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CONSIDERATIONS FOR EXPANDING ACCESS TO FAMILY PLANNING THROUGH HEALTH INSURANCE FOR GARMENT WORKERS IN BANGLADESH

Building the Case for Workers, Employers, and Insurers

USAID FROM THE AMERICAN PEOPLE

HP+ HEALTH POLICY PLUS

DECEMBER 2021

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Abbreviations

AAR	Africa Air Rescue
CYP	couple years of protection
DMPA-SC	subcutaneous depot medroxyprogesterone acetate
HP+	Health Policy Plus
IUD	intrauterine device
LARC	long-acting reversible contraceptive
NGO	nongovernmental organization
USAID	U.S. Agency for International Development
USD	U.S. dollar

Background

Many countries face a plateau in donor resources for family planning commodities and services. Better use of existing donor resources (e.g., improved allocative and technical efficiencies through better targeting of subsidized or free products), as well as increased direct budget support to family planning programs from the government, can compensate the slowing down in external funding. However, given the persistent constraints on government health spending in low- and lower-middle-income countries, general budget spending is often best invested in family planning efforts that target specific subsets of the population rather than the general population. Therefore, in countries where health insurance schemes include the poor and near-poor (e.g., national health insurance, community-based health insurance, commercial insurance, or other bespoke schemes), there may be an additional approach: integration of a set of family planning services within insurance benefits packages. Insured beneficiaries could thereby gain access to a broad method mix and appropriate counseling services for no out-of-pocket spending at the point of care.

Insurance scheme administrators who are open to including family planning counseling and methods within an existing benefits package and then to operationalizing and implementing the family planning benefits would benefit from understanding several factors. The purpose of this report is to present and discuss several design considerations for health insurers in Bangladesh regarding the potential addition of family planning products and services to benefits packages for workers in the country's garment sector. Based on document review and stakeholder consultations, the report summarizes findings on the demand for family planning by the target population. It also addresses the feasibility of developing insurance products targeted to the garment sector that include selected family planning services that can be delivered with high quality and no out-of-pocket costs. The report draws lessons from efforts to add family planning products and services to benefits packages in other low-resource settings; these lessons may aid similar efforts for ready-made garment workers in Bangladesh. Finally, the report serves as advocacy material for employers to highlight how the provision of a broad range of family planning services to their workers would accrue benefits for both their workforce and corporate growth.

Family Planning in Bangladesh

While Bangladesh has significantly increased its modern contraceptive prevalence rate in recent years, almost one third of pregnancies in the country are still unintended. This large number of unintended pregnancies is likely due to a combination of unmet need for family planning, method failure, discontinuation, and switching of methods (Huda et al., 2017). Within 12 months of initiation, the discontinuation rate for pills was high at 42 percent, compared to 34 percent for injectables and 11 percent for implants (NIPORT and ICF, 2020). The government of Bangladesh has a target of reducing discontinuation rates for all methods to 20 percent by the end of 2021; however, discontinuation rates rose from 30 percent in 2014 to 37 percent in 2018. On average, married Bangladeshi women report wanting 1.6 children, but their actual fertility rate is 2.3 (see Figure 1) (Huda et al., 2017).

Figure 1. Key Family Planning Data for Bangladesh

FAMILY PLANNING INDICATORS

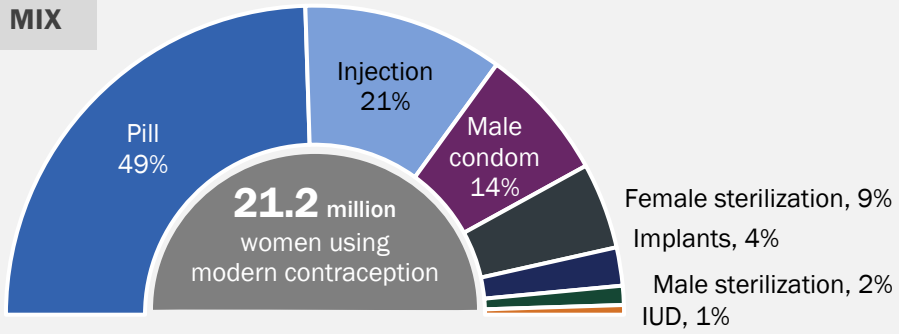
2.3
Total fertility rate

12%
Unmet need
Married women

52%
Modern contraceptive prevalence rate (mCPR) All women

44%
mCPR
Married, sexually active adolescents 15–19 years of age

MODERN METHOD MIX



FP2020 COMMITMENTS (2017–2021)

INDICATOR	2017	2021
Reduce total fertility rate	2.3	2.0
Reduce discontinuation rate of family planning method	30%	20%
Increase share of long-acting and permanent methods	8.1%	20%
Increase contraceptive prevalence rate	62%	75%

Figure data sourced from: NIPORT and ICF, 2020; FP2020, 2017; World Bank, n.d.; Track20, n.d.

The current family planning method mix skews heavily toward short-acting methods, with oral contraceptives being the most widely used method (Huda et al., 2017). The use of long-acting reversible contraceptives (LARCs) and permanent methods has declined over the last two decades; although implants and intrauterine devices (IUDs) are available at no cost from the public sector, uptake is low. The discouraging response to LARCs could be an indication that Bangladeshi women who might prefer LARCs lack access to them. It could also mean that providers are not being adequately incentivized to provide a broad method mix or high-quality services.

Bangladesh's *Costed Implementation Plan for the National Family Planning Programme* for 2016–2020 estimates that the cost of a commodity represents 45 percent of the total cost of delivering a service on average, with the remainder attributable to personnel, supplies, and overhead. However, there is substantial variation of cost distribution between methods: of the total costs in the public sector, commodity costs for implants account for 78 percent, while costs for IUDs account for only 22 percent. In addition, supply-side constraints are significant, with only 26 percent of facilities offering LARCs or permanent family planning methods (Huda et al., 2017).

Within the private sector, services for these methods require out-of-pocket payment at the time services are sought. Integrating family planning services into insurance schemes that cover services delivered through private facilities would provide an opportunity to reduce the financial barrier to women seeking access to LARCs. In addition, strategic purchasing reforms may be implemented through insurance; essentially, insurance providers could establish a framework to determine which family planning services policyholders could purchase, from whom to purchase them, and how to pay for them. Such reforms could help align contracted providers' behavior with desired outcomes, in particular the provision of a broad method mix of sufficient quality and with pre- and post-counseling services.

Insurance penetration is low in Bangladesh. Nonetheless, for certain segments of the population who can be reached with digital health insurance products, integration of a broad range of methods into the benefits package could promote greater choice. Greater choice, in turn, could promote greater uptake of methods as well as greater use of methods with lower failure and discontinuation rates.

The Garment Sector in Bangladesh

The ready-made garment industry is the largest employer of women in Bangladesh, currently engaging almost 3.2 million women (Akter, 2017). Female garment workers are often young married women from rural areas who have low education and poor literacy (SNV Netherlands Development Organization, 2019). For most of these women, accepting a position in the garment industry is the first opportunity to participate in the formal workforce (Ahmed, 2004). Such a position provides them with an important source of income, economic independence, and greater decision-making power. The promising opportunities associated with employment in the sector, however, often entail low wages, long hours, poor working conditions, and negative health impacts.

Despite wage increases in 2013, the gap between the legal minimum wage in the ready-made garment sector and an adequate living wage is considered the highest in the world (UNICEF, 2018). In January 2019, after sustained pressure from garment sector workers, wages were revised for certain grades of workers (The Daily Star, 2019). These wage revisions have reduced the minimum wage gap. Nonetheless, female garment workers remain particularly vulnerable due to their socioeconomic status and low education levels. Women are often placed in lower positions that involve dealing with dangerous chemicals and equipment, and women are typically paid less than their male counterparts (Humayun et al., 2014). A recent evaluation conducted using the Business for Social Responsibility's HERhealth model found that female garment workers earned a monthly salary of between 6,300 and 6,500 Bangladeshi taka

(between USD 74 and 76) to work more than 11 hours a day on average (Hossain et al., 2017). Because of these low earnings, women are forced to live in urban slums and typically commute 20 to 30 minutes to the factory they work in. This combination of low wages and long working hours undermines female garment workers' access to adequate healthcare (Hamid, 2018).

From the employers' perspective, ready-made garment factories often exhibit low retention rates, as workers move from one factory to another for improved wages or conditions. This high employee turnover, in turn, results in higher costs for employers, as employers need to replace and train workers on a near-constant basis. Employees having better access to healthcare would therefore be mutually beneficial for workers and employers.

Access and Use of Family Planning Products among Garment Sector Workers

Accessing reproductive health and family planning services, especially access to LARCs and injectables, remains a challenge for female garment workers. Factories employing more than 300 workers are required by law to provide basic healthcare facilities and personnel. Currently, many ready-made garment factories house a mini-clinic where a nurse, paramedic, or medical assistant (supported by a part-time doctor) provide preventive and limited curative care to workers. However, reproductive health services are not prioritized in mini-clinics, and service providers are often not trained to address workers' family planning needs. When mini-clinics do have the capacity to provide family planning services, their offerings are limited to short-acting methods. Despite having access to factory mini-clinics, most garment workers access their family planning methods (all types) outside the factory. Sources of contraception in Bangladesh fall within four main categories: the public sector (i.e., hospitals, health centers, and field workers); the private sector (i.e., private hospitals and clinics, qualified or traditional doctors, and pharmacies); nongovernmental organizations (NGOs) (i.e., NGO clinics and field workers); and other private sources (i.e., shops, friends, or relatives) (NIPORT and ICF, 2020). The remainder of this section examines the opportunities and challenges related to procuring family planning methods from the private sector.

Since 2010, private sector participation in family planning programs has increased as clients' demand for family planning services from the private sector has grown. The private sector is now the dominant source of contraceptive methods, with 49 percent of women 15–49 years of age obtaining their contraception from private sources in 2018 (see Figure 2), up from 38 percent in 2007 and 43 percent in 2014 (NIPORT and ICF, 2020).

Figure 2. Source of Most Recent Modern Contraception Method Among Women 15–49 Years of Age

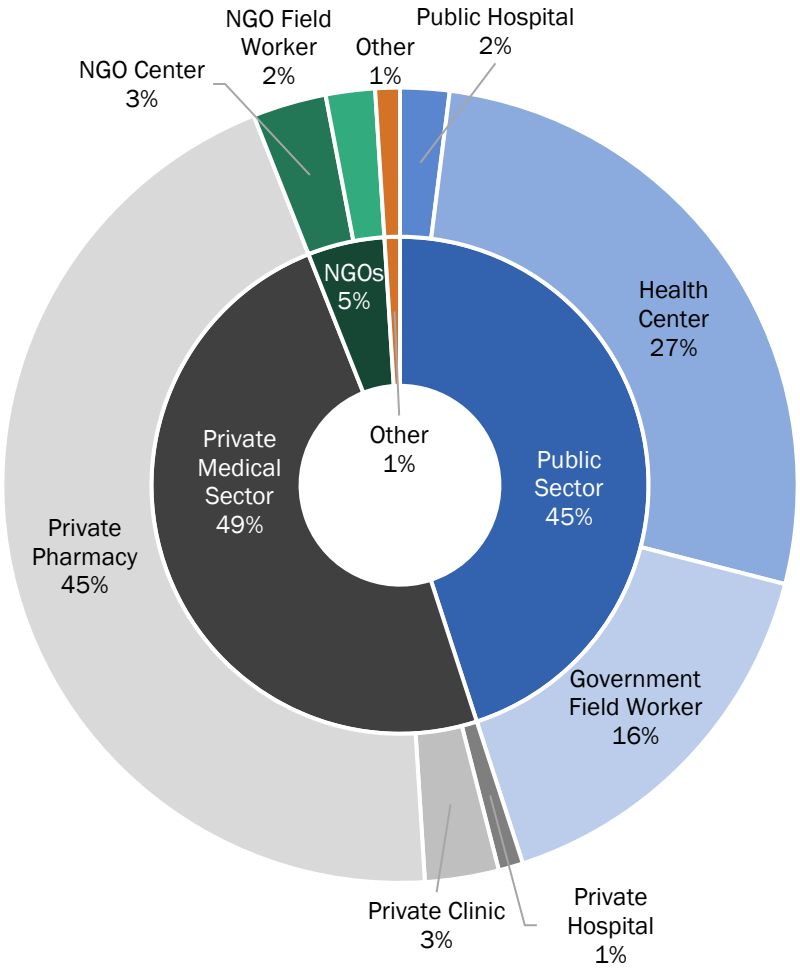


Figure data sourced from: NIPORT and ICF, 2020

Bangladesh's social marketing program is a large contributor to the increased utilization of private sector sources of family planning. The Social Marketing Company carries several brands of oral contraceptives, injectables, implants, IUDs, and condoms, which are distributed through a network of retail outlets such as pharmacies, small shops, kiosks, a network of private health providers (Blue Star), and NGOs (NIPORT and ICF, 2020). Many women, including female garment workers, show a strong preference for the Social Marketing Company's contraceptives. Qualitative research with female garment workers under the Bill and Melinda Gates Foundation-funded (re)solve project found that most respondents preferred nongovernmental brands from the private sector. This preference—echoed in the responses to the survey implemented by the U.S. Agency for International Development (USAID)-funded Health Policy Plus (HP+) project for this activity—is due to a perceived increase in side effects from government contraceptives, as compared to the Social Marketing Company's products and brands.

In terms of methods, most women accessing contraception in the private sector choose short-acting methods—especially pills, which are inexpensive to purchase. In contrast, LARCs are in low demand; although high in cost, LARCs can be obtained for free from a public sector facility (79 percent of IUDs, 51 percent of injectables, and 88 percent of implants are obtained from public facilities) (NIPORT and ICF, 2020). *The Family Planning Spending Assessment of Bangladesh for FY 2018–2019* estimated the commodity costs for IUDs and implants at USD 11.51 and USD 22.26, respectively (Institute of Health Economics, 2019). For garment workers, the costs associated with LARCs are a significant barrier to obtaining these methods in the private sector. When a female garment worker expresses interest in a LARC that is not offered at a mini-clinic, the mini-clinic health worker typically refers the woman to a nearby healthcare facility. However, given their long working hours, female garment workers generally struggle to access the public facilities where LARCs are free of charge and must instead visit a private or NGO clinic, where they will be required to pay a (not always subsidized) fee (EngenderHealth, 2018). When these women, who already rely on private providers, face the choice between the more expensive upfront cost of LARCs versus the ongoing but low cost of short-acting methods, they often opt for the more affordable option.

To exacerbate matters, recent research by SNV Netherlands Development Organisation has found that female garment workers lack accurate information and knowledge about LARCs. SNV's 2019 *Report on the Baseline Study of Working with Women Project-II* study found that, while knowledge of family planning methods among garment workers is very high (91 percent), there are large gaps between knowledge of short-acting versus long-acting reversible methods. Study participants had very high knowledge of pills (95 percent), injectables (83 percent), and condoms (69 percent); less than half of the participants, however, had adequate knowledge of implants (43 percent) and IUDs (11.3 percent). Misconceptions about LARCs remain high, leaving female garment workers with a strong fear of side effects, including a perceived threat of sterilization. Female garment workers have limited experience with the healthcare sector and low education; these contextual factors contribute to these women's generally low knowledge and substantial concerns about LARCs, which in turn reinforce Bangladesh's skewed method mix toward short-acting methods.

Expanding insurance products to include injectables—namely subcutaneous depot medroxyprogesterone acetate (DMPA-SC) (brand name Sayana Press)—could also better respond to garment workers' needs. As an "all-in-one" presentation of the traditional intramuscular DMPA, DMPA-SC can empower garment workers to exercise more control over their family planning decisions and could expand family planning access by increasing opportunities for garment workers themselves to self-administer injections. After some initial skepticism around the appropriateness of self-injection in the Bangladeshi context, the National Technical Committee of the National Family Planning Program in Bangladesh approved in October 2018 a 12-month pilot to assess the contraceptive method's acceptability and feasibility within the national family planning program. The product has since been approved for use in the country.

Currently, factory mini-clinics are not offering DMPA-SC as a method even though they are supposed to provide three-month injectables. In line with the broader Bangladeshi context, factory mini-clinics exhibit considerably lower uptake of injectables than pills. However, with appropriate counseling, uptake of DMPA-SC could improve significantly. The USAID-funded Mayer Hashi-II project found that education sessions led to an increase in female garment

workers' preference for injectables; after the sessions, 31 percent of users opted for injectables compared to 39 percent opting for oral pills from factory mini-clinics (EngenderHealth, 2018). With sufficient training, women can independently acquire and administer DMPA-SC every three months. This arrangement allows them to take greater control of their contraceptive needs without having to rely on a healthcare provider for access. Studies in several countries have shown high rates of women accepting self-administration once trained appropriately and, critically, lower discontinuation rates with this method than with provider-administered injections (Cover et al., 2018; Bertrand et al., 2018; Burke et al., 2018). Given that the rate of discontinuation for injectables in Bangladesh remains high at 34 percent, self-administration of DMPA-SC could dramatically decrease unintended pregnancies and help garment workers achieve their desired fertility levels (NIPORT and ICF, 2020). The provision of DMPA-SC through insurance for garment sector workers would therefore increase access and ultimately provide broader choice.

Rationale for Including Family Planning in Insurance Products for Bangladesh's Garment Sector

The limited uptake of LARCs and injectables represents a critical missed opportunity for female ready-made garment workers in Bangladesh. SNV's recent research found that most female garment workers are in their reproductive prime. Almost 76 percent of female garment workers within the study were below 30 years of age, and 79 percent were married (SNV Netherlands Development Organisation, 2019). As a woman's median age at first birth is 18.2 years, and as ideal family size is often reached by mid- to late-twenties, these women face long periods of fertility during which they must protect themselves from unwanted pregnancies (NIPORT and ICF, 2020). The average rate of method discontinuation (within 12 months of method uptake) remains high at 36 percent, particularly among short-acting methods (rates for condoms and pills are 40 percent and 34 percent, respectively, compared to 7 percent for implants) (Huda et al., 2017). Furthermore, women in Bangladesh space births at an average of 47 months between births. In terms of birth spacing preferences, however, 72 percent of women who have one child and 84 percent of women who have two children would prefer to wait at least two years before having another child. This preference highlights the significant proportion of mothers who may wish to consider alternatives to short-acting family planning methods. It also highlights the need to ensure these women receive accurate information and access to a broad range of methods. Insurance can play a critical role in increasing access to a wider range of methods for female garment workers in the country.

An additional reason for including family planning—LARCs and injectables in particular—in insurance products for garment workers is that, with these methods, discontinuation is less frequent, indicating women are more likely to avoid unintended pregnancies. In addition, LARCs are highly effective, low-maintenance, long-lasting, and discrete. With such high reliance on injectables and pills, increasing female garment workers' access to and use of LARCs and injectables via insurance can reduce their unmet need for contraception, reduce unintended pregnancy, and help garment workers attain their fertility goals.

In addition, increasing the accessibility and affordability of LARCs and injectables through the private sector using health insurance would provide female garment workers with greater choice in contraception methods. Women could choose not only the method they prefer but also the

contraceptive brands and sources that best meet their needs. Although pills are available for free through the public sector, 58 percent of pill users still opt to access pills through the private sector or NGOs, mostly from private pharmacies (NIPORT and ICF, 2020). Family planning clients thus seem willing to pay for better access and quality through the private sector, if these are affordable. By extension, if LARCs and injectables can be made more accessible through the private sector for a nominal fee or even no charge at the point of access by using an insurance mode, pent-up demand for longer-acting family planning methods could be released.

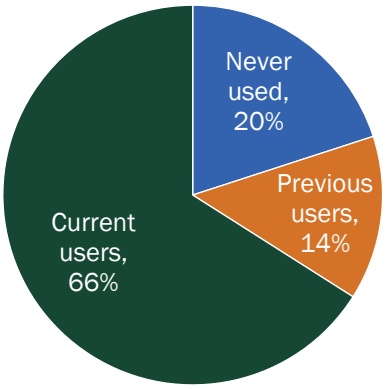
Finally, increasing access and voluntary utilization of LARCs and injectables is a priority for the government of Bangladesh. The government has developed a national long-acting and permanent method strategy to accelerate uptake of LARCs and injectables as part of the Family Planning 2020 commitments made in 2016 (i.e., commitments to achieve a more balanced modern contraceptive method mix and to increase access to and availability of LARCs and injectables) (EngenderHealth, 2011; FP2020, 2016). Incorporation of LARCs and injectables into employment-based insurance schemes would therefore complement these public efforts and promote a shift toward these methods for appropriate users.

Results from a Survey of Garment Workers

To ground literature review findings and consultations with local partners, HP+ conducted an anonymous, voluntary, self-administered survey in 10 factories in and around Dhaka. The purpose of the survey was to develop a better understanding of garment sector workers' attitudes toward family planning services, access, method preferences, and insurance. The survey included a total of 204 survey respondents. Of the respondents, 97 percent were female while 74 percent were 20–29 years of age, 18 percent were 30 years of age or over, and 8 percent were under 20 years of age. (Additional information on the survey methodology is included in Annex A.)

As shown in Figure 3, 66 percent of survey respondents were current contraceptive users. Among current users, 85 percent were using the pill and 14 percent were using injectables. None of the respondents were currently using LARCs.[1] About 10 percent of the current contraceptive users accessed family planning via the mini-clinic; in comparison, 26 percent used public facilities and 64 percent relied on the private sector. When asked where they would prefer to receive family planning services, 15 percent of all the respondents indicated they would prefer the mini-clinic, 5 percent pointed to the public sector, and 80 percent said they would prefer the private sector. Taken together, the responses to these two questions suggest that most female garment workers may be willing to forego the convenience and low cost of the onsite mini-clinic to access the higher-quality service and privacy offered by off-site private clinics.

Figure 3. Contraceptive Use among Survey Respondents



[1] These findings are consistent with previous surveys of family planning use conducted with garment sector workers.

Among all respondents, 55 percent indicated they would consider using a LARC to meet their contraceptive needs if provided with more information on the options, risks, and benefits. When asked what deterred them from switching from their current method to LARCs, respondents reported the top factors to be cost, desire to have more children, pressure from their husband or family, religious concerns, fear of side effects, and availability of the method. Two of these key barriers—cost and availability—could be addressed through inclusion of family planning services in health insurance. Indeed, when asked how interested they would be in accessing health insurance from their employer, 89 percent of the respondents indicated they would be very interested, and their average stated willingness to pay was USD 1.40 per month.

When asked which family planning methods they would like to see covered by such an insurance product, respondents gave varying answers: 35 percent pointed to packages that would include short-acting methods and injectables only, 6 percent indicated a preference for LARCs only, and 1 percent preferred permanent methods. Regarding mixed packages, 24 percent of respondents preferred a combination of short- and long-acting reversible methods and injectables, while 31 percent indicated a preference for all methods.

Further investigation is needed to understand how garment workers experience availability of family planning as a barrier (e.g., geographic location of providers, hours of operation, discrimination). However, the responses to the survey suggest that insurance and contracting with private providers to deliver family planning services could meet female garment workers' needs for family planning, including LARCs and injectables.

Employer Considerations

Ensuring coverage of a broader method mix for female garment workers in Bangladesh would help these workers to have fewer unintended pregnancies in line with their fertility goals. With fewer unintended pregnancies, the number of women in need of maternal and newborn care and maternity leave would decrease, reducing factory and individual-level maternal health costs. In addition, having fewer women on maternity leave and fewer women opting out of the workforce because of family responsibilities would increase factory productivity and reduce employee turnover. Finally, including family planning in health insurance as an employee benefit may support increased employee satisfaction and improved employee retention.

Inclusion of Family Planning Services in Insurance: Design Considerations

Building on a desk review, in-country consultations, and responses from the survey of garment workers, HP+ has identified several key considerations for insurers and employers intent on collaborating to add family planning services to a pre-existing health insurance product for

ready-made garment workers in Bangladesh.[2] The following sections explore in turn each of the following seven elements related to the design of such a product:

1. Inclusion of family planning services in an insurance benefits package
2. Employer involvement
3. Voluntary/compulsory design
4. Expected use of different family planning methods by covered users
5. Estimated costs associated with delivering selected family planning services
6. Locations for accessing insurance-covered family planning services
7. Payment mechanisms for delivering insurance-covered family planning services

1. Inclusion of Family Planning Services in an Insurance Benefits Package

Garment workers are over-reliant on short-acting methods, which are associated with high discontinuation rates, and have limited access to LARCs. Therefore, the benefits package should focus on increasing the accessibility and availability of LARCs and newer injectables, such as DMPA-SC, for which there is evidence of lower discontinuation rates in other settings. The package should not include permanent methods, given the low interest in these methods among this segment of the population. The package should include multiple components of service provision, utilizing a rights-based approach to ensure that family planning users can make an informed choice to meet their reproductive health needs.

First, the package should support the delivery of high-quality counseling from a provider and family planning education and information, preferably through a mobile platform. Package components should also include commodities, associated supplies, and insertion and removal services (including necessary pre-screening and post-procedure follow-up) (see Table 1). The inclusion of each of these service components is critical. Together, these components would ensure that providers are appropriately reimbursed for the provision of comprehensive, quality care and that female garment workers can make an informed choice on what method best suits their needs.

Table 1. Family Planning Service Components for Inclusion in Package

Pre-family Planning Selection Services
Health information and education
High-quality family planning counseling

[2] HP+ initially planned to collaborate closely with Telenor Health to include family planning products and services in the company's "Tonic" suite of health insurance products for ready-made garment workers in Bangladesh. However, the plan was undercut in 2019 when Telenor saw the departure of key staff and changed its strategy. Accordingly, HP+ has expanded the scope of the present report by identifying considerations that could be useful to any insurer interested in adding family planning services to their benefits packages in Bangladesh.

Family Planning Service	Commodities	Pre-screening	Supplies	Providers' Time
Implant	Jadelle, Implanon	N/A	Infection-prevention materials, local anesthetic, implant applicator, surgical tape, adhesive bandage, elastic bandage, and gauze	Doctor/nurse or other health practitioner time
IUD	Copper-bearing IUD	Pelvic examination and risk assessment for sexually transmitted infections	Antiseptic, IUD inserter	Doctor/nurse or health practitioner time
Injectables	DMPA-SC (brand name Sayana Press)	N/A	Infection-prevention materials	First injection: health practitioner time Subsequent injections: self-administered

Health information and education: Unfortunately, the presence of a skilled provider and access to services do not necessarily lead to the voluntary uptake of contraception, particularly when women lack access to accurate information and the education needed to promote informed choice. For female garment workers in Bangladesh, the gap between their knowledge of short-acting methods and their knowledge of LARCs is an important barrier that limits demand for and uptake of LARCs. Therefore, to ensure female garment workers have access not only to affordable high-quality family planning services but also to the information they need, HP+ recommends that the health insurance package also include tailored educational messages delivered via mobile technology. These messages can include family planning information, with a focus on increasing awareness and knowledge of LARCs, and questionnaires to identify women who may want to consider seeking more information about LARCs from a provider. Market data from Telenor indicated that 72.5 percent of garment workers reported having their own mobile phone, and 96.8 percent reported having access to a mobile phone; these proportions are likely to have risen since COVID-19 due to stimulus packages being delivered digitally. Therefore, mobile messaging would have the capacity to reach a wide number of women in the garment industry.

High-quality family planning counseling: Counseling is a critical element in the provision of high-quality family planning services. To support female garment workers' right to make voluntary, well-informed choices about contraception, the health insurance package must offer high-quality pre- and post-family planning counseling. Moreover, that counseling must include comprehensive evidence-based and unbiased information about the full range of methods that might meet women's needs. Counseling components should follow the World Health

Organization Medical Eligibility Criteria as outlined in the *Family Planning: A Global Handbook for Providers* (WHO/RHR and CCP, 2018). Namely, the components should include the following:

- Method descriptions
- Method effectiveness
- How the method works (for LARCs, this includes explaining insertion and removal procedures)
- Method advantages and disadvantages
- Who the method is and is not recommended for
- How to use the method
- Possible side effects (clarify any misconceptions)
- Reasons to return to the provider (including to discontinue the method or switch methods)

2. Employer Involvement

The deployment of the insurance package described in this document would require the identification of employers who demonstrate a strong interest in providing access to health insurance coverage for their employees. These employers would need to understand the value in providing comprehensive family planning services (beyond the oral pills available at a factory mini-clinic) and their own role in creating a pathway to reaching the target population of female garment sector workers. These employers' willingness to contribute to a portion of the premium, at least at the outset, would significantly facilitate adoption and expansion until employers and employees realize the tangible benefits of insurance coverage for family planning services.

As mentioned previously, promoting a deep understanding of the individual and factory-level benefits of implementing employment-based health insurance that includes comprehensive family planning services would help to generate interest among employers.

3. Voluntary/Compulsory Design

Whether a voluntary or compulsory enrollment model is adopted should be determined in collaboration with employers. A compulsory model, in which all employees are required to join the scheme, may require employers to subsidize most of the premium costs as not all employees may be willing or able to contribute the full cost. A voluntary model may be more acceptable given that the provision of employer-sponsored insurance coverage for garment sector workers is still nascent in the country, but it would also push back the break-even point for the insurer.

4. Expected Use of Different Family Planning Methods by Covered Users

Utilization numbers were computed by method based on the modern contraceptive prevalence rate and the estimated coverage scale-up, using data from Bangladesh's *Costed Implementation Plan for the National Family Planning Programme* for 2016–2020.

HP+ first projected the total number of covered members based on the number of employees in the factories with which local partners were engaged. Then HP+ considered the proportion of employees who were female and of reproductive age before applying LARC and injectable

acceptance rates by age band. Two membership scenarios were considered: 5,000 employees, representing a single factory, and 75,000 employees, representing up to a dozen factories of various sizes.

As Figures 4 and 5 suggest, based on current utilization preferences, DMPA-SC would have almost four times more users than combined LARCs. Specifically, a single factory, or the first scenario, would see an estimated 517 DMPA-SC users compared to 141 LARC users, and the second scenario would see an estimated 7,273 DMPA-SC users compared to 1,985 LARC users.

Figure 4. Projected DMPA-SC Users in First Year

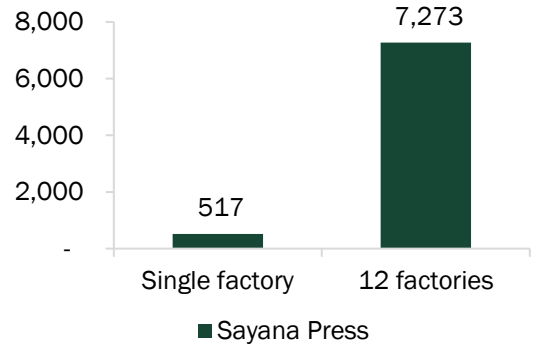
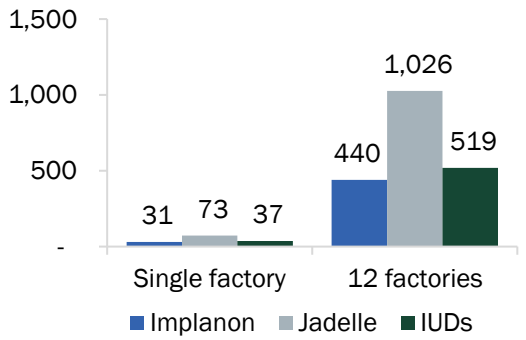


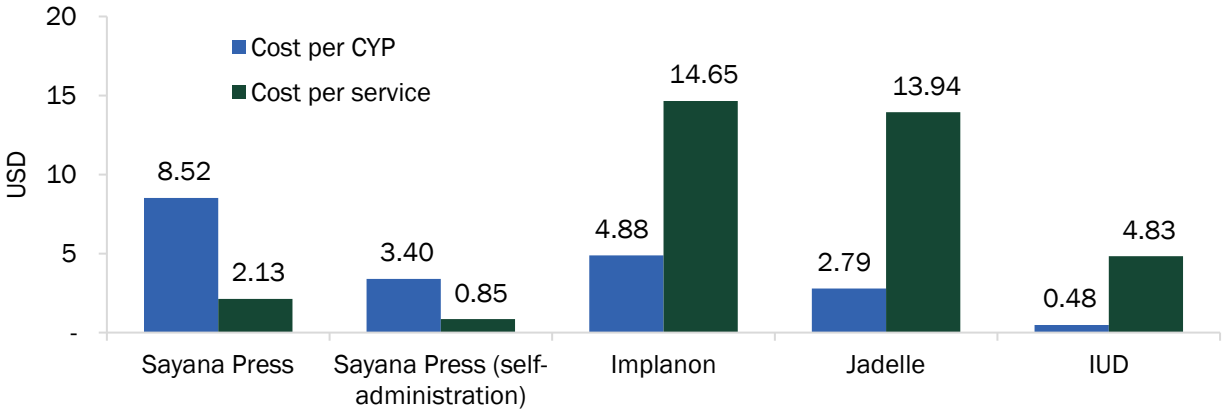
Figure 5. Projected LARC Users in First Year



5. Estimated Costs Associated with Delivering Selected Family Planning Services

HP+ used unit cost information from the Bangladesh *Costed Implementation Plan*, 2016–2020 to estimate costs associated with delivering selected services. Cost elements included the commodity, medical supplies, personnel, and overhead. Analysis of cost per couple years of protection (CYP) and per service reveal the relative inaccessibility of implants (Implanon and Jadelle) due to their high commodity cost (see Figure 6). The cost per CYP is lowest for IUDs (USD 0.48) despite the moderate upfront service cost. The analysis also reveals that when DMPA-SC (Sayana Press) is self administered, its cost per CYP drops significantly (from USD 8.52 to USD 3.40); this decreased cost per CYP makes it comparable with implants (USD 4.88 for Implanon and USD 2.79 for Jadelle).

Figure 6. Unit Costs per CYP and per Service



HP+ calculated the total cost per year of providing the proposed package of family planning services by applying the unit costs per CYP to the expected utilization of each service annually. This approach to calculation smooths out the costs incurred across the population of covered members and accounts for the fact that LARCs incur a higher cost in the year of provision, but no cost in subsequent years. The difference is significant when comparing across methods that provide vastly different CYPs. A gradual shift to self-administered DMPA-SC as user acceptability increases was built into the assumptions (namely, self-administration increases from 20 percent in Year 1 to 50 percent in Year 2 and to 80 percent in Year 3). Given the significant proportion of women who are projected to elect to use injectables over LARCs, the per-member cost gradually decreases over the years (see Table 2).

Table 2. Cost per Member per Year of Providing Selected Family Planning Services

Year 1	USD 1.12
Year 2	USD 1.03
Year 3	USD 0.92

6. Locations for Accessing Insurance-Covered Family Planning Services

Since 2010, Bangladesh has seen a dramatic increase in the number of private for-profit health providers, local manufacturers of family planning commodities, medical colleges and hospitals, pharmacies, and private clinics. The number of healthcare providers who staff these facilities has also increased. As of 2016, the country counted 2,983 registered private hospitals and clinics and 5,220 registered private diagnostic centers (NIPORT et al., 2016). Among these registered private facilities, more than 60 private medical college hospitals and nearly 1,500 private clinics, as well as thousands of pharmacies, provided family planning services.

This rapid expansion of the private sector provides a unique opportunity to increase the accessibility and availability of family planning services, especially LARCs, for female garment workers. Qualitative research under the (re)solve project, as well as the survey conducted by HP+ for this report, found a strong preference for private clinics among female garment workers. Private clinics are perceived to provide better quality of care, including more confidential services, and access to nongovernment brands of family planning commodities.

Yet female garment workers' limited financial means often prevent them from obtaining LARCs in the private sector. Insurers offering employment-based health insurance should therefore contract with private providers and facilities located near the participating factories, as well as private facilities within the communities in which female garment workers live, to offer LARCs and injectables to the workers. This approach would align with the recommendations of prior analyses on integrating family planning services within health insurance in Bangladesh that identified the private sector as an untapped resource for the provision of LARCs financed through insurance (Avenir Health, 2016).

In addition, as the HP+ survey indicated, factory mini-clinics also present an opportunity to improve the quality and variety of family planning services that are available to workers onsite. To realize this opportunity, local health insurance partners would need to support training for factory mini-clinic health workers and introduce and adapt norms for family planning counseling, method provision, and, where necessary, referral practices.

7. Payment Mechanisms for Delivering Insurance-Covered Family Planning Services

Two insurance design issues are relevant to this discussion: the mode of provider payment and the claims process model.

Provider payment mode: A fee-for-service rate based on the full cost of delivering selected family planning services to insured garment workers is the first option for payment to private providers. Given that these services require time (for appropriate counseling) and involve commodities and supplies for insertion and removal, the insurance needs to reimburse providers appropriately for their service to convince them to maintain their participation in the scheme. The fee-for-service payment mode has raised suspicion because it may tempt providers to over-deliver services; however, in the specific context at hand, this concern is less severe due to the historically low demand for LARCs and the recent introduction of DMPA-SC. In addition, education on family planning methods through a digital platform messaging system could help garment workers make informed decisions that are not exclusively reliant on providers' guidance. Alternatively, in a larger scheme, under which the purchaser would buy services on behalf of a significantly larger population, the insurer's ability to control providers' access to reimbursements may provide an opportunity to negotiate payment mechanisms away from fee for service and toward case-based payment—or even inclusion within a capitated rate for a given population.

Claims process models: There are two primary claims process models: the reimbursement model and the cashless model. The reimbursement model involves the provision of direct cash back to the insured member upon submission, review, and approval of a claim. The cashless model involves the insurer engaging with a network of providers to offer reimbursements for services provided based on claims submitted by the providers. Both models have their pros and cons, and either could initially be used with specific employers until insurer, provider, and member preferences emerge, at which point the preferred model could be adopted. Growing experience suggests, however, that cashless models are preferred by policyholders. Cashless models tend to increase policyholders' trust in the insurance product, especially in environments where policyholders' ability to advance the cost of treatment is limited and the insurer's capacity to reimburse them promptly is insufficient.

Relevant Lessons from Other Countries

To contribute international lessons to the design of an insurance package for garment workers in Bangladesh that includes family planning, HP+ conducted a desk review of microinsurance products that cover family planning products and services, specifically LARCs, in low- and middle-income countries. This review, which covered 160 insurance products, reveals that there are currently more operational initiatives covering family planning products in the public sector (including through social insurance) than in the private sector. Indeed, very few private insurance products in low- and middle-income countries include family planning in their benefits packages. The following sections offer a selection of products from both the public and private sectors in low- and middle-income countries across Latin America and the Caribbean, Africa, and Asia that include family planning products and services in their benefits packages.

Public Insurance Schemes

Public insurance schemes that include family planning products are prevalent across Latin America and the Caribbean, Africa, and Asia largely due to consistent advocacy efforts demonstrating cost-savings for maternal healthcare spending. In Africa, Rwanda and Tanzania include family planning products in their national health insurance schemes, and Zambia and Uganda are following close behind with proposals to integrate family planning products (Naik et al., 2014; AFP, 2017, 2021; Ravindran et al., 2020). Ghana has included family planning in its national insurance scheme, but family planning product delivery is not yet operational (Chaitkin et al., 2015). Latin American and Caribbean countries appear to be champions of LARC inclusion in their social health insurance policies. Chile, Colombia, Costa Rica, the Dominican Republic, Guatemala, Haiti, and Peru all provide free LARCs through their public schemes in addition to availing free LARCs to their uninsured populations (Fagan et al., 2017). According to Impact Insurance (2013), the Nicaraguan Social Security Institute offers an insurance product that covers family planning counseling and contraception. In Asia, a product called PESO for Health in the Philippines had a public, voluntary, multi-category scheme that covered family planning services in the 2000s, though it has since been terminated (Impact Insurance, 2012).

Private Sector Initiatives

Africa: Africa Air Rescue (AAR) Healthcare in Tanzania covers 54 percent of the market share of the country's medical insurance sector, contracting with 250 public and private providers, including 300 AAR-accredited hospitals. After three years of advocacy and partnership building, facilitated by Advance Family Planning and its local partners, in 2016, AAR Healthcare agreed to cover family planning and its associated charges for up to 300,000 Tanzanian shillings (USD 138). AAR first piloted family planning among its Wellness Services staff. Advance Family Planning had made the case that resources invested in contraceptive methods could help to lower the high costs of maternal healthcare. Indeed, the pilot results included increased company efficiency and reduced misconceptions around family planning. AAR Healthcare then began to cover all LARCs, including IUD and implant insertion and removal visits, for its client population. In the first year of operationalization, 4,600 clients accessed family planning services with AAR Healthcare insurance, and 80,000 women were projected to have benefitted from this coverage (AFP, 2016).

Latin America: In Colombia, private health insurance schemes cover LARC methods for a USD 10 co-pay (Fagan et al., 2017). Chile's private Instituciones de Salud Previsional insurance schemes, which cover 17 percent of the population, include all LARC methods in their benefits packages, with limited or zero co-pay (Fagan et al., 2017). Guatemala's rural, community-based insurance, referred to as Aseguradora Rural Microinsurance, is a for-profit scheme made possible through a partnership with Banrural, a large local bank focused on the rural population. This scheme has demonstrated that the decision to cover preventative gynecological services for women can reduce overall health expenses (Center for Health Market Innovation, 2021a).

Asia: In Bangladesh, the Grameen Kalyan Health Program is a not-for-profit, community-based microinsurance for health that launched in 1993. Grameen Kalyan is branded as a comprehensive health service financing and delivery program for Grameen Bank members and other village members. Its benefits package includes family planning (Center for Health Market Innovation, 2021b). The Alka Hospital and Sonography Clinic in India operates a model driven by healthcare providers that offers a voluntary, individual policy. Family planning products and

services are included in the benefits, along with antenatal care, delivery and surgery, and postnatal care.

This desk review suggests that, even though examples and lessons are very limited, inclusion of family planning coverage in the benefits packages of private insurance products is feasible. Bangladesh thus has an opportunity to place itself at the forefront of global innovation in insurance by ensuring its products include family planning components such as those discussed in this report.

Conclusion

Although the government of Bangladesh funds the majority of the country's family planning program, most of those resources target the provision of short-acting methods. The present analysis has identified a need for the inclusion of a broader range of family planning commodities and services, especially higher-cost LARCs and injectables, for an important segment of the country's population: female garment workers. The analysis has shown Bangladesh's potential to make a significant impact on access to family planning services for this population by working closely with private health insurance providers and private healthcare providers. The following are key lessons learned from this analysis:

- **Cost is only one of several barriers to access.** The proposed insurance intervention focuses on removing the high out-of-pocket costs associated with accessing LARCs and injectables through the private sector, as costs form a key barrier to greater uptake. However, efforts to address social, logistical, and cultural barriers need to take place concurrently to ensure more widespread and sustainable adoption of LARCs and injectables in Bangladesh.
- **Beneficiary population characteristics should be carefully considered due to the impact on scheme expenditures.** Targeting garment sector workers for health insurance that includes family planning services is likely to have a high impact given the age and gender of these workers. This limited focus on such a specific group of beneficiaries, however, reduces the ability of the scheme to pool risk and manage utilization. This concern can be partially addressed by expanding enrollment to the broader public but can only be fully addressed when the product is subsumed into a population-wide health insurance or universal health coverage scheme.
- **Insurance design features are critical to success.** Decisions on either a voluntary or compulsory model, the provider payment mode and claims process model, and employers' willingness to subsidize premiums can cumulatively facilitate or hinder the success of the initiative.
- **Blended finance can play a pivotal role.** The proposed insurance intervention seeks to fill a gap in family planning service provision by expanding access to LARCs and injectables through private providers while Bangladesh continues on its journey toward universal health coverage. At a later stage, a national health insurer may provide such services for broader segments of the population through contracting with both public and private providers, rendering this type of intervention redundant. The government or donors providing an element of co-financing may help prompt such an expansion of

services by making integration of services into existing insurance packages feasible and attractive to a private insurer.

- **Communication strategies must be targeted.** The benefits of family planning integration into insurance, though likely apparent to those operating at the family planning program level, need to be carefully communicated according to the perspectives of employers, employees, insurers, and providers. For example, if there are increased costs for the employer associated with co-financing premiums to provide coverage on an expanded package that includes family planning services, the benefits of improved worker productivity and reduced turnover need to be presented concurrently. Similarly, for female garment workers to take advantage of this insurance benefit, misconceptions about LARCs and injectables need to be addressed, and social and behavioral change efforts need to be undertaken to shift the social norms around these types of methods.

This analysis has helped correct the impression that free access to family planning services in the public sector in Bangladesh necessarily equates to sufficient access to and utilization of a comprehensive set of methods for female garment workers. In reality, the method mix used by these workers is skewed, and the workers have a high propensity to seek family planning services from the private sector, when affordable. Further efforts to integrate family planning into private health insurance packages are critical to address the immediate gap in Bangladesh and in other countries where similar circumstances exist. These efforts should be directly aligned with—and may eventually be subsumed into—each country's universal health coverage journey at the appropriate time.

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Annex A. Methodology for Key Informant Interviews

A pretested, self-administered survey was conducted from September 2019 to October 2019 to assess contraceptive practices among garment workers in Bangladesh. The respondents were selected purposively based on selection criteria to identify married women/men of reproductive age (19–49). All respondents were workers in one of ten garment factories in the Dhaka and Gazipur districts. The survey sample consisted of 204 respondents: 20 respondents from nine of the factories and 24 respondents from one factory. The survey respondents were identified by the managers of each of the factories based on the respondents' literacy and marital status. The pretested survey that was administered dealt with quantitative and qualitative values. The surveyor facilitated an introduction and group discussion for the garment workers before administering the survey.

Sample sites:

1. Quattro Fashion Ltd., Kainzanul, Mirzapur Bazar, Gazipur
2. Ever Fashion Ltd., Plot D (204-206), BSCIC Industrial Estate, Tongi, Gazipur
3. Bellissima Apparels Ltd., BSCIC Industrial Estate, Tongi, Gazipur
4. Haesong Korea Ltd., Zirabo, Ashulia, Savar, Dhaka
5. Apex Fashion Ltd., Shakhipur, Kaliakoir, Gazipur
6. Magpie Knit Wear Ltd., Plot 141, Yarpur, Zirabo, Savar, Dhaka
7. Magpie Composite Textile Ltd., 832/833, Dewan Edris Road, Amtala, Savar, Dhaka
8. Tosy Knit Fabrics Ltd., Sahara Super Market, BSCIC Road, Tongi, Gazipur
9. Rupa Knitwear (Pvt) Ltd., Kunia, Borobari Board Bazar, Gazipur
10. Rupa Fabrics Ltd., Kunia, Borobari Board Bazar, Gazipur

For more information, contact:

Health Policy Plus
Palladium
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@thepalladiumgroup.com
www.healthpolicyplus.com