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POSTPARTUM FAMILY PLANNING IN BANGLADESH

BRIEF 3

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INTRODUCTION In Bangladesh, slightly over three million births occur every year, approximately 1.1 million of these in the health facility.[1] This large volume of institutional deliveries has created an opportunity to provide postpartum family planning (PPFP) services. Most institutional deliveries occur in facilities operated by the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MOHFW[2]) (58%), followed by private facilities (30%), non-governmental organization (NGO) clinics (7%), and facilities under the Directorate General of Family Planning (DGFP) (5%).[3] Institutional deliveries, especially cesarean deliveries, provide an inherent opportunity for obstetricians to offer postpartum female sterilization (PPFS) to women who have decided not have more children. Two-thirds of institutional deliveries in Bangladesh are cesarean. More than 90% of the cesarean deliveries are performed at private and DGHS facilities (52% and 40% respectively). These non-DGFP facilities are not fully capacitated to provide PPFP, particularly long-acting reversible contraceptives (LARCs) and permanent methods (PMs). To increase uptake of LARCs and PMs during the immediate postpartum period (i.e., within 48 hours of delivery), EngenderHealth's Mayer Hashi II (MH-II) project, funded by the United States Agency for International Development (USAID), strengthened existing systems to expand access to PPFP services.

INTERVENTIONS

Bangladesh introduced PPFP services in a few select facilities in the early 1980s, but did not establish a structured approach to mainstream this service. PPFP began to draw significant attention among policymakers and program managers when MH-II initiated its PPFP intervention in 2008 in collaboration with the DGFP, DGHS, NGOs, and private providers. MH-II advocated for policy changes and provided capacity building support to existing service providers in order to expand access to and increase availability of quality PPFP services.

Policy Advocacy

The MH-II project leveraged the platform created by its work under the predecessor project (Mayer Hashi I, or MH-I) while adding new approaches to achieve project goals (Table 1). Advocacy activities of MH-I succeeded in fostering an enabling environment through policy changes that expanded the availability of PPFP services and improved monitoring. Particularly, MH-I's advocacy work resulted in enabling DGHS facilities to provide PPFP services. MH-II's advocacy efforts facilitated the integration of PPFP counseling with antenatal

[1] In Bangladesh, an increase of facility-based deliveries occurred over the life of the project, from 37% in 2014 to 50% in 2018.
[2] In Bangladesh, MOHFW has a bifurcated administration with two departments having independent service delivery systems, namely DGHS and DFGP.
[3] DGHS. 2015. "Emergency Obstetric Care (EmOC) Performance Report 2014." Dhaka: Management Information System, DGHS.

Table 1: Policy Changes and Expansion of PPFP Services

Indicator	MH-I	MH-II
Expanding availability of PPFP services	• Invovlement of nurses of DGHS inprovision of intrauterine devices (2010) • Exemption of DGFP accreditation for DGHS-registered facilities to receive FP commodities and funds (2011) • Integration of PPFP with maternity services (2010) • Introduction of PPFP service provision in DGHS-registered and monitored facilities (A joint DGHS-DGFP circular in 2011)	Approval of two policies through the National Technical Committee: • Use of implant and progestin-only pills as immediate PPFP methods (2016) • Counseling women on PPFP during all antenatal and postnatal check-ups and immunization services (2016) Provision of an Imprest Fund and FP commodities for DGHS and private facilities to provide LARC and PM services, including PPFP services (2018)
Improving monitoring	Inclusion of PPFP as a separate indicator in DGFP management information system forms (2013)	

care, postnatal care, and immunization services; the inclusion of implant and progestin-only-pills into the method range as immediate PPFP methods; and the provision of an Imprest Fund and family planning (FP) commodities for DGHS and private facilities.

Capacity Building

PPFP clinical training. MH-II provided PPFP training on postpartum intrauterine device (PPIUD) insertion and removal and PPFS in 338 clinic sites across 53 districts. MH-II conducted a central-level training-of-trainers workshop with 81 trainers from the DGFP, DGHS, and private sector, who then cascaded training to 338 physicians and 699 mid-level providers. Of the 1,037 individuals trained in PPFP clinical skills, 69% were from the public sector (DGFP: 39%, DGHS: 30%), 23% from NGO sector, and 8% from the private sector (Table 2).

PPFP orientation. MH-II also oriented 2,502 doctors and 5,098 mid-level providers (e.g., family welfare visitors, nurses, and paramedics) on PPFP (Table 2). As PPFP was a new service, MH-II conducted facility-wide orientations to ensure all providers at targeted facilities understood the importance of PPFP, were able to reflect upon the possible changes in service provision, and had the ability to provide related information and referrals to clients. EngenderHealth delivered these orientations where PPFP services were integrated in order to create referrals and synergies within the facility.

Clinical trainee follow-up visits. EngenderHealth introduced posttraining follow-up visits to reinforce provider performance, promote quality of services, troubleshoot, and provide onsite coaching for providers. MH-II tasked trainers with undertaking follow-up visits using a simple checklist. A minimum of 15% of clinical trainees received follow-up visits with within three to six months following the basic training. A total of 269 of the clinical trainees (26%) received follow-up visits at respective facilities.

ACHIEVEMENTS

Outcomes

Enhanced coverage. MH-II scaled up PPFP services at 338 facilities with the required infrastructure and the highest delivery caseloads; 73% of these facilities were government facilities. As a result of MH-II support, the number of facilities providing PPFP services increased from 111 in 2013 to 338 in 2018. Currently, 91 private and NGO facilities are able to provide PPFP services compared with 47 in 2013 (Table 3).

Increased uptakes in PPFP services. Between October 2013 and September 2018, 73,282 women adopted PPFP methods

Table 2: Providers Trained and Oriented, October 2013 to September 2018

Training Type	Provider Type	DGFP	DGHS	NGO	Private	Total
Clinical training	Doctor	87	120	73	58	**338**
	Mid-level provider	310	193	170	26	**699**
Non-clinical orientation	Doctor	334	1,507	156	505	**2,502**
	Mid-level provider	1,768	1,632	536	1,162	**5,098**

Source: MH-II database

[4] An "Impress Fund" is an advance of money paid to an organization or an individual for providing LARCs and PMs, including PPFP service provision. Imprest money is used to reimburse users for travel and food costs and wage loss, cover transportation for the referrer, and pay fees to service providers.

Table 3: Number of Facilities that Received PPFP Interventions

Facility Type	MH-I project	MH-II project
Public		
Medical college hospital	9	17
District hospital	22	53
Mother and child welfare center	24	55
Upazila health complex	7	30
Union health and family welfare center	0	92
National training institute	2	0
Subtotal	**64**	**247**
NGO		
NGO clinic	14	62
Private		
Private hospital/clinic	33	29
Total	**111**	**338**

Source: MH-II database

within 48 hours postpartum (PPFS: 53,433; PPIUD: 19,849) (Figure 1). PPFP uptake was remarkably high in Project Year 4 (October 2016–September 2017). Until September 2017, the increase in PPFP uptake corresponded to the expansion of PPFP facility coverage. In Project Year 5 (October 2017–September 2018), MH-II implemented PPFP activities in only three districts and 37 hard-to-reach upazilas; hence, low uptake of PPFP that year is attributable to limited geographic coverage. A comparison with national uptake revealed that PPFS accounted for a significant share of total female sterilization uptake between October 2016 and September 2017. During this period, nearly one-fifth of all new female sterilization users in the country were PPFS adopters.

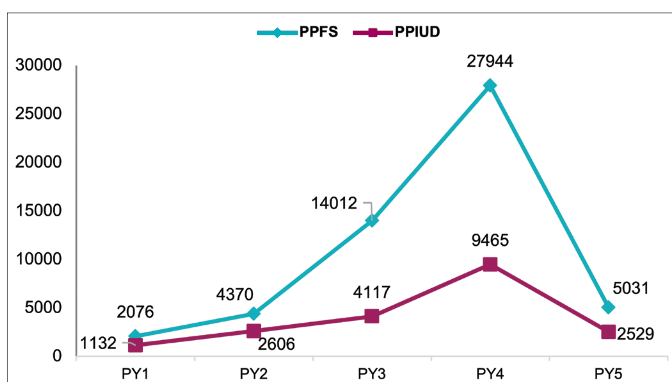

Figure 1: Trends in PPFP Uptake

Source: MH-II Database
Notes: PY=Project Year; in PY5, MH-II implemented activities in limited locations.

During most of the project period, there was a missed opportunity related to increasing PPFP uptake due to unavailability of FP commodities and Imprest Funds at many DGHS and private facilities. Further, the few PPFP procedures completed at DGHS facilities were not recorded completely. Moreover, DGHS facilities only reported their service statistics occasionally and most private facilities did not report their PPFP uptake at all.

Sustainability

Through the advocacy efforts that aimed to ensure access to PPFP and the support focused on building the clinical skills of providers, EngenderHealth has significantly contributed to mainstreaming PPFP into DGFP and DGHS systems. During MH-II, geographic coverage and facility coverage more than doubled. MH-II trained 1,037 clinical providers across the country who are now qualified to provide PPFS and PPIUD services. MH-II also developed a pool of central trainers who can further support institutional capabilities through skills and knowledge transfer activities.

As a result of MH-II's advocacy efforts with the DGFP, DGHS, MOHFW, and Ministry of Finance, the government has created an Imprest Fund to support the provision of FP commodities and enable DGHS and private facilities to provide LARC and PM services. Previously, there were no specific regulations on how these facilities would obtain necessary FP supplies. As instructed by the Ministry of Finance, the MOHFW issued a circular in 2018 in favor of allocating Imprest Funds to 92 DGHS facilities.

EngenderHealth's advocacy efforts also resulted in the integration of PPFP into the central planning of the MOHFW, including the inclusion of PPFP in its Operational Plan under the Health, Population, and Nutrition Sector Development Program 2017-2022 as well as in the National PPFP Action Plan.

CHALLENGES

PPFP Training and Service Delivery

- Limited opportunities for clinical practice during training emerged as a key barrier to increasing the availability of quality PPIUD services. Even after the training, some providers lacked adequate experience and confidence in PPIUD insertion.
- Provider training in interpersonal communication and counseling was not adequately covered through the clinical trainings.

- At DGHS and private facilities, antenatal and postnatal care providers lacked the skills to provide information and counseling on PPFP to pregnant women or new mothers who visited the facilities for check-ups.

Client Awareness of PPFP

- At DGHS facilities, coordination between antenatal care units and labor and delivery units is poor; hence, obstetricians remained unaware of clients' PPFP needs. Often, intensive counseling for PPFP is not offered, as obstetricians and nurses lacked the time required for screening and counseling women for PPFP.
- The capacity of the DGFP's field service delivery staff is extremely limited and cannot support follow-up care for women who deliver at home at regular intervals (e.g., 7 days postpartum, 42 days postpartum, three months postpartum, and six months postpartum) in order to educate them about PPFP and provide counseling services.

CONCLUSION

EngenderHealth has successfully engaged public-sector providers, particularly DGFP providers, in expanding access to PPFP services and has contributed to a notable increase in PPFS uptake in the context of plateauing female sterilization uptake. The DGFP began scaling-up PPFP activities in the national FP program. Further improvements in the provision and uptake of PPFP largely depend on developing the capacity of DGHS facilities and private clinics offering delivery and postpartum services, as these facilities jointly conduct 88% of institutional deliveries and 92% of cesarean deliveries. The national FP program moving forward needs to focus on:

- **Building capacity and enhancing linkages within DGHS facilities.** Building the capacity of all obstetricians at DGHS facilities to provide PPFS services is the first step. The second step is to generate interest among DGHS providers to offer PPFP services. At the same time, DGHS facilities need to establish linkages between their antenatal care units and labor and delivery units to identify and address clients' needs for PPFP. A direct referral linkage between DGFP outreach workers and DGHS providers is also important.
- **Increasing private sector involvement.** Building the capacity of private providers and strengthening effective coordination mechanisms between DGFP and private facilities is needed to further expand access to PPFP services, particularly PPFS.
- **Building counseling skills.** The provision of PPFP counseling during antenatal care, delivery or pre-discharge, postnatal care, and immunization services requires building counseling skills at all of those service points.
- **Reaching women who deliver at home.** The national FP guidelines and protocols need to include explicit instructions for providing PPFP information and counseling to women who deliver at home at specific intervals.

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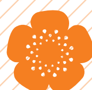

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