BANGLADESH

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Government of Bangladesh's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Government of Bangladesh's national family planning (FP) and reproductive health (RH) policy is outlined in a number of documents, including the National Communication Strategy for Family Planning and Reproductive Health (2008); the National Adolescent and Reproductive Health Strategy (2006); the Costed Implementation Plan for the National Family Planning Programme (2016–2020); and the Health, Population, and Nutrition Sector Development Program 2011–2016. The latter document's main strategies aim to expand access to and quality of maternal, neonatal, and child health services; strengthen FP interventions to attain replacement-level fertility; strengthen support systems; and increase the health workforce at all levels.

The government revises the country's national plan, which includes postabortion care (PAC), every three to five years. The plan aims to improve the quality and promotion of maternal health services and to strengthen emergency maternal and obstetric care services. The Ministry of Health and Family Welfare (MOHFW) is the governing body responsible for RH/FP programs in the country

Legal Status of Abortion

Bangladesh's Penal Code (1860) establishes that abortion is illegal except when performed to save a woman's life. Despite this legal restriction, the country authorizes a procedure called menstrual regulation. Menstrual regulation refers to the use of manual vacuum aspiration 8 to 10 weeks after a missed period.

PAC TRAINING AND STANDARDS

The FP branch of the MOHFW, with technical assistance from EngenderHealth, developed Bangladesh's clinical PAC standards. These clinical guidelines provide information on uterine evacuation methods, the provision of FP counseling and voluntary contraceptive services (including emergency contraception), infection prevention, and preparedness for PAC complications.

Currently, seven cadres of mid-level healthcare workers provide FP and RH services in Bangladesh. Of these cadres, nurses, sub-assistant community medical officers, nurse-midwives, and family welfare visitors receive training for at least 18 months. However, only family welfare visitors and registered midwives receive training on the use of manual vacuum aspiration for PAC (Ipas, 2013).

STRENGTHENING SERVICE DELIVERY

Bangladesh previously provided healthcare through two separate MOHFW directorates, the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP), with PAC provided by DGHS facilities (Ipas, 2013).

Following advocacy efforts by the Bangladesh Nursing Council, the Directorate of Nursing Services, the Obstetrical and Gynecological Society of Bangladesh, and various international organizations, Bangladesh's MOHFW is now supporting DGHS and DGFP integration and coordination for PAC-related policymaking and in directing the national

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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PAC program (Ipas, 2013). The Obstetrical and Gynecological Society of Bangladesh was also key in advocating for the increase the use of manual vacuum aspiration and misoprostol for PAC and the inclusion of long-acting reversible contraceptives (LARCs)—i.e., implants and intrauterine devices—in the FP method mix offered to PAC clients (Begum et al., 2014).

Bangladesh is committed to increasing the availability of LARCs and permanent contraceptive methods within the community. To address this, the MOHFW recruited 1,320 family welfare visitors, 805 of whom have received training on intrauterine device service provision (FP 2020, 2016).

BARRIERS TO PAC

Women in Bangladesh face multiple barriers to accessing PAC and FP services. While FP counseling is frequently provided as part of PAC, clients in DGHS facilities are significantly less likely to receive FP methods due to a lack of availability (IPAS, 2013; Vlassof et al., 2012). Further, while a large proportion of PAC clients receive counseling, the number of PAC providers offering FP methods remains a challenge: 66% of providers reported not offering any FP method to women following counseling and, of those who did, fewer than half of the clients actually received a method (Guttmacher, 2012).

The cost of PAC further proves to be a barrier for many women; while public sector facilities are more likely to provide PAC than private sector facilities, more than half of PAC cases treated were in the private sector (Guttmacher, 2012). This suggests that women may face barriers in accessing PAC in public sector facilities and that the quality of PAC in public sector facilities may also be poor (Guttmacher, 2012).

FINANCING MECHANISMS

Bangladesh does not have a national health insurance plan with which to finance healthcare costs. The contraceptive market is segmented and the public sector, the private sector, and nongovernmental organization (NGO) programs all play a role in distributing contraceptives (Ahmed et al., 2015). Still, the government remains the major provider of voluntary contraceptive methods, serving almost half of all users, with government fieldworkers supplying up to 20%; the private sector provides contraceptives to 47% of all users and NGOs fill the remaining gap (Ahmed and Islam, 2015).

Despite this, drugs on the national essential drugs list and other medicines are generally free to clients. The public sector is the primary source of oral contraceptives, condoms, and LARCs, and all public-sector FP service centers provide PAC (FP, misoprostol, and emergency care) for free. NGOs provide these services at a nominal fee.

In Bangladesh, FP is relatively inexpensive for women and provides a high return on investment. On average, $1 spent on FP saves approximately $2 in antenatal, maternal, and newborn healthcare–related costs (Ahmed et al., 2015).

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BANGLADESH		Year	Source
Demographic/background indicators			
Country population	167,164,986	2018	World Bank[1]
Total fertility rate	2.1	2016	
Maternal mortality per 100,000 live births	176	2015	
Age at first birth	18.0	2014	Demographic and Health Survey, 2014
Newborn mortality per 1,000 live births	18	2017	UNICEF Data[2]
Infant mortality per 1,000 live births	27		
Under-five child mortality per 1,000 live births	32.4		
Proportion of deliveries by a skilled birth attendant	42%	2014	Demographic and Health Survey, 2014
Proportion of pregnancies with four antenatal care visits	31%		
Proportion of live births after which women receive a postnatal check within two days of delivery	36%		
Abortion and FP-related indicators			
Number of abortions	1,624,000	2014	Guttmacher Institute, 2014
Abortions per 1,000, all women of reproductive age (WRA)	29		
Number of women who experience complications from clandestine abortion	384,000		
Number of unintended pregnancies	4,411,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unintended pregnancies averted due to use of modern contraceptive methods	7,559,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	3,025,000	2017–2018	
Number of maternal deaths averted due to use of modern contraceptive methods	6,600	2017–2018	
Modern method contraceptive prevalence rate, all WRA	45.5	2017–2018	
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	8.5%		
Sterilization (male)	2.2%		
Intrauterine device	1.1%		
Implant	3.2%		
Short-acting methods		2017–18	
Injection (intramuscular and subcutaneous)	23.0%		
Pill	50.1%		
Condom (male)	11.9%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	0.0%		
Unmet need for FP[3] (2018)	14%	2017–18	Demographic and Health Survey, 2014
Unmet need for spacing	6.0%		
Unmet need for limiting	8.0%		

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN
[2] https://data.unicef.org/country/bgd/
[3] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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