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THEME: INTEGRATED AND COMPREHENSIVE SRH SERVICES: A GLOBAL VIEW

Commentary: Sustaining progress towards comprehensive reproductive health services in Bangladesh

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Bangladesh has made major shifts in health policy and programme initiatives since the 1994 International Conference on Population and Development (ICPD). The lead author of this commentary has previously described the pivotal post-ICPD change in 'health policy priorities and investments, from a narrow focus on family planning to comprehensive services for sexual and reproductive health (SRH)' (Jahan & Germain, 2004). Where is Bangladesh today? What have we learned, and what is the way forward?

With 157 million people and a current per capita income of only US$1044, Bangladesh has made remarkable, unexpected progress towards the health Millennium Development Goals (MDGs). After independence in 1971 until the mid-1990s, Bangladesh invested primarily in child survival and vertical family planning services, mainly for women. Notable innovations included recruitment of thousands of women outreach-workers to deliver contraceptives to the recipient's doorstep, and wide provision of 'menstrual regulation' services in primary health centres (Johnston, Oliveras, Akhter, & Walker, 2010). The contraceptive prevalence rate (CPR) increased from 8% to 45%, and the total fertility rate (TFR) declined from 6.3 to 3.3 in this period (National Institute of Population Research and Training [NIPORT], Mitra and Associates, MEASURE DHS, & ICR, 2013).

Maternity care drew little attention, however. Thousands of traditional birth attendants (TBAs) were trained from 1978 and 1979 through the global 'Safe Motherhood Initiative' until 1997. While TBAs can play useful roles, a failure to integrate them into the health system and lack of investment in essential obstetric care meant that the maternal mortality ratio (MMR) declined slowly, from 620 per 1,00,000 live births in 1980, to 574 in 1990 (General Economics Division Planning Commission Government of the People's Republic of Bangladesh, 2010; Khan, Jahan, & Begum, 1986).

Bangladeshi activists advocated nationally and internationally in the 1990s to promote more comprehensive reproductive health services. Following the ICPD, in 1995 civil society and women's organisations were invited for the first time by the government and development partners to help design a new national health strategy and programme. These groups significantly influenced the content and adoption of the first Health and Population Sector strategy (HPSS) in 1996, and the five-year health and population sector

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programme (HPSP) that ran from 1998 to 2003 (Jahan, 2003). Both of these initiatives embraced the comprehensive ICPD approach to sexual and reproductive health and rights (SRHR), and set working priorities in line with Bangladesh's epidemiological profile.

Because STI and HIV prevalence were low, the new programme prioritised continued delivery of contraception and menstrual regulation services, and added an emphasis on skilled birth attendants and emergency obstetric care (EmOC). Notwithstanding gaps in implementation, HPSP produced significant positive outcomes; for instance, maternal mortality started to decline significantly (NIPORT, MEASURE Evaluation, & International Centre for Diarrhoeal Disease Research, Bangladesh [ICCDRB], 2012).

Nonetheless, powerful constituencies, particularly the family planning lobby, opposed a key reform of the HPSP: unification of the health and family planning wings of the Ministry of Health & Family Welfare, which was undertaken to facilitate the delivery of integrated reproductive health services. Moreover, sustained civil society participation planned under HPSP was neglected during the programme's roll-out. In the absence of an effective counterweight to HPSP's opponents, a new government after 2001 reversed the unification decision (Jahan, 2003).

Despite this setback, other elements of HPSP continued, particularly contraception delivery, menstrual regulation services and EmOC (Jahan, 2003). Additionally, other important advancements were made to sustain comprehensive reproductive health services in Bangladesh. Private-sector facilities also began to offer obstetric care. The two five-year national programmes after HPSP added nutrition and HIV/AIDS to their working priorities. The government of Bangladesh partnered with NGOs to deliver services to the urban poor (Afsana & Wahid, 2013). Moreover, increased attention was given to violence against women, including the establishment of one-stop crisis centres in public hospitals for women survivors of violence (Khanom, Saha, Begum, Nur, & Tanira, 2010).

Bangladesh is widely acknowledged for its reduction of unmet need for contraception (now 11%), and its much lower TFR of 2.3 (NIPORT et al., 2013). Maternal mortality has declined to 194 per 1,00,000 live births with increasing use of antenatal care (68%), and met need for EmOC reaching 56% in 2010 and 2011 (NIPORT et al., 2012, 2013). Abortion-related deaths are now only 1% of maternal deaths (Khan et al., 1986), compared to one-third in the late 1970s (NIPORT et al., 2012; Rochat et al., 1981). Women's empowerment, as indicated by increases in education, employment and mobility outside the home, has undoubtedly contributed to progress in maternal health as well (Sen, 2013). Yet, paradoxically, the use of skilled birth attendants is still low (31.7%), progress on anaemia and under-nutrition is stagnant, and adolescent marriage and pregnancy remain high (NIPORT et al., 2012, 2013).

More effective policies, planning, budgeting and programmes are required to meet old and new challenges, especially for reaching adolescents, lower wealth quintiles, and those living in hard-to-reach areas. Service providers must be trained to deliver on the 'Rights' in Sexual and Reproductive Health and Rights. The health system needs to strengthen service regulation and quality assurance, and remedy chronic absenteeism of health-care providers and shortage of essential drugs. Services should also be expanded to address reproductive morbidities, sexual health and cervical and breast cancer as capacity increases.

Above all, accountability in all its forms including institutional, professional, social, and political, must be improved, in particular by strengthening autonomous civil society. The advocacy and watchdog roles of civil society are critical for generating the political

will, financing, and human resources required for universal access to and protection of SRHR in Bangladesh.

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