Sources of Family Planning

Bangladesh

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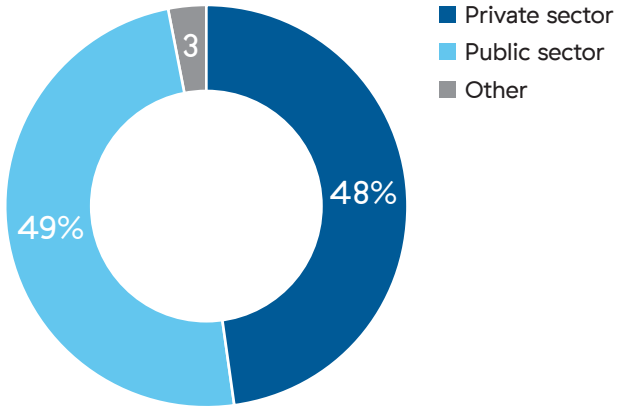
Understanding where women obtain their family planning methods can help programs to better target their resources and increase overall access to modern contraception. This brief is one in a series of country briefs that examines where women obtain modern contraception by method, geography, age, and socioeconomic status. Through a secondary analysis of the 2014 Bangladesh Demographic and Health Survey, the brief explains where married modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Bangladesh.

Key Findings

- Nearly one-half (48%) of modern contraceptive users rely on the private sector for their method.
- Bangladesh has a high and equitable modern contraceptive prevalence rate across population groups, including urban and rural women as well as poorer and wealthier women.
- More than two-thirds of the youngest users rely on the private sector for family planning.
- Thirty-five percent of the poorest modern contraceptive users obtain their method from the private sector.
- One-third of the wealthiest contraceptive users rely on public sector sources.

Source of modern contraceptives



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at **PrivateSectorCounts.org**.

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Modern contraceptive prevalence rate and method mix

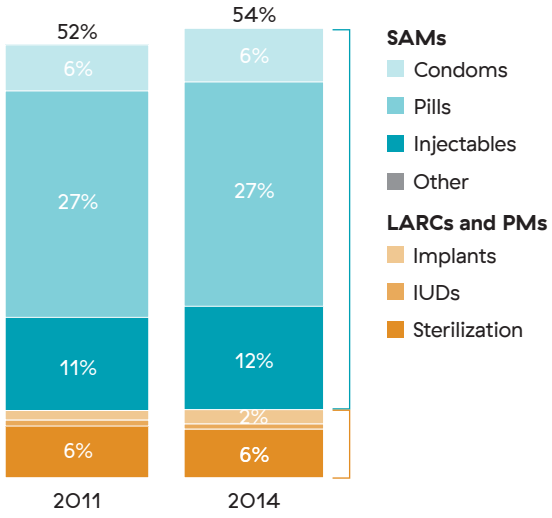
Among currently married women of reproductive age in Bangladesh, more than half (54 percent) use modern contraception.[1] Since 2011, short-acting methods (SAMs)—primarily pills and injectables—have been the most popular methods among married women (46 percent) and are responsible for the country's modest modern contraceptive prevalence rate (mCPR) increase. Fewer women use long-acting reversible contraceptives (LARCs) and permanent methods (PMs), which have remained stable at 8 percent.[2]

Sources for family planning methods

Among all modern contraceptive users in Bangladesh, nearly half rely on the public (49 percent) and private (48 percent) sectors. Three percent use other sources.[3] These source patterns are similar to those reported in 2011. SAM users are slightly more likely to obtain their method from a private than public source, while LARC and PM users are more likely to visit a public than a private facility.

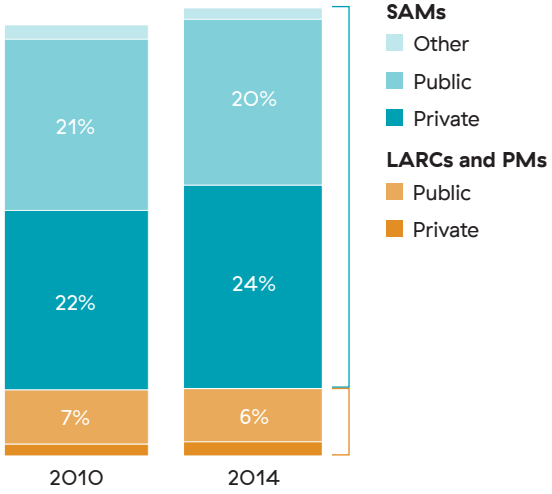
Among pill users, Bangladesh's leading method, 55 percent use private sources and 42 percent use public sources. For injectable users, the public sector is a more common source than the private sector (61 percent versus 34 percent, respectively). Among condom users, who constitute 12 percent of all modern method users, the private sector is the primary source (83 percent).

Pills and injectables are the dominant methods in Bangladesh



Note: Numbers may not add due to rounding.

SAM users rely nearly equally on public and private sources to obtain their method



[1] This brief focuses on currently married women, as the Bangladesh Demographic and Health Survey (DHS) does not collect family planning data from unmarried women.

[2] SAMs include injectables, contraceptive pills, male condoms, and fertility-awareness methods. LARCs and PMs include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Surveys do not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

[3] Public sector sources include public hospitals, maternal and child welfare centers, Upazila health complexes and health and family welfare centers, satellite clinics and outreach, community clinics, and field workers. Private sector sources include private hospitals, clinics, and doctors; NGOs including static clinics, satellite clinics, field workers, and depo holders; and pharmacies, drug stores, and shops. Other sources include friends, relatives, non-qualified doctors, and women who did not know or report the source. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

Private sector sources

Among all private sector users, the majority (84 percent) obtain their method from a pharmacy, drug store, or shop. In addition, 9 percent rely on NGOs and 7 percent on hospitals or clinics. The two methods most commonly sought from the private sector are pills and condoms. Nearly all pill and condom private sector users obtain their contraceptive from a pharmacy or shop (94 percent and 97 percent, respectively).

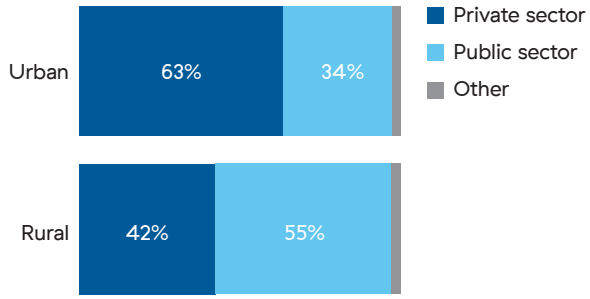
Rural and urban areas

Bangladesh has an equitable mCPR in urban (56 percent) and rural (53 percent) areas, which is unusual compared with global patterns in which the mCPR tends to be lower in rural areas. Urban contraceptive users are more likely to purchase their method from the private sector (63 percent) compared with rural users (42 percent). The method mix varies between urban and rural areas, as well. Condoms, the method most commonly sought from the private sector, are more popular among urban users than among rural users (21 percent versus 8 percent, respectively). Injectables, however, are less commonly used in urban areas than in rural areas (17 percent versus 25 percent, respectively). Pills remain the most popular method across urban and rural areas, relied on by approximately half of users. Contraceptive sources vary by division, as well. Private sector use is highest in Chittagong (56 percent) and Dhaka (54 percent) and lowest in Rangpur (39 percent). The population in Rangpur, Sylhet, and Khulna is at least two-thirds rural, which helps explain the lower private sector use.

Contraceptive source by age

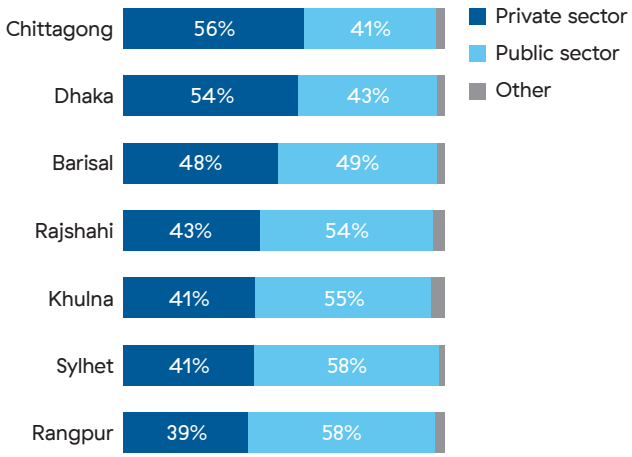
Contraceptive users age 15–19 and 20–24 are more likely than users age 25–49 to rely on the private sector (67 and 57 percent versus 44 percent, respectively). The prevalence of condom use does not vary by age. However, users age 15–19 and 20–24 are more likely to rely on pills (64 and 55 percent), which are commonly sought from the private sector, than users older than age 25 (47 percent). As expected, women ages 25 and older are more likely to be sterilized (15 percent) than users younger than 25 (1 percent).

Two out of three urban users rely on the private sector



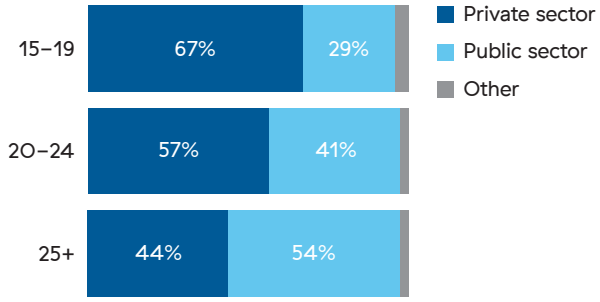
Percent of users in each group who obtain modern contraception from each source

Contraceptive source varies by division



Percent of users in each group who obtain modern contraception from each source

Younger contraceptive users rely more heavily on the private sector



Percent of users in each group who obtain modern contraception from each source

Contraceptive source by socioeconomic status

In Bangladesh, the mCPR is similar between the poorest and wealthiest women (55 and 53 percent).[4] Among the poorest urban and poorest rural modern contraceptive users, 35 percent rely on private sources. Nearly two-thirds (64 percent) of the wealthiest contraceptive users obtain their method from the private sector and one-third from the public sector. The wealthiest contraceptive users rely more on the private sector for SAMs (69 percent) than they do for LARCs and PMs (34 percent).

Nearly 4 in 10 of the poorest contraceptive users in Bangladesh rely on the private sector

One-third of the wealthiest contraceptive users in Bangladesh use the public sector

Implications

Bangladesh has a high and equitable mCPR across population groups, including urban and rural women as well as poorer and wealthier women. The country's contraceptive market is mature and, accordingly, both the public and private sectors are important sources of contraception. The private sector is heavily relied on among users of SAMs, particularly condoms and pills. Yet nearly half of pill users—the most popular method in Bangladesh—obtain their method from public sources. An opportunity exists to transition pill users with the ability to pay to private sources. This market segmentation strategy would free up public sector resources and enable the public sector to more effectively serve women who prefer more expensive, long-acting methods. Additionally, among injectable users, the second most popular method, the majority obtain their method from the public sector. Social marketing and social franchises, such as the Blue Star Program, are one mechanism to continue facilitating access to injectables through the private sector. Increasing provision of depot medroxyprogesterone acetate (DMPA) subcutaneous injectables in pharmacies—the most popular private sector source—could also help improve private sector participation. This would also help to ensure that women who are more likely to rely on private sources, such as youth, have access to the full range of methods. These strategies will provide greater opportunity for the private sector to serve those segments of the population with the ability to pay for contraceptive services, thereby fostering a more efficient, sustainable market.

[4] The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset-based wealth index. The wealthiest women are those in the top two wealth quintiles.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the generous support of the American people through USAID. The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

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