



Mayer Hashi Project

Achieving Positive Policy Changes for Family Planning in Bangladesh

INTRODUCTION

Contraceptive prevalence has increased dramatically in Bangladesh over the last 30 years, from just 8% in 1975 to 61% in 2011 (NIPORT et al., 2012). As a result of the high levels of contraceptive use and a process of social change, the total fertility rate has fallen from 6.3 to 2.3 lifetime births per woman over that same period. Oral contraceptives are the most popular family planning method (used by 27% of ever-married women), followed by injectables (11%). Currently, only 8% of married couples use a long-acting or permanent method of family planning (LA/PM)—or about 13% of all family planning use in Bangladesh.

Yet while the Bangladesh family planning program has become one of the most successful such programs in the world, clients still often may be denied access to the contraceptive of their choice as a result of policy barriers and medical eligibility criteria that are incompatible with World Health Organization (WHO) guidance. Such barriers contribute to the low use of LA/PMs. A more conducive policy environment might be expected to contribute to greater use of LA/PMs, in conjunction with improved service delivery and increased demand.

The Mayer Hashi project¹ applies EngenderHealth's Supply–EnablingEnvironment–Demand (SEED) programming model to its activities in Bangladesh (EngenderHealth, 2011). This model states that programs will be more successful if supply, demand, and the enabling environment are addressed comprehensively. And one of the most significant aspects of the enabling environment involves the policies that affect people's ability to meet their reproductive intentions. Therefore, Mayer Hashi undertook a careful, structured process to try to achieve significant policy changes in Bangladesh.

SELECTION OF POLICY ISSUES

Provision of family planning services in Bangladesh is guided by medical and social eligibility criteria formulated and/or approved by the National Technical Committee (NTC) of the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MOH&FW). In addition, the overall family planning program is guided by a range of broad national policies, such as the National Population Policy (2004, under revision), the National Health Policy (2010), the Maternal Health Strategy (2001), the National Communication Strategy for Family Planning (2006), and the National LA/PM Strategy (2011).

¹ The Mayer Hashi project in Bangladesh (May 20, 2009–September 30, 2013) is an Associate Award supported by the U.S. Agency for International Development (USAID)/Dhaka under the global RESPOND Project. Mayer Hashi is managed by EngenderHealth in partnership with John Hopkins Bloomberg School of Public Health Center for Communication Programs and the Population Council. It works in 21 districts of Barisal, Chittagong, and Sylhet divisions to: 1) address the need for family planning through expanding contraceptive choices, with an emphasis on LA/PMs; and 2) prevent postpartum hemorrhage using clinical and community approaches.

At its start in 2009, Mayer Hashi conducted an assessment of LA/PM-related laws and regulatory policies. The assessment focused on policies and regulations that inhibit LA/PM service provision and use, such as: restrictions on specific methods; restrictions on service delivery and distribution; registration, licensing, and certification policies, which constrain contraceptive options; and advertising and promotion regulations. A detailed report was developed for internal use, while a summary report in tabular format was reviewed and discussed by the National Family Planning Advisory Committee during an April 13, 2010, meeting. The Advisory Committee and other experts helped determine which policies and regulations needed to be changed most urgently.

STEPS IN THE POLICY ADVOCACY PROCESS

Mayer Hashi followed a structured approach to achieve desired family planning policy changes. First, it initiated the formation of a National Family Planning Advisory Committee, with the Director General of the DGFP as the Chair and EngenderHealth as the Secretariat. This Committee serves as a forum to discuss and advance relevant policy issues among all stakeholders. The advocacy process included the following steps:

1. **Identifying and prioritizing important policy barriers.** Mayer Hashi started out by developing a broad policy matrix that included a number of policies, rules, and regulations that could be addressed.
2. **Reviewing international literature** on family planning policies and social and medical eligibility criteria. Mayer Hashi staff gathered scientific articles and background information on each of the advocacy topics.
3. **Initiating discussion** with service providers, fieldworkers, program managers, and clients, to determine the most pressing policy barriers to LA/PM use and to receive their recommendations. This information was used to further build the evidence file on each topic.
4. **Conducting advocacy training** for central and district-level DGFP and DGHS officials and for representatives of national and international nongovernmental organizations (NGOs), to strengthen their capacity to plan and participate in organized, coordinated, and strategic advocacy activities. The first part of the training focused on the development of advocacy skills, while in the second part of the training the participants created advocacy action plans for priority prevention topics. After the training, Mayer Hashi continued to collaborate with many of the participants on implementing actual advocacy initiatives and pursuing policy change together. To ensure that LA/PMs become more widely accessible within the family planning program, broad support is needed from a wide variety of technical leaders and advocates. Thus, technical, medical, and program leaders at the national, divisional, and district levels were identified and trained to be advocates for family planning and for LA/PMs. The trainings were organized with the Futures Institute, a RESPOND Project global partner.

5. **Organizing discussions and interviews** with population experts, policymakers, and selected representatives of national and international organizations on the identified policy barriers and receiving their recommendations. These interviews helped prioritize the issues in the policy barriers matrix.
6. **Discussing the policy barriers at various meetings and conferences**, to create awareness and start gaining support. Once the key priority issues were identified, such meetings helped to broaden awareness and support for policy change.
7. **Vetting the identified policy barriers in the National Family Planning Advisory Committee**, to obtain the support of the members of the committee.
8. **Raising awareness among the NTC members.** A short briefing paper was developed on each of the policy issues to be presented in the NTC, using national and international literature. All NTC members were contacted before the meeting to raise their awareness and ensure that they would be motivated to change the policy.
9. **Preparing for the meeting** with the relevant DGFP staff. The prioritized policy issues were then raised in the NTC meeting by the Line Director, Clinical Contraception Service Delivery Program (CCSDP) of DGFP, who had also placed the issues on the meeting agenda. It is important to note that while Mayer Hashi did the preparatory work, the issues were introduced at the meeting by government officials, reflecting their ownership and involvement. The Line Director, CCSDP, would conduct the presentation on the topic and lead the discussion, and only where necessary did Mayer Hashi staff provide supplementary information.

RESULTS OF ADVOCACY THROUGH THE NTC

Through this continuous advocacy process, the NTC members agreed to six policy changes. These changes and source documentation are described in Table 1. Notably, the WHO medical eligibility criteria and other international evidence were very helpful in convincing the policymakers. In some cases, the members of the NTC asked for local evidence. For example, provision of injectables and implants to nulliparous women was considered at the 56th NTC meeting, but the committee postponed its decision because of concerns about providing these contraceptives to nulliparous women (despite international evidence to the contrary and even though a majority of NTC members were in favor). A small Technical Review Committee was formed to study the technical and social aspects of injectable and implant provision in Bangladesh and to prepare a recommendation to the DGFP.

This Technical Review Committee met on November 3, 2010, and decided the following:

- Implants can be provided to nulliparous women.
- As the use of injectables may cause amenorrhea and return of regular menstruation can be delayed, some

further research is warranted; the Committee members recommended web-searching on the management of amenorrhea and conducting a trial.

The committee's recommendations were placed before the next NTC meeting for ratification. At the 57th NTC Meeting (on January 9, 2011), it was agreed that implants can be given to nulliparous women.

PATHWAYS TO POLICY CHANGE

In addition to using the NTC as a vehicle for policy change for barriers that are related to social and medical eligibility criteria, Mayer Hashi is also using other avenues of policy advocacy to work on improving the enabling environment for LA/PMs—primarily by closely collaborating with the DGFP and DGHS and organizing frequent meetings with relevant officials. The information collected during program implementation is then used to convince such officials of the importance of the issues in question. Mayer Hashi staff regularly conduct joint field visits to increase officials' awareness of critical obstacles in the field, such as the inability of non-DGFP facilities to access FP supplies, or the effects of very complicated DGFP registration or reporting procedures. This approach emphasizes the strength of implementing programs according to the SEED Programming Model. Because Mayer Hashi is involved in providing technical assistance on supply and demand issues, barriers identified in these

areas can then be taken up for policy change to improve the enabling environment.

Examples of such policy changes include the following:

- **Introduction of postpartum family planning services:** To increase the availability of family planning services, Mayer Hashi is working to introduce family planning services into non-DGFP sites where they previously had not been provided. The main focus is on integrating postpartum family planning services into the maternal health services in the service centers of DGHS and private-sector facilities. In the past, no specific regulations existed on how these facilities would obtain necessary supplies and funds. Using Mayer Hashi's field experience of providing postpartum family planning services at non-DGFP sites, the Directors-General of the DGHS and DGFP signed a detailed joint circular that is helping to improve the enabling environment for postpartum family planning services by DGHS and private facilities (Memo No. DGFP/CCSDP/Admin-47/2008/9030, dated April 28, 2011).

A second policy approved by DGFP and DGHS in 2011 states that DGHS-registered facilities, either private or NGO, do not require separate registration from the DGFP to receive family planning commodities and funds. As the DGFP registration procedure is rather cumbersome, this measure is crucial for **greater**

TABLE 1. KEY POLICY CHANGES, BANGLADESH, 2010–2012

Before the policy change	After the policy change	Source
Only couples with at least two living children, of whom the youngest is at least two years old, were eligible to adopt a permanent method.	A woman can accept tubectomy during a cesarean delivery of the second child. A woman or a man may accept voluntary surgical contraception if she/he has two children (without any mandatory age requirement for the last child). [Approved May 11, 2010]	Circular issued by Director General, DGFP, Memo No. DGFP/CCSDP/ Sterilization Program-54/98/Part-2/6063 Date: 24.05.2010
Only Family Welfare Visitors under the DGFP and trained NGO paramedics were authorized to insert an intrauterine device (IUD), while nurses under the Directorate General of Health Services (DGHS) or in the private sector were not allowed to do so.	DGHS staff nurses and nurses at private hospitals are permitted to provide IUD services after being trained. [Approved May 11, 2010]	Circular issued by Director General, DGFP, Memo No. DGFP/CCSDP/Sterilization Program-54/98/Part-2/6061 Date: 23.05.2010
The injectable Depo-Provera (DMPA) could be given only in the two weeks before and after the scheduled reinjection date.	The DMPA window period has been extended up to four weeks after the scheduled reinjection date. [Approved May 11, 2010]	Circular issued by Director General, DGFP, Memo No. DGFP/CCSDP/Sterilization Program-54/98/Part-2/6062 Date: 24.05.2010
Implants and injectables could only be used by women with at least one child.	Nulliparous women are allowed to accept implants. [Approved January 9, 2011] (The decision on injectables is still pending.)	Circular issued by Director General, DGFP, Memo No. DGFP/CCSDP/Sterilization Program-54/98/Part-2/7841 Date: 07.02.2011
Progestin-only pills were only available in the private sector.	The NTC recommended that the progestin-only pill be included in the national family planning program. [Approved February 28, 2012]	Minutes of 59th NTC meeting, Memo No. DGFP/MCH-S/NTC-4/138/95(Part-5)/331 Date: 08.04. 2012
Sino-implant (II) was not yet available in the Bangladesh family planning program.	Sino-implant (II) can be introduced into the family planning program after successful completion of a one-year acceptability trial (to be completed in June 2012). [Approved January 9, 2011]	Minutes of the 57th NTC meeting, Memo No. DGFP/MCH-S/NTC-4/138/95(Part-4)/74 Date: 26.01.2011

private-sector involvement (both for NGOs and private facilities) in the provision of LA/PMs and postpartum family planning services (Memo No. DGFP/CCSDP/Admin-47/2008/9030, dated April 28, 2011).

- **Bottom-up contraceptive projection through client segmentation:** In the past, the DGFP would set performance benchmarks for each district and upazila at the central level and communicate these to the lower levels. Officials at these levels were encouraged to achieve these targets, but they had no influence over or ownership of them. In June 2010, after extensive advocacy, the DGFP introduced local-level projection for family planning methods based on client segmentation. The idea behind this projection approach is to let the community's service needs be the driving force behind the program priorities, rather than centrally derived targets. Service providers and upazila and district officials feel ownership over program goals that they set themselves. The tools and methodology for bottom-up contraceptive projection were developed and were tested in Hobigonj, Laxmipur, and Pirojpur districts. After revision and updating of the worksheets, instruments, and tools, the DGFP initiated national-level scale-up in June 2011 (DGFP Operational Plan, 2011–2016). This included Mayer Hashi-supported training for the Deputy Directors, Family Planning, and district statistical assistants, as well as upazila family planning managers and upazila statistical assistants from all 64 districts. Mayer Hashi will continue to provide support to the national scale-up through intensive follow-up and coaching to institutionalize the DGFP's bottom-up contraceptive projection process in FY 2012–2013.

CHALLENGES

Policy change is not the end of the process. Once a policy is changed, the updated policy needs to be disseminated and followed up to ensure that it is being implemented. For some policy changes, implementation is more challenging than achieving the actual change, even though the process may have been long. One such example is making implants available to nulliparous women. On January 9, 2011, the NTC agreed that

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nulliparous women can use implants, and a circular was sent out to that effect. However, field visits showed that in reality, very few nulliparous women in Bangladesh were accepting the implant. It appears that very few young women were being informed of the fact that they were eligible to use this method; as a result, they did not ask for it. In addition, many service providers either had not heard that the policy had changed or did not agree with the change, and therefore they did not offer the implant to nulliparous women. A third factor that played a role was that because of the implant's popularity at the moment, it was often in short supply; as a result, managers considered the method more suitable for multiparous women and discouraged providers from offering it to nulliparous women. Mayer Hashi is sharing further information on implant use by nulliparous women with service providers and is using ongoing training and orientation to increase their awareness. In addition, managers will receive a new circular highlighting the policy change.

CONCLUSION

The experience in Bangladesh shows that a structured advocacy process can lead to policy change. It is important to realize that any policy change is a complex process that may require quite a long time and close collaboration with multiple actors, in particular the Government. In the advocacy process, it is important for the advocates to join forces, to be flexible, and to be willing to change strategies and sometimes use multiple approaches at the same time.

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