Bangladesh at 50: Some reflections

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Breakdowns and renewals in politics

In contrast to steady socio-economic development, our political trajectory has been uneven. After independence we began our journey as a multi-party parliamentary democracy. Within a year Bangladesh adopted a constitution which enshrined four fundamental principles of state, nationalism, democracy, secularism and socialism. But in the last 50 years we have faltered in making a steady progress along the path of the founding principles. There have been deviations and breakdown but also renewals.

Democracy was the first foundational principle that came under assault. Within four years post-independence, the state moved in an authoritarian direction and Bangladesh fell under military rule in 1975 which continued for 15 years.

The initial constitutional commitment to two other foundational principles, secularism and socialism were negated when the military took power. Through martial law ordinances the first military ruler removed secularism as a fundamental principle of state, withdrew prohibition on religion-based organisations thus again creating opportunities for abuse of religion for political purposes.

He redefined socialism as "economic and social justice", reversed policies of public ownership over financial institutions and industries and initiated market-friendly policies. These policies were sustained by successive regimes and our mainstream political parties stopped talking about socialism. The second military ruler made Islam the state religion and further widened opportunities for the growth of the private sector.

A people's movement finally overthrew military rule in 1990. We thought we had been given a second chance to renew our democratic journey. For the next 16 years power rotated between two major political parties, the Awami League (AL) and the Bangladesh Nationalist Party (BNP) through four elections which were organised by non-party caretaker governments, a system which we devised to ensure fairness of elections and participation of all political parties.

But regular elections and rotation of power did not improve the quality of our democracy. The opposition faced repression and attempts were made to control the media and civil society. The parliament became non-functional as the opposition chose to boycott its sessions and instead resorted to street agitations, hartal and blockades which hurt the economy and peoples' everyday life.

In 2007 our fragile electoral democracy again broke down and the military intervened when the two major parties failed to agree on the composition of the poll-time government. A military-backed civilian government ruled for two years. It finally organised an election in 2008 which was won by the AL-led Grand Alliance. The victorious Alliance made electoral promises to improve the quality of our democracy. We again hoped that we would have a third chance for democratic renewal.

But in 2011 the poll-time non-party caretaker government system was abolished and since then the AL and the BNP could not agree on a mutually acceptable formula for participating in elections. The BNP led alliance boycotted the 2014 elections where the majority of seats were won uncontested by members of the ruling alliance. In the 2018 elections the BNP and the other opposition parties contested the elections at the last moment but there were allegations of widespread vote abnormalities. Since 2014 our elections have lost credibility.

Undemocratic practices in electoral democracy

Since the return of electoral democracy in 1990 Bangladesh had consistently scored low in all global surveys of democracy. Our scores had been particularly low in the 'rule of law' indicator. The independence of what is known as horizontal accountability institutions which means government institutions that are mandated to demand accountability of the executive branch such as the parliament, judiciary, ACC, EC, Human Rights Commission etc. are important in establishing checks and balances and ensuring rule of law. The low score on 'rule of law' underscores not only the weakness of our democratic institutions, it also highlights the lack of security of our citizens who cannot be sure that their basic human rights will be guaranteed by the state.

In contrast to low score in the rule of law, the 'voice' indicator, which measures the strength of the vertical accountability institutions, which means accountability of the government to the citizens was showing steady progress since 1991. Vertical accountability is measured by freedom of the media and civil society, free and fair elections etc. But in recent years the 'voice' indicator is also showing a declining trend. The flawed elections, repression of political opposition and measures to control the media have raised concerns about the democratic future of Bangladesh.

Looking forward

Bangladesh has made significant strides in social and economic development. The state is now much stronger than it was 50 years ago. Our economy is also now on a much stronger footing. This should enable us to feel more confident and prioritise the task of building stable democratic institutions which will sustain our ambition of long-term development and becoming a developed country in another 20 years.

The challenges of building and strengthening democratic institutions are many and we need actions on various fronts. Here I will prioritise work on three areas. First, our media and civil society organisations should be given full freedom to work independently so that they can perform their role as accountability institutions. The Digital Security Act which has had a chilling effect on freedom of expression needs to be revised in consultation with relevant stakeholders.

Second we need to restore the credibility of our electoral process. We have demonstrated in the past that we are capable of organising free, fair, peaceful and participatory elections. What we now need is the political will to organise such credible elections again. To achieve that goal all political parties need to come to an understanding that they will give up the practice of 'winner takes all' culture that had made our politics confrontational and exclusionary, and marginalised the loser thus making our political discourse intolerant with little space for public reasoning.

Third, we will need to work to reestablish citizens' trust in the rule of law where one law for all will prevail without partisan application of law enforcement. It is a difficult task but we need to shift from an access-based to a rule-based system.

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Bangladesh's journey with health in the past 50 years

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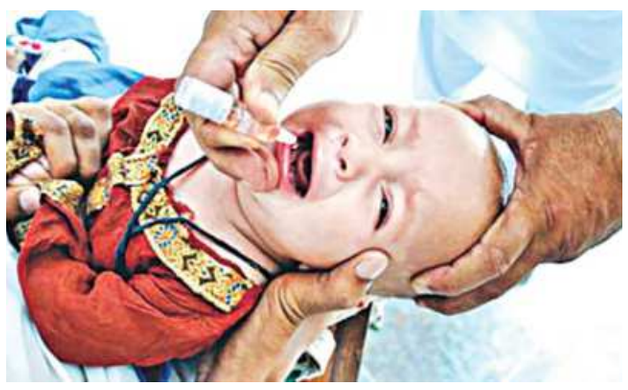
The Universal Declaration of Human Rights proclaimed by the United Nations General Assembly on 10 December 1948 in its article 25 mentions that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." The United Nations expanded upon the "Right to Health" in article 12 of the International Covenant on Economic, Social and Cultural Rights in 1966 by stating that, "The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The constitution of the People's Republic of Bangladesh in article 15 mentions that, "It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care."



Bangladesh is often cited globally for its success stories in the health sector. One such is with family planning through fertility regulation. The first post-independence National Population Census of 1974 found that the total fertility rate (TFR) was 6.9 per women. The TFR declined sharply to 5.1 births in 1989 and to 3.3 births in 1996. After a decade-long stall in fertility during the 1990s, at around 3.3 births per woman, the TFR further declined by one child to 2.3 births in 2011. In 2019 the TFR in Bangladesh was said to be 2.0. With the global TFR at 2.5 in 2019, India's TFR was 2.3, Pakistan's was 3.3, and Sri Lanka and Nepal's were both 2.0.

The other cited success story is with immunisation. Bangladesh has developed an effective national immunisation programme starting from 1979 with the implementation of the Expanded Programme on Immunisation (EPI). EPI efforts were seriously considered only after 1985 when the country made its commitment to the United Nations to reach universal child immunisation by 1990. The EPI coverage remained less than two percent in 1984. By 2017, 89 percent of children aged 12–23 months were fully vaccinated against the major vaccine-preventable diseases such as tuberculosis, diphtheria, pertussis, tetanus, hepatitis, Haemophilus influenzae type B, poliomyelitis, pneumonia, and measles.

> Bangladesh demonstrated a steady improvement in child nutrition outcomes during the past decade, particularly in recent years. The stunting rates among children under the age of five have reduced from 41.3 percent in 2011 to 31 percent in 2017-18, and wasting has decreased from 15.6 percent to 8.4 percent.

Bangladesh received a UN award in 2010 for its remarkable achievements in attaining the Millennium Development Goals (MDGs), particularly in reducing the child mortality rate. Its under-five mortality rate in 2019 was 28 per 1,000 live births. Infant mortality rate and neonatal mortality rates were 21 and 15, respectively, per 1,000 live births in the same year. All these contributed to achieving a life expectancy of 73 years in 2019 for Bangladesh. At the same time, global life expectancy was 72 years; in India, it was 69; in Pakistan, it was 67; in Nepal, it was 71; and in Sri Lanka, it was 76 years.

Bangladesh demonstrated a steady improvement in child nutrition outcomes during the past decade, particularly in recent years. The stunting rates among children under the age of five have reduced from 41.3 percent in 2011 to 31 percent in 2017-18, and wasting has decreased from 15.6 percent to 8.4 percent. Findings from the Multiple Indicator Cluster Survey (MICS) 2019 reveal that the level of stunting has even declined from 42 percent in 2012-13 to 28 percent in 2019. Wasting, however, has remained unchanged with a slight increase from 9.6 percent in 2012-13 to 9.8 percent in 2019, according to MICS. The level of underweight has declined significantly from 31.9 percent in 2012-13 to 22.6 percent in 2019.

Bangladesh has one of the best health networks in the public sector. There are 47,678 domiciliary workers with 13,907 community clinics at ward level, 4,646 union level facilities, 424 Upazila health complexes, 59 district hospitals, 18 medical college hospitals and 12 specialised institute hospitals, plus various other types of facilities. However, shortage and skill-mix imbalance of human resources, limitations in equipment, medicines and other supplies deter obtaining adequate benefits from these resources. Public expenditure on health in Bangladesh stands at 0.47 percent of gross domestic product (GDP) – not only one of the lowest in the world but also low when compared to the average of the lower-middle-income countries (LMICs), which is 2.8 percent, or the average in the South Asian region, which is 2.1 percent. In addition to being one of the lowest public expenditure on health, there is a disparity in geographical (i.e. by division) and residential (i.e. by rural-urban) distribution. This gap leads to the thriving growth of the private sector. Healthcare facilities under the directorate general of health services (DGHS) are 2,258 registered private hospitals and 5,321 clinics. Hospital beds under DGHS are 54,660 and 91,537 in private hospitals.

Household Income and Expenditure Survey (2016) found the utilisation of health services as 33 percent from pharmacy/dispensary/compounder, 23 percent from non-qualified doctors' chambers and 15 percent from qualified doctors' chambers. Public sector facilities are utilised altogether by 14 percent - five percent by Upazila health complexes, three percent by government district/ Sadar general hospitals, two percent by government medical colleges and specialised hospitals, and two percent by the community clinics. Bangladesh remains a negative outlier in financially protecting its population, especially the poor. This is evident from the high out-of-pocket (OOP) spending by households on health (72 percent), which is one of the highest in the world -- even higher than the average in countries with similar income, i.e. 39.6 percent for low-income countries (LICs) or 39.4 percent for LMICs. The alarmingly large share of OOP expenditures puts financial strain on households due to unforeseen and unprotected expenses for the treatment of illnesses. This is evident from the fact that in 2016, about seven percent of the population was forced into impoverishment due to OOP expenditures.

Limited capacities of the public sector both in terms of service delivery and regulating the ever-growing private sector are aggravated by poor coordination in fragmented public health systems into several directorate generals under two divisions of the ministry. The situation worsened with corruption in all possible spheres coupled with a lack of governance, transparency and accountability.

Government's Health Care Financing Strategy 2012-2032 identified three challenges: (i) inadequate health financing; (ii) inequity in health financing and utilisation; and (iii) inefficient use of existing resources. All of these, accompanied by management inefficiency, lack of governance, transparency and accountability, and a near absence of regulation in private sectors, are the key challenges facing the public health sector.

Some ways of challenging mitigation include: (i) substantial increase in the government budget for the health sector along with appropriate allocation and efficient utilisation; (ii) strengthening of management capacities at different levels with the provision of reward and punishment; (iii) enhancement of coordination among the different segments of the public health system together with the determinants of health; and (iv) improvement in regulation for the private sector.

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