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Private providers' knowledge, attitudes and misconceptions related to long-acting and permanent contraceptive methods: a case study in Bangladesh

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Abstract

Objective: In Bangladesh, use of long-acting and permanent methods of contraception (LAPMs) remains stagnant. Providers' limited knowledge and biases may be a factor. We assessed private providers' knowledge, misconceptions and general attitudes towards LAPM in two urban areas. The ultimate goal is to shape programs and interventions to overcome these obstacles and improve full method choice in Bangladesh.
Study design: Trained data collectors interviewed a convenience sample of 235 female doctors (obstetricians–gynecologists and general practitioners) and 150 female nurses from 194 commercial (for-profit) health care facilities in Chittagong City Corporation and Dhaka district. Data were collected on the nature of the practice, training received, knowledge about modern contraceptives and attitudes towards LAPM [including intrauterine device (IUDs), implants, female and male sterilization].
Results: All providers, and especially doctors, lacked adequate knowledge regarding side effects for all LAPMs, particularly female and male sterilization. Providers had misconceptions about the effectiveness and convenience of LAPMs compared to short-acting contraceptive methods. Implants and IUDs were generally perceived more negatively than other methods. The majority of providers believed that husbands favor short-acting methods rather than LAPMs and that women should not use a method that their husbands do not approve of.
Conclusions: Our findings document knowledge and attitudinal barriers among private for-profit providers in urban areas affecting their provision of accurate information about LAPM choices. Practitioners should be offered the necessary tools to provide women full access to all modern methods, especially LAPMs, in order to contribute to decreasing unmet need and improving full method choice in Bangladesh.

Keywords: Family planning; Contraception use; Long-acting methods; Bangladesh; Private sector

1. Introduction

In 2012, almost 645 million women in the developing world used modern methods of contraception [1]; however, regional estimates show only very small increases or plateaus in modern contraception use from 2008 to 2014 [2]. For example, from 2008 to 2014, modern method use increased in Asia from 60.9% to 61.6%, in Latin America from 66.7% to 67.0% and in Africa from 23.6% to 27.6%. Increased access to a wide range of modern methods of contraception [including oral contraceptive pills (OCs), implants, injectables, vaginal rings, intrauterine devices (IUDs), condoms and sterilization, among others] is a critical component of strategies to improve maternal and child health and reduce unmet need for modern contraception [2]. Long-acting and permanent methods (LAPMs), which comprise the long-acting and reversible methods of IUDs and implants as well as the permanent methods of female and male sterilization, are the most effective modern contraceptive methods and are safe and convenient to use [3,4]. LAPMs are also more reliable than short-acting contraceptive methods (such as condoms, OCs and injectables) for

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delaying, spacing and limiting births [5]. Yet, LAPM use is still low in many developing countries, and national family planning policies and contraceptive security strategies often overlook the potential role of these methods [4].

In Bangladesh, the use of modern contraceptive methods is high—but while 54.1% of married women of reproductive age report using a modern method, just 8.1% use LAPMs, while the other 46.0% use short-acting methods. LAPM use in Bangladesh is low compared to countries like India, Jordan or Nepal where 34.1%, 16.9% and 22.0% of married women of reproductive age report using LAPM, respectively [6]. Also, LAPM use in Bangladesh has decreased over the last two decades, accounting for 38.8% of all modern methods in 1991 to 20.5% in 2000, 15.4% in 2011 and 15.0% in 2014 [7]. Reasons for low LAPM uptake are unclear but may include a variety of factors. On the demand side, barriers include stigmatization (viewing sterilization as a method for the poor), religious views that disfavor permanent methods and concerns about side effects of the IUD and implants [8,9]. On the supply side, providers sometimes incorrectly apply policy-related eligibility criteria related to age and marital status and other nonpolicy criteria related to parity and a husband's consent [10], according to research in Tanzania [11], Ghana [12] and Senegal [13]. For Bangladesh, there are indications that inadequate coverage and low-quality services in the predominantly public-sector program also hinder LAPM uptake [8]. Providers' lack of knowledge, biases and misconceptions may also play a role in some settings [14,15].

Although the private for-profit sector in Bangladesh (including private hospitals and clinics, doctors' clinics and pharmacies) provides 43% of all modern contraceptive methods, it provides only 18% of all LAPMs [7]. An assessment in Bangladesh found anecdotal evidence that some private providers did not have the knowledge and training to provide LAPMs effectively and that some providers were biased against LAPMs [16].

To better understand factors affecting LAPM uptake in Bangladesh, we assessed private providers' knowledge, misconceptions and general attitudes towards LAPMs in two urban areas in Bangladesh. We explored differences by type of provider, with the goal of developing and implementing interventions to overcome these obstacles and contribute to decreased unmet need while improving full method choice in Bangladesh.

2. Materials and methods

Between March and June of 2013, we conducted a survey of 385 health care providers at commercial (for-profit) private health care facilities in two of the largest urban areas in Bangladesh: Chittagong City Corporation and Dhaka district. These are the major metropolitan areas of Chittagong and Dhaka divisions (two of eight total divisions in the country) located in southeastern and central Bangladesh, respectively. The Strengthening Health Outcomes through the Private Sector (SHOPS) Project funded this study as part of its exploration of potential program activities to be implemented in these two areas. The SHOPS Project focused its efforts primarily on Dhaka but also planned a smaller set of activities in Chittagong and thus conducted this study to gather information relevant to planning project interventions. The survey targeted three types of health professionals: (a) obstetricians–gynecologists (ob-gyns); (b) general practitioners (GPs), including graduate doctors with an MBBS degree, who provide reproductive health services; and (c) nurses.

For sampling purposes, we compiled lists of facilities in the two urban areas based on the most currently available information provided by the Directorate General of Health Services, the Obstetrical and Gynecological Society of Bangladesh, Nuvista Pharmaceutical Company and Square Pharmaceuticals. These lists were not comprehensive, and contact information for providers was not always up-to-date or accurate. We included only facilities considered private practices. We divided private practices on the lists by size into large (50 or more beds), medium (10–49 beds) and small (fewer than 10 beds, including private clinics). We relied on number of beds because information on the number of providers at each facility was not available. Then, we gave the data collection teams a list of facilities and a target number of interviews to complete for each specific geographic area. The data collectors were instructed to select all of the large facilities on their lists and then a mixture of medium and smaller facilities, with the objective of having a final sample in which large, medium and small facilities were approximately equally represented (i.e., approximately one third of the sample for each of the three sizes of facilities). Random sampling was not feasible due to budgetary restrictions, considering the spread of practices in such large urban areas.

The data collection teams approached a total of 202 private practices, and 194 (96%) agreed to allow their health personnel to participate in the survey. No incentive or reimbursement for participation was offered. Our final sample consisted of providers from 157 facilities, of which 45 (29%) were considered large facilities, 48 (31%) were medium-sized facilities and 64 (41%) were small facilities. The data collection teams were instructed to interview a convenience sample of a maximum of three ob-gyns or GPs and three to four nurses per facility. Since we did not have a full list of all doctors and nurses for each facility, randomly choosing interviewees was not possible; we directed the surveyors to interview the first doctors and nurses who were available and who agreed to take the survey. We limited the sample to female providers because the vast majority (estimated >95%) of ob-gyns and nurses in Bangladesh are women and because among the small number of male ob-gyns and nurses, very few focused exclusively on family planning services and counseling. Out of 280 ob-gyns and GPs that were approached, 235 (84%) agreed to take the survey; all the nurses agreed to participate. Our final sample consisted of 155 ob-gyns, 80 GPs and 150 nurses.