

# EXPANDING CONTRACEPTIVE CHOICES THROUGH POLICY ADVOCACY IN BANGLADESH

## BRIEF 4



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**INTRODUCTION** Bangladesh has made notable progress in improving its national family planning (FP) program, and ensuring adherence to international standards, guidelines, and policies, including the World Health Organization medical eligibility criteria. The Directorate General of Family Planning (DGFP) under the Ministry of Health and Family Welfare (MOHFW)<sup>1</sup> decides on the inclusion or modification of FP policies and undertakes necessary actions to implement new or updated

policies. The DGFP has long been committed to expanding access to FP services; yet, policy restrictions and client eligibility criteria continue to limit clients' choice of contraceptive methods. Policy restrictions and eligibility criteria are key barriers to FP uptake and specifically contribute to low uptake of long-acting and reversible contraceptives (LARCs) and permanent methods (PMs). EngenderHealth, through its Mayer Hashi II (MH-II) project, funded by the United States Agency for International Development (USAID), provided technical assistance to the DGFP to modify policies that restrict method choice options. The project used a structured process to promote a more conducive policy environment in order to expand access to FP services broadly and increase use of LARCs and PMs in particular.

### POLICY CHANGES AND IMPLEMENTATION

#### Developing Policy Assessment Matrix

MH-II undertook two actions to develop a policy assessment matrix.

First, MH-II conducted a systematic assessment of laws and regulatory policies related to the delivery of FP methods. In the process, MH-II reviewed a number of documents including (1) relevant international literature on FP policies; (2) national, regional, and global medical eligibility criteria for providing FP services; (3) national social eligibility criteria, in terms of parity of women; and (4) World Health

Organization guidelines and selected country guidelines on the range of service providers who can provide what methods. Through this desk review, MH-II identified critical gaps and policy restrictions that inhibit FP service provision and use in Bangladesh.

Following the desk review, MH-II interviewed DGFP program managers, service providers, fieldworkers, and clients to determine the most pressing policy barriers to uptake of injectables, LARCs, and PMs. MH-II then interviewed population experts, policymakers, and selected representatives of key national and international organizations to gather perspectives on the identified policy barriers.

<sup>1</sup> In Bangladesh, the MOHFW has a bifurcated administration with two departments having independent service delivery systems, namely Directorate General of Health Services (DGHS) and DGFP.

The project utilized these perspectives to build a local evidence base on each policy issue and synthesized recommendations in order to prioritize critical policy issues.

### **Conducting Evidence-Based Advocacy**

#### **Policy Formulation through the National Technical Committee (NTC)**

MH-II shared the necessary evidence and resources on the identified policy barriers with the Member-Secretary of the NTC.<sup>2</sup> Simultaneously, MH-II held a national-level workshop to sensitize DGFP program managers on the identified policy issues. MH-II also facilitated two regional workshops to sensitize DGFP regional managers and medical professionals. Following these workshops, the DGFP in consultation with MH-II, determined which policies and regulations needed to be addressed most urgently.

MH-II helped the DGFP prepare policy agendas for discussion at the NTC meeting. The Member-Secretary of the NTC, who is also a senior DGFP official, brought policy agendas for discussion at the scheduled NTC meeting. Simultaneously, MH-II developed briefing papers (based on national and international literature) that demonstrated the rationale for revising the specific policies that were presented during the NTC meeting. As a result, NTC members agreed to 12 policy changes (Box 1).

MH-II has continuously conducted advocacy and sensitization activities, which frequently required complex, flexible, and lengthy processes. For policy advocacy efforts, MH-II adjusted strategies and employed multiple approaches in order to facilitate policy revisions, under the guidance of the NTC. For example, one of the policy changes required a feasibility study; for another policy change, the NTC formed a sub-committee to conduct an in-depth analysis of the proposed change and MH-II provided the necessary evidence and resources to the sub-committee in garnering the approval.

Advocacy efforts required close collaboration with multiple actors. For example, MH-II closely collaborated with the Directorate

General of Health Services (DGHS) and organized frequent meetings with relevant DGFP and DGHS officials in order to expand FP services at DGHS facilities where they previously had not been provided.

#### **Policy Formulation through Ministries**

MH-II conducted intra- and inter-ministerial advocacy activities to create an enabling environment at DGHS and private facilities supportive of expanded LARC and PM services. As a result of a complex, prolonged advocacy initiative—which included a series of evidence-based, action-oriented meetings between MH-II, the DGFP, the DGHS, the MOHFW, and the Ministry of Finance—DGHS facilities are now able to access an Imprest Fund<sup>3</sup> and FP commodities, particularly commodities for LARC and PM services. Previously, there were no specific regulations on how these facilities could obtain necessary FP supplies and access support from the fund.

#### **BOX 1: LIST OF POLICY CHANGES**

- i) Community healthcare providers able to provide secondary and subsequent doses of injectables
- ii) Injectable users to receive 500 mg calcium tablets fortified with vitamin D every three months
- iii) Female sub-assistant community medical officers able to provide intrauterine device (IUD) services
- iv) Implants available to clients, irrespective of parity, as immediate postpartum family planning (PPFP)
- v) The standard-dose oral pill available for managing excessive bleeding following implant use
- vi) Progestin-only pills available to clients as immediate PPFP
- vii) PPFP counseling to be provided during antenatal care, postnatal care, and immunization visits
- viii) Family welfare assistants able to provide first and subsequent doses of injectable contraceptives
- ix) Pills, condoms, and injectables available at immunization sites
- x) One family welfare visitor assigned to each district hospital and government medical college hospital
- xi) Cotton underwear provided to non-scalpel vasectomy clients for pain management
- xii) Imprest fund or permanent advance funds available to DGHS facilities to provide PPFP services

#### **Implementation of Revised Policies**

MH-II completed four major steps to support the DGFP and DGHS in implementing the revised policies.

<sup>2</sup> The provision of FP services in Bangladesh is guided by medical and social eligibility criteria formulated and/or approved by the NTC, which is the highest body in the national FP program under the MOHFW to decide on the policies. The NTC is formed by the MOHFW and is a 30-member committee headed by the DGFP; its Member-Secretary is also from the DGFP.

<sup>3</sup> An Imprest Fund is an advance of money paid to an organization or an individual for providing LARC and PM including PPFP services. Imprest money is used to reimburse the costs of users' travel, food, and wage loss; the costs of transportation fees for the referrer; and the fees for service providers.

**Step 1: Interpretation and circulation.** MH-II helped translate policy changes into administrative directives. MH-II also helped the relevant DGFP unit issue circulars on each of the revised policies. On behalf of the DGFP, MH-II distributed paper copies of government directives to a total of 4,726 program managers and service providers within the DGFP, the DGHS, and selected NGOs.

**Step 2: Orientation.** MH-II attended monthly meetings of district and upazila family planning committees to orient program managers and service providers on new FP policies. In addition, MH-II staff briefed government and NGO service providers about the policy revisions during various field activities, including trainings, FP camps, and quality assurance visits.

**Step 3: Curriculum updates.** MH-II provided technical assistance to the DGFP in updating the National FP Manual with all the revised policies and associated service protocols. In addition, MH-II developed technical briefs on each revised policy for the service providers and fieldworkers.

**Step 4: Capacity building.** MH-II provided clinical training to the trainers and service providers on new FP methods and services available as a result of the policy changes.

## ACHIEVEMENTS

- **Bringing services closer to clients' homes.** The DGFP's field workers can now provide all injectable doses at clients' homes. Additionally, women can now access their second and subsequent doses of injectables instantly from providers at community clinics, usually located within two kilometers of their homes. Updated policies also expanded access to oral contraceptives, condoms, and injectables at immunization sites in the community for the women who bring their children for vaccinations.
- **Removing restrictions to expand clientele.** The policy change allowed for the inclusion of implant and progestin-



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only-pills in the method range as immediate postpartum FP (PPFP) options. MH-II's advocacy efforts also facilitated the integration of PPFP counseling into antenatal care, postnatal care, and immunization services.

- **Expanding contraceptive services.** PPFP services are now integrated into maternal health services, which are available in DGHS hospitals and private facilities. Likewise, women receiving maternal health services from DGHS facilities receive counseling and have access to intrauterine devices (IUDs) and implants during the immediate postpartum period.

## CHALLENGES

MH-II identified several challenges to the implementation of the revised policies during visits to local health facilities and meetings with managers, providers, and clients.

- Initiatives undertaken by DGFP program managers and facility managers to implement the policy changes were limited to disseminating the policy changes at monthly meetings. DGFP district and upazila program managers lacked specific guidance on how to implement the changes.
- DGHS and private facilities have not prioritized implementation of the FP policy changes. These facilities lacked clarity about the nature of the policy changes and how to integrate new services with existing and related services.
- Implementation suffered when the primary task of providing new services remained

with DGHS providers, especially during the postpartum period when clients must see multiple providers.

- Ensuring coordination between doctors and mid-level providers remains a key challenge to providing postpartum implant services immediately after normal deliveries conducted by mid-level providers, as only doctors are allowed to insert implants.
- Policy revisions allowing task-sharing within a single facility was not effective. For example, at union health and family welfare centers, female sub-assistant community medical officers are now able to provide IUDs but family welfare visitors have long been responsible for IUD insertions; this has created conflicts in IUD service provision.
- Few women were informed about new methods or services that they were eligible to use, which affected method uptake. This indicates limited efforts of field workers to motivate prospective clients.

## CONCLUSIONS

MH-II's advocacy efforts contributed to several key revisions of FP policies and regulations in Bangladesh aimed at improving access to and increasing use of injectables, LARCs, and PMs. However, the government was unable to implement the policy changes uniformly across all facilities. The DGFP facilities have expanded FP services related to the revised policies, but the DGHS facilities were unable to fully implement similar changes. It is worth noting that MH-II's work was limited to conducting advocacy for policy changes and did not

include ensuring policy implementation. In addition to contributing to policy revisions, MH-II is credited for conducting clinical and non-clinical trainings on new FP methods or services among DGFP, DGHS, NGO, and private providers—building upon the policy revisions. Yet, full policy implementation moving forward requires the following:

- The DGFP needs to establish a system to track the progress of implementation of revised policies and regulations so that its program managers at national and local levels can systematically monitor performance and provide necessary support.
- After revising any policy, DGFP program managers and service providers at different levels need to receive an orientation on the revisions. In addition, district- and upazila-level meetings are needed to connect local-level managers with service providers. It is also necessary to organize coordination meetings with DGHS, NGO, and private providers to harmonize policy implementation processes. The DGFP's field workers also need to be oriented on revised policies so that they can inform and motivate the prospective clients appropriately.
- The DGFP should form district-level policy implementation committees; these committees should engage both DGFP and DGHS program managers at district and upazila levels. These committees should meet quarterly to assess progress related to policy revision implementation and to identify strategies that influence service providers.

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