

Assessment of a Post Partum Family Planning (PPFP) Intervention in Selected Areas of Bangladesh*

Background

Closely-spaced pregnancies increase the risk of poor maternal and child health outcomes.¹ In Bangladesh, 11% of non-first births occur within 24 months of the previous birth, according to the 2017–2018 Bangladesh Demographic and Health Survey (BDHS). The total fertility rate (TFR) in Bangladesh is 2.3 births per woman, which is 0.6 higher than the desired rate of 1.7. Additionally, 10% of married women have an unmet need for family planning (FP).² Postpartum family planning (PPFP) plays a critical role in preventing unintended and closely-spaced pregnancies during the first year after childbirth by offering FP counseling and services.

The World Health Organization (WHO) identifies multiple contact points with maternal, newborn, and child health (MNCH) services during this period, providing opportunities to integrate PPFP. With the recent rise in antenatal care (ANC) coverage and facility deliveries in Bangladesh, there is a significant opportunity to provide PPFP services through both public and private health facilities.^{1,3} Approximately two-thirds of facility deliveries occur in private health facilities, while one-third take place in public facilities, mainly under the Directorate General of Health Services (DGHS). Nearly 90% of women receive ANC from these facilities, presenting an opportunity to integrate FP counseling and services widely.

Since 2002, the Government of Bangladesh (GoB) has implemented PPFP initiatives, initially promoting tubectomy and later expanding to include IUDs and other methods across public and private facilities. Recently, the DGHS and the Directorate General of Family Planning (DGFP) enacted two government orders (GOs) to institutionalize PPFP services, aiming to increase immediate PPFP acceptance (Figure 1). However, the extent to which women accept PPFP when counseled during ANC or offered methods during delivery remains underexplored in Bangladesh.

Therefore, it is essential to evaluate the impact of systematic PPFP counseling and service provision during ANC, delivery, and postnatal care (PNC) on the uptake of FP method uptake during the postpartum (PP) period.

Figure 1. Timeline of PPFP interventions and GO implementation

2002

The **GoB** begins **PPFP** interventions by offering tubectomies to women undergoing caesarean sections and normal vaginal delivery in **16 government facilities**.

2009–2012

The **PPFP program**, including IUD and tubectomy, is scaled up in **104 public, private, and NGO facilities**.

2023

The **GOs** have been in place for over **4 years**, but implementation processes remain undeveloped, leaving significant gaps.

2008

DGHS, DGFP, EGH, and USAID introduce IUD and tubectomy on a pilot basis at Ad-Din Hospital, marking the first systematic effort to initiate **immediate postpartum IUD services**.

2019

Two GOs direct the **DGHS** to provide **PPFP services** at its facilities and instruct the **DGFP** to fund and supply **short-term methods and LARC/PM** at private facilities.

* This brief is based on the report, [Assessment of a Postpartum Family Planning Intervention in Selected Areas of Bangladesh](#), D41, July 2024.

¹ Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: The unfinished agenda. *The Lancet*; 368 (9549):1810–1827. Retrieved from: [Family planning: the unfinished agenda - PubMed \(nih.gov\)](#)

² National Institute of Population Research and Training (NIPORT) and ICF. (2023). Bangladesh Demographic and Health Survey 2022: Key Indicator Report. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

³ Tafere, T.E., Afework, M.F., & Yalew, A.W. (2018). Counseling on family planning during ANC service increases the likelihood of postpartum family planning use in Bahir Dar City Administration, Northwest Ethiopia: a prospective follow up study. *BMC Contraception and Reproductive Medicine*, 3 (28). <https://doi.org/10.1186/s40834-018-0081>.



Objectives

This study aimed to achieve three primary objectives:

1. To measure the effect of strengthened and systematic PPFP counseling during ANC visits at health facilities and/or offering FP methods during facility-based delivery on the acceptance of FP methods during the PP period.
2. To understand women's perspectives on receiving counseling on PPFP during ANC visits at facilities and/or during facility delivery, and their decision-making process regarding the use of FP methods during the PP period.
3. To examine healthcare providers' view of PPFP service delivery, including the overall service delivery system.

Methods

Study design

The assessment was a comparative study with an intervention and a comparison group, tracking pregnant women from pregnancy through three months postpartum in both arms. The study used a mixed-methods approach, measuring PPFP use among women in both the intervention and comparison groups three months after delivery.

Study sites

The study was conducted in three intervention facilities and two comparison facilities in the Chattogram division. The intervention group included one Mother & Child Welfare Centre (MCWC), one Upazila Health Complex (UHC), and one private hospital, all receiving technical support from the USAID-funded MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP) to enhance PPFP counseling and services. The comparison group comprised one MCWC and one UHC in the same division, both operating under standard GoB programs.

Study participants

The study included two population groups:

- Pregnant women who delivered at either intervention or comparison facilities
- Pregnant women who sought ANC services at these facilities

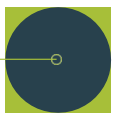
Data collection

A team of six data collectors, supervised by two coordinators, conducted in-person surveys at participants' residences three months after delivery. To achieve the required sample size, enrollment continued until the target was met (Table 1). Interviews lasted 45–50 minutes and used a structured questionnaire covering background and household characteristics, reproductive history, FP knowledge and use, ANC, delivery, PNC, and exposure to PPFP counseling.

The survey data was complemented with qualitative data from 27 counseling session observations during ANC, labor, and PNC across intervention and comparison facilities. Additionally, 24 in-depth interviews (IDIs) with women, categorized as PPFP acceptors and non-acceptors, and 13 key informant interviews (KIIs) with providers and facility managers were conducted.

This study addresses **two key research questions:**

1. *Did PPFP counseling at ANC and around delivery help increase PPFP use?*
 - If yes: *Invest to improve and increase PPFP counseling at ANC and around delivery.*
2. *Was PPFP counseling at ANC and around delivery higher in MaMoni MNCSP-supported facilities compared to facilities where MaMoni MNCSP did not provide any support?*
 - If yes: *Promote or scale up MaMoni PPFP activities.*
 - If no: *Assess the strengths and weaknesses of MaMoni PPFP activity in promoting PPFP counseling at ANC and around delivery.*



Data analysis

Quantitative analysis used percentage distribution and multiple logistic regression to assess PFP counseling's effect on initiation. Qualitative data were audio-recorded, transcribed in Bengali, and analyzed using thematic analysis with inductive coding. Data reliability was ensured through independent coding by two researchers, with results validated by sharing with knowledgeable respondents.

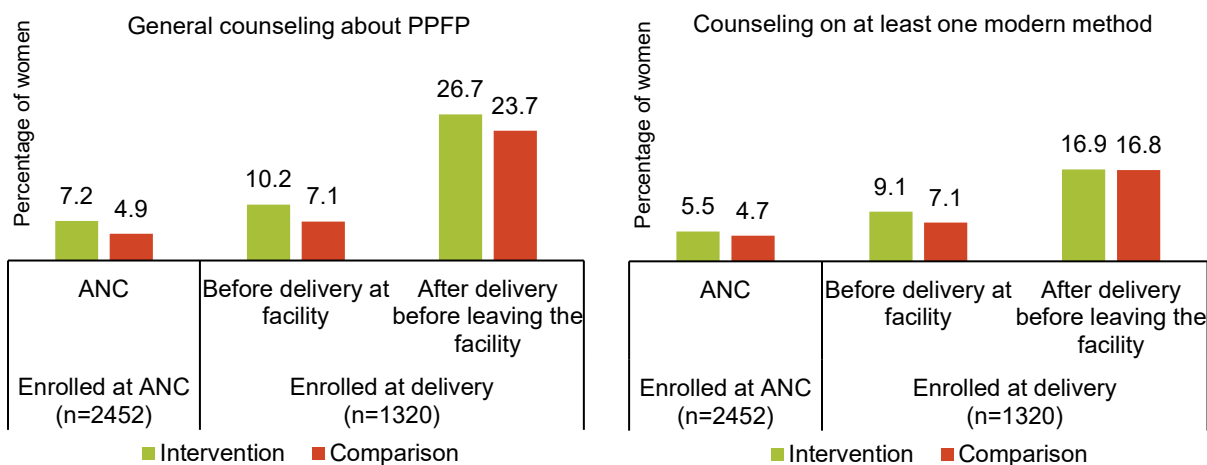
Table 1. Study areas and sample size in each facility

Enrolled during	Intervention			Comparison	
	MCWC	UHC	Private hospital	MCWC	UHC
ANC	574	730	262	–	–
Delivery	249	394	255	–	–
ANC	–	–	–	490	396
Delivery	–	–	–	133	289

Results

Among all clients interviewed, only 5.8% received PFP counseling during ANC, with no statistically significant difference between intervention and comparison facilities. The percentage of clients who received counseling before delivery was slightly higher at 8%, increasing fourfold (21.7%) after delivery but before leaving the facility. In both study arms, counseling on at least one modern method was around 5% during ANC, 8% before delivery, and 17% after delivery. Information on long-acting reversible contraception/permanent methods (LARC/PM) availability and FP counseling immediately after birth was even lower, with similar rates between study arms (Figure 2). FP leaflet distribution was almost nonexistent in the comparison arm.

Figure 2. Percentage of women received FP counseling during ANC, before and after delivery



Multivariable analyses suggest that counseling before and after delivery was significantly higher in intervention facilities than in comparison facilities. The likelihood of receiving PFP counseling increased significantly with higher parity. Qualitative findings from KIIs indicate that providers paid less attention to counseling women with lower parity. PFP counseling was significantly lower in UHCs than in MCWCs: 2.1% vs. 17.4% before delivery, and 17.2% vs. 44.9% after delivery. UHC providers viewed PFP counseling as less of a priority due to the presence of a separate FP department on the premises. Providers cited limited human resources and high patient flow as barriers to adequate FP counseling during ANC or around delivery time. However, two weeks of ANC observation sessions revealed that facilities serve patients for only three hours daily, from 10 a.m. to 1 p.m., despite a provision to serve for six hours.

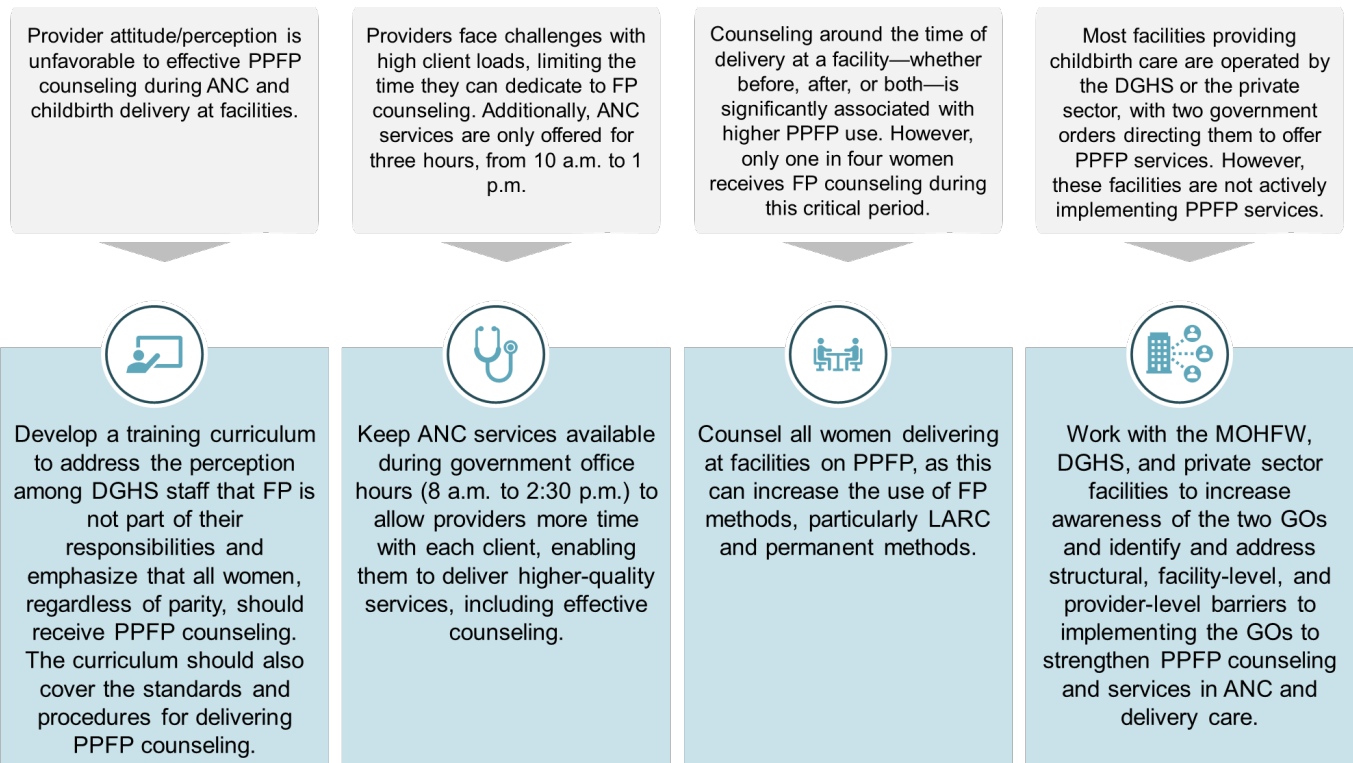


Approximately 56% of women interviewed adopted a FP method within three months postpartum, with 51% adopting modern methods. Among women who had a facility birth but did not receive counseling at the delivery place, 47.9% adopted a FP method. In contrast, the adoption rate was significantly higher among those who received counseling before delivery (69.4%), after delivery (77.5%), or both. Multivariable analysis indicates that PPF counseling around delivery is significantly associated with increased FP use at three months postpartum. However, it is uncertain whether this is a causal effect of counseling, as clients with a pre-existing interest in PPF might be more likely to seek counseling or recall it and subsequently adopt PPF. Additionally, women cannot adopt a LARC/PM at delivery without receiving counseling.

Thematic analysis of descriptive data revealed that women expressed that labor was not an ideal time for FP counseling. Mothers expected counseling from a doctor with sufficient time and responsiveness. Ultimately, mothers identified PNC as a suitable time for PPF counseling.

Recommendations

We offer the following recommendations based on the study findings:



For more information

D4I supports countries to realize the power of data as actionable evidence that can improve programs, policies, and—ultimately—health outcomes. We strengthen the technical and organizational capacity of local partners to collect, analyze, and use data to support sustainable development. For more information, visit <https://www.data4impactproject.org/>

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the Data for Impact (D4I) associate award 7200AA18LA00008, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Palladium International, LLC; ICF Macro, Inc.; John Snow, Inc.; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government. FS-24-711 D4I