March 2024

Policy Brief

Family Planning Needs across the Life Cycle in Bangladesh: System Considerations for the DGFP and DGHS

A recent technical brief synthesized evidence from a series of analyses conducted by Data for Impact (D4I) of family planning (FP) behaviors across the life course to provide evidence-based recommendations for FP policies in Bangladesh (Rahman et al. 2023a). That brief introduced the "Life Cycle Approach to Family Planning," which is a person-centered approach that addresses different FP needs at each stage of the reproductive life cycle. Different points in the life cycle offer different opportunities to reach individuals with specific and tailored interventions. In this brief, we elaborate on some system considerations for the Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS) to implement this approach.

Background

According to the Bangladesh Demographic and Health Surveys (BDHS), both the total fertility rate and the mean ideal family size have remained at around 2.3 births per woman since 2011 (D4I, 2022). The percentage of women ages 15–49 with two children who want no more children has declined from 82% in 2011 to 68% in 2022, suggesting a preference for larger families in the most recent survey (NIPORT & ICF, 2023). The contraceptive prevalence rate likewise stalled at 62% from 2011, although it increased slightly to 64% in 2022 (Data for Impact, 2022; NIPORT & ICF, 2023).

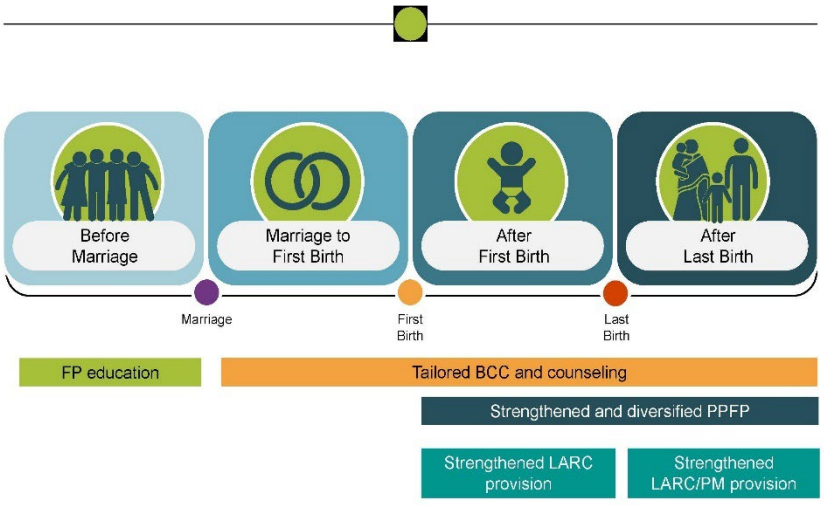
Nevertheless, unintended pregnancies still occur in Bangladesh. As of 2017 and 2022, married women:

- Had an unmet need for FP—12% in BDHS 2017/18 and 10% in BDHS 2022.
- Had mistimed births in the last three years—13% in BDHS 2017/18.
- Experienced unwanted births in the last three years— 26% in BDHS 2017/18 (NIPORT & ICF, 2020).

A Life Cycle Approach to FP

Figure 1, taken from Rahman et al. 2023a, summarizes the specific programmatic activities that can be implemented to operationalize the life cycle approach across the four stages of an individual's reproductive life. Education with tailored information on FP through a variety of information channels is recommended for the first stage, before marriage. Recommendations for the stage of marriage to first birth include tailored behavior change communication to young couples on the benefits of waiting to have their first child and offering a range of spacing methods to newly married couples who want to delay the first birth. An additional

Figure 1. Life cycle approach to FP service delivery



recommendation for this life cycle stage is to increase economic opportunities for young married women (Rahman et al., 2023a). Strengthening and diversifying postpartum family planning (PPFP) services is essential for the life cycle stages after the first birth as well as after last birth. Through these efforts, strengthened provision of long-acting reversible contraceptives and permanent methods (LARCs/PMs) can have synergistic effects by enabling individuals to switch from less effective short-acting methods to more effective long-acting contraceptive methods, particularly in the life cycle stage after the last desired birth, if they wish to do so.

Implementing a Life Cycle Approach: System Considerations for the DGFP and DGHS

Strengthening and Diversifying PPFP Services

Cleland et al. (2015) reviewed 35 studies (with about half of the studies being from low- and middle-income countries) that evaluated the effect of postpartum interventions on FP use. They found that carefully designed PPFP interventions of different types can improve use of FP methods. Immediate PPFP is considered to be a proven high impact practice (HIP) in FP (HIPS, 2022). There is strong evidence that offering counseling and services as part of facility-based childbirth care prior to discharge from the health facility helps increase immediate PPFP use (HIPs, 2022). Women can be counseled on PPFP during antenatal care (ANC), with possibly multiple counseling sessions taking place during multiple ANC visits and around the time of childbirth at a facility. This will allow them to make an informed decision about an appropriate method for them, involve family members in choosing a method, and to plan to adopt their chosen method after delivery, including planning for immediate PPFP in the facility where childbirth takes place if they choose an immediate PPFP method such as a postpartum intrauterine device. A recently completed implementation research study in Bangladesh shows promising results of increased PPFP use associated with counseling around childbirth at five facilities (two mother and child welfare centers, two upazila health complexes (UHCs), and one private hospital)—before delivery, before and after delivery but before discharge, or after delivery but before discharge (Rahman et al., 2023b). Preliminary findings from an ongoing intervention of ANC counseling on PPFP and offering LARC/PM during delivery at two private hospitals in Natore District, Bangladesh, shows that adoption of LARC/PM before discharge was significantly higher than in two comparison private hospitals (Uddin et al., 2023).

The current high rate of ANC and facility delivery in Bangladesh provides good opportunities to strengthen PPFP services. However, among the public-sector ANC and delivery services, the contribution of DGHS facilities is much larger than the DGFP facilities, and therefore, the scope of the DGFP in PPFP method provision is quite limited. Many deliveries also take place in the private sector (NIPORT & ICF, 2023). Therefore, it is very important that the DGHS and private-sector facilities be strongly engaged in delivering PPFP services, especially postpartum LARC and PM. There has been a missed opportunity with not effectively engaging the DGHS and private-sector facilities in providing postpartum LARC and PM services in Bangladesh.

Two government orders (GOs), also known as circulars, were put in place in early 2019; key directives from these GOs are summarized in Table 1. The first GO directed the DGHS to provide PPFP services at DGHS facilities (medical college hospitals, specialized hospitals, district hospitals, UHCs, and union-level facilities) and ensure that essential human resources, effective logistics systems, supplies, and appropriate financial management systems were in place. The GO specified that LARCs and PMs should be provided by registered and trained providers, that medical eligibility criteria for the provision of PMs should be followed, and that intrauterine devices (IUDs) and other short-acting methods should be delivered by trained nurses/midwives (DGFP, 2019a). The second GO called for the

provision of PPFP services (short-term methods and LARCs/PMs) by trained providers at participating private sector facilities under a memorandum of understanding (MOU) signed among the DGHS, DGFP, and private facility owners' association, with funds and supplies provided by the DGFP (DGFP, 2019b). Inadequacies in facility readiness for providing LARCs and PMs is a concern (Haider et al., 2019; Dana et al., 2023), but adherence to the instructions given by the GOs will help lessen readiness inadequacies.

Implementation Status of the GOs

The GOs address the most essential inputs required to effectively initiate PPFP services at public and private sector facilities. Although the GOs have been in place for more than four years, implementation processes have not been developed and serious gaps remain. There are no DGFP and DGHS documents on the initiation of the GOs' directives, and there are no monitoring mechanisms to track what has and has not been done to implement the GOs. A recent discussion with a DGFP Clinical Contraception Services Delivery Program (CCSDP) official revealed that only a few sporadic activities at some medical college hospitals have been carried out. Similarly, during a recent PPFP implementation research study, conversations with five managers of UHCs and owners of private-sector clinics across the country regarding the PPFP GOs found that none of them were aware of the GOs (Rahman et al., 2023b). This anecdotal evidence provides an indication of the lack of implementation of the directives of the GOs. The same implementation research study found low levels of PPFP activities in DGFP, DGHS, and private facilities (Rahman et al., 2023b). Some of these facilities were covered by technical assistance inputs from a system strengthening project, yet PPFP promotional activities or offering methods at delivery is uncommon in these facilities despite the existing GOs with clear directives on the provision of LARC and PM.

Table 1. Directives provided in the GOs on PPFP, the DGFP, and the DGHS, 2019

GO on PPFP service provision at DGHS facilities (March 2019)	GO on PPFP service provision at private sector facilities (March 2019)

• Provide PPFP services from DGHS facilities (medical college hospitals, specialized hospitals, district hospitals, UHCs, and union-level facilities).
• Identify a unique person in each facility who will do logistics management.
• DGFP district/Upazila store/office will provide logistics and supplies routinely.
  ◦ Ensure required supplies in labor room or/and OT room.
  ◦ Directly purchase required supplies using imprest fund*.
• In each participating facility, manage a separate bank account on PPFP-service related imprest fund and its expenses.
• Follow the GO (dated 1-24-2019) on financial and accounting procedures.
• LARC and PM should be provided by registered and trained providers.
• IUD and other short-acting methods should be provided by trained nurses/midwives.
	• PPFP services be provided from private sector facilities.
	• A tripartite MOU be signed (DGHS, DGFP, and private facility owners' association). Upazila FP office will provide required imprest fund and logistics and supplies to the facilities that express their interest.
	• Funds and supplies will be provided under Upazila Inventory Management System of the DGFP.
	• FP service providers of participating facilities must be trained on method provision.
	• Medical Officer - Maternal and Child Health (MO-MCH) or Upazila FP officer (UFPO) and their staff will train/orient focal point and FP service providers and will provide direct support to implement the PPFP activities.
	• Identify a logistics management focal point (nurse/midwife) at each participating facility.

GO on PPFP service provision at DGHS facilities (March 2019)	GO on PPFP service provision at private sector facilities (March 2019)
• Follow the medical eligibility criteria for PM provision.	• PPFP service provision be supervised by Head OB/GYN or senior consultant or equivalent personnel of the facility. • LARC and PM should be provided by registered and trained providers. • IUD and other short-acting methods should be provided by trained nurses/midwives. • Medical eligibility criteria be followed. • Any unintended issue (if it arises) will be jointly resolved by (a) Civil Surgeon, (b) DDFP, and (c) representative of owners' association in consultation with local MO-MCH and UFPO

* a cash account that is used to pay for small, routine expenses.

Diversifying LARC/PM Service Provision

Currently, only DGFP providers and facilities provide LARC and PM services. According to the GO mentioned above, the DGHS and private facilities are also supposed to provide these services, but the products, supplies, and financial resources should be channeled through local-level DGFP officials. This is a system barrier to providing these methods. Reforming regulatory mechanisms for LARCs and PMs to allow DGHS facilities to have their own resources channeled through their service delivery system could help expand the accessibility of LARCs and PMs at DGHS facilities. For the private-sector facilities, following provisions in the GO should enable them to deliver postpartum LARC/PM services. However, as mentioned above, currently PPFP services are uncommon in DGHS and private facilities.

Mainstreaming LARC and PM training is another way to expand access to these FP services. Currently, medical school students take one or two theoretical classes on FP methods (CCSDP, 2021). It is not required for medical school graduation that they undergo a practice session on LARCs and PMs under the supervision of a practicing provider. There are no practice sessions on the provision of IUD, implant, tubal ligation, or scalpel vasectomy for medical school graduates, and therefore, they cannot provide these services without having on-the-job special training on these methods. Only DGFP providers, once employed, receive training on these methods. As of now, IUDs are provided by family welfare visitors, and it is not a popular method as indicated by low level of acceptance and high level of discontinuation (NIPORT & ICF, 2020). Diversifying the providers able to provide IUDs to include doctors and medical officers would increase access to postpartum IUDs and potentially increase use and decrease discontinuation of this method.

Recommendations

The following recommendations will help enhance the accessibility to PPFP services, especially LARCs and PMs, through engaging the DGHS and private-sector facilities and providers.

- Provide technical assistance to DGHS and private-sector facilities to implement the directives given in the GOs facility by facility.
  - Include all DGHS facility levels where childbirth services are provided from Upazila to higher levels to implement the PPFP GO directions.
  - Sign the tripartite MOU as directed in the GO and select credible private-sector facilities to provide LARC and PM services. Include a selected number of private-sector facilities across all Upazilas in the country to implement the PPFP GO directions.
- Reform regulatory mechanisms for LARCs/PMs to create a health system environment that allows users to choose a provider/facility from the DGFP, DGHS, or private sector. Make LARCs/PMs available in DGHS and selected private-sector facilities, independent of DGFP involvement.
- Introduce practical training sessions on LARCs and PMs for medical school graduates during their practical training period, i.e., internship period; providing the option for graduates to take these sessions will allow them to provide these methods to their clients in facility-based public or private practice.
- Introduce IUD training for medical graduates and allow them to practice IUD insertion to enhance IUD use.

Conclusion

Bangladesh has entered a state of high use of facilities for delivery care, which provides the opportunity to implement the high-impact practice of immediate PPFP and increase access to LARCs/PMs. A shift from the existing high use of less effective short-acting methods to more effective LARCs/PMs would result in reduced unintended pregnancy. There are important government orders on PPFP service delivery, but the directives given in the orders are not being implemented. We provide some recommendations to enhance access to PPFP and LARCs/PMs to increase individuals' options to meet their spacing and limiting needs across their reproductive life cycle.

Suggested Citation

Rahman, M., Haider, M.M., Rahman, M.M., Khan, S., & Curtis, S. (2023). Policy Brief: Family planning needs across the life cycle in Bangladesh: System Considerations for the DGFP and DGHS. Chapel Hill, NC, USA: Data for Impact.

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the Data for Impact (D4I) associate award 7200AA18LA00008, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Palladium International, LLC; ICF Macro, Inc.; John Snow, Inc.; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government. FS-24-657.