A SAGE Whitepaper

Improving Maternal Health: A Comparison among Bangladesh, Nepal and Sri Lanka

Journal of Health Management

www.sagepub.in

SAGE Publishing

Article

Improving Maternal Health: A Comparison among Bangladesh, Nepal and Sri Lanka

Journal of Health Management
19(4) 523–536

sagepub.in/home.nav
DOI: 10.1177/0972063417727614
http://jhm.sagepub.com

Bijoy Krishna Banik[1]

Abstract

A number of South Asian countries (such as Nepal and Sri Lanka) with modest economic growth and less amount of investment in human development are able to reduce high maternal mortality rate (MMR) quickly than other countries, including Bangladesh. Comparing success experience of Nepal and Sri Lanka with that of Bangladesh thus emerges as the critical requirement of the hour. The main objective of the article based on secondary sources was therefore to explore the factors that worked behind the relative success in Nepal and Sri Lanka and to compare these factors in the context of Bangladesh. As found, long-term policies, better availability of and accessibility to maternal health care services, strong political will and monitoring system are the contributing factors to the success. It concludes that Bangladesh is able to achieve the sustainable development goal for health if bio-social approach—placing importance to not only medical advancement but also social development—to improve maternal health is followed.

Keywords

Good political will, maternal mortality rate, bio-social model, Bangladesh, Nepal, Sri Lanka

Introduction

Many countries have been able to reduce high maternal mortality rate (MMR) using a variety of different models of care. For instance, the USA is providing hospital-based comprehensive maternal health care (MHC) services, while Denmark, Norway, Sweden and the Netherlands are providing domiciliary services. Bangladesh (albeit only in the Matlab region to a limited extent), Cuba, Egypt, India (only Tamil Nadu and Gujarat provinces), Iran, Jamaica, Malaysia, Nepal, Sri Lanka and Thailand have adopted different strategies, such as, increasing the proportion of skilled birth attendants (SBAs) and upgrading education and training of local-level health workers for achieving the target—reducing two-third MMR between 2000 and 2015 (Amery, 2009; de Bernis et al., 2003, p. 40; Hussein et al., 2011). Bangladesh, one of the South

[1] Professor of Sociology, University of Rajshahi, Rajshahi, Bangladesh.

Corresponding author:
Bijoy Krishna Banik, Professor of Sociology, University of Rajshahi, Rajshahi, Bangladesh.
E-mail: bkbanik2001@yahoo.com

Asian countries, has achieved nationwide but slow progress in maternal health (MH) although the MMR in certain areas, such as, Matlab with limited extent and some urban slum areas, dropped significantly due to community-based interventions. It has been asserted that achieving the first target of the 3rd Sustainable Development Goal (SDG) for Bangladesh is a challenge, but not out of reach (Arman, 2010; *bdnews24*, 29 January 2011; Chowdhury et al., 2011; Koehlmoos et al., 2011; Moral, 2010, 2011; Nasreen et al., 2011). Unlike Bangladesh lagging behind fulfilling the target, two other South Asian countries (Nepal and Sri Lanka) have made better progress towards achieving this goal. The current MMR in Bangladesh, Nepal and Sri Lanka is between 170 and 200, 170 and 35, respectively (*Prothom Alo*, 20 October 2014, p. 1; *Prothom Alo*, 20 October 2014, p. 14; *Daily Star*, 20 October 2014). Success stories of Nepal and Sri Lanka have therefore led me to explore how Sri Lanka and Nepal are able to reduce high MMR faster than Bangladesh. Comparing the experience of Nepal and Sri Lanka with that of Bangladesh is also a motto of this attempt.

The main objective of the article is therefore to explore the factors that have worked behind the relative success in Nepal and Sri Lanka, compared to Bangladesh. Sharing positive lesson of each country for further betterment of MH is another objective of this article. The main basis of it was secondary sources, including newspaper reports, academic books and articles, different reports. The article is organized in the following manner. The second part briefly highlights theoretical premise of the study which is followed by making a comparison among the three countries introducing the current condition of Bangladesh, highlighting better achievement of Sri Lanka in MH and showing the ways of reducing high MMR in Nepal. An attempt is made to develop arguments in the penultimate part. A conclusion is drawn and policy implications are given in the final part.

Theoretical Premise

Countries with moderate or high economic growth and large amount of investment in human development achieve better MH. Adopting national health policy (NHP), in particular MH related, with a significant participation of people in the policy formulation stages, introducing midwifery services and family planning programme (FPP) at the earliest time, recruiting many medically trained health personnel, retaining them in the rural and remotest areas and strong monitoring their activities, updating health records have contributed to increasing the availability of and accessibility to MHC services for all women which ultimately led the above said countries to achieve this remarkable progress. Increasing the literacy, particularly female, rate, huge media penetration and up gradation of female position in society appear to have developed awareness among people about making decision of taking health care services resultantly receiving the right health care services from the right place at the right time (AbouZahr, 2003; Fraser, 2005; Grisaru & Samueloff, 2004; Shiffman & del Valle, 2006). That means, countries with less MMR have placed weight on not only medical advancement but also societal development, resultantly following bio-social approach to improve MH. In other words, they look at MH problem as a whole that includes both biological (medical) and social (gender relation in society and health care system) issues.

The improvement in MH around childbirth and post-delivery in European and North American countries were very modest in the last century. The main contributing factors were the determination to improve home delivery; the presence of a professional during baby delivery; the coverage of midwifery services in every local community with close supervisory follow-up, including a reporting system from the midwife to the doctor resultantly transferring medical technology from doctors to midwives, the

availability of blood transfusion facility, the introduction of antibiotics, better access to safe Caesarean, abortion and post-abortion services, the expansion of public health, the introduction of a nationwide health care system and an increasing allocation of the budget to development, including health sectors (Beaglehole & Bonita, 1997; Loudon, 2000; Maclean, 2005; Mavalankar & Rosenfield, 2005; McAlister & Baskett, 2006).

Some transitional countries,[1] such as Egypt, Honduras, Malaysia, Sri Lanka and Thailand, reduced MMR by more than a half during the last three or four decades. A combination of initiatives like long-term investment in midwifery training and referral hospitals, free care and a supportive system with regulation, control and supervision of the medical and midwifery profession, and information to confirm progress, appeared to have supported this remarkable success (Campbell, 2003; Danel & Rivera, 2003; Koblinsky & Campbell, 2003). That means, they follow low-level medical interventions backed up by a strong basic health care system. Nepal, one of the developing countries, was able to slow down its high MMR during the last few decades due to an increased contraceptive prevalence rate (CPR), lowering the number of mothers with anaemia by supplying iron capsules at free of cost, availability of abortion facilities, cash allowance for poor mothers to give birth in the health centre and an increase in the health budget at the national level (Suwal, 2008).

The experience of the above-mentioned countries suggests that scientific development as well as social change contribute a lot to the promotion of MH. That means, they follow the bio-social model in the reduction of high maternal deaths. It can thus be postulated that all developing countries may reduce high MMR as per their target set in the 3rd SDG following the bio-social model of disease.

Main Findings

Bangladesh with an area of 144,000 sq. km, one of the most populous countries, has a huge population of nearly 152.5 million, of whom three-quarters live in the rural areas, one quarter lives below the poverty line and around 90 per cent are Muslims. The annual population growth rate is 1.09. It has one of the highest densities of population (1,015 per sq. km) in the world (*Daily Star*, 17 July 2012; Islam, 1978; *Prothom Alo*, 29 August 2014; UNDP, 2009). In 1757, the British grabbed power in India and the British rule ended with the partition of the Indian sub-continent in 1947. Bangladesh got independence through a bloodshed war with Pakistan in 1971 and has democratically been governed (Ahmed, 2009; Jahan, 2004; Pandey, 2004; Riaz, 2003).

Like other patriarchal societies, women used to be assests of males. However, their position in society has significantly been changing because of the introduction of free female education up to higher secondary level, incentives given by the government to families for female education, awareness developed through many civic activities and wider engagement of females in income generating activities (ADB, 2001, p. 4; Rahman, Parkhurst & Normand, 2003, p. 12). The female infant mortality rate has reduced from 93 in 1994 to 64 in 2004, then to 37 in 2009, female life expectancy rate increased from 65.4 years in 2003 to 68.7 in 2009, the mean marriage age for girls was 19.9 years in 1994, while it rose to 20.31 in 2008, female school enrolment rate increased by 13.5 per cent between 1991 and 2001 and female labour force participation increased to 6.6 in 2001 from 4.4 per cent in 1991 (BBS, 2010; GED & UNDP, n.d., p. 4; MOHFW, 2010).

Bangladesh, an emerging middle-income country with per capita income (US$ 1569), has therefore been able to create a better position in social indicators in comparison to other South Asian countries (*Prothom Alo*, 20 October 2014). To be precise, Bangladesh has achieved the 129th position among 150

countries in the Human Development Index in 2010 (UNDP, 2010) and has been able to position herself in the middle human development country group (UNDP, 2011). That means, Bangladesh gives emphasis on economic growth as well as human development that has caused in bringing about positive scenario in different health-related indicators.

The early introduction of FPP in 1953 (Afroza, nd; Larson & Mitra, 1992; Randall, 2012) albeit some argue that the programme is not expanding rather stalling (*Prothom Alo*, 24 March 2016; Uddin & Rahman, 2006), better availability of and accessibility to MHC services due to the adoption of fragmented health-related policies, operationalization of issue-centred programmes, introducing community-based health care services and health workers and setting up health centres at people's doorsteps (MOHFW, 2014; NIPORT, Mitra and Associates, & Macro International, 2005, 2009, 2012), other development efforts like moderate improved sanitation coverage (UNICEF, 2013), voucher scheme for MH (Ahmed & Khan, 2011; MOHFW, 2014), maternal and newborn health initiatives (MOHFW, 2014) and maternity leave policy (Anam, 2008; *Dhaka Mirror*, 12 January 2011; *Women Magazine*, 1 January 2011) have contributed to the improvement of MH. However, the progress Bangladesh has achieved in reducing the MMR is not as the same as Nepal and Sri Lanka. Un-implementation of a long-term NHP, MH-related policy in particular, availability of midwifery-based services, including comprehensive emergence obstetric care (EmOC) on a massive scale, in limited areas, lack of good political will—the same percentage of GDP for health and defence each—and poor condition of vital registration system, less availability of menstruation regulation and blood transfusion facilities are prime reasons for this worse situation (Chowdhury & Osmani, 2010; CRH, 2011; Islam, 2009; Muhammad, 2015; Sikder et al., 2015; WHO, 2012).

In contrast, Sri Lanka, an island of 65,610 sq. km and of 21.3 million people with a growth rate of 0.9 per cent where most of the people live in rural areas, seems to be an egalitarian society owing to liberal political and religious principles—Buddhist (Caldwell, 1986; Fernando, 2000, p. 14; United States State Department, 2011). The gross domestic product (GDP) per person is about US$ 4942 and around 1.8 per cent of GDP is spent on health care, of which, 0.23 per cent is for mother and child health (MCH) indicating positive political will of the government in the progression of health indicators. The adult literacy rate for females and males is 89.7 and 92.6 per cent, respectively (*Prothom Alo*, 20 October 2014, p. 1; Senenayake et al., 2011, p. 78; UNDP, 2010). Buddhist philosophy, colonial support to education expansion, the announcement of free education and the availability of educational facilities have also created an enabling environment for girls' education. This has resulted in girls outnumbering boys in schools. The ratio of girls to boys at primary, secondary and tertiary levels is 99, 105.7 and 187 respectively (DoC&S, 2009).

Growing female education has contributed to reducing total fertility rate from 5 in 1963 to 2.3 by 1993, increasing female marriage age (24.8 in 1987 while it was 18.3 years in 1901) abetting teenage pregnancies, providing more access to both print and electronic media that make women aware of their health, and increasing CPR from 59.6 in 1986 to 65.5 in 1993 due to the introduction of FPP in the 1960s (Gunaserera & Wijesinghe, 1996, p. 769; Perera et al., 2012; Senenayake et al., 2011, p. 78). All these positive changes have increased and improved health care services, eventually contributing to the reduction of MMR (Fernando, Jayatilleka & Karunaratna, 2003, p. 94). Besides these, political leaders always show their interests in the improvement of women status and their health. They have placed emphasis on human development along with economic prospect. For this reason, the health budget has always been increasing what Shiffman and Okonofua (2007) consider as an indicator of good political will.

Maternity services began to be provided from the last quarter of the nineteenth century. Midwifery services have been available since the first decade of the twentieth century (Bjorkman, 1985; de Bernis et al., 2003, p. 41; Mavalankar, Vora & Sharma, 2007; Senanayake, 1998; Silva & Wickramasuriya, 2001).

Special attention was given to services for rural people and blood transfusion facilities were available from the 1950s (Caldwell, 1986, p. 195; Fernando et al., 2003; Koblinsky, Campbell & Heichelheim, 1999, p. 403; Senanayake, 1998, pp. 115–116; Senenayake et al., 2011). Community midwives are the front-line health workers who usually register all pregnancies and are able to identify complicated cases that need to be referred. There has been strong supervision of their services and they have full dedication to their services (Pathmanathan et al., 2003, pp. 115–116; Senenayake et al., 2011, p. 84). No sanctioned posts were found vacant due to rigorous and efficient administration which reflects that there is a strong monitoring system. There is also a strong monitoring system of maternal deaths through the civil registration system.

An NHP and other previous and subsequent health-related policies, adopted in a systematic way, have given more emphasis on providing health care, particularly MCH, services at people's doorsteps, consequently, there are more primary health care centres (PHCCs) and basic emergence obstetric care centres than the international standard. The same percentage of pregnant mothers are able to deliver babies in institutional settings which ensure the safety and security of the expectant mothers and babies (Gunasekera, Wijesinghe & Gunasekera, 1996, p. 1162; Mavalankar et al., 2007; Pathmanathan et al., 2003, p. 31; Senenayake et al., 2011, p. 80; UNFPA-Asia, 2009; Womendeliver, n.d.). Besides these, other social development initiatives, such as food subsidies and supplementation and maternity benefits in the 1940s (Fernando et al., 2003, p. 94) gave ample opportunity for females, especially poor, to have sufficient food that may protect pregnant mothers from malnutrition and high improved sanitation coverage (UNICEF, 2013) have contributed to the reduction of high MMR.

Unlike Bangladesh and Sri Lanka, Nepal is a landlocked country covering 147,181 sq. km and having a population of 29.3 million people. The annual population growth rate is 1.9 per cent. The Nepalese population consists of predominantly Hindus (81 per cent), followed by Buddhists (11 per cent), Muslims (4 per cent) and others (4 per cent). Sixteen per cent of Nepalese live in urban areas and GDP is US$ 1106 (*Prothom Alo*, 20 October 2014, p. 1; WHO, 2007a). Nepal is also a gender-based and feudalistic society. After restoring democracy and introducing various developmental activities, everything is seemingly changing. The provision of basic and reproductive health care services is enshrined as people's rights in the interim constitution and the increasing budget for health sector—2.2 per cent of GDP in 2012 and 2.6 per cent in 2013 (UNDP, 2014)—reflecting that political leaders have good political will to bring improvement to women's lives.

Nepal has been one of the fastest movers in HDI rankings since 1970. In 2010 its rank was 138 out of 177 countries. Free primary education for all was introduced in 1971 and was extended to the secondary level in 2007 (UNDP, 2010; United States State Department, 2010). This has resulted in increasing literacy rate to 54 per cent (2001) from 23 per cent (1981) to 40 per cent (1991). But the gender gap in literacy was quite striking in 1981 (male 34 per cent and female 12) but improved in 2001 (male 65 per cent and female 43) due to improving woman position in society. The female enrolment rate at primary, secondary and higher secondary levels in 2001 was 44, 42 and 41 per cent, respectively (Jha, 2007; Ministry of Education, 2011). The overall adult literacy rate in 2008 is estimated at 63.2 per cent (male 74.7 per cent and female 53.1 per cent) (CBS, 2009).

All five-year and other development plans put importance to health care provision (Bhandari, Gordon & Shakya, 2011; DFID, 2011; WHO, 2007a). Moreover, the safe motherhood (SM) has been considered an important component of primary health care in the NHP (adopted in 1991) which resulted in the creation of many short- and long-term plans for the SM. Specific policies relating to the SM were adopted based on common people's participation (Malla et al., 2011; MoH&P, 2010; Nepal Red Cross Society, n.d.; SSMP, 2010; WHO, 2007a). Besides these, the safe delivery incentive programme was introduced in 2009 for addressing access barriers (Bhandari et al., 2011, p. 27; Ensor, Clapham & Prasai,

2008, p. 6; Malla et al., 2011, p. 65; NPC, 2010; Simkhada et al., 2006, p. 261; Witter et al., 2011, pp. ii85–ii86). In addition, abortion was legalized in 2002 (Bhandari et al., 2011, pp. 27–28; Uprety, 2005, p. 139). Lastly, the early introduction of the FPP in 1959 (Tamang, Govind & Catherine, 2010), consequently the huge expansion of family planning (FP) services, makes its methods available which ultimately encourages married couples to use them. The CPR therefore increased from 26 (1996) to 43 per cent (2011) (USAID, ERA & Nepal, 2011).

All these policies and programmes are trying to make health care services available to the people. Consequently, each village has at least one PHCC and the numbers of health posts and sub-health posts with 24-hour maternity services have been increasing (Ailuogwemhe et al., 2005, p. 3; Dev et al., 2008, p. 14; Niraula, 1994, p. 152; NPC, 2010, p. 48). Various strategies, such as the national SM long-term plan (2002–2017), later known as the National SM and Newborn Health Long Term Plan (2006–2017), the National Policy on SBAs (2006), a pre-service direct entry course for midwives, in-service SBA training strategy (2009), were adopted for increasing the number of SBAs (Malla et al., 2011; MoH&P, 2010; Nepal Red Cross Society, n.d.; SSMP, 2010; WHO, 2007a). Moreover, compulsory rural service was introduced for retaining SBAs in rural and remotest areas (Ailuogwemhe et al., 2005; Ghimire, 2009; Shankar, 2010) which resulted in increasing rural mothers' access to institutional baby deliveries compared to their counterparts. All maternal deaths have begun to be scrutinized. Necessary actions or remedies have also been made based on the results of scrutiny (Malla et al., 2011, pp. 63–66; WHO, 2007a).

However, similarities and differences among three countries are depicted in the Table 1.

Table 1. Similarities and Differences among Three Countries

Indicators	Bangladesh	Nepal	Sri Lanka
Geographic area	144,000 sq. km	147,181	65,610
Total population	152.5 million	29.3	21.3
Population growth rate	1.07	1.9	0.9
Gross domestic product (GDP)	US$ 1,569	US$ 1,106	US$ 4,942
Religion (majority)	Islam	Hindu	Buddhist
Position of women	Improving	Improving	Nearly equal
Mean age of female at marriage	20.31	17.2	24.8
Free educational facilities for females	Higher secondary level	Secondary level	University level
Female literacy	53.8%	53.1%	89.7%
Political system	Parliamentary democracy	Representative democracy	Semi-presidential democracy
Political ideology	Democratic	Socialistic	Socialistic
Colonial legacy	Yes	No	Yes
Health-related policies, plans and programmes			
Health policy	Yes (fragmented)	Yes (integrated)	Yes (integrated)
Length of planning	Short term	Long term	Long term
Maternal health policy	No	Yes	No

(Table 1 Continued)

(Table 1 Continued)

Indicators	Bangladesh	Nepal	Sri Lanka
Institutional delivery	Increasing	Increasing	Mostly done
Blood transfusion facilities	Not up to standard	Improving	Very good
Improved sanitation coverage	Moderate (55%)	Low (35%)	High (91%)
Inclusion of reproductive health in constitution	No	Yes	Yes
Legalization of abortion	No	Yes	No
Massive midwifery based programmes	Yes (limited extent)	Yes	Yes
Family planning programme	Stalling	Improving	Improving
Community-based programmes	Limited areas	Widely spread	Widely spread
Vital registration system	No	Yes	Yes
Localization of policy	No	Yes	Yes
Maternity leave facility	Yes	No	Yes

Source: Author's own.

Main Discussions

Bangladesh has a vast plain land that gives it an advantage to easily cover health care services for all whereas Nepal and Sri Lanka have mountainous areas. However, it has huge population as compared to other two countries. So it is difficult for Bangladesh to bring all people under the coverage of health care services that could be one of the main reasons for prevailing high MMR. Position of women in Bangladesh and Nepal has been improving while that in Sri Lanka has almost been equal to male. Wang (2014) has connected gender equality with the promotion of MH. In Sri Lanka, mean age of females at marriage is five and ten years more compared to Bangladeshi and Nepalese woman marriage age, respectively. A strong associational relationship between maternal mortality and marriage at early age, inducing couples to raise a family at an early age, is found (Alexander et al., 2003; Chang et al., 2003; Koblinsky et al., 2009; McCarthy & Maine, 1992; Padhye & Lakhey, 2003; Shahraki, 2007; Suwal, 2008; Ujah et al., 2005).

This indicates that Sri Lankan women have low possibility to have many children resultantly less possibility of facing risks during baby delivery. In contrast, Bangladeshi and Nepalese females are more likely to have pregnancy at their earliest ages which push them at greater risks. Education has always been prioritized in Sri Lanka. Making education free up to the university level and emphasizing female education create awareness among people about making decision at the right time for taking health care services from the right places at the right time. This consciousness helps mothers to be free from hazardous conditions. Bangladesh and Nepal have recently adopted policies for increasing literacy rate in particular female education. In addition, Sri Lanka is the only country among the three who has been following socialistic philosophy at the state level that ultimately ensures regional and class-based equality in the availability of and accessibility to MHC services, resultantly reducing high MMR here. Conversely, regional and socio-economic status-based inequality found in Bangladesh (*Prothom Alo*, 27 March 2016; Say & Rosalind, 2007; WHO, 2007b) and Nepal (Say & Rosalind, 2007; WHO, 2007b) which causes variation in MMR across region and class.

Bangladesh has recently adopted an NHP but it is yet to implement it completely. Even, as reported in Zafarullah and Banik (2015), people participation in the formulation of health policy was low. This causes people unaware about the progress and implementation of the health policy. It has also many programmes and projects with short-term duration effect of which has not been estimated accurately. In some cases, no impact has been found once projects and programmes are not continued. In addition, no MH-related specific policy adopted and midwifery-based services are provided in limited places here. On the other hand, Nepal and Sri Lanka have integrated health policy, including MH, long-term planning and programmes with its rigorous implementation and widely covered midwifery-based services that create an enabling environment to monitor the progress of MH. This strong monitoring system ultimately helps reduce the MMR. This argument is corroborated by others (Barbazza et al., 2015; Kabene et al., 2006; Reynolds & Elizabeth, 2013; WHO, 2010).

The number of baby deliveries in the service centres has slowly been increasing in Bangladesh and Nepal whereas the number is higher in the context of Sri Lanka. Blood transfusion facilities are available in some urban areas of Bangladesh while those are improving in Nepal and widely available in Sri Lanka. Institutional facilities therefore ensure mothers at high risks required health care facilities that ultimately save their lives from dangers. The FPP has been stalling in Bangladesh whereas the number of people taking contraceptives in Nepal and Sri Lanka is increasing. This means that Nepalese and Sri Lankan families are more likely to have few children that ensure few deaths during baby delivery. Bangladesh has recently adopted and implemented community-based work forces in health service delivery while Nepal and Sri Lanka introduced this scheme earlier. In Nepal and Sri Lanka, dispensing basic health care services through community workers has caused in reducing huge burden of pregnant mothers in hospitals at the secondary or tertiary levels that also gives medically trained personnel much time for giving attention to serious patients. All these issues reveal that Sri Lanka has given more emphasis on biomedical approach to the improvement of MH which has recently been followed in Bangladesh and Nepal. This is a possible reason for which Sri Lanka is able to curtail high MMR at the faster rate compared to other two South Asian countries.

Nepal and Sri Lanka always prioritize reproductive health as it has been enshrined in their constitutions and have been increasing health budget continuously, apparently indicating that political leaders of these two countries have shown their commitments (i.e., good political will) to the improvement of MH understanding the danger of women health relating to pregnancy and baby delivery. Abortion was legalized in only Nepal. Vital registration system is strictly followed in Nepal and Sri Lanka. The progression of MH can easily be identified. In contrast, exclusion of reproductive health issue from the constitution, continuation of the same amount of development budget for health sector, less availability of rigorous vital registration system in Bangladesh indicate that political leaders have less political will to improve the MH situation further. Rosenfield, Min and Freedman (2007), Shiffman (2003) and Shiffman and Okonofua (2007) have shown that good political will is a must for bringing about change in woman position in society vis-à-vis improving MH. However, in some cases, maternity leave for formal workers is available in Bangladesh and Sri Lanka.

Conclusion

The Sri Lankan successful experience (MMR 35) shows that most maternal deaths can be prevented with less advancement in medical technology. What is needed is a literate female population, better access to health services, including FP, good quality ante- and post-natal care, and the political will to succeed. In Nepal, the government has been formulating many plans for addressing MH issues and adopting

various strategies for implementing these plans and programmes that seem to have contributed to increasing the number of institutional deliveries which may bring high MMR to an acceptable level.

Bangladesh has been providing EmOC services on a limited scale since the last two decades that has caused in reducing MMR slowly compared to the other two countries. As suggested for Bangladesh from the progress and experiences of Nepal and Sri Lanka, speeding-up the provision of the EmOC (basic and comprehensive) is the one, not the only, effective way of achieving the expected reduction in MMR. Bangladesh therefore needs to increase the supply of MH-related facilities as much as possible. In addition, the lesson other developing countries, Bangladesh in particular, can learn from Nepal and Sri Lanka is that it would be possible to cut high MMR if maternal services are provided through midwives backed up by doctors and a good referral system and supported by moderate public expenditures, health policies with appropriate long-term plans and strategies are adopted, the government has good political will to prioritize health issues and continue the existing policy and plans of the predecessors with necessary amendments.

However, the following specific actions can improve health condition of mothers in both Bangladesh and Nepal.

Policy Implications

1. For Bangladesh and Nepal, increasing marriage age for females could be one of the ways of improving the worse condition of mother health. In this regard, strong political will is necessary.
2. Reducing, for Bangladesh and Nepal, region and class-based inequality in the availability of and accessibility to MHC services is another possible way of reducing high MMR.
3. It is urgent for Bangladesh to take necessary steps to implement NHP as per its objectives and to adopt MH-related long-term policy and programme. In this regard, good political will is an urgent.
4. Bangladesh and Nepal need to increase clinical services more.
5. It is necessary for the Bangladesh government to enshrine the issue of reproductive health in the constitution and to legalize abortion in some cases understanding the effects of mother loss at the household and society levels.

Note

1. They are basically trying to achieve MMR that developed countries already achieved. In this sense, they belong to neither the developed nor the developing country group.

References

AbouZahr, C. (2003). Safe motherhood: A brief history of the global movement 1947–2002. *British Medical Bulletin*, *67*(1), 13.

ADB. (2001). *Women in Bangladesh*. Country Briefing Paper, Asian Development Bank (ADB), Hongkong.

Afroza, S. (nd.). *Achievements and challenges of family planning in Bangladesh*. NIPORT. Retrieved 14 March 2016, from http://www.iedcr.gov.bd/pdf/files/NPHC%20WEB/UPLOAD-3/Thematic%20Session/5_DG%20NIPORT%20NPHC.pdf

Ahmed, R. (2009). Interface of political opportunism and Islamic extremism in Bangladesh: Rhetorical identification in government response. *Communication Studies*, *60*(1), 82–96.

Ahmed, S., & Khan, M. (2011). A maternal health voucher scheme: What have we learned from the demand-side financing scheme in Bangladesh. *Health Policy and Planning*, *26*(1), 25–32.

Ailuogwemhe, J., Rajbhandari, R., Illiaki, E., Villar, M., & Dieterich, M. (2005). *Tackling shortages of health care workers in rural Nepal: 'Train to Retain'*. Boston: Harvard School of Public Health.

Alexander, S., Wildman, K., Zhang, W., Langer, M., Vutuc, C., & Lindmark, G. (2003). Maternal health outcomes in Europe. *European Journal of Obstetrics and Gynecology*, *111*(S), 78–87.

Amery, J. (2009). Editorial: Safe motherhood case studies: Learning from South Asia. *Journal of Health Population Nutrition*, *27*(2), 87–88.

Anam, R. L. (2008). Inadequacies and variations of maternity leave policies throughout the world: Special focus on Bangladesh. *BRAC University Journal*, *5*(1), 93–98.

Arman, S. (2010, May 24). Appraising our MDGs. *The Daily Star*.

Barbazza, E., Margrieta, L., Haw, K., & Juan, T. (2015). Health workforce governance: Processes, tools and actors towards a competent workforce for integrated health services delivery. *Health Policy*, *119*(12), 1645–1654.

BBS. (2010). *Key indicators on sample Vital registration system—2009*. Dhaka: Bangladesh Bureau of Statistics (BBS).

bdnews24. (2011, January 29). New approach cuts maternal mortality. Retrieved from bdnews24.com.

Beaglehole, R., & Bonita, R. (1997). *Public health at the crossroads: Achievements and prospects*. Cambridge: Cambridge University Press.

Bhandari, A., Gordon, M., & Shakya, G. (2011). Reducing maternal mortality in Nepal. *BJOG: An International Journal of Obstetrics & Gynaecology*, *118*(Suppl. 2), 26–30.

Bjorkman, J. W. (1985). Health policy and politics in Sri Lanka: Developments in the South Asian welfare state. *Asian Survey*, *25*(5), 537–552.

Caldwell, J. C. (1986). Routes to low mortality in poor countries. *Population and Development Review*, *12*(2), 171–220.

Campbell, O. (2003). Egypt, 1992–2000. In M. A. Koblinsky (Ed.), *Reducing maternal mortality: Learning from Bolivia*, *China*, *Egypt*, *Honduras*, *Indonesia*, *Jamaica*, *and Zimbabwe* (pp. 5–37). Washington, D.C.: The World Bank.

CBS. (2009). *Nepal Labour Force Survey 2008: Statistical report*. Kathmandu: Central Bureau of Statistics (CBS).

Chang, J., Elam-Evans, L., Berg, C., Herndon, J., Flowers, L., Seed, K., & Syverson, C. J. (2003). Pregnancy-related mortality surveillance—United States, 1991–1999. *MMWR Surveill Summ*, *52*(2), 1–8.

Chowdhury, O. H., & Osmani, S. R. (2010). Towards achieving the right to health: The case of Bangladesh. *The Bangladesh Development Studies*, *33*(1/2), 205–273.

Chowdhury, S., Banu, L., Chowdhury, T., Rubayet, S., & Khatoon, S. (2011). Achieving Millennium Development Goals 4 and 5 in Bangladesh. *BJOG: An International Journal of Obstetrics & Gynaecology*, *118*(Suppl. 2), 36–46.

CRH. (2011). Improving the quality of nursemidwives in Bangladesh: Addressing barriers of midwifery course in diploma in nursing and midwifery training. Centre for Reproductive Health (CRH), ICDDR,B. Knowledge Translation Brief No. 9.

Daily-Star. (2012, July 17). Population growing by 1.37pc. *The Daily Star*.

———. (2014, October 20). Dhaka second to Colombo. *The Daily Star*.

Danel, I., & Rivera, A. (2003). Honduras, 1990–1997. In M. A. Koblinsky (Ed.), *Reducing maternal mortality: Learning from Bolivia*, *China*, *Egypt*, *Honduras*, *Indonesia*, *Jamaica*, *and Zimbabwe* (pp. 5–37). Washington, D.C.: The World Bank.

de Bernis, L., Sherratt, D., AbouZahr, C., & Van Lerberghe, W. (2003). Skilled attendants for pregnancy, childbirth and postnatal care. *British Medical Bulletin*, *67*(1), 39–57.

Dev, P. P., Suvedi, B. K., Pradhan, A., Hulton, L., Matthews, Z., & Maskey, M. (2008). *Investigating recent improvements in maternal health in Nepal: Analysis of the 2006 Nepal Demographic and Health Survey*. Calverton, MD: Macro International Inc.

DFID. (2011). MDG 5-Driving down maternal mortality in Nepal. Retrieved 26 January 2012, from https://www.gov.uk/government/case-studies/mdg-5-driving-down-maternal-mortality-in-nepal

Dhaka Mirror. (2011 January, 12). Maternity leave now for six months. *Dhaka Mirror.*

Do, Q. T., & Lyer, L. (2010). Geography, poverty and conflict in Nepal. *Journal of Peace Research*, *47*(6), 735.

DoC&S. (2009). *MDG indicators of Sri Lanka: A mid term review-2008*. Colombo: Department of Census and Statistics (DoC&S).

Ensor, T., Clapham, S., & Prasai, D. P. (2008). What drives health policy formulation: Insights from the Nepal maternity incentive scheme? *Health Policy*, *30*(2), 1–10.

Fernando, D. (2000). Health care systems in transition III. Sri Lanka, Part 1. An overview of Sri Lanka's health care system. *Journal of Public Health Medicine*, *22*(1), 14–20.

Fernando, D., Jayatilleka, A., & Karunaratna, V. (2003). Pregnancy-reducing maternal deaths and disability in Sri Lanka: National strategies. *British Medical Bulletin*, *67*(1), 85–98.

Fraser, A. (2005). Approaches to reducing maternal mortality: Oxfam and the MDGs. *Gender and Development*, *13*(1), 36–43.

GED & UNDP. (n.d.). *A situation analysis report on health* (*MDG 4*, *5 and 6*) *Bangladesh: A baseline for needs assessment and costing*. Dhaka: General Economic Division (GED), Planning Commission, Government of the People's Republic of Bangladesh and UNDP Bangladesh.

Ghimire, L. V. (2009). Retaining health manpower in developing countries. *The Lancet*, *374*(9686), 291.

Grisaru, S., & Samueloff, A. (2004). Primary nonmedically indicated cesarean section ('section on request'): Evidence based or modern vogue? *Clinics in Perinatology*, *31*(3), 409–430.

Gunasekera, P., Wijesinghe, P. S., & Gunasekera, D. (1996). Learning from primary care in developing countries. *British Medical Journal*, *312*(9003), 1161–1162.

Gunaserera, P. C., & Wijesinghe, P. S. (1996). Maternal health in Sri Lanka. *The Lancet*, *347*(9003), 769.

Hussein, J., Bell, J., Dar lang, M., Mesko, N., Amery, J., & Graham, W. (2011). An appraisal of the maternal mortality decline in Nepal. *PLoS One*, *6*(5: e 19898), 1–10.

Islam, M. B. (2009). Blood transfusion services in Bangladesh. *Asian Journal of Transfusion Science*, *3*(2), 108–110.

Islam, N. (1978). *Development strategy of Bangladesh*. Oxford: Pergamon Press.

Jahan, R. (2004). Bangladesh in 2003: Vibrant democracy or destructive politics? *Asian Survey*, *44*(1), 56–61.

Jha, H. B. (2007). Women in Nepal's education system. *The Telegraph Weekly*, 28 Febuary.

Kabene, S. M., Carole, O., John, M. H., Mark, A. S., & Raymond, L. (2006). The importance of human resources management in health care: A global context. *Human Resources for Health*, *4*(20), 1–17.

Koblinsky, M. A., & Campbell, O. (2003). Factors affecting the reduction of maternal mortality. In M. A. Koblinsky (Ed.), *Reducing maternal mortality: Learning from Bolivia*, *China*, *Egypt*, *Honduras*, *Indonesia*, *Jamaica*, *and Zimbabwe* (pp. 5–37). Washington, D.C.: The World Bank.

Koblinsky, M., Anwar, I., Mridha, M., Chowdhury, M., & Botlero, R. (2009). Reducing maternal mortality and improving maternal health: Bangladesh and MDG 5. *Journal of Health*, *Population and Nutrition*, *26*(3), 280.

Koblinsky, M., Campbell, O., & Heichelheim, J. (1999). Organizing delivery care: What works for safe motherhood? *Bulletin of the World Health Organisation*, *77*(5), 399–406.

Koehlmoos, T. P., Islam, Z., Anwar, S., Hossain, S. A. S., Gazi, R., Streatfield, P. K., & Bhuiya, A. U. (2011). Health transcends poverty: The Bangladesh experience. In D. Balabanova, M. McKee & A. Mills (Eds), *'Good health at low cost' 25 years on: What makes a successful health system?* (pp. 47–81). London: London School of Hygiene & Tropical Medicine.

Larson, A., & Mitra, S. N. (1992). Family planning in Bangladesh: An unikely success story. *International Family Planning Perspectives*, *18*(4), 123–129.

Loudon, I. (2000). Maternal mortality in the past and its relevance to developing countries today. *The American Journal of Clinical Nutrition*, *72*(Suppl.), 241S–246S.

Maclean, G. D. (2005). Dimension, dynamics and diversity: A 3D approach to appraising global maternal and neonatal health initiatives. In R. E. Balin (Ed.), *Trends in midwifery research* (pp. 261–317). New York: Nova Biomedical Books.

Malla, D., Giri, K., Karki, C., & Chaudhary, P. (2011). Achieving Millennium Development Goals 4 and 5 in Nepal. *BJOG: An International Journal of Obstetrics & Gynaecology*, *118*(Suppl. 2), 60–68.

Mavalankar, D., & Rosenfield, A. (2005). Maternal mortality in resource-poor settings: Policy barriers to care. *American Journal of Public Health*, *95*(2), 200.

Mavalankar, D., Vora, K., & Sharma, B. (2007). Strengthening midwifery services in India based on lessons learnt from Sweden and Sri Lanka. *Vol. W.P.No. 2007-06-07*. Ahmedabad: Indian Institute of Management.

McAlister, C., & Baskett, T. (2006). Female education and maternal mortality: A worldwide survey. *Journal of Obstetrics and Gynaecology Canada*, *28*(11), 983–990.

McCarthy, J., & Maine, D. (1992). A framework for analysing the determinants of maternal mortality. *Studies in Family Planning*, *23*(1), 23–33.

Ministry of Education. (2011). Nepal education in figures 2011 At-A-Glance. Kathmandu: Ministry of Education, the Government of Nepal.

MoH&P. (2010). Women deliver conference: Safe motherhood in Nepal. Retrieved 27 January 2012, from http://www.womendeliver.org/assets/Women_Deliver_-_Minister_speech_June_10.pdf

MOHFW. (2010). *Health Bulletin 2010*. Dhaka: Management Information System (MIS), Director General of Health Services (DGHS). Ministry of Health and Family Welfare (MOHFW), Dhaka, Bangladesh.

———. (2014). *Health Bulletin 2013*. Dhaka: Management Information System (MIS), Director General of Health Services (DGHS). Ministry of Health and Family Welfare (MOHFW), Dhaka, Bangladesh.

Moral, S. (2010, April 30). Samanwayheen seba, matreemeetrur har komche na (Uncoordinate services, maternal mortality rate not decreasing), *Prothom Alo*.

———. (2011, February 14). Deshe Matreemetru komate ullekhjogya saflya (Good progress in reduction of maternal mortality rate of Bangladesh), *Prothom Alo*.

Muhammad, A. (2015). Bangladesh—A model of neoliberalism. *Monthly Reiew*, *66*(10), 35.

Nasreen, H. E., Nahar, S., Al Mamun, M., Afsana, K., & Byass, P. (2011). Oral misoprostol for preventing postpartum haemorrhage in home births in rural Bangladesh: How effective is it? *Global Health Action*, *4*(1), 7017.

Nepal Red Cross Society. (n.d.). Blood services. Retrieved 10 July 2012, from http://www.nrcs.org/core-area/hc-blood-service.php

NIPORT, Mitra and Associates, & Macro International. (2005). Bangladesh demographic and health survey (2004). Dhaka, Bangladesh and Calverton, MD: National Institute of Population Research and Training (NIPORT), Mitra and Associates and Macro International.

———. (2009). Bangladesh demographic and health survey (2007). Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training (NIPORT), Mitra and Associates and Macro International.

———. (2012). Bangladesh demographic and health survey, 2011: Preliminay report. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training (NIPORT), Mitra and Associates and Macro International.

Niraula, B. B. (1994, October 1). Use of health services in hill villages in central Nepal. *Health Transition Review*, 151–166.

NPC. (2010). *Nepal Millennium Development Goals: Progress report*, *2010*. Kathmandu, Nepal: National Planning Commission (NPC), Government of Nepal.

Padhye, S., & Lakhey, B. (2003). 'Brought Dead'-cases of maternal mortality. *Kathmandu University Medical Journal*, *1*(3), 184–186.

Pandey, P. K. (2004). Political culture in Bangladesh: Does leadership matter? *Social Change*, *34*(4), 24–37.

Pathmanathan, I., Liljestrand, J., Martins, J. M., Rajapaksa, L. C., Lissner, C., de Silva, A., … & Singh, P. J. (2003). *Investing in maternal mortality: Learning from Malaysia and Sri Lanka*. Washington, DC: The World Bank.

Perera, W. L. S. P., Lillian, M., Rohini De, A. S., & Tushara, F. (2012). Family planning services in Sri Lanka: Client's nonmedical expectations and the health systems nonresponsiveness. *South East Asia Journal of Public Health*, *2*(1), 54–59.

Prothom Alo. (2014, August, 29). Bangladesher daridra manchitra (Poverty Map of Bangladesh). *Daily Prothom Alo.*

———. (2014, October, 20). Samajik Suchke Varter cheye egiye Bangladesh (Bangladesh ahead India in social indicators). *Daily Prothom Alo*, p. 1.

———. (2014, October, 20). Air noy matri mtritu (No more maternal death). *Daily Prothom Alo*, p. 14.

———. (2016, March, 24). Durbal hoye parchhe paribar parikolpana karjakam (Family planning program has been weakening). *Daily Prothom Alo.*

Prothom Alo. (2016, March, 27). Daridra shishuder meetrajhuki dhigun nirkhrera seba kom pay (Double death risks for poor children, less services for illiterate). *Daily Prothom Alo.*

Rahman, S. A., Parkhurst, J., & Normand, C. (2003). Maternal health review Bangladesh. Dhaka: Policy Research Unit (PRU), MOHFW, Government of Peoples Republic of Bangladesh.

Randall, E. (2012). Family planning programmes review. Retrieved 10 March 2016, from http://www.populationmatters.org/documents/programmes_review. pdf

Reynolds, H. W., & Elizabeth, G. S. (2013). A systematic approach to the planning, implementation, monitoring and evaluation of integrated health services. *BMC Health Services Research*, *13*(1), 168.

Riaz, A. (2003). 'God willing': The politics and ideology of Islamism in Bangladesh. *Comparative Studies of South Asia*, *Africa and the Middle East*, *23*(1/2), 301–320.

Rosenfield, A., Min, C., & Freedman, L. (2007). Making motherhood safe in developing countries. *New England Journal of Medicine*, *356*(14), 1395.

Say, L., & Rosalind, R. (2007). A systematic review of inequalities in the use of maternal health care in developing countries: Examinig the scale of the problem and the importance of contet. *Bulletin of the World Health Organisation*, *85*(10), 733–820.

Senanayake, P. (1998). Safe motherhood: A success story in Sri Lanka. *World Health*, *51*(1), 28–29.

Senenayake, H., Goonewardene, M., Ranatunga, A., Hattotuwa, R., Amarasekera, S., & Amarasinghe, I. (2011). Achieving Millennium Development Goals 4 and 5 in Sri Lanka. *BJOG: An International Journal of Obstetrics & Gynaecology*, *118*(Suppl. 2), 78–87.

Shahraki, A. (2007). Maternal mortality in Isfahan Province 2001–2006. *Journal of Medical Sciences*, *7*(8), 1340–1344.

Shankar, P. (2010). Attracting and retaining doctors in rural Nepal. *Rural and Remote Health*, *10*(3), 1420.

Shiffman, J. (2003). Generating political will for safe motherhood in Indonesia. *Social Science & Medicine*, *56*(6), 1197–1207.

Shiffman, J., & del Valle, A. (2006). Political history and safe motherhood disparities between Guatemala and Honduras. *Population and Development Review*, *32*(1), 53–80.

Shiffman, J., & Okonofua, F. (2007). The state of political priority for safe motherhood in Nigeria. *BJOG: An International Journal of Obstetrics & Gynaecology*, *114*(2), 127–133.

Sikder, S. S., Alain, B. L., Hasmot, A., Abu, A. M. H., Rolf, D. W. K., Sucheta, M., et al. (2015). Availability of emergency obstetric care (EmOC) among public and private health facilities in rural northwest Bangladesh. *BMC Public Health*, *15*(1), 36.

Silva de, J. K. M., & Wickramasuriya, K. (2001). Maternal and child health and family planning services in Sri Lanka. In H. M. S. S. D. Herath, R. d. A. Seneviratne & H. T. E. I. Fernando (Eds), *Public health development in Sri Lanka* (pp. 11–19). Colombo: College of Community Physicians of Sri Lanka.

Simkhada, B., van Teijlingen, E. R., Porter, M., & Simkhada, P. (2006). Major problems and key issues in maternal health in Nepal. *Kathmandu University Medical Journal*, *4*(2), 258–263.

SSMP. (2010). SSMP summary brochure. Retrieved 9 July 2012, from http://www.safemotherhood.org.np/pdf/ssmp_exit_brochure.pdf

Suwal, J. (2008). Maternal mortality in Nepal: Unraveling the complexity. *Canadian Studies in Population*, *35*(1), 1–26.

Tamang, A., Govind, S., & Catherine, P. (2010). The status of family planning and reproductive health in Nepal. Centre for Research on Environment, Health and Population Activities (CREHPA).

Uddin, M. A., & Rahman, M. L. (2006). Stalling of human fertility in Bangladesh: Causes and consequences. *The CDR Journal*, *1*(2), 133–140.

Ujah, I., Aisien, O., Mutihir, J., Vanderjagt, D., Glew, R., & Uguru, V. (2005). Factors contributing to maternal mortality in north-central Nigeria: A seventeen-year review. *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive*, *9*(3), 27–40.

UNDP. (2009). *Human Development Report 2009*. New York: United Nations Development Programme (UNDP).

———. (2010). The real wealth of nations: Pathways to human development. *Human Development Report 2010*. New York: The United Nations Development Programme (UNDP).

UNDP. (2011). Managing natural resources for human development: Developing the non-oil economy to achieve the MDGs *Timor-Leste Human Development Report 2011*. New York: The United Nations Development Programme (UNDP).

———. (2014). *UNDP Nepal Annual Report 2014*. New York: The United Nations Development Programme (UNDP).

UNFPA-Asia. (2009, January 17). SAFE MOTHERHOOD: The Sri Lanka experience (Video Clip). Retrieved from in http://video.unfpa.org/video/048265011001-safe-motherhood-the-sri-lanka-experience

UNICEF. (2013). *A snapshot of sanitation*, *hygiene and drinking water safety in South Asia—2013 update*. Kathmandu, Nepal: United Nations Children's Fund (UNICEF).

United States State Department. (2010). Background note: Nepal. Retrieved 12 July 2012, from http://www.state.gov/r/pa/ei/bgn/5283.htm

———. (2011). Background note: Sri Lanka. Retrieved 12 July 2012, from http://www.state.gov/r/pa/ei/bgn/5249.htm

Uprety, A. (2005). Body politics in Nepal. *Development*, *48*(3), 134–139.

USAID, New ERA, & The Government of Nepal. (2011). *Nepal demographic and health survey*, *2011: Preliminary report*. Kathmandu: The USAID, New ERA, and the Government of Nepal.

Wang, G. Z. (2014). The impact of social and economic indicators on maternal and child health. *Social Indicators Research*, *116*(3), 935–957.

WHO. (2007a). *Policy papers on health Nepal*. Kathmandu: Country Office for Nepal, World Health Organization (WHO).

———. (2007b). *Health inequities in the South-East Asia region*. Research Report. World Health Organization (WHO).

———. (2010). *Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies*. World Health Organization (WHO).

———. (2012). *Situation assessment of public and private blood centres in Bangladesh*. Research Report, World Health Organization (WHO).

Witter, S., Khadka, S., Nath, H., & Tiwari, S. (2011). The national free delivery policy in Nepal: Early evidence of its effects on health facilities. *Health Policy and Planning*, *26*(Suppl. 2), ii84–ii91.

Womendeliver. (n.d.). Reducing maternal mortality: Countries to inspire continued commitment, 2012. Retrieved 8 March 2012, from www.womendeliver.org/.../Maternal_Mortality_Success_Stories.pdf

Women Magazine. (2011, January, 1). Six month maternity leave from Jan. *Women Magazine.*

Zafarullah, H., & Banik, B. K. (2015). Muddling through: Limitations and challenges of the health policy process in Bangladesh. *Journal of Asian Public Policy*. DOI: 10.1080/17516234.2015.1082690

About the Author

Ghyanendra Nath Bajpai, a distinguished leader in Indian business was the chairman of the Securities and Exchange Board of India (SEBI). Earlier, he was the chairman of the Life Insurance Corporation of India (LIC). Mr Bajpai is known for his visionary leadership. He has served/serves as a non-executive chairman and a director on corporate boards in India and other countries, received awards for contribution to business and authored several books. He has been the chairman of the Corporate Governance Task Force of International Organization of Securities Commissions and the chairperson of the Insurance Institute of India (III).

As the chairman of SEBI, Mr Bajpai oversaw the orderly functioning of India's securities markets. With a vision to make India a global benchmark, he initiated numerous reforms and innovations in India's securities markets. The Indian securities market now ranks as one of the most advanced in emerging markets and may well surpass developed markets in certain respects.

As chairman, Mr Bajpai transformed LIC to meet the challenges of deregulation and competition from global insurance companies. Under his leadership, LIC became a financial powerhouse with the largest asset base in the Indian subcontinent.

Mr Bajpai has been a member of the board of directors at General Insurance Corporation of India, ICICI Bank, Unit Trust of India, UTI Bank now Axis Bank, Tata Chemicals, Jindal Steel, Thane Electric Supply Co., National Housing Bank, Discount and Finance House, Indian Railway Finance Corporation, India International Insurance Ltd, Singapore and Ken-India Ltd, Nairobi (Africa).

He was also the non-executive chairman of National Stock Exchange, Stock Holding Corporation of India, LIC Housing Finance Ltd and LIC International EC Bahrain and LIC Nepal Ltd.

Currently, Mr Bajpai is a consultant on Corporate Governance and also a non-executive chairman and non-executive director of several corporates in India. He heads Intuit Consulting Pvt Ltd, a boutique consulting outfit engaged in providing high-quality value-added advice and service in building excellence in Corporate Governance. Several large corporates have benefited out of his sagacious advice. Improving the effectiveness of the board is a greatly admired advice of Mr Bajpai.

Mr Bajpai is on the board of advisors of Indian Army Group Insurance Fund and a member of Governing Board of National Insurance Academy. He was the chairman of Indian's National Pension Trust Board. Earlier, he has served on the Governing Board of Indian Institute of Management, Lucknow.

He has been a visiting faculty at leading institutes of management and training. He was the visiting Professor of Middlesex University, London. He is being regularly invited to speak at seminars in India and abroad. He has delivered lectures at London School of Economics (LSE), Harvard University and so on and also addressed OECD and IMF seminars. He has written three popular books: The Securities Market, Marketing of Insurances and How to Become a Super Successful Salesman.

He received a number of awards, notable among them being the 'Outstanding Contribution to the Development of Finance' award from the prime minister of India and 'W. G. Chirmule Puraskar, 2014' for commendable contribution in the fields of insurance and regulation of stock market.

Mr Bajpai holds a master's degree in commerce from the University of Agra and a degree in law (LLB) from the University of Indore. He is an avid golfer.