



## LESSONS LEARNED FROM INTEGRATION OF POSTABORTION CARE, MENSTRUAL REGULATION, AND FAMILY PLANNING SERVICES IN BANGLADESH

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### INTRODUCTION

#### Context of Abortion in Bangladesh

Although the Bangladesh penal code restricts abortion except to save the life of a woman, since 1979 the Government of Bangladesh has allowed Menstrual Regulation (MR) to induce menstruation and thus to return to non-pregnancy either at the time of, or within 8-10 weeks of the due date of menstruation (Akhter 1998). Accurate data on the incidence of abortion in Bangladesh is not available because of under-reporting and lack of record keeping. However, a survey in 2010

found an estimated 653,000 MR procedures were performed in health facilities nationwide (Singh et al. 2012). An additional 647,000 induced abortions were performed in the same year, the majority of which were unsafe (Singh et al. 2012). It is estimated that 231,400 women suffered from complications following induced abortion in 2010 (Singh et al. 2012). As a result, Postabortion Care (PAC) is an important service provided to women with incomplete abortion, either due to unsafe abortion, incomplete safe abortion, or miscarriage.

#### Role of the DGHS & DGFP in MR, PAC, and FP Services

The Bangladesh public health system provides health care through facilities governed by two separate directorates under the Ministry of Health and Family Welfare. MR services are provided through a partnership between the Directorate General of Family Planning (DGFP) and a key group of Non-Governmental Organizations (NGOs); PAC services are provided by facilities mainly under the Directorate General of Health Services (DGHS) and some of DGFP facilities. These systems result in reduced quality of care, particularly for PAC patients. PAC is most often provided by the obstetricians/gynecologists in in-patient wards using Dilatation and Curettage (D&C) under general anesthesia. Women receive this suboptimal technology even for uncomplicated cases when World Health Organization (WHO)-recommended methods such as Manual Vacuum Aspiration (MVA) are widely available in Bangladesh. In addition, PAC patients are significantly less likely to receive Postabortion Family Planning (PAFP) as compared to MR clients, in large part because family planning services are not available in DGHS facilities. A study in Jessore found that only 2 percent of PAC patients as compared to 55 percent of MR patients received postabortion contraception (Huda et al. 2010). This study recommended working toward improved post-procedure contraception delivery and evidence-based appropriate technology use for all procedures by improving collaboration and integration between DGHS and DGFP.

## Project Description

Ipas designed and implemented an 18-months pilot project with the goal of enhancing collaboration between DGHS and DGFP to integrate MR, PAC and Family Planning (FP) services at 16 selected facilities. Doctors, Nurses and Family Welfare Visitors (FWVs) were provided with training on WHO-recommended MVA technology for MR and PAC with pain management. Supply of necessary commodities was ensured either through government channels or supplemented by Ipas Bangladesh. Overall, the project's goal was to ensure that providers in each facility were able to provide MR, PAC and family planning services to any woman who requested the service.

### Box 1. Intervention objectives for each Directorate of the health system

#### DGFP System

- Strengthen existing MR services by refreshing skills in MVA and motivation for providing postabortion family planning
- Introduce quality PAC services using MVA
- Support services by FWVs at union level facilities to provide MR using MVA and strengthen referral to the associated Upazila Health Complex for PAC services

#### DGHS System

- Introduce MR services at district and medical college hospitals
- Add family planning services to postabortion care at district and medical college hospitals
- Introduce quality outpatient PAC services in district and medical college hospitals and shift PAC provision from D&C to WHO-recommended technology (MVA and/or MA)
- Introduce MR & PAC service provision by nurses

## METHODS

This study evaluated the success of Ipas Bangladesh's effort to integrate MR, PAC and FP services across DGFP and DGHS facilities. In conjunction with DGFP and DGHS representatives, facilities were purposively selected for participation in the pilot project to include urban (Dhaka and Narayanganj) and rural (Habiganj) districts, existing basic infrastructure for provision of services, and accessibility by Ipas staff and consultants to ensure and support program implementation. The Reproductive Health Services Training and Education Program (RHSTEP) clinic at Dhaka Medical College Hospital

(DMCH) was included in the study as the outpatient department of DMCH.

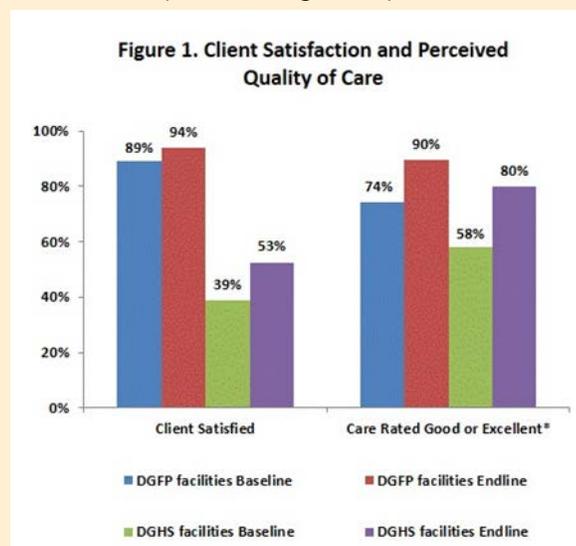
Ipas staff conducted a baseline assessment in selected project sites to understand current patterns of service provision under the existing model. This assessment identified opportunities for integrating and upgrading services, including provider training, facility improvements, and commodity supply. Next, eligible providers participated in training events on clinical skills as well as process changes for integration of services at their facilities. After training, a whole site orientation was conducted at each pilot facility to ensure that all staff understood the importance of the issue, proposed changes to service provision, and the process for implementation. Subsequently, trainers from DGHS and DGFP facilities and Ipas staff maintained contact with trained providers by phone and in-person to support quality service provision and address clinical and administrative challenges.

**Table 1. Number of uterine evacuation cases at baseline and endline, facility logbook data**

	Baseline	Endline
<b>DGFP Facilities</b>		
Narayanganj MCWC	18	95
Habiganj MCWC	58	46
Sonargaon UHC – FP Unit	26	37
Nabiganj UHC – FP Unit	9	24
Aushkandi FWC	12	8
Bara Bhakair FWC	4	6
Bausha FWC	3	5
Darogolla FWC	26	42
Debpara FWC	7	7
Hossainpur FWC	24	51
Kaliarbhanga FWC	7	3
Kargaon FWC	4	3
Kurshi FWC	3	7
Pirojpur FWC	13	19
<b>DGHS Facilities</b>		
Dhaka Medical College Hospital	69	255
Victoria Hospital, Narayanganj	8	34
Sonargaon UHC – Health Unit	20	29
Nabiganj UHC – Health Unit	22	22

Data sources used for this evaluation included client exit interviews, interviews with providers and facility managers, and facility logbook data. Structured client

exit interviews were conducted in-person by trained data collectors at the six project sites with sufficient caseload (client exit interviews were not conducted at the 10 Family Welfare Centers (FWCs) that were part of the pilot project). Interview data were collected at two time points. Baseline data were collected at the beginning of the project period (December 2011 – January 2012), and endline data were collected during the last two months of the project (February – March 2013). Client exit interviews were administered to all eligible and consenting clients during a designated time period at each facility. Women were eligible to participate if they were at least 18 years of age and had a MR or PAC procedure that day. A total of 105 women participated at baseline, and 107 participated at endline. Data were collected and processed by Association for Septic Abortion, Bangladesh (BAPSA). Women were asked about the care that they received at the facility, including details about their procedures and perceived quality of the care they received. A provider communication score was calculated based on 11 questions about specific aspects of provider communication, such as providing information on self-care after the procedure and warning signs of complications. Each of these yes/no questions was weighted equally, and the score ranged from zero for providers who did not communicate on any of the measures to 11 for providers who communicated on all of the aspects that were assessed. The overall mean score was 6.3 (SD=3.6; Range: 0-11).



All trained providers and facility managers were interviewed by trained data collectors in project sites. At

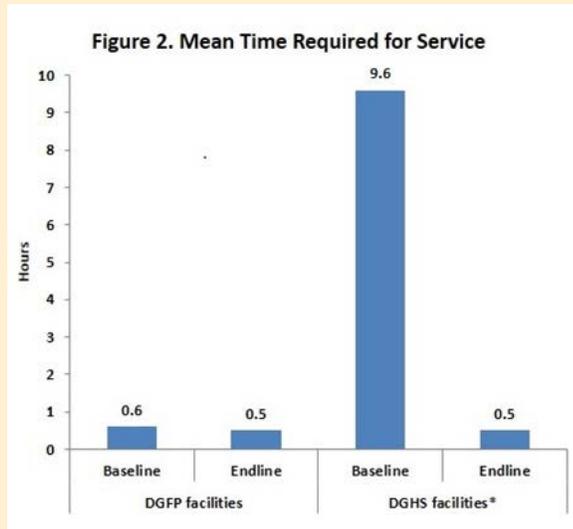
baseline, 30 providers and nine facility managers were interviewed, and at endline, 30 providers and 14 facility managers were interviewed. The same facility managers and providers were interviewed at baseline and endline when possible. Facility logbook data were collected during the first three months of service provision in the facility (baseline) and during the last three months of the project period (endline). Less than 10 percent of values were missing for each variable, and means and percentages were calculated among non-missing values. Chi-square tests were used to test for differences between categorical variables, and t-tests were used to test for differences between continuous variables. Significance was assessed at an alpha of 0.05. All analyses were conducted using Stata/SE version 12.1.

	Baseline (n=105)		Endline (n=107)		p-value
	n	(%)	n	(%)	
Age					0.62
Less than 20 years	10	(9.6)	4	(3.7)	
20-24	32	(30.8)	31	(29.0)	
25-29	28	(26.9)	30	(28.0)	
30-34	19	(18.3)	24	(22.4)	
35-39	13	(12.5)	16	(15.0)	
40-44	2	(1.9)	2	(1.8)	
Missing	1	(0.9)	0	(0)	
Mean Age (SD)	26.6	(5.7)	27.4	(5.4)	0.33
Education Level					0.99
No education	38	(36.2)	39	(36.4)	
Primary	40	(38.1)	40	(37.4)	
Secondary or higher	27	(25.7)	28	(26.2)	
Marital Status					1.00
Married	105	(100)	107	(100)	

## FINDINGS

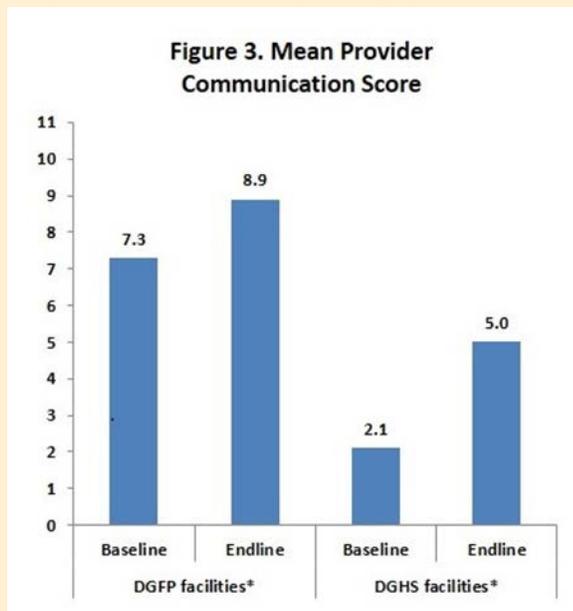
The pilot project was carried out in 16 health facilities: one medical college hospital and its associated RHSTEP clinic, one district hospital, two Maternal and Child Welfare Centers (MCWCs), two Upazila Health Complexes (UHCs), and 10 Family Welfare Centers (FWCs). A total of 30 providers were trained on MR and PAC and oriented to short-term family planning methods in these facilities during the project period. A detailed list of the facilities included in the study and a comparison of their uterine evacuation (UE) caseload during the baseline and endline periods can be found in Table 1. UE caseload increased in most facilities between baseline

and endline (Table 1). While an increase in caseload was not an objective of this project, this finding provides evidence of an increase in MR service provision at the union level.



### Demographic Characteristics

Among the clients interviewed for this study, most were 20-29 years of age and married (Table 2). Education varied in the sample, with approximately one-third of women in each category: no education, primary education, or secondary or higher education (Table 2). Women were very similar in baseline and endline samples based on these key demographic characteristics.



### MR, PAC and FP Service Integration

During the project period there was a great increase in women reporting MR service provision in DGHS facilities, from 0 percent at baseline to 44 percent at endline ( $p < 0.001$ ) (Table 3). Though the change was not statistically significant, there was also an increase in PAC service provision in DGFP facilities, from 13.5 percent at baseline to 25 percent at endline ( $p = 0.110$ ) (Table 3). There was also an increase in the proportion of UE procedures that women reported to be done by midlevel providers. In DGFP facilities, this proportion increased from 57.2 percent at baseline to 100 percent at endline ( $p < 0.001$ ), and in DGHS facilities, the proportion of procedures performed by midlevel providers increased from 16.7 percent at baseline to 49.2 percent at endline ( $p = 0.003$ ) (Table 3). Prior to this project, most UE procedures in DGHS facilities were performed using D&C (85 percent), but after implementation of this project, the proportion of procedures performed using D&C fell to 12 percent ( $p < 0.001$ ) (Table 3).

Postabortion family planning provision also improved during the project period. The proportion of women accepting a PAFP method increased from 3.2 at baseline to 45.8 at endline in DGHS facilities ( $p < 0.001$ ) (Table 3). The proportion also increased in DGFP facilities, but this increase was not statistically significant. In DGFP facilities, a larger proportion of women received long-term methods during the project period. At baseline, only 12.1 percent of women accepted a long-term method, compared to 29.2 percent at endline ( $p = 0.033$ ) (Table 3). In DGHS facilities, all of the women who accepted a method received a short-term method. Women who did not accept a family planning method were asked the reason. In both types of facilities, the proportion of women reporting that they did not accept a method because the facility did not have the method they wanted fell to 0 percent at endline (Table 3). Another important reason for not accepting a method was not being offered a method, which increased from 3.4 percent at baseline to 51.6 percent at endline in DGHS facilities (Table 3). Other important reasons that women reported included that they would take a method later, and that they had not decided on a method yet.

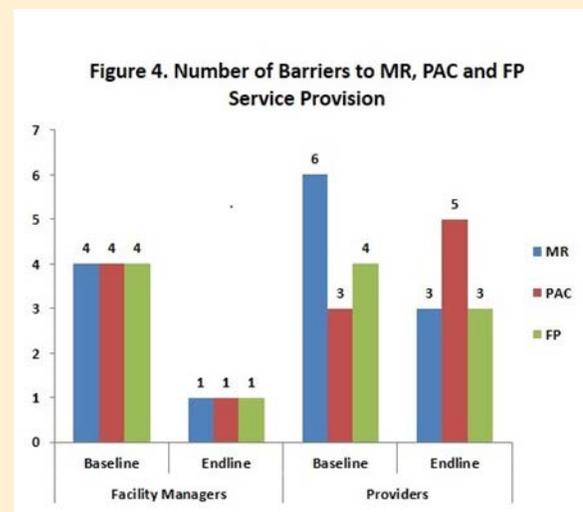
## Women's Perspectives on Quality of Care

Provider training focused on improving both clinical and patient care skills, and this study showed improvements in both measures, especially in DGHS facilities. In both DGFP and DGHS facilities, a higher proportion of clients reported being satisfied with the care they received at baseline as compared to endline, but this difference was not statistically significant (Figure 1). In DGFP facilities the proportion of women rating the care they received as good or excellent increased from 74 percent at baseline to 90 percent at endline ( $p=0.038$ ) (Figure 1). In DGHS facilities the proportion of women rating the care they received as good or excellent increased from 58 percent at baseline to 80 percent at endline ( $p=0.030$ ) (Figure 1). The total time spent to receive UE services was also measured, and this decreased dramatically in DGHS facilities from an average of over nine hours at baseline to under one hour at endline ( $p<0.001$ ) (Figure 2). The mean provider communication score increased significantly in both DGFP and DGHS facilities. In DGFP facilities, the mean provider communication score increased from 7.3 at baseline to 8.9 at endline ( $p=0.001$ ) (Figure 3). In DGHS facilities, the mean provider communication score increased from 2.1 at baseline to 5.0 at endline ( $p<0.001$ ) (Figure 3).

## Provider and Facility Manager Perspectives

The provider and facility manager interviews demonstrated that even at baseline, both groups strongly supported MR, PAC and FP service provision in their facilities. The number of barriers to service provision reported by both facility managers and providers decreased between baseline and endline (Figure 4). At baseline, facility managers listed a variety of barriers to service provision, including lack of a separate space for service provision, need for provider and support staff training, and lack of necessary medical equipment. At endline, the only barrier mentioned by facility managers was the lack of a separate room for MR, PAC or FP services. Providers mentioned similar barriers as the facility managers at baseline. At endline, providers focused on the need for a separate room for service provision as well as a need for additional training and assistance from support staff. The number of additional supports needed to provide quality MR, PAC and FP services also decreased between baseline and

endline (Figure 5). At baseline, facility managers identified MVA training and improved equipment and drug supply as their primary needs for additional support. At endline, the managers primarily discussed needing a private counseling area as well as FP training. At both baseline and endline, providers discussed training on MVA and FP as the primary areas where additional support was needed. Providers also mentioned needing a private counseling area at both baseline and endline. Improved equipment and drug supply was commonly discussed at baseline, but this was not a key need for additional support at endline among the providers.



## DISCUSSION

This project was successful in integrating MR, PAC and FP services across DGFP and DGHS facilities. The provider and facility manager interviews demonstrated that this project was also successful in improving equipment and drug supply to the pilot facilities as these were the primary barriers to service provision reported at baseline but not at endline. There is also evidence that interventions such as provider training, site improvement, and follow-up helped to improve the quality of services provided to women. After the project, women received a higher quality of care, both in terms of the clinical care that they received and their perceptions of that care. Use of WHO-approved UE methods increased during the project period, as did postabortion family planning provision. In addition, women were more likely to rate their care as good or excellent at endline, and experienced improved provider communication and

less time spent. Postabortion family planning, especially in DGHS sites, needs continued support, as many women are still not being offered a family planning method after their procedures. In addition, long-term family planning methods continue to be underutilized in both DGHS and DGFP facilities.

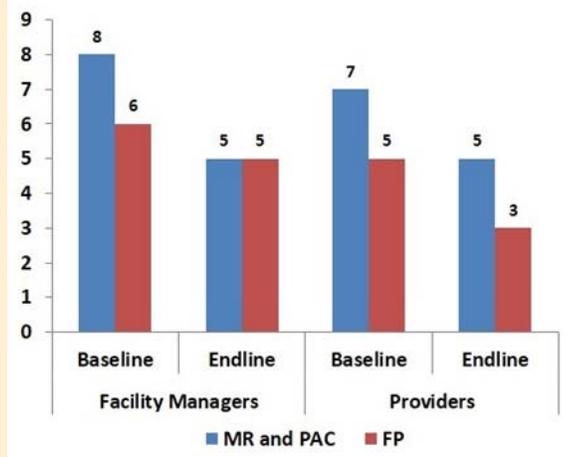
	DGFP facilities				DGHS facilities				Overall						
	Baseline (n=74)		Endline (n=48)		Baseline (n=31)		Endline (n=58)		Baseline (n=105)		Endline (n=107)		p-value		
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)			
UE Service Type													0.656		
MR	64	(86.5)	36	(75.0)	0	(0)	26	(44.1)	64	(61.0)	62	(57.9)			
PAC	10	(13.5)	12	(25.0)	31	(100)	33	(55.9)	41	(39.0)	45	(42.1)			
Provider Type													<0.001		
Doctor	30	(42.3)	0	(0)	23	(82.1)	30	(50.9)	53	(53.5)	30	(28.6)			
Midlevel provider	41	(57.2)	46	(100)	5	(17.9)	29	(49.1)	46	(46.5)	75	(71.4)			
Procedure Type													<0.001		
MVA	72	(97.3)	48	(100)	4	(12.9)	39	(66.1)	76	(72.4)	87	(81.3)			
D&C	2	(2.7)	0	(0)	27	(87.1)	7	(11.9)	29	(27.6)	7	(6.5)			
Other	0	(0)	0	(0)	0	(0)	13	(22.0)	0	(0)	13	(12.2)			
Pain Management Provided	61	(82.4)	46	(95.8)	0.028	29	(93.5)	58	(86.3)	0.232	90	(85.7)	104	(97.2)	0.003
Post-abortion FP Accepted	45	(60.8)	37	(77.1)	0.061	1	(3.2)	27	(45.8)	<0.001	46	(44.2)	64	(58.8)	0.023
Type of FP Accepted					0.033					<0.001					0.069
Short-term method	36	(48.7)	23	(47.9)		1	(3.3)	26	(44.1)		37	(35.6)	49	(45.8)	
Long-term method	9	(12.1)	14	(29.2)		0	(0)	1	(1.7)		9	(8.7)	15	(14.0)	
No method	29	(39.2)	11	(22.9)		29	(96.7)	32	(54.2)		58	(55.0)	43	(40.2)	
Reasons for Not Accepting an FP Method					0.018					0.003					<0.001
Did not want a method	2	(6.9)	0	(0)		5	(17.2)	1	(3.2)		7	(12.1)	1	(2.4)	
Not offered a method	1	(3.4)	1	(8.1)		1	(3.4)	16	(51.6)		2	(3.4)	17	(40.5)	
Facility did not have method she wanted	9	(31.0)	0	(0)		2	(6.9)	0	(0)		11	(19.0)	0	(0)	
Will take a method later	6	(20.7)	9	(81.8)		15	(51.7)	9	(29.0)		21	(36.2)	18	(42.9)	
Have not decided on a method yet	4	(13.8)	0	(0)		3	(10.3)	3	(9.7)		7	(12.1)	3	(7.1)	
Husband not at home	2	(6.9)	0	(0)		2	(6.9)	1	(3.2)		4	(6.9)	1	(2.4)	
Provider advised a permanent method	5	(17.2)	1	(8.1)		0	(0)	1	(3.2)		5	(8.6)	2	(4.8)	
Did not think about it	0	(0)	0	(0)		1	(3.4)	0	(0)		1	(1.7)	0	(0)	

## RECOMMENDATIONS

- Scale up integration of MR, PAC and FP services to ensure that women are able to access these services at both DGHS and DGFP facilities.
- Provide family planning training to DGHS providers on both short-term and long-term

methods. Long-term methods are also underutilized in DGFP facilities, and additional training on long-term family planning methods should be considered.

Figure 5. Number of Additional Supports Needed to Provide Quality MR, PAC and FP Services



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