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# Bangladesh Family Planning Private Health Sector Assessment



BRIEF

**SHOPS**

Strengthening Health Outcomes  
*through* the Private Sector

**Summary:** This brief is a summary of the Bangladesh private sector assessment of long-acting and permanent family planning methods and injectable contraceptives, conducted by the SHOPS project in 2011. Shalu Umapathy prepared this brief, which presents the assessment methods, findings, and key recommendations across three areas of analysis: market and demand, availability of services, and supply of long-acting and permanent family planning products.

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**Keywords:** Asia, Bangladesh, condoms, contraceptives, family planning, fertility, injectables, IUD, long-acting permanent methods, oral contraception, reproductive health

**Recommended Citation:** SHOPS Project. 2013. *Bangladesh Family Planning Private Health Sector Assessment*. Brief. Bethesda, MD: SHOPS Project, Abt Associates.

**Cover photo:** Save the Children

**Project Description:** The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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**Cooperative Agreement:** No. GPO-A-00-09-00007-00

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# Bangladesh Family Planning Private Health Sector Assessment

The United States Agency for International Development (USAID)/ Bangladesh commissioned the SHOPS project to conduct a private sector assessment in Bangladesh that would inform potential strategic investments in long-acting and permanent methods (LA/PMs) and injectable contraceptive service provision in the private sector. Few publications address LA/PMs and even fewer focus on the private sector. The assessment defined the private sector as nongovernmental organizations and for-profit health providers. This brief summarizes the methods, findings, and key recommendations of the assessment.<sup>1</sup>

## Background

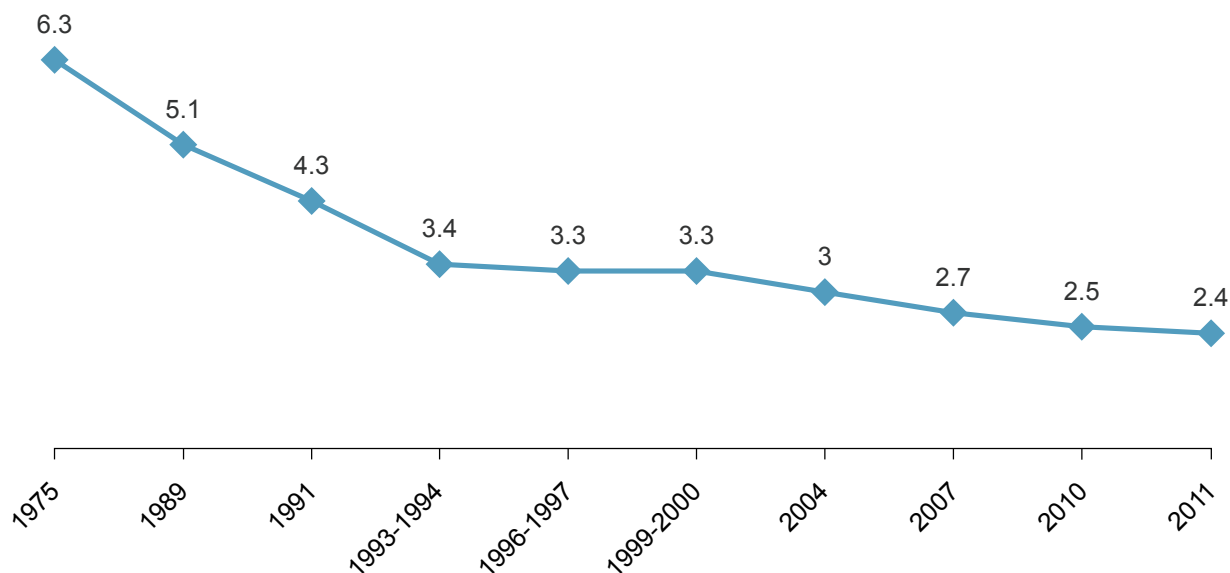
Located in South Asia, Bangladesh is home to 150 million people, nearly half of whom live below the poverty line. While the country's gross domestic product nearly doubled between 2006 and 2011, the health needs of the country are far from being met. Basic health indicators such as malnutrition affect 40 percent of children and 30 percent of women, and tuberculosis prevalence is the sixth-highest in the world.

In regard to family planning, the country's total fertility rate decreased from 6.3 births per woman in 1975 to 3.4 in 1994 (see Figure 1). Total fertility rate continued to fall in the ensuing 16 years at a much slower rate until it reached 2.4 births per woman in 2011. The driver for the rapid initial drop in fertility was a committed family planning program that had strong support from the highest levels of government and society. Since its founding as an independent country in 1971, Bangladesh has had a directorate general of family planning at the same administrative level as the overall health directorate. It is the only country with such an arrangement. Additionally, the National Population Council is chaired by the prime minister and includes the participation of all ministers involved in development.

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<sup>1</sup> Rahaim, Stephen, Jahiruddin Ahmed, Meaghan Smith, and Helen Li. June 2011. *Bangladesh Private Sector Assessment of Long Acting and Permanent Family Planning Methods and Injectable Contraceptives*. Bethesda, MD: SHOPS Project, Abt Associates.

Figure 1. Total Fertility Rate, Women Ages 15–49



Source: BDHS 2011

Active support for the national family planning program from doctors and other health providers in the early days of the country's independence was due in part to a sense of national purpose and social welfare. Family planning and population control was an important cause for these providers who wished to contribute to national development goals. As a result, all methods including LA/PMs were perceived positively. During the interviews for this assessment, many retired public sector doctors recalled that providers would speak with pride about the number of vasectomies and tubectomies they had performed during their careers.

The government also built a nationwide infrastructure of upazila (subdistrict) health complexes, conducted community-level outreach, and improved service capacity to push health services to the poor. The tremendous number of government-employed paramedics, known as family welfare visitors (FWVs), and family welfare assistants (FWAs) trained over the years were an important force for promoting and providing family planning services. Stakeholder interviews indicated that this critical supply of family planning support has been depleted as FWVs and FWAs are retiring and not being replaced. In the private sector, national organizations like BRAC, Marie Stopes International, and NGOs supported through USAID-funded projects like the NGO Service Delivery Project and the Smiling Sun Franchise Program have developed large-scale community health worker and service promoter networks that provide family planning services. One

of the critical players in family planning in Bangladesh is Social Marketing Company, which operates the largest social marketing program in the world based on volume of products distributed. Through oral contraceptives, condoms, and injectable sales, the organization accounts for 35 percent of the country's contraceptive prevalence rate (Bangladesh Demographic and Health Survey 2007).

Over the past decade, Bangladesh has changed considerably, especially within its national health system. There has been an explosion in the number of for-profit health providers; local manufacturers of family planning commodities (primarily oral and injectable hormonal contraceptives); and private medical colleges and training institutes, doctors, nurses, and paramedics. The Directorate General of Family Planning in the Ministry of Health and Family Welfare, which led the country's successful family planning program throughout the 1970s and 1980s, emphasized the importance of the private sector in meeting the family planning needs of the population. This includes the role of the private sector in the provision of LA/PMs as indicated in the new National Strategy for Improving the Uptake of Long-Acting and Permanent Methods.

### Scope of the Assessment

The private sector family planning assessment was designed to:

1. Understand which private sector actors are well-positioned to provide or expand quality LA/PM services. The actors may include for-profit providers, NGOs (especially those with large national reach), professional associations, for-profit hospitals and clinics, and private teaching colleges.
2. Identify and define the potential barriers, gaps, and needs that NGOs and for-profit providers face in becoming effective providers of quality LA/PM services.
3. Assess consumer demand for LA/PMs obtained through private providers and determine the needs for quantifying and segmenting the market to target consumers effectively.

## METHODS

SHOPS conducted a comprehensive literature review of published and gray literature related to the Bangladesh health system, family planning services, private health sector, financial sector, and major relevant donor-funded programs. The goal was to better understand the factors affecting the LA/PM market, demand for these methods, service availability, and supply. The assessment team then interviewed more than 60 stakeholders from government, NGO, and for-profit health providers; the pharmaceutical and financial industries; USAID and leaders of relevant USAID- and other donor-funded projects; family planning users and non-users; and other key informants. These stakeholder interviews were critical to understanding the

*In a new national strategy, the Ministry of Health and Family Welfare emphasized in a new national strategy the importance of the private sector in meeting the family planning needs of the population.*

attitudes held by public and private sector actors, donors, implementers, and users.

## FINDINGS

### Market and Demand

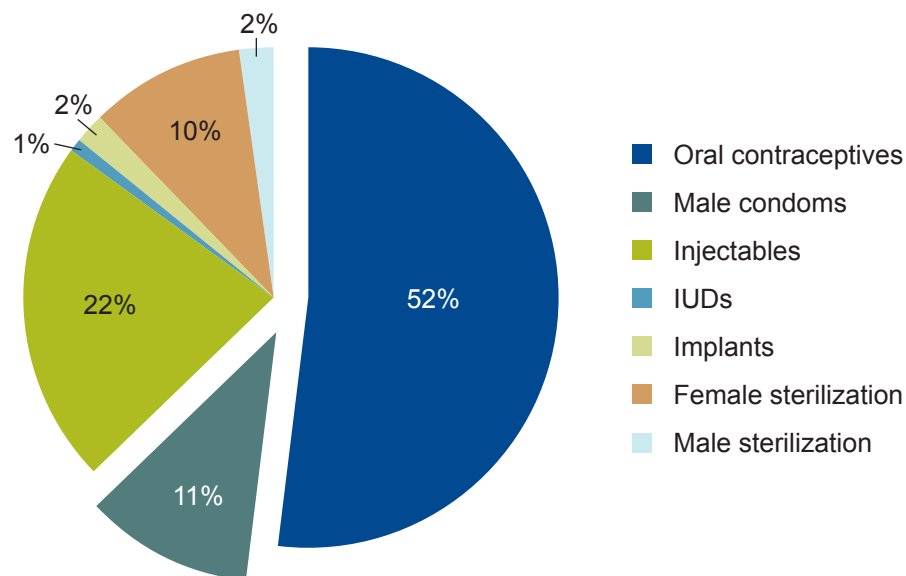
Bangladesh's unmet need for family planning is composed of the 53 percent of women of reproductive age who use no family planning method. Forty-two percent of women of reproductive age use modern methods and 5 percent use traditional methods (BDHS 2011). Overall, use of modern methods (see Figure 2) has increased from 48 percent in 2007 to 52 percent in 2011.

### Family Planning Statistics in Bangladesh

- 17 percent unmet need for family planning services and products
- 63 percent of urban and 62 percent of rural women report that they do not wish to have more children
- 99 percent of women know of at least seven methods of family planning

Despite 63 percent of women reporting that they do not wish to have more children, less than 6 percent of women have accepted a permanent method, indicating a significant need for LA/PMs in the country.

Figure 2. Use of Modern Family Planning Methods



Source: BDHS 2011



## Family Planning Method Mix

BDHS data suggest that there has been an increase in injectable and implant use from 2007 to 2011, while oral contraceptive use has declined (see Table 1).

**Table 1. Percent Change in Modern Method Use, 2007–2011**

	2007	2011	Percent Change
Oral contraceptives	60.3%	52%	-14%
Male condoms	9.5%	11%	16%
Injectables	14.8%	22%	49%
IUDs	1.9%	1%	-47%
Implants	1.5%	2%	35%
Female sterilization	10.6%	10%	-5%
Male sterilization	1.5%	1%	35%

Sources: *BDHS 2007 and BDHS 2011*

Note: Numbers are rounded to the nearest one-tenth of a percent.



*A woman visits a pharmacy in Bangladesh*

Stephen Rahaim

**Table 2. Source of Family Planning Method by Sector, 2011 (%)**

Source	Female Sterilization	Male sterilization	IUDs	Injectables	Implants	Oral Contraceptives	Condoms
<b>Private Sector</b>							
Hospital/clinic	21	4	4	2	1	0	0
NGO	3	5	7	8	5	3	2
Pharmacy	0	0	0	14	0	44	69
Other private source	1	0	0	9	0	7	11
<b>Total private sector</b>	<b>24</b>	<b>9</b>	<b>11</b>	<b>33</b>	<b>7</b>	<b>55</b>	<b>82</b>
<b>Public Sector</b>							
Government hospital	20	24	9	1	9	0	0
Family welfare center	5	6	35	18	27	6	3
Upazila health complex	42	52	28	5	43	2	1
Satellite clinic	0	0	0	11	0	3	0
Maternal and child welfare center	7	7	10	2	13	0	1
Government field worker	0	0	1	24	0	31	11
Other public source	1	0	6	6	2	2	1
<b>Total public sector</b>	<b>75</b>	<b>88</b>	<b>89</b>	<b>66</b>	<b>93</b>	<b>45</b>	<b>17</b>
<b>Total other sources</b>	<b>1</b>	<b>4</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: BDHS 2011

Note: Totals may not equal 100 due to rounding.



### **Oral contraceptives and condoms**

**Prevalence:** Oral contraceptives continue to be the preferred modern method among women of all education levels, and account for 30 percent of the country's contraceptive prevalence rate (Bangladesh Maternal Mortality Survey 2010). Pharmacies distribute 69 percent of all condoms, exceeding distribution of all other channels.

**Drivers of demand:** The sizable preference for oral contraceptives in Bangladesh is attributable to a variety of factors. Oral contraceptives are inexpensive and local manufacturers have been producing them for several years. Interviews with providers and family planning program professionals indicate that providers tend to prefer oral contraceptives as they believe the method is quicker and easier to counsel, screen, and distribute. Once prescribed, patients can go to easily accessible pharmacies to purchase the product.

**Risks and challenges:** Informant interviews indicate that the high level of migrant labor in the country has resulted in couples using oral contraceptives as a just-in-time method for family planning. This incorrect use of the method requires further consumer education programs.

## **Family Planning Methods Sourced from the Private Sector**

Private sector sources account for nearly 44 percent of modern family planning methods used, with 40 percent representing pharmacies where only oral contraceptives and condoms are available. These pharmacies are often a person's first point of contact with the health system, yet play virtually no role in the provision of LA/PMs.

### **Injectables**

**Prevalence:** Injectables have become an increasingly popular method among women of all education levels, increasing from 7 percent in 2007 to 11.2 percent in 2011 (BDHS 2011). Both the public and private sectors drive demand for the method, as 66 percent of injectables are sourced through the public sector and 33 percent are sourced through the private sector (see Table 2).

**Drivers of demand:** Informant interviews suggest that this relatively high prevalence is partly a result of the change in policy to allow nongraduate medical providers (drug sellers and similar pharmacy staff with specialized training) to provide the method through for-profit pharmacies participating in the Social Marketing Company Blue Star network.

**Risks and challenges:** Informant interviews also suggest that injectables provide users a level of freedom from a daily behavior of taking pills or an event-based behavior like negotiating and using a condom. Side effects

are the leading cause for discontinuation (BDHS 2011). Some informants interviewed felt that discontinuation could be addressed by improving provider counseling related to side effects, particularly when distributed through pharmacies.

### **IUDs**

**Prevalence:** IUDs have low prevalence as a family planning method, with a 0.9 percent rate of use and a relatively high level of dissatisfaction and discontinuation (Bangladesh Maternal Mortality and Health Care Survey 2010). Within the total method mix in Bangladesh, only vasectomies have a lower rate of use (0.7 percent) over the past 30 years. Of the 0.9 percent of users, 63 percent of IUDs are sourced through the public sector from family welfare centers and upazila health complexes, compared with the 11 percent sourced from private hospitals and NGOs.

*None of the 18 public or 45 private medical colleges currently train graduate doctors in IUD insertion and removal.*

**Drivers of demand:** While it is difficult to pinpoint why IUDs never developed a positive reputation in Bangladesh, informant interviews suggest that negative provider perceptions have contributed significantly. FWVs are permitted to insert IUDs, which has resulted in negative perceptions about the method from doctors, who previously were the only cadre qualified to insert IUDs. Among users, side effects and health concerns are the leading cause of discontinuation of IUDs (BDHS 2011). Informant interviews indicate that most IUD insertions or tubal ligations performed in the private sector are integrated with delivery or done postpartum, for higher-income women.

**Risks and challenges:** While there were once many FWVs trained to insert IUDs, there are now an increasing number of FWV vacancies across the public sector upazila health complex system. The low use of this method means that few trained IUD providers in both public and NGO facilities, and especially in the private sector, have opportunities to maintain their skills in IUD insertion and removal. This could lead to a lack of or inappropriate screening and counseling and poor-quality insertions, which could contribute to client dissatisfaction and discontinuation of use. Exacerbating this lack of qualified IUD providers is the fact that none of the 18 public or 45 private medical colleges currently train graduate doctors in IUD insertion and removal, leaving specialized provider training to only the government or NGOs. Further, IUDs are only available through government facilities and NGOs offering IUD services.

Attempts to increase the availability and use of this method in the for-profit sector have not been successful. Most notably, Social Marketing Company's attempt to pilot IUD delivery through ob/gyns participating in the Blue Star network has produced few users and there has been a significant drop-out of providers due to a lack of interest among their clients. One individual provider informed the assessment team that she had inserted only five IUDs in the past three years, despite being well-regarded in her community and having a relatively high patient flow.

## **Implants**

**Prevalence:** The Directorate General of Family Planning noted a recent spike in the popularity of single rod implants, from 0.7 percent in 2007 to 1.1 percent in 2011 (BDHS). This is supported by distribution data from the Directorate's supply chain. The spike is of some concern to the Ministry of Health and Family Welfare, as it could be difficult for the government to sustain the cost of a large increase without planning for it through a procurement cycle.

**Drivers of demand:** The USAID Mayer Hashi and RESPOND projects conducted a user acceptability study, which found that most women using Sino-implant (II) had a favorable experience. The study observed 595 women who chose Sino-implant (II) during a routine family planning visit. Ninety-five percent said their experience was favorable at six months, but mentioned that the primary aspect of the method that they disliked was the change in their menstrual patterns. Despite this side effect, 75 percent of women said they would recommend the product to a friend. The study shows that demand for implants can grow if the products are available to and supported by providers in both the public and private sectors.

**Risks and challenges:** This method is primarily available through public sector facilities and large NGO networks like Smiling Sun Franchise Project and the Urban Primary Health Care Project, which receive all of their commodities through the public sector supply chain. A small percentage of implants are reported to be sourced through private hospitals, but these facilities are likely out of reach to low-income populations. Without a supply of this product across all types of private sector facilities, implants are a missed opportunity for LA/PMs in Bangladesh.

*Demand for implants can grow if the products are available to and supported by providers in both the public and private sectors.*

## **Tubectomies and vasectomies**

**Prevalence:** While there has been a small increase in vasectomies (0.7 percent in 2007 to 1.2 percent in 2011), the overall number of vasectomies remains low, after a significant decline from their utilization peak in the late 1980s. Preliminary reports from the 2011 BDHS indicate that tubectomies have remained steady at 5 percent, a decline from a peak of 9 percent in 1991.

**Drivers of demand:** The introduction of nonscalpel vasectomies does not seem to have made a significant difference in their acceptance among men. The recent increase may be attributable to a small, localized program that trained men who had received vasectomies to champion the method.

**Risks and challenges:** Informant interviews reveal the negative public perception of tubectomies and vasectomies as family planning methods for the poor. Given this bias, shifting this product up-market to audiences who have the ability to pay for services will be challenging. Another barrier to increasing tubectomies and vasectomies is the limited ongoing presence

of LA/PM services in rural areas. Despite NGOs operating hundreds of satellite clinics, these facilities are staffed for only one day per month, during which they report high levels of client flow.

### **Service Availability**

The private health sector is making important contributions to Bangladesh's health indicators; it is responsible for the majority of the 10-year steady increase in facility-based births, which increased from 8 percent to 23 percent overall and 2.7 percent to 11 percent in for-profit facilities (Bangladesh Maternal Mortality Survey 2010). There has been significant growth in the presence and reach of for-profit facilities throughout the country, especially in urban and peri-urban areas. Examples of facilities include private hospitals and outpatient clinics, diagnostic centers, and pharmacies—many with consulting physicians—and independent doctors with private chambers.

*There has been significant growth in the presence and reach of for-profit facilities throughout the country, including hospitals, outpatient clinics, diagnostic centers, and pharmacies.*

The government of Bangladesh plans to create up to 18,000 community health clinics, nearly 12,000 of which have already been established. However, many are not currently operational or are lacking staff, equipment, or supplies. LA/PMs are not regularly available at operational clinics, but some service delivery NGOs stage monthly mobile services, including LA/PMs, in these facilities.

### **Providers**

There are several types of medical professionals allowed to provide LA/PMs in Bangladesh. Only ob/gyns commonly provide all types of LA/PMs, and are generally located in urban and peri-urban settings. Ob/gyns in particular are known to have a dual practice (both public and private) across multiple facilities.

Nurses are not numerous in Bangladesh, but as evidenced by the increasing number of private medical schools starting nursing programs, it is anticipated that the number of nurses will grow. Paramedics are more common, especially in the public sector, where they are known as FWVs. As has been noted, retirements are depleting their number and the Directorate General of Family Planning is not training replacements. While the only LA/PMs that nurses and paramedics are qualified to provide are IUD insertions and injectables, these two groups of professionals are critical in providing counseling services for various methods, especially relative to the amount of counseling provided by ob/gyns and general practitioners.

Several organizations serve the LA/PM provider community: the Bangladesh Medical Association, the Bangladesh Medical Private Practice Association, and the Obstetrical and Gynecological Society of Bangladesh. This last association is known for approving and certifying national training guidelines for family planning and has been pursuing opportunities to become a training institution for providers. All three associations are

represented in the National Technical Committee, which is responsible for most significant decisions made related to health care regulation.

### **Medical Education**

Currently, none of the 18 public or 45 private medical schools teach LA/PM methods as a clinical skill or offer the opportunity to practice the methods in internship. The government of Bangladesh and donors have not supported training of existing private sector providers in these services at a scale sufficient to fill vacancies. Although availability of general training for paramedics and degreed nurses has recently expanded, these programs are not readily available for private providers. While the government, supported by the Mayer Hashi project, has made significant progress in streamlining the training curriculum, the blocks of time required are too long for a private provider to be away from the clinic; his or her absence often means revenue and income are lost (see Table 3).

**Table 3. Required Training for Family Planning Providers**

<b>Method</b>	<b>Available to</b>	<b>Days of Training Required (Basic)</b>	<b>Days of Training Required (Refresher)</b>
<b>IUD</b>	Nurses, paramedics, general practitioners	12	6
<b>Sterilization</b>	Ob/gyns, general practitioners	18	12
<b>Implant (single-rod)</b>	Doctors	2	Not specified
<b>Implant (single-rod)</b>	Nurses, paramedics, non-graduate medical providers	Not specified	Not specified

### **Workplace Programs**

In addition to government, NGO, and for-profit private providers, the large industrial base in Bangladesh has begun to develop health facilities and some capacity to provide a basic level of health services to factory employees. The best example of this is the garment industry, which is required to meet international standards of working conditions, including basic primary health care. The Bangladesh Garment Manufacturers and Exporters Association is providing essential health services, and, through partnerships with Marie Stopes International and the Smiling Sun Franchise Program, is providing family planning services including LA/PMs on-site at their facilities. For services not available on-site, Marie Stopes International and the Smiling Sun Franchise Program refer clients to their static clinic locations.



### **Policy Barriers**

Informant interviews suggest that private providers lack awareness of the policies and regulations for their required registration and certification for provision of family planning and LA/PMs. While the Directorate General of Family Planning created and distributed circulars explaining revised policies on social requirements for LA/PMs and the requirements for registration and certification, these do not appear to have reached many providers or have filled the knowledge gap on these issues. This lack of awareness is exacerbated by a pervasive inconsistency in the application of policies and regulations among public, NGO, and for-profit facilities.

### **LA/PM Supply**

All LA/PMs in Bangladesh are sourced through the government supply chain through a World Bank-pooled procurement system with a third-year tender. The government purchase is generally stored in a central warehouse and then distributed to family planning officers at upazila health complexes, who then distribute the products to public sector or NGO facilities such as Social Marketing Company or the Smiling Sun Franchise Program.

While private providers are able to receive products from the public supply system, government restrictions have resulted in virtually no availability of LA/PMs. These restrictions include the requirement that all facilities which provide LA/PM services must provide the product for free, must maintain separate and auditable financial records for these products, and must participate in the complex government reimbursement scheme. Organizations like Social Marketing Company that provide these services generally charge a nominal service fee to recover some operating costs. Until recently, there was no supply of IUDs or implants available to for-profit providers.



Hirshini von Kalm



## ***Manufacturing and Distribution***

**Injectables:** Techno Drug is the only manufacturer currently providing injectables to the public supply chain. Renata Pharmaceutical and Incepta Pharmaceutical are investigating the potential production of injectables for public tender, which continues to limit private provider access to the products. Nuvista Pharmaceutical is a local firm that began producing and testing injectables in 2012, but its plan to produce the product is on hold.

**IUDs:** Interviewed private providers could not name a commercial source from which they could procure IUDs even if they wanted to provide the method. This may be because there was no local manufacturing of IUD products until 2012. In that year, a local firm, JMI Syringes & Medical Devices Ltd. established a relationship with the government of Bangladesh and registered its Copper T 380A IUD product with the drug administration authority. This resulted in a procurement of 400,000 units by the government, which will account for the private sector supply over the next few years. The procurement reduces the need to include IUDs in the next public tender and provides a significant cost savings to the government.

**Implants:** Implants are yet not manufactured in Bangladesh by any company. Techno Drug, Renata, and JMI Syringes & Medical Devices Ltd., have indicated that they are potentially interested in manufacturing locally. Given that implants are not available in the local market for private facilities, this is an important opportunity for private sector provision of LA/PMS.

## ***Availability***

**Private Providers:** Social Marketing Company distributes donated injectable commodities through its Blue Star network of chemist shops and pharmacies, which are run by trained staff who can provide all injections except the first for consumers. Other private providers are likely able to procure injectables through commercial sources, but this is a small portion of overall injectable distribution.

There is no formal access to IUDs and implants for private providers, although BDHS data show that there is likely some leakage among dual-practice providers. Social Marketing Company is currently collaborating with USAID and USAID partners to establish a supply of IUDs and implants freely available to private providers.

**Users:** Injectables are increasingly available in the for-profit sector but only through for-profit pharmacies that participate in Social Marketing Company's Blue Star network, which receives and sells the product at a subsidized price. Pharmacists trained as nongraduate medical providers are able to provide all injectable doses after the consumer has received the initial dose from a doctor. On rare occasions, women access injectables from providers who have purchased their own supply of the product.

In some countries, users purchase IUDs and implants and bring them to providers for insertion. In Bangladesh, these products are neither available to private providers, nor the consumer.

## RECOMMENDATIONS

### Market and Demand

Expand the demand for LA/PMs through focused promotion and by targeting consumers and providers.

- Conduct formative research to better understand client preferences, in addition to provider behavior.
- Develop an interpersonal health provider behavior change initiative to improve provider perceptions of LA/PMs and dispel biases based on incorrect or dated medical information.
- Support the scale-up of LA/PMs including postpartum IUDs and tubectomies at high-volume private sector facilities.
- Conduct strategic communication activities to reposition LA/PMs in the minds of potential clients.

### Service Availability

Leverage relationships with USAID partners to extend services to rural areas while building the capacity of experienced national and local institutions to provide services more sustainably.

- Support the scale-up of NGO outreach and satellite clinics to extend availability of services in rural and hard-to-reach areas.
- Build the counseling and referral capacity of the extensive number of nonqualified health providers in rural areas, often referred to as nongraduate medical providers.
- Support the government's contracting out to national-level NGOs to support the operation of vacant community-level clinics. Build capacity of district- and upazila-level organizations to operate these facilities in a sustainable way.

Work with the industrial sector to identify strategies for public-private partnerships that improve access to LA/PMs for employees.

- Expand USAID mobile clinic programs to garment factories to quickly capitalize on existing relationships, operations, and logistics.
- Initiate a consultative process with large companies to engage in a public-private partnership that meets employee needs.
- Establish a global alliance among large employers, associations representing their employees, corporate buyers, USAID, and the government of Bangladesh to scale programs.

Extend LA/PM training to private providers through relevant channels.

- Restructure the Directorate General of Family Planning's LA/PM training to better suit the schedules and requirements of private providers.
- Identify public-private partnerships to extend trainings to all private doctors, nurses, and paramedics through private provider associations and other channels.
- Integrate LA/PM clinical and counseling skills into public and private medical college coursework and clinical internships.

Improve communication and orient private providers on LA/PM methods, policies on provider and facility certification, and eligibility requirements.

- Host district-level dialogues and orientations to bring together public NGOs and private providers, and better understand each party's needs, challenges, and interests.
- Explore additional forums for public-private dialogue to clarify policies and regulations, discuss and improve the communication and application of policies and regulations, and improve understanding between the public and private sectors.

### **LA/PM Supply**

Support a commercial supply of LA/PM products available to for-profit providers not participating in the public sector supply chain or network.

- Support Social Marketing Company to operate as a wholesaler of IUDs and implants, and distribute to the for-profit sector.
- Engage local manufacturers to explore public-private partnerships to make their LA/PM products available to lower-income levels through their existing distribution and marketing networks.
- Encourage local manufacturing and distribution of injectables and implants to for-profit providers.

## **CONCLUSION**

There are numerous opportunities for USAID to increase availability of LA/PMs through the private sector and improve the utilization of LA/PMs in the overall family planning method mix in Bangladesh. While the market for LA/PMs in Bangladesh has some unique and significant barriers to the entry of for-profit providers and the development of a commercially viable and sustainable LA/PM market, the time for making strategic investments is now. The increased interest in long-acting methods like injectables—among consumers, providers, and local manufacturers—should be capitalized on by family planning programmers with a careful eye on how to facilitate the development of a commercially viable market and an interest in other long-acting methods.

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**BRIEF**

Bangladesh Family Planning Private Health Sector Assessment

For more information about the SHOPS project, visit: [www.shopsproject.org](http://www.shopsproject.org)



Abt Associates Inc.  
4550 Montgomery Avenue, Suite 800 North  
Bethesda, MD 20814 USA  
Telephone: 301.347.5000 • Fax: 301.913.6019  
[www.abtassociates.com](http://www.abtassociates.com)