Landscape Analysis | 2020

Long Acting Reversible Contraceptives and Permanent Methods (LARC & PM)

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Acronyms

BDHS	Bangladesh Demographic and Health Survey
CPR	Contraceptive Prévalence Rate
CC	Community Clinic
CHCP	Community Health Care Provider
CIP	Costed Implementation Plan
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DP	Development Partner
DGNM	Directorate General of Nursing & Midwifery
ECP	Emergency Contraceptive Pill
FP	Family Planning
FPCS-QAT	Family Planning Clinical Services and Quality Assurance Team
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
FYP	Five Year Plan
GoB	Government of Bangladesh
HPNSP	Health Population and Nutrition Sector Program
HF	Health Facility
LARC&PMs	Long-acting Reversible Contraceptive and Permanent Methods
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MCWC	Mother & Chile Welfare Centre
MOHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
mCPR	Modern Contraceptive Prévalence Rate
NSV	No-Scalpel Vasectomy
OP	Operational Plan
OCP	Oral Contraceptive Pill
OT	Operation Theatre
PIP	Programme Implementation Plan
QIT	Quality Improvement Team
SAM	Short Acting Methods
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
SACMO	Sub Assistant Community Medical Officer
TNA	Training Needs Assessment
TFR	Total Fertility rate
ToR	Terms of Reference
ToT	Training of Trainers
UFPO	Upazila Family Planning officer
UH&FPO	Upazila Health & Family Planning officer
UNFPA	United Nations Population Fund
USAID	United State Agency for International Development
UH&FWC	Union Health and Family Welfare Center
UHC	Upazila Health Complex
VSC	Voluntary Surgical Contraception

Preface

1. Background

Bangladesh (GoB) National Family Planning Program spanning over the past three decades, is probably one of the most examined and well-documented FP programs in the world [[1]]. Bangladesh has experienced a sevenfold increase in its contraceptive prevalence rate (CPR) in less than forty years from 8% in 1975 to 62% in 2017 and the total fertility rate (TFR; from 6.3 to 2.3) during 1993 to in 2017[[2]]. However, despite this progress, more than one-third of pregnancies are still unintended which may be attributed to unmet need for family planning and discontinuation and switching to short acting methods after initiation of their use. The main reasons for methods switching were side effects of the methods such as bleeding, weight loss and feeling of arm numbness. Method switching was significant among who had one child, plan to postpone fertility, and whose husbands were not aware of their wife's use of the method. In the provision of family planning service, the health care providers should give adequate information about each method and risks of method switching. Appropriate family planning Information Education and Communication (IEC) and Behavioral Change Communication (BCC) strategies should be emphasized. An in-depth interview was conducted by Shukhi Jibon with the facility managers and field level staffs of DGFP to know the switching status of the dropped-out clients. During this interview, Service providers responded that method switching from long-acting contraceptives to short acting method is high and side effects of the methods were major reasons for shifting method (*Figure 1 & Figure 2*).

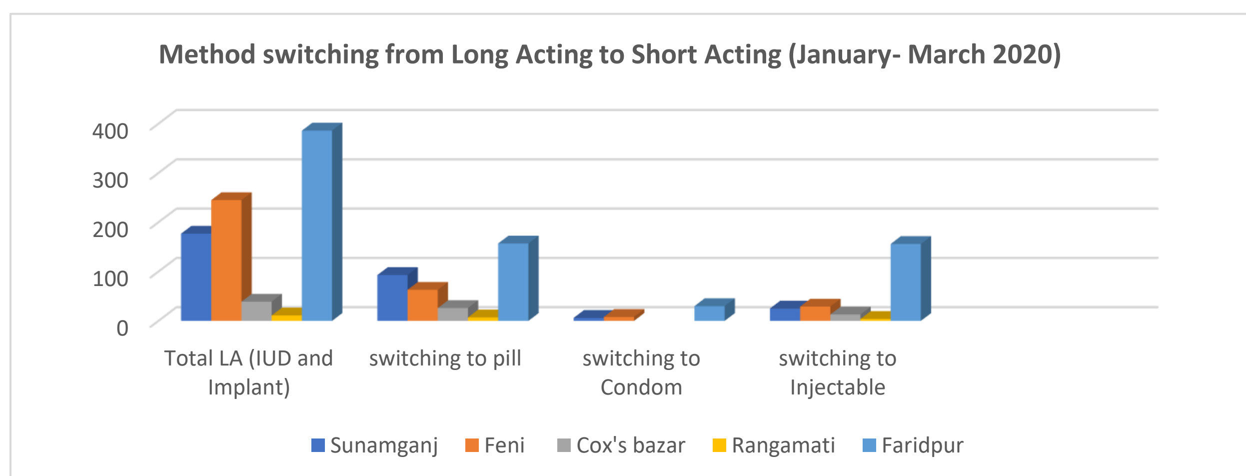

Figure 1: Method Switching from Long Acting to Short Acting

[1] Bangladesh Evaluation, Long-term and Permanent Methods of Family Planning. December 2007-page 15

[2] Bangladesh Demographic and Health Survey 2014. National Institute of Population Research and Training (NIPORT). Dhaka

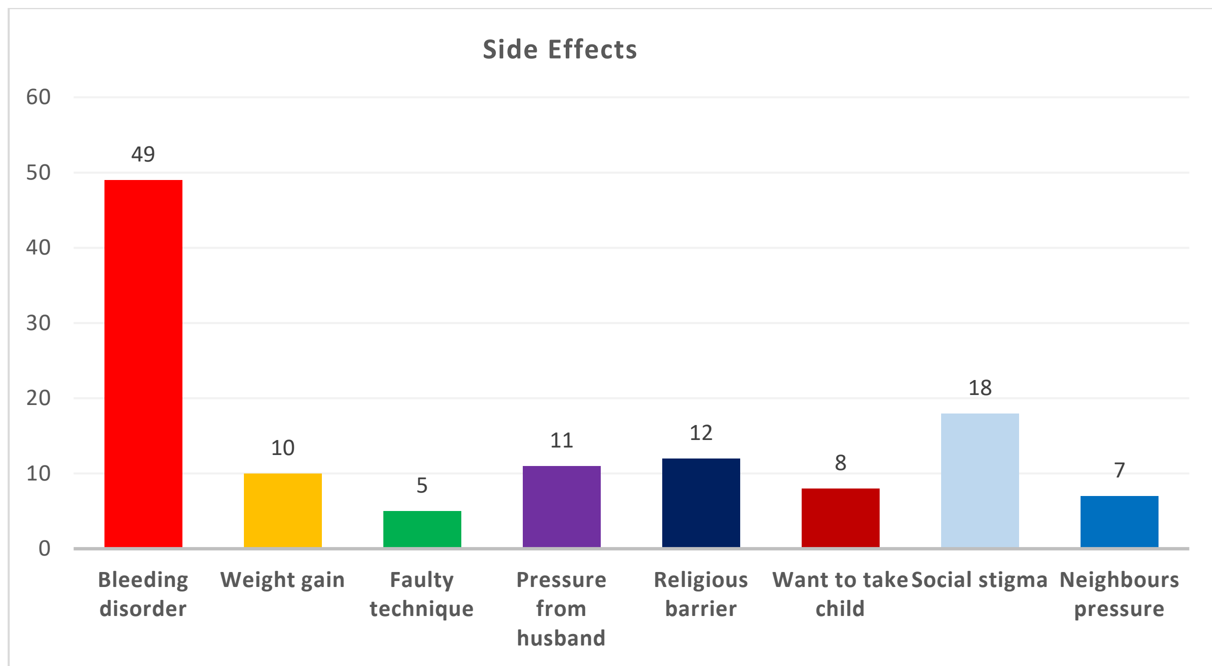

Figure 2: Side Effects of Long Acting Methods

CPR plays a significant role in assessing the demographic impact of family planning (FP) programs [3]. Married women in the country are having 0.7 more children than they desire, meaning that the total fertility rate (TFR) would be 30% lower if unplanned pregnancies were avoided [4]. While this may also be explained by unmet need for family planning, which is equally important to explore the effectiveness of family planning programs in addressing issues related to contraceptive method use. These issues include method discontinuation and switching from short acting to long acting method, method mix, and method failure [5]. Moreover, short acting method dependent (90%) CPR is also one of the causes of high dropout rate (37%), which is mostly contributed by oral contraceptive pill (41.6%), injectables (34%) and male condom (44.7%).

Long Acting Reversible Contraceptives and Permanent Methods (LARC & PMs) are divided into two categories: hormonal and non – hormonal methods. While Implant and levonorgestrel-releasing intrauterine system (LNG - IUS) are the hormonal ones, non-hormonal methods include IUD (Also known as TCu-380A), and Tubectomy and NSV are the permanent methods. All those LARC & PMs except LNG-IUS are available in Bangladesh FP program along with short acting methods OCP, Injectables, and male condom.

[3] Bairagi R, Islam M, Barua MK. Contraceptive failure: levels, trends and determinants in Matlab, Bangladesh. J Biol Sci. 2000;32:107–23.
[4] Bairagi R, Islam M, Barua MK. Contraceptive failure: levels, trends and determinants in Matlab, Bangladesh. J Biol Sci. 2000;32:107–23.
[5] Bairagi R, Islam M, Barua MK. Contraceptive failure: levels, trends and determinants in Matlab, Bangladesh. J Biol Sci. 2000;32:107–23.

Ideally, family planning programs should offer a wide range of methods and appropriate counseling that allows users to take informed decision and easy access to quality follow-up services. Other factors such as, method satisfaction, continuation and switching are also associated with quality FP services delivery [[6]]. Studies on contraceptive use dynamics typically addressed the mentioned three aspects in order to provide guidance for improving services. Evidences from these studies have a number of programmatic implications, including better monitoring and evaluation of program activities, improved effectiveness in meeting the needs of users, and more generally, improved ability of governments to achieve goals set for contraceptive use, total fertility, and for maternal and child health services [[7]]

Although numerous studies on discontinuation and switching and fertility intention and contraceptive practices (LARC & PMs uses) in Bangladesh exist, these studies have not been systematically collated and reviewed while determining the factors associated with women's contraceptive practices and fertility behaviors

2. Objectives of the Analysis

The general objective of the landscape analysis is to identify, revolve and use evidence-based report for the development of more effective policies and interventions for FP services in Bangladesh focusing on LARC & PMs.

The *specific objectives* of the analysis are:

I. To propose evidence-based country profile report explaining comprehensive view of the current status of LARC & PMs uses in Bangladesh.

II. To identify interventions for improving service utilization and further expansion of methods at community and facility levels in Bangladesh

III. To get opinion of the program managers and service providers of DGFP about the barrier and opportunities associated with LARC & PMs services delivery

IV. To come up with recommendations in connection with quality of FP services provision, capacity development of FP service providers, policy integration, creating enabling environment, generating demand to underpin LARC & PMs services

[6] Bongaarts J, Sinding S. Family planning as an economic investment. Washington D.C. 2011.

[7] Bongaarts J, Sinding S. Family planning as an economic investment. Washington D.C. 2011.

3. Description of the studies reviewed

3.a Methodology

We conducted an extensive landscape analysis on LARC & PMs uses in Bangladesh. Method of this analysis includes qualitative in-depth interviews, secondary data analysis from existing available reports, articles and DGFP MIS, and program SWOT analysis.

An in-depth interview was conducted by Shukhi Jibon with the facility managers and field level service providers of DGFP. Information collected through Key informant interviews of FP program managers and service providers by using prescribed questionnaire (Annex A). Key informant interviews were conducted taking 30 participants from different cadres of service providers from Dhaka, Chattogram and Sylhet division.

A total 30 articles were identified through database search and after final screening 12 articles were included in this synthesis. To understand the program trends, information has been collected from DGFP MIS.

3.b SWOT Analysis

This landscape analysis identifies program priorities derived from the SWOT analysis considering following areas:

- FP support system functionality
- Quality of FP counseling and services
- Competency of service providers
- Enabling environment for FP service delivery
- Demand and supply status of FP services, including discontinuation and switching of contraceptives
- Cross-sectorial collaboration and coordination for FP services

Table 1: SWOT Analysis FP System and Services

STRENGTHS	WEAKNESSES
Family Planning Services • Availability of guidelines, standards, job aids, learning resource packages and IEC materials for FP • Clearly outlined and resourced FP objectives and activities in the sector program of the MOHFW (HPNSP for 2017–2022)	**Family Planning Services** • High vacancy across all the service providers at different levels. • Inadequate compliance of services providers with protocols and guidelines • Weak and irregular supervision and monitoring of FP services • Inadequate maintenance of equipment • Lack of a post-training follow-up mechanism

STRENGTHS	WEAKNESSES
• Availability information, education and communication (IEC) and social and behavior change communication (SBCC) materials on FP • Supportive roles of NGOs and private sector • Availability of free services and supplies in all public health facilities	• Inadequate focus on privacy and confidentiality • Provider bias • Lengthy process of policy changes • Improper use of IEC materials • Inadequate on-the-job training
Human Resources • Availability of at least one female health care provider (HCP) in all the service centers • Experience service providers — Service providers are paid from the govt exchequer — Well-designed capacity development programs	**Human Resources** • Limited number of qualified FP trainers at the local levels, particularly for CBT, M&SS, & Community Based PPFP • Lengthy recruitment process • Job descriptions are not updated considering current service provision need
Leadership • Availability of supportive rules, laws and protocols • Commitment of MOHFW, donor agencies and other stakeholders for FP	**Leadership** • Weak inter-ministerial and sectorial coordination among the agencies of MOHFW • Inadequate political commitment • Inadequate evidence-based decisions
Monitoring and Evaluation • Availability of regular surveys and reports (Bangladesh Demographic and Health Survey, Health Facility Survey, Training Needs Assessments) — Well established Management Information System (MIS) — Gradual scaling up of online MIS	**Monitoring and Evaluation** • Lack of data validity and reliability • Insufficient monitoring and evaluation system for FP services • Insufficient dissemination and utilization of data for decision-making at all levels • Inadequate researches and studies
Logistics and Finance • Strong distribution mechanism • Contraceptives procurement is sufficiently estimated and budgeted • Operational Plan activities are properly costed and funded • Presence of strong SMC	**Logistics and Finance** • Less spending than the budgeted figure • Lengthy procurement system • Lengthy OP revision process

STRENGTHS	WEAKNESSES
Community • Availability of IEC materials (printed, audio and video) • Acceptance of FP services by the communities • Well-designed SBCC strategy	**Community** • Lack of sustainable community mobilization campaign • Less access to mass media, particularly in remote places • Cultural and traditional barriers of community • Religious and illiteracy barriers
OPPORTUNITIES	**THREATS**
Family Planning Services • Multiple institutions or organizations for providing services and supporting FP services • Donor interest to support FP programs in Bangladesh • Emerging private sector **Human Resources** • Availability of good number of female service providers, including physicians in the private and NGO sector • Availability of public and private education institutions and training centers **Leadership** • Support from national and international organizations • Related policy and strategy documents availability **Monitoring and Evaluation** • Availability of national monitoring tool like National Monitoring Checklist (NMC) • Availability of MEL experts • Scopes for using different media for FP information dissemination **Community** • Male support for FP programs	**Family Planning Services** • Lack of coordination among organizations providing FP services, or supporting FP services • Fragmented FP service delivery • Dependence of foreign source for LARC& PMs procurement. • Ever increasing contraceptive prices • Natural calamities (COVID-19, flood, cyclone) **Human Resources** • High vacancy and lengthy recruitment process • Inadequate FP Knowledge of the Pvt sector health workers **Monitoring and Evaluation** • Inadequate technology support for routine MIS • Too much dependency on hard copies for reporting and recording. **Logistics and Finance** • LARC&PMs contraceptives are procured from international sources • Urban FP services are mostly provided by the privet sector and NGOs **Community** • Misconception of religious leaders on FP at the community level • Social stigma and taboo • Inadequate community development activities

4. Use of Family Planning Methods

BDHS 2017 reports that 62% of currently married women aged 15–49 years in Bangladesh are using any contraceptive methods, with 52% using modern methods, and the rest 10% is contributed by traditional method users. The rate of contraceptive use has increased significantly from eight percent in 1975, to 62% in 2017. However, this rate has slowed since 2004, increasing by four percentages points over the past decade, while the use of modern contraceptive methods has decreased from 54% in 2014 to 52% in 2017 mainly due to the decline in use of the oral pill and injectables. While plateauing CPR and high dropout rate (37%) and unmet need (12%) are positively correlated, these indicators are driven by lack of program innovation, inadequate side effect management, high vacancy of service providers, inadequate monitoring and supervision, insufficient facility readiness, as mentioned in different internal reports of DGFP.

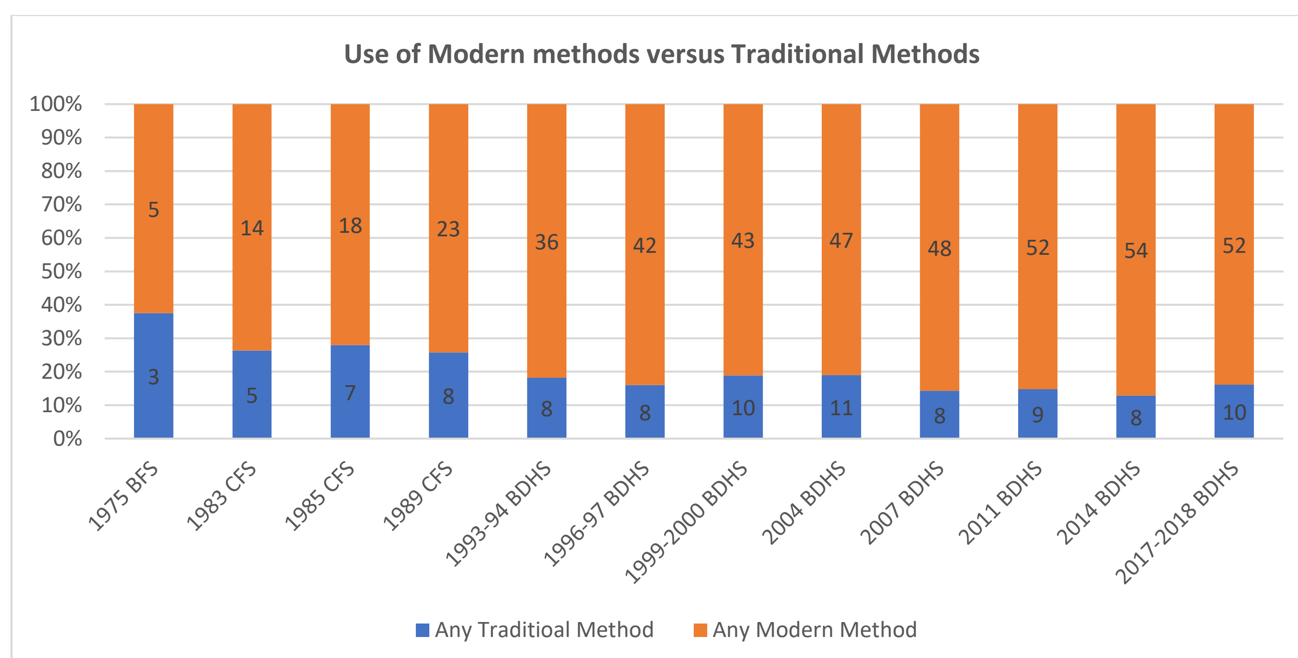

Figure 3: Uses of Modern Method vs Traditional Method

Current use of FP methods among women varies by place of residence, age and parity. Use of any modern contraceptive method is higher in urban than rural areas. BDHS 2017 explored that 52% of women use modern contraceptive methods. Amongst the modern methods, pill is the most popular method (25.4%), followed by injectables (10.7%), male condom (7.2%), female sterilization (4.8%), male sterilization (1.1%), IUD (0.6%), and implants (2.1%). Traditional methods are used by 10% of the users and majority (7%) use the rhythm method (periodic abstinence).

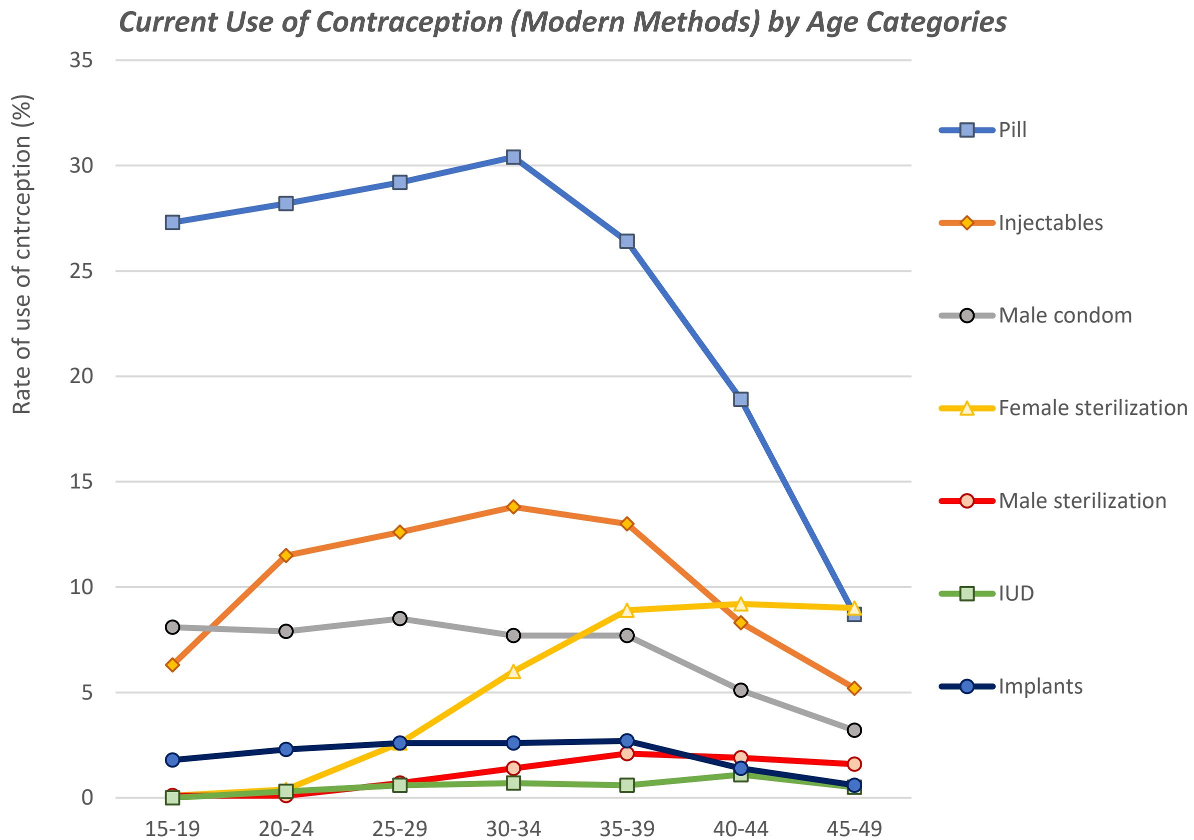

Figure 4: Current Use of Contraception (Modern Methods) by Age Categories | Source: BDHS, 2017-18

5. Awareness of family planning

Results from the BDHS 2017-18 showed that knowledge of family planning methods were widespread throughout Bangladesh, with the total demand for family planning in Bangladesh is 74% of which 70% has been satisfied using modern methods. Unmet need for FP remains unchanged at the level of 12% since BDHS 2014. Chattogram division has got highest unmet need (18%) and lowest in Rangpur (8.1%). It also shows that unmet need is lower among the group with secondary and higher level of education (7. 1%). If we compare the wealth quintiles, unmet need increases with higher wealth; it increases with every higher quintile except the highest quintile. Though the level of knowledge is wide spreading, individual level of awareness remains low because of socio-cultural and religious barrier, misconceptions, and concern for side effect.

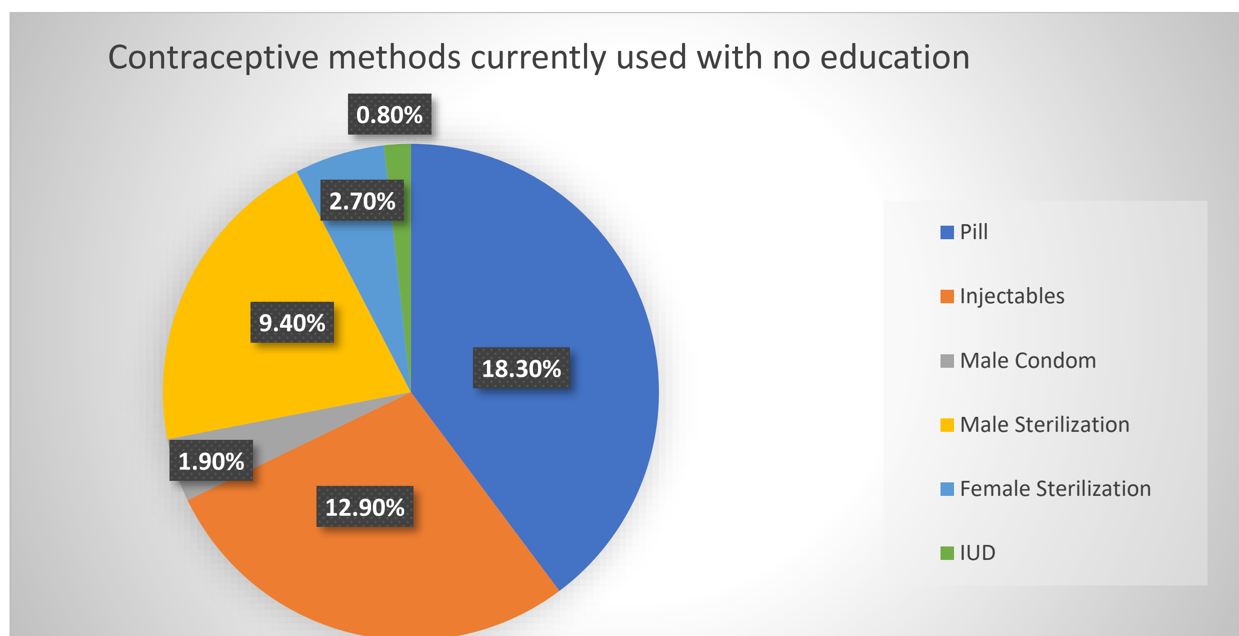

Figure 5: Contraceptive methods currently used with no education

6. Capacity development of family planning services

Capacity development activities of FP services delivery could be grouped into three types: basic training, practicum (to develop the knowledge and skills that will enable FP providers to perform according to standards), and refresher (i.e., follow-up) training. Managers from DGHS, MOs, SACMOs, FWVs, and midwives receive their basic and practicum training on FP methods before joining the service followed by refresher trainings while in-service. It needs to look for different alternatives for Upazila-level RMOs and obstetrician-gynecology consultants, who have been trained on LARC & PMs by Mayer Hashi Project, should be encouraged to provide LARC & PMs services. In contrast, FWAs and CHCPs receive all their trainings—basic training, practicum, and refresher training—during in-service. Training Needs Assessment (TNA) 2019 explored the competency areas of FP service providers, including the level of knowledge, attitudes and practices.

Training Needs Assessment (TNA) 2019 conducted by Shukhi Jibon reported that, the most elevated level of comfort was appeared by MOs at 69%, trailed by SACMOs 59%, FWAs 46%, FWVs 39% and CHCPs 34% and midwives at 18%. TNA also explored that on average 40% of providers are not comfortable with their current skills level to counsel clients for FP services.

Most of the MOs, who are the sole provider of Tubectomies and NSVs, do not feel comfortable performing these procedures (50% and 68% respectively). Similarly, 59% FWVs do not feel comfortable with their skills to insert IUD (TNA 2019). Moreover, FWAs and CHCPs provide the subsequent doses of injectables at community level, but 40% of FWAs and 45.2% of CHCPs

reported that they do not feel comfortable performing this task. From pathfinder experience of ongoing mentorship activities and from TNA findings, it is evident that lack of follow up trainings, and supportive supervision are the causes of lacking confidence of the service providers.

It can be interpreted that the lack of comfort of FP service providers with different services was rooted in the inadequacy of the trainings they have received. They also expressed their lack of confidence in the areas of counseling, management of side effects, infection prevention. Inadequate confidence level is mainly driven by lack of refresher and follow up trainings and lack of practicum with the clients during training. TNA shows that the FP service providers received their basic, practicum, and refresher trainings a long time ago. On average, MOs and midwives received their last refresher training on Counseling on FP Methods 9.5 years earlier, followed by FWAs (7.1 years earlier), FWVs (4.9 years earlier), SACMOs (4.4 years earlier), and CHCPs (2.9 years earlier). MOs received their last refresher training on LARC-PMs 8.6 years ago on average, while FWVs received the same training 4.5 years earlier on average.

7. Availability of services

Accessibility and quality of FP services in Bangladesh are primarily influenced by the vacancy of human resources and multitask responsibilities of the service providers. BHFS 2017 shows that 86 percent of the health facilities provide modern family planning (FP) services, including a large range of methods. Contraceptives stock status is influenced by natural calamities like flood, cyclone and lengthy procurement process. In 2017, the proportion of health facilities that offered family planning methods and services showed an increase over 78% in 2014. The survey also mentioned that 78% facilities had FP methods, which is less than reported in the 2014 survey (87%), overall availability of FP guidelines in health facilities decreased slightly from 54% to 49% in 2014 and 2017 respectively. Over half (56%) of the facilities that offered FP had staffs who received in-service FP training, while less than 5% of the facilities provide male or female sterilization.

Overall, FP service readiness has been declined from the level of 25% in 2014 to 22% in 2017 mainly due to decrease in availability of FP guidelines, FP commodities (only injectables (BHFS/2017), lack of trained service providers and equipment. World Health Organization also came up with similar finding in 2017. Under this circumstance, even though IUD services are available in all the facilities, including UH&FWCs, other LARC & PMs services are mostly provided in the camps that are organized periodically in the Upazila Health Complexes. Quality services delivery in those camps is also challenging because of high number of clients on the camp dates. Moreover, in most of the cases operational theater (OT) of the UHCs need to be shared, as there is no dedicated OT for FP services delivery at the UHCs.

8. Associated factors affecting LARC & PMs uptake

Different studies and reports explored number of fundamental reasons behind low uptake of LARC & PM in Bangladesh. The supply-side reasons are associated with the public-sector program weakness and demand-side ones are associated socio-cultural barriers. It should be noted that the public sector is the main provider of long-acting and permanent methods - i.e., implants (87.8%), and IUD (78.8%), female sterilization (63.1%), and male sterilization (87.5%) (BDHS.2017). There has been a recent policy change of expanding such services through the private sector. While half (49.3%) of the users of modern FP methods are getting their services from the private sector, this sector mainly supplies short term methods - i.e., pills (55.5%) and condoms (78.2%) (BDHS, 2018).

Program weaknesses are also featured by poor infrastructure, poor physical quality of services and quality of care, and inadequacy of key service providers. Quality of LARC &PMs services provided at the upazilla level are well below the ideal level because of poor conditions of infrastructure and equipment and shortages (Chowdhury and Hammer 2004; Schuler et al 1998). Significant number of MO-MCH positions are lying vacant (MOHFW 2012a), while MO-MCHs are the lone provider of implants, tubectomy and NSV at the upazila level and below. This situation coupled with absence of Health care providers (MOHFW 2012b) are adversely affecting services availability. Furthermore, the client-provider interactions are poor in the public-sector facilities (Schuler et al. 1998; 2002) because service providers are overburdened with additional responsibilities, shortage of manpower, knowledge gap, and in some cases they don't have enough time for proper counselling which sometimes hampers providers attribute towards clients during service delivery. The side effects and complications of LARC&PMs acceptors are hardly addressed (Mahbub-E-Alam 2009).

The major demand-side issues are: stigma among affluent and educated couples against tubectomy and NSV, as these are perceived as "methods for the poor,"; NSV is perceived as an unsuitable method primarily because of lack of knowledge of physiological processes of the procedure; religiously inclined couples' reluctance of considering the permanent methods as a method of fertility limitation; perceived and observed side effects or complications of IUD and implants (Mahbub-E-Alam 2009).

There is a multiplicity effect of low demand and program weakness in the Eastern region. In supply side, the Eastern region is characterized by general program weakness, e.g., high vacancy and absenteeism of managers and service providers coupled with less developed and poorly maintained infrastructure at the Upazila level and below (MOHFW 2012b). These are the key factors influencing accessibility to and quality of care for LARC & PMs. In demand side, the Eastern region is characterized by higher desired family size (BDHS 2017) and thus low demand for fertility limitation associated with peoples' conservative outlook and greater reliance on traditional beliefs. Given this situation, overall contraceptive demand is likely to be fragile, i.e., the intensity of demand for LARC & PMs is likely to be low; couples may not be that determined to adopt a permanent method. In contrast, a woman may accept pill or injectables with an

understanding that she can drop it anytime she wants. Thus, demand for LARC & PMs is likely to be low.

9. Policy Environment

MoHFW strategy is to increase FP services accessibility with increased number of service delivery points. The strategies and approaches are supported by Population Policy, 4th HPNSP, FP 2020 and 7th Five-year plan. Political commitment and policy coherence are very essential to align the target for all policies and plan for better FP program implementation. However, within the government, policies and plans have different goals and achievement targets such as, Bangladesh population policy,2012 has expected TFR 2.1 and CPR 72% by 2015, while TFR and CPR target mentioned in the 7th five-year plan and sector program are 2.0 and 75% respectively by 2022. Differences of goals and targets could be attributed to the policy environment, which is influenced by different factors, including availability and costs of FP and RH technologies, and emerging public health issues.

10. Interventions aiming to increase LAPM users

10.a Task shifting and task sharing

Task shifting is always the most appropriate way to optimize health worker tasks for balancing the gap of family planning, maternal health and HIV/AIDS services. This approach is also instrumental in addressing problems associated with vacancy situation.

While availability of high quality and client-centered FP services is one of the approaches that could increase FP acceptors, including LARC & PMs, low uptake of which seems to be largely associated with the vacancy of MO-MCHFPs and other service providers. Considering the complicated recruitment process, it is assumed that high vacancy situation is unlikely to improve in near future. To address this issue, it needs to look for different alternatives. Under the task sharing approach, Upazila level RMOs and obstetrician-gynecology consultants, who have been trained on LARC & PMs by the earlier (2015 -2017) USAID MH (Mayer Hashi) project, could be encouraged to provide LARC & PMs services at least once in a week at the Upazila Health Complexes which was monitored by Mayer Hashi Quality Assurance Team. UH&FPOs could facilitate the service delivery process and UFPO should instruct her/his community-level providers namely FPIs, FWVs, and FWAs to refer client to the monthly camp organized by RMOs or obstetrician-gynecology consultants. [8] This strategy would be helpful in ensuring more FP

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[8] The Future of Long-acting and Permanent Methods of Contraception in Bangladesh

service providers at the UHCs and would help to reduce clients waiting time to get the services. Orientation and trainings for those service providers could be supported by well-designed mentorship program. To implement this strategy, better coordination between DGHS and DGFP needs to be ensured.

10.b Resource Mobilization

Among 10 directorates of MoHFW, DGHS, DGFP and DGNM are directly aligned with health and family planning service provision. DGFP is the prime directorate for providing family planning services,and providers under this directorate receive training based on their cadre status. Beside DGFP, even though some of the DGHS and DGNM service providers such as, UH&FPO, RMOs and obstetrician-gynecology consultants and midwives are trained on FP services, they don't have the willingness to provide FP services largely because of lack of coordination among the ministry agencies. According to TNA, approximately 60% of the frontline FP service providers have more than 25 years of work experience. This implies that a significant number of service providers will retire soon and currently 40% of frontline FP service provider positions are vacant. Given this situation, it would be useful for DGFP to address the vacancy issue by taking support from DGHS and DGNM service providers, whose capacity could be developed through providing refresher training, follow-up training or in-service training. Other resources like equipment, space and operation theater could be shared between DGHS and DGFP, as both the services are mostly provided from the same facility at the Upazila and union level. To facilitate the resource sharing process, clearly outlined roles and responsibility in the MoU could be helpful.

10.c Strengthening of FPCS-QIT

DGFP is committed to ensure quality FP services delivery, and in this regard, it is important to focus on clients' rights, including their rights to information, access, choice, safety, privacy and confidentiality, dignity, opinion, comfort and continuity. In order to reduce VSC related morbidity and to eliminate preventable mortality by providing technical support and conducting on-spot training on various aspects of VSC services four Sterilization Surveillance Teams (SST) with 4 Foreigner and 4 Local Medical Consultants was formed in 1982. Later, temporary clinical methods such as IUD and Injectables were included in the scope of work of the SST and renamed as Family Planning Clinical Supervision Team (FPCST) to reflect the added dimensions of clinical contraception services.

Since 1992 eight regional supervisors (FPCS-QAT) have been working to supervise and monitor the quality of care related to Family Planning Clinical Methods, MCH services, service providing centers, service providers and clients. During the third sector program FPCST-QAT is expanded and renamed as FPCS-QIT, which is further expanded during ongoing 4th sector program (HPNSP 2017-22) covering all the districts. With the help of FPCS-QIT number of initiatives have been taken to improve quality of care for delivering LARC & PMs services. The initiatives are : development of a Strategy on LARC & PMs addressing Fundamentals of Care (FoC); ensuring informed and voluntary decision making process in FP program; assuring safety for clinical techniques and procedures; providing a mechanism for ongoing quality assurance and management; and establish clients' rights and address provider's needs at the core of FP service

delivery. In connection with ensuring clients' rights, DGFP has developed a Program Manager's Manual on Informed Choice and Voluntarism (ICV) to strengthen and monitor ICV in FP program.

Currently FPCS-QITs are working in each of the 64 districts aiming to ensure quality LARC & PMs services delivery. This initiative is focusing on strengthening quality assurance (QA) systems for FP services within facility, practicum-based training, facility readiness and in-service training along with mentoring, monitoring and supportive supervision at the field level. To strengthen these initiatives more effectively, Pathfinder already started working jointly with the FPCS-QITs to improve the quality of services.

10.d Clinical and counseling Skills development

Clinical trainings in family planning has some limitations and challenges: inadequate client flow for practicum session; long distance of the training institute from practicum site; lack of conducive environment; inadequate training facilities; inadequacy of quality trainers etc. According to the TNA report, most of the providers got their last FP refresher training at least five to ten years ago and expressed lack of confidence to provide services. Possibly low client load per provider and lack of refresher trainings are causing knowledge and skill loss due to limited practice. In this regard training programs should address performance gaps in knowledge and skills for all cadres of providers. To minimize costs and service disruption and to enhance sustainability, blended learning approaches should be developed. Moreover, around 60% frontline FP service providers have more than 25 years of work experience meaning that a significant number of service providers are likely to reaching retirement age. Given the high percentage of present and future vacancy, recruitment and training of all the new providers should be accelerated.

Current trainings are for the most part instructive classroom-based with limited practicum sessions and lack of provider follow-up by trainers. Furthermore, there is limited capacity in practicum training. In this regard development of e-learning materials and blended learning activities would be very useful, and introduction of different training approaches need to be explored. DGFP, NGOs, and development partners could collaborate through MoU aiming to increase LARC & PMs uptake which is needed to ensure sustainable FP program in terms of increased uptake, low dropout rate and unmet need for contraception. [9]

10.e LARC & PMs Uptake Projection

The 'Reality Check' tool10 was used for FP commodity projection from 2020 to 2022 (EngenderHealth , 2019). The results are shown in below table. Government's target is to increase the CPR to 75%, use of LARC & PMs to 20% by 2021, reduce unmet need to 10% by 2021. While projecting the method-mix, all these goals were considered simultaneously.

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[9] The Future of Long-acting and Permanent Methods of Contraception in Bangladesh

[10] Reality Check" is an Excel Workbook based tool used for projection. It helps to assess past trends in the contraceptive prevalence rate (CPR) and predict country specific future scenarios based on the local context.

Table 2: FP Commodity Projection (Method-mix)

Method	2019 (%)	2020 (%)	2021 (%)	2022 (%)
CPR	67.2	69.8	72.4	75.0
MCPR	56.3	58.5	60.7	62.9
All LARC & PM Method	9.33	9.69	10.06	10.42
Male sterilizations	1.19	1.24	1.29	1.33
Female sterilizations	5.21	5.41	5.61	5.82
IUDs	0.65	0.68	0.70	0.73
Implants	2.28	2.37	2.46	2.54
Injectables	11.61	12.06	12.51	12.96
Pills	27.55	28.63	29.70	30.78
Male condoms	7.81	8.11	8.42	8.72
Other traditional methods (e.g. massage)	10.85	11.27	11.69	12.12

10.f Community Engagement Strategy

Looking at the method mix, almost 90 percent contraceptive users are female, it could be deduced that Family Planning program in Bangladesh is a woman focused program, while men are the key decision makers in the family. Shukhi Jibon has been providing support to the national family planning program for increasing contraceptive uptake with different approaches, including male engagement particularly with marginalized population. Contrary to the more traditional exclusion of men from reproductive health discussions or interventions, Shukhi Jibon seeks to ensure conversation and more equitable decision-making around family planning between couples, as well as to encourage wider shifts in social and gender norms by involving men.

Shukhi Jibon is collaborating with IEM, DGFP which has been conducting following SBCC activities under the ongoing sector program:

- Campaign on permanent & long acting contraceptive methods, delayed marriage, newborn care, breast feeding;
- Motivational meeting for Newlywed and Low-parity couples at upazila level on FP, MCH, RH, safe motherhood, birth- spacing;
- Orientation workshop for marriage registers, religious leaders, madrasah & schoolteachers on FP, MCH, RH, adolescent health care, safe motherhood & delayed marriage;
- Skill development workshop & IPC for service providers (FWA, FPI, FWV, SACMO etc.);
- Poster, leaflet, booklet, brochure, flipchart production and distribution;
- Display of billboards, hoardings etc;

- Media campaign through BTV, other private TV channel, Bangladesh Betar and private FM Radio channels for Population & Health communication program;
- The goal for involving men is to encourage more equal conversation and participation with both men and women in reproductive health, not at the cost of women's participation and voice.
- Consistent with the "reflection and action" rather than a message approach to behavior change, males need to be encouraged to support exploration and reflection with their peers and in their communities.

11. Recommendations

The implementation of the FP services has policy implications that require timely decision-making. Policy decisions and advocacy are extremely important for motivating the FP providers, continuous availability of FP commodities, improving financing and efficiency in FP, conducting research and improving overall management and monitoring systems. Therefore, an effective policy environment and advocacy are important elements for the success of the FP services. These create and maintain a supportive environment for improving the delivery and use of FP services. There is a need for advocacy with policymakers, managers, senior officials and development partners to raise support for the FP services in terms of funding, political commitment and visibility.

Along with DGFP service providers, nurses, midwives and other DGHS service providers need to be capacitated on LARC & PMs services. DGHS and DGFP coordination needs to be strengthened so that resources sharing barriers and difficulties could be avoided e.g., HR, facilities and equipment. Shukhi Jibon already started to provide competency-based training by involving DGHS providers and supervisors. Advocacy to prepare joint Action plans for DGFP and DGHS based on LARC & PMs strategies.

NIPORT, DGFP and DGHS should participate in developing annual capacity development plan. Emphasis on human resource capacity strengthening through utilizing the competency-based training approaches. Prioritize practicum-based training, refresher, on job follow-up. Shukhi Jibon already started capacity building activities in its intervention areas. IT and admin related officials need to be trained to ensure systematic and real time training information and reporting.

Need to emphasis on PPFP and Community based PPFP & PAC-FP services within DGFP & DGHS facilities. Shukhi Jibon has already started to provide ToTs and cascade trainings to the DGFP &DGHS providers and supervisors on community PPFP & PAC-FP strategy.

Formal training programs should be supported by mentorship and supportive supervision activities, and on the job trainings. Shukhi Jibon has been implementing mentorship program taking mentors and mentees from DGHS and DGFP service providers. Mentorship, as a tool for

supportive supervision, can complement supervisory visits and periodic performance review by improving individual capacity of the service providers contributing to quality service delivery at workplaces. Mentorship as a positive developmental relationship will support identifying provider needs, providing updated technical knowledge, improving capacity of service providers and generating connections and collaboration between various departments of the system through mobilizing members of the mentorship support teams.

Stock outs of FP methods can put a woman at risk of unintended pregnancy. A secured and reliable supply pipeline is required to ensure contraceptives availability for clients. This will only be achieved through close collaboration between the government, other RH stakeholders, and partners who support the supply chain for the FP program.

Advocate, capacitate and encourage family planning and health facility staffs, CHWs community-based health workers and / or community-based Health Facility Operations Management Committees –to prioritize the community level awareness activities. Engaging the community leaders as a promoter of wellbeing; utilizing the community leadership in community sessions like – Courtyard / community focused activities. Bridging between community-based leaders (Religious leaders – Imam, purohit etc., School Teachers, Political leaders & influencers, Youth clubs' leaders and cultural leaders) & frontline health workers so that quality FP services could be ensured and maintained.

Improving/increasing male involvement on family planning, while they are the major decision makers behind the curtains. Shukhi Jibon already started to work on it.

Organizing & attending compulsory counselling sessions with marriage registration; providing training to traditional providers and pharmacy shopkeepers. Updating FP contents in the medical curriculum. Orientation to private and public sector providers jointly on quality assurance and improvement of FP services.

12. Conclusion

Although success of the family planning program in Bangladesh has been widely acclaimed, many challenges remain, particularly low uptake of LARC & PMs. National family planning program needs to identify demand- and supply-side strategies that can help to overcome these challenges. At the same time, a renewed commitment from government bodies to implement and monitor such strategies, as well as to maintain ongoing collaboration with independent organizations is needed. The notable progress in country's family planning program must be continued and strengthened to reach its goal of increased contraceptive accessibility leading to better maternal health.

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10. *Costed Implementation Plan for the National family Planning Program, Bangladesh, 2016-2020, Ministry of Health & Family Welfare (MoHFW), Bangladesh, Final report 23rd December 2015*
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ANNEXES

Annex A: Key Informant Interview Questionnaire

Respondents Information:

<table>
<tr><td rowspan="4">Name of the provider:</td><td colspan="2" rowspan="4"></td><td rowspan="4">Age:</td><td colspan="2">18-25</td></tr>
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<tr><td></td><td>UFPO</td></tr>
<tr><td></td><td>FPI</td></tr>
<tr><td rowspan="3">Facility type:</td><td></td><td>UH&FWC</td><td rowspan="3">Contact Details</td><td colspan="2" rowspan="3"></td></tr>
<tr><td></td><td>UHC</td></tr>
<tr><td></td><td>MCWC</td></tr>
</table>

Questions:

1. How many clients received services in last 3 months? Among them how many clients received FP method?

2. Did they have any prior knowledge of FP methods?

3. Did they have any interest in a particular FP method?

4. Which method the clients are using most now and why?

5. What are the myths and misconcepts heard during providing FP services?

6. During removal of FP methods (IUD/Implanon/Jaddle) did the client tell that she felt much pain/discomfort during insertion?

7. Do you think that any side effects, risks and complication can reflect for method discontinuation and switching?

8. How they have contacted for the follow-up? When?

Shukhi Jibon