The Reproductive Health Programme and Equity Considerations in Bangladesh: Lessons for Countries in the South

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OUTLINE OF PRESENTATION

- INTRODUCTION
- COUNTRY CONTEXT
- OBJECTIVES & DATA SOURCES
- SUCCESS IN RH OUTCOMES
- INEQUITIES IN RH OUTCOMES
- LESSONS LEARNED

1. INTRODUCTION

- High priority attached to containing population growth and improving health of the people since Independence
- Further impetus following adoption of the 1994 ICPD POA, MDGs, and SDGs
- SDG 3 aims, among others, to achieve UHC, and provide access to safe and effective medicines and vaccines for all
- Out of 17 SDGs, seven other SDGs have bearing on the determinants of health

1. INTRODUCTION (contd)

- Sector Wide Approach planning (SWAp) adopted in developing 5-year Health, Nutrition and Population Sector Programmes (HNPSP)
- The 4th HNPSP (2017-2022) aims to improve equity, quality and efficiency with the overall objective of gradually moving towards UHC and achieve SDG 3 targets by 2030
- The 4th HNPSP targets are, by 2022, to:
  - reduce neonatal mortality to 12 per 1,000 live births, IMR to 18, under-5 mortality rate to 34, MMR to 121 per 100,000 live births
  - increase % of 4+ ANC visit to 50
  - increase % delivery by SBAs to 65
  - increase CPR to 75

2. COUNTRY CONTEXT

- Large population
- Very high population density
- Major demographic and socio-economic changes:
  - decline in fertility
  - improvements in education
  - marked increase in access to mass media
  - rapid urbanization
  - rise in female employment
  - enhanced women's status
  - rise in per capita income
  - decline in poverty

3. OBJECTIVES AND DATA SOURCES

(i) review success Bangladesh achieved in its RH outcomes and *compare RH & selected indicators with PPD member states*

(ii) examine inequities in RH outcomes

(iii) share lessons with countries in the South

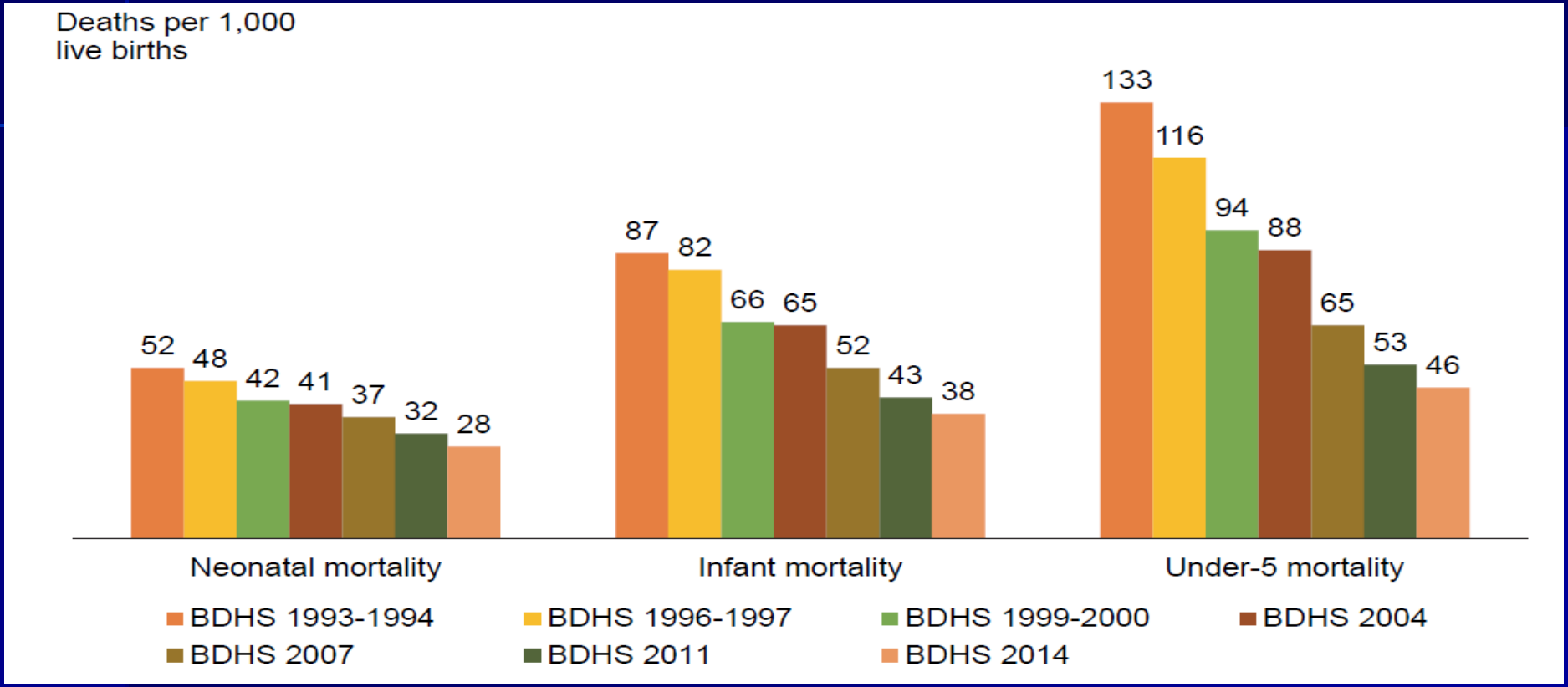
Paper based on:

(a) data from BDHSs (1994 to 2014), its predecessor surveys, UHSs (2006 & 2011), MMSs (2001 & 2010), UN agencies and The World Bank

(b) author's in-depth understanding of the RH programme

4. SUCCESS IN RH OUTCOMES

Figure 1: Trend in Childhood Mortality Rates, 1989-2014

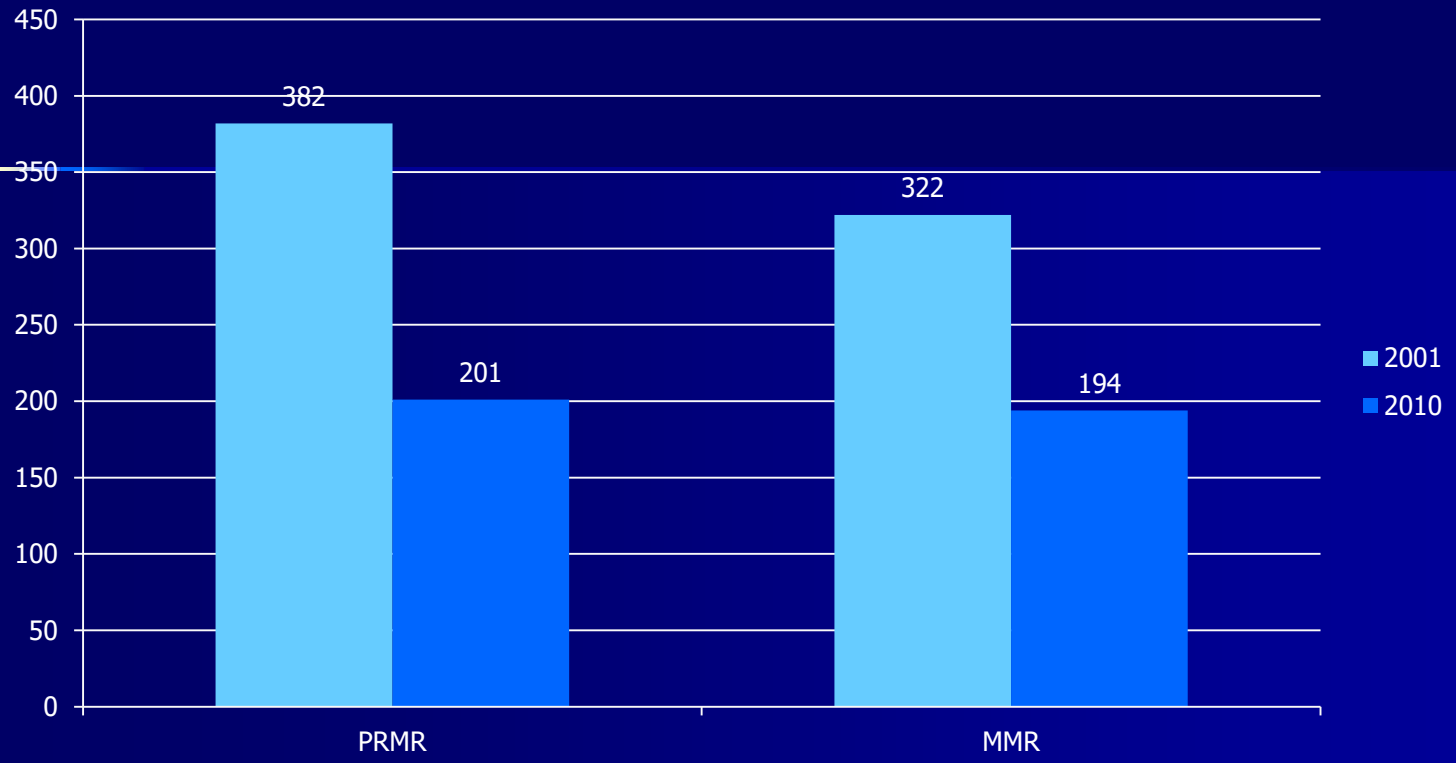


- ***Considerable decline in childhood mortality***

✓ Decline in IMR from 87 to 34 (44%). Lower than in 10 PPD member states, ranging from 8.6 (Sri Lanka) & 9.4 (Thailand) to 100 in Mali

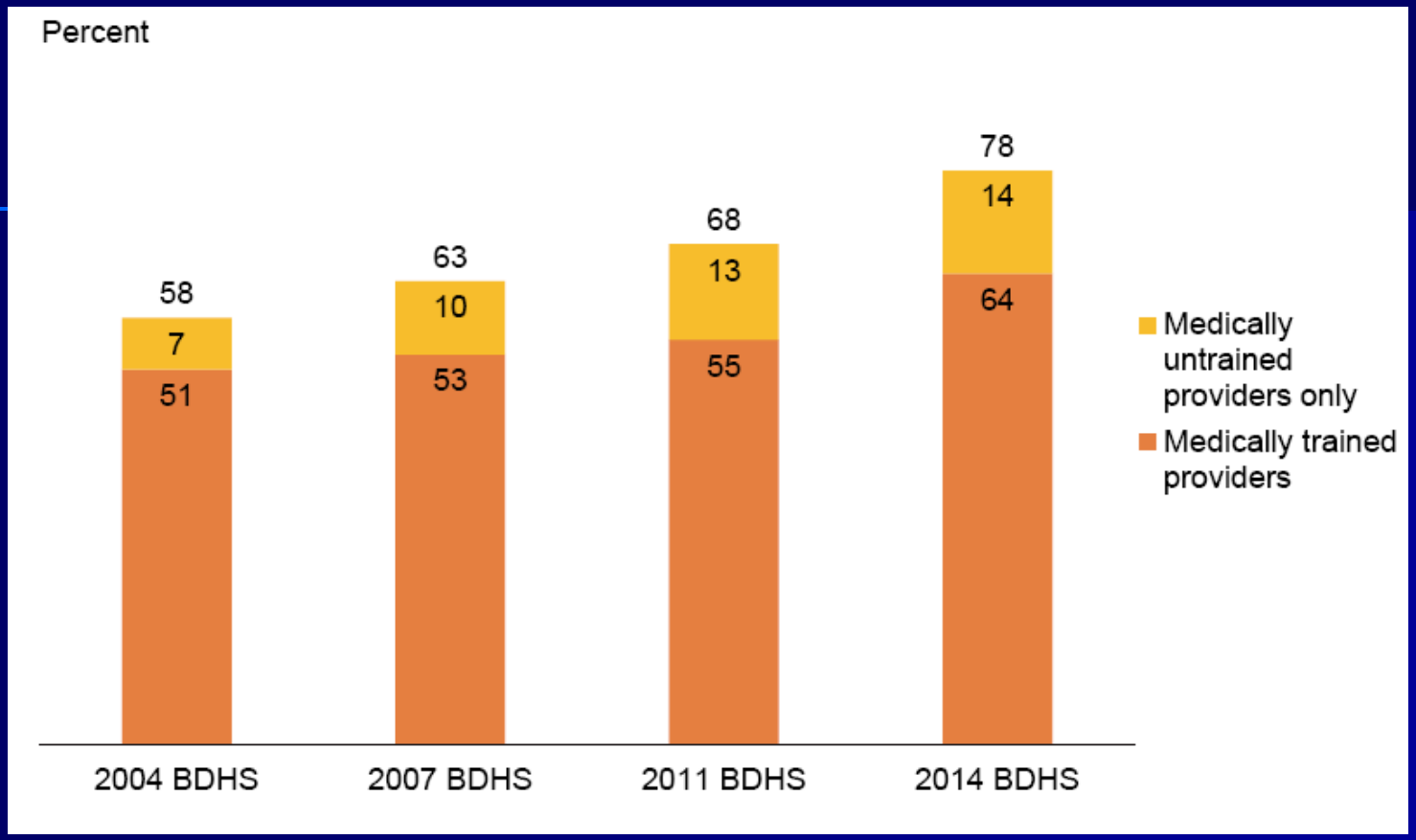
✓ About 3 times decline in U-5 mortality from 133 to 46 . Lower than in 12 PPD member states, ranging from 9 (Sri Lanka) & 10 (China) to 111 in Mali

Figure 2: Trend in MMR, 2001-10



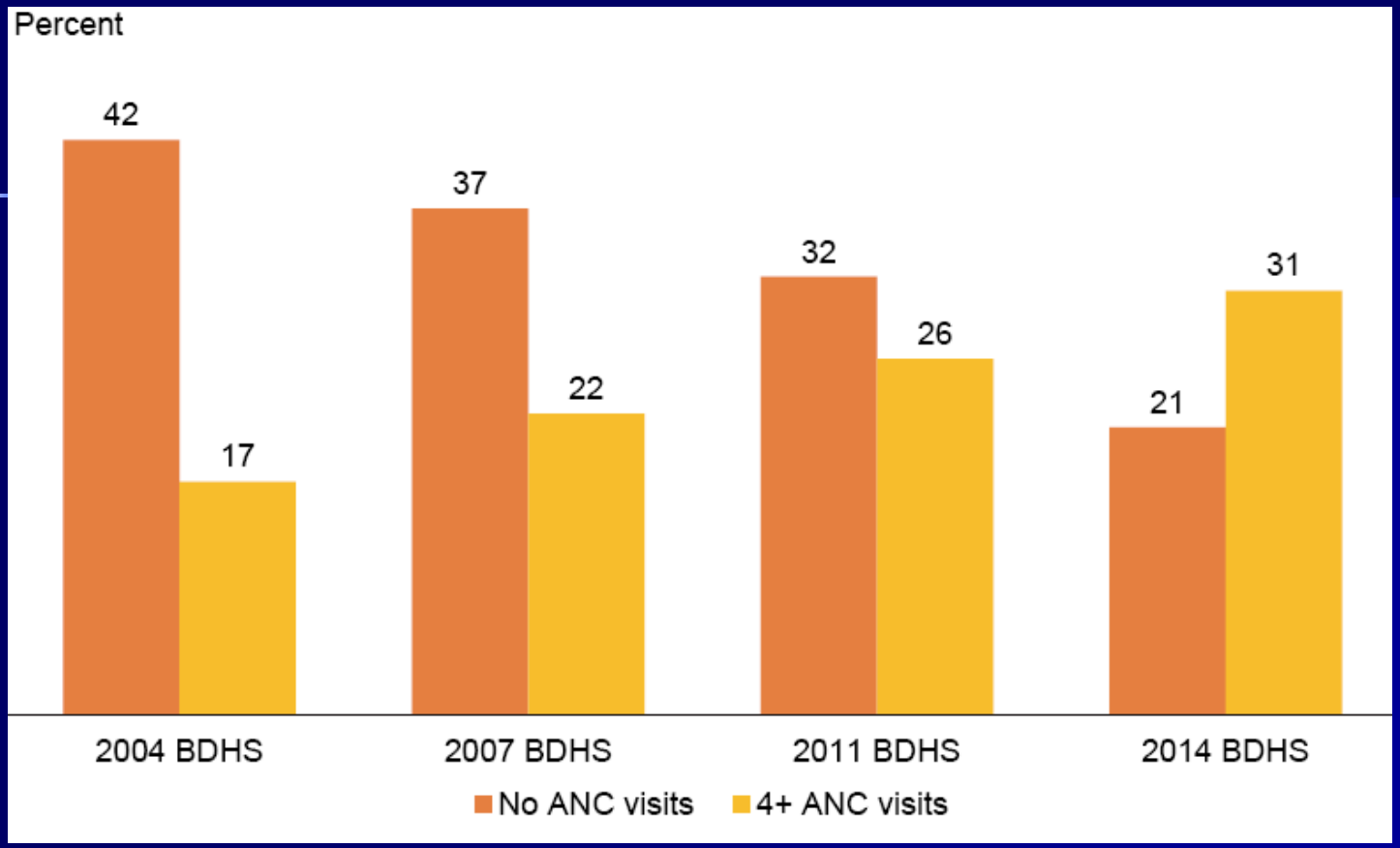
- ***Decline in MMR from 322 deaths per 100,000 live births in 2001 to 194 in 2010 .***
- ***Lower than in 10 member states, ranging from 20 (Thailand) to 814 (Nigeria)***

Figure 3: Trend in use of ANC, 2004-2014



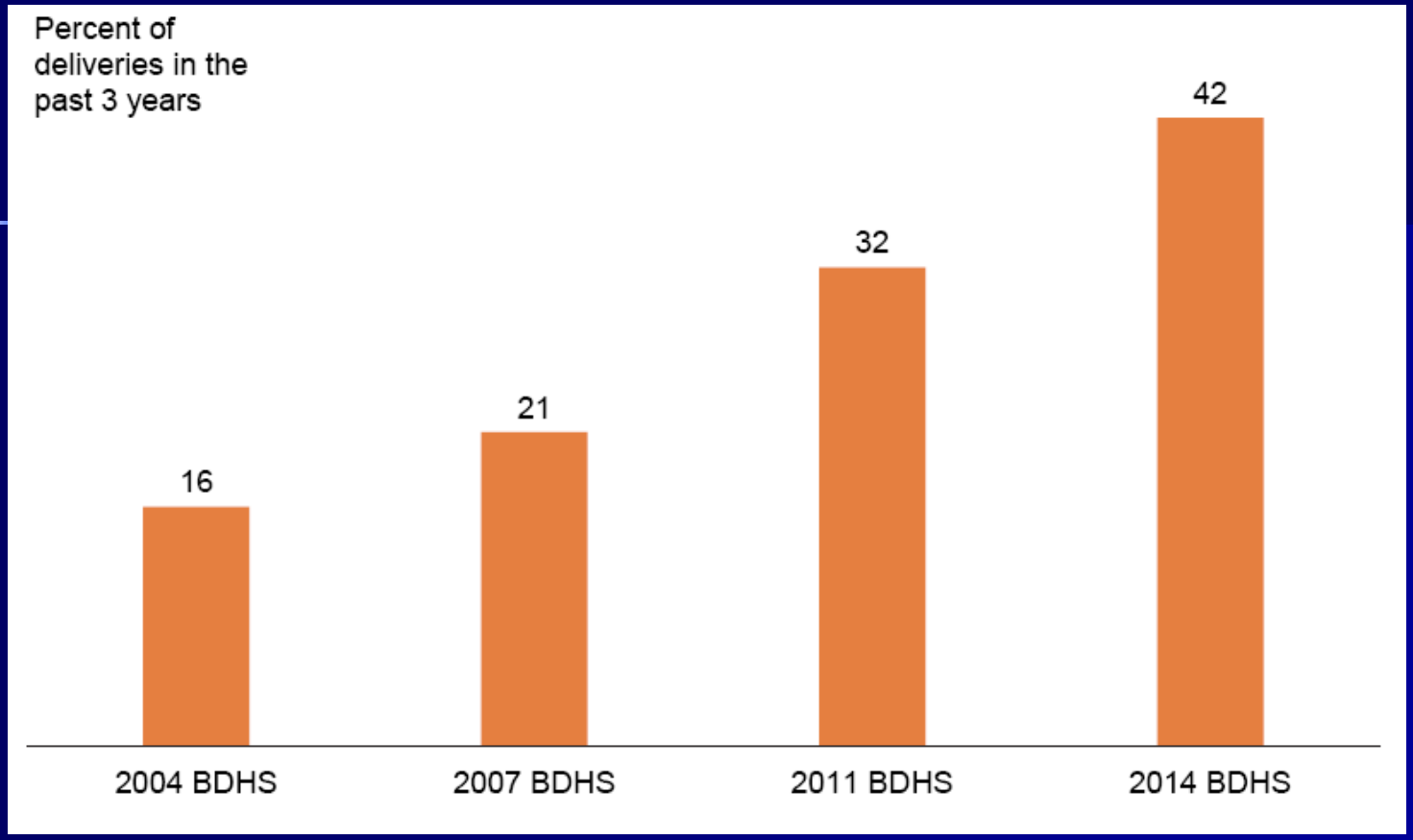
- ***Increase in % of last births receiving at least one ANC from a qualified provider from 51% in 2004 to 64% in 2014***

Figure 4: Trend in number of ANC visits, 2004-2014



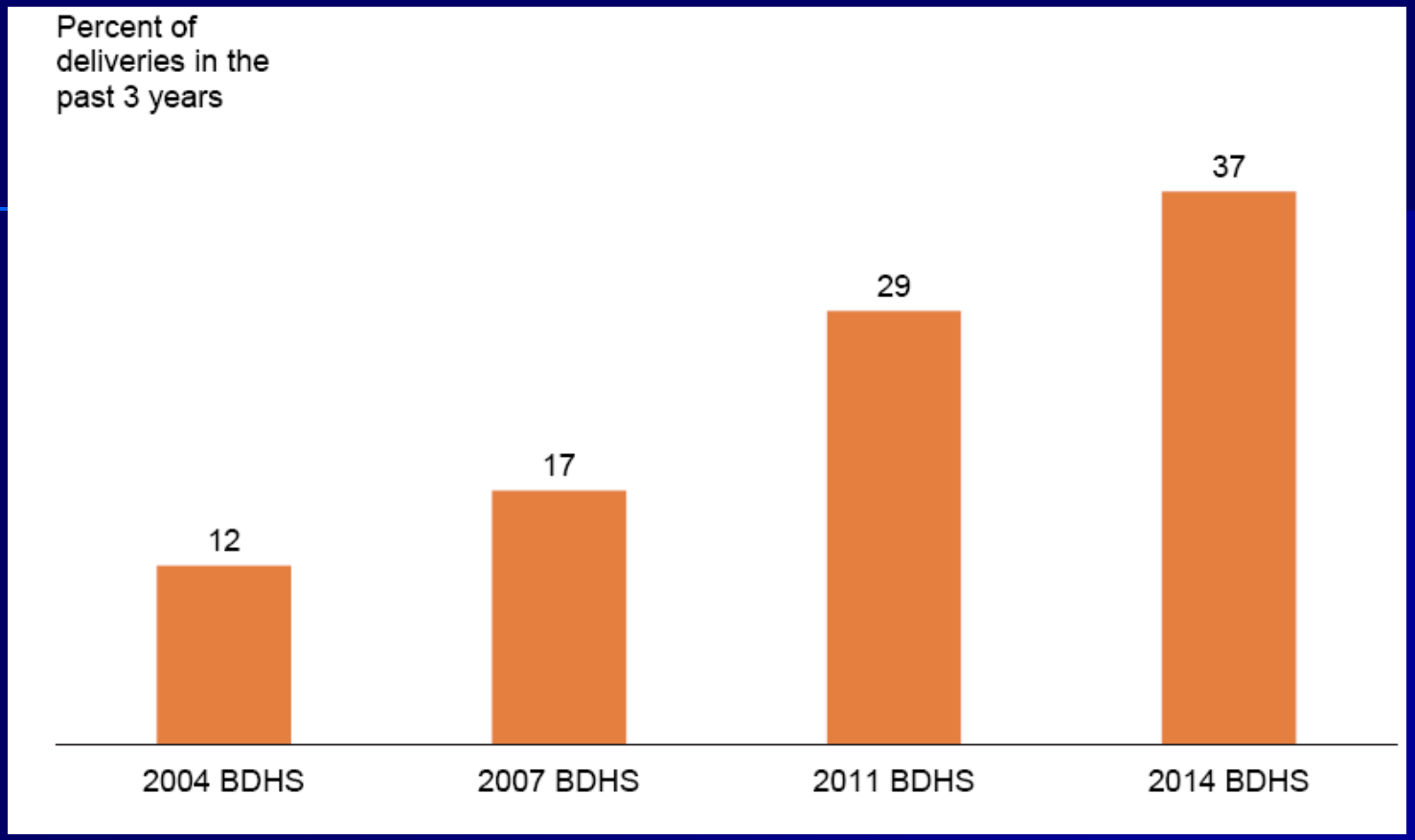
- ***2-fold increase in % of pregnant women receiving 4+ ANC visits from 17 % in 2004 to 31% in 2014***
  - ***Lower than in most states, ranging from 7% (Zimbabwe) to over 90% (China, Jordan, Sri Lanka, Thailand)***

Figure 5: Trend in skilled attendance at deliveries, 2004-2014



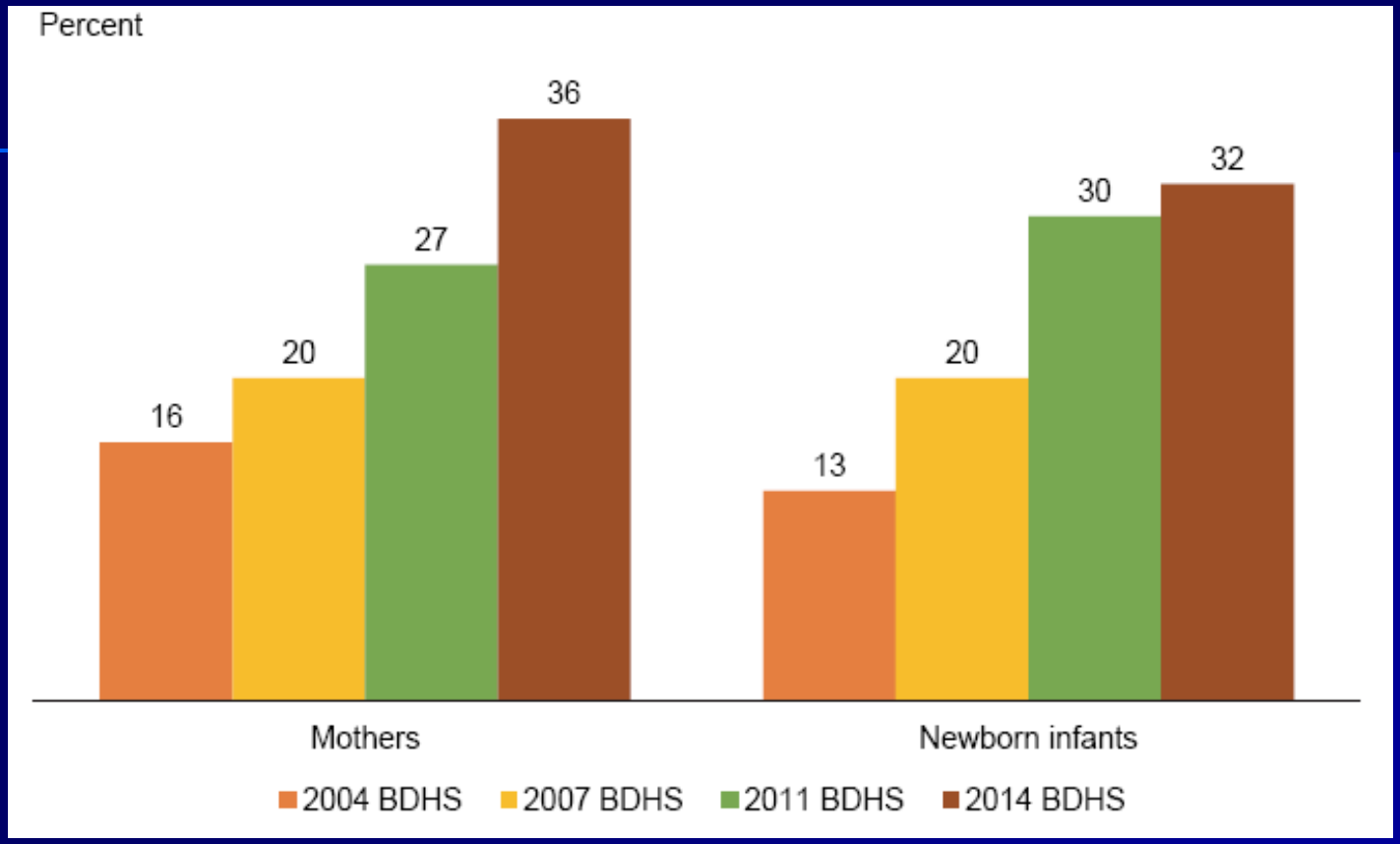
- ***2.5-fold increase in % of live births delivered by skilled birth attendants from 16% in 2004 to 42% in 2014***
  - ***Lower than in 20 states, ranging from 28% (Ethiopia) to over 90% (Colombia, Mexico, South Africa, Sri Lanka, Thailand) and 100% (China and Jordan)***

Figure 6: Trend in facility births, 2004-2014



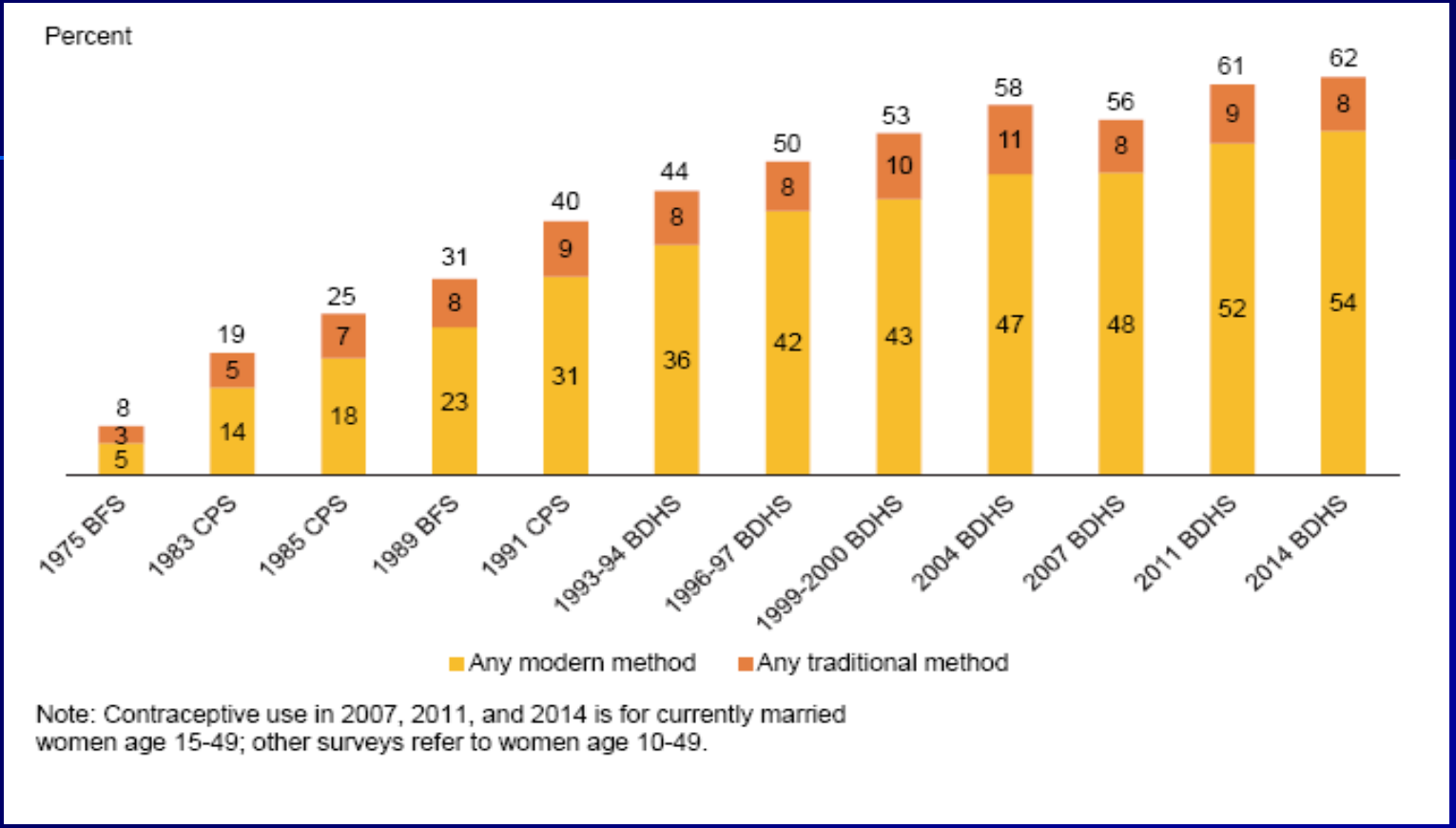
- ***3-fold increase in % of births delivered at facility from 12 % in 2004 to 37 % in 2014***
  - ***Lower than in 21 states, ranging from 16% (Ethiopia) to over 90% (Colombia, Jordan, Mexico, South Africa, Sri Lanka, Vietnam) and 100% (China and Thailand)***

Figure 7: Trend in use of PNC for women and children from medically trained provider within two days of delivery, 2004-2014



- ***Increase in use of PNC for women (2 times) and children (2.5) times from medically trained provider within two days of delivery***

Figure 8: Trend in CPR among currently married women, 1975-2014



Note: Contraceptive use in 2007, 2011, and 2014 is for currently married women age 15-49; other surveys refer to women age 10-49.

- ***8 times increase in CPR from around 8% in 1975 to 62% in 2014***
  - ***Higher than in 16 states, ranging from 13% (Benin) to 80% or more (China, Colombia, Thailand)***

Factors contributing to success

- **strong political will and commitment**
- **programmatic improvements**
- **major socio-demographic and economic changes**

Factors contributing to success (contd)

- **Decline in child mortality due to:**
  improved coverage of effective interventions
  improvements in socioeconomic condition

- **Decline in MMR due to:**
  reduced fertility
  increased skilled delivery attendance
  involvement of NGOs & private sector
  improvements in socioeconomic condition

5. INEQUITIES IN RH OUTCOMES

- Higher child mortality in rural areas, slums, among the less educated, and the poor
- Higher MMR among older women, in rural areas, the less educated, the poor, in Sylhet and Chittagong divisions
- % of women receiving 4+ ANC visits, births attended by qualified providers and delivered at facility lower in rural areas and slums; and inversely associated with women's education and household wealth status

5. INEQUITIES (contd)

- Challenges faced by FP programme: (i) slowing down in rate of increase in CPR, (ii) regional variations in CPR, (iii) low CPR among married adolescents, (iv) declining share of LAPM, and (v) high discontinuation rate

- Child and maternal malnutrition major problems, especially in rural areas and slums; and inversely associated with education and household wealth status

5. *Factors responsible for Inequities*

- ***Programmatic weaknesses:***
- **"one-size-fit-approach"**
- **insufficient functional coordination between DGHS and DGFP**
- **infighting between medical and non-medical personnel**
- **shortage of skilled manpower**
- **absenteeism**
- **weak 'Facility Readiness'**
- **inadequate QOC**
- **inadequate BCC activities**
- **inadequate inter-sectoral collaboration**
- **lack of effective referral system**
- **inadequate collaboration with NGOs and private sector**

5. *Factors responsible for Inequities (contd)*

- weak monitoring and supervision
- limited funding
- weak implementation capacity
- limited stewardship role of MOHFW

Socio-demographic and economic constraints:

- relatively low female ages at marriage and childbearing
- high adolescent fertility
- large number of out -of -school children & dropout
- low female employment and lack of "decent jobs"
- relatively high poverty

6. LESSONS LEARNED

- Bangladesh achieved considerable success in its RH outcomes
- 13 other higher performing (HP) PPD member states achieved better RH outcomes than Bangladesh : China, Colombia, Egypt, India, Indonesia, Jordan, Mexico, Morocco, South Africa, Sri Lanka, Thailand, Tunisia and Vietnam
- 12 other PPD member states (Benin, Ethiopia, Gambia, Ghana, Kenya, Mali, Nigeria, Pakistan, Senegal, Uganda, Yemen and Zimbabwe) have not achieved desired RH outcomes

6. LESSONS LEARNED (contd)

- **Most HP member states, including Bangladesh, achieved success in their RH outcomes due to several factors:**
  - ***commitment of governments***
  - ***integrated service delivery***
  - ***development of various interventions***
  - ***involvement of multiple non-health sectors***
  - ***improvement in nutritional status***
  - ***increased funding for the sector***
  - ***enhancing implementation capacity***
  - **improvements in socioeconomic condition**

6. LESSONS LEARNED (contd)

- ***Need to undertake research to document "best practices" in RH in selected HP PPD member states,***

  giving due consideration to:

  regional representation

  differences in level of socio-economic development

  variations in RH outcomes

- **Findings of the research will help LP states to strengthen their RH programmes**

Thank you