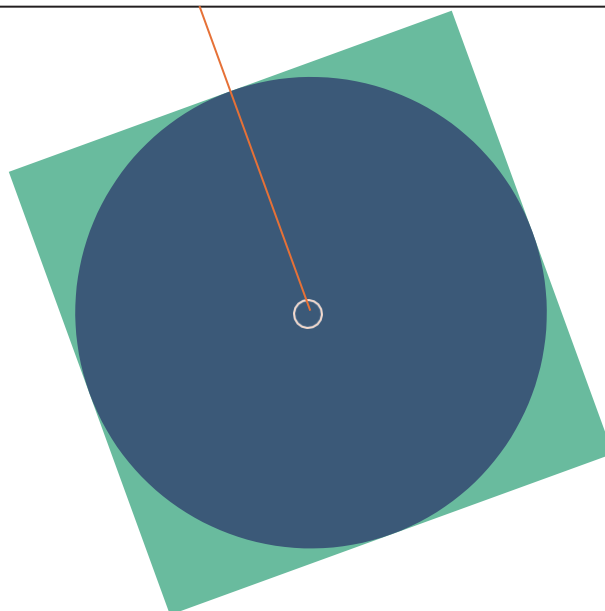


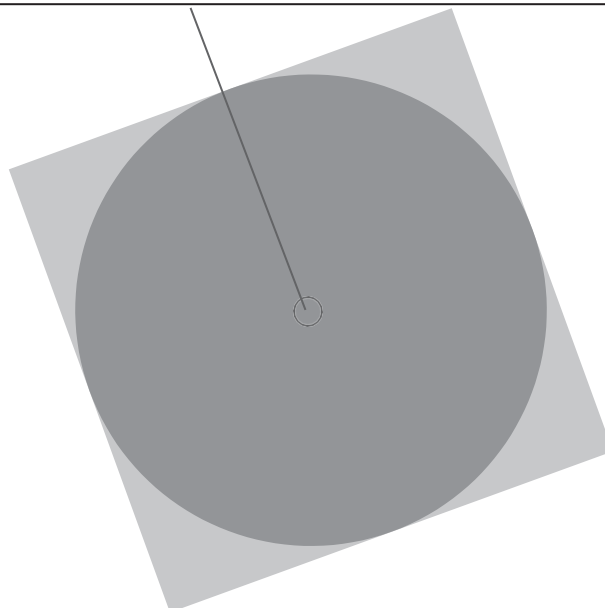
The availability of and readiness for providing long-acting contraceptives and permanent methods in Bangladesh



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Background

In Bangladesh, the contraceptive prevalence rate has plateaued at 62 percent since 2011. In 2017–2018, only nine percent of couples reported using long-acting reversible contraceptives (LARC), which are implants and intrauterine devices (IUDs), or permanent methods (PM), which are tubectomy and non-scalpel vasectomy (NSV). During the same time period, approximately 57 percent of women in the country say they want no more children (NIPORT, et al., 2019).

The nine percent prevalence of LARCs and PMs is low in light of the majority desiring no more children and in comparison to global contraceptive data. Those data show that more than one in three women elsewhere use LARCs and PMs and that these methods account for 56 percent of global contraceptive prevalence (United Nations, Department of Economic and Social Affairs, Population Division [UN DESA], 2015).

One hypothesis for the low usage in Bangladesh is that it may result from a range of supply- and demand-side barriers. In 2014, there were 3,914 community-level health and family welfare centers (UHFWCs) in Bangladesh that are mandated to provide IUDs; and 586 facilities (425 upazila health complexes [UHCs], 97 maternal and child welfare centers [MCWCs], and 64 district hospitals [DHs]) from upazila to district levels that are mandated to provide IUDs, implants, tubectomy, and NSV.

Data for Impact (D4I), an associate award of MEASURE Evaluation Phase IV, and Research for Decision Makers at icddr,b—both of which are programs funded by the United States Agency for International Development ((USAID)—conducted an analysis of data from the 2014 Bangladesh Health Facility Survey (BHFS) to explore supply-side constraints that have likely affected access and use of LARCs and PMs in Bangladesh (Haider et al. 2019).

The analysis of these constraints was done before the 2017 BHFS (NIPORT et al. 2019a) and therefore does not reflect information from that report that shows some increase in the availability of IUDs in facilities compared to the 2014 findings (NIPORT et al 2016). Between the two reports, however, there are no notable changes in the availability at facilities of implants, tubectomy, and vasectomy and only minimal change was observed in the availability of trained staff for family planning (FP) during this time. Thus, the 2014 key findings and recommendations presented here can be taken as representative of the current scenario for LARC and PM uptake.

Findings

The availability of LARC and PM

Table 1 shows the percentage of facilities that reported in the 2014 BHFS that they provide these methods—63 percent provide IUDs, 39 percent provide implants, and 28 percent provide tubectomies and NSVs. Fewer than 40 percent of DHs provide implant, tubectomy, or NSV and just over 50 percent of MCWCs provide tubectomy or NSV. The availability of LARC and PM is relatively higher in UHCs than in DHs and MCWCs. The availability of LARC and PM is substantially lower in facilities run by nongovernmental organizations (NGOs) than in public-sector facilities, except for IUDs. A minor proportion (fewer than 10%) of private-sector facilities provide LARC or PM.

Table 1: Percentages of facilities reporting to provide LARC or PM services, BHFS 2014

Type of facilities	IUD	Implant	NSV	Tubectomy
All types	63	39	28	28
Public-sector facilities	69	78	62	63
<i>District hospital</i>	47	39	29	34
<i>UHC</i>	85	84	69	69
<i>MCWC</i>	84	80	53	55
<i>UHFWC</i>	67	-	-	-
NGO facilities	62	29	18	17
Private-sector facilities	8	7	6	5

Based on the 2014 BHFS data, we show in Table 2 the estimated numbers of UHFWCs, UHCs, MCWCs, and DHs that provide LARC and PM. Of the 3,914 UHFWCs, 1,299 do not provide IUDs. Among the 586 UHCs, MCWCs, and DHs, 127 do not provide implants, 216 do not provide tubectomies, and 224 do not provide NSV.

Table 2. Number of public-sector facilities, by type, and by method availability and readiness

Facility type	#No. of facilities	IUD			Implant			Tubectomy			NSV		
		Do not provide	Provide but not ready	Provide and ready	Do not provide	Provide but not ready	Provide and ready	Do not provide	Provide but not ready	Provide and ready	Do not provide	Provide but not ready	Provide and ready
DH	64	34	20	10	39	14	10	42	4	18	45	7	12
UHC	425	66	177	182	69	145	211	131	39	255	134	80	211
MCWC	97	16	43	38	19	18	60	43	8	45	45	13	39
UHFWC	3,914	1,299	2,931	184	--	--	--	--	--	--	--	--	--
All facilities	4,500	1,415	3,171	414	127	177	281	216	51	318	224	100	262
Percent within method		28%	63%	8%	22%	30%	38%	37%	9%	54%	38%	17%	45%

Note: A total of 586 facilities (64 DHs, 425 UHCs, and 97 MCWCs) are mandated to provide all four LARC and PM methods. "--" means the field is "not applicable" to that facility

With a closer inspection of the 2014 BHFS data and a discussion with personnel of the Directorate General of Family Planning (DGFP), we found that a common reason that facilities do not offer LARC or PM is that often providers are not available. Provider vacancy is a long-standing issue, as is adequate training for providers.

Readiness to provide LARC and PM

Table 3 shows the percentage of facilities that were ready to provide these contraceptive methods. A facility reported to provide LARC or PM is classified as fully ready if, on the day of the survey, it had all four readiness components—(1) a trained provider, (2) guidelines, (3) equipment and supplies, and (4) post-procedure medicines available. Only 14 percent of public-sector facilities were found fully ready to provide IUD or tubectomy, 39 percent and 28 percent were found ready to provide implant and NSV, respectively. Readiness varies among facility types. UHCs are more ready to provide IUDs than are other types. DHs are more ready to provide implant, tubectomy, and NSV than are others. MCWCs fare worse than either UHCs or DHs in terms of readiness and UHFWC readiness for IUDs is very poor (only 7%).

Full readiness for providing IUDs is comparatively better in NGO and private-sector facilities than in public-sector facilities but these facilities are less ready to provide implant, tubectomy, and NSV. NGO facilities are marginally more ready than UHCs and MCWCs to provide tubectomy.

Table 3: Percentages of facilities that are fully ready to provide LARC or PM

Type of facilities	IUD	Implant	NSV	Tubectomy
Public-sector facilities	14	39	28	14
<i>District hospital</i>	35	58	39	19
<i>UHC</i>	51	41	28	13
<i>MCWC</i>	47	23	24	16
<i>UHFWC</i>	7	-	-	-
NGO facilities	40	26	13	18
Private-sector facilities	40	17	21	0

Source: 2014 BHFS

Readiness by components

Table 4 shows the percentage of facilities by the four readiness components mentioned above. The last column in this table shows the percentage of facilities deemed fully ready. Note that the percentage of full readiness is substantially smaller than readiness for any single component. For example, only 14 percent of public facilities are fully ready to provide IUDs, but 76 percent have a trained provider, 67 percent have guidelines, 21 percent have equipment and supplies, and 93 percent have post-procedure medicines. The only facilities included in this accounting are those that reported they provide LARC or PM. Because of the scarcity of private-sector facilities in the sample, their results are not shown.

Looking at the four readiness components, it can be seen that post-procedure medicines are almost universally available among all types of facilities (i.e., almost 100%) regardless of type of facility and method. The next most available component of readiness is that there is a trained provider present and guidelines are in place. Among public facilities, 71 percent of UHFWCs had trained providers who provide IUDs. Between 87 percent and 100 percent of UHCs and DHs have trained providers for all LARC and PM methods. But only about half of MCWCs have trained providers for LARC and PM. Looking only at the availability of guidelines, 64 percent of UHFWCs, 76 percent of UHCs, and 94 percent of DHs have guidelines.

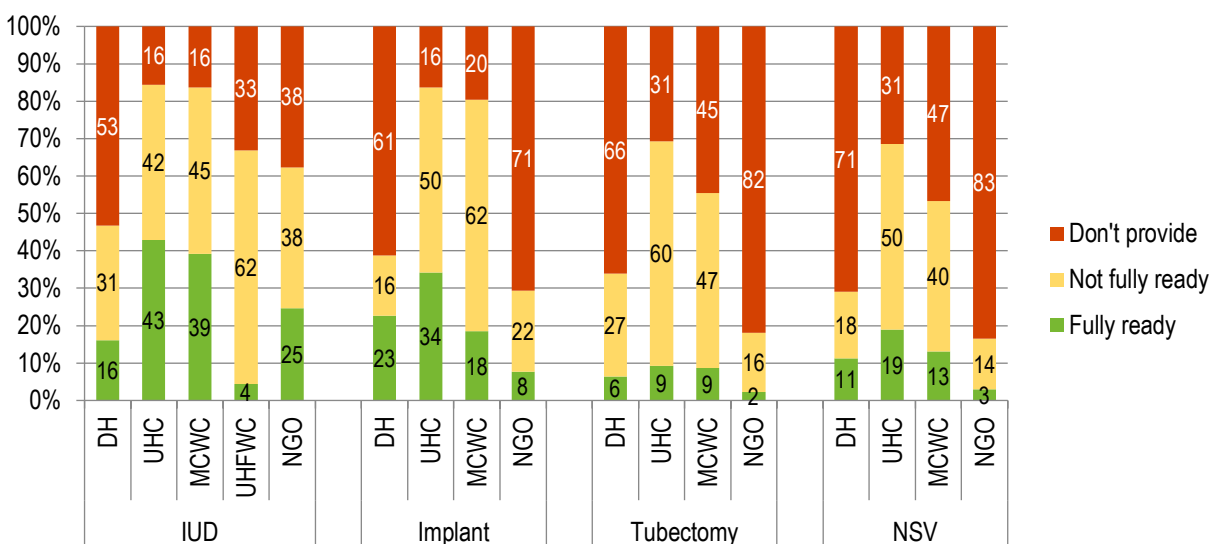
Equipment and supplies are the weakest component among all facilities and for all methods. Slightly over one in ten UHFWCs (12%) have the necessary equipment and supplies. Between 45 percent and 64 percent of DHs, MCWCs, and UHCs have the necessary equipment and supplies for providing IUDs; 53 percent to 63 percent of these facilities have equipment and supplies for implants; 18 percent to 29 percent have equipment and supplies for tubectomy; and 36 percent to 49 percent are equipped for NSV. NGO facilities score consistently better on full readiness than do public facilities for IUDs. However, they score comparably for other methods.

Table 4. Percent of facilities providing LARC and PM that have the necessary components for provision

Type of facility	Trained provider	Guidelines	Equipment & supplies	Post-procedure medicines	% Ready = having all 4 components
IUD					
All public facilities	76	67	21	93	14
<i>District Hospital</i>	100	86	45	100	34
<i>UHC</i>	99	76	64	100	51
<i>MCWC</i>	92	78	62	100	47
<i>UHFWC</i>	71	64	12	92	7
NGO facilities	92	87	61	93	40
Implant					
All public facilities	83	79	57	100	39
<i>District Hospital</i>	100	92	63	100	58
<i>UHC</i>	89	78	57	100	41
<i>MCWC</i>	49	78	53	100	23
NGO facilities	63	83	46	92	26
Tubectomy					
All public facilities	84	81	20	98	14
<i>District Hospital</i>	100	90	24	100	19
<i>UHC</i>	89	80	18	98	13
<i>MCWC</i>	51	84	29	94	16
NGO facilities	57	81	44	87	18
NSV					
All public facilities	82	81	38	97	28
<i>District Hospital</i>	100	94	44	100	39
<i>UHC</i>	87	80	36	97	28
<i>MCWC</i>	49	82	49	96	24
NGO facilities	48	70	39	97	13

Figure 1 shows the status of public- and NGO-sector facilities for those that do not provide LARC or PM [shown in red], those that provide LARC or PM but are not fully ready [shown in yellow], and those that provide the methods and are fully ready [shown in green]. The fact that the proportion of green is small, means that readiness is poor. Likewise, the large amount of red illustrates that the proportion of facilities that do not provide LARC and PM is widespread.

Figure 1. Percentage of facilities by status of provision and readiness to provide LARC and PM



Discussion

Health and FP policy planners and managers may find it helpful to consult our classification of health facilities providing LARC and PM. We describe three groups: those who do not provide those services, those who do provide the services but can't be deemed fully ready, and those who provide the services and are considered fully ready. A sizeable proportion of the large health infrastructure in Bangladesh are not providing these services that ought to be delivered. Of the 3,914 UHFWCs, 1,299 do not provide IUDs; of the 586 UHCs, MCWCs, and DHs, 127 do not provide implants, 216 do not provide tubectomy, and 224 do not provide NSV.

This problem stems in part from the unavailability of providers, which is a serious health systems issue that has not been dealt with for decades. The lack of trained medical staff to provide the services is a major challenge to readiness, particularly in MCWC, and three of the LARC and PM methods require a medically trained provider. Ensuring regular training schedules and increasing the availability of trained doctors to staff MCWCs, would likely go a long way to increasing readiness for LARC and PM. An in-service training refresher on clinical aspects of these methods every 24 months is recommended (World Health Organization, 2013).

Lack of readiness to provide LARC and PM is common across facility types in public, NGO, and private sectors. A second factor for this lack is the unavailability of equipment and supplies, which is an issue for all LARC and PM methods across all tiers of facilities, but is particularly acute in the lowest tiers. Given the considerable work in Bangladesh to develop a logistics management information system (LMIS) for FP, this result is somewhat surprising. However, the current FP LMIS is geared toward provision of short-acting FP methods, and decision makers may simply not have appropriate information to take action on securing equipment and supplies for LARC or PM. Developing new strategies to ensure the availability of these FP commodities could significantly mitigate the supply-side barriers to LARC and PM and thus possibly increase their uptake in Bangladesh.

We found that many NGO facilities do not provide LARC and PM and our analysis shows that fewer than 10 percent of private-sector facilities offer these services. This means there are thousands of NGO and private-sector facilities across the country that could be providers. These findings show a tremendous and untapped potential to increase the network of facilities providing LARC and PM.

Because most private-sector facilities offer delivery and most offer caesarian section, the government could engage these facilities to provide LARC and PM. In fact, in 2019, both the Directorate General of Health Services (DGHS) and DGFP circulated a memo on the provision of postpartum family planning through DGHS and private facilities—including proposed processes to implement—but it gained no traction. Roughly half a million deliveries take place in DGHS facilities and one million in private facilities annually. Thus, 1.5 million mothers are potential clients for postpartum LARC and PM.

Recommendations

Our overarching recommendations on the status of LARC and PM provision and use in Bangladesh focus on actions to improve demand for and use of these methods followed by a table of recommendations for facilities on providing LARC and PM.

The government agencies concerned could take several actions to increase demand, such as:

- DGFP should enhance its FP communication activities to provide information on the availability of LARC and PM. Currently, there is hardly any dissemination on LARC and PM directed at potential clients.
- DGHS facilities should offer IUDs, implants, and tubectomy to women who give birth in their facilities. About half a million deliveries take place annually in DGHS settings.
- The government should facilitate the offering of IUDs, implants, and tubectomy in private-sector facilities. About a million deliveries take place in private-sector facilities annually.
- Pregnant women should be informed about the possibility of accepting postpartum IUDs, implants, and tubectomy during their ANC visits. Currently, no counseling activities about postpartum family planning exist in places where ANC services are given.

Further, actions at various facility levels are suggested in Table 5, on the next page.

Table 5. Evidence-based recommendations for facilities

Evidence	Recommendations
<p>The availability of LARC and PM was poor in public-sector facilities that are mandated to provide these methods</p> <ul style="list-style-type: none"> • Among the DHs, UHCs, and MCWCs that were designated to provide all LARCs and PMs, 22%, 37%, and 38% do not provide implants, tubectomy, and NSV, respectively. Among all types of facilities, including UHFWCs that were designated to offer IUDs, 28% did not provide them. • A common reason for not offering LARC or PM service is the unavailability of trained staff. 	<ul style="list-style-type: none"> ➔ Ensure that each public-sector facility mandated to provide LARC and PM do, indeed, offer it. ➔ Ensure trained staff for providing LARC and PM are available so that the services can be offered.
<p>The availability of LARC and PM was very poor in NGO and private-sector facilities.</p> <ul style="list-style-type: none"> • Among NGO facilities, more than 80% do not provide PMs and about 40% do not provide IUDs. • More than 90% of private-sector facilities do not provide LARC or PM. 	<ul style="list-style-type: none"> ➔ The government should engage both NGO and private-sector facilities to expand their services to include LARCs and PMs. There are large numbers of private-sector facilities that provide maternal services and could provide LARC and PM. ➔ The government should develop mechanisms to help these facilities get training, supplies, and funding required for LARC and PM.
<p>Poor availability of trained staff in facilities</p> <ul style="list-style-type: none"> • Half of MCWCs do not have trained staff for implant, tubectomy, and NSV. • One-half to two-thirds of NGO facilities do not have trained staff for implant, tubectomy, and NSV. • The proportion of providers receiving training in last 24 months is low, at 39% (NIPORT et al. 2019). 	<ul style="list-style-type: none"> ➔ Establish a routine annual hiring system based on the projection of staff need. ➔ Implement LARC and PM training in public-sector facilities so that relevant providers are trained every 24 months. ➔ The government should assist NGOs and private-sector agencies to obtain similar training.
<p>Availability of required equipment and supplies for providing LARC and PM was consistently low in public facilities.</p> <ul style="list-style-type: none"> • Only 14% of facilities are ready to provide IUDs or NSV, 39% and 28% are ready to provide implant and tubectomy, respectively. • Facility requisition of supplies is ad-hoc, with no systematic analysis of past use and future needs. 	<ul style="list-style-type: none"> ➔ Introduce a requisition system on a fixed day every two months, which should be based on past use and future requirements. ➔ Implement regular monitoring of stock status for LARC and PM equipment and supplies at frontline facilities, such as MCWC and UHFWC. ➔ Increase accountability of officials in charge of government health facilities.
<p>The readiness of the NGO and private-sector facilities was poor though slightly better than those in the public sector. NGO and private facilities also faced similar challenges in the availability of trained staff, equipment, and supplies.</p>	<ul style="list-style-type: none"> ➔ NGOs and private-sector facilities should develop requisition and procurement systems similar to public facilities. The government should help develop these systems. ➔ Monitor NGO clinics for availability of equipment and supplies for LARC & PM.

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