

POLICY BRIEF
**ADVANCING SEXUAL
AND REPRODUCTIVE
HEALTH AND RIGHTS
AND FAMILY PLANNING
SERVICES DURING
DISASTERS**



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PATHFINDER

Despite Bangladesh's significant progress advancing sexual and reproductive health and rights and family planning, urgent challenges remain for communities prone to extreme natural disasters. Disaster-induced crises often exacerbate pre-existing high rates of unintended pregnancy, unsafe abortion, and maternal morbidity and mortality.^{1,2,3,4} A pre-designed workplan is pivotal for ensuring the availability, accessibility, and affordability of sexual and reproductive health and rights and family planning services during and after disasters.

1 M.R. Haque, N Parr, S Muhidin, "Climate-Related Displacement and Antenatal Care Service Utilization in Rural Bangladesh," *Int Perspect Sex Reprod Health* 46 (2020): 175-185.

2 M.R. Haque, N Parr, S Muhidin, "The effects of household's climate-related displacement on delivery and postnatal care service utilization in rural Bangladesh," *Soc Sci Med* 247 (Jan 2020) 112819.

3 M.R. Haque, N Parr, and S Muhidin, "Parents' healthcare-seeking behavior for their children among the climate-related displaced population of rural Bangladesh," *Social Science & Med* 226 (2019): 9-20.

4 Haque, Parr, and Muhidin, "Climate-related displacement, impoverishment and healthcare accessibility in mainland Bangladesh," *Asian Population Studies* 16 (2020): 220-239.

Background

Sexual and reproductive health and rights (SRHR) and family planning services save lives; however, millions of people in Bangladesh cannot exercise their rights to high-quality SRH and family planning services, even before disaster strikes. Committed to closing this gap, Bangladesh has made notable progress in improving maternal and child health (MCH) and family planning indicators (See Figures 1 and 2), as reflected in Bangladesh's progress report on the Millennium Development Goals and Sustainable Development Goals (SDGs).

Figure 1. Progress in antenatal care (ANC), delivery, and postnatal care (PNC), 1995–2022

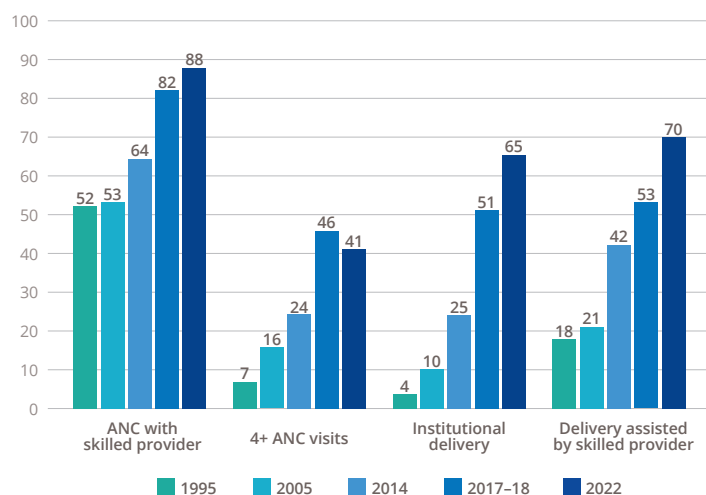
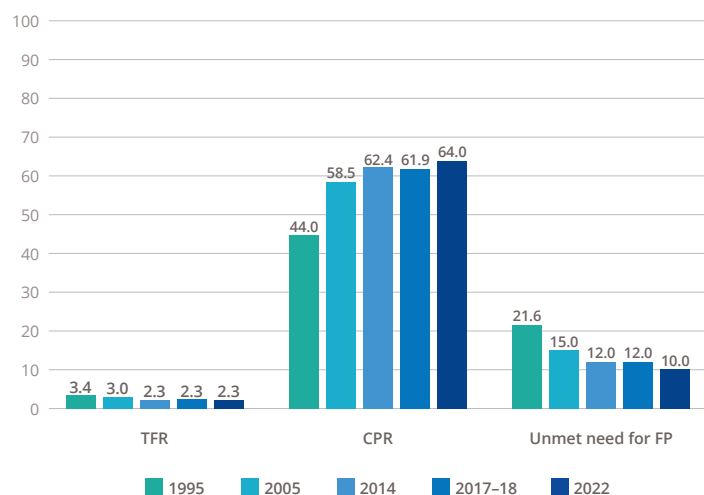


Figure 2. Progress in total fertility rate (TFR), contraceptive prevalence rate (CPR), and unmet need for family planning (FP), 1995–2022



Despite Bangladesh's remarkable progress advancing SRHR and voluntary family planning, urgent challenges remain.

Need for services before disaster strikes

In Bangladesh, nearly 1 in 4 adolescent girls ages 15–19 has begun childbearing.⁵

Nearly 20% of currently married women want to wait at least two years to have a child,⁶ and 57% do not want any more children.⁷ Yet, 10% of currently married women have an unmet need for family planning.⁸

37% of contraceptive users discontinue their method within 12 months.⁹

59% women do not get the recommended four or more ANC visits during their pregnancy.¹⁰

More than 1 in 3 women gives birth at home, often without a medically trained provider.¹¹

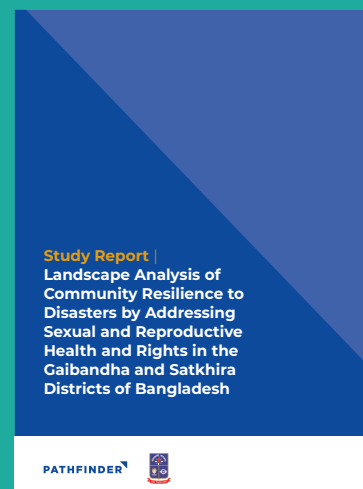
87% of mothers who do not give birth at a health facility do not receive a PNC visit from a trained provider within two days of delivery.¹²

Approximately 3,700 women died from maternal causes in 2020 alone.¹³

Unequal access to and utilization of sexual and reproductive health (SRH) and family planning services due to individuals' socioeconomic, cultural, and geographic attributes persist.^{14,15}

Generating evidence in two disaster-prone districts

Bangladesh ranks seventh in the world among countries suffering most from extreme weather events;¹⁶ yet, until recently, there was a scarcity of information about the effects of disasters on households' SRHR. From May–November 2021, Pathfinder Bangladesh and the University of Dhaka conducted a study in two climate-vulnerable districts—Gaibandha and Satkhira. The goal of the study was to sketch a holistic picture of socioeconomic and health stressors associated with disaster-related shocks and people's decision-making processes and actions related to disaster resilience—with careful attention to SRHR. Findings suggest that disasters cause socioeconomic disadvantages, threaten food security, and create barriers to SRHR services for women in Gaibandha and Satkhira. Furthermore, women and girls experience acute vulnerability related to SRHR, ANC, safe delivery, and PNC during disasters. For more, read the full study report on pathfinder.org.



5 National Institute of Population Research and Training (NIPORT) and ICF. "Bangladesh Demographic and Health Survey 2022: Key Indicators Report." (Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF, 2023). 6–8 NIPORT and ICF, BDHS 2022.

9 National Institute of Population Research and Training (NIPORT) and ICF. "Bangladesh Demographic and Health Survey 2017–18." (Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF, 2020). 10–12 NIPORT and ICF, BDHS 2022.

13 World Health Organization, "Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division." (Geneva: WHO, 2023). License: CC BY-NC-SA 3.0 IGO.

14 NIPORT and ICF, BDHS 2022.

15 NIPORT and ICF, BDHS 2017–18.

16 Eckstein D, Künzel V, and Schäfer L. (2021). Global Climate Risk Index 2021. Berlin: Germanwatch.

Emergencies exacerbate challenges

Communities affected by natural disasters and prone to extreme weather events face significant barriers to the realization of their SRHR. A study conducted by Pathfinder Bangladesh and the University of Dhaka in two disaster-prone districts in Bangladesh—Gaibandha and Satkhira—shows that, on average:

84%

of respondents said natural disasters affect women's reproductive health.¹⁷

3 in 4

respondents suffered from at least one SRH- and FP-related problem. While care was needed for 80% of these cases, only 61% received care—most from an untrained provider.¹⁸ 40% of these women were left behind and out of care during disasters for multiple reasons during an emergency.

7%

of pregnant women gave birth in a health center during the most recent disaster.

<19%

of pregnant women received the WHO-recommended four or more ANC visits during the most recent disaster.

26%

received no ANC.¹⁹

People living in disaster prone districts experience...

HIGH

- prevalence of child marriage
- prevalence of adolescent motherhood
- rate of cesarean-delivery-related difficulties

LOW

- incidence of modern sanitary napkin use for menstrual hygiene
- understanding of SRHR services, obtained predominantly from informal channels

Disasters increase girls' physical and economic insecurities and intensify pre-existing drivers of child marriage.^{20,21}

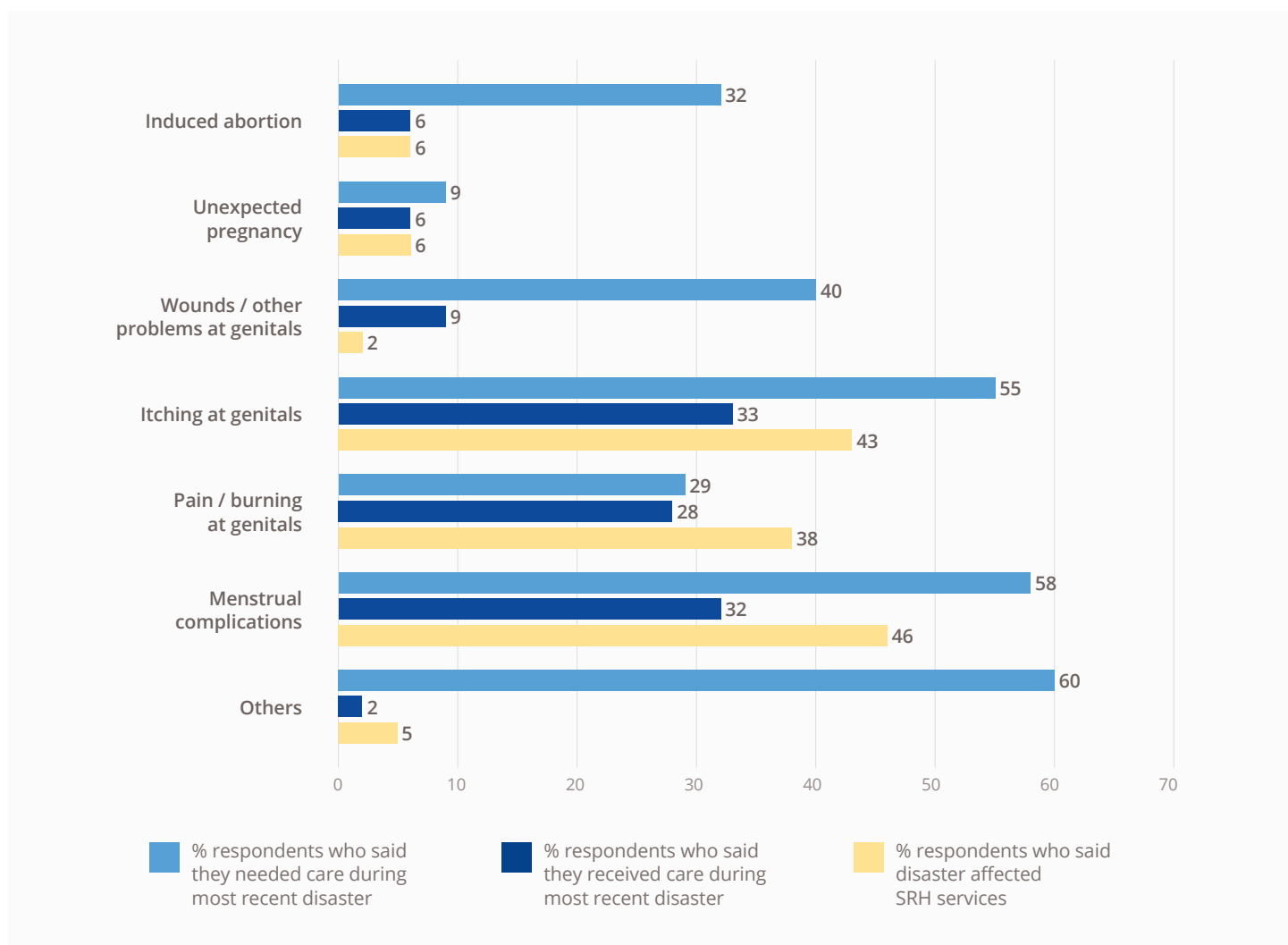
84.2%

of the respondents said GBV increased during disasters.

56.9%

of the respondents experienced gender-based violence (GBV) during the last disaster.

Figure 3. Respondents (%) describe SRHR needs, care received, and impact of most recent disaster on service delivery, by type of SRHR issue



Reasons respondents identified for their limited use of health centers and skilled care for ANC, delivery, and PNC during disasters included the following: they did not feel the care was important, costs were beyond their capacity, they lacked information, they feared COVID-19 infection, they experienced disaster-induced difficulties, family tradition served as a barrier, and their previous experience was poor.

During disasters, the availability of and access to health care services often decreases, while the need for SRHR and family planning services increases. Inequity in the achievement of good overall health outcomes, including SRHR-, family planning-, and gender-related outcomes, is heightened by Bangladesh's frequent exposure to natural disasters, including climate-related disasters.^{22,23,24} The adverse effects of natural disasters ultimately threatens Bangladesh's health sector's ability to achieve Universal Health Coverage.

22 M.R. Haque, N Parr, and S Muhidin, "The effects of household's climate-related displacement on delivery and postnatal care service utilization in rural Bangladesh," *Social Science & Medicine* (2020): 112819.

23 M.R. Haque, N Parr, and S Muhidin, "Climate-Related Displacement and Antenatal Care Service Utilization in Rural Bangladesh," *International Perspectives on Sexual and Reproductive Health*, 46 (2020): 175-185.

24 Pathfinder and Department of Population Sciences, U of Dhaka. "Landscape Analysis of Community Resilience to Disasters."

Reasons for limited use of SRH and family planning services

Evidence shows that limited use of SRH and family planning services are associated with disaster-induced disadvantages, such as transportation barriers, financial hardship, and threats to people's lives and homes; disruption in the provision of routine services; societal norms; and a poor understanding of SRH- and family-planning-related issues and perceived needs.²⁵ Qualitative data²⁶ as well consultation with key stakeholders, including government officials and implementing partners, reiterate and expand upon the many barriers people and health systems face:

Lack of perceived need for and prioritization of SRH and family planning services

People are less attentive to SRH- and family planning-related issues during a disaster, especially during a moment of crisis, which ultimately reduces the use of health care services.

"SRH is still not considered a right [during emergencies]."

—Communication Media Specialist, Department of Disaster Management

"I know little about reproductive health and rights."

—17-year-old married woman, Gaibandha

"Every year there is a flood here. We are poor people. We don't have a house. We have to struggle with what we earn. I am very weak since my baby died, but we can't afford to visit a doctor again."

—25-year-old pregnant woman, Satkhira

Shortage of service providers

SRH and family planning service delivery is affected by a shortage of human resources, particularly during a disaster.

"Human resources, particularly in disaster-prone areas, needs to be increased, as one person can't do everything, and the service provider and receiver ratio is out of standard."

—Director, Maternal and Child Health, and Line Director, Maternal Child Reproductive Adolescent Health, Maternal and Child Health Unit, Directorate General of Family Planning (DGFP)

"Users of SRH and family planning services decrease due to lack of service providers. Some work areas become very burdensome [for a provider] ... because of patient pressure. Most of the time, [positions in] fixed posts also remain vacant."

—Deputy Secretary, Program Management and Monitoring Unit, Ministry of Health and Family Welfare

"During the last flood, I ran out of my contraceptive pill, and the [family planning field workers] could not come, so I had to take the risk of an unwanted pregnancy for a long time."

—22-year-old postpartum mother, Gaibandha

Lack of skilled human resources

Health and family planning workers who are available have not received sufficient training and do not have the necessary skills to provide SRH and family planning services during a disaster.

“There is a lack of in-service training and capacity building to provide health care in emergencies.”

—Deputy Director of Family Planning, Sylhet

Insufficient coordination

Inter-ministerial coordination among multiple actors at the local level, such as disaster management committees, development partners, local leaders, and health care providers, is essential to ensure effective continuation of regular services during a disaster.

“To deal with the emergency, a coordinated plan is needed at all levels, including community members. [There needs to be a] plan with specific tasks to ensure the provision of SRH and family planning care along with a budget allocation for the emergency period.”

—SRH Specialist, multilateral organization

“There should be increased messaging on mass media about drills as part of [disaster] preparedness ... directions on how SRHR and family planning services can be obtained during emergencies.”

—Director, Information, Education, and Motivation Unit, DGFP

“Area-specific disaster mapping with affected population size for disaster-prone districts is needed for gap analysis and for the development of needed human resources and supply of logistics.”

—Health Director, international NGO

Lack of preparedness plan and policy

Facing an emergency almost every year, Bangladesh has made progress in disaster management; however, Bangladesh’s health systems is not yet prepared to deliver minimally required SRH and FP services during disaster-induced crises. SRH and family planning services for a large, growing population are managed on an ad-hoc basis during disaster periods.

“SRH- and family-planning-related support during an emergency is currently provided under the general guidelines. Research on context-specific frequent disasters and preparedness of service delivery system for SRH and family planning in an emergency is needed to develop a strategic plan and financial allocation of resources.”

—Line Director, Clinical Contraception Services Delivery Program Unit, and Line Director, Field Services Delivery Unit

“Disaster response committees at district and upazila levels should be activated. For SRHR and family planning, DGFP should be included in these committees. Health facility readiness should be ensured.”

—Deputy Program Manager, Adolescent and School Health, Directorate General of Health Services (DGHS)

“There should be location mapping of pregnant women in the areas. It will make resource mobilization easier, and emergency preparedness plan will be easier.”

—Senior Deputy Director, local NGO



A flooded village on the outskirts of Sylhet city. Photo: Pathfinder International Bangladesh

Lack of sufficient support

Emergencies affect everything, including the local health system, providers, communities, and people's mobility. Targeted support is needed to deliver regular services during and after a disaster.

"It costs money to get health care. Even if we get free government services, we can't afford other expenses including travel."

—22-year postpartum mother, Satkhira

"I could not continue [my preferred] family planning method despite my desire to do so, as the pill ran out during the floods last year."

—21-year-old pregnant woman, Gaibandha

Lack of disaster-resilient health centers

The structural design of health facilities is similar across Bangladesh, and many facilities are adversely affected by disasters.

"SRH and family planning services are essential, especially for a prolonged emergency, but the shelter houses are not female friendly and have no [space] to provide these services."

—Director, Maternal and Child Health, and Line Director, Maternal Child Reproductive Adolescent Health, Maternal and Child Health Unit, DGFP

Conclusion and policy recommendations

Under Bangladesh's 4th Health, Population and Nutrition Sector Program (HPNSP), a wide range of programs have been implemented to address the health-related targets of the SDGs, including efforts to advance SRHR and family planning. Despite significant improvements in a range of health areas, including maternal and child health, critical gaps remain. Due to the scarcity of specific programs and action plans to meet the SRH and family planning needs of people affected by natural disasters, the health and well-being of a large number of Bangladeshis—particularly women who bear the greater burden of disaster—are threatened year after year. As climate change makes flooding and cyclones more unpredictable and monsoons more extreme, fragile disaster preparation efforts and rural health systems will continue to be pushed to their limits, forcing people in Bangladesh to go without family planning and other lifesaving health services they need.

It's time to ensure the most disaster-affected communities in one of the world's most climate-vulnerable countries have reliable access to quality SRHR and family planning services. Operational plans and specific interventions to ensure SRHR and family planning services in emergencies need to be incorporated into the next sector program. To develop preventative and adaptive activities that support the Ministry of Health and Family Welfare's (MOH&FW) strategic goals, strengthen communities and health systems to become resilient to future disaster-induced shocks, and ensure no woman or girl is left behind, the USAID-funded Shukhi Jibon project recommends the following strategies:

Advance gender-responsive and gender-transformative climate action.

Where communities experience a high prevalence of child marriage, have a limited understanding of SRHR, and are dependent on informal channels for SRHR-related information, social awareness, and media campaigns can prove beneficial. Shukhi Jibon recommends involving local volunteers, youth champions, influential local leaders, and services providers of government and nongovernmental agencies in campaigns focused on the adverse effects of child marriage. Furthermore, to reduce baseline levels of gender-based violence (GBV) and the overall prevalence of violence against women, intra-crisis action is needed. Consider creating opportunities to increase women's role in family decision-making, offering ecologically supportive income-generating activities that involve women and girls, and raising awareness about the effects of GBV and solutions for addressing it.

Promote gender-transformative climate action by addressing the linkages between climate change and SRHR. Seize opportunities to strengthen these linkages within the Gender Action Plan under the United Nations Framework Convention on Climate Change (UNFCCC), the Women and Gender Constituency (of the UNFCCC), and through the national adaptation plan (NAP) development process. Set targets for inclusive, gender-balanced, multi-sectoral stakeholder participation in climate policy. As a starting point for addressing SRHR, use gender-responsive climate action:

A gender-responsive approach should integrate gender perspectives at all levels of decision-making to ensure the full and meaningful participation of women and to achieve gender-equitable outcomes. This must involve consulting with women on climate action regardless of their level of education or access to power, and ensuring a just transition to a low-carbon economy that does not perpetuate gender inequality.²⁸

It is essential to include women-focused civil society organizations and people in all their diversity in participatory policy processes.

Enhance integration across programs.

The integration of SRHR and family planning services as an emergency need within central and local disaster management activities may effectively increase SRH and family planning coverage, particularly in disaster-affected areas where the existing health workforce faces challenges to deliver quality services during an emergency. Address issues related to SRHR and family planning service delivery as well as facility readiness in

28 Office of the United Nations High Commissioner for Human Rights, "Analytical study on gender-responsive climate action for the full and effective enjoyment of the rights of women," (Human Rights Council: May 2019).

29 Ministry of Disaster Management and Relief, "Standing Orders on Disaster 2019," Government of the People's Republic of Bangladesh (2019), https://modmr.portal.gov.bd/sites/default/files/files/modmr.portal.gov.bd/policies/7a9f5844_76c0_46f6_9d8a_5e176d2510b9/SOD%202019%20_English_FINAL.pdf

Bangladesh's Standing Orders on Disaster (SOD)²⁸ to better serve people who are displaced or face barriers to access due to disaster. Specifically, it is important to include and specify the role of the Directorate General for Family Planning (DGFP) within the SOD and to include DGFP representation within national and local disaster management committees.

In addition, ensure climate change adaptation and mitigation measures are incorporated into sector-specific plans, such as agriculture, infrastructure development, urban planning, family planning, and other reproductive health services. Promote data and knowledge sharing to track standardized indicators and monitoring systems to facilitate cross-program analysis and evaluation.

Improve emergency preparedness and facility readiness.

Due to the alarmingly low utilization of quality ANC, delivery, PNC, and other SRHR-related care during disasters, make special arrangements to increase reproductive, maternal, newborn, and child health (RMNCH) coverage and service utilization. It is critical to revisit existing policies and develop a strategic action plan—outlining what to do, how to do it, and who will do it—to ensure SRHR and family planning services are delivered during moments of crisis. Furthermore, customized disaster preparedness plans are needed across geographical areas that experience varying types and degrees of disaster. For example, resource allocation for flood-prone areas and drought-prone areas should be different.

Recognizing that transportation and geographic access have emerged as key barriers to service delivery and use during disasters, invest in emergency preparedness and multi-option response systems to ensure continuous access to essential services. For example, consider the delivery of SRHR and family planning services at home, through telemedicine, by boat, and by involving trained birth attendants based in communities. Consider disaster-affected populations' increased dependency on pharmacies and alternative care providers. Involving and building the capacity of drug sellers at pharmacies may improve the quality and use of health services, including family planning, especially in disaster-prone areas.

Strong investments are also needed to ensure adequate supply of logistics—including SRHR-related products, such as contraceptives and sanitary napkins—for advanced distribution. High-impact community distribution practices, such as the advanced distribution of misoprostol for the prevention of postpartum hemorrhage and the advanced distribution of chlorhexidine for neonatal cord care, as well as the distribution of contraceptives, may also be valuable when a climate event is forecasted.

Hazard-specific health facility assessments should be conducted to identify and improve health facilities' readiness, with allocation of budget to address areas for improvement in a coordinated manner.

It is important to recognize that providers also fall victim to disasters. Prepare and plan for the mobilization of human resources from neighboring areas.

Enhance providers' skills.

Provide in-service training for health care providers and volunteers on climate change and its health effects, develop a comprehensive work plan for providers with a focus on the delivery of SRHR services during disasters, and build dedicated networks of health workers, including family planning providers, local volunteers, youth champions, and local leaders for coordination before, during, and after disasters.

Generate evidence to close gaps.

Investments in resilient health systems—with a focus on SRHR—provide opportunities to address persistent barriers to the realization of the right to health while addressing underlying causes of vulnerability to climate change.

Invest in research to address evidence gaps and integrate the analysis of SRHR and climate data. Greater investment in research, with an intersectional lens, on the social and gender dimensions of climate change and action is needed, so the evidence base and argument can be strengthened and incorporated in global policies, plans, and programs. Climate-related sex-disaggregated data need to be systematically collected and analyzed.

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**“Integration of family planning into
disaster management programs will be
very beneficial for both service providers
and receivers.”**

—Upazila Program Officer, Gaibandha



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