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Summary

The Covid-19 pandemic has exacerbated and drawn fresh attention to long-standing systemic weaknesses in health and economic systems. The virus – and the public health response – has wrought significant disruption on sexual and reproductive health and rights (SRHR) and maternal, neonatal and child health (MNCH) in Bangladesh. Known negative health outcomes include increased domestic and gender-based violence, child marriage, negative mental health, and adverse child health outcomes.

This scoping paper for the Covid-19 Learning, Evidence and Research Programme for Bangladesh (CLEAR) aims to inform future research and policy engagement to support response, recovery, progress, and future health system resilience for SRHR and MNCH in Bangladesh, following the Covid-19 crisis. We present what is known on disruptions and impacts, as well as evidence gaps and priority areas for future research and engagement.

Keywords

Sexual and reproductive health and rights (SRHR); maternal, neonatal and child health (MNCH); Covid-19; health services; health seeking; health system; Bangladesh.

Authors

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Executive Summary

Bangladesh has made exceptional progress in women's and children's health in recent decades, despite many socioeconomic challenges. This is reflected in its success achieving key Millennium Development Goals (MDGs). However, progress in areas such as maternal mortality and family planning uptake have stalled in recent years, and serious barriers remain to sexual and reproductive health and rights (SRHR) and maternal, neonatal and child health (MNCH) including care quality and access, and out-of-pocket costs.

Before Covid-19, Bangladesh's health system was already overstretched. Then, especially in the early stages of the pandemic, panic and uncertainty, resource diversion, and national lockdown led to further unavailability and acute disruption of SRHR and MNCH services. These included: unavailability of health workers due to fear, sickness, or redeployment; closure or reduced service hours; transportation and material resource challenges (e.g. personal protective equipment); and provider limitations in conducting effective triage.

There was reduced health service utilisation as patients stayed away for fear of Covid-19, stigma, or forced isolation. Ability to access care was also impacted due to pandemic- and lockdown-related economic pressures. Not knowing how to access adapted services, or dissatisfaction with services provided, may also have played a role in lower utilisation.

The broader health impacts to SRHR and MNCH are not yet clear, but evidence does show significant increases in domestic violence and child marriage with more economically vulnerable people, such as poor and displaced women and girls, being disproportionally affected.

This Working Paper finds that considerable gaps remain in understanding how the pandemic has impacted SRHR and MNCH in Bangladesh and what this means for recovery, addressing negative impacts, and building more effective resilient systems.

For example, further research is needed to understand how service quality has been impacted by the pandemic, including the perceptions, experiences, and challenges of service users and providers, and new quantitative data on service availability and utilisation. Evidence on how the pandemic has affected sexual health and related services (such as unwanted pregnancies and menstrual hygiene) is also lacking – especially as it relates to marginalised social groups.

Most existing evidence focuses on the early pandemic period, especially lockdown. It will be important to monitor what the emerging SRHR and MNCH service landscape looks like as the health system evolves in the wake of Covid-19. Digital exclusion,

which disproportionately affects women, will become increasingly important to understand and mitigate.

In Bangladesh, there is limited coordination between public and private health sectors in terms of data collection and analysis, and routine operation and emergency response. Mapping the actions, capacities, and incentives of different actors may illuminate how coordination can be improved for SRHR and MNCH. Additionally, little is known about how communities themselves (as well as lower-level governance institutions and civil society networks) responded to the pandemic and the innovations, adaptations, and local resources they leveraged to support SRHR and MNCH.

Both opportunities and challenges exist for research, engagement, and influence in SRHR and MNCH in Bangladesh. Opportunities for researchers include a growing evidence base on which to build on and complement. Existing government projects and upcoming policy development processes may present opportunities for influence.

Several challenges will also need to be navigated, including persisting taboos around many areas of SRHR and an overmedicalisation of health (which downplays the importance of rights, equity, quality, governance, and accountability). Systemic complexity and public system rigidity may also undermine efforts to influence change

It is critical that future research efforts engage key stakeholders across government, research, civil society, professional associations, and communities to collaboratively identify problems and priorities from the start. Bringing diverse stakeholders together can be challenging, and power dynamics must be managed to ensure the least powerful voices are heard.

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Acronyms

ANC	antenatal care
BRAC	Bangladesh Rural Advancement Committee
CGSRHR	Centre for Excellence in Gender, Sexual and Reproductive Health
CLEAR	Covid-19 Learning Evidence and Research Programme for Bangladesh
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EPI	Expanded Programme on Immunisation
GBV	gender-based violence
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
IDS	Institute of Development Studies
IPV	intimate partner violence
JPGPH	James P. Grant School of Public Health
KI	key informant
KII	key informant interview
MDG	Millennium Development Goal
MNCH	maternal, neonatal and child health
MOHFW	Ministry of Health and Family Welfare
MOLGRD&C	Ministry of Local Government, Rural Development and Cooperatives
NGO	non-governmental organisation
PNC	postnatal care
PPE	personal protective equipment
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UN	United Nations

1. Introduction

The Covid-19 pandemic exacerbated and drew fresh attention to long-standing systemic weaknesses in health and economic systems. Among its wide-reaching damages are significant disruptions to sexual and reproductive health and rights (SRHR) and maternal, neonatal and child health (MNCH) across the world – mainly in the global South – and especially among the most vulnerable (Banke-Thomas and Yaya 2021; Endler *et al*. 2021; Hamadani *et al*. 2020; Mukherjee *et al*. 2021; Strong *et al*. 2021; UNICEF *et al*. 2021).

In Bangladesh, fear, panic, and a context of limited resources at the outset of the pandemic have combined with severe economic shock, plunging 20 million more people into poverty in 2020 (UNDP Bangladesh 2022), to have similar negative consequences for SRHR and MNCH in the country (UNICEF Bangladesh 2020). This Working Paper illustrates what is known about these impacts, looking at basic indicators such as service provision, utilisation, and outcomes, as well as to other important dimensions central to health including service quality, accountability, equity, and rights.

In our review of academic and grey literature, supported by interviews with experts, we present evidence from these areas, gaps in the knowledge, and highlight priorities for future research. We describe mitigation efforts and adaptations as well as initiatives and research aiming to understand and address SRHR and MNCH challenges in the wake of Covid-19. We also identify the key stakeholders who have been involved so far and who could be engaged in future activities.

Part of the Covid-19 Learning, Evidence and Research Programme for Bangladesh (CLEAR) led by the Institute of Development Studies (IDS), this scoping work aims to inform potential future research and policy engagements to support response, recovery, and further progress around SRHR and MNCH in the wake of the Covid-19 pandemic in Bangladesh.

2. Methods

Our methodology included a review of both academic and grey literature, key informant interviews (KIIs), and webinar-based discussions with key stakeholders. We describe the methods in further detail here.

2.1 Desk-based review

Authors conducted a desk-based literature review by searching for keywords in PubMed and Google Scholar. Searches were restricted to articles from 2020 to the present day (searches occurred between 10 February and 15 March 2022). Additional relevant sources cited in the publications identified through these platforms were also followed up. Table 2.1 lays out the key terms and themes used to structure searches.

As not enough time had passed for much research and analysis to be published in academic journals, grey literature sources were also used to capture insight into the developing situation. To identify these sources, the authors searched ReliefWeb and other websites of relevant organisations, such as BRAC's James P. Grant School of Public Health (JPGPH) the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), and various United Nations (UN) agencies, including UN Women and the United Nations Population Fund (UNFPA). Data sources suggested by key informants were also followed up for evidence. Basic Google searches were also used to identify further sources, including media reports.

Information about the broader pandemic and pre-pandemic context was also gathered to contextualise findings around SRHR and MNCH.

Table 2.1 Search terms and focus themes used to structure literature search and analysis

Term/theme 1	Term/theme 2	Term/theme 3[1]
Bangladesh	Covid-19 OR pandemic	Sexual and reproductive health (SRH) – Contraception / contraceptive use – Family planning / counselling – Abortion / menstrual regulation – Sexually transmitted infections (STIs) Sexual and reproductive health and rights (SRHR) – Menstrual hygiene management[2] – Maternal, neonatal and child health (MNCH) – Maternal, neonatal and child mortality – Antenatal care (ANC) and perinatal care – Maternity and obstetric services and care – Birth location – Breastfeeding – Infant and child health and nutrition – Immunisations – Child marriage – Education

1 Additional variations of the terms under Term/theme 3, including single words, were used in searches (e.g. 'reproductive').

2 Menstrual hygiene management was later added, with follow-up searches being conducted after the original search period.

2.2 Key informant interviews

In total, 15 semi-structured interviews with key informants (KIs) were conducted online or by telephone. Participants were identified from the professional networks of the authors and the CLEAR team, the websites of key organisations (including the Bangladesh Health Watch and BRAC JPGPH), and were selected from across research, civil society, and government communities.

KIs represented research organisations (n=9), international non-governmental organisations (n=8, one of which includes seven participants who attended one single interview), civil society (n=2), and two were independent consultants. They were asked for their perspectives on:

1. How the pandemic and control measures have impacted SRHR and MNCH in Bangladesh;
2. Priorities for future research and action;
3. The policy landscape, including priorities of policymakers and opportunities for research to influence policy; and,
4. The wider landscape of stakeholders working in this area.

During and after each interview, notes taken by the interviewer were input into a Rapid Assessment Procedure (RAP) sheet (Vindrola-Padros *et al*. 2020), which allowed for quick synthesis and analysis within a short timeframe. Refer to Annexe 1 for more information about KIIs, including the schedule to guide interviews.

Overall, KI insights echoed what was found in the literature and were helpful in identifying additional themes, issues and marginalised populations (e.g. LGBTQI). KIs also helped to identify many of the priority areas for research as presented in this paper and raised important connections between SRHR/MNCH and broader health system questions.

2.3 Webinar

A webinar was held in late-March 2022 to bring together key stakeholders (including several of the KIs), to review, validate, and add nuance to the findings and conclusions. Following a briefing of the paper and a presentation of findings, participants discussed and fed into the identified priorities for future research to support response, recovery, and progress in SRHR and MNCH. Key findings from these discussions have been integrated in this paper.

2.4 Limitations

2.4.1 Literature review

Due to the emergent nature of the issues being researched and the fact that limited insight and analysis had made it into formal or easily identifiable outputs and channels at the time of research, key insights may have been missed. It is also likely that the authors have missed some key terms and themes (e.g. menstrual hygiene), although this particular issue was followed up.

2.4.2 Key stakeholder engagement

Despite efforts, the authors were mostly unable to speak with KIs currently serving in relevant government positions apart from one high-level official who attended the webinar.

3. Context

In Bangladesh, the Covid-19 pandemic emerged in a context where SRHR and MNCH already faced critical challenges. This section outlines key background information, including a brief description of the health system, the pre-pandemic status of SRHR and MNCH, and the emergence and overall response to Covid-19 in the country in early 2020.

3.1 Bangladesh's fragmented health system

The health system in Bangladesh is highly fragmented, with the public sector making up only one part. There is a great diversity of government, non-governmental organisation (NGO), for-profit, and informal health providers operating in parallel, and only seldomly in collaboration with one another (Bloom *et al*. 2014). Centralised public data collection mechanisms, such as the District Health Information Software-2 (DHIS2), thus only capture a small slice of the picture of what is happening with health services and utilisation in Bangladesh.

The different structures of rural and urban health systems present further confusion. In urban regions, local authorities are responsible for providing primary care services including in the areas of SRHR and MNCH (usually through various private sector providers), while in rural areas, the national level Ministry of Health and Family Welfare (MOHFW) is responsible for this (primarily delivered through resourcing of public facilities). In both urban and rural settings, the informal sector (e.g. informal drug sellers, 'village doctors', and traditional birth attendants), is least well understood. This includes in relation to the role it has played during the pandemic. Despite what can seem like a chaotic and dysfunctional patchwork of diverse actors with different levels and forms of knowledge, incentives and ways of working, the emergence of the private sector alongside the expansion of the public sector's community-based services has been credited in part with drastic improvements in population health (Ahmed *et al*. 2013).

3.2 Gains and setbacks for SRHR and MNCH in Bangladesh

Women's and children's health had been increasingly improving in Bangladesh in recent decades. In 2010, the UN recognised the country for exceptional progress towards Millennium Development Goals (MDGs) 4 and 5a: to reduce child and maternal mortality in the face of socioeconomic challenges (WHO and MOHFW 2015). Indeed, from 1990 to 2011, under-five child mortality reduced from 151 to 53 in 1,000 live births while the infant mortality rate dropped from

87 to 43 in 1,000 live births, and maternal mortality declined from 574 to 194 in 10,000 live births (Ahmmed *et al*. 2021). Programmes such as the Maternal Health Voucher Scheme and Emergency Obstetrical Care Services (EmOCs), expansion of family planning, and the rapid development of the private health sector have been recognised as contributing to the reduction of maternal mortality (WHO and MOHFW 2015). Meanwhile, the Expanded Programme on Immunisation (EPI), which brought critical childhood vaccination services directly to communities, has greatly reduced preventable childhood diseases (Hanifi *et al*. 2022).

However, SRHR and MNCH continue to face significant challenges in Bangladesh. Cost remains a major barrier: 74 per cent of health expenditure is out-of-pocket, while the government contributes just 27 per cent (Mahmood *et al*. 2022). This puts poorer people at a particular disadvantage. Unfortunately, further improvements in maternal mortality and family planning use have both stalled over the last decade (NIPORT, icddr,b and MEASURE Evaluation 2017; Khan and Islam 2022), prompting reflections on service quality and access as explanations (Chowdhury and Raza 2018; Hossain *et al*. 2021).

3.3 Covid-19 and government response measures in Bangladesh

The first case of Covid-19 in Bangladesh was reported on 8 March 2020. By 26 March, the government shut down all public and private offices, learning institutions, non-essential industries, and both domestic and foreign road, air, and rail travel. This nationwide lockdown – framed as a public holiday – mandated people to stay at home and leave only for essential purposes (Hamadani *et al*. 2020). The lockdown, which applied to all but the exception of essential services such as pharmacies and food markets, remained in place until 30 May 2020, although localised lockdowns continued to be imposed in areas with high Covid-19 transmission rates after this date (*ibid*.). Many face-to-face activities and services remained suspended or closed even during non-lockdown periods. In person-schooling was suspended for a year and a half, with further school closures imposed once again with the emergence of the Omicron variant (Paul 2022; Ritchie *et al*. 2020). As will be covered more fully in this paper, many in-person health services were suspended or adapted – and, in many cases, had not returned to functioning as they were prior to the pandemic at the time of research.

Despite these measures, Bangladesh still saw high viral cases and death rates, which may be due to various contextual aspects including the difficulty of social distancing in such a densely populated country, a lack of access to hygiene supplies, limited Covid-19 testing, and a large informal economy which is difficult to regulate (Anwar *et al*. 2022).

3.4 Broader impacts of Covid-19 and response measures

In Bangladesh, both the Covid-19 pandemic and the measures put in place to mitigate the spread of the virus have had substantial negative impacts on livelihoods, key industries, and workers' rights. In particular, researchers have noted concerning negative economic impacts in the country including hits to national gross domestic product, damage to the ready-made garment and tourism sectors, a rise in the cost of living (including food prices and rents), and increasing poverty (Alam 2022). Lockdowns led to the loss of employment and livelihoods for 20 million informal workers, and middle-income earners were also affected (Gautam *et al*. 2022; Hossain 2021). Qualitative research with a group of Dhaka-based domestic workers indicated they faced challenges paying rent and bills and buying food due to loss of employment, while those in work faced increased workload and violations of their rights (Wasima and Rahman 2022). Gender-based vulnerabilities have intersected with economic vulnerabilities as over 90 per cent of working women in Bangladesh are employed in the informal economy, which was badly affected (UN Women 2020a).

The loss of urban livelihoods also led to significant outmigration from cities, with many urban dwellers being forced to return to villages (AFP and Al Jazeera 2021). However, rural economies also suffered due to delays in the harvest, challenges selling produce, and increased costs of inputs, with female-headed, young, or casually employed households being most negatively impacted (Malek *et al*. 2021). Loss of income, particularly among already vulnerable poor and marginalised populations, was noted by KIs as being a critical concern with respect to the ability of people to access SRHR and MNCH services which, like most health services, require out-of-pocket expenditure for the most part.

4. Evidence of Covid-19 impacts on SRHR and MNCH in Bangladesh

In this section, we outline existing evidence on the impacts of the pandemic on SRHR and MNCH, including supply-side and demand-side factors for services and health outcomes. Although health system factors are central, SRHR and MNCH are also often relevant to education, rights-based organisations and networks, and humanitarian aid.

4.1 Health system and service impact and disruption

Despite the overall progress on health outcomes achieved over the past 50 years, health systems in Bangladesh faced multiple challenges – even before Covid-19 emerged. It has one of the lowest 'health-worker-to-population' ratios globally and, like other low- and middle-income countries (LMICs), many of its facilities lack essential infrastructure such as piped water and hand soap (Hassan *et al*. 2020).

With the official arrival of Covid-19 into the country in March 2020, the health system was thrown into shock. Observers of the early weeks and months described how uncertainty, fear, and limited resources caused widespread panic among health-care professionals, causing many to abstain to work. Similarly, many patients requiring care either did not seek it or could not obtain it (Reza *et al*. 2020). Although the government's March 2020 *Preparedness and Response Plan for Covid-19* emphasised the importance of maintaining essential health and nutrition services (Mhajabin *et al*. 2022), a range of factors meant that this did not always happen. Some of the key causal factors that emerged in the literature and from KIIs are noted below.

Fear of Covid-19 infection and inadequate PPE and triage

Existing research and KIIs emphasised the fear among health workers of contracting Covid-19 at work in a context of limited personal protective equipment (PPE), and without knowledge, guidance, equipment, or infrastructure to identify, triage, or treat patients with Covid-19 – or even for non-Covid-19-related health issues in this context. Senior specialists, many of whom were older and thus at higher risk for Covid-19, were less available to provide in-person care (Mahmood *et al*. 2022). Many health workers resigned, including due to pressure from families who were worried about their safety (Nguyen *et al*. 2021). Staff were worried about patients actively hiding Covid-19 symptoms (Mahtab and Azad 2021). Media reports indicated that many pregnant women

with Covid-19 symptoms in rural areas were refused care in the early part of the pandemic (Papri 2021).

Facilities closures due to staff illness

Health workers who contracted Covid-19 were unable to provide care, leading to increased strain on remaining staff or the closure, or at least reduced operating hours, of some facilities due to staff illness.

Limited guidance, training, and information

It was noted early on that standard training on Covid-19 management and prevention was limited for all types and levels of health workers in Bangladesh (Bangladesh National Nutrition Council 2020). Even by September 2020, many months after Covid-19's initial emergence in the country, fewer than 25 per cent of surveyed NGO health workers (Nguyen 2021) providing maternal health and child nutrition services in Dhaka had received training on how to adapt antenatal care (ANC) services or provide breastfeeding or new-born support in the context of Covid-19.

Suspension of some SRHR and MNCH services

Child immunisation programmes and family planning programmes were initially suspended at the outset of Covid-19, making them unavailable for a period of time (Ahmed *et al*. 2020). The provision of long-acting and reversible contraceptive methods, such as intrauterine devices and implants, fell sharply during lockdown (Hossain *et al*. 2020).

Services continued to be subject to disruption

Disruption continued even services had officially resumed (Rabbani and Islam 2020). One study described how child immunisation drives (under the EPI) in the rural subdistrict of Chakaria were not always able to go ahead as they relied on community volunteers offering their homes as sites for the activities. Homeowners' concerns about safety or the unavailability of vaccinators led to delays (Hanifi *et al*. 2022). Services for women and girls, such as menstrual hygiene management, SRHR services, and girl and women-friendly spaces in refugee camps were also shut down or difficult to access for a time, while gender transformative programming was also suspended (Guglielmi *et al*. 2020). Provision of some ANC services, particularly those requiring in-person contact, such as anthropometric measurements for pregnant women and babies, was also reduced in Dhaka (Nguyen *et al*. 2021)

Changes in protocols

Some adaptations to health services, such as the decision to take only upper arm measurements to determine whether a child is malnourished (instead of height and weight) to reduce social interaction in the Rohingya refugee camps have caused concern. As arm measurements alone are insufficient to reliably determine states of malnutrition, this risks some vulnerable children being missed and consequently not being provided with urgent care (Anwar *et al*. 2022).

Redeployed resources and facilities

Many public health system resources and health-care workers, including in SRHR and MNCH, were also diverted from routine activities to the Covid-19 response. A study in a Dhaka slum community found that the public hospital that residents would normally attend became a Covid-19 treatment centre, forcing residents to find alternatives (Mahmood *et al*. 2022). Data from the Directorate General of Health Services (DGHS) suggested that at one point in the early pandemic only half of district hospitals across the country were providing emergency obstetric care (Akhter *et al*. 2021).

Movement restrictions and lack of transport for health workers

Door-to-door and community-based services such as those delivered by mobile community health workers (including health assistants and family welfare assistants who provide child immunisations, family planning support and other basic care) were also interrupted by movement restrictions and the lack of transportation (Ahmed *et al*. 2020; Hanifi *et al*. 2022).

Limited or inappropriate supplies

Health workers reported not receiving enough PPE, medications, hygiene materials (soap, sanitiser), or SRHR commodities (e.g. condoms, pills) to meet patients' needs, and feared stockouts in the early pandemic (Akhter *et al*. 2021; Hossain *et al*. 2020). A study in four rural subdistricts in southwest Bangladesh found that some women community health workers reported PPE gowns as inappropriate as they could not wear them over a sari, that they were teased and stigmatised for wearing them, or that they were simply too uncomfortable to wear in the heat (Akhter *et al*. 2021).

Other health worker challenges

The increased workloads and stress faced by health workers, and the lack of corresponding increases in pay to reimburse them, have negatively impacted staff morale (Mahmood *et al*. 2022). One study reported that community health workers surveyed in November and December 2020 in Khulna, Rajshahi, Sylhet,

and Cox's Bazar reported having had less supportive and regular supervision during the pandemic (Frontline Health Project 2021).

Governance issues

Interviews with technical experts about health system impacts in slum communities suggested failures in top-level governance in pandemic management including overly centralised decision-making, inadequate cross-sector consultation and community engagement, and inefficient or misused resources (Mahmood 2022). Concerns were also raised around transparency of central decision-making, the influence of political factors, and a lack of accountability for health services (including predating Covid-19). Issues related to inadequate implementation were emphasised. For example, even in the context of recovered global supply chains for contraceptive products, bottlenecks in distribution networks and allocation at lower levels can result in failed provision to health facilities. The failures of public sector to engage with private health providers also contributed to the lack of availability of preventive, rehabilitative, and curative health care for non-Covid-19-related health issues (Ainul *et al*. 2020; Reza *et al*. 2020).

4.2 Service adaptations, mitigation measures, and recovery

At the time of interview, many KIs perceived that health services were returning to 'normal' or pre-pandemic levels of functioning; however, it remains to be sufficiently evidenced whether this has been the case. One survey of community health workers noted that nearly all respondents (370 in total) had been able to resume their normal routines six months into the pandemic. However, it is likely that further waves of Covid-19 created additional disruption (Frontline Health Project 2021). At the same time, KIs gave examples of how the diversion of health resources towards Covid-19 activities continued to be an issue in some service contexts. For example, midwives in Cox's Bazar have been deployed to administer Covid-19 vaccines, reducing the midwifery services provided. Despite this, efforts to mitigate service disruptions have been made at multiple levels. Studies noted the commitment of health workers and networks on the ground to continue providing life-saving ANC and immunisation services (Akhter *et al*. 2021; Rana *et al*. 2021) while the national government hired 2,000 new physicians and 5,000 nurses in June 2020 to reinforce public health services (Nguyen *et al*. 2021) – although there have been concerns among experts about their disproportionate deployment within urban areas or at district levels (Mahmood *et al*. 2022). Other small-scale and more targeted initiatives have been implemented, such as the deployment of 300 mobile midwives to fill gaps in

maternal health services and increase the proportion of births occurring in health facilities (UNFPA 2020).

4.2.1 Guidance for care provision

With support from development partners and technical experts, the government has also developed guidance on the continued and safe provision of essential services in Bangladesh. This has included the *National Guideline on Infection Prevention and Control in Healthcare Settings with Additional Measures for Covid-19* (the first version of which was developed in March 2020), the *National Guideline for Providing Essential Maternal, Newborn and Child Health Services in the Context of the Pandemic* released in May 2020 (Mhajabin *et al*. 2022), and the *Nutrition Essential Services Continuity Guidelines During Covid-19 Pandemic* in June 2020 (Nguyen *et al*. 2021). They include information on how health-care providers can practice infection prevention control, identify possible Covid-19 patients, and conduct effective triage while continuing to provide essential health services. While these guidelines and associated trainings may have played a role in keeping non-Covid-19 services functioning in ways that reduced the spread of the virus (Mhajabin *et al*. 2022), it is unclear from existing evidence whether they have translated into improved service availability. Furthermore, they have been developed by and promoted primarily in the public sector, which is just one part of the health system.

4.2.2 Digital and telephone-based services

Published literature and KIIs emphasised health service adaptations to digital or telehealth models. Such shifts have been common in many countries during the pandemic, and the limitations and risks of this have not gone unremarked (World Bank 2021). In 2016 in Bangladesh, a national telehealth system called Shastho Batayon 16263 was set up. This went on to have new significance in the pandemic with calls reaching over 85,000 per day at the peak, even though it was staffed only by 150 physicians and 30 health information officers (Ahmed *et al*. 2022). Despite the popularity, one study found that only half of slum dwellers in a Dhaka study site knew about it (Mahmood *et al*. 2022), while another presented questions about how telemedicine may compromise service quality and patient trust (Chowdhury *et al*. 2021). Specific services and facilities also adapted by shifting to telephone-based models. In their systematic study of MNCH services in Dhaka, Nyugen *et al*. (2021) found that 37 per cent of antenatal services and nearly 50 per cent of counselling services for pregnant women and mothers moved to telephone-based services. This, however, did not translate into utilisation. The study noted other ways that providers attempted to ensure key health services such as immunisations were delivered, including by

coordinating vaccination drives and by actively calling and messaging mothers to make appointments with updated information about Covid-19 guidelines.

4.2.3 Pandemic impacts on health-seeking behaviour and health service experience

In addition to the supply-side issues described above, MNCH and SRHR health-seeking practices among the population were also impacted by the pandemic and by control measures. Although it is not necessarily clear whether drops in quantitative utilisation data represent the unavailability of services or a lack of uptake by people needing care, research examining data from national routine service data sources (such as the DHIS2, which monitors only public sector services), suggests there have been significant falls in SRHR and MNCH service utilisation during the pandemic. For instance, Mhajabin *et al*. (2022) reported that DHIS2 data reflected a 41 per cent, 52 per cent, and 56 per cent drop in facility-based births at the *upazila*,[3] district, and tertiary health facility levels respectively in April 2020 compared to January. A study by Ahmed *et al*. (2021) also found other striking declines in mothers receiving ANC, family planning clinic attendance, vaccinations given to children, and facility-based births during the initial lockdown (see Table 4.1 below).

Table 4.1 Percentage decline in patients accessing reproductive, maternal, neonatal and child health services in Bangladesh (March–April 2020 vs March–April 2019)

	% decline in women receiving ANC	% decline in family planning attendance[4]	% decline in child immunisations given	% decline in facility-based births
March 2020	28	100	14	40
April 2020	57	100	50	67

Source: Authors' own, based on data from National Health Information System and T. Ahmed *et al*. (2021).

[3] An *upazila* is an administrative region in Bangladesh.

[4] Government family planning clinics had been closed as a matter of policy in the early stages of the lockdown.

Similarly, reporting on ANC, institutional delivery, and postnatal care (PNC), Ainul *et al*. (2020) reported that PNC and ANC visits remained 20–25 per cent lower in June and July 2020 than the same months in 2019 (especially for second, third, and fourth ANC visits), while institutional deliveries remained 10–15 per cent lower by that time.

These significant falls in utilisation, however, may not reflect an accurate picture. KIs reported that these initially significant percentages may have been the result of district health managers being overwhelmed at the outset of the pandemic, and simply unable to input data into the DHIS2 even though services were in fact being provided. Over time, they were able to catch up, meaning that queries of DHIS2 data made later on actually reflected less significant drops in utilisation during these periods.

That said, researchers considering non-DHIS2 data, such as Nguyen *et al*. (2021), also reported drops in utilisation in Dhaka-based facility visits by pregnant women and mothers with infants in health and nutrition counselling utilisation (including telephone-based services), and child immunisations. Utilisation rates did not recover even after the initial lockdown, with facility visits dropping a further 8 percentage points and child immunisations a further 5 percentage points in their sample by September 2020. Other services identified as having experienced drops in utilisation included children's surgeries (Farooq *et al*. 2021), hospital admissions (Nuzhat *et al*. 2022), and care for under-fives, including immunisation (Rana *et al*. 2021). One study estimated that 3.2 million children missed their scheduled vaccinations between March and May 2020 compared to 2019 (Hanifi *et al*. 2022).

One icddr,b-linked study which considered both public and private sector service utilisation in rural subdistricts of Baliakand found there were really **no** differences in health care uptake for ANC, skilled birth attendance, PNC, or essential new-born care (ENC) during the early pandemic phase (defined as April–June 2020) (Mhajabin *et al*. 2022). Possible explanations include that this rural area was less affected by the pandemic, was not enforcing control measures as strictly, benefitted from government guidance on continuing service provision safely, and that communities were able to adapt and cope. The authors also report the discrepancy could be accounted for by the inclusion of private health service data in this study, noting that most facility-based births in Bangladesh take place in private facilities even in normal times. As clinical Covid-19 response mainly occurred through the public sector, private services would not necessarily have faced the same kinds and scale of disruption, such as resource diversion from routine care, and thus may not have experienced falls in utilisation on the same scale as the public sector.

Despite this discrepancy, the literature and KIs offered several explanations for why demand for many health services was lower. This included a widely

reported fear of Covid-19 infection outside the home, including in health-care facilities. Pregnant women interviewed by Akhter *et al*. (2021) worried they might get infected by blood pressure machines or weighing scales. Other reasons included expectations that health-care providers would not be available to provide services, reduced hours of health facility operation, lack of transportation (relating both to mobility restrictions and inability to pay for transportation), families wanting women to remain at home, and requirements to present a negative Covid-19 test to access services (Akhter *et al*. 2021; Mahmood *et al*. 2022; Mahtab and Azad 2021; Nguyen *et al*. 2021). The latter requirement was challenging to satisfy due to very limited, unaffordable, and inefficient testing services. Although mentioned far less, quality of services may also have been an issue, with patients feeling unsatisfied physically distant in-person care (Rahman *et al*. n.d.) which may not have resulted in appropriate diagnosis (Mahtab and Azad 2021).

The picture is less clear in terms of impacts to health service utilisation in Bangladesh, particularly given the fragmented nature and complexity of the health system. There is evidence that private sector utilisation, including of informal health services – already at a high baseline level – may have increased during the acute phase of the pandemic, at least among urban slum dwellers (Mahmood *et al*. 2022). As mentioned, the private sector was also recognised as important in a rural study (Mhajabin *et al*. 2022). The role of information, such as the extent to which the population was aware of adaptations to services, is also unexplored. Evidence suggests that women have had less access to clear information about Covid-19 than men. This might also be true of other health issues and related resources and services (Hasan *et al*. n.d.; UN Women and Women Count 2020).

4.2.4 Evidence on the impacts to SRHR and MNCH outcomes

Given the existing issues with incomplete and delayed public availability of health management information services data and other forms of health outcomes data, the true impacts of Covid-19 on SRHR and MNCH will take time to uncover. At present, evidence remains sparse on the impacts to health outcomes, although there are worries that maternal mortality rates, along with other negative outcomes, are likely to have risen (Rahman *et al*. 2021).

One area where there is considerable evidence on the impact to outcomes, however, is gender-based violence (GBV) and intimate partner violence (IPV). Several reports and studies have reported increases during the pandemic, particularly during the lockdowns (Gottert *et al*. 2021). For instance, BRAC reported a 70 per cent increase in incidents of violence against women and girls (VAWG) from March to April 2020 compared to 2019 (Human Rights Watch 2020), while married Rohingya and Bangladeshi girls were twice as likely to

report that GBV had increased in their community during the pandemic (Guglielmi *et al*. 2020), and that support services were closed (Banik *et al*. 2020; UN Women 2020b). Increased numbers of murders, rapes, attempted rapes, psychological abuse, coercion, and harassment have been documented (MJF 2020; Sifat 2020a, 2020b). This increase in violence has been widely linked to the exacerbated economic pressures facing households due to the pandemic (Clisby and Choudhury 2022; Mahtab and Azad 2021), but also to long-standing and internalised misogynistic social norms and practices (Sifat 2020a). Others have reported on the challenges of accessing and navigating legal systems given the stigmatisation and harassment faced by women who seek legal justice (Sultan *et al*. 2021). Following intense social pressure and public protests, the government increased the penalty for rape to the death penalty in 2020 (Ellis-Petersen 2020).

Another area with evidence of impacts to outcomes is **child marriage**. Due to schools having been shut for face-to-face teaching for a year and a half, reports of hundreds of additional instances of child marriage in the country raised fears (Hossain *et al*. 2021). In June 2020, 462 child marriages were reported, a 272 per cent increase from May (Afrin and Zainuddin 2021). Possible reasons suggested include: long-term school closures; economic pressures; the opportunity to forgo wedding expenses; the return of male migrant workers seeking brides; and social insecurity (*ibid.*). Yukich *et al*. (2021) predicted there could be as many as 85,000 to over 500,000 additional child marriages in Bangladesh as a result of pandemic shocks by 2035. The rise in child marriage is likely to come with a rise in adolescent maternal death, as childbirth is the leading cause of death among girls aged 15–19 (Cousins 2020). Both married Bangladeshi and Rohingya girls were more likely to report worsening health during the pandemic than their non-married counterparts (Baird *et al*. 2022).

There is also emerging evidence on the impacts of Covid-19 on a range of **child health issues**, including mental health problems during the lockdown period (Yeasmin *et al*. 2020). A study found that children admitted to an icddr,b-run Dhaka hospital during the pandemic were significantly more likely to have severe complications (dehydration, sepsis, and convulsions) than the pre-pandemic period and that babies younger than six months who were born during the pandemic were much more likely to have stunting and wasting than pre-pandemic, and were more likely to die (Nuzhat *et al*. 2022). This reflects global patterns and worries of a ‘syndemic’ of Covid-19 and malnutrition (Oxfam 2021). A study by researchers at BRAC JPGPH found that infant nutrition was likely to have been severely impacted by hikes in the price of baby food, formula, and milk during the pandemic (Sara *et al*. 2020). While there does not yet seem to be data suggesting an increase in preventable diseases among children, millions of missed immunisations in Bangladesh may yet result in such increases (Hanifi *et al*. 2022).

4.2.5 Intersectional considerations

The economic impacts of Covid-19 on women have already been noted. Underscoring the greater vulnerability of women to the economic impacts of the pandemic, a large-scale survey found that women in Bangladesh reported greater decreases in government support, assistance from NGOs, income from other family businesses, food and income from their own production, remittances received, income from paid jobs, properties and investments, and support from family and friends than men during lockdown (UN Women and Women Count 2020). Women are therefore likely to be disproportionately represented among the 'new poor' in Bangladesh: a portion of the population which has been, or will be, plunged into poverty for the first time by the pandemic – likely with significant implications for health (Power and Participation Research Centre 2020).

Gender also intersects with other axes of social and economic marginalisation to result in heightened vulnerability, including for SRHR and MNCH outcomes and service access (Rahman *et al*. 2022). Important intersectional considerations include the following.

Youth status

As reflected in the data on child marriage and health, children and adolescents are particularly vulnerable. Qualitative work with adolescents in Sylhet and Chittagong found they had experienced negative impacts on their mental health, education, food security, and ability to access general health services (including due to stigma associated with the possibility of having Covid-19), with most impacts felt more acutely by adolescents from poorer or rural households (Alam *et al*. 2021). Although no published research could be found, two KIs suggested that adolescent SRHR was put at risk by school closures as young people often learn from one another, or access services or supplies such as menstrual hygiene products in, or on their way to and from, school. The loss of this opportunity due to school closures removed their chance to keep such visits private from disapproving family members. Importantly, girls in particular experienced greater restrictions on their mobility (*ibid.*).

Social minority status

Although little to no data could be found on SRHR or MNCH services and utilisation relating to ethnic or religious minorities (e.g. Dalits, river gypsies, Hindus, tea garden workers) in the context of the pandemic, it is likely that they may face additional barriers or discrimination/stigmatisation that could compound any challenges they already have in accessing services. One study utilising community scorecards to understand how satisfied people were with services including health services during the pandemic found that, in some districts, these marginalised groups were poorly treated or excluded, such as with accessing health information (LNOB 2020). Long-standing social, cultural, and economic exclusion of groups such as tea garden workers – ethnic communities originally

from south India (Al-Amin *et al*. 2017) – are likely to have deepened in the pandemic. Similarly, discrimination against Hindu religious minorities has risen during Covid-19 (Doftori 2021), which could further hinder their access to services.

LGBTQI status

Due to ongoing stigmatisation and discrimination, LGBTQI groups frequently face challenges accessing health-care services. Being economically vulnerable, many have also been under increased stress in the pandemic. As one KI explained, the Hijra, a group of transgender women who live in specific socio-communal configurations, rely on informal, day-to-day economic activities which have been severely disrupted. They face frequent discrimination and during the pandemic they have been stigmatised as virus carriers (Jalil *et al*. 2020). Homosexuality also remains highly stigmatised as well as criminalised in Bangladesh, making access to health-care services for many LGBTQI populations more challenging (Inge 2018). Recent crackdowns on online spaces and public health measures against in-person gatherings significantly impacted LGBTQI communities who rely on such spaces for support, including information sharing. One study found that some in this community also worried about the loss of gender affirming care/pharmaceuticals and sexual health services during the pandemic (BRAC JPGPH n.d.).

Occupational type

Sex workers face challenges accessing health care even in normal times, being often stigmatised or refused for service. A 2020 study found that sex workers across Bangladesh faced significant income losses due to lockdown and fears of Covid-19 (on the part of both clients and the workers themselves). This greatly compromised their ability to access available private health care (including ANC), while the public sector remained unreliable as facilities were often closed, or the care offered was experienced as substandard (e.g. lack of physical examination) (Rahman *et al*. n.d.).

Further dimensions which may be relevant to SRHR and MNCH access and utilisation may include disability, geography (urban versus rural), and education level.

5. Knowledge gaps and opportunities for research

There are considerable gaps in understanding of how the pandemic has impacted SRHR and MNCH in Bangladesh and what this means for policymakers, practitioners, and health service providers in terms of recovery, addressing negative impacts, and building more effective resilient systems in the future. Below are priorities for research and engagement in both the short- and long term. These cover aspects that are both more specific to SRHR and MNCH and concerning broader health system governance. A graphical representation of these identified research priorities and timeframes can be found in Annexe 2.

5.1 Research priorities in SRHR and MNCH

Although there is now some quantitative understanding of service availability and utilisation during the pandemic, there is very limited exploration of **service quality**, and the experiences and perceptions of service users and providers beyond the challenges they have faced to provide or access care (although aspects of these, too, could be further fleshed out in the short term). For example, there is limited consideration of the technical challenges raised by the pandemic (e.g. limited transportation and reduced income) in the context of gendered social relations and power dynamics within the household and community, with the exception of GBV. Such relations, including how they may have shifted throughout the pandemic, may have further implications for health seeking for SRHR and MNCH. Quality aspects may include further exploration of patients' experiences of services, and the outcomes of service seeking, as well as supply-side factors that have affected service quality.

Evidence also appears to be mostly or completely unavailable on a range of SRHR services, utilisation, and outcomes in the pandemic context. These include:

- abortion or 'menstrual regulation';
- unwanted pregnancies;
- menstrual hygiene;
- SRHR for youth, men, and single women; and,
- sexual health and services (e.g. STI screening).

In addition to greater understanding of how these and other aspects of SRHR and MNCH health have been impacted during the pandemic, it will also be

important to explore how short-term disruptions to services and health seeking may impact medium- and longer-term health outcomes. It will be important to anticipate, monitor, track, unpack, and mitigate risks and potential future negative health outcomes, particularly for social groups vulnerable during the pandemic with respect to SRHR and MNCH. Possible questions might include:

- What will the future outcomes be for infants and children born in the absence of medically trained attendants, who did not receive their vaccinations, or who became severely ill during the pandemic prior to seeking treatment?
- What are the implications for future health and wellbeing for women and girls who must live with the trauma of increased IPV and GBV during the pandemic, and in a context of ongoing economic pressure?
- What might the long-term impacts of school closures be on children, and is there a risk of a 'lost-generation' growing up with poorer future health?

As quantitative data on these outcomes, as well as others including maternal, infant and child mortality and morbidity (e.g. from vaccine preventable diseases), begin to emerge, it will be important to contextualise this within qualitative understandings of what has led to or enabled these outcomes in order to better inform mitigation strategies. A focus on the most vulnerable groups, including the poor, displaced, and minority groups, will also be critical to understand and mitigate inequities between different groups. Aggregate-level data can obscure such inequities, and thus reinforce policies and practices which may actually sustain or deepen marginalisation for some groups.

Although there has been some attention to how pandemic-related economic pressures and heightened discrimination have impacted service access, health seeking and overall wellbeing among some marginalised communities as earlier described, the experiences of many vulnerable social groups remain un- or under-explored with respect to SRHR and MNCH specifically. Key populations whose experiences during the pandemic to date – and into the future – require additional attention include:

- unmarried, widowed, divorced, or abandoned women;
- youth;
- people with disabilities;
- gender and sexual minorities;
- sex workers;
- Hindus and other religious minorities;
- tea garden workers;

- 'floating', or homeless populations;
- Bede ('river gypsies');
- Dalits (a minority population facing significant discrimination on basis of caste background);
- displaced populations; and,
- digitally excluded groups.

Especially for people at the intersections of different marginalised socioeconomic positions and identities, additional layers of economic and social exclusion and discrimination may have further impacted their ability to access SRHR and MNCH services. It is important to disentangle how impacts differently and disproportionately affect various marginalised groups to ensure equity and justice in response, recovery, and longer-term plans for preparedness, resilience, and general progress.

Another critical group that requires additional attention are health workers who provide SRHR and MNCH services. Although many of the challenges and barriers they faced during the pandemic have been documented, there is more to learn about how they can be better resourced, supported and prepared for future crises, as well as for normal functioning in the future. The effectiveness of crisis training and communication networks within and across public and private health sectors may be a key issue to investigate to support future improvement.

Finally, as we move into the medium-term, it will be important to consider how the health system has shifted and evolved in the wake of the pandemic and what the emerging service landscape looks like for SRHR and MNCH in Bangladesh. Most existing evidence focuses on the early pandemic period, especially lockdown. Emergent 'new normals' will interact with pre-existing constraints and realities in the health system, community, and households, such as limited staff and gender norms. With the concern over digital exclusion, for instance, any widespread and long-term adoption of digital or telephone-based services could mean that those lacking access to or skills in using communication technologies are left behind. These exclusions are also gendered as only around 60 per cent of women in Bangladesh are the registered owners of the mobile phones they use, while nearly 80 per cent of men are (UN Women and Women Count 2020). There are likely also age-related contours to this.

5.1.1 Priorities for health system governance and beyond

SRHR and MNCH are profoundly affected by the broader health system and its governance, and thus research and engagement must also prioritise these areas.

In Bangladesh, there is limited coordination between public and private health sectors in terms of data collection and analysis, routine operation, and emergency response.

In the short term, a better understanding of the role of the private sector (including for-profit formal and informal providers as well as non-profit providers) during the pandemic is essential, as most existing evidence refers mainly to the public sector. On one hand, mapping out who did what may illuminate the extent to which the private sector may have served as a source of resilience during the crisis when the public sector, shifting gears to emergency response, was unable to continue adequately supporting many services. On the other hand, for-profit private sector services are likely to have excluded a substantial proportion of the population unable to pay for services. This better understanding may support recognition of how improved coordination – in terms of governance, service provision and data collection and analysis – between the public and private sector could be achieved, not just in terms of future crisis response, but also in 'normal' times into the medium- to long-term. Critically, this is likely to look different in rural and urban contexts due to their different primary health-care structures. Better understanding and achievement of cross-sector coordination **beyond** health, such as in economic and social welfare, will also be important for improving SRHR and MNCH and protecting against future health shocks as public health responses.

Another critical and underexplored governance issue relates to accountability for poor health services in both the public and private sector, and how this can be addressed to improve service availability and quality. This is particularly important for marginalised groups who may disproportionately have negative experiences of health services due to low quality, inappropriate, or non-tailored services, and discrimination or stigma (LNOB 2020). Importantly, there may also be opportunities within the emerging post-pandemic health system for marginalised groups to claim or realise health rights, such as through digital tools for accountability, or even for directly accessing services that may be considered taboo. That said, the risks of digital activity, including exclusion, surveillance, and privacy breaches should not be ignored.

Finally, little is known about how people, households, and communities themselves responded to the pandemic, including what kinds of information, innovations, adaptations, and locally based resources they have leveraged to support SRHR and MNCH. Local actors and networks to consider include both health-related and non-health-related local governance institutions and civil society networks, including in the formal, informal, and traditional spheres. For example, although often inactive (RTM 2012), formal local health management committees made up of various government, health, and community actors may have played key roles in some settings. Informal support networks made of up

local women's groups may also have played important roles (Ehsan and Jahan 2021). It will be important for researchers and policymakers to better understand the role of decentralised action in preventing maternal and child mortality, as well as other negative health outcomes during and in the wake of the pandemic, and how greater support and recognition of community-based response can contribute to resilience against future crises and improved SRHR and MNCH in normal times. Local institutions and networks may be more trusted and accessible for local people, making them critical sites for inquiry and action, while improved community engagement in higher-level governance processes is also important.

5.1.2 The importance of focusing on these issues

As earlier outlined, Bangladesh has a history of improvements in SRHR and MNCH, but that success has plateaued in recent years. With the pandemic having dealt a significant blow to services and utilisation, several KIs expressed worry that the country will not meet SDG 3 for reducing maternal mortality to less than 70 per 100,000 live births (from 186 per 100,000 in 2016) (Tabassum 2022). Other hard-won gains in family planning and contraceptive use and infant and child health may also be in danger of slipping in the coming years if co-productive efforts to understand and mitigate setbacks are not made (see Box 5.1). Crucially, such understanding requires going beyond the descriptive to illuminate the 'Why?' and 'How?' of negative impacts to these and other related health issues. Questions of process, governance, health system functioning and coordination, service quality and accountability, and gender relations and power dynamics are therefore necessary to filling out this picture. Continuing to monitor and interrogate these dimensions will also be critical to informing ongoing efforts to mitigate negative outcomes and create more resilient health, social and economic systems that uphold SRHR and MNCH for all.

Box 5.1 What does it mean to co-produce health research and planning?

To maximise the effectiveness and benefits of health research and planning, it is essential to involve communities – the users and target beneficiaries of services – from the earliest stages of identifying problems and priorities through to implementation. This can ensure efforts are ethical, appropriate, and more impactful (Tembo *et al*. 2021).

Source: Authors' own.

A study looking at the long-term impacts of the 1970 Bhola cyclone showed that there were significant long-term implications of this disaster for the health, schooling, and capacities of adults who were exposed to the event as infants and children, thus providing further impetus for action (Eskander and Barbier 2022).

5.2 What are the policy impediments and opportunities to influence change?

5.2.1 Impediments

Persisting conservative attitudes

KIs identified a range of potential barriers to research influencing change in SRHR and MNCH both in a pandemic and post-pandemic context, many of which were challenges prior to Covid-19. These include persisting conservative attitudes towards SRHR in society, which is also reflected in the policy landscape. KIs emphasised that SRHR is interpreted narrowly, and mostly limited to family planning and reproductive services, with minimal attention to sexual health services such as STI screening and treatment, or menstrual hygiene. This may explain the lack of evidence in these, and other, SRHR areas. Even the private sector, which now provides the majority of reproductive health services, has not stepped in to fill the gap due to the prevailing social/religious context. SRHR education is also very limited in schools, with a similarly narrow focus and teachers even skipping material due to shame or discomfort. Issues of relationships, gender, and sexuality are also completely absent from the curriculum. This indicates the challenge of developing more robust support around adolescent SRHR in particular and for other groups including gender and sexual minorities, as well as the challenge of challenging patriarchal gender norms. SRHR services are often only targeted at married women, even if implicitly, leaving many groups excluded from critical health care.

Medicalisation of health

Another impediment to the influence of research may be the overarching medicalisation of SRHR and MNCH which is dominant in Bangladesh. This is evident in the strong public health framing of SRHR and MNCH in the literature, with little exploration of rights, equity, quality, governance, or accountability. These aspects may also be ignored in the policy sphere, which may be more oriented towards quantitative or technical information. Any discussions of the former should therefore be contextualised within the latter when engaging in these spaces. Government actors may be particularly sensitive to framings which question their actions or integrity, and so work looking at systems of public accountability should be framed constructively, with an emphasis on what can realistically be done to make improvements.

System complexity

The inherent complexity and dynamism of the health system which research may aim to influence could in itself impede change. As already suggested, Bangladesh's health system is highly complex and fragmented, made up of a mix of public and private systems and providers, both formal and informal, which rarely collaborate. Key stakeholders within the governance apparatuses of the public system are frequently shifting, with politically appointed ministers and other officials rotating every three to four years (or less) and little institutional knowledge being passed on. Health under the public system is also fragmented between the DGHS and the Directorate General of Family Planning (DGFP) within the MOHFW, and also the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C), the latter being responsible for primary health care in urban areas.

Institutional rigidity

Despite this fragmentation, there is also rigidity in the public system. As mentioned throughout this paper, public monitoring systems are highly centralised. Health financing in the public sector is also relatively rigid and inflexible, running in five-year cycles. There is also a disconnect between policy levels and implementation.

Intersectoral engagement challenges

SRHR and MNCH are also influenced by factors that lie beyond the health system; in economic, social, and political realms. In this way, change requires action across a range of systems and the involvement of a wider range of related sectoral government bodies. Other private sector societal levers, including cultural and economic, institutions, norms, and networks also play roles.

5.2.2 Opportunities

Growing evidence base

Opportunities for influencing policy change can be found in the growing evidence base on and awareness of the impacts of the pandemic on SRHR and MNCH – which may lead to engagement opportunities. Bangladesh's next Demographic Health Survey is also underway and results (which will be available in a few months), may present new data and generate fresh enthusiasm for government actors to engage in related issues.

Researchers from the Centre of Excellence for Gender, Sexual and Reproductive Health and Rights (CGSRHR) at BRAC JPGPH have also produced, and continue to produce, relevant evidence with a focus on the intersections between the impacts of the pandemic, different forms of social vulnerability, and SRHR. This should be consulted to ensure complementarity or collaboration on future research in this area. The icddr,b is also looking to be

more active in this area, expanding their usual scope of public health to include rights and equity.

Existing government projects and policy opportunities

KIs confirmed that government actors are indeed interested in such evidence and would be open to learning that can be applied to operational decision-making. Existing projects that the government is already invested in (such as the Health and Gender Support Project, a joint government and World Bank project to address the gap in health services by June 2023), may present opportunities to engage (WHO Bangladesh 2021). Policy opportunities, including the 2023 launch of a new Health Nutrition Sector Development Plan, the government's mechanism to strategically plan and finance the public health system every five years, will also likely present opportunities for engagement, and possible policy influence.

Strategic framing

It may be helpful to consider language carefully in the framing of research and advocacy for progressive change in the context of a conservative or hostile social and/or political landscape towards aspects of SRHR and MNCH. For instance, the term 'menstrual regulation' has been strategically used instead of the term 'abortion' (even though it is essentially abortion permitted up to 12 weeks after the last menstrual cycle), which would be unacceptable in the context. There may be space for creative or strategic use of language and framing around adolescent SRHR ('life skills') or other sensitive topics that could help to influence progressive change for sexual and gender diverse populations, sometimes, along with other stigmatised groups, strategically referred to as 'key populations'.

6. Key stakeholders in SRHR and MNCH in Bangladesh

There are a range of key stakeholders with responsibilities for or involvement in SRHR and MNCH in Bangladesh who would be interested in evidence in these areas, as described below. Researchers should engage and collaborate to ensure relevance and impact of future work in this area.

6.1 Government and public health system stakeholders

Firstly, officials and programme managers in the DGHS and the DGFP within the MOHFW at the national level are central to public sector policy, resource allocation and programme and system management. MOLGRD&C is also critical as it is responsible for primary health care within urban areas. Both the DGHS and the DGFP are also responsible for routine data collection, including the DHIS2. The National Institute of Population Research and Training (NIPORT), an autonomous research institute under the MOHFW, is also involved in data production, particularly through leading comprehensive Demographic Health Surveys in the country.

The Parliamentary Standing Committees on Family Welfare and Local Government for Urban Health which are headed by Members of Parliament (MPs) but also include ministers and other high-level government stakeholders and elected officials were also mentioned by KIs as audiences that might be receptive to evidence, and where political will and pressure might be generated.

As suggested throughout this paper, cross-sector working beyond health is also important for crisis recovery, response, and future resilience, and so stakeholders in other ministries, such as the Ministry of Women and Child Affairs, the Ministry of Social Welfare, and even ministries governing business and trade when it comes to engaging private sector actors, may be important collaborators or audiences for future research.

In the context of the pandemic, other important stakeholders adjacent to but independent of the state include the National Technical Advisory Committee on Covid-19, made up of independent experts who have advised the government on its Covid-19 response, including on matters beyond health.

Other independent public bodies include the National Human Rights Commission, which lobbies for the rights of marginalised people including women and gender diverse and sexual minorities.

At the local level in rural areas, district and subdistrict health officials and providers, as well as local health management committees (which include local MPs, service commissioners, leaders, NGO and hospital representatives, journalists, and community members who are meant to ensure quality of care and accountability of service providers) are important stakeholders. Although they are meant to meet once a month, health committees are often defunct due to an absence of leadership, for example with MPs often being away or members having other priorities (RTM 2012).

6.2 Development partners and agencies

A range of UN agencies including UNFPA, United Nations Children's Fund (UNICEF), and UN Women, as well as international development partners such as Population Council, Save the Children, Ipas Bangladesh, Marie Stopes International Bangladesh, World Vision Bangladesh, the Guttmacher Institute, and the Family Planning Association of Bangladesh (an affiliate of International Planned Parenthood Federation), have been or are actively engaged in research, advocacy, collaboration with government, and/or service delivery for SRHR and/or MNCH in Bangladesh. Several partners worked with the government to develop guidance for the safe provision of primary health-care services in the context of the pandemic. Further scoping of the focuses and activities of these different actors should be conducted in order to ensure that research priorities are building on, complementary to, and cognisant of their activities – even if in a critical capacity.

6.3 Research organisations

As mentioned earlier, local research institutions including the CGSRHR at BRAC JPGPH and the icddr,b regularly engage in, publish, and disseminate research on SRHR and MNCH. The icddr,b has tended to take a mainly public health and technical framing and has focused more on MNCH, while the CGSRHR has tended to more explicitly focus on SRHR, and to use rights- and justice-based framings. The latter have also more closely focused on the experiences of marginalised groups.

Researchers should build on and complement work done by these organisations. They would also benefit from engagement with them and their networks. Although having a smaller profile, the Centre for Clinical Research and Health Innovation of the Sajida Foundation has also recently contributed to evidence on how the pandemic has impacted SRHR and MNCH. Another important domestic research organisation is the Power and Participation Research Centre which looks at the intersections between health and economics. They have focused on the emergence of the 'new poor' in the wake of Covid-19 in Bangladesh, and

therefore may shed light on the profound links between socioeconomic circumstances and SRHR and MNCH.

6.4 Professional societies

The Obstetrical and Gynaecological Society of Bangladesh (OGSB) is a professional association of obstetricians and gynaecologists with 2,350 members practicing in both public and private health sectors across Bangladesh. It was mentioned by several KIs as particularly influential when it comes to SRHR and MNCH issues in the country, with government stakeholders always keen on seeking the organisation's perspective. The OGSB should be engaged for future research and action.

6.5 Civil society

The most visible civil society organisations working on SRHR and MNCH in Bangladesh are those already mentioned: international development partners; research organisations/NGOs such as the BRAC JPGPH and the icddr,b. However, there are a range of smaller, grass-roots organisations involved in advocacy and innovative service provision at local levels. These include Narripokkho, an organisation that campaigns against violence against women and for health and reproductive rights of women and young people in the community. Their activities include trying to activate local health management committees, monitoring government health-care facilities to support accountability, and working with local authorities on solutions to current issues and challenges.

Another organisation is the Bandhu Welfare Society, a community-led organisation working to support sexual minority and gender diverse populations through capacity building and advocacy, including, for example, a platform for youth SRHR called Right Here Right Now. In general, organisations that are run by or that work with sexual and gender minorities face discrimination and their formal recognition in Bangladesh is challenged due to widespread stigmatisation, so partnerships with them must be sensitive to this.

There are likely many other community-based organisations and informal networks not captured in this review which may be engaging in innovative research, advocacy, and interventions around SRHR and MNCH at the local level. It is important that future research and engagement seeks the perspectives, expertise, and collaboration of such organisations, as they will bring unique knowledge of contextual realities and challenges, and of priorities of community members that larger organisations and government stakeholders may miss.

6.6 Strategies for stakeholder engagement and influence

6.6.1 Engaging government

Government stakeholders may be particularly challenging to engage due to their busy schedules and long list of priority issues, particularly those in high levels of government. Additionally, while they may be interested in and committed to progress in SRHR and MNCH, and to broader health systems strengthening and universal health coverage, they may also be sensitive to approaches that critique their actions and decisions. However, their buy-in and involvement is critical if research evidence is to influence policy or practice, so it is important that they are engaged from the start of research programmes and help to shape research questions and approaches. Engaging individual champions rather than generic approaches to government stakeholder involvement was suggested by KIs to be a potentially more effective strategy.

Research agendas that consider themes such as accountability for health and health services should be approached constructively, avoiding overly critical charges without presenting concrete and realistic suggestions for action and change. Government actors may also be more oriented towards quantitative public health data and descriptive information about health system issues such as availability or coverage of services, and less open to qualitative data such as how patients experience services, which they may dismiss as anecdotal or find overly challenging if negative. Efforts should be made to present data, particularly qualitative data, in ways that are accessible and have clear implications for action. Contextualising qualitative data within a broader quantitative picture, and vice versa, will be important.

Finally, timeliness of data is important when working with government stakeholders (and others involved in programme management and service provision). Detailed reports shared after a long intervening period, may seem outdated and less relevant, and enthusiasm among stakeholders may have waned. If possible, researchers should find ways of feeding their learning into stakeholder engagement processes on a regular basis through regular updates and briefs to maintain interest and support change in real time. A key challenge is the relatively short time periods in which high-level government officials may be in their posts as their window for affecting change will be limited. Engaging with incoming officials is important to maintain momentum, particularly if a change occurs during the research period. Additionally, presenting to Parliamentary Committees may offer opportunities to generate political will across a broader panel of government and elected officials.

6.6.2 Convening diverse stakeholder groups

In addition to government stakeholders, engaging various other stakeholders including research organisations and independent experts, development partners, civil society, and networks (including at the community level), and professional associations and health-care providers is important to ensure that research builds on and complements existing evidence and work, and benefits from diverse and broad networks through which it can be disseminated. Such broad-based groups should ideally be convened from the start of a research effort to ensure that all parties have contributed to research questions and approaches. This will ensure the research is indeed filling an important gap, and that it will be more likely to influence change.

Workshops were mentioned by KIs as a useful and popular tool through which to bring together diverse stakeholders and to facilitate sharing of multiple perspectives and discussion. Table-top exercises, in which participants address a simulated crisis or scenario are another suggested way of facilitating engagement and getting stakeholders to consider how evidence can be applied to recovery, response, routine functioning, and future resilience in the health system for SRHR and MNCH both in the context of a crisis and in ‘normal’ times.

With diverse stakeholder groups, it will be important to manage power dynamics carefully, ensuring that the least powerful actors are heard and given space to express their perspectives. This starts with getting them to the table, which requires a thorough scoping of who is active in the area (both thematic and geographical) that the research is aiming to address, especially at the grass-roots level.

Careful facilitation can support inclusive engagement, for example through breakout groups with opportunities to feed into plenary discussions, or through ring-fencing time and resources for less powerful actors to express their view. Often it is these voices that can speak more expertly to the challenges and realities on the ground, especially for marginal communities. That said, researchers should also be wary of the possibility of ‘elite capture’, even of grass-roots organisations.

7. Key findings

The evidence clearly shows that key SRHR and MNCH services and health seeking were disrupted in Bangladesh during the pandemic – particularly during the early days, such as during national lockdown.

Known negative health outcomes from pandemic disruptions (including the indirect effects of economic pressures) include increased domestic and gender-based violence, child marriage, negative mental health, and adverse child health outcomes.

The priorities and opportunities for research to support response, recovery and progress are:

- More evidence is needed, both quantitative and qualitative, on how health outcomes have been impacted by pandemic disruptions – not only in the short-term but also into the longer-term.
- Less is known about impacts to a range of SRHR services/utilisation or how marginalised groups have been affected with respect to SRHR and MNCH.
- Impacts to service quality are also largely unknown and should be investigated retrospectively and in the future.
- Greater understanding of the role of private health actors and of community-based response during the pandemic is needed to improve coordination and to better allocate resources in the future.
- Co-production of solutions for response, recovery, and progress between these groups and the public sector is critical.
- It is important to understand how the emerging SRHR and MNCH service landscape (e.g. possible widespread and long-term adoption of digital services) may interact with pre-existing health system and community constraints, including gender inequality.
- Other questions of health system governance, including issues of accountability for health services and community engagement are also important to foster public health and the strength of the health system.

8. Conclusion

SRHR and MNCH, like other primary health issues, have been significantly disrupted by the Covid-19 pandemic in Bangladesh. Disruptions have been caused not only by the virus and the panic and chaos of the early phase, but also by response measures to control transmission, such as the national lockdown and other restrictions. The indirect economic impacts of the pandemic will continue to reverberate long into the future. While many services may have 'returned to normal' two years into the pandemic, the early and ongoing disruptions are likely to have long-lasting effects including what may be permanent changes to health service provision, such as the normalisation and expansion of digital and telephone-based services. This may have both negative consequences (especially for the 'digitally excluded'), and positive impacts (increasing coverage, including for sensitive sexual and reproductive care which people may avoid accessing in person due to fear of stigmatisation).

Furthermore, those adversely impacted by acute disruptions, such as the inability to access family planning leading to unwanted pregnancies, or by child marriage due to the economic devastation of poor households, will likely face significant challenges into the future. It is critical that researchers and other key stakeholders continue to investigate how the crisis has impacted, and continues to impact, service provision, utilisation, and health outcomes (in both the public and private sectors), and to translate this knowledge into action for response and recovery in the short term, and greater health system effectiveness and resilience in the medium- to long term. As SRHR and MNCH are not independent of broader health system and governance issues, improved coordination, accountability, transparency, and equity within and beyond the health system is needed so that all in Bangladesh, especially the most vulnerable groups, are to be able to realise their rights to health.

Annexe 1: Key informant interviews

Key informant identification

Key informants for this work were identified through project networks, and through snowballing techniques in which key informants were asked to suggest and, if appropriate, introduce the author to additional experts.

Interview protocol

At the start of interview, key informants were briefed on the purpose of the research and their participation in it, and were given the opportunity to ask questions. The interviewer then requested their permission to record the interview, informing them that the recording would be stored securely, accessible only to the interviewer. The interview then took place, with the interviewer utilising a pre-prepared guide, but allowing the discussion to be guided by the priorities and expertise of the key informants. At the end of each interview, which lasted between 45 minutes and an hour, key informants were told of the upcoming webinar at which findings would be presented, and an opportunity for further discussion would be facilitated, and asked if they would like to receive an invitation. They were also informed that the final reports resulting from this work would be shared with them following publication.

CLEAR key informant interview guide

Thank you for agreeing to participate in this interview. It is really useful that we get to understand how Covid-19 has affected SRHR and MNCH issues in Bangladesh, and your expert inputs are invaluable in helping us achieve this goal.

In order not to miss anything that you say, it would be great if we can record this interview. Is this okay with you? The recording and transcript will be stored securely, and not used for any purposes other than for this research.

Key informant information

- Name, position, and expertise/experience
- Sector (e.g. civil society, research, government, private sector)

Pandemic impacts

- What, in your view are/have been the pandemic impacts on SRHR and MNCH **services** (e.g. due to public health measures, staffing issues, supply chains etc.)
  - availability, quality, accountability
- Pandemic impacts on SRHR and MNCH **outcomes** (including due to changed health seeking behaviours)
- Intersectional lens: Are some groups disproportionately affected? How have impacts affected different social groups?

Research and evidence

- Who is producing it? Who are the key actors leading research and evidence in this area (SRHR/MNCH) in your view? How do different actors frame the issues?
- What are the gaps, and what more knowledge is needed?
- What knowledge should be prioritised? What kind of research should be commissioned in the short- and long term?
- Who is interested in evidence on these issues? Who are the consumers of this knowledge or target audience? What kind of outputs or policy engagement would be useful?
- Are there any opportunities for research, on which areas?
  - Funders, partners, policy champions, etc?

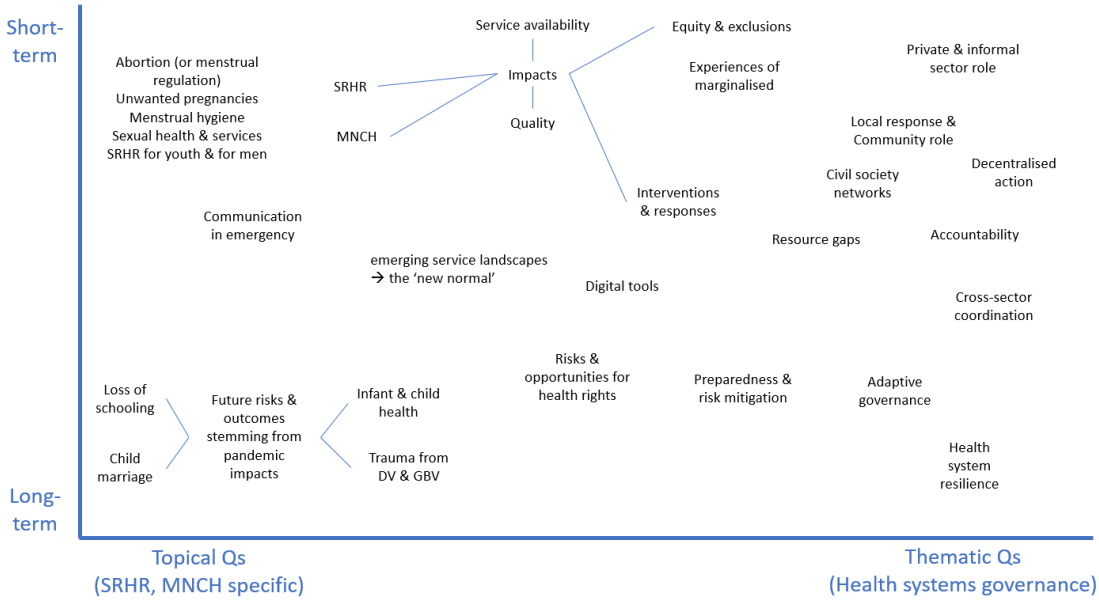
Policy

- Who are the key policy actors in these areas?
- To what extent have these issues been prioritised in pandemic response and policy?
- Have there been any policies or initiatives (state and non-state) that have emerged to mitigate disruptions in these areas? Press for specifics (which ones, what is the coverage, any stats etc.)
- Are there policies or initiatives that you would like to see?
- Are there any impediments or opportunities to policy change?
- Are there opportunities for research/policy partnerships to emerge?

Further research

- Do you have any contacts that you think we should seek to interview?
  - In government, research, or civil society?
- Are there any reports or databases you would like to refer us to?
- Would you be interested in attending a seminar for the presentation of our findings, and discussion with other stakeholders?

Annexe 2: Research priorities – graphical representation



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