRTSP and BAPSA in engaging with the broader NGO community and the Directorate.

At the time, the Ford Foundation objected to the appointment of the executive director of MRTSP on the grounds that he did not have the appropriate qualifications, but support from key members of the executive committee enabled him to secure the position over the Ford Foundation's objections. By his own account, the executive director was reluctant to hire a medical professional for the central office for fear of becoming redundant. Accordingly, MRTSP did not build its capacity to participate more broadly, and it relied, under pressure from the donors, on consultants to oversee the medical aspects of its operations. After MRTSP became an NGO, the president of BAPSA became the chair of the executive committee, and within a short time, its only gynaecologist member. The chairperson was supposed to be a rotating position, but the BAPSA president held it throughout most of the 1990s. According to interviewees, she prevented other gynaecologists from becoming elected to the executive committee, and discouraged MRTSP from hiring a permanent medical professional, thereby ensuring that all members of the committee, as well as MRTSP's central office staff, deferred to her professional authority. In 1991, a director general of the NGO Affairs Bureau insisted that the executive director step down from his position, along with one of the executive committee members, allegedly because they were involved in firing one of his (the director general of the NGO Affairs Bureau) relatives. The executive director duly became director of programs, indicating the strength of the NGO Affairs Bureau, but he continued to run the organization regardless of the change to his formal job title. For the position of executive director, the executive committee agreed to name the former secretary of health's brother, a retired civil servant and physicist by training. Interviewees noted that although he had none of the appropriate qualifications, the executive committee assumed that through his familial relationship to the former secretary of health, he would be good for relations with the government, and moreover, that he did not pose a threat to the professional authority of the chairperson.

As mentioned above, the chairperson of MRTSP, who was also the president of BAPSA, was an influential individual who may have been able to but who did not influence the Directorate of Family Planning to take an active role in the management of the MR training program. Further, although all NGOs were required to submit their annual plans to the NGO Affairs Bureau and to the appropriate ministry for vetting, this was more of a formality than a meaningful opportunity for exchanging information and for joint planning. After MRTSP became an NGO, no one from the Directorate of Family Planning held any ex-officio management positions. In short, neither the MCH Services Unit nor any other government agency actively managed or oversaw the MR training program at any time during the entire implementation period, in spite of the nominal responsibility of the Directorate of Family Planning for the overall implementation of the MR policy, and in spite of the clear importance of the MR training program to the successful implementation of the policy.

Because the Directorate of Family Planning did not actively manage or oversee the training program, it may have been unaware of any deficiencies in the program. For example, the MRTSP centres provided training in MR to all medical students specializing in gynaecology, even though only a small proportion of them went on to pass the civil service exam and work in government clinics after completing medical school. At the same time, MRTSP training courses did not reach all the government providers already employed in government facilities in need of MR training. The MR training provided to doctors could therefore legitimately be criticized on the basis of cost effectiveness. However, as noted in the previous chapter, a critical feature of the MR policy in Bangladesh was that it provided for the bulk of the MR procedures to be performed by lay health workers known as Family Welfare Visitors, or FWVs. An important issue, therefore, was to look after training to FWVs, not training to doctors.

Most Family Welfare Visitors were village women with less than high school education. However, unlike medical students who received training in MR as part of the regular gynaecology curriculum, FWVs did not receive training in MR as part of their 18-month basic training, or as part of their in-service refresher training. The National Institute for Population Research and Training was the government agency that provided FWVs with their basic training and in-service training. Because the National Institute for Population Research and Training had neither the service

centres nor the MR clients necessary to deliver the specialized training in MR, it was appropriate to establish separate MR training for FWVs. Reports suggested that MR training, however, was not well coordinated with the basic training or in-service training offered by the National Institute for Population Research and Training. As a result, many Family Welfare Visitors received no training in MR before assuming their government posts, and some were not trained until several years later (Begum, et al., 1986).

The government's distancing from the MR training program was also reflected in the funding arrangements for training. The Pathfinder Fund was the sole donor providing financial and technical support for MR training from 1974 until 1983, when it was forced to withdraw its support for all MR-related activities due to policy decisions by the United States Agency for International Development, as discussed later in this chapter. Before withdrawing, the Pathfinder Fund made arrangements for the training initiative to become a 'Special Project' of the Ministry of Health, and for the balance of its private funds for MR training to be administered to the 'Special Project' by another American NGO, the Population Crisis Committee, which was followed by 7 years of funding from the Ford Foundation, and 6 years of funding from Swedish International Development Agency, all organizations that, unlike the Pathfinder Fund, received no part of their funding from the United States Agency for International Development.

Two aspects of these funding arrangements are important to note in order to understand the factors that constrained and enabled the implementation of the MR policy. The first, positive, aspect, was that subsequent donor support was arranged prior to withdrawal of the previous support, to thereby ensure uninterrupted financial and technical support to the Menstrual Regulation Training and Services Program and hence, to the Ministry of Health's implementation efforts. The representative and relevant program officer of the Ford Foundation at the time, both advocates of the MR program, were seen by many of the persons interviewed to have played a key role in leveraging the Swedish International Development Cooperation Agency's original funding, and in ensuring its continuance throughout the period under examination. After leaving the Ford Foundation, the representative became the vice-president of the International Women's Health Coalition, and with support from the Ford Foundation and from the Swedish International Development Cooperation Agency, she and her program staff continued to provide technical assistance to MRTSP,

BAPSA and the two other NGOs providing MR training until approximately 1994 when the International Women's Health Coalition terminated its formal activities in Bangladesh. During implementation, there were at least four turnovers of the Swedish International Development Cooperation Agency staff responsible for funding in health. Through the Coalition's formal reviews and informal discussions, it played an important role in persuading the relevant successive staff of the Swedish International Development Cooperation Agency to continue funding MR. Many interviewees indicated that no training in MR would have taken place in Bangladesh without external donors; this pattern of assuring continuity prior to withdrawing support was therefore a critical enabling factor for the implementation of the MR policy.

The pattern of handing responsibility for providing MR assistance over to a subsequent external donor ended in 1997, when the Swedish International Development Cooperation Agency decided no longer to earmark its funds for MR, but instead to provide general, unallocated, funds to the Ministry of Health and Family Welfare to spend on its health and population sector plan. The reason for that critical decision in 1997 had to do with the second, negative aspect of the funding arrangements. When the Swedish International Development Cooperation Agency originally assumed funding for MR training in 1991—and indeed, before that when the Ford Foundation originally assumed its funding of MR training in 1984—its officials anticipated that the Government of Bangladesh would eventually begin funding the MR training activities from its general revenue fund. However, although the Ministry of Health and Family Welfare contributed to the training program in the form of space, a few salaries, and travel allowance for trainees, the donors never reached an agreement with the Ministry of Health and Family Welfare to subsume MR training into its revenue budget.

5.2.2 *Providing Services*

According to government policy, MR services were available throughout the implementation period at all government hospitals and health and family planning clinics at all administrative levels throughout the country (Akhter, 1988:209). By about 1995 this included 13 Medical College hospitals, 64 District hospitals, and 93 Maternal Child Welfare Centres at the district level; 358 operational *thana* health complexes within the 464 sub-districts of the country; and 3,000 Union Health and Family Welfare Centres at the union, or lowest, level of the health care delivery

system. At all of these facilities, MR was officially available during the first 6-8 weeks gestation by a female paramedic called the Family Welfare Visitor, and/or during 6-10 weeks gestation by a physician, using manual vacuum aspiration in either case. In theory, services were free, and spousal consent was not required (Piet-Pelon, 1998).

5.2.2.1 Number of MR Procedures Performed

Due to underreporting by providers, the precise number of MR procedures performed at these facilities is unknown, but according to all available estimates, the number of MRs performed each year increased dramatically from 1979 to 1997. The official Ministry of Health and Family Welfare statistics indicate that the number of MR procedures increased from approximately 4,400 in 1979 to over 122,000 in 1997. However, as shown by Table 5.1 below, several people have concluded that the Ministry of Health and Family Welfare statistics suffer from a high degree of underreporting (Amin, et al., 1989, Begum, et al., 1987, Measham, et al., 1981). A 1986 survey, for example, found that government providers reported less than one-third of the number of MR procedures that they had actually performed (Amin, et al., 1989, Begum, et al., 1987). Similarly, Singh et al. estimated that in 1995, 468,000 MRs were performed, compared to 81,000 reported by the Directorate of Family Planning (1997).

Table 5.1

Number of MR Procedures Performed

Year	Official Statistics	Source	Other Estimates	Source
1979	4,412	(Piet-Pelon, 1998)	Not available	---
1983	58,579	(Piet-Pelon, 1998)	Not available	---
1986	69,086	(Piet-Pelon, 1998)	241,442	(Begum, et al., 1987)
1990	91,574	(Piet-Pelon, 1998)	261,894	(Kamal, et al., 1993)
1995	80,883	(Piet-Pelon, 1998)	468,299	(Singh, et al., 1997)
1997	122,187	(Bangladesh Association for Prevention of Septic Abortion, 1997)	Not available	---

As indicated in Table 5.1, official counts of MR procedures may represent only one-third to one-fifth of the total actual number of MRs performed by government providers. Johnston attributed the underreporting to the providers who had no incentive to report, and who on the contrary may have wished to cover up procedures that were performed outside their official capacity on a fee-for-service basis, and thus illegally (1999). Amin similarly stated "in the context of anti-abortion mores in Bangladeshi society, many MR adopters might have chosen to remain anonymous or to adopt MR clandestinely, with providers suppressing records, and sometimes collecting fees from the client" (1989:16). In any event, the government's official performance statistics indicated 1,343,646 MR procedures were completed between 1979 and 1997 (Bangladesh Association for Prevention of Septic Abortion, 1997, Piet-Pelon, 1998), indicating that perhaps as many as 4-6 million MR procedures were actually performed by government providers. Over roughly the same time period, the fertility rate in Bangladesh was approximately halved. The dramatic decline in the fertility rate has generally been attributed to an increase in modern contraceptive use. However, some interviewees interpreted the MR figures presented above, as a clear indication that MR also contributed to the decline in

fertility, and that it was therefore successful in achieving the population control objectives for which the policy was originally formulated.

5.2.2.2 Illegal Abortions

Several studies have been conducted to estimate the total rates of induced abortion in Bangladesh, as presented in Table 5.2.

Table 5.2

National Rates of Induced Abortion, 1978-1997

Year	Rate (abortions/year)	Source
1978	780,000	(Rochat, et al., 1981)
1983	204,000	(Khan, et al., 1986)
1990	450,000	(Kamal, et al., 1993)
1995	730,000	(Singh, et al., 1997)

Table adapted from (Johnston, 1999)

Johnston suggests that the variation in the abortion rate estimates can be explained by the type of estimation technique used rather than by an actual change in the rate of abortion over time (1999). For example, Rochat et al. used an estimation technique based on deaths resulting from complications of induced abortion (1981). The researchers found that one third of 1,218 maternal deaths that occurred in 1978 were due to complications of induced abortion. To estimate the total number of abortions that occurred, the researchers multiplied the ratio of abortion deaths to maternal deaths by the maternal mortality rate, the crude birth rate, and the national population giving them a figure of 7,800 abortion deaths per year. Based on the assumption that abortion deaths represented one percent of the total number of abortions, they arrived at a national annual abortion rate of 780,000. In 1983, Khan et al. arrived at a national abortion rate of 204,000 by multiplying the abortion rate they found in one district of Bangladesh by the crude birth rate and the national population (1986). Kamal et al. estimated a national abortion rate of 450,000 in 1993 based on the number of abortions reported by government providers, and assumptions about the number of abortions provided by private and traditional practitioners (1993).

Singh et al. estimated a national abortion rate of 730,000 in 1995 based on the number of women hospitalised for complications of abortion multiplied by the ratio of women who had abortions and were not hospitalised to the women who had abortions and were hospitalised (1997).

Table 5.3 compares the MR rates from Table 5.1 to the total abortion rates in Table 5.2, and according to some persons interviewed suggested that relatively large numbers of women continued to resort to illegal abortion in spite of the MR program.

Table 5.3

MRs Compared to Total Abortions

Year	MRs (Table 5.1)	Total abortions (Table 5.2)	Difference (Illegal abortions)
1978	Not available	780,000	Not available
1983	58,579	204,000	145,421
1986	241,442	Not available	Not available
1990	261,894	450,000	188,106
1995	468,299	730,000	261,701

If this was indeed the case, as interviewees speculated, why did any women in Bangladesh continue to resort to illegal abortion given the availability of MR services from 1979-1997? Several researchers have sought to answer this question through in-depth qualitative research with women who were known to have undergone dangerous illegal abortion or menstrual regulation[4] and through quantitative surveys among women hospitalised for complications of illegal abortion or menstrual regulation (Anowar-ul Azim, 1992, Begum, et al., 1991). Like the other researchers, Caldwell et al. found that some women initially sought treatment from illegal providers "due to greater familiarity with local providers, inadequate information about safer alternatives, and often low quality government services, and in many cases, concerns over high charges in the government system for services that are intended to be free" (1997:iv). Other women who sought treatment from illegal providers had initially approached government providers, but had been turned away

[4] See (Caldwell, et al., 1997, Fauveau and Blanchet, 1989, Hossain, et al., 1997, Islam, 1982, 1992).

for various reasons. Two surveys found that about 30 percent of all potential MR clients were rejected by government providers (1987, Begum, et al., 1986), and another study indicated that nearly half of rejected women made a subsequent attempt to have an abortion, either from different government providers or from other, illegal, providers (Kamal and Begum, 1990). In studies of the reasons for rejections, almost ninety percent of cases were found to be because potential clients lacked information about the availability of MR services and about the gestational age up to which MR was allowable (1987, Begum, et al., 1986).

These studies suggested that one of the major reasons why so many women resorted to illegal abortions despite the availability of MR services was because they did not know when and where to seek government MR services. As indicated in the preceding paragraph, this answer was suggested as early as 1986, together with the obvious remedy of strengthening the public awareness program to advise Bangladeshi women of the government services available to them. Such information would not only have provided women with the information that so many of them did not have about when and where to seek services, but it would also have addressed virtually all of the other difficulties that women faced in accessing the MR program. For example, if women knew that the services were supposed to be free, and that spousal consent was not required, and if they knew how and where to complain in the event that they were wrongly refused services, they would have been more likely to have received the services that they required and that their government since 1979 had pledged to provide them with.

If indeed significant numbers of women continued to resort to illegal abortion throughout the implementation period, the MR policy was not well implemented. The consequences of this implementation deficiency in terms women's mortality and morbidity have not been thoroughly researched, for reasons that are explored later in this chapter, but could be expected to be at least as serious as the consequences of failing to provide high quality MR services.

5.2.2.3 The Quality of MR Services

International observers have generally described a kind of a success story in terms of the program's success in providing women in a resource-poor setting with access to high quality early abortion services (Dixon-Mueller, 1988, Swedish International Development Cooperation Agency, 1996). Despite the illegal status of

abortion, according to this story, the government made menstrual regulation widely and freely available, and it trained paramedics—essentially lay health workers—to deliver MR services safely and effectively. Bangladesh is one of the few developing country abortion success stories, and its MR policy is often held up as a model in terms of training paramedics (Ipas and IHCAR (Division of International Health; Departiment of Public Health Sciences; Karolinska Institutet), 2000). Analysis of evaluations of the MR program, however, show that significant deficiencies had been identified in the quality of MR services provided in Bangladesh.[5]

Early studies suggested that paramedics could deliver MR safely and effectively under optimal conditions (Akhter, et al., 1982, Bhatia, et al., 1980, 1980). The handful of evaluations that were conducted over the implementation period, however, indicated that actual field conditions were typically less than optimal. Providers surveyed in the field reported, for example, that they faced difficulties in replacing worn equipment, and were sometimes forced to use the same syringe and cannulae as many as 200 times, when the manufacturer recommended single use. They also complained of a shortage of basic equipment including the means to disinfect the cannulae between uses. Equally disturbing from these field evaluations were the findings of shortages of emergency equipment, the lack of an effective referral system, and the lack of supervision for paramedics. Furthermore, a 1986 study indicated that as many as one-third of all MRs were performed by persons without formal training, which constituted a violation of the policy, and which posed an increased risk to women's health. Even among trained paramedics, less than a third felt "fully confident" in their ability to perform MR, especially in difficult cases (Begum, et al., 1986).

Because of these less than optimal field conditions, it should not be surprising that in 1997, Singh et al. using hospital records, estimated that four percent of women who underwent MR suffered complications that required hospitalisation, when MR is generally considered to be a low-risk procedure where complications requiring hospitalisation should be rare (1997). For example, a ten-year study of 170,000 first trimester abortion procedures using manual vacuum aspiration similar to MR reported only 9 complications per 1,000 women, including only 0.7 per 1,000 (or 0.07%) that required hospitalisation, and no deaths (Hakim-Elahi, et al., 1990). Interviewees

[5] See (Ahmed, 1983, Akhter, 2000, 1991, Begum, et al., 1984, 1987, 1986, Kamal and Begum, 1990).

reported that the root causes of the unnecessary complications of MR procedures in Bangladesh were documented and discussed with the MCH Service Unit on a number of occasions by BAPSA, but although the technical solutions were known and relatively easy to implement, they were not followed up. BAPSA conducted five formal evaluations and presented them to the director general of the Directorate of Family Planning, responsible for implementation within the Ministry of Health, and his staff. "Scarce resources" was sometimes offered as the reason for the Ministry of Health's inability to address the known implementation deficiencies with the MR and other Ministry of Health and Family Welfare programs, yet this alone does not provide a satisfactory answer since arguably the resources required to treat the unusually high rate of MR complications could have been used to address many of the deficiencies.

5.2.2.4 Maternal Mortality

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (World Health Organization, 1979). Since 1967, several population-based studies have been conducted in Bangladesh to measure maternal deaths. These are summarized in Table 5.4 below in terms of maternal mortality ratios, or the number of maternal deaths per 100,000 live births. As can be seen from the table, unlike with fertility rates over the same period, it is difficult to determine a consistent downward trend in maternal mortality ratios over the years.

The World Health Organization, together with UNICEF and UNFPA, compiled global estimates of maternal mortality indicating that in 1995, the world's maternal mortality ratio was around 400 per 100,000 live births, with regional ratios ranging from a low of 11 for North America to a high of 1,000 for Africa. The region with the second highest maternal mortality ratio was Asia, with 280 (World Health Organization, 1995). It therefore appeared from the data presented in Table 5.4, which was prepared by a quasi-governmental organization for presentation at a Safe Motherhood Conference in Dhaka in 1994, that the maternal mortality ratios in Bangladesh from 1967 to 1990 were relatively high. The World Health Organization further asserted that the data pointed "to a still widespread reliance on unsafe [induced abortion] practises, in spite of menstrual regulation having been authorized already in 1978" (1996:2).

Table 5.4

Maternal mortality ratios

Study by	Period	Population base	Maternal mortality ratio
ICDDR,B	1967-68	180,000	710
ICDDR,B	1968-70	180,000	490
ICDDR,B	1976-85	187,000	520
BAMANEH	1982-83	267,000	620
Alauddin, M.	1982-83	341,000	570
BAMANEH	1982-83	137,000	480
BAMANEH	1985	63,000	470
BBS	1987	221,000	610
BBS	1988	220,000	590
ICDDR,B	1982-90	105,000	440

Source:(Akhter, 1994)

The largest of the population-based studies referred to in Table 5.4—the 10-year study conducted by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) from 1976 to 1985—indicated that abortion was one of the leading causes of maternal mortality, accounting for 19% of all maternal deaths (Faveau, 1994). Similarly, a 1996 report by the World Health Organization, in analysing the causes of adult female deaths from 1976 to 1989 in ICDDR,B's project area Matlab, commented that the proportion of such deaths that could be attributed to abortion was "extremely large, and might point to a high number of, in particular, illegal abortions, as well as to poor conditions under which they are performed" (1996:17).

Measuring maternal mortality is notoriously complicated (Barreto, et al., 1992). Accordingly, there may have been some basis for discounting much or all of the data above on the grounds that it was inconclusive in demonstrating that maternal

mortality ratios remained high in Bangladesh throughout the MR implementation period or that abortion accounted for a significant proportion of maternal deaths. By the same token, however, there was no basis for believing there had been any improvement in maternal mortality statistics over the implementation period.

5.2.3 *Evaluating the Policy*

In the absence of complete certainty and perfect administration, the policy analysis literature proposes that monitoring program delivery and evaluating program success are necessary (Hogwood and Gunn, 1984). In Bangladesh, evaluation has been an accepted part of the policy process that has been reflected in various management information systems that have routinely captured data about the activities of Ministry of Health and Family Welfare programs, and that have reported aggregated and summarized management information to the Ministry of Health and Family Welfare managers responsible for implementing those programs. In addition, there were a number of government agencies specifically responsible for evaluation, such as the National Institute for Population Research and Training, the National Institute for Public and Social Medicine, the Bangladesh Medical Research Council, and the Implementation Monitoring and Evaluation Department, that conducted evaluations and special studies of important government programs, functions, and development projects over the years.

Until 1992, however, none of the Ministry of Health's management information systems contained a separate category to record the number of MR procedures performed by government physicians or paramedics (Ross and Chowdhury, 1997). In 1992, MR was accorded its own coding so that it no longer had to be included by default under the category of other methods of family planning practised by women. Even after 1992, however, notwithstanding the underreporting problem where providers reported only a fraction of the MR procedures that they had performed, the raw MR data that were captured by the Ministry of Health's information system were never summarized or included in the Monthly Performance Reports that were routinely prepared and disseminated to managers within the Ministry of Health and Family Welfare and to donors interested in the family planning program. BAPSA's bi-monthly newsletter was the only place that national monthly and annual MR service statistics, based on information collected from the MIS Unit, could be found. Without even basic information about the impact of the MR policy, it is not surprising that the richer information about the policy that would

be required in order properly to evaluate it—data about gestational age, complications, follow-up, and post-MR family planning acceptance, for example—was not routinely captured and reported. In addition, although the original policy statement on MR specifically described it as a part of the national family planning program, MR was generally excluded from the evaluations and special studies of the family planning program that were conducted during the period 1979 to 1997. No evaluations of the MR program were conducted, initiated or encouraged by the Ministry of Health and Family Welfare over the entire period of the program's implementation.

Similar to its approach to providing MR training as discussed above, the Directorate of Family Planning adopted a distinctly "hands-off" approach to evaluation with respect to MR. Interviewees suggested that the Directorate was made aware of the studies of MR that were carried out by NGOs, but it did not participate in the design or implementation of any of the research studies conducted by the Pathfinder Fund (Ahmed, 1983), BAPSA (Begum, et al., 1984, 1987, 1986), or others (Begum, et al., 1991, Kamal and Begum, 1990).

The Directorate of Family Planning did encourage local level Ministry of Health and Family Welfare officials and providers to cooperate with the research studies, and it did attend the dissemination seminars held to discuss the research findings. In total, seven dissemination seminars were held by BAPSA from 1979 to 1997. According to BAPSA's MR Newsletter, the various high level officials from the Ministry of Health and Family Welfare who attended these seminars "addressed the participants and assured continued government help in bringing in quality of services and thereby reducing maternal mortality and morbidity as well as controlling population growth" (Bangladesh Association for Prevention of Septic Abortion, 1987:1). In addition to the BAPSA studies and dissemination seminars, MRTSP held at least three workshops from 1979 to 1997 to discuss implementation issues and, in addition to advisors, directors, trainers and former trainees from the MRTSP sites, the workshop participants included central and local level Ministry of Health and Family Welfare officials.

In most cases, the implementation deficiencies were discussed in the seminars and workshops, but no corrective action was taken to address the deficiencies. For one research study, however, where it was found that 30% of

women seeking MR services were rejected by government providers (Kamal and Begum, 1990), a Technical Advisory Committee was formed to help the Ministry of Health and Family Welfare follow up the recommendations of the study. The committee was chaired by the director general of the Directorate of Family Planning, and comprised senior Ministry of Health and Family Welfare officials responsible for supporting the MR program as well as representatives from the four MR training and services NGOs.

The Technical Advisory Committee met approximately five times between 1990 and 1997 and, looking back on its accomplishments, the executive director of BAPSA at the time judged that the committee effectively addressed only three issues. First, it made a decision about the number of times that providers should use MR kits, and issued a circular to that effect. (It seems unlikely that merely issuing a circular would have solved the problem of providers using worn equipment. According to BAPSA, when providers, especially female paramedics, tried to replace worn equipment from their supervisors or government supply stores, they were usually asked to pay a small kickback based on the assumption that the providers charged for services and therefore had money to pay. The need to pay this kickback would likely have served as sufficient disincentive to following a written directive, for which there was neither reward for compliance nor penalty for non-compliance.) Second, the committee successfully influenced the Ministry of Health and Family Welfare to facilitate the flow of MR equipment from the central to the local levels by instituting tighter supervision and accountability controls. Finally, it convinced the Ministry of Health and Family Welfare to change the format of its reports so that MR would be included under Maternal and Child Health rather than under Family Planning. The committee did not address the substantive issues relating to the high rejection rates found by the study.

In summary, the Ministry of Health and Family Welfare did not directly monitor or evaluate the MR services that were provided by its health care workers from 1979-1997. Nor did it design, influence, participate in or substantively follow up the findings from any of the evaluations of the program that were performed by NGOs. The underlying reasons for the Ministry of Health's reluctance to evaluate the implementation of its MR program and to take timely corrective action where appropriate are addressed in the remainder of this chapter.

5.3 Reasons for the Gap Between Policy and Implementation

The deficiencies in the implementation of the MR program were well documented and communicated to the Ministry of Health, together with the technical solutions that would have addressed those deficiencies. The question that the author sought to answer in this chapter is why the Ministry was unable or unwilling to address the deficiencies. Three primary reasons were suggested during the research. Some persons interviewed felt that the deficiencies were not serious enough to warrant attention. Many others suggested that the Ministry lacked the managerial capacity effectively to address the implementation deficiencies. The final, most compelling, argument was that the Ministry of Health and Family Welfare was constrained in its ability to address the known implementation deficiencies because of explicit opposition to abortion from the United States Agency for International Development from the early 1980s onwards, and because of opposition implicit in religious values and societal norms. These arguments are examined in depth in the remainder of this chapter.

5.3.1 Low Relative Priority

According to some interviewees, the Ministry of Health and Family Welfare viewed either that the MR policy objectives were being satisfactorily achieved, or they were not sufficiently significant in light of other government priorities to warrant attention. The wheel may have been a bit wobbly, so to speak, but it wasn't broken and therefore it did not require the attention demanded by other wheels that the government also had to keep rolling.

The policy implementation literature suggests that what may be considered failure to one group may be considered success to another, because different groups perceive the ends, means, and outcomes differently. According to Lane, "whether a goal has been achieved or not depends on how the goal and the outcomes are perceived by the actors involved in the implementation process" (1997:308). This appears to be directly relevant to the case of the implementation of the Bangladesh MR policy insofar as the goal of the policy appears to have been perceived differently by different actors and even by the same actors over the duration of the implementation period.

In spite of claims by some outside observers that the Ministry of Health and Family Welfare introduced MR as a health intervention (International Women's Health Coalition, 1994, Swedish International Development Cooperation Agency, 1996), Ministry of Health and Family Welfare documents indicated that the original objective of the MR program was population control, which was an urgent and fundamental priority of the government in its early years. Bangladesh showed impressive results in addressing this priority, with dramatic declines in the total fertility rate from 6.3 births per woman in the early 1970s to approximately 5 births per woman in the 1980s to 3.3 births per woman in 1996-1997 (Cleland, et al., 1994) and it was generally believed, by the director of MIS within the Directorate, as well by as by some outside observers (Amin, 1996, Badrud Duza, 1990, Kamal, 1992, Singh, et al., 1997) that the MR program contributed to these dramatic results.

Whether in fact abortion, including MR and abortion provided by private and traditional practitioners, influenced fertility decline has been the subject of debate in Bangladesh (Johnston, 1999). This debate was sparked in part by speculation that the increase in contraceptive use, as well as changes in other proximate determinants of fertility, could not adequately explain the steep decline in fertility from the 1970s to 1996-1997 (Mitra, et al., 1994). Some demographers concluded that abortion did not significantly contribute to this fertility decline (Cleland, et al., 1994), nonetheless, government officials interviewed for this research remained convinced that MR made an important contribution to the decline in fertility rates. For those who viewed MR as a population control intervention, this represented an important "bottom line" indicator of successful policy implementation.

For those who viewed MR as a women's health intervention, a change in the total fertility rate would not have been a meaningful indicator. There is some evidence that the Ministry of Health and Family Welfare became more interested in MR as a health intervention in the early 1990s. For example, until 1992, MR was recorded by family planning field workers under "other" modern methods of contraception, indicating that the procedure was primarily considered to be a fertility control intervention until then. After 1992, MR procedures were recorded under Maternal Child Health interventions, indicating that a shift in the way MR was perceived and evaluated. In terms of evaluating its impact, Ministry of Health and Family Welfare officials and other supporters of the MR policy and program interviewed for this research generally assumed that by providing an alternative to

unsafe and illegal abortion, the MR program saved women's lives. In spite of the lack of hard research data, interviews suggested that Ministry officials perceived manual vacuum aspiration to be superior to traditional abortion practises.

It could be argued, therefore, that the MR policy as implemented contributed both towards population control and improved women's health. Indeed, about three quarters of the persons interviewed for this research indicated that they felt that the program was satisfactorily achieving its objectives, and that scarce management resources were therefore appropriately directed towards government priorities other than the implementation of the MR policy. Nonetheless, most of these same persons felt the Ministry of Health and Family Welfare could have been motivated to address the known deficiencies in the implementation of its MR program had the constraining factors discussed below not been present.

5.3.2 Lack of Capacity

Lack of bureaucratic capacity is often identified as a critical constraint to implementing government policies in many developing countries (Grindle and Thomas, 1991). In Bangladesh, primary health care services in general have suffered from a lack of public confidence, as evidenced by the fact that only 15 percent of people suffering from any illness visited a government health facility (World Bank, 1996). Within such an environment, perhaps it would be unreasonable to expect the Directorate of Family Planning to have been able to address the known deficiencies in the implementation of the MR policy.

There are at least two aspects to the 'lack of capacity' argument: the capacity of health care workers to provide the services required by the new policy, and the capacity of program managers to manage implementation. The former type of capacity was identified by Grindle and Thomas as a significant constraining factor on implementation in many of the 16 population policy case histories that they reviewed. Efforts in Bangladesh to overcome the initial inadequate capacity of the Directorate of Family Planning to implement the MR policy in terms of numbers of adequately trained health care workers is described above. The second aspect of capacity, which is examined in this section, concerns the ability of the Directorate adequately to manage the implementation effort.

Persons within and outside the Directorate of Family Planning suggested that one of the reasons for the Directorate's inability to address the known deficiencies in the implementation of the MR program was that it lacked the managerial capacity to do so. Like their counterparts in other developing countries, several ministries and institutions within the Government of Bangladesh were the beneficiaries of technical assistance grants, institutional strengthening projects, and capacity development efforts aimed at improving the abilities of those ministries and institutions to manage government programs since the early 1970s. The Ministry of Health and Family Welfare in Bangladesh was no exception. The United Nations Fund for Population Activities, United Nations Children's Fund, and the World Health Organization, for example, provided intense technical assistance to the Ministry of Health and Family Welfare from the mid-1980s to 1997, specifically to help the Ministry provide a more effective maternal health program. UNFPA assistance resulted in the creation of a special unit within the Ministry to address maternal health, with special project staff and full-time international consultants. By contrast, support to the MR program was largely provided through NGOs that operated independently of the government and that did not attempt to build the implementation capacity of the MCH Service Unit.

It is plausible that the MCH Services Unit had limited managerial capacity to implement its MR program, and that efforts to strengthen its capacity would have been valuable. This conclusion would be consistent with a model of the policy process in which implementation is simply a matter of doing what has already been decided, and unsuccessful implementation is interpreted as a 'lack of capacity' or as a mere technical inability to implement the policy. It seems likely, however, as some of the policy literature suggests, that a lack of technical managerial skills provides at best only a partial explanation for the failure of the MCH Services Unit to implement the MR policy.

From about 1981 to 1997, the United States Agency for International Development provided financial and technical support to NGOs to develop population and health sector plans, and to publish demographic data. In addition, through NGOs, the United States Agency for International Development published policy papers and promoted various forums for dialogue with national policy makers and senior level bureaucrats to build a strong government commitment to family planning. Efforts to support the MR NGOs did not result in any sense of government ownership of or commitment to the program. Without this commitment from senior

levels of the Ministry of Health, it is not surprising that mid-level program managers and administrators within the Directorate of Family Planning nominally responsible for the implementation of the MR program did not address the known implementation deficiencies. Their performance would not have been evaluated based on the results of the MR program. Thomas and Grindle, in analysing 16 population policy case histories, observed that "soft commitment" to population policy initiatives is readily apparent to program managers, and that "without the necessary support of policy elites, bureaucratic commitment is unlikely and successful program implementation impossible" (1994:64).

Even if the managerial skills of the MCH Services Unit and other relevant bureaucratic institutions had been strengthened, the MR policy would possibly still not have been implemented effectively in Bangladesh, precisely because of the lack of bureaucratic commitment referred to by Grindle and Thomas. The same lack of bureaucratic commitment and lack of top level support was manifest in the 'scarce resources' argument examined earlier in this chapter—an argument that surfaces a third aspect of capacity but that articulates a symptom rather than a cause of the problem. The major underlying reasons for the lack of commitment and support are explored in the following section of this chapter.

5.3.3 Opposition to the Policy

The most convincing argument advanced by interviewees for the Ministry's inability or unwillingness to address the known deficiencies in the implementation of the MR policy was that it felt constrained in being able to discuss the policy openly and freely because of explicit opposition to abortion by the United States Agency for International Development (USAID) and, to a greater extent, because of conservative religious and social values. This argument is explored below.

5.3.3.1 USAID

Crane asserts: "As in other areas of public policy in developing countries decision-making concerning abortion is strongly affected by external influences" (1994:242). This research supports Crane's assertion by showing that the anti-abortion position of the U.S. government, expressed by USAID, had direct effects on the Ministry of Health's ability to implement its MR policy from 1979 to 1997, as well indirect effects including the imposition of an overall paralytic effect on policy and program discussion related to abortion.

The United States had begun to shift its position from support to opposition of abortion in developing countries during the time that the MR policy was formulated in Bangladesh. In 1973, the United States Congress passed the Helms Amendment to the Foreign Assistance Act of 1961 which prohibited the use of United States foreign aid funds to "pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practise abortions" (Center for Reproductive Law and Policy, n.d.:1). By 1982, "USAID announced new restrictions on recipient governments, private voluntary organisations, and research institutions, including prohibitions on the procurement or distribution of MR kits and abortion equipment; prohibitions on the training of individuals for the performance of abortion as a means of family planning and prohibitions on the funding of biomedical research relating to abortion, among other restrictions" (Dixon-Mueller, 1990:309).

In sharp contrast to the U.S. position expressed at the first World Conference on Population ten years earlier, the American delegation to the International Conference on Population held in Mexico City in 1984 held that population growth had a neutral effect on economic development. (Ironically, by 1984 many developing countries had reached the conclusion expressed by the United States in 1974 that population growth could have a detrimental effect on economic development and that family planning programs were therefore important for health and economic development.) Further, the U.S. "broadened its attack on abortion in a manner that sent shock waves through the Mexico City conference" by announcing that "the United States does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part" (Dixon-Mueller, 1990:309).

The Mexico City Policy was defined in a standard clause routinely inserted in grants and co-operative agreements that recipients had to sign as a condition of receiving funds from the United States Agency for International Development after 1984. The clause prohibited American NGOs from using U.S. government funds to assist foreign NGOs that "perform or actively promote abortion as a means of family planning"[6] even if the abortion-related activities were financed from segregated funds

[6] According to the Law and Policy Project, "In the Mexico City Policy, AID has defined "abortion as a method of family planning" to mean abortion when used to space births or protect a woman's general physical or mental health. The clause does not affect abortions performed to save the life of

raised from private sources, and even if those activities comprised a small fraction of their overall health program (Crane, 1994, Dixon-Mueller, 1990).

In 1985, the U.S. Congress held back $10 million of its $46 million grant to UNFPA on the grounds that $10 million amounted to the equivalent of what UNFPA allegedly provided to support coercive abortions in China. Similarly, the U.S. withheld $11 million of projected funding to IPPF, on the grounds that some of its overseas affiliates provided abortion services. A year later, the U.S. ceased funding both UNFPA and IPPF entirely (Coeytaux, et al., 1993, Dixon-Mueller, 1990, Jacobson, 1990, Warwick, 1982). According to Warwick, "The A.I.D. administrator said his agency had withdrawn support from IPPF because the abortion-related activities of IPPF member affiliates violated the new U.S. population policy" (1982:14). United States funding to these two organizations was not reinstated until the election of a Democratic president in the U.S. in 1993. Sundstrom noted the ripple effects of the U.S. policy led many independent agencies to avoid controversial statements concerning abortion (1993). Similarly, many family planning agencies removed abortion from their family planning programs to protect their funding (Coeytaux, 1988), or at least down played its role (Sundstrom, 1993).

The American shift in policy on abortion had direct implications in Bangladesh. The Pathfinder Fund, an American NGO, had used its U.S. government funds to support the Ministry of Health and Population Control's Model Clinic in Dhaka, which provided MR as part of its family planning services from 1974. As the U.S. government's anti-abortion stance became more obvious under the Carter Administration (1977-1981), the Pathfinder Fund realised that it would have to use non-U.S. government funds to support MR at Model Clinic, and to keep these monies completely separate from funds provided by USAID to support the Model Clinic's other family planning services. According to the Pathfinder Fund, however, he was unable to keep the Clinic's accounts completely separate. A visiting USAID official discovered that the same clinic that received U.S. government funds was also providing MR services, and at that point the Pathfinder Fund was forced to make a difficult decision, described by the former chief executive officer of the Pathfinder Fund Boston in these words, "The only way was to either stop funding abortion or

the woman or performed in cases of rape or incest" (Development Law and Policy Program. 1989:2).

fund everything" with private funds, "the entire clinic" (Gamble, 1998). The Pathfinder Fund did run the clinic for a short time entirely with private funds, but in 1983, knowing that the Mexico City Policy was shortly to be coming into effect, the Pathfinder Fund decided to terminate its support for MR training and services after a nine-year commitment. According to its chief executive officer at the time, the Pathfinder Fund had to stop "because of USAID pressure, otherwise it would have lost 90 percent of its overall budget" (Gamble, 1998).

Immediately prior to withdrawing its support, the Pathfinder Fund negotiated with the Ministry of Health and Population Control to incorporate the MR training program as an autonomous project of the Government of Bangladesh. At the time, there were about five such "Special Projects" attached to the Ministry of Health and Population Control. The Pathfinder Fund also persuaded one of its donors to provide a year-long bridge grant to the Ministry of Health and Population Control through the Population Crisis Committee, an American NGO that received no part of its operating funds from USAID.

Several Bangladeshi NGOs that relied on U.S. government funds administered through American NGOs also had to choose in 1983-1984 between continuing MR-related activities or losing their U.S. funding. Because of their heavy reliance on U.S. funding, most of the NGOs felt that they had no choice. The oldest and largest family planning NGOs—Concerned Women for Family Planning, the Family Planning Association of Bangladesh, and the International Centre for Diarrhoeal Disease Research, Bangladesh—abandoned their MR activities, which one leader recalled as "a heartbreaking decision" (Khan, 1998) that she tried to mitigate by helping to establish the Bangladesh Women's Health Coalition to which she could refer MR clients. Beyond these Dhaka-based organisations, the imposition of U.S. policy was felt by over 100 local NGOs that received funding from USAID through three American NGOs, and through the Family Planning Council of Voluntary Organisations, an autonomous project of the Ministry of Health and Population Control.

USAID required each of its grantees to sign a clause certifying that they would not use their AID grant to fund foreign NGOs that "perform or actively promote abortion as a method of family planning." The head of the Family Planning Council's secretariat explained that by making dramatic examples of a few NGOs,

U.S. restrictions were strictly adhered to (Rouf, 1998). He recalled, for example, in 1981, an official of USAID visiting a small NGO clinic saw MR included in a list of services, and closed the clinic immediately. Ten years later, a visiting official saw a government Family Welfare Visitor providing MR in a clinic funded by USAID, and closed it down on the spot. By 1995 it was estimated that NGOs funded by USAID provided family planning and health services to approximately 20% of all contraceptive users in Bangladesh (United States Agency for International Development and Bangladesh Office of Population and Health, 1995) but because of the conditions of their funding, none of them were permitted to discuss with women the availability of MR as an option, despite the fact that MR was an official part of the national family planning program of the Government of Bangladesh.[7]

The Mexico City Policy did not affect direct American bilateral assistance to foreign governments.[8] Nonetheless, USAID provided significant support to the Ministry of Health and Population Control through American NGOs, and whenever this occurred, MR had to be ignored. For example, since 1984, the Ministry of Health's management information system—which was developed with assistance from U.S. government funds through an American NGO—has excluded MR service statistics from monthly performance reports aimed at policy makers, donors and technical assistance agencies (Ross and Chowdhury, 1997). Similarly, in 1996 it was noted that the Office of Logistics had excluded MR equipment from a project designed to improve procurement, monitoring and distribution of family planning commodities and medical and surgical requisites for the public sector (Ross and

[7] According to the Mexico City clause, to "actively promote" abortion includes but is not limited to counselling, referral, and advocacy of abortion. Specifically, it refers to (1) operating a family planning counselling service that includes providing advice or information on the benefits or availability of abortion as a method of family planning' (2) lobbying a foreign government to legalise or make abortion available as a family planning method; (3) conducting public information campaigns about the benefits or availability of abortion as a family planning method; (4) advising a woman that abortion is available in the event other contraceptives are not used or fail; (5) encouraging a woman to consider abortion (Development Law and Policy Program, 1989).

[8] According to the former vice-president of the Population Crisis Committee, "The first major modification of the Mexico City policy was to confine its application to multi-lateral and non-governmental organizations (NGOs). Governmental grantees were exempted from the policy's anti-abortion requirements, apparently out of respect for their national sovereignty. Foreign nations were thus permitted under the policy to receive U.S. family planning funds and to continue to support abortion using other segregated funds. As the policy was eventually implemented by the United States Agency for International Development (AID), this exemption was also extended to government-sponsored entities, such as national universities or research institutions, even when they are sub grantees of a private U.S. organization. This modification allowed some domestic organizations largely to escape the consequences of the restrictions. The change also deflected much of the official protest by foreign governments" (Camp, 1987:36).

Chowdhury, 1997). The director of the logistics unit asserted that USAID could not prevent the Ministry of Health and Family Welfare from collecting and reporting data on MR equipment as a part of the project, but at the same time he indicated he would be unwilling to do so without a formal request letter from the Swedish International Development Cooperation Agency, the donor then supporting MR (Ross and Chowdhury, 1997). USAID has also provided support for several Demographic and Health Survey reports, which provide comprehensive census data important to health and population policy makers, but that have consistently ignored MR even though it has been speculated that the rapid decline in the Total Fertility Rate could be attributed in large part to MR (Badrud Duza, 1990).

All USAID grants have been characterised by this kind of systematic refusal to acknowledge the existence of MR, including grants made through U.S. cooperating agencies to assist the Ministry of Health and Population Control in expanding and improving family planning and maternal child health service delivery, and in gaining support for family planning and maternal child health among policy makers and at the village level. The National Family Planning IEC Strategy and Implementation Plan for 1994, for example, made no mention of MR. In addition, the USAID-funded Local Initiatives Project that worked with local officials to manage family planning services was estimated to have covered about 15 percent of the country in 1995, reaching a population of 10.23 million in 103 sub-districts. In all of these efforts MR services were ignored even though they were officially part of the national family planning programme.

USAID also provided support for policy-oriented research and evaluation, including research implemented by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) designed to pilot test innovative management and service delivery models for the government system. Before U.S. government restrictions came into effect, ICDDR,B conducted a pilot project demonstrating that paramedical staff could provide MR services, which as discussed in chapter 4 was among the research that motivated the Ministry of Health and Population Control to introduce the MR policy (Bhatia, et al., 1980, Bhatia and Ruzicka, 1980). Later, however, U.S. government restrictions prevented ICDDR,B from examining the role of abortion in reducing maternal deaths. For example, ICDDR,B conducted an intervention study designed to reduce maternal mortality, and although the researchers recognised that unsafe abortion accounted for a significant portion of

maternal deaths, MR could not be included as one of the interventions in the study due to the AID restrictions. The study findings concluded, "a key gap in the data is information on induced abortion. The decline in abortion deaths in the intervention area was the largest for any single cause of obstetric death. Providing induced abortion was not listed as one of the interventions of the study, but the government training for midwives includes early abortion. Although the Matlab midwives cannot be shown to have been directly responsible for the decline in abortion deaths, this finding serves as a reminder that safe abortion services are an important component of programs attempting to reduce maternal deaths in developing countries" (Maine, et al., 1996:186).

Similarly, the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (formerly the Bangladesh Fertility Research Program), a Special Project of the Government of Bangladesh whose early research on MR influenced the Ministry of Health and Population Control's decision to introduce MR (see chapter 4), was forced to stop all abortion-related research or lose its funding from USAID-funded Family Health International (formerly the International Fertility Research Program). All three of the Institute's directors were heavily involved in establishing the Ministry of Health and Population Control's MR policy and program, and two of them, with doctoral degrees from Johns Hopkins University in the U.S., were considered by many of the persons interviewed to be highly respected researchers. The World Health Organisation tried to give the Institute two grants for abortion-related research in the 1980s and 1990s. Under the Mexico City Policy, however, the Institute was unable to accept the grants, and the funds were passed on to independent research organisations with less research capacity and less ability to influence government policy. USAID thus constrained research that might have helped to evaluate the status of the MR program.

Moreover, USAID was actively engaged in awareness raising and advocacy activities designed to influence policy, involving technical assistance and training/capacity building activities for the government and private organisations. Specifically this included helping to establish the "Future Challenges of FP/MCH" National Steering Committee chaired by the secretary of health (now the National Integrated Population and Health Programme Corporate Steering Group), helping the Ministry of Health and Family Welfare prepare its five-year development plans, and publishing policy papers. In all of these efforts, USAID exerted a paralytic effect on

policy dialogue in Bangladesh. A senior civil servant seconded to the World Bank said that the subject of MR was "studiously avoided" in policy discussions with the donors while the head of an American NGO funded by USAID felt that the Ministry of Health and Family Welfare denied the existence of the MR program in policy discussions. Statements similar to these were made by a number of people interviewed. The "political climate" created by the Mexico City Policy had the effect of making other international organisations involved in family planning, such as United Nations Fund for Population Activities, the World Health Organisation, the World Bank, and the International Planned Parenthood Federation either extremely cautious in their approach to abortion, or directly prohibited their involvement (Crane, 1994). This was certainly the case in Bangladesh where abortion was kept out of most policy dialogue.

A former secretary of health explained that the Government's dependence on USAID made it "careful to take care of the minds of USAID policymakers." In Bangladesh, U.S. government assistance to the Ministry of Health and Family Welfare MOHFW between 1992 and 1996 represented approximately 21 percent of total foreign aid (Buse, 1999). USAID contributed $300 million to the health sector in Bangladesh from 1987 to 1997, and in 1997 signed a consecutive agreement for $210 million over seven years (Alauddin, 1998). The implications of aid dependence on the policy environment in Bangladesh has been well documented,[9] and is illustrated by the following quote:

> An inexorable consequence of the over-dependence on foreign funds is that the country's political and economic freedom to choose is substantially compromised. Each year the government has to seek funds from donor countries to keep up its modest development activities. A failure to attract sufficient funds meant that many developmental projects would have to be shelved. Since foreign aid is a major source of employment of the educated people and of aggregate demand, a drying up of aid could cause serious resentment and dislocation in the economy. The resulting turmoil could easily unseat the ruling government. (Taslim, 1994:292)

The Mexico City Policy remained in force from 1984 until Clinton rescinded the Mexico City Policy in 1993 and openly stated his administration's support for reproductive choice, including access to safe abortion. Although the policy was

[9] See (Faaland, 1981, Islam, 1994, Islam, 1977, 1982, Sobhan, 1990, Thomson, 1991).

rescinded in 1993, the Helms Amendment remained in place, as well as other legal and political constraints (Crane, 1994). This created some confusion as to American policy on abortion and as to the resultant implications for United States official development assistance. Many of the examples cited above indicate that in Bangladesh, the Mexico City Policy continued to be applied after 1993. Effectively, then, the position of the American government and USAID on abortion shifted from support to opposition early in the period of implementation of the MR policy, and continued throughout the period. This shift had a profound impact on the implementation of the MR policy in Bangladesh. However, many of the people interviewed for this research perceived USAID's influence as being less of a constraining factor than religious opposition, as discussed in the following section.

5.3.3.2 Religious Views

In contrast to the overt opposition to abortion asserted by USAID as discussed above, religious opposition to MR was implicit, and was exerted through personal interpretations and perceptions of Islam, rather than through spoken messages or direct actions by religious groups or religious leaders. In this section, the general rise in Islamic fundamentalism in Bangladesh during the implementation period is examined, to help understand the forces that helped to shape attitudes held by Ministry of Health and Family Welfare bureaucrats, policy makers, and others at the time. Next, this section examines more specific religious attitudes held by Ministry of Health and Family Welfare officials and other actors towards the MR policy, and assesses the extent to which such attitudes constrained the Ministry in its implementation of the MR policy.

Throughout the MR implementation period, Islam became increasingly prominent as a symbol of national identity (Kabeer, 1989), and the religious right gained political strength.[10] Kabeer contends that post-liberation Bangladesh "completed a full ideological circle which has taken it from a position of official secularism to one not far removed from the Islamic status of pre-liberation days" (Kabeer, 1989:10). How did this happen? Several authors including Kabeer have observed that successive leaders in Bangladesh, particularly General Ziaur Rahman

[10] For a discussion of the rise of the religious right in Bangladesh, see (Amin and Hossain, 1995, Kabeer, 1989, Murshid, n.d., Nasreen, , Rashiduzzaman, 1994).

(1977-1981) and General Ershad (1983-1990), both brought to power by way of military coups, used Islam as a means of gaining political legitimacy.

President Zia had some legitimacy derived from his role as a leader in the war, but he "required an ideology to counter the official secularism of the Awami League and to undermine its still considerable support" (Kabeer, 1989:21). Islam, said Kabeer, "offered an obvious and powerful alternative to win over right-wing Islamic elements who had been discredited by their pro-Pakistan politics in 1971, but who had regrouped since the Awami League lost its hold on state power" (1989:21). In 1977, President Zia replaced the principle of secularism in the Constitution with "absolute trust and faith in Almighty Allah" (Kabeer, 1989, Nasreen,). By the same Proclamation Order he inserted: "In the name of Allah, the Beneficent, the Merciful" in the preamble to the Constitution, and added a new clause that read: "The state shall endeavour to consolidate, preserve and strengthen fraternal relations among Muslim countries based on Islamic solidarity" (Kabeer, 1989:22). He lifted a ban on religious parties (Kabeer, 1989) and he actively cultivated the support of religious groups through government patronage and through projection of his commitment to the idea of a "mosque centered society" (Nasreen,).

Without any nationalist or other credentials, President Zia's successor, General Ershad also "used" Islam as a source of legitimacy. His strategy was to play the Islamic card without sharing power with the fundamentalists (Kabeer, 1989). In 1983, President Ershad introduced in Parliament an amendment to the Constitution that made Islam the state religion (Amin and Hossain, 1995, Kabeer, 1989, Nasreen,). He introduced the Muslim call to prayer in television broadcasts, and required female newscasters to modify their dress (Kabeer, 1989). He also refused to ratify clauses related to inheritance, marriage, child custody, and divorce in the Convention on the Elimination of All Forms of Discrimination Against Women because they contradicted religious personal laws in force in Bangladesh (Kabeer, 1989, Murshid, n.d.). President Ershad also tried to introduce an Islamic school curriculum but was unsuccessful due to public opposition (Kabeer, 1989). Nonetheless, the religious educational system flourished with government support. From 1978 to 1992, the number of *madrassah* (religious) schools more than tripled to over 6,000, the number of teachers increased from approximately 21,500 to almost 95,000, and student enrolment grew from 375,000 to over 1.7 million (Murshid, n.d.).

The Jamaat-I-Islami, a religious right-wing political party whose platform includes a call for an Islamic state and Islamic law (Amin and Hossain, 1995) had only 425 full members and 40,000 associate members in 1969. These numbers grew to 650 and 100,000 respectively by 1980 (Kabeer, 1989), and by the time President Ershad was overthrown in 1990, the religious right had gained considerable political power. In the first "free and fair" elections held in 1991, the Jamaat-I-Islami was one of five major political parties to contest the election. It and other pro-Islamic groups won 19 of 300 seats in Parliament with 14.4% of the popular vote, which gave the religious right "a legislative swing power to promote their causes" (Rashiduzzaman, 1994:985). Moreover, the Bangladesh National Party fell short of a clear majority, and was only able to form a government when the Jamaat-I-Islami helped it elect 28 of the 30 seats reserved for women (Kochanek, 1996) leaving the Bangladesh National Party politically indebted to the Jamaat-I-Islami.

Kabeer has argued that successive attempts to win support from the Islamic constituency and to balance "conflicting gender ideologies implicit in different aid packages" (Kabeer, 1989:28) led to contradictions and tensions in state policy towards women, such as preaching Islam to accommodate the Saudis while practising population control to accommodate the Americans. The way the MR policy was formulated and implemented in Bangladesh is an example of the conflicts and contradictions suggested by Kabeer. The policy is premised on the contradiction that MR is not abortion, and as shown in the previous section on the United States Agency for International Development, conflicting ideologies in different aid packages certainly contributed to tensions in implementation.

The interviews revealed that a similar tension between Islam and public policy was played out at the individual level. Some people claimed that Ministry of Health and Family Welfare bureaucrats failed to implement the policy because they personally objected to abortion, and more people agreed that if the minister and/or secretary at the time were personally opposed to abortion, bureaucrats would be hesitant to act. Many doctors interviewed indicated that they personally would never perform an MR procedure except to save the life of a woman because they objected to abortion on religious grounds. Ministry of Health and Family Welfare officials interviewed confessed that it was difficult to address the implementation of the MR policy actively and openly for fear of rousing the "sleeping tiger" of religious opposition, which they perceived to exist in a dormant state.

Interestingly, all Ministry of Health and Family Welfare officials interviewed perceived religious opposition to be a larger impediment to the effective implementation of the MR policy than opposition from USAID, even though religious opposition to MR was never openly expressed and even though the direct effects of USAID opposition were extensive. In part, this may have been due to a desire on the part of Ministry of Health and Family Welfare officials to appear not to be unduly influenced or controlled by USAID or any other external party. However, Islamic fundamentalists gained considerable political power over the MR implementation period, so it is possible that such groups had more immediate influence on domestic politics than U.S. foreign policy. In addition, unlike the influence of USAID, Islam permeated Bangladeshi society. To the extent that religious beliefs caused individual doctors, bureaucrats, policy makers, and other actors to conclude that the MR policy was wrong for them personally, the tensions and contradictions suggested by Kabeer clearly came into play. The interviews suggest these individual beliefs were widespread, and expressed in terms of a fear of rousing a sleeping tiger. This collective fear of latent religious opposition appears from all accounts to have been the single largest reason why the Ministry of Health and Family Welfare of Bangladesh was unwilling to address known deficiencies in the implementation of its MR policy.

5.4 Chapter Summary and Analysis

5.4.1 Chapter Summary

The chapter noted a number of deficiencies in the provision of MR training, services, and evaluation that had all been discussed with but not followed up by the government. One study estimated that 4% of women receiving MR in Bangladesh suffered complications requiring hospitalisation, whereas other studies suggested the figure should have been less than one-tenth of one percent, or, in other words, that the complication rate was more than 40 times higher than expected. Even more disturbing was the data suggesting that several hundreds of thousands of women continued to resort to illegal abortion each year, primarily because they did not know when and where to seek government MR services. In terms of providing both quality services and access to service, then, the policy was not well implemented. At least partly as a consequence, there was no appreciable reduction in the relatively high maternal mortality ratios in Bangladesh over the implementation period, and there

was evidence to suggest that induced abortion was a major cause of maternal deaths. The research sought to determine why the government was unwilling or unable to address the known deficiencies in the implementation of its MR policy.

One of the possible underlying reasons for the government's failure to better implement its MR policy may have been that it did not perceive there was a sufficiently high priority problem to address. When abortion was placed on the policy agenda in Bangladesh, it was considered a legitimate means of population control, actively encouraged by the international community, specifically including the United States. Thereafter, however, the U.S. Congress passed the Helms Amendment, and even later the Mexico City Policy came into effect, which severely restricted abortion-related activities and which had a profound impact on the implementation of the MR policy in Bangladesh. Among other things, it made it unacceptable to discuss MR as a method of family planning in Bangladesh and internationally after 1984. Nonetheless, there were indications that at least until 1992, decision makers in Bangladesh continued to view MR as a method of family planning and, because of the dramatic decline in fertility rates attributed to MR and other methods of family planning, the "deficiencies" in the implementation of the MR policy may have been considered relatively unimportant.

After 1992, MR procedures were recorded under Maternal Child Health interventions, so it is possible that around that time, decision makers changed the way they viewed MR. As a maternal child health intervention, although the incidence of illegal abortion should have been a concern, there was little conclusive evidence as to the extent of the problem, and the "half full" portion of the glass—again without persuasive research data but using plain common sense—suggested that MRs even under less than optimal field conditions had to be safer than illegal abortions and that scarce government resources should therefore be directed to higher priority areas, women's health being a lower priority than population control in any case.

Another plausible, but by itself unsatisfactory, explanation that was explored in this chapter as to why the MR policy was not implemented better was that the government had neither the managerial capacity nor the sense of ownership in and commitment to the policy that would have been required to do so. This "explanation" seemed to describe a symptom rather than a cause of the problem, and simply led to further questions as to why that was the case. Ultimately, the answers suggested by

the research were that government did not have the ability to overcome overt opposition to the policy exerted by USAID, and that it did not have the will to face implicit latent opposition to the policy inherent in what decision makers and bureaucrats alike perceived to be widely held religious condemnation of abortion.

The most immediate direct impact of the shift in U.S. policy towards abortion was to force the Pathfinder Fund to terminate its financial support of MR training and services after nine years of commitment, including the singularly important role that the Pathfinder Fund played in placing abortion on the policy agenda and in introducing MR into the national family planning program. Over 100 local NGOs including the oldest and largest family planning NGOs in Bangladesh were similarly forced to abandon their MR activities, including even mentioning the availability of MR to women, in spite of the fact that MR remained an official part of the national family planning program. Further, data on MR services that continued to be reported by family planning field workers were not summarized by the main management information system of the Ministry of Health, because that system was developed with assistance from U.S. government funds through an American NGO. Accordingly, MR service statistics were not included in monthly performance reports provided to policy makers, donors and technical assistance agencies after 1984. Similarly, data on MR was consistently omitted from census data compiled for health and population researchers and policy makers, MR equipment was excluded from a project designed to improve procurement and distribution of family planning commodities of a project design, MR was not mentioned in the information, education and communication strategy for the national family planning program, and MR was ignored in a large project to work with local officials to manage family planning services, all largely because of restrictions on the use of USAID funds. Moreover, although many researchers speculated that abortion was an important variable in accounting for maternal mortality, research organizations that received any funds from USAID were not allowed to conduct any research relating to abortion. In addition, as already alluded to, USAID influenced the policy dialogue in Bangladesh by ignoring MR in capacity building and technical assistance activities, such as the preparation of five-year development plans and the establishment of a steering committee to oversee the family planning and maternal child health programs. The Government of Bangladesh did not have sufficient resources to draw upon to counter the effects of the overt opposition summarized above and, accordingly, the "lack of capacity" argument that was commonly but vaguely

suggested by respondents as an underlying reason for the government's inability to respond to the known deficiencies in the implementation of the MR policy was found in the final analysis to have merit.

Finally the shift in attitudes towards religion in Bangladesh was almost as dramatic as the shift in the U.S. policy on abortion, and the effects on the implementation of the MR policy were at least as profound. The war was portrayed by the west Pakistanis as a holy war, and the first policies of the new country of Bangladesh reflected disillusionment with the notion of Islamic unity and with the concept of religion as a political determinant. The Constitution deliberately adopted a position of strict secularism, and all religious parties were banned. Since that time, however, primarily because of the political use of religion by military leaders to gain legitimacy, religious references were inserted into the Constitution, the Muslim call to prayer was introduced to television broadcasts, the religious educational system flourished with government support, and the ban on religious parties was lifted. In Parliamentary elections that were held in 1991, religious parties won 19 of 300 seats with 14.4% of the popular vote. Those elections did not provide a clear majority for any party, and therefore left religious parties with an important swing vote. During the implementation period, Bangladesh thus "completed a full ideological circle [. . .] to one not far removed from the Islamic status of pre-liberation days "(Kabeer, 1989:10).

There is no evidence to suggest religious attitudes towards abortion changed over the period covered by this research, only that religion became a more powerful contextual factor for decision makers and managers to consider. Religious groups did not take a position on abortion or on the MR policy. They tacitly accepted the policy as a population control measure, but neither this tacit support nor any opposition that may have been felt was ever expressed by religious leaders in Bangladesh. Nonetheless, some individuals interviewed for this research indicated that they were personally opposed to the policy because of their religious beliefs. To the extent that individual doctors, bureaucrats and policy makers held personal religious attitudes and cultural values that conflicted with the MR policy, the political will necessary to implement the policy would clearly have been weakened. Even those who could claim no personal tension recognized the possible ramifications of rousing the sleeping tiger of religion. This collective fear of arousing latent religious opposition

appears to have been the single largest reason why the Government of Bangladesh was unwilling to address known deficiencies in the implementation of its MR policy.

5.4.2 Analysis

The Grindle and Thomas model requires an assessment of the characteristics of a policy in order to predict whether the response to its implementation will be felt primarily in a public arena or primarily within the bureaucracy. The arena of response, in turn, dictates the stakes involved and the resources required. The extent to which the Grindle and Thomas model could be used to explain the implementation of the MR policy is examined in depth below.

5.4.2.1 Policy Characteristics

The *costs* of some reforms may be concentrated in government with little apparent impact elsewhere, such as with the reorganization of the public service or with the establishment of a new government agency. The costs of other initiatives, however, such as raising income tax rates or reducing food subsidies, may be broadly dispersed over a large segment of the public. Similarly, the *benefits* of reform initiatives may be concentrated in government—such as when the efficiency of the public sector is improved or when a budget surplus is increased—or they may be dispersed through, for example, the provision of roads or educational services that are used by a large segment of the public. When the costs of the reform are dispersed, or visible to the public, and benefits are concentrated, or not visible to the public, Grindle and Thomas hypothesized that the reaction to the initiative would primarily take place in the public arena. When the costs are concentrated and benefits dispersed, the reaction would primarily take place within the bureaucracy.

The MR policy stipulated that MR services were to be provided free of charge. The economic costs were therefore concentrated in government. The benefits accrued directly to the women who received the 1.3 million, perhaps as many as 6 million, MR procedures performed from 1979 to 1997. The Grindle and Thomas model therefore predicted that the reaction to the MR policy should have taken place primarily within the bureaucratic arena. As we have seen, there was no public reaction to the introduction of MR into the national family planning program; the response was indeed contained within the bureaucratic arena.

Some reforms, such as currency devaluation, are "self-implementing" because they do not require depth of *administrative resources or technical skills* to sustain them. In such cases, according to the Grindle and Thomas model, there is likely to be a public reaction, which is often strong because of the same reform's broad and immediate impact. Reforms that have a high administrative content or that are technically complex, on the other hand, will not have an immediate impact on the public and successful implementation will depend, according to the Grindle and Thomas model, on competence and support in the bureaucracy. The MR policy was of the non-self-implementing kind of reform initiatives, and therefore, the Grindle and Thomas model again correctly predicted a bureaucratic, rather than a public, reaction to the implementation of the policy.

Grindle and Thomas contend that if extensive *participation* is required to carry out the reform, such as when large numbers of people must be mobilized to collaborate in a change, a public reaction is more likely. On the other hand, where little organized participation is required or if participation is required on an individual or case-by-case basis, such as when granting licenses or permits, the response is likely to be confined to the bureaucracy. Moreover, the fewer the bureaucratic actors involved, the higher the probability that the reform will be implemented as intended. The MR policy required participation on an individual, case-by-case basis, and there were a large number of bureaucratic actors involved. Accordingly, the model predicted a bureaucratic response with less likelihood that the policy was implemented as originally intended.

The shorter the *duration* before the full impact of the change is visible to the public, according to the Grindle and Thomas model, the more likely that the reaction to the reform will be stronger and more public. Conversely, the longer the time needed to implement the reform, the more likely that potential conflict and resistance will emerge and that administrative capacity within the system will determine the implementability and sustainability of the reform. It could be argued in light of the relatively large numbers of illegal abortions that the MR policy was not fully implemented almost two decades after it had been officially proclaimed part of the national family planning program. Accordingly the model predicted a bureaucratic response with administrative capacity the key determinant of the success of the implementation effort. A lack of bureaucratic capacity was in fact one of the main

reasons suggested during this research for the government's apparent inability to address known deficiencies in the implementation of the MR policy.

5.4.2.2 Stakes

The Grindle and Thomas model accurately predicted from the characteristics of the MR policy that the reactions to the policy would be played out primarily within the bureaucracy. With a different set of policy characteristics, a public reaction may have been predicted, which Grindle and Thomas assert would have led to the mobilization or formation of pressure groups to oppose the reform in a variety of ways, including perhaps making international headlines, conducting mass protests, or overthrowing the government in a military coup. Such reactions were not unknown in Bangladesh at the time, but also were not triggered by the implementation of the MR policy.

When responses to reforms are played out primarily within the administrative apparatus, according to Grindle and Thomas, the stakes are much lower. At issue is the viability of the reform, not the survival of the regime. Stakes involve individual or department goals, rather than the high stakes of reforms played out in the public arena. The stakes involved in the case of the MR policy in Bangladesh were indeed kept low.

5.4.2.3 Resources

Political resources are essential in implementing a reform that generates a strong public reaction. With respect to the formulation and implementation of the policy, it appears that policy makers in Bangladesh may have decided that the political resources at their disposal were not sufficient to overcome a possible strong reaction in the public arena. Legal abortion was abandoned as an agenda item, the policy was cloaked in ambiguity, and a low profile was maintained so as to avoid attracting the attention of USAID and to avoid rousing the sleeping tiger of religion, all in deliberate attempts to lower the stakes and to keep the reactions to the policy in the bureaucratic arena.

While all reforms require political resources, according to the Grindle and Thomas model, *bureaucratic resources* are relatively more important to implement and sustain those policy reforms that are played out in the bureaucratic arena. Grindle and Thomas contend that financial, managerial, and technical resources need

to be mobilized by public managers to overcome the negative reactions that are encountered by all policy reforms, and to increase the chances that reform decisions will lead to the results originally intended.

Financial and technical resources were mobilized in order to implement the MR policy in Bangladesh. A series of international donors provided uninterrupted funding and technical support to the Menstrual Regulation Training and Services Program (MRTSP) for MR training and services. Similarly, the Bangladesh Association for the Prevention of Septic Abortion (BAPSA) was supported by international donor funds and technical assistance to recruit MR trainees and to conduct research and evaluation into MR activities.

Except for the period 1983-1991 when MRTSP was considered a special project of the Ministry of Health, the MR training program was run completely autonomously of the government. Even during the period when it was considered a special project, the Ministry did not play an important or active role in the management of the MR training program. Similarly, the efforts of BAPSA and two other NGOs that provided MR training were not monitored, supervised, coordinated or otherwise managed by any unit or department of the Government of Bangladesh. The inability to mobilize sufficient managerial capacity was a critical constraining factor in the implementation of the MR policy. The reasons for the lack of managerial capacity suggested by the research were both because foreign donors and technical assistance agencies chose to support the MR NGOs rather than to build the implementation capacity of government managers, and because government managers and their supervisors did not feel a sense of commitment to the policy. The latter, in turn, appears to have been due to perceived conflicts between the MR policy on one hand, and religious attitudes and cultural values on the other.

In summary, the Grindle and Thomas framework accurately predicted that the response to the implementation of the MR policy would be played out primarily in the bureaucratic arena, and that the stakes would therefore be lowered. It further predicted that primarily bureaucratic resources would be required to implement the policy to the extent that it was. As summarised in table 5.5, however, it is interesting to note that additional bureaucratic resources would appear to have addressed only one of the four primary reasons suggested by the research for the government's

unwillingness and inability to address the known deficiencies in the implementation of the MR policy.

Table 5.5

Comparison of Research Findings to Analytical Framework

Government response	Reasons suggested by research	Resources required to address problem
Unwilling to address deficiencies	Low relative priority Religious opposition	Political Political
Unable to address deficiencies	Opposition from USAID Lack of capacity	Political Bureaucratic

6.0 Sustaining the MR Policy

6.1 Introduction

The third of three main aims for this research was to provide insights to better enable supporters of the MR policy to assist the Government of Bangladesh in sustaining the policy in the future or, in other words, to make an analysis *for* policy. This chapter is concerned with that aim. It builds upon the "lessons learned" in the analysis *of* the policy process followed in the past, particularly the analysis of why the government was unable and unwilling to better implement its MR policy from 1979-1997, as set out in the previous chapter. In chapter 5, we saw that primarily additional political resources were required to address the underlying reasons as to why the government was unwilling and unable to better implement its policy in the past. In this chapter, we assess the likely resources available to sustain the MR policy in future, with a view to identifying additional resources that might be mobilised to enhance the chances of success.

The research defines the future of the MR policy as commencing with the Health and Population Sector Programme (HPSP) for 1998-2003, and the chapter begins with a discussion of the opportunities for sustaining the policy presented by a new international agenda at the time the HPSP was set, and by the HPSP itself. The chapter then turns to an analysis of the reactions to the policy that can be anticipated from each of the major actor groups. The analysis is summarised in a series of political "maps" that portray the likely sources of political support and opposition under various possible future scenarios, and that lead to assessments as to the likelihood that the MR policy will be sustained under each scenario. The chapter closes with possible strategies for expanding the "policy space" for sustaining the policy in future, by mobilising additional bureaucratic and political resources.

6.2 Opportunities

The context within which the MR policy and other health policies of the government may be sustained in future will differ from the contexts described in previous chapters because of the major health sector reform in Bangladesh represented by HPSP. As described in more detail below, the changes in Bangladesh mirrored international trends in health sector reform.

6.2.1 The New International Agenda

The Fifth Health and Population Sector Programme (HPSP) of the Ministry of Health and Family Welfare was developed at a time when there were two noteworthy international trends in heath sector reform. The first such global trend was initiated by the 1993 World Bank Development Report entitled Investing in Health (1993), which called for public and private sectors in developing countries to take on new roles to improve the health status of populations and at the same time to contain health care costs. The report proposed a new methodology for developing country governments to define a minimum package of services and to base government spending on epidemiological and economic analysis leading to the establishment of a list of priority health interventions ranked by health gain per dollar spent. Many of these features were incorporated in HPSP, with significant implications for the MR policy.

The second international trend was to broaden the definition of population policy, which until the early 1990s had primarily involved adopting programs to provide contraceptive services as the main means to achieving demographic targets set for reducing population growth. This trend was marked by the International Conference on Population and Development (ICPD), which was sponsored by the United Nations and held in Cairo in 1994. The ICPD Programme of Action recognized the complex interrelationships between population and sustainable development, and called for policy reforms that placed greater emphasis on social development that supported the most marginalized members of society—specifically the poor, and especially poor women who constitute the majority of the world's poor—as a fundamental element of population policy (United Nations General Assembly, 1994). Accordingly, the ICPD Programme of Action believed the reproductive rights of women as well as their reproductive and sexual health were central to population policy, and agreed that universal access to reproductive health care should be achieved by the year 2015.

Abortion was specifically recognized as a major public health concern in the ICPD Programme of Action. Accordingly, governments were urged to reduce the incidence of unsafe abortion, to ensure that services were safe when not against the law, to offer reliable information and compassionate counselling for all women with unwanted pregnancies, and to provide quality services for all women who suffer the

consequences of unsafe abortion. These recommendations were echoed in the agreement reached by the Fourth World Conference on Women held in Beijing in 1995 (United Nations General Assembly, 1995) and they represented a significant advancement on the recommendations of the 1984 United Nations population conference, which had merely declared, "abortion should in no case be promoted as a method of family planning" (Blane and Friedman, 1990:1). Several persons interviewed commented that the recommendations provided governments, donors and NGOs with the official sanctions they needed to begin to address or to resume addressing unsafe abortion as a major public health problem in Bangladesh.

6.2.2 *Health Sector Reform and its Promise for MR*

The goal of the Health and Population Sector Programme (HPSP) for 1998-2003 was to improve the health of the people of Bangladesh, particularly by reducing maternal and infant mortality and morbidity, by reducing fertility to replacement-level growth by the year 2005, and by improving nutritional status (Ministry of Health and Family Welfare, 1998). Unlike previous five-year plans for the sector, HPSP incorporated the concept of a package of essential services for women and children, based on the recommendations of the 1993 World Bank report and of the ICPD as described in the preceding section. To enable the efficient and effective delivery of the package of essential services, the Government of Bangladesh planned to provide a range of integrated and coordinated support services including appropriate staff, physical infrastructure, logistic support, quality assurance systems, behaviour change and communications programs, management information systems, and research capabilities.

This research hypothesized that MR, as one of the essential services included in the package, could theoretically have benefited from these support services. In particular, MR training needs could have been assessed and integrated with all other training required by government providers to deliver the essential package of services. Similarly, the management information and quality assurance systems of the government could presumably have been expanded to incorporate MR services such that accurate information about the numbers and quality of MR services could be captured, summarized and reported to line managers. In addition, the logistics support system could have been expanded to incorporate MR and ultimately to enable better forecasting, procurement and distribution of MR equipment. Also, effective behaviour change and communications efforts could have ensured that women

throughout Bangladesh were provided with accurate information about where, when and how to seek MR services. Finally, the government in theory could have ensured that adequate numbers of sufficiently qualified providers were working in fully supplied facilities to ensure that MR services could safely and efficiently be provided to all women who required them. In short, all of the technical difficulties experienced with the implementation of the MR policy from 1979-1997 could have been addressed, in theory, by HPSP.

In addition to promising the integrated support services described above, HPSP proposed a new delivery system and a different funding mechanism to provide greater assurance of coordinated, efficient and cost-effective health care. The new health delivery system meant that clients would receive health and family planning services from a single service point, something that was actually impossible under the previous public health system structure with two strictly separate directorates within the Ministry of Health and Family Welfare. Further, instead of consisting of a number of individually-funded projects each concerned with a narrow range of health services, HPSP involved a pooling of government and donor funds to finance the health and population sector as a whole. The new delivery and funding mechanisms implicit in HPSP afforded MR broader financial and political support from donors and from the government than it had ever enjoyed in the past. The likelihood that this potential may be realized is assessed below.

6.3 Opponents and Would-Be Supporters

A linear model of implementation would assume that since HPSP includes MR in the list of essential services, the "real" work of policymaking has been completed. All that remains is for another group—the managers and administrators—to carry out the decision that has already been made, and the promise of HPSP for MR will be realized. Decision makers therefore need only ensure there is adequate capacity within the implementing agency to carry out the reform, and to maintain the political will to see it through.

The interactive model of implementation that is being applied to this research, on the other hand, considers an almost limitless number of potential outcomes, depending upon the reactions that will be elicited during the implementation process. "Decision makers and implementers inevitably face

opposition in attempting to pursue reform initiatives; in consequence, it is important to consider feasibility in terms of support and opposition to change, what stakes they and the government they serve have in pursuit of reform, and the political and bureaucratic resources needed to sustain such initiatives" (Grindle and Thomas, 1991:125). This section considers the likely reactions from each of the major actor groups that will be affected by the future implementation of the MR policy.

6.3.1 *The Ministry of Health and Family Welfare: Competent Managers?*

To realize the full potential for MR under HPSP, it would be essential for the Government of Bangladesh to assume a new, more proactive, management role in future. Training and other aspects of the MR program could continue to be delivered by NGOs, but overall responsibility, direction and control would have to be exercised by the Ministry of Health and Family Welfare. Chapter 5 showed that the limited capacity of the Ministry was one of the reasons that the government was unable to address known deficiencies in the implementation of the MR policy. For the same reason the government did not demonstrate the leadership to articulate policy directions for the MR program under HPSP, or to specify the roles to be played by the NGO, private and government sectors.

HPSP's Programme Implementation Plan contained statements of policy for each of the essential services, each of which was supposed to be supported by five-year implementation plans complete with goals, objectives and progress indicators (Ministry of Health and Family Welfare, 1998). For certain of the essential services, notably family planning and Safe Motherhood, these policy directions and implementation plans were detailed, clear, and well conceived, in large part due to technical assistance received from external actors as discussed more fully later in this chapter. For other essential services, however, including MR, the prevention and control of RTI/STD/AIDS, infertility, and adolescent care, the policy statements and implementation plans were less well developed.

The statement of policy articulated by the Ministry of Health and Family Welfare in respect of MR services was confusing, vague, and silent with respect to known deficiencies such as illegal fees and the needs of unmarried women:

> Menstrual Regulation (MR) and Unsafe Abortion: Existing information suggests that each year about 2.8% of all pregnancies undergo MR and about 1.5% undergoes induced abortion. A significant number of these are conducted in the public facilities, but under unsafe conditions. Although significant number of doctors and paramedics (about 12,000) received formal training in MR, and rate of complications and side effects have been reduced over times, still unsafe termination of pregnancies mostly occurs due to inadequate trained personnel and logistic support. In addition many women do not know of a provider or are not aware of time limits and access to legal MR services is poorer in rural areas than urban areas. These also contributed to the factors related to unsafe abortion and MR causing avoidable morbidity and mortality. Adequate training and supplies has been ensured to minimize unsafe abortion or MR. MR activities will also play an important role in lowering the number of septic abortions with low complication rate and thus reducing morbidity and mortality due to illegal abortion. (Ministry of Health and Family Welfare, 1998:22-23)

The Ministry of Health and Family Welfare did not directly attempt to develop a detailed operational plan to implement the policy statement quoted above, but instead asked two NGOs, the Bangladesh Association for the Prevention of Septic Abortion (BAPSA) and the Menstrual Regulation Training and Service Program, to prepare proposals that are discussed in greater detail later in this chapter. This appeared to be a reasonable process, since prior to HPSP the Ministry relied entirely upon these NGOs to identify and satisfy specific needs for MR training, to ascertain inventories of MR equipment at MR sites, to determine the timing and composition of orders for additional equipment, and to conduct research and evaluations related to MR. However, instead of serving as the Ministry's starting point for ensuring that the implementation plan for MR was consistent, the proposal from the BAPSA was adopted without revision. In fact, according to representatives of USAID, the Directorate of Family Planning merely inserted the BAPSA proposal in a loosely bound document that was described as an operational plan for the implementation of the MR program from 1998-2003, without even copying the proposal onto Directorate letterhead, and provided that document to donors for information purposes.

Concerned by the Directorate's apparent lack of leadership on this issue, the Swedish International Development Cooperation Agency initiated technical assistance to the Directorate for the purpose of ensuring that MR was properly considered under HPSP, specifically by developing a detailed implementation plan that defined how MR would be addressed by each of the support services and that

specified roles for the Ministry of Health and Family Welfare and for the NGO sector (Rasmusson, 1999). The Steering Committee of Health and Population Support Office representing the donor consortium supported the initiative, but no technical assistance was ever reached between the Swedish International Development Cooperation Agency and the Directorate (Rasmusson, 1999).

Based upon the passive, hands-off, approach to MR taken by the Directorate of Family Planning and by the Ministry of Health and Family Welfare throughout the implementation period as described in chapter 5 and during the early years of HPSP as described above, it appears the Government of Bangladesh may continue to be unwilling to provide the direction, management and leadership required for it to ensure the full potential of MR under HPSP is realized, unless it receives significant support from other actors. The likelihood that other actors will be able to provide such support is described below.

6.3.2 *MRTSP and BAPSA: Former Champions*

The primary NGO that provided MR training and services in Bangladesh since even prior to the formulation of the MR policy was the Menstrual Regulation Training and Services Program (MRTSP). Support for recruiting trainees and conducting research and evaluation of the MR training and services was provided by the Bangladesh Association for the Prevention of Septic Abortion (BAPSA) since 1982. As mentioned above, the Government of Bangladesh accepted BAPSA's suggestions for a detailed implementation plan to be adopted in order to deliver MR under HPSP, without any criticism, amendment or comment. It may have been reasonable for the government to expect that, after decades of essentially managing the MR program with financial and technical assistance from a series of external donors, the MR NGOs would have the requisite vision and capacity to develop an appropriate operational plan for MR. This confidence in MRTSP and BAPSA, however, appears to have been unjustified.

HPSP represented a significant change to the way MR was to be delivered. Nonetheless, the MR NGOs proposed to continue to provide the same activities that they had provided over the previous two decades. MRTSP proposed an ambitious 10-year training schedule that represented nearly double its capacity at the time. That proposal may have been acceptable if more trained providers were all that were required. However, many of the known deficiencies in the implementation of the MR

policy, such as the lack of knowledge about when and where to seek MR services, were unrelated to training. Furthermore, the MRTSP proposal recommended providing training for in-service doctors and medical students, as well as private sector physicians, when Family Welfare Visitors delivered the majority of MR services. BAPSA similarly proposed to continue to recruit the staff required for MR training, to continue to monitor the quality of MR care, to continue to provide MR information to women, and to continue to monitor the distribution of MR equipment. This reflected a clear lack of appreciation of the new model under HPSP wherein MR was to be integrated with other health care services, and supported by government-wide recruiting, monitoring, information and logistical supply mechanisms that could be expected to more cost-effectively provide system-wide coverage than a small NGO that in the past could afford to visit no more than a handful of the thousands of health clinics in the country in any given year.

The lack of appreciation for the new model for health care delivery under HPSP may have been due in part to the lack of participation by the MR NGOs in the preparations for HPSP. MRTSP attended a single planning meeting before being requested to prepare its suggestions for the detailed implementation plan for MR. BAPSA did not attend any. In a meeting of the Technical Advisory Committee that was formed to follow up the high rejection rates for MR services as discussed in the previous chapter, the government asked the MR NGOs to prepare a joint paper responding to the following questions:

- What have the MR organizations been doing in the last few years?
- Why should the Government of Bangladesh provide funds to the MR NGOs?
- What will the MR NGOs do in the future?
- How will the MR NGO's help the Government of Bangladesh in providing MR training and services? (Kamal, 1998)

The government's request was not accompanied by any written instructions or background materials, or by any explanations as to how the government intended to use the joint response to the above questions. There was no significant dialogue with the MR NGOs as to the broad health sector reforms being contemplated by the government. Accordingly, it is not surprising that the proposals by the MR NGOs as

summarized above contained "more of the same" activities rather than responding to the new model implicit in HPSP.

With stronger leadership, MRTSP and BAPSA might have projected a broader vision for the program and for their role in the new HPSP regime. However, over the previous several years, these organizations had been led by the same individuals who, at the time of the research, were within a few years of retirement. The upcoming void in leadership appeared to some interviewees to provide an opportunity to reconsider the mission of these organisations, and to recruit appropriately qualified individuals to lead them forward. With new vision and direction, MRTSP and BAPSA could refashion themselves to work in concert with the government under the HPSP model, similar to the way some large family planning NGOs had already positioned themselves at the time of the research to provide evaluation services that the government could be expected to contract out, under the overall direction and control of the government. It is not possible to predict whether such new leaders will be recruited in future. At the time of the research, however, there had been no succession planning or thought given to the next generation of leaders in either of these organisations. With the same or like-minded leadership in future, it is unlikely that these organizations will demonstrate the vision and exercise the initiative to contribute significantly to any of the government's efforts to sustain its menstrual regulation policy. Such outstanding vision and initiative should not be required in these NGOs in any event since, in theory, these qualities could exist solely within the government, which would then merely contract out to the NGO community the MR services required. While it would be preferable to have capacity in both of these major actor groups, neither appears to have the vision necessary to realise the potential promise of MR under HPSP.

6.3.3 *International Donors and Technical Assistance Agencies: A Mixed Bag*

International agencies providing financial and technical assistance to Bangladesh in the areas of maternal and child health could be categorized as champions of MR, opponents of MR, or neutral towards MR. The majority fall into the third, neutral, category, actively working neither for nor against MR but concerned about other health interventions. Because such players have not been actively working to oppose MR, however, is not to say that their activities did not adversely affect the implementation of the MR policy. In fact, by concentrating attention and scarce resources within the Ministry of Health and Family Welfare on

their own areas of interest, one could argue that neutral international agencies reduced the capacity otherwise available within the Ministry to address the implementation of the MR policy.

During the 1990s UNFPA, UNICEF, the World Bank, the Canadian International Development Agency, the Norwegian Agency for Development, and the European Union, provided funds and technical assistance to the Ministry of Health and Family Welfare for Safe Motherhood projects.[11] As a result, the Safe Motherhood initiative was well established, as reflected in the carefully developed policy directions and implementation plan contained in HPSP. Similarly, USAID aggressively advocated family planning independently of its role as an opponent of MR. It provided financial and technical assistance to develop population and health sector plans, to publish demographic data and policy papers, and to promote various forums for dialogue with national policy makers. As a result, by the time of HPSP, Safe Motherhood and family planning were high profile initiatives commanding the time and attention of line managers and bureaucrats as well as policy makers. Because time and attention are limited, finite, commodities, this necessarily had the effect of displacing the amount of resources that could be devoted to MR.

The theory of HPSP incorporated a pooling of all government and donor funds to finance the health and population sector as a whole. In the early years of HPSP, however, not all donors agreed to contribute to the pool. The Canadian International Development Agency and the United States Agency for International Development, for example, indicated that they would continue to earmark their funds for specific activities and purchases for an unspecified interim period (Gerein, 1998). The earmarking of funds was not done to prohibit financing of MR activities, but again the probable effect will be to concentrate scarce management resources on the earmarked activities and purchases, when such resources should theoretically be evenly spread across a broader package of essential services.

Ironically, the Swedish International Development Cooperation Agency, which was the sole international agency included in the champions of MR category at

[11] In 1987 WHO, UNDP, UNFPA, and other international agencies launched the Safe Motherhood Initiative urging governments, NGOs and others to recognize and address high maternal mortality. Although abortion was recognized as the cause of one quarter of maternal deaths, no preventive action was recommended (Sundstrom, 1993) and the issue of abortion has remained largely unattended by international agencies to date.

the time of HPSP, decided to pool its funds with other willing donors, thereby relinquishing some or all of its direct influence over the specific use of those resources. The Swedish International Development Cooperation Agency funded the MR program in Bangladesh through a series of bilateral agreements beginning in 1991. Like the Ford Foundation before it, the Swedish International Development Cooperation Agency staff interviewed for this research suggested that the Agency began its funding with the anticipation that the Government of Bangladesh would gradually assume more and more responsibility for the costs of what was supposed to be a regular ongoing program. Over the years until HPSP, however, the government did not begin funding any of the costs of its MR program. It relied upon the Swedish International Development Cooperation Agency to supervise and manage the MR funds and did not become involved at all, contrary to the Agency's initial expectations. The Swedish International Development Cooperation Agency recognised that HPSP provided an opportunity to force the Government of Bangladesh to assume ownership for its MR program without withdrawing the Agency's financial support for MR and, accordingly, it decided to pool its funds. While this decision was theoretically sound, the implications are likely to be detrimental to the immediate future implementation of the MR policy because of the limited capacity of the Government of Bangladesh to manage the program, as discussed above. From the narrow standpoint of sustaining the MR program over the immediate term, observers maintained that the Swedish International Development Cooperation Agency may have been better advised to follow the example of other donors such as the Canadian International Development Agency and the United States Agency for International Development who chose to continue earmarking their funds for an interim period, and/or to accompany its pooling decision with technical assistance designed to strengthen the capacity of the Directorate of Family Planning to manage the MR program.

The major opponent of MR amongst the international agencies at the time HPSP was introduced was the United States Agency for International Development. Although the Mexico City Policy was rescinded in 1993, the Helms Amendment, which prohibited the use of American foreign aid funds to be used for abortion, remained in place at the time HPSP was introduced. Moreover, since 1995 foes of family planning and abortion rights in the U.S. Congress sought to add restrictions, similar to but more onerous than the Mexico City Policy, to foreign operations appropriations bills and to State Department reauthorisation bills (Center for

Reproductive Law and Policy, n.d.). They won their battle in January 2001 when Republican George W. Bush reinstated the Mexico City Policy, and passed the new "global gag rule"[12] as one of his first official acts as president. Existing and future restrictions could become an issue in future if and when the USAID decides to pool its funds. One possible outcome of such a decision could be that the USAID may exert pressure to have MR removed from the essential services package as a condition of pool funding.

6.3.4 Women's Groups: Potential Champions?

The stated objective of the MR policy changed from population control at the time that the policy was formulated, to reproductive health during the implementation period. When the objective changed, women's groups became—or could have become—legitimate stakeholders in the MR policy. This section explores the likelihood of women's rights advocacy organizations and of certain other women's groups to play a role in enabling the Government of Bangladesh to sustain its MR policy in future.

Women's groups comprises a large and diverse collection of actors. By the mid 1990's, over 500 organizations were officially registered with the Ministry of Women's Affairs, in addition to the thousands of NGOs with social welfare and charity programs aimed at meeting the needs of women beneficiaries (Jahan, 1995). These organizations could be categorized as belonging to one of four groups: development NGOs with programs affecting women; professional women's associations; women's groups associated with political parties; and women's rights advocacy organizations (Jahan, 1995, Kabeer, 1989).

The majority of development NGOs have worked as social welfare, charity, or service organizations with the poor and landless throughout rural Bangladesh. A small number of progressive NGOs, however, have changed their approach from welfare to collective empowerment. They are involved in traditional activities with poor rural women, such as credit and health care, as well as group formation and

[12] The global gag rule disqualifies foreign NGOs from receiving USAID funds either directly or through U.S. intermediaries if they use their own, non-USAID funds to perform legal abortions or to lobby their own governments on abortion issues. Unlike the Mexico City Policy, which is an administrative policy, the global gag rule has been written into U.S. law (Center for Reproductive Law and Policy, n.d.).

consciousness-raising about the roots of economic oppression and gender discrimination. Most of these organizations are based in rural areas and reach women who fall outside the orbit of women's political organizations (Kabeer, 1989). Their training sessions include feminist and class issues such as male violence, dowry, polygamy, verbal repudiation, wages, land rights, and police harassment (Jahan, 1995, Kabeer, 1989). None of the development NGOs has ever expressed a public position on or interest in abortion or MR.

The professional women's organizations include the likes of the Federation of University Women and the Federation of Business and Professional Women. They are run by professional, highly educated women from the elite classes of Bangladeshi society, and operate primarily as welfare organizations targeting needy and distressed women (Chowdhury, 1994). Ain-O-Shalish Kendra is comprised of a group of lawyers who are concerned with eliminating all forms of legal discrimination. Although its director touched on the topic of abortion in her publication Legal Status of Women in Bangladesh (Sobhan, 1978), neither Ain-O-Shalish Kendra nor any other professional women's organization has ever expressed a public position on or interest in abortion or MR.

The women's groups associated with the two main centrist political parties–the Awami League and the Bangladesh National Party–by and large follow party or state lines (Chowdhury, 1994, Kabeer, 1989). While they are interested in laws that support equal rights for women, they generally do not become involved in policy matters; rather, they work as social welfare organizations with poor and needy women. The women's groups associated with the left wing political parties have given broader expression to women's rights (Kabeer, 1989). In particular, Mahila Parishad (Women's Council) has been credited with mobilizing public support for women's issues including dowry and discrimination against women. At the time of this research, it was becoming increasingly involved in the health policy arena and it had at one point in its recent history expressed a position on abortion and MR (Moslem, 1998).

Women's rights advocacy organizations represent the subset of women's groups in which this research was primarily interested. In many other countries of the world, especially in North America and Europe, abortion made it onto the policy agenda primarily due to pressure from such groups in those countries (Solinger,

1998). However, women's rights advocacy organizations in Bangladesh did not influence agenda setting, formulation or implementation of the country's MR policy. Nonetheless, because of changes in the international context in the mid-1990s, primarily the mandate given by the United Nations International Conference on Population and Development in 1994 and by the Fourth World Conference on Women in 1995 to increase access to safe abortion and to consult women in the policy process, this research hypothesized that women's groups could become more legitimate stakeholders in the future of the MR policy and program. This hypothesis was supported by Amin and Hossain who maintained that the agreement reached at the ICPD provided "an unassailable framework for women's rights advocates to press for the enforcement of reproductive rights and freedoms" (Amin and Hossain, 1995:1343). Similarly, Germain and Kim asserted that the International Conference on Population and Development and the Fourth World Conference on Women agreements with respect to abortion specifically provided "a strong basis to expand access to services, to liberalize laws and regulations, and to ensure the accountability of governmental and international agencies" (1998:ii).

Only four advocacy organizations were identified by government officials, local NGO representatives, international donor agencies and international women's groups as important women's groups that had addressed reproductive health and rights at some point in their history. These included Women for Women, Bangladesh Women's Health Coalition, UBINIG (Policy Research for Development Alternatives), and Naripokkho (For Women). No other groups were perceived to have an agenda that included reproductive health and rights advocacy.

Bangladeshi researchers Amin and Hossain similarly reported that women's groups in Bangladesh "have largely remained conspicuously silent on the issues of sexuality" and there have been "few attempts to explicitly articulate the notion of the right to reproductive health or freedom, including the right to self-determination" (Amin and Hossain, 1995:1324-1325). By way of explanation, Jahan asserted that "there is little discussion of women's sexuality, including freedom of choice and homosexuality. These remain controversial within the women's movement; many consider them private and personal issues and so controversial that raising either increases the risk of backlash against the women's movement" (1995:107). Jahan pointed out that nascent women's movement did not work actively to mobilize support for women who had been raped during the war, and in interviews with

women leaders in the mid 1990s, she found that "many groups and individuals were still hesitant to challenge the society's strong patriarchal traditions and feared that doing so would invite a backlash that would hurt victims more" (1995:95).

6.3.4.1 Mahila Parishad

Mahila Parishad is one of the largest women's groups in Bangladesh, with a primarily urban middle class membership (Chowdhury, 1994) that numbered over 30,000 in 1997, more than double its membership in 1988 (Chowdhury, 1994). In 1996, Mahila Parishad was asked by the Ministry of Health and Family Welfare to take part in a consultative process in which NGOs, women's groups, private sector health care providers, government officials, and donors provided input into the preparation of the Fifth Health and Population Sector Programme. Following a series of meetings, the Ministry asked Mahila Parishad and certain NGOs to organize district level workshops designed to seek client and provider views on government health services (Moslem, 1998). One outcome of these workshops was a recommendation that Health Watch Groups consisting of government officials, NGO representatives, community leaders, professionals and clients, particularly women and the poor, be formed to plan, implement and monitor government health and family planning activities (Bangladesh Rural Advancement Committee, 1997). Mahila Parishad expected to be involved in monitoring government services through the Health Watch Group mechanism and, accordingly, it was well positioned to help ensure that the potential promise of MR under the new HPSP as described at the beginning of this chapter was realized.

Mahila Parishad has maintained that abortion should be legalized in order to make services safer and more accessible. In fact, a committee within Mahila Parishad introduced new abortion legislation to its General Assembly in the early 1980s, which if approved by the General Assembly would have become the basis for a campaign to change the law. No decision was reached by the General Assembly, however, so the campaign was never launched. Interviewees had a hazy knowledge about the implementation of the MR policy, and explained that while Mahila Parishad felt that abortion was an important right for women, its members considered it less important than other rights concerning dowry, inheritance, child guardianship, marriage, and uniform family law. It therefore appeared unlikely that Mahila Parishad would use its position as a member of the Health Watch Group to encourage the government to expand access and improve the quality of MR services. Should it become interested

in the effective provision of MR services, however, Mahila Parishad has demonstrated that it can be an effective lobbyist. It has been credited with leading a signature campaign and vigorous lobbying of women Members of Parliament, which led to the passage of the Prohibition of Dowry Act of 1980 (Jahan, 1995). Chowdhury also reported that Mahila Parishad influenced the government to ratify the Convention on the Elimination on All Forms of Discrimination Against Women in 1995 through meetings, press conferences, rallies, and by working with other women's organizations to mobilize public opinion (1994). However, at the time of this research, the leaders and membership of Mahila Parishad had not identified any deficiencies in the implementation of the MR policy that needed to be addressed and, accordingly, it appeared unlikely that it would play a significant role in the future implementation of the MR policy.

6.3.4.2 Women for Women

Women for Women was one of the four women's rights advocacy organizations perceived to be pursuing an agenda that included reproductive health and rights. The organization describes itself as a research and study group engaged in raising social awareness about "the subordinate position of Bangladeshi women" by addressing the need for "social transformation" through research, communication and advocacy (Jahan, et al., 1993:i). The group works to create "a positive and pro-active attitude toward gender issues at national policy-formulation and decision-making level."(Jahan, et al., 1993:i) It claims credit for influencing the Ministry of Planning to adopt the principle of mainstreaming gender concerns across sectors, and to include specific sector policies in the Fourth Five-Year Plan. Women for Women facilitated dialogue between the Ministry of Planning and women's groups, culminating in a national convention in 1984, where gender policies were drafted. According to one of its founding members, "the researchers' professed non-political stance and professional style made them acceptable spokespersons to the policy planners of an authoritarian regime, most of whom belonged to the same social class" (Jahan, 1995:99).

In 1993—at the same time that several international women's groups were holding regional meetings and caucuses to coordinate and articulate women's input to the 1994 United Nations International Conference on Population and Development—Women for Women organized a national convention on Reproductive Rights and Women's Health. Women for Women judged that the convention topic had not "yet

received adequate coverage in Bangladesh [. . .] and women's reproductive right as a basic human right has not been recognized in the country so far" (Jahan, et al., 1993:ii). The purpose of the convention was to come up with a clear conceptualisation of reproductive rights and women's health that would be used as the basis of further public debate and that could be used as guidelines for policy action. The convention included three presentations on reproductive health, three presentations on reproductive rights, and a five-member panel discussion on the legal aspects of reproductive rights. The convention concluded with a series of recommendations including the following pertaining to the legalization of abortion:

> As a significant step towards the protection of women's health and reproductive rights, abortion should be legalized in Bangladesh as in several muslim [*sic*] majority countries. Health services necessary for safe abortions should be provided both by government and non-government agencies. An adult woman's own decision about abortion should have legal recognition. (Jahan, et al., 1993:100)

In the panel discussion leading up to the above recommendation, one of the panellists, a well-known feminist lawyer in Bangladesh, asserted that the Bangladesh Constitution provided a legal basis for a woman's right to end her pregnancy (Hossain, 1993). Two years later, she made the same argument in a paper that was published by the American University Law Review (Amin and Hossain, 1995). Several experts argued that failure to legalize abortion forced many of the women who sought services beyond the 10-week limit provided by the MR policy to seek illegal, unsafe abortions. Legal sanction was also perceived as a way to create an enabling environment wherein women would be free to decide on their own whether to terminate an unwanted pregnancy, instead of being constrained by harassment, persecution, extortion, and social condemnation. It would also clarify the legal status of MR to provide a more stable basis for the policy, and permit the Ministry of Health and Family Welfare to strengthen its public awareness program to advise women of the services available to them, which as noted in the previous chapter would have addressed virtually all the other difficulties that women faced in accessing MR services. In particular, one expert suggested that legal sanction would mean that women individually and collectively could demand minimum medical standards, and compensation for any negligence by government service providers, including the failure to make services available.

The arguments summarized above reflected two different rationales for legalizing abortion. First, the rights rationale, which maintains that a woman's right to terminate a pregnancy is a basic and inalienable right that is protected by various fundamental principles of human rights, and second, the health rationale, which condemns illegal abortion as a major contributing factor to women's mortality and morbidity (Correa, 1994). Regardless of the underlying rationale, however, the convention's recommendation to legalise abortion was never pursued. In addition, it appears the convention failed to achieve its main objective of clearly conceptualising reproductive rights and women's health in order to foster further public debate and to serve as guidelines for policy action. No public debate ensued and no guidelines for policy action were prepared or followed up.

Interviews suggested that the failure to pursue the recommendation to legalize abortion was a deliberate strategy. Unlike in other countries that attempted to liberalize restrictive abortion laws, Bangladesh had an MR policy that at least purported to provide safe abortion services throughout the country in spite of the law. In other countries women had little to lose by launching a high profile, controversial legal campaign, but it was widely reported that such action in Bangladesh conceivably could have resulted in a stricter interpretation of the existing law and a curtailment or abandonment of the existing MR policy (Germain and Kim, 1998). For this reason, it is unlikely that any organization in Bangladesh will choose in the foreseeable future to risk the potential backlash that could arise from a campaign to legalize abortion.

One of the organization's youngest members suggested that most of the members of Women for Women were linked to the power structure through familial and personal connections, and that these relationships prevented them from pursuing issues that might become too high profile or controversial. As an example of the organization's conservatism, she suggested that Women for Women, like most other first-generation women's groups that emerged in Bangladesh in the early 1970s, would never claim that women have a 'right' to abortion because doing so would be perceived to be giving women 'license to free sex'. From the time of its organization of the 1993 convention to the time of my interview with them in 1997, Women for Women had had no further involvement in reproductive health or rights issues, and MR and abortion were not on its agenda. It appears highly unlikely that Women for

Women will be a significant player in enabling the Ministry of Health and Family Welfare to sustain its MR policy in future.

6.3.4.3 Bangladesh Women's Health Coalition

Initiated in 1980, the Bangladesh Women's Health Coalition (BWHC) became well known internationally as a model of the kind of comprehensive reproductive health services that could be provided in a resource-poor setting (Kay and Kabir, 1988). Instead of following a vertical health planning and programming model, BWHC ran a dozen women-centered reproductive health services clinics that provided comprehensive high quality services to its clients. In BWHC clinics, for example, a woman who obtained an MR would also receive family planning counselling and other health services—an integrated package, in other words, of the essential services that all Government of Bangladesh health clinics are to provide under HPSP. Further, BWHC has a special role in the national MR program. It has for a long time provided MR training to government health workers, and is an active member of the MR Coordination Committee.

The Executive Director of BWHC at the time was very well known internationally as a strong advocate in the reproductive health movement that led up to International Conference on Population and Development. Through her publications, presentations at conferences, and informal networking, respondents suggested that she proved influential in shaping the international agenda for reproductive health. Within Bangladesh, donor representatives and other NGOs reported that BWHC's voice was faint behind the well-connected, well-funded voices of the family planning organizations. BWHC appeared to have been a lone voice speaking against the chorus of voices that were all speaking in favour of the demographically driven, vertical family planning program. As a result, this research found that BWHC was not able to influence domestic reproductive health policy to any appreciable extent, and it was specifically not focused on ensuring the MR policy was properly implemented in government-run clinics in Bangladesh.

The Coalition's leadership changed in the early 1990s, and after a short period when BWHC was run by its former medical director, a senior administrative staff who had been with BWHC since its founding became its director. Since the mid-1990s, the new director reported that he and his staff have represented BWHC on the government's technical advisory committees, but have not been as influential in

controlling the agenda as the relatively professional and well-connected representatives of the USAID-supported family planning organizations on the same committees. BWHC plans to continue in its important technical role, as an MR training organization and member of the MR Coordination Committee, and in this role to advocate for more effective implementation of the policy under HPSP. Given the difficulty that it has faced so far in influencing government policy on its own, however, the diretor was slightly pessimistic about BWHC's potential to effectively advocate for the MR policy.

6.3.4.4 UBINIG

UBINIG is a policy research organization operating on the margins of the women's health movement (Rozario, n/d) that has been working on reproductive rights issues since the early 1980s. UBINIG is an acronym where the Bangladeshi name (Unnayan Biikalper Niti Nirdharoni Gobeshona) translates to Policy Research for Development Alternatives. True to its name, it has actively campaigned for alternatives—any alternatives—to the Government of Bangladesh's population policy. The discourse led by UBINIG has been critical of the implementation of the national family planning program, and has called for example for "freedom from violence, coercion, and inappropriate use of reproductive technology" (Akhter, 1998). In the mid-1980s, UBINIG was involved in an international campaign against incentive payments for sterilization in the Bangladesh family planning program on the grounds that these were indirectly coercive (Hartmann, 1995). Similarly, in 1989, UBINIG initiated a network that it called the Resistance Network Against Harmful Contraceptives on Women's Bodies. The network addressed the use of Depo-Provera and Norplant in Bangladesh using research findings, according to UBINIG staff, provided by UBINIG.

UBINIG staff indicated that they had not focused on the MR policy to the date of this research, although one of its members was reported in the press as "vehemently" protesting MR on the grounds that it is being promoted as a means of contraception among poor women who have no choice but to accept it (Rashid, 1997). Interviews with two UBINIG staff suggested that as an organization, UBINIG would be critical of the policy. Certainly it appears unlikely that UBINIG would completely reverse tactics in future in order positively to campaign for better implementation of a part of the government's family planning program. One member that I interviewed, for example, expressed her view that the donor and government

efforts to encourage the participation of women's groups in the implementation of HPSP was nothing more than a means of legitimising the government's plans irrespective of the views of women's groups.

Several of the officials from the Ministry of Health and Family Welfare that I interviewed, as well as international donor representatives and NGO leaders, suggested that UBINIG's critical approach has been effective in influencing public policy, mainly by attracting the attention of donors who subsequently exerted pressure on the Ministry of Health. As a result of the campaign against sterilization, for example, the Swedish, British, Dutch and Norwegian aid agencies voiced their concern to the Government of Bangladesh, and the Swedish International Development Agency and UNICEF eventually withdrew their funds from the Government's Third Five-Year Population Program (Hartmann, 1995). Additionally the Dutch, West German, Canadian, Australian, British and Norwegian aid agencies entered into separate bilateral agreements with stipulations that their funds not be used towards sterilization (Rozario, n/d). One UBINIG member that I interviewed said she recognized that her organization had effectively influenced the Ministry of Health and Family Welfare in this way, but felt the inadvertent strategy was "unethical" and, because it essentially exploited the government's dependence on foreign aid, that it "violated principles of national sovereignty" (Akhter, 1998).

6.3.4.5 Naripokkho (For Women)

Naripokkho (For Women) has also been a vocal critic of the government's population policy and family planning program. It, too, was involved in the sterilization campaign referred to above, and it was a part of the resistance network that expressed its concerns with the use Depo-provera and Norplant in Bangladesh. In the late 1980s, activists from Naripokkho filed a writ petition before the Supreme Court challenging the validity of a government bill to establish Islam as the state religion. More recently, however, according to one Naripokkho member who also works at UNICEF, Naripokkho has shifted its strategy to work more cooperatively with government, "providing support, not just criticism" (Huq, 1998). In interview, she asserted that the Ministry of Health has begun to respond to this shift in strategy, enabling Naripokkho to influence policy from the "inside." For example, the former secretary of health asked Naripokkho to assist the Ministry in drafting a country paper for the International Conference on Population and Development and to serve as a part of the official government delegation to the 1994 conference. In addition, in a

series of workshops after the Cairo conference and after the Fourth World Conference of Women in Beijing, Naripokkho was among those asked by the Ministry of Health and Family Welfare for input into the policy implications and implementation issues to address in responding to the Plans of Action from the two conferences.

The extent to which Naripokkho has been able to influence health policy from the inside is open to question. A founding member of the organization indicated that through its work at the grass roots levels, Naripokkho has become aware of problems with the implementation of the MR policy relating to both quality of care and access to services. In fact, she expressed her belief that abortion should be legalized in order that access to services could be expanded beyond the 10-week limit imposed by the current policy. However, unlike other issues that Naripokkho has taken on such as acid throwing, violence against women, and rights of sex workers, these beliefs have not been translated to sustained and concerted action. In part, this is because Naripokkho recognizes abortion as a "silent issue", or one that cannot be openly talked about for fear of risking the entire, albeit imperfect, MR policy. In addition, Naripokkho is a small organization with a mere handful of activists who all work as volunteers and who are spread thinly across a number of issues. With such limited perceived cost-benefits and opportunity costs, it is not surprising that neither Naripokkho nor any other special interest group had effectively lobbied for better implementation of the MR policy to the time of my research.

It appears unlikely that any of the women's groups examined above will have a significant influence on the future implementation of the MR policy. Jahan wrote about the "serious and contentious debate" among women's groups in Bangladesh as to "whether women's groups should work with and attempt to improve the existing family planning program," as Naripokkho is attempting to do, "or whether by its very nature such a population program is coercive and exploits women" as UBINIG believes (Jahan, 1995:101). Another author maintained that women's groups in Bangladesh lack a "theoretical construct and socio-political strategy" and operate in a "fragmented, issue-based and primarily conciliatory" manner (Ahmed, 1985:29). Efforts to improve women's health have been fragmented and have not fostered dialogue or collective action amongst women's groups. In contrast, the issue-based critical strategy that has characterized the predominant approach of the major actors in this arena has more successfully mobilized women's groups and led to consensus and concerted action that has had an impact on public policy. In the context of either

approach, while some prominent women's groups agree that abortion should be legalized, they also agree that the risks of a legalization campaign outweigh the potential benefits. Further, few women's groups perceived significant deficiencies in the implementation of the MR policy that need to be addressed in future. In such a context, it is unlikely that a women's "movement" for MR will emerge, whereby women's groups find common ground to launch a collective, united effort to press for better implementation of the MR policy in future.

6.3.5 The Medical Establishment: Disinterested Fence-Sitters

It was judged by those interviewed for this research that the Bangladesh Medical Association and the Society for Obstetrics and Gynaecology could, as in other countries, be influential actors in advocating for safe and legal abortion (Akhter, 2000). These organizations had not become involved in policy discussions concerning MR, however, and some people felt that they had not become involved in any other health policy issues, other than to lobby for matters of self-interest to its members, such as pay scales and benefits for doctors serving in government posts.

Some of the doctors interviewed for this research felt that MR was a non-medical procedure involving such basic technology that lay health workers were able to apply them. For that reason, MR—and, for the same reason, family planning—was not perceived as being a matter that warranted the considered attention of the medical establishment. At the same time, other doctors were highly critical of the performance of lay health workers. The head of a local health policy and research organization speculated that Safe Motherhood, an initiative to reduce maternal mortality, had made it on to the agenda of the medical establishment precisely, because, in contrast to MR, it included advanced medical and surgical procedures and technologies for emergency obstetric care. The Obstetrical and Gynaecological Society of Bangladesh, which is considered the highest professional body in the field of maternal health, worked closely with the United Nations Children's Fund to establish policies and programs for emergency obstetric care in Bangladesh (Ministry of Health and Family Welfare, 1997). Given that unsafe abortion continues to be one of the leading causes of maternal mortality and morbidity in Bangladesh (Mavalankar, et al., 1997), it is possible that some members of the Obstetrical and Gynaecological Society of Bangladesh may one day feel compelled to address the provision of menstrual regulation or safe abortion.

If MR does make it onto the agenda of the medical establishment in Bangladesh in future, possibly through involvement in developing policies and programs to reduce maternal mortality, it is difficult to predict how the conservative, male-dominated Bangladesh Medical Association and Society for Obstetrics and Gynaecology would be likely to comment. Several of the doctors interviewed for this research indicated they recognized the need for MR to achieve the important population control objectives of the Ministry of Health and Family Welfare and that they supported MR for that reason, but that for personal moral and religious reasons, they would not perform such a procedure themselves except to save the life of a woman.

6.3.6 *Religious Groups: Sleeping Tigers*

The gradual rise in religious conservatism and growth in the political strength of religious groups was noted in the previous chapter as being one of the most significant constraints on the effective implementation of the MR policy. During the early years of HPSP, there were signs that religious conservatism was continuing to grow in Bangladesh. The effects of the likely continuance of this trend for the foreseeable future will be to continue to constrain the Ministry of Health and Family Welfare in its efforts to sustain the MR policy in future.

The gradual rise in religious fundamentalism described in chapter 5 continued, and included specific attacks on women's sexual and reproductive rights. Aside from the internationally publicized case of Taslima Nasreen (Rashiduzzaman, 1994), the controversial feminist writer against whom Islamic fundamentalists issued a *fatwa* to kill in 1993, hundreds of poor rural women were persecuted by village mullahs and their patrons through *fatwas* for allegedly violating Islamic personal law and codes of conduct (Hashmi, 2000). Between 1990 and 1995 26 victims of *fatwas* were killed, and others were banished from their communities, or committed suicide in disgrace (Hashmi, 2000). A series of *fatwas* were issued against women accused of adultery and fornication, in some cases brought to light by the fact of becoming pregnant (Amin and Hossain, 1995). These women were sentenced to stoning, caning, and in one case, burning at the stake (Amin and Hossain, 1995). Other fundamentalist attacks targeted the staff and beneficiaries of rural development NGOs involved in social change, especially women's empowerment, allegedly because these organizations were spreading Christianity and anti-Islamic Western ideology (Hashmi, 2000).

Amin and Hussein observed that in the above cases the availability of contraception and abortion would have pre-empted the village courts and its ensuing consequences, but the "risk of exposure and the lack of information combined to insure that the options of contraception and abortion [. . .] were not available" (1995:1342). The possible "solution" observed by Amin and Hussein is precisely what the fundamentalists fear: that the availability of abortion would permit women to engage in illicit sex without consequence. This was also the basis of early religious opposition to family planning as illustrated in the following quote from the Islamic Foundation in Bangladesh: "Free distribution and easy availability of contraceptives to unmarried, even married people away from their families, is illegitimate. The uncontrolled distribution of contraceptives has opened the floodgates of adultery and fornication or adultery programme for turning our women folk [. . .] into half prostitutes as in the west, and be condemned to the most perpetual hell" (Amin and Hossain, 1995:1335).

Amin and Hussein asserted that fundamentalist attacks in Bangladesh have been politically motivated, and that the use of religious and sectarian symbols has been "a significant factor in their ability to gain political concessions particularly in periods of political stalemate" (1995:1340). Menstrual regulation was not used as a religious symbol to gain political concessions during the implementation of the MR policy. Nonetheless, the mere recognition of its suitability for this purpose was sufficient to constrain the Ministry of Health and Family Welfare in its ability to talk openly about the MR policy and to provide women with information about it. There is no evidence to suggest the Ministry or any of the other players will overcome their fear of rousing religious opposition—referred to by many respondents as the "sleeping tiger"—in future. Rather, the Ministry of Health and Family Welfare can be expected to continue to be unwilling to address the known deficiencies in the implementation of the MR policy, whether MR is considered a part of the essential package of services under HPSP or not.

If the "sleeping tiger" should awaken in future, the MR policy would appear to be highly vulnerable. When the policy was formulated, there was limited discussion about the legality of MR. At that time some persons felt that MR should not be considered to be abortion because the fact of pregnancy could not reliably be established at the time of the procedure. This contention was never tested in a court

of law, however, and advances in medical science, which make it possible to determine pregnancy at or before the time that an MR procedure would take place, have since negated the validity of the argument. It is quite possible that a legal challenge in future would result in a conclusion that the MR policy was in conflict with the penal code, which would have to be resolved either by amending the penal code or by abandoning the MR policy. A successful campaign to legalise abortion—whether in response to a future legal challenge of the MR programme or to pre-empt such a challenge—would first require a domestic constituency for abortion to be built. None of the other major players could reasonably be expected to be strong allies in the foreseeable future.

It should be noted that a future legal challenge to the MR policy need not necessarily be raised on religious grounds. Similarly, objections to the policy on religious grounds need not necessarily be raised by religious leaders or by religious groups. Any individual could use MR as a symbol for political purposes, whether primarily motivated by a desire for political power, or because of a sincere belief that MR was contributing to a breakdown of familial and social order. If the former, there is an increased chance that MR would be selected rather than another government program that might be more strongly defended, because MR does not enjoy strong support from any of the major players.

6.3.7 *Political Opposition Parties: Playing with Fire*

Political opposition in Bangladesh is characterized by non-cooperation and confrontation. The years of military coups are still relatively recent; modern tactics include simply refusing to debate issues in Parliament by boycotting Parliamentary sessions, protests, and calling nationwide strikes known as *hartals*. In Bangladesh today, however, *hartals* do not represent the last resort tactics of an oppressed general population that has no voice in the formulation of government policies, but rather a convenient and effective way for opposition parties to force the government of the day to listen seriously to its demands, which typically include a call for the government to resign. *Hartals* are serious business; with hundreds of thousands of persons typically amassing to listen to speeches and then marching the streets to ensure all businesses are properly closed to demonstrate their disapproval of government policies. From June 1996 to April 2001, 93 days of hartal were enforced by opposition political parties, resulting in an estimated $5.6 billion in economic losses (Bangladesh Observer, 2001).

Opposition by confrontation and non-cooperation is likely to continue in future. In this environment, either side in the confrontation regardless of ideology may use any convenient symbol so long as it can be manipulated for political gain. MR would appear to lend itself to such a purpose because while most respondents assumed that no political party would be likely actively to defend menstrual regulation, the policy could be used to discredit the government in power. In 1990 the major opposition parties used antagonism against a controversial heath policy bill on the part of doctors to discredit and eventually to remove the government, even though the opposition parties actually approved of the policy (Chowdhury and Chetley, 1996).

6.4 Predicting Outcomes and Finding Room to Manoeuvre

A central assertion in the Grindle and Thomas model is that policy elites can, through purposeful action, alter the "policy space" for the introduction of reform initiatives. In the remainder of this chapter examines the "space" available to reformers to successfully implement and sustain the MR policy in future under a variety of possible future scenarios.

6.4.1 Bureaucratic Response

As we have seen in previous chapters, the response to the formulation and implementation of the MR policy to date has been confined to the bureaucratic arena. The state of equilibrium surrounding MR is not expected to be upset by the introduction of HPSP and, accordingly, the most likely future scenario is that reactions to efforts to sustain the MR policy in future will primarily be felt in the bureaucratic arena. Set out in Figure 6.1 below is a "map" of the political support and opposition that might be expected in such an event. The map is an adaptation of Crosby's "force-field analysis," which depicts only one dimension: degree of support or opposition. In addition, the map below sets out an assessment of the degree of influence each actor group could bring to bear on the policy debate, by considering the degree to which support or opposition could be mobilized and how powerful each group is likely to be, as suggested in the discussions on each actor group presented above.

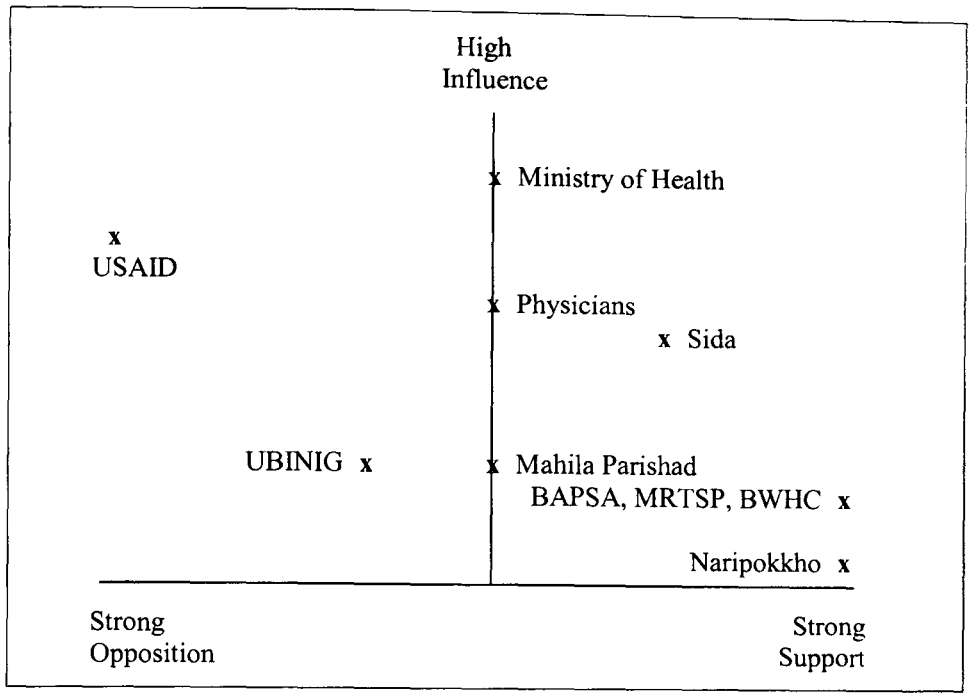

Fig. 6.1. Bureaucratic Reaction. A "map" of the political support and opposition that might be expected if reactions to future implementation efforts are contained to the bureaucratic arena.

There are a number of possible future scenarios inherent in the above "map." The most likely future scenario is that government decision makers, managers and health care workers will continue to be ambivalent about providing MR services, and not assume a strong leadership role to ensure MR is provided as one of the essential services. Instead, it will continue to rely on MRTSP and BAPSA to set the direction for the program, and MR will lose the direct attention and support from international donors that has maintained the momentum for the policy over the past two decades. Because attention will be focused on other elements of the essential services package, and because the Ministry of Health and Family Welfare will continue to fear arousing religious opposition that will continue to be silently threatening, MR will continue to hobble along, eventually dying a natural death. Future training efforts, for example, or monitoring and evaluation efforts, may not deal extensively with MR because of lower perceived relative priorities, and future communications strategies may be less aggressive because of a perceived need to maintain a lower profile for such potentially controversial matters. In this way, the quality of MR services could be expected gradually but steadily to deteriorate, and because the Ministry will be busy

dealing with other day-to-day matters, no one will notice the day when MR remains a part of the package of essential services in name only.

A slightly more pessimistic possible future scenario is one where opposition to abortion on the part of international donors, most likely the U.S., accelerates the natural death cycle for the program. Under this scenario, the government could be pressured to remove MR from the package of essential services, while still being allowed to retain MR as an official government program. The Ministry of Health and Family Welfare has neither the capacity nor the desire to offset this kind of opposition through alternative activities that ensure MR continues to be well implemented, and accordingly this kind of opposition would hasten the demise of the MR program. The probability of this scenario materializing increased with the January 2001 election of a Republican administration in the United States and the subsequent reinstatement of the Mexico City Policy.

An even more pessimistic possible future scenario could involve a legal challenge that the government realizes it could not win in the courts. MR, after all, can readily be proven medically and legally to be abortion, which is contrary to the Penal Code. To avoid a high stakes game in the public arena as outlined below, this could force the Ministry of Health and Family Welfare to abandon the MR policy entirely. Better to distance oneself from a policy formulated and implemented by a previous regime than to jeopardize the current regime. The "map" presented in Figure 6.1 depicts insufficient political support to prevent the policy from being sacrificed in this manner.

6.4.2 *Public Response*

Although it appears most likely that reactions to future efforts to sustain the MR policy will be contained to the bureaucratic arena, it is conceivable that under certain circumstances, the MR policy could become more highly visible to the public in future. Bangladesh has a history of politics by confrontation, and a history of regimes being overthrown by military coups or popular movements. The stakes would therefore be raised considerably if the MR policy ever came under public attack. At the same time, a single Member of Parliament intent on embarrassing or bringing down the government, or perhaps an angry, morally outraged citizen who considers him/herself to be religious, could challenge the policy at any time. If the sleeping tiger of religion were roused in the process, it is difficult to envision the

survival of the MR policy. Unlike most western societies where strong pro-choice movements have been mobilized, there are few supporters of the MR policy in Bangladesh.

The "map" of political support and opposition that might be expected in the event of a strong public reaction to the MR policy as set out in figure 6.2 strongly suggests there are insufficient political resources to overcome a reaction in the public arena.

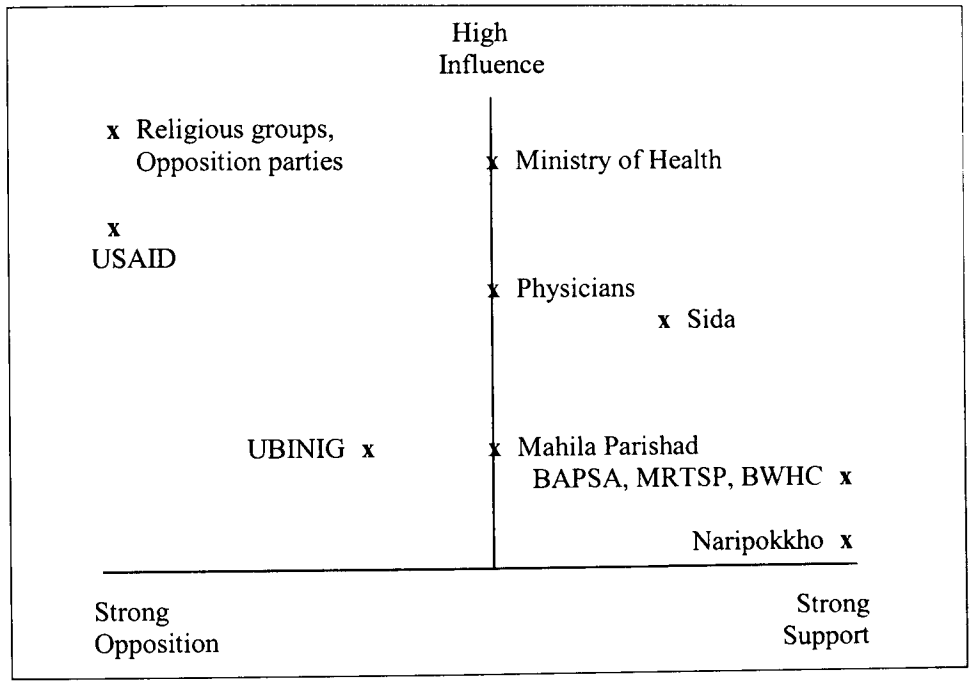

Fig. 6.2. Public Reaction. Political support and opposition that could be expected if future implementation efforts resulted in a strong public reaction.

6.4.3 *Mobilising Additional Resources*

The above analysis indicates that, unless purposeful action is taken to mobilise additional resources, it is unlikely that the MR policy will be implemented as intended and sustained in future. The remainder of this section examines the scope for enlarging the "policy space" for future implementation, by identifying additional bureaucratic and political resources that could be mobilised in support of the MR policy.

6.4.3.1 Bureaucratic Resources

A fundamental problem with the implementation of the MR policy is that there is insufficient managerial capacity within the Ministry of Health and Family Welfare to set the overall direction for the policy, to coordinate the strategy and work plans for MR with the strategy and work plans for other parts of HPSP, to oversee the efforts of Family Welfare Visitors and NGOs in delivering services, and periodically to monitor and evaluate achievements in relation to plan. Reformers could consider whether technical assistance might usefully be provided to the Ministry of Health and Family Welfare to build its managerial capacity specifically in relation to its management of the MR program, similar to the way managerial capacity for Safe Motherhood and family planning initiatives have been purposefully built through other technical assistance.

Financial resources are another important bureaucratic resource. Menstrual regulation has been supported in the past by funds from international donors, specifically earmarked for MR training and services. As described earlier in this chapter, the pooling of funds decision by the Swedish International Development Cooperation Agency will probably be detrimental to the future implementation of the MR policy. Reformers may consider whether additional, specifically earmarked, funds may usefully be provided to assure future implementation of MR services. In this respect, it should be noted that in the past, international donor funds have generally been used for MR training and equipment, while the Government of Bangladesh has paid the salaries of MR providers. At the same time, because of a lack of incentives, providers have greatly underreported the number of MR procedures they have completed. This, in turn, leads to other problems, such as an inability to monitor and evaluate MR services, an inability to ensure sufficient supplies and equipment are on hand when required, and an apparently widespread practise of government providers illegally charging fees for the performance of MR services. Given that MR training other than refresher training should be of lesser relative importance in future, reformers may consider whether the same quantum of financial support could more usefully be provided for MR services, rather than for MR training.

Bureaucratic resources also include technical resources. The term *menstrual regulation* has been used to date in Bangladesh to refer to early abortions using manual vacuum aspiration technology. In future, it may be possible to use medical

abortion rather than manual vacuum aspiration to perform the same early abortions. Medical abortion refers to pregnancy termination usually before 9 weeks' gestation resulting from the use of abortion–inducing medications taken over two courses over 36 to 48 hours. A third visit is generally required two weeks later to ensure that the procedure resulted in a complete evacuation of the uterus. There may be scope for introducing medical abortion—or what one interviewee referred to as *MMR*, or *medical MR*—into Bangladesh. However, a number of technical issues would need to be addressed first, particularly whether it would be feasible to require women to make multiple visits to a health care facility. Reformers could consider the desirability of following up on an international symposium on medical abortion held in Bangladesh in 1992. While the participants at the symposium were sceptical as to the potential benefits of medical abortion, they endorsed the idea of conducting a controlled trial (Kamal, 1992).

6.4.3.2 Political Resources

All reforms, according to Grindle and Thomas, require political support. In a high stakes public arena, political resources are of paramount importance. Even when the reaction is contained to the bureaucratic arena, however, we saw in chapter 5 that it can be difficult to implement a reform as intended without adequate political resources. The analysis presented in this chapter similarly suggests that because of a lack of adequate political resources, it will likely not be possible to sustain MR in the future even in a low stakes bureaucratic implementation arena. Accordingly, any strategy aimed at better implementing and sustaining the policy in future must include a component to build additional political support for the MR policy.

We have seen that the MR policy was initially formulated and implemented as a population control intervention. There was no need to build support among policy elites for MR in this context, because they viewed population growth as a serious problem that they could and should address. It is less clear, however, that there is consensus on the need for MR as a maternal health intervention. The challenge for reformers is to identify and then build upon those common values held by a subset of policy elites, in order to build high-level support for the policy as a women's health intervention. The new international context and the stated objective of HPSP to reduce maternal mortality and morbidity may serve as a useful basis for building this support.

Similarly, a strategy could be considered to build coalitions of support that ultimately are able to effectively lobby the Ministry of Health and Family Welfare to ensure that the Ministry includes realistic goals and objectives for MR in its implementation plans, and to ensure that it effectively monitors, evaluates and continues to improve its MR services. Such a strategy could revolve around one or more selected women's groups such as Naripokkho (for Women), that could be strengthened and supported in their efforts to build consensus and support with other actors, particularly other women's groups and physicians, who in future may come to view MR as a legitimate agenda item where they could play important roles in advocating for MR as a maternal health intervention. In this way, the future "map" of political support conceivably could be made to resemble the one depicted in Figure 6.3.

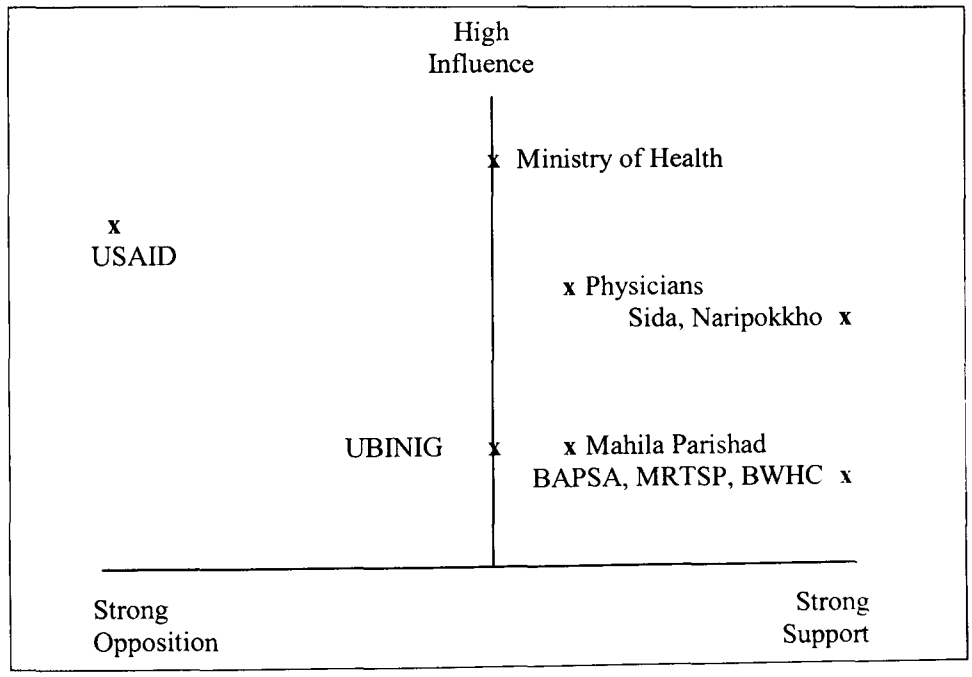

Fig. 6.3. Coalition of Support. Political support and opposition conceivable after purposeful action to shift the positions and capabilities of certain major actors, and with reactions contained to the bureaucratic arena.

The map shown in figure 6.3 represents the most optimistic future scenario that could realistically be expected. It presumes that there will be no strong public reaction to the future implementation of the MR policy, and therefore it requires above all that the policy not be made more visible to the public than it has been, for

example through an attempt to strengthen the legal basis for abortion and MR, or through a high-profile publicity campaign. The sleeping tiger should not be provoked. Even with the potential additional political resources suggested by figure 6.3, the MR policy would likely be unable to survive a strong reaction in the public arena. In a lower stakes bureaucratic arena, however, if additional bureaucratic and political resources could be mobilised as suggested above, there would be much greater assurance that the policy would be implemented as intended and sustained in future.

7.0 Conclusions

7.1 Introduction

There were three main aims or objectives for this research:

- To document "the story" of how MR came to be placed on the policy agenda in Bangladesh, how and why the policy was formulated the way it was, and why the policy was not implemented as well as it could have been;
- To apply the analytical framework and to test the propositions inherent in the theoretical model of policy reform in developing countries as advanced by Grindle and Thomas; and
- To provide insights to better enable supporters of the MR policy to assist the Government of Bangladesh in sustaining its MR policy in future.

The extent to which the research served each of these objectives is discussed in turn below.

7.2 The Story of the MR Policy

The research contributed to the body of knowledge by documenting the story of how the MR policy was formulated and implemented in Bangladesh. The agenda-setting and formulation story documented in chapters 3 and 4, respectively, had never been told before, certainly not in such a comprehensive and fully researched manner. The research covered over 20 years and is based on a wide range of sources. The case study is of interest because Bangladesh remains to date the only country in the world with a restrictive abortion law where MR was introduced on a large-scale basis as a matter of government policy. Further, it is one of the few countries in the world where the provision of government-sanctioned abortion services is not restricted to physicians.

The implementation story documented in chapter 5 contradicts to a large extent the success story that has generally been told internationally about the MR policy. Far from the high quality services that the program successfully provided to the women of Bangladesh as a result of the policy, as many international observers would have us believe, there were a number of relatively serious implementation

deficiencies. The deficiencies themselves were not disclosed by the research. In fact, they were known by actors within Bangladesh specifically including managers and decision makers within the Ministry of Health and Family Welfare. The deficiencies were taken as a given, and the research explored the question as to why the government was unable and/or unwilling to address them, another question that had previously not been addressed in the literature.

The most significant limitation in the research into the story of the MR policy was that I was unable to interview the director of Maternal Child Health Services who was in charge of the MR program throughout the 1980s and early 1990s. With his input, the micropolitical bureaucratic relationships and "lack of capacity" argument presented in chapter 5 could have been explored in greater depth. Another, unavoidable, limitation, was that the research relied heavily upon the recollections of individuals. Although many inaccuracies and discrepancies were detected through triangulation and removed from the story documented in chapters 3-5, it is possible that some remain. The story may thus be fine-tuned through additional research in future, especially by "insiders". I believe, however, that the story will remain substantively the same as the one documented in chapters 3-5, and further that a careful and thorough researcher with access to complete information will recount essentially the same story.

7.3 Theoretical Framework

Another contribution to knowledge of the research is that it applied a political economy model to attempt to explain the entire life cycle of a health policy in a developing country. Many of the policy models briefly outlined in chapter 1 could have been used to explain parts of the MR policy cycle. Kingdon's (1984) model of agenda setting, for example, could have been applied to that phase of the process. The "focussing event" was the formation of the new country and the need to devise policies for it. The "problem stream" was represented by the demographics of the country, specifically population density and population growth. The "policy stream" was the development of manual vacuum aspiration technology and the acceptance by doctors to the use of family welfare visitors to perform the abortions. The "political stream" included favourable opinions towards abortion and population control amongst the intellectual elite, coupled with a general view amongst the elite that there was a problem that had to be addressed and that could and should legitimately be

addressed by the government. The "policy entrepreneur" who recognized a "policy window" had opened because the three streams had come together, and who was responsible for coupling solutions to problems was the Pathfinder Fund, and the "policy entrepreneur" who coupled the problems and solutions to politics were the first directors of the Model Clinic. Similarly, the bureaucratic politics models of decision making might usefully have been used to explain how the MR policy was formulated, by exploring the power relationships and bargaining between bureaucratic actors, and Goggin's (1990) arguments suggesting state decisions result from bargaining among parties at the national and local levels could have been used to explain much of what happened during the implementation of the MR policy. Few of the models, however, could have been used on their own to explain the entire policy cycle, with a specific series of questions to explore at critical junctures in the process, and with relatively specific hypotheses about the relationship between critical variables in the policy process and the subsequent course of the policy in its life cycle. For academics interested in a theoretical model capable of explaining the process of the entire life cycle of policy reforms—particularly reforms in developing countries—the research should be of value by testing the political economy model of public choices and policy change in developing countries as advanced by Grindle and Thomas. The research provides a useful addition to the limited body of academic literature on the policy process in the health sector of developing countries.

It was useful to analyse the story told in chapters 3-5 using the Grindle and Thomas model of public choice and policy change. It provided a way to think systematically about the "how" and "why" of the MR policy, and more specifically to understand how policy outcomes are a function of contextual conditions, agenda-setting circumstances, and policy characteristics. The model was not designed to and it did not predict outcomes in terms of what choices would be made or how successfully particular reforms would resolve particular public problems. Further, the model was developed from specific cases of policy reform in developing countries. Therefore, although the model is useful for analysing cases that are already reasonably well documented or known, it could not have been used as the structure for developing cases of policy reform in the first instance. That is, the story of MR told in chapters 3-5 could not have been developed to the same degree if the model had been applied deductively to derive the story, as opposed to retrospectively to analyse a story developed inductively and independently of the model.

The specific propositions and hypotheses inherent in the Grindle and Thomas model held to a large extent in explaining the process of the MR policy. In the decision making stage of the process however, when the policy was formulated, international influence was found to carry significantly greater weight than that predicted by the relevant hypothesis. It may be that this reflected the fact that Bangladesh was one of the most aid-dependent countries in the world, and that as a new country under military rule at the time, the underlying conditions were so different from those inherent in the Grindle and Thomas model that the predictions should not have been expected to be accurate. On the other hand, it may be that the Grindle and Thomas model gives undue weight to bureaucratic implications.

The Grindle and Thomas model was primarily developed from cases written by mid-career officials from developing countries attending a six-week course at the Edward S. Mason Program in Public Policy and Management at the Kennedy School of Government. The officials had all been personally involved in the particular reform effort. This provided the case studies with a depth of insider knowledge that would be difficult for an outside researcher to bring to a case study. It may also have resulted, however, in a bias with respect to the perceived relative importance of government policy makers to the process. Certainly persons interviewed for this research tended to overstate the relative importance of their individual and institutional roles in the MR policy process, partly because they could not have known and did not know the full extent of activities by other actors.

Grindle and Thomas themselves, in reviewing 16 population policy case histories written up by outsiders, found micropolitical and bureaucratic concerns to be less important than predicted, and conversely they found relationships with international donors to be more important than predicted. Further, although all 16 cases were found to have been formulated under circumstances of politics-as-usual, macropolitical factors having to do with the potential of cultural and religious conflict to destabilise the political system were of central concern, precisely as noted in chapter 4 for the MR policy but in sharp contrast to hypothesis 2. It could be that the mid-career officials who developed the original case studies were unaware of these macropolitical factors, just as the Chief Executive Officer of the Pathfinder Fund recalled being unaware of the government's early attempts to legalize abortion in Bangladesh. This research provided insufficient basis for proposing any modifications to the model and its inherent propositions and hypotheses. Future

researchers using the model, however, should be aware of possible bias built into the model because it was developed primarily from the perspectives of officials personally involved in reform efforts.

In addition, we saw in chapter 5 that although the response to the implementation of the MR policy was contained in the bureaucratic arena, additional bureaucratic resources would only have addressed one of the four primary reasons suggested by the research for the government's unwillingness and inability to address the known deficiencies in the implementation of its MR policy. Grindle and Thomas acknowledge that all reforms require political resources to be successfully implemented, but their framework tends to understate the importance of political resources in successfully implementing reforms when a bureaucratic arena of response is anticipated, at least in the case of the MR policy in Bangladesh. This may have been due to the fact that abortion is a highly controversial issue that is perceived as being threatening to the social order in Bangladesh—a salient characteristic of the policy that is not given adequate weight in Grindle and Thomas model. That is, the fundamental assertion that an assessment of policy characteristics is required to predict or explain the implementation process was found to hold true. However, the model did not explicitly require an examination of all of the specific policy characteristics that were most relevant to explaining the implementation of the MR policy in Bangladesh.

In addition to the policy characteristics proposed by Grindle and Thomas, the case of the MR policy suggests that a policy that is perceived as being highly controversial and threatening to the social order can be expected to face strong reactions in the bureaucratic implementation arena, for two main reasons. First, the policy may be at odds with the embedded orientations of a significant portion of the bureaucratic managers and workers expected to implement the policy. Second, policy elites and bureaucratic managers may perceive the unexpressed but nonetheless real and strong objections of established institutions such as religious institutions to the policy. These kinds of reactions to the implementation effort represent a kind of passive resistance where an implementation failure may be vaguely attributed to a lack of political will. In any event, it appears that to successfully implement such a policy, additional political resources are required.

The central argument of the Grindle and Thomas model—that policy is determined by elites who are not entirely forced by events, interest groups or external agencies to make particular choices but rather who manoeuvre within context, circumstances and characteristics particularly at 3 critical junctures in the policy process—was found to hold true and to explain many of the variables in the case of the MR policy in Bangladesh. Contextual conditions especially, both in terms of the embedded orientations of bureaucrats and decision makers and in terms of the broader societal and cultural context of Bangladesh, were seen to be the single-most critical variable that placed legal abortion on the policy agenda in the first instance, and then caused policy elites to craft a semantically different MR policy, which in turn could not be implemented as well as originally intended. By assessing the agenda-setting circumstances and the policy characteristics, it was possible to explain important aspects of the policy formulation and implementation phases of the policy, respectively. On the whole, then, the research confirmed the usefulness of the model as tool for analysis *of* policy, in retrospectively examining and explaining public choices and policy change in developing countries.

7.4 Insights to Improve the Chances of Future Sustainability

Chapter 5 noted that in spite of the fact that early abortion services were available free of charge to all women in Bangladesh through the government health care system since 1979, hundreds of thousands of women continued to resort to illegal abortion services every year. There was also evidence that complications from the abortions that were performed through the government health care system were more than 40 times higher than expected. As a result, the maternal mortality ratio in Bangladesh continued to significantly exceed norms for the region, and induced abortion was suspected to be a primary cause. More simply put, many Bangladeshi women died from unsafe abortions, in spite of the MR policy. While that may not have been a central concern to those who viewed the MR policy as a population control intervention, it is a clear indication of a shortcoming as a maternal health intervention. Accordingly, a third aim of this research was to provide insights to enable supporters of the policy to assist the Government of Bangladesh in better implementing and sustaining its MR policy in future. This was achieved through a prospective application of the Grindle and Thomas framework in an analysis *for* policy.

One of the express aims of the Grindle and Thomas framework is that it be used as an analytic tool *for* policy. That is, the systematic analysis of the variables suggested in the framework and their interrelationships could be undertaken in order that necessary or desirable action may be identified and taken in order to alter the nature and direction of the policy process at each of three critical junctures. This part of the research was concerned with only one of those junctures, and it accordingly applied the political economy model of policy implementation to assess the political and bureaucratic resources available to implement and sustain the MR policy in future, with a view to considering how they could be expanded or mobilised.

Chapter 6 observed a number of possible future scenarios for the MR policy, the most likely of which is that the policy will not be sustained. To sustain the policy, it appears it will be necessary first of all to avoid a reaction in the public arena—a strategy that has been successfully pursued since 1979 when the policy was formulated. Secondly, additional bureaucratic resources could usefully be provided in specific managerial, financial, and technical areas as detailed in chapter 6. Most critically, however, coalitions of political support likely consisting mainly of women's groups and physicians, would appear to be required in order to sustain the policy in future as a maternal health intervention. The research achieved its aim of generating the above insights, and in the process confirmed the usefulness of the Grindle and Thomas framework as an analytical tool that could be used prospectively in an analysis *for* policy.

Annex 1: Chronology of Major Events

1950s	International population establishment supports population control including use of abortion.
1960's	USAID supports the development of manual vacuum aspiration (MVA) equipment for early abortion.
1965	Pakistan, including pre-independent Bangladesh, becomes the second developing country to adopt a large-scale government family planning program.
1971	Tensions between East and West Pakistan erupt into a nine-month civil war.
	East Pakistan becomes the independent nation of Bangladesh and a populist government assumes power.
	USAID funds Batelle Northwest Laboratories to develop manual vacuum aspiration technology.
1972	First sanctioned abortions in Bangladesh for women raped during the War of Liberation.
	International family planning conference held in Bangladesh, legal abortion advocated by Ministry of Health (MOH) officials, Pathfinder Fund gives MOH money to set up MR services.
1973	First Five Year Plan (1973-1978) of the Government of the People's Republic of Bangladesh includes strong recommendation for legalizing and providing abortion for population control.
	U.S. amends its Foreign Assistance Act (Helms Amendment), to prohibit use of U.S. funds directly to support or promote abortion.
	International conference of medical professionals at the University of Hawaii pronounces MVA as medically safe, and endorses the term *menstrual regulation*.
1974	UN World Conference on Population is held, with the U.S. advocating population control interventions and developing countries arguing for a new economic order.
	The Ministry of Health sets up MR services in a Model Clinic, and conducts research on MR; key MOH officials support MR.
	Pathfinder provides support for MR services and small-scale training at the Model Clinic.
	Symposium on Law and Population held in Tunis recommends that MR should be treated as falling outside restrictive abortion laws.
1975	Populist leader assassinated along with 46 members of his family, and a series of military coups ensue. Martial law established.

1976	Population policy includes a statement indicating abortion under certain circumstances would not be considered an offence under the Penal Code.
	Conference of Latin American physicians supports the 1974 recommendation of the Tunis Symposium on Law and Population.
1977	General Ziaur Rahman assumes power, gives high priority to population control and tacit support to MR, but rejects demands to legalize abortion.
	Findings of the first 1,068 MR cases treated by the Model Clinic are published.
	The Ministry of Health commissions the Bangladesh Institute of Law and International Affairs (BILIA) to review laws impacting the government's population policy, with abortion as the first of eight priority areas. BILIA recommends amending the penal code to permit abortion.
1978	MOH requests Pathfinder to set up large-scale MR training district-level teaching hospitals.
1979	Martial law lifted.
	Official government documents refer to MR as part of the national family planning program.
1981	General Ziaur Rahman assassinated, vice-president assumes power.
1982	General Ershad assumes power in bloodless coup. Martial law established.
	Pathfinder helps to establish the Bangladesh Association for the Prevention of Septic Abortion (BAPSA).
	USAID announces new restrictions on funding of abortion-related activities, including prohibitions on procurement or distribution of MR kits.
1983	Under pressure from USAID Pathfinder withdraws support for MR, and turns the balance of its MR funds over to the Population Crisis Committee to administer.
	Numerous Bangladeshi family planning NGOs abandon MR activities.
	MR training program incorporated as special project of the government, called the Menstrual Regulation Training and Services Program (MRTSP).
1984	U.S. announces strong anti-abortion policy at the UN Conference on Population in Mexico City (Mexico City Policy).
1984-1990	The Ford Foundation, which, like the Population Crisis Committee, received no, funding from USAID, funds MR activities.
1985	U.S. Congress withholds funding to UNFPA and to International Planned Parenthood Federation because abortion-related activities of those organizations violated the Mexico City Policy.
1986	Martial law lifted.

1990-1995	Attacks on women's reproductive rights in Bangladesh step up.
1991	President Ershad overthrown, interim government established, and first democratically elected government comes to power led by the Bangladesh National Party. Opposition boycotts new Parliament.
	MRTSP changes status from a special project of the government to an NGO.
1991-1997	Swedish International Development Cooperation Agency (Sida) funds MR activities.
	Studies show implementation problems in terms of both quality of and access to MR services.
1992	MR began being coded as a Maternal Child Health intervention, rather than as a method of family planning.
1993	U.S. Democratic President Clinton rescinds Mexico City Policy, but Helms Amendment remains in effect and chill effect of Mexico City policy continues.
1994	United Nations International Conference on Population and Development held in Cairo, recognizes abortion as a major public health issue; Bangladeshi Prime Minister Khaleda Zia boycotts conference under pressure from other Islamic countries over abortion issue.
	Important international ally, the International Women's Health Coalition terminates its programs in Bangladesh.
	After all opposition members of Parliament resign, the Bangladesh National Party accedes to demands for fresh elections. Opposition parties, however, boycott the elections, refuse to accept the results, and resume demands for free and fair elections under a caretaker government.
1995	United Nations Fourth World Conference on Women held in Beijing,
1996	After a 25-month stalemate between the government and opposition parties, the Bangladesh National Party dissolves Parliament, a caretaker government is established, and new elections held. Awami League comes to power in 1996 elections.
1998	Important international ally, the Ford Foundation, closes office in Bangladesh.
	Health reforms introduced under the Health and Population Sector Plan (1998-2003).
	Sida begins pooling, rather than specifically earmarking, MR funds.
2001	U.S. Republican President Bush reinstates Mexico City Policy and institutes the global gag rule, prohibiting direct or indirect use of USAID funds by any organizations that perform abortions that are legal in their countries or that lobby their own governments on abortion issues.

Annex 2: List of Persons Interviewed

1	Ms. Merle Goldberg	Former President, National Women's Health Coalition
2	Mr. Richard Gamble	Former President, The Pathfinder Fund, (1971-1983)
3	Mr. Manzoor Majumder	Director (Programs), Menstrual Regulation Training and Service Program (1991-present), Former Executive Director, (1985-91) Former Accounts cum Admin Officer, (1983-85)
4	Dr. Mesbahul Karim	Executive Director, Menstrual Regulation Training and Service Program (1991-present)
5	Ms. Quazi Suraiya	Deputy Director of Programs and Administration, Menstrual Regulation Training and Services Program
6	Dr. Nahid Chowdhury	National Coordinator, Population Council Former Acting Executive Director, Bangladesh Women's Health Coalition Former Medical Director, Bangladesh Women's Health Coalition
7	Ms. Tahera Yasmin	Country Representative, OXFAM Former Director, Saptogram
8	Dr. M. Hafizur Rahman	Deputy Director, Bangladesh Institute for Research and Promotion of Essential and Reproductive Health Technologies
9	Ms. Nilufar Ahmad	Social Scientist, The World Bank
10	Mr. A.B.M. Gulam Mostafa	Former Secretary, Ministry of Health and Population Control (1983-86)
11	Mr. Jalaluddin Ahmed	Director, South-South Centre Former Director, Bangladesh Family Planning Board (1972-74) Former Joint Secretary, Ministry of Health and Population Control (1976-79)
12	Dr. Hosne Ara Ali	Medical Officer, Mohammadpur Fertility Services and Training Center (1975-present)
13	Dr. Sabera Rahman	Director, Mohammadpur Fertility Services and Training Center
14	Dr. Zafrullah Chowdhury	Founder and Director, Gonoshasthaya Kendra
15	Ms. Suraiya Ahmed	Former Project Coordinator, Menstrual Regulation Training and Service Program (1983-85) Former Program Officer, Menstrual Regulation Unit, Pathfinder Fund (1983) Concerned Women for Family Planning (1977-1983)
16	Mr. Manzoor Ul Karim	Former Secretary, Ministry of Health and Population Control (1985-89)
17	Mrs. Mufaweza Khan	Executive Director, Concerned Women for Family Planning
18	Dr. Mohammed Alauddin	Country Representative, Pathfinder International

19	Mr. Sobir Ali Khan	Admin. Officer, Dhaka Medical College Hospital
20	Dr. Meherun Nessa	Private Physician (MBBS 1950)
21	Prof (Dr.) Abdul Bayes Bhuiyan	Project Director, OGSB Maternity Hospital, Vice-president, Obstetrics and Gynaecology Society of Bangladesh Former Prof., Dhaka Medical College (Obs. and Gyn.) Former Assoc. Prof., Rangpur Medical College (1972-74)
22	Prof A.K.M. Anowar-ul Azim	Head, Obs. and Gyn. Dept., Z.H. Sikdar Medical College President-Elect, Obstetrics and Gynaecology Society (2000-02) Former Head, Obstetrics and Gynaecology Dept., Dhaka Medical College Former Junior Consultant, Khulna Medical College (1971)
23	Dr. Zohra Khanam	National Consultant, Maternal Child Health-Family Planning, United Nations Fund for Population Activities Former Medical Officer, Mohammadpur Fertility Services and Training Center
24	Mrs. Haidary Kamal	Former Executive Director, Bangladesh Association for the Prevention of Septic Abortion (1983-88)
25	Dr. Syed Jahangeer Haider	Executive Director, Research Evaluation Associates for Development Former Director, National Board of Women's Rehabilitation Program (1972-75)
26	Dr. Shafiqur Rahman	Former Director, National Institute of Population Research and Training, Ministry of Health and Family Welfare (1979-83) Former Director, Bangladesh Fertility Research Program, Ministry of Health and Family Welfare (1979-85) Former Director, MCH Services, Ministry of Health and Family Welfare (1975-79) Former Director, Mohammadpur Fertility Services and Training Center, Ministry of Health and Population Control (1979-1980)
27	Dr. Altaf Hossein	Acting Executive Director, Bangladesh Association for Prevention of Septic Abortion Former Director (Research), Bangladesh Association for Prevention of Septic Abortion
28	Ms. Debra Efroymson	Regional Advisor, Program for Appropriate Technology in Health Canada
29	Ms. Shireen Jahangir	Women in Development Advisor, World Bank Former Chief, Planning Commission
30	Mrs. Gule Afroz Mahboob	Former Acting Director, Pathfinder Fund (1983-84) Former Sr. Program Officer, Pathfinder Fund (1982-83)
31	Mrs. Mahnur Rahman	Consultant, Family Planning Association of Bangladesh Director Training, National Institute for Population Research and Training (1989-91) Former Deputy Director Post Partum Family Planning Clinic, Ministry of Health and Population Control (1974-76)

32	Ms. Salma Sobhan	Human Rights Lawyer Director, Ain O Kendra
33	Dr. Habibur Rahman	Coordinator, Bangladesh German Technical Cooperation, National Institute for Population Research and Training (German Agency for Technical Assistance) Former Program Officer, Pathfinder Fund (1978-83) Former Admin. Officer, Menstrual Regulation Expansion Program Pathfinder Fund (1978)
34	Prof (Dr.) T.A. Chowdhury	Former Director Institute of Post Graduate Medicine and Research
35	Prof (Dr.) Feroza Begum	President, Bangladesh Association for the Prevention of Septic Abortion (1983-present) President, Executive Council, Menstrual Regulation Training and Service Program (1991-present)
36	Dr. Halida Akhter	Director, Bangladesh Institute for Research and Promotion of Essential and Reproductive Health Technologies Former Program Officer, Ford Foundation Former Medical Officer, Mohammadpur Fertility Services and Training Center
37	Ms. Sigma Huda	Advocate, Bangladesh Supreme Court Executive Council, Bangladesh Association for the Prevention of Septic Abortion Executive Council, Bangladesh Women's Health Coalition Founder and Director, Bangladesh National Women's Lawyers Association
38	Dr. Abdur Rouf	Executive Director, Population Services and Training Centre
39	Dr. Jahir Uddin Ahmed	Director, Maternal Child Health Services and Line Director (Essential Service Package) Directorate of Family Planning, Ministry of Health and Family Welfare
40	Dr. C.P. Maskey	Team Leader, Family Planning Clinical Surveillance Team, World Health Organization
41	Dr. A.K.M. Mahbubur Rahman	National Medical Consultant, Family Planning Clinical Surveillance Team
42	Dr. Enamul Karim	Task Manager, Population Sector Strategy (World Bank)
43	Dr. Sadiqa Tahera Khanam	Consultant, BAPSA Former Director, National Institute of Preventive and Social Medicine (NIPSOM) (1994-1996) Former Professor Maternal Child Health, NIPSOM (1984-1986) Former Medical Officer, Azimpur Maternity Hospital (1963-1977)
44	Mr. Ole Overaas	First Secretary, Norwegian Agency for International Development
45	Dr. Ubaidor Robb	Country Representative, Population Council, Dhaka
46	Mr. Azizul Karim	Joint Chief (Planning) Ministry of Fisheries and Livestock (1996-present)

		Ministry of Health and Family Welfare (1976-1996) Former Joint Chief (Planning) Former Deputy Chief (Planning) Ministry of Health and Family Welfare Former Assistant Chief (Planning)
47	Dr. A.J. Faisel	Country Representative, Engender Health
48	Dr. Sajeda Amin	Researcher, The Population Council, New York
49	Dr. Alan Margolis	Senior Medical Advisor, International Women's Health Coalition (1987-1994)
50	Dr. Malcolm Potts	Medical Director, International Planned Parenthood Federation (1968-1974)
51	Mr. Klas Rasmusson	First Secretary, Swedish International Development Cooperation Agency
52	Dr. Nancy Gerein	Director, Technical Advisory Unit, Canadian International Development Agency
53	Mr. Brad Herbert	Social Sector Team Leader, the World Bank
54	Dr. Yasmin Ahmed	Country Director, Marie Stopes Clinic Society Assistant Director, Bangladesh Institute for the Promotion of Essential Reproductive Health and Technologies
55	Mr. Dhiraj Kumar Nath	Joint Secretary, Ministry of Shipping Former Joint Secretary, Ministry of Health and family Welfare (1981-85 and 1993-1995)
56	Ms. Tahera Ahmed	Assistant Representative, United Nations Population Fund
57	Mr. Shamim Ahsan	Senior Policy Advisor, National Integrated Population and Health Program Former Secretary, Ministry of Health and Family Welfare (1993-1994)
58	Ms. Marjan Kroon	First Secretary, The Royal Netherlands Embassy
59	Ms. Sadeka Helima	Associate Professor, Sociology, Dhaka University
60	Ms. Margaret Neuse	Team Leader, Population and Health Team, United States Agency for International Development
61	Ms. Natasha Ahmad	Staff Member, UBINIG, Policy Research for Development Alternative
62	Ms. Roushan Jahan	Founding Member, Women for Women
63	Mr. Richard Green	Deputy Director, United States Agency for International Development
64	Dr. Mehtab Currey	Health and Population Advisor, Department for International Development, United Kingdom
65	Dr. Fauzia Moslem	Member, Mahila Parishad
66	Ms. Farida Akhter	Executive Director, UBINIG, Policy Research for Development Alternative
67	Dr. Shamsher Ali	Member, Executive Council, Menstrual Regulation Training and Services Program

68	Ms. Therese Blanchet	Anthropologist
69	Dr. Yuwa Hedrick-Wong	Managing Director, Research, Strategic Intelligence
70	Dr. Yasmin Ali Haque	Project Officer, Health and Nutrition Section, UNICEF
71	Dr. Momena Khatun	Program Manager, Maternal Health Services, Directorate of Family Planning, Ministry of Health
72	Dr. Ashraf Ali	Deputy Director, Maternal Health Services, Directorate of Family Planning, Ministry of Health
73	Mr. Mohammed Ali	Chief, Management Change Unit Former Secretary, Ministry of Health and Family Welfare
74	Dr. Henry Perry	Child and Maternal Health Advisor, BASICS, Child Survival and Urban Immunization Project
75	Dr. J.S. Kang	Senior Population Officer, The World Bank
76	Dr. Nalia Khan	Professor, Bangladesh Institute of Child Health
77	Mr. Anwarul Azim	Executive Director, Bangladesh Women's Health Coalition
78	Dr. Nazneen Akhter	Director, Programs, Bangladesh Women's Health Coalition
79	Ms. Nasreen Huq	Coordinator, ICPD Follow-up Project, Naripokkho
80	Dr. Atiqur Rahman Khan	Section Chief, Population and Maternal Child Health, The Planning Commission 1980-1986

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