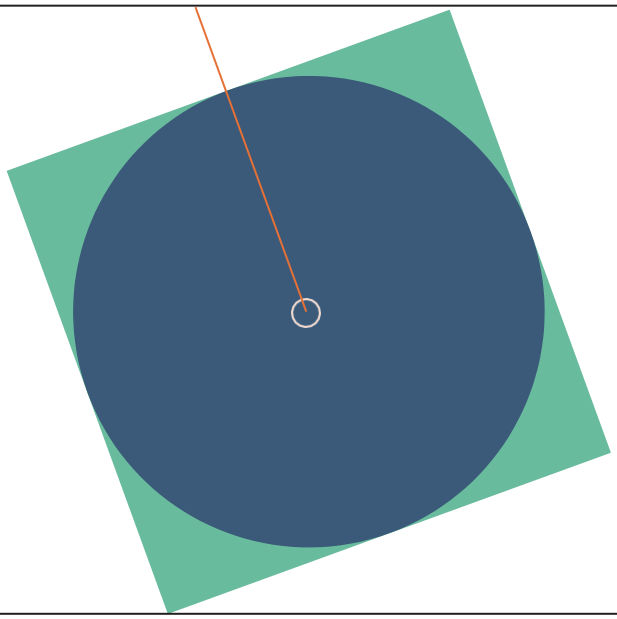
Policy Brief December 2020

The status of postpartum family planning in Bangladesh: A situation analysis and way forward



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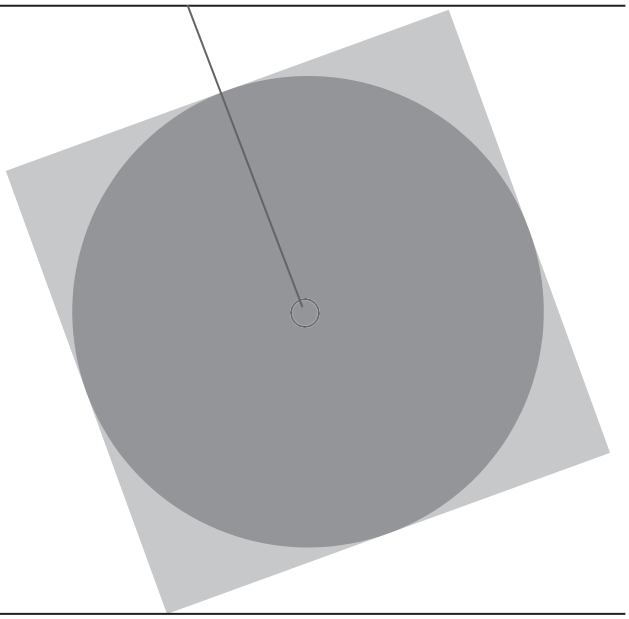

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Contents

Background

The aim of postpartum family planning (PPFP) is to prevent unintended pregnancies and closely spaced pregnancies through the first 12 months following childbirth (World Health Organization [WHO], 2012). An effective PPFP component in family planning (FP) programs helps to improve infant and child health and some maternal health outcomes through the reduction in short birth intervals. According to the 2017-2018 Bangladesh Demographic and Health Survey (BDHS), 11 percent of second and higher order births were born after an interval of less than 24 months; these births are at higher risk of infant death (National Institute of Population Research and Training [NIPORT] and ICF, 2020).

Most women in Bangladesh use short-acting methods of contraception such as pills, condoms, and injectables for birth spacing and limiting. Among all currently married women ages 15-49, 62 percent were currently using a contraceptive method according to the 2017-2018 BDHS and 43 percent were using a short-acting modern method. While these methods are generally appropriate in the postpartum period, the PPFP program in Bangladesh is by and large focused on providing postpartum IUDs, implants, and tubectomies during facility delivery. These methods have lower discontinuation and failure rates than the widely used short-acting methods, but only 9 percent of married women ages 15-49 reported currently using these methods in 2017-2018. This suggests that the PPFP program has not been successful in providing these methods to women who want them at the time of delivery. Widespread voluntary uptake of postpartum IUD, implant, and tubectomy would shift the contraceptive method-mix from less effective to more effective methods, which would contribute to longer birth intervals and reductions in menstrual regulation, abortions, and unintended births.

The PPFP program in Bangladesh began in 2002. Initially it was focused on providing postpartum tubectomy but had little success in increasing the use of this method. More recently, provision of IUDs (since 2008) and implants (since 2016) at delivery have been included in the PPFP program. Although various pilot trainings and other intervention projects have been implemented in the public, nongovernmental organization (NGO), and private sectors since 2008, implementation of the PPFP program has generally been weak and spread thinly. One challenge for the PPFP program has been low levels of facility deliveries in Bangladesh; only 9 percent of births occurred in a health facility in 2001, and this had only increased to 23 percent by 2010 (NIPORT, et al., 2012). However, the percentage of births delivered in a health facility has increased substantially in the last few years, with 50 percent of deliveries now taking place in a health facility (NIPORT, et al., 2019), providing a window of opportunity to deliver effective voluntary PPFP in conjunction with facility delivery.

Theory of change: Supply, enabling environment, and demand generation model

The following actions are needed for a PPFP-program to take off:

- Generate demand among pregnant women by giving information about PPFP availability
    - Counsel pregnant women during antenatal care (ANC) visits to a) choose an appropriate and effective postpartum FP method based on their spacing and limiting needs and preference, and b) if they choose a method that is available at the time of delivery, to decide before delivery which method to accept.
- Ready facilities to provide PPFP
    - Have required trained providers
    - Have required equipment and supplies
- Boost the enabling environment to enhance availability of postpartum IUD, implant, and tubectomy during facility delivery
    - Engage Directorate General for Health Services (DGHS) facilities in offering PPFP
    - Engage private-sector facilities and providers, primarily OB/GYNs, in offering PPFP

Below, we review documents and data related to these three essential elements for the uptake of PPFP in Bangladesh.

Status

In 2016, a national PPFP action plan was approved by the Government of Bangladesh (GOB). The plan identified several challenges, shown in Table 1.

Table 1. Constraints/challenges to increasing access to PPFP services

Constraints/challenges	Solutions
Demand constraints	
Lack of client awareness of availability of PPFP services	Demand-generation activities related to PPFP services need to be undertaken at different levels with communities, providers, and field workers.
No or limited information about postpartum family planning during ANC, postnatal care (PNC), and immunization visits	Recently the National Technical Committee (NTC) has given approval to integrate information about PPFP during all ANC, PNC, and immunization visits, and to make short acting methods like pills, condoms, and injectables available from the immunization sites.
Program/facility readiness constraints	
Limited availability of trained service providers	• Have dedicated regional trainers pool and plan for training of all service providers engaged with maternity services • Along with EngenderHealth, Directorate General of Family Planning (DGFP) has also begun provider trainings to quickly increase the number of PPFP service providers
Availability of Kelly's forceps for postpartum IUD placement	This equipment needs to be added to the IUD essential equipment list.
Enabling environment constraints	
Provider bias toward Postpartum IUD	Advocacy and training to address provider misconceptions and biases.

Generate demand among pregnant women by giving information about PPFP availability

As mentioned above, the demand for Long-Acting Reversible Contraception (LARC) and permanent methods (PM) of contraception is low in Bangladesh. Generally, FP demand generation activities are poorly implemented, and the situation is deteriorating over time. Consider two indicators—Women–FP worker contact and women's exposure to FP messages—as examples. Women–FP worker contact, measured by percentage of women visited by FP workers in the last six months, declined from about 40 percent in 1994 to about 20 percent in 2017. Similarly, women's exposure to FP messages, measured by the percentage of women who heard, saw, or read a FP message in TV, radio, or newspaper in the past month, declined from about 50 percent in 1994 to 26 percent in 2017 (NIPORT and ICF, 2020).

The most effective way to promote PPFP is believed to be by providing information about PPFP during ANC. Promoting PPFP during ANC is not practiced in Bangladesh, though the national PPFP action plan recently included this as a key intervention. However, there is evidence that women have some knowledge about the availability of PPFP. In 2015 and 2017, two surveys in 46 districts of Bangladesh (MEASURE Evaluation 2016, 2018; Rahman, et al., 2019) showed:

- 20% of women knew that an IUD can be inserted during normal or caesarian delivery at a facility;
- 28% of women knew that a tubectomy can be obtained during normal delivery at a facility; and
- 65% of women knew that a tubectomy can be obtained during caesarian delivery at a facility.

Ready facilities to provide PPFP

In 2014, there were 64 district hospitals (DHs), 425 upazila health complexes (UHCs), and 97 maternal and child welfare centers (MCWCs) in Bangladesh that provided delivery services. These facilities are mandated to provide LARC and PM. All 3,914 health and family welfare centers (HFWCs) in the country are mandated to provide IUDs, but a limited number of HFWCs provide delivery services. Data from the 2014 and 2017 Bangladesh Health Facility Surveys (BHFS) show that the above-mentioned facilities have been facing serious challenges in terms of availability of and readiness to provide FP methods (NIPORT, et al., 2016; NIPORT and ICF, 2019). The problems are at two levels: 20 percent of the DHs, UHCs, and MCWCs do not provide IUDs, 22 percent do not provide implants, and 37 percent do not provide tubectomies (Haider, et al. 2019; Rahman, et al. 2020). Among those facilities which provide these services, lack of readiness for effective and high quality provision of such services was common—only 40 percent, 48 percent, and 48 percent were ready to provide IUDs, implants, and tubectomies, respectively (Haider, et al., 2019; Rahman, et al., 2020). The availability of and readiness for providing LARC and PM at NGO and private facilities—widely available in Bangladesh—are also as poor as in the public-sector facilities mentioned above (Haider, et al., 2019).

Lack of trained providers and lack of availability of equipment and supplies are the two important elements that explain most of the availability and readiness problems. To cite an example, MCWCs are supposed to be the main source of facility delivery and thus PPFP, but half of them do not have trained providers for providing implants and tubectomies. This absence of trained providers is due to the high vacancy levels of providers in MCWCs, which has persisted for many years. Lack of equipment and supplies is associated with the fact that there is no systematic and routine requisition system of equipment and supplies considering a reasonable buffer stock of items.

Provide postpartum IUDs, implants, and tubectomies during facility delivery

The success of the PPFP program depends on the extent to which PPFP is offered at delivery. A survey conducted by MEASURE Evaluation[1] shows:

- 14% of women who delivered at facilities were offered IUD[2] or tubectomy (9% with normal delivery and 17% with caesarian delivery)
- 3% of women who delivered at facilities accepted IUD/tubectomy at birth
    - i.e., about 23% of those who were offered accepted a method (6% with normal delivery and 29% with caesarian delivery accepted a method)
- More women with caesarian delivery at public facilities (23%) were offered IUD/tubectomy than at private facilities (17%) but acceptance was greater in private facilities (31%) than public facilities (23%)

These findings indicate that the low uptake of PPFP among women delivering in facilities is at least in part driven by them not being offered the option and that, when offered the option, about a quarter of women accepted it. Women who had caesarian sections were more likely to be offered and to accept a PPFP method.

In Bangladesh, about 1.5 million (15 lac) births are delivered in facilities (one million [10 lac] at private-sector facilities and half a million [5 lac] at public-sector facilities). Based on the acceptance rates above, if all women delivering at facilities were offered a method, there could be approximately 350,000 (23% of 1.5 million) women receiving PPFP annually, most of which would be tubectomies. This number is about 2.4 times the number of permanent methods provided and 46% of the LARC and PM procedures provided by the DGFP in 2017 (Rahman, et al., 2019).

Boost the enabling environment to enhance availability of postpartum IUDs, implants, and tubectomies during facility delivery

The national PPFP action plan (see Table 1, on page 5) has identified (a) limited availability of trained providers, and (b) provider bias challenges/constraints to the promotion of PPFP. The 2017 MEASURE Evaluation Survey (Rahman, et al., 2019) findings support the limited availability of trained providers as it was found that:

- 46% of OB/GYNs and 51% of MO-MCHs received training on LARC and PM in recent years
- 27% of OB/GYNs and 25% of MO-MCHs received training on PPFP in recent years

This situation can be improved with appropriate interventions. There are many more challenges according to the national action plan as well as various studies and documents. Most of the challenges are enabling-environment issues which have not been addressed for many years:

- One-third of facility deliveries take place at facilities that are governed by DGHS (a small proportion take place at MCWCs governed by DGFP). Studies indicate that the DGHS providers do not perceive FP as being their responsibility and therefore are reluctant to promote PPFP.
- Two-thirds of facility deliveries take place in the private sector, and most of the providers are OB/GYNs who have not been engaged in the promotion of PPFP and sometimes are indifferent to providing it.
- Imprest funds for LARC and PM procedures are governed by DGFP, and both DGHS and private providers encounter difficulties in reimbursement of the providers' fees. This has been an issue for some time.

[1] The surveys identified 4,494 births born during April 2014 to June 2017; 46 percent took place in facilities (65% of facility deliveries took place in the private sector); and 28 percent were caesarian (or 61% of facility deliveries were caesarian).
[2] Implant was not included as a PPFP method during the 2015 survey.

Recommendations

Generate demand among pregnant women for PPFP

- Provide information on appropriate PPFP based on clients' birth spacing and limiting needs at ANC visits and support them to make an informed choice of postpartum method. Qualified doctors (OB/GYNs and physicians) provide ANC to 76 percent of women and FWVs and equivalent providers provide ANC to another six percent of women (NIPORT, et al., 2019a). Doctors often have limited time to spend on extended counseling with their clients. This counseling can be done by specially trained counselors at the facility. Since there are no counselors in either the public- or private-sector systems, it will be necessary to institute a position of counselor in the facilities where ANC is provided.
    - Advocate with OB/GYNs and physicians to introduce a counselor position at their facilities and provide PPFP information to ANC-seeking mothers.
    - Encourage other ANC providers (FWVs and equivalent providers) to provide PPFP information during ANC visits.
- Encourage FWAs to increase coverage and provide PPFP information during home visits. FWAs are supposed to counsel pregnant mothers at homes but their coverage is poor.
- Provide behavior change communication (BCC) materials with appropriate PPFP information to every pregnant woman through ANC providers and counselors.
    - Supply PPFP leaflets to the private-sector providers and counselors
    - Supply job aids for counselors and providers in both the public and private sectors.

Ready facilities to provide PPFP

- Resolve the chronic provider vacancy situation to enhance PPFP promotion in particular, and LARC and PM services in general.
- Allocate a budget for the provision of PPFP methods at DGHS facilities to cover imprest funds and equipment and supplies required for PPFP procedures. DGHS should consider PPFP services as their own. Currently, PPFP is considered as a service of DGFP even though most public sector deliveries are provided by DGHS.
- Facilitate the engagement of private sector providers (mainly OB/GYNs) in PPFP promotion efforts. A mechanism of direct reimbursement of provider fees and other supply costs payable to licensed OB/GYNs should be developed and implemented.
- Introduce in the logistic management information system (LMIS) of DGHS and DGFP a routine requisition system of equipment and supplies considering a reasonable buffer stock of items.

Boost the enabling environment to enhance availability of IUDs, implants, and tubectomies during facility delivery

- Effectively execute the instructions of the Director General of DGHS that specify the guidelines and service delivery processes to provide IUD, implant, and tubectomy during delivery at DGHS facilities (DGFP, 2019a).
- Meaningfully engage private-sector health facilities to execute the instructions of the Director General of DGHS that provide guidelines and service delivery processes to provide IUD, implant, and tubectomy during delivery at private-sector facilities (DGFP, 2019b).

Increase knowledge of how to enhance PPFP service delivery

- Undertake implementation research on the promotion of PPFP. Some suggested research topics include:
    - The feasibility of introducing hormonal IUDs, since they have lower side effects than the copper IUDs currently included in the program
    - Approaches to address misconceptions and provider bias on postpartum IUDs; for example, some highly skilled providers argue that providing IUD immediately after birth increases the risk of expulsion, and thus are reluctant to promote it
    - Test approaches to address the imprest fund issues that have been identified
    - Test approaches to effectively engage the private sector in PPFP service delivery
    - Test approaches to provide effective PPFP counseling during ANC

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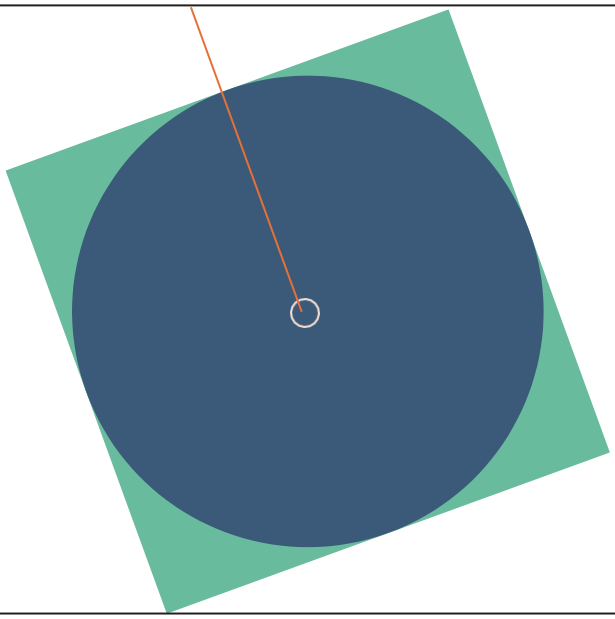

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