Bangladesh National Strategy 2011-2016 Improving the Uptake of Long-Acting and Permanent Methods in the Family Planning Program

Improving the Uptake of Long-Acting and Permanent Methods in the Family Planning Program

Bangladesh National Strategy 2011-2016

Directorate General of Family Planning
Dhaka, Bangladesh

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Mayer Hashi

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Secretary, Ministry of Health and Family Welfare

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Secretary
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh

সচিব
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার

Foreword

Family planning use has increased dramatically in Bangladesh over the last 30 years, from just 8% of all couples in 1975 to 55% in 2007; while at the same time the total fertility rate has come down from 6.3 to 2.7 children per woman. The contraceptive pill is by far the most popular method. Use of the long-acting/permanent methods of contraception in Bangladesh has declined from 36% of the method mix in 1989 to 13% in 2007. Currently less than one in five FP users choose a long-acting or permanent method, and there is a high unmet need for spacing and limiting.

The Bangladesh Family Planning Program has successfully introduced the concept of family planning, made family planning use a social norm, and established services and community linkages to meet client needs. Over the past 35 years, the Program primarily used public and NGO services, while the role of the private sector is starting to increase. In order to further reduce the total fertility rate to replacement level or below, the Government intends to build on its lessons learned and use these to address the high unmet demand and bring more variety in the method mix with an emphasis on long-acting and permanent methods (LA/PMs).

Long acting and permanent methods are the most effective methods of contraception. Intrauterine devices (IUDs) and implants can be beneficial for individuals at various points in their reproductive life; they are highly effective, cost effective, safe, and suitable for those individuals who want to delay; space or limit births. Female and male sterilizations are an excellent option for individuals who would like to limit their fertility.

This National LA/PM Strategy document presents the Government's comprehensive vision towards increasing the use of long acting and permanent methods of contraception, and is intended to provide guidance for all stakeholders—Government, private sector and non-governmental organizations—in designing, implementing and evaluating interventions to increase the use of quality long-acting and permanent methods in the family planning program. I call upon all stakeholders to contribute to its implementation.

Md. Humayun Kabir

Acknowledgements

Despite major accomplishments by the Bangladesh Family Planning Program, the current use of long-acting and permanent methods (LA/PM) is still below expectation. Enhancing method uptake calls for a holistic approach that includes improving service delivery, building providers' capacity, ensuring commodity security, creating demand, ensuring community involvement and providing a conducive policy environment. As such, it is of key importance that a National LA/PM Strategy is in place that outlines approaches in all these areas for all public, NGO and private sector actors.

The development of this National Strategy for Improving the Uptake of Long-Acting and Permanent Methods in the Family Planning Program was initiated by the Clinical Contraceptive Services Delivery Program (CCSDP) of the Directorate General of Family Planning (DGFP), Ministry of Health and Family Welfare (MoH&FW). The Mayer Hashi Project provided technical assistance in its development. The Mayer Hashi Project is funded by USAID/Dhaka under the Global RESPOND Project, managed by EngenderHealth in partnership with the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and Population Council.

The outline of the strategy as well as the Mission, Vision and Objectives and first ideas for content were contributed by participants in Stakeholders workshops organized in Dhaka, Chittagong and Sylhet on December 13, 2009, December 20, 2009 and January 27, 2010. We would also like to acknowledge the contribution of the members of the National Family Planning Advisory Committee, formed under the overall guidance of Director General, Directorate General of Family Planning for giving directions and guidance to the outline as well as the overall content of the document.

M. M. Neazuddin
Director General,
Directorate General of Family Planning

Preface

Four contraceptive methods are categorized as long-acting or permanent: intrauterine devices (IUDs), implants, female sterilization or tubal ligation, and vasectomy. IUDs and implants are long-acting methods; when removed, return to fertility is prompt. According the latest WHO eligibility criteria, almost all women are eligible for IUDs and implants.

Worldwide, IUDs are the most popular nonpermanent long-term method of contraception. However, in Bangladesh, only 0.9% of eligible women are using this device. IUDs are highly effective in preventing pregnancy for ten years and also very cost effective when women use it for at least three years. Sub-dermal implants also provide highly effective, long-acting contraception. These implants consist of one or two rods that deliver a progestin. Currently Implanon, a one-rod implant is available in the Bangladesh Family Planning Program, while an acceptability trial for a two-rod implant, Jadelle, has been completed. Though current implant use is still low, they are gaining in popularity.

In Bangladesh, 5% of eligible women have opted for tubal ligation. It is a permanent method and should be performed only for women who are fully informed and choose to prevent pregnancy permanently. Vasectomy has been gaining popularity in Bangladesh over the past three years, but at the time of the 2007 Bangladesh Demographic and Health Survey only 0.7% of eligible couples opted for this method.

Long-acting and permanent methods are by far the most effective methods of contraception available; they are also very safe and convenient. They are all clinical methods, and thus must be provided by trained personnel in health facilities. The methods have a very long lifespan, requiring fewer visits to health providers, which saves the clients time, effort and money, while at the same time easing the client load at the service sites. In addition, these methods do not require daily motivation or reminders on the part of the users, and thus have higher continuation and effectiveness rates.

Long-acting and permanent methods of contraception are vital to fulfilling the Government of Bangladesh's goals of improving the health of its population and achieving national development goals, including reducing population growth. To attain the necessary progress in LA/PM use, bold action will be required by all actors in a joint approach. As BCC plays a vital role in the promotion and revitalization of LA/PMs and has not received sufficient attention in recent years, it is specifically highlighted in this Strategy. With this Strategy now in place it is my belief that all our partners will contribute their support and assistance towards its implementation.

Dr. A. K. M. Mahbubur Rahman
Line Director,
Clinical Contraceptive Services Delivery Program (CCSDP),
Directorate General Family Planning

Abbreviations

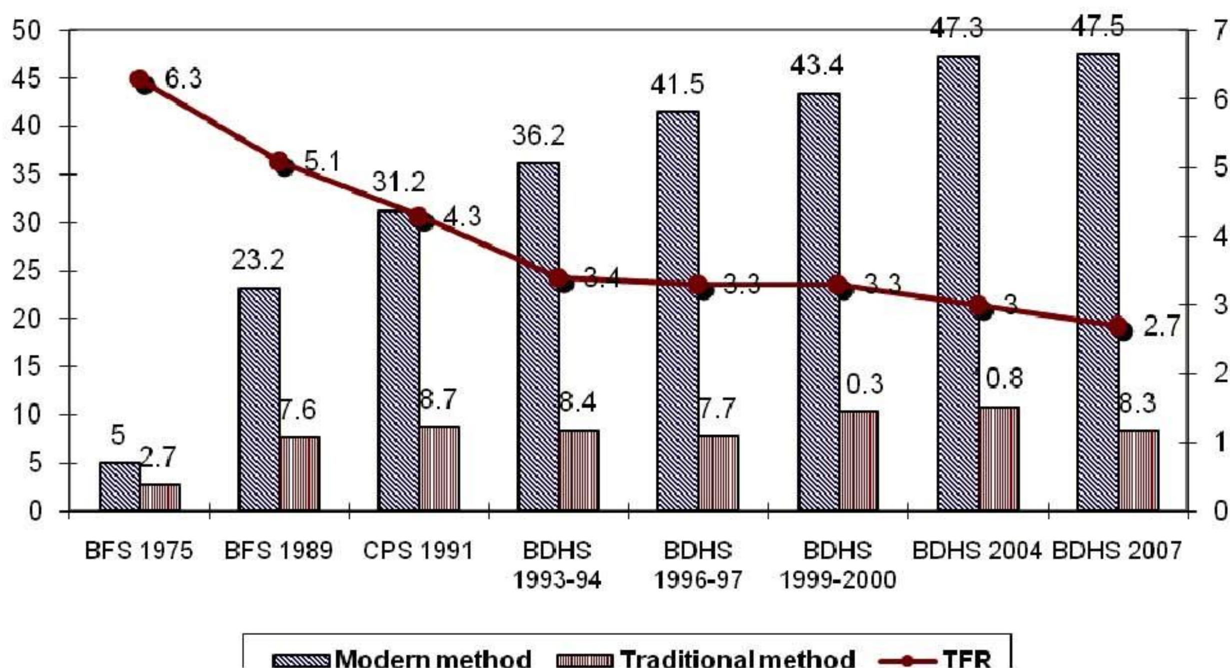
ADCC	:	Assistant Director, Clinical Contraception
AFWO	:	Assistant Family Welfare Officer
BCC	:	Behavior Change Communication
BDHS	:	Bangladesh Demographic Health Survey
CPR	:	Contraceptive Prevalence Rate
CYP	:	Couple Year Protection
DDFP	:	Deputy Director of Family Planning
DGFP	:	Directorate General of Family Planning
DGHS	:	Directorate General of Health Services
FoC	:	Fundamentals of Care
FPCST	:	Family Planning Clinical Supervision Team
FWA	:	Family Welfare Assistant
FWV	:	Family Welfare Visitor
FWVTI	:	Family Welfare Visitors' Training Institute
GOB	:	Government of Bangladesh
H&FWC	:	Health and Family Welfare Center
IUD	:	Intra Uterine Contraceptive Devices.
LA/PM	:	Long-acting and/or permanent methods
MCHTI	:	Maternal Child Health Training Institution
MCWC	:	Maternal and Child Welfare Center
ME&R	:	Monitoring, Evaluation and Research
MIS	:	Management Information System
MO	:	Medical Officer
MOHFW	:	Ministry of Health and Family Welfare
MOLGRDC	:	Ministry of Local Government and Rural Development C
NGO	:	Non-Government Organization
NIPORT	:	National Institute of Population Research and Training
NSV	:	No-Scalpel Vasectomy
Ob-Gyn	:	Obstetricians and Gynecologists
PAC	:	Post Abortion Care
PINA	:	Performance Improvement Needs Assessment
PP BTL	:	Postpartum Bilateral Tubal Ligation
PP IUD	:	Postpartum Intra Uterine Devices
PPFP	:	Postpartum Family Planning
QoC	:	Quality of Care
RMO	:	Resident Medical Officer
SACMO	:	Sub-Assistant Community Medical Officer
SMC	:	Social Marketing Company
Sr. FWV	:	Senior Family Welfare Visitor
SSFP	:	Smiling Sun Franchise Program
TA	:	Technical Assistance
TOT	:	Training of Trainers
UFPO	:	Upazilla Family Planning Officer
UH&FPO	:	Upazilla Health and Family Planning Officer
UP	:	Union Parishad; Upazila Parishad
UPHCP	:	Urban Primary Health Care Project
USAID	:	United States Agency for International Development
VSC	:	Voluntary Surgical Contraception
YMC	:	Young Married Couple

Bangladesh has an estimated population of 166.5 million in 2009 (BBS, 2009), and a total land area of 147,500 square km, making it one of the world's most densely populated countries, with a population density of around 1,000 per square km. The population has a very young age structure—with one third of the population under 15 years of age-leading to continued future growth even after replacement level fertility is reached. Compounding the fast population growth are environmental factors, like shrinking agricultural land and increasing salinity, resulting in large-scale rural-to-urban migration.

Use of Long Acting and Permanent Methods of Family Planning

Family planning use has increased dramatically in Bangladesh over the last 30 years, from just 8% of all couples in 1975 to 56% in 2007. As a result of the high contraceptive use and a process of social change, the total fertility rate has come down from 6.3 to 2.7 children per woman. This has been achieved despite the fact that in recent years the use of modern contraceptive methods has remained stagnant at 47% (NIPORT et al, 2007). The contraceptive pill is by far the most popular method. The use of long-term methods did not increase in recent years; in fact there was a slight decrease in the use of these methods from 11 to 9%. There also was an increase in unmet demand for family planning between the 2004 and 2007 Demographic and Health Surveys from 11 to 17%, indicating further room for growth in contraceptive use. There is little variation in contraceptive use by women's education levels, while urban women (62%) use contraceptives slightly more often than rural women (54%).

Figure 1. Trends in contraceptive prevalence and total fertility rate in Bangladesh, 1975–2007



Among family planning users, 40% indicate that they use a method of contraception to limit their family size (BDHS, 2007). Long acting and permanent methods (LA/PMs) have many advantages for couples who have already achieved their desired family size. Yet, among these couples, only 20% use such methods. Furthermore, the overall percentage of couples using LA/PMs has fallen, from 12.2 in 1991 to 7.3% in 2007.

Despite slight declines in the percentage of users over the past decade, the annual number of implants, tubectomies, and vasectomies provided in Bangladesh increased fourfold, and the number of IUD insertions doubled. These increases reflect the growing acceptability of these methods. However, the data also illustrate challenges: The sharp decrease in the numbers of implant and IUD acceptors in 2007 reflects nationwide disruptions in the supply chain. It is interesting to note that sterilizations increased during that time period.

A number of factors have contributed to the increases in family planning use over the past 30 years:

- Strong political commitment to FP program;
- Flexibility to make policy adjustment in response to emerging needs;
- Multisectoral behavior change communications (BCC) interventions to establish a small family norm;
- A good infrastructure for FP service delivery;
- Increased involvement of nongovernmental organizations; and
- Strong support from the international donor community.

Several challenges remain as Bangladesh's demographic transition continues:

- Residual momentum of population growth due to past high fertility;
- Strain on programmatic resources due to the growing demand for family planning;
- Weak counseling;
- Weak supervision and monitoring;
- Staff shortages and delay in recruitment;
- Lack of continuity in the supply of contraceptives, especially IUDs and implants;
- Need for improvement in the quality of facilities and service;
- Directorate General Family Planning (DGFP) MIS capacity and its limited use of data for decision making and local-level planning;
- Unsupportive Kwami religious leaders (a faction of Imams); and
- Need for increased male participation in programs.

(Sources: NIPORT, et al 2007; and annual reports and workplans from ACQUIRE Bangladesh, 2004–2008)

The Government Health System and Infrastructure

According to Bangladesh's constitution, the government is obliged to ensure adequate

health care for its citizens. To meet this commitment, 7% of the national budget is allocated to the health, nutrition, and population sector. In Bangladesh, these investments are made as part of the government's overall Poverty Reduction Strategy Paper (MOH&FW, 2008).

The health care system is headed by the Ministry of Health and Family Welfare (MOH&FW), which functions through five Directorates (Health; Family Planning; Nursing; the National Institute of Population Research and Training (NIPORT); and Drug Administration) and a number of centers and departments, such as training, research, management and information system (MIS), and logistics (DGFP, 2005). The management and delivery of family planning services occurs primarily through the Directorate General of Family Planning (DGFP), with peripheral involvement of other directorates, centers, and departments.

Services are organized into seven divisions (each with a divisional director responsible for support and human resource functions) and 64 districts (each with an Assistant Director Clinical Contraception (ADCC), a deputy director responsible for FP/RH and related maternal and child health services (DGFP, 2005). There are three types of family planning providers: medical officers (MOs), who are physicians; sub-assistant community medical officers (SACMOs), paramedics, and family welfare visitors (FWVs), female health service with 18 months of basic training in FP services. At the district and national levels, the health and FP departments are separate, even though these departments work together at the upazila and union levels (WHO SEARO, 2007).

In Bangladesh a well-designed service delivery infrastructure has evolved over the years. Public sector infrastructures include: (i) more than 13,000 Community clinics from where IUD and injectables services could be provided but, which are not yet fully functional; (ii) 4,500 Health and Family Welfare Clinics (H&FWC) which can utilized for providing LA/PMs of which 1,500 are upgraded to provide all FP and delivery services but are sporadically used; (iii) 407 Upazila Health Complexes (UHCs) but, regular LAPM services are not available in some of these facilities; (iv) 97 Mother and Child Welfare Centers (MCWCs) located at the district /upazila/union levels of which district-level facilities are regularly used for LA/PMs (v) 64 district sadar/general hospitals which rarely provide FP services except some tubectomy during C-section; (vi) 14 public sector medical college hospitals all of which do not provide FP services; (vii) more than 30 private medical college hospitals and a large number of private clinics, most of which do not provide any FP services except un-reported tubal ligation along with C/section. Moreover, there are (viii) more than 400 NGO facilities with relatively good FP infrastructure but seldomly used for providing LA/PMs.

On a regular basis, all four LA/PM services are available at facilities at all the district level MCWCs and most of the upazila level upazila health complexes (UHCs). At a union-level facility, only the IUD is available regularly; the other three LA/PMs are available from some of the centers on monthly special days.

Behavior Change Communication

Nine out of ten couples in Bangladesh indicate that they know modern family planning methods (BDHS, 2007), but this knowledge is quite superficial. Attitudes towards certain methods, especially clinical and permanent ones, are often quite negative. There are many myths and misperceptions, particularly about long-acting and permanent methods of contraception. In general the public knows that male and female sterilization are permanent methods and that they are meant for couples who do not want any more children; however an exploratory study by BCCP conducted in 2003 found a lack of specific and detailed information about LA/PMs among non-users. There is also a lack of knowledge about where to obtain permanent methods. The BCCP study found that the users of long-acting methods had many misperceptions about permanent methods, while users of short-acting methods had misperceptions about long-acting methods (Knowing Customers' Insight about PLTM, 2003).

The 2003 study findings also showed that men and women have incorrect information on permanent methods which prevents them from using these methods. As such, inadequate method-specific promotion of LA/PMs among potential clients, lack of detailed information (duration, advantages, side effects, etc), and existing misconceptions on LA/PMs are among the key reasons behind the current knowledge and practice gap.

The NSV Campaign Evaluation (EngenderHealth, 2008) revealed that 83% of respondents did not want anymore children. Among those who did want more children, 86% preferred to space the birth of their next child beyond 49 months. This shows that there is potentially a large audience for long-acting methods once these people receive correct information.

Review of various program documents found that the following factors are major barriers in adopting LA/PM:

- Heavy dependency on short-acting methods;
- Fear and repercussions related to social or religious taboos regarding LA/PMs;
- Misconceptions about complications or side effects;
- Lack of service providers at the facility and in the community with adequate information and communication skills;
- Inadequate involvement of men in informed decision making about contraceptive use;
- Women's education on family planning and general low status in society.

Past and Present Family Planning Communication Initiatives

After Bangladesh became independent, a range of family planning communication initiatives were implemented. The emphasis of the family planning program in its first

two decades was on clinic and field-based counseling. In 1975, the Information, Education and Motivation (IEM) Unit was established under DGFP. The two key objectives of this unit were: (1) promote the concept of the small family size; and (2) generate demand for family planning and maternal and child health services. The activities of the IEM Unit have been critical to the success of the Bangladesh family planning program.

In the late 1970s, the first family welfare assistants were hired to provide counseling to couples at their homes and supply their family planning methods. Also during this time, the first multi-media campaign was implemented using a variety of mass-media in combination with interpersonal communication to increase awareness about family planning. In the 1980s the focus of communication efforts was on attitude and behavior change. Satisfied family planning acceptors became change agents in their communities. The 1990s was marked by the development of the Health and Population Sector Program, demonstrating a sectoral approach to family planning demand generation. Supporting BCC materials for family planning programs were developed by governmental as well as non-governmental organizations including booklets, leaflets, posters, videos, flipcharts and TV spots.

BCC gaps and lessons learned

Studies carried out by governmental and non-governmental organizations highlight gaps and lessons learned in the BCC programs implemented thus far in Bangladesh with a focus on LA/PM (List of documents reviewed in Appendix 3).
These are highlighted here so that they can be addressed in the Strategy and overcome in future efforts. The following gaps were identified:

Policy level:

- Limited national stewardship on family planning BCC;
- Limited involvement of political leaders at national level in making public statements on family planning.

Program level:

- Lack of broad comprehensive FP/LAPM campaigns at the national and regional levels;
- FP BCC interventions carried out by GO and NGOs are vertical and isolated; there is no coordination to achieve a synergistic effect;
- Lack of continuity of promotional activities; i.e communication activities are mostly project specific and time bound;
- Limited effort to scale up or replicate successful communication approaches;
- Little effort to address method-specific myths and misconceptions to popularize LA/PMs;
- Under or non-utilization of other government sectors (Ministry of Local

Government and Rural Development Cooperation (MOLGRDC), Ministry of Women and Children Affairs (MOWCA), Ministry of Social Welfare (MOSW), Department of Mass Communication, Department of Youth Development, Ministry of Religious Affairs (MORA) etc.) and private sector resources to promote LA/PM.

Provider level:

- Lack of capacity at the decentralized level and in the field to deliver BCC messages;
- Lack of quality counseling to reduce FP discontinuation and address unmet need;
- Limited number of motivated providers for effective promotion of LA/PMs and lack of service providers' motivation to use BCC materials and job-aids;
- Service providers' personal attitudes: many have personal biases against certain LA/PMs and will not recommend them to clients; and
- Limited number of motivated providers for effective post-procedure counseling to deal with side-effects and complications.

Communication approach:

- Limited use of media-mix to provide complete and comprehensive information;
- Non-activation of community resources and lack of significant participation of community-level stakeholders to create an enabling environment;
- Little attention to enhance male participation;
- Limited lifecycle specific promotion of long acting and permanent method (un -packing of LAs and PMs);
- Limited utilization of the strengths of existing service delivery networks/ systems (use of communication channels such as mobile video van, community resource groups, etc) to extend the reach of messages on LA/PM; and
- Lack of method specific, audience-focused print and electronic enter-educative materials and messages on LA/PMs in easy language and local dialects.

Lessons learned:

- Repeated LA/PM communication campaigns generate confidence among potential clients;
- Comprehensive audience-specific BCC interventions increase outcomes;
- Orientation and practice help providers and field workers become more confident and effective communicators;
- Community discussions help in deepening the awareness level of the community decision makers and dispelling FP-related myths and misconceptions while providing social support for method use;
- Effective orientation can break religious conservatism and negative barriers on FP;
- Male involvement is essential for the success of LA/PM programs;
- Satisfied acceptors can be very effective advocates of LA/PMs;
- Establishing linkages with all relevant actors, including NGOs and the private

sector, increases the sustainability of the promotion of LA/PM services;

- Good collaboration, team approaches and a multi-sectoral approach contribute in increasing the reach of messages;
- Motivated providers and effective pre- and post-procedure counseling creates satisfied clients and increases acceptance of LA/PMs; and
- The pro-active role of national level leadership in promoting sterilization services greatly contributes to breaking the silence about these methods and in creating a momentum in the family planning program.

Mission and Objectives

Vision

Increased popularity of long-acting and permanent methods of contraception, making them the method of choice for all couples who wish long-term spacing or who would like to limit their childbearing.

Mission

To achieve a 20% share of long acting and permanent methods in the total method mix by the year of 2016.

Goal

Reduce the unmet need for LA/PMs (including for young married couples and postpartum women) from 17% to 10% and reduce long-acting method discontinuation rates.

The Specific Objectives that will contribute towards achieving this goal are:

1. Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

2. Improve the quality of LA/PM services in all designated service centers, including the quality of LA/PM behavior change communication and counseling.

3. Advance public-private partnerships to increase the availability of LA/PM services.

4. Ensure LA/PM commodity security in the public and private sector.

5. Create an enabling environment to facilitate LA/PM access for all couples wishing long-term spacing or limiting, including reduced policy barriers.

6. Increase the use of LA/PMs through demand creation and community mobilization among all couples wishing long-term spacing or limiting.

Strategies for the implementation of each objective are described in the next chapters. Chapter 9 outlines suggested indicators for monitoring and evaluating progress in implementing the elements of the LA/PM Strategy.

Introduction

Access to LA/PM services means the degree to which these services can be obtained at an effort and cost acceptable to and within the means of the majority of the population. In spite of the recent increasing trend of LA/PM performances, the yearly acceptance is still far below the number of couple eligible for accepting LA/PMs and who expressed a wish for limiting or long-term spacing in the Demographic and Health Surveys. Programs in other low resource settings have demonstrated that when LA/PMs are effectively introduced or revitalized, women and men will use them.

Specific Objective:

Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

Proposed Strategies:

A. Ensuring skilled service providers at all designated service delivery centers

B. Developing capacity on LA/PM at all levels.

A. Ensuring skilled service providers at all designated service delivery centers

Non availability of service providers at the facilities is a great challenge for the Family Planning Program and in particular for LA/PMs, as they are clinical methods. Approaches to meet the need for skilled providers include:

- Apply appropriate selection criteria and administrative rigor in posting and placement procedures;
- Establish provider pools at district level and provide services within the district on a regular schedule;
- Provide accommodation for doctors in remote areas in particular; make security arrangements especially for female doctors, and wherever possible ensure placement of couples;
- Ensure continuous skills-based and on the job training;
  Select providers who may not currently be providing services but have the potential to offer those services; e.g. private practitioners who can perform NSV at
- Government facilities with proper training;
  Endorse rules for providing LA/PM services by DGHS providers;

- For periods of time let DGHS physicians provide LA/PM in places **where an** MO(MCH-FP) is not available;
- Involve Surgeons and Obs/gyn professionals for service delivery and recanalization;
- Form roving teams with public and/or private doctors, in particular for the hard to reach areas.
- Scale-up training on immediate postpartum IUD and tubectomy for maternity providers.

B. Capacity Development on LA/PMs

Capacity development on the LA/PMs refers to the approaches or strategies used to improve performance at the individual, organizational, and broader systems level. The following capacity building strategies are proposed:

Making better use of existing capacity

- Activate all the Model family planning clinics attached to the Medical Colleges for LA/PM pre-service and in-service training and service provision, including immediate postpartum tubectomy and IUD;
- Utilize NIPORT in collaboration with DGFP for non-clinical training related to LA/PMs; like religious leaders orientation and field workers orientation/training;
- Identify potential NGO and private sector agencies capable of providing LA/PM training and ensure their certification;
- Recognize and list all National LA/PM Trainers in the public, private and NGO sector;
- Work with clinical staff (eg.- obs/gyn practioners) who already have the capacity to provide LA/PM without additional training;
- Arrange refresher training on LA/PMs for those who need it.

Strengthening existing capacity

- Provide TOT/Training/Orientation on LA/PMs according to needs identified;
- Develop national and regional trainers pools;
- Organize skills-based training by trainers from the pool;
- Adapt the existing curricula, standard guidelines, technical issues;
- Set up training centers with all training equipments and facilities;
- Use a variety of training approaches, including on the job training, and long distance online training courses;
- Identify gaps in trainers' capacities using trainers evaluation checklist and provide necessary support including hands-on coaching.

Creating new capacity

- Provide training in immediate postpartum tubal ligation and postpartum IUD;
- Integrate LA/PM in the training curricula of pre-service training of the medical

colleges, nursing and medical assistant;

- Involve and train clinical staff who have the capability to serve as LA/PMs providers but who are currently not working as such (eg**. –Nurses for IUD services,** private doctors for NSV & Tubectomy).

Ensuring medical monitoring

- Assign DGFP and DGHS staff for medical monitoring at division/region/district/ upzila level;
- Use available checklists to assess performing to standard for clinical methods;
- Use available checklists to assess facilities for providing LA/PM services;
- Use the National FP Service Delivery Guideline (currently under revision);
- Develop a system of accountability;
- Develop a system of on-the-job training to address skills-deficiencies.

Improving the Quality of Care

Introduction

Improvement of quality of care is essential to reduce method discontinuation, frequent switching of methods, and to promote acceptance and encourage overall effective use. Improvement of quality of care remains a key intervention to achieve further increases in overall contraceptive prevalence and in LA/PM in particular. It is important to focus on both counselling and technical skills. Improved provider skills in counselling can effectively address issues such as appropriate choice of methods, knowledge to deal with side effects and encourage continuity, and facilitate cross referrals as and when necessary. Improved technical skills, especially for aseptic precaution and screening for contraindications, can reduce side effects and complications and, thereby, promote method continuation and effectiveness. Given the lack of knowledge as well and misconceptions by the general public method on LA/PMs, efforts should focus on raising the awareness and availability of under-used methods, overcoming provider biases for and against certain methods, and strengthening provider's counselling skills.

Specific Objective:

Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

Proposed Strategies:

A. Ensure constant and sustained attention to the Fundamentals of Care (FoC)

B. Establish clients' rights and provider's needs at the heart of LA/PM service delivery.

A. Ensure Constant and Sustained Attention to the Fundamentals of Care (FoC)

The Fundamentals of care is a set of essential and basic elements for the success and sustainability of health and family planning care interventions. It consists of three important components:

a) Ensuring informed and voluntary decision making:

This is a process by which an individual arrives at a decision about FP/health care, based on options, information, and understanding. To make an informed choice about their reproductive health, a client must have access to service options and receive and understand the information relevant to making a decision. To ensure

informed and voluntary decision making, the following aspects need to be in place:

- Service options are available and accessible
- Providers use comprehensive job-aids and give clients accurate information to aid them in the decision-making process
- Providers ensure effective counseling and client provider interaction
- Providers enable a voluntary decision-making process

b) *Assuring safety for clinical techniques and procedures:*

Medical safety is a critical issue for clients and providers. It relates to the procedures that are conducted and the clinical environment in which they are carried out. Clinical techniques and procedures are considered safe when skilled providers practice according to updated, evidence based-standards and guidelines and infection prevention protocols, and procedures are performed within a physical structure appropriate for managing clinical and surgical services. For assuring safety for clinical techniques and procedures the following provisions need to be in place.

- Written medical guidelines, protocols, and standards are regularly updated and consistently implemented.
- Providers perform FP/RH services, according to up-to-date national standards
- Providers correctly implement all infection prevention practices and procedures to protect clients and themselves.
- Providers appropriately handle emergency situations.
- Providers ensure prompt and appropriate management of side-effects and complications.
- Supervisors regularly conduct medical monitoring at the facility level to assess the readiness and the processes of service delivery and make recommendations for improvement using checklists.
- Service statistics data are collected and used for decision-making at the service delivery level.

c) *Providing a mechanism for ongoing quality assurance and management:*

Ensuring high quality services is a continuous process requiring strong management mechanisms to create a positive enabling environment for service delivery. There should be systems for supervision, training, logistics, and monitoring and evaluation function effectively to provide high quality services that satisfy its clients and increase demand.

For providing a mechanism for ongoing quality assurance and management the following provisions need to be in place.

- Quality Assurance (QA) mechanisms are implemented at the facility level to analyze and address service delivery issues.

- Facilities and providers receive supportive supervision to create an enabling environment for service provision.
- Providers have adequate knowledge and skills to perform their job.
- Facilities have adequate infrastructure, supplies, and equipment to deliver quality services.
- Providers have clear job descriptions and expectations.
- Providers regularly receive feedback on their performance.
- Providers are adequately motivated to perform according to standard.
- Providers participate in a process of ongoing problem-solving and quality improvement at facility level; and provision of a supportive management system, including appropriate reward system for good work.
- At the management level, there are needs for well-functioning LA/PM training, supervision, and supply of logistic system based on up-to-date and evidence-based protocols and guidelines that meets the client's needs.

B. Establish Clients' Rights and Provider's Needs as the Heart of LA/PM Service Delivery.

At the center of LA/PM service delivery is the contact between an informed client and a skilled, motivated service provider taking place in an appropriately staffed, managed, and functioning clinical facility resulting in meeting the needs of the client in a quality manner. Such an encounter will produce a satisfied LA/PM acceptor and thus increase the overall number of quality LA/PM acceptors.

Suggested quality of care indicators and tools to measure improvements in quality are attached in Appendix 1.

Advancing LA/PM in the private sector

Introduction

IContraceptive security calls for comprehensive approaches that go beyond the public sector. [1]Expanding private sector involvement is essential, not only in helping to respond to the growing demand, but also in ensuring equity in the market. Re-directing better-off clients to the private sector will free up limited donor and public resources for the poorest. The Government can create favourable conditions to induce more private providers to enter the family planning market. While the private sector in Bangladesh already plays an important role in providing temporary methods, they play a very limited role in the provision of LA/PMs. To extend LA/PMs to more clients, public private partnerships should be further explored and expanded.

Specific Objective:

Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

Proposed Strategies:

A. Explore the role of the private sector in providing LA/PMs based on the experience in other countries.

B. Implement measures to stimulate private sector involvement in LA/PM service delivery.

A. Explore the role of the private sector

An exploratory study should be conducted to advance the issue of private sector involvement in LA/PM service delivery. In addition, meetings can be organized between the MOH&FW and private sector representative to identify the key issues hampering/facilitating private sector involvement in LA/PM service delivery to further advance the issues.

B. Implement measures to stimulate private sector involvement

The private sector constitutes of health providers, manufacturers, importers, distributors and retailers. It can be divided in three subsectors: commercial entities, NGOs and social marketing organizations. In Bangladesh the public

[1]This chapter is based on information from the following publication: The POLICY Project, 2004. Creating Conditions for Greater Private Sector Participation in FP/RH: Benefits for Contraceptive Security. Policy Issues in Planning and Finance. No. 4. June 2004.

sector is the predominant source providing contraceptives to 50% of all users, however, the contribution of the public sector has been declining (BDHS, 2007). In 2007, 44% of modern method users were getting their methods from a private medical source, with pharmacies being the most important source, serving 35% of the users. Another 7% use non-medical private sources, mostly shops. The NGO sector serves 5% of the clients. In the private sector, there is an active social marketing program that distributes pills, condoms and injectables through pharmacies, small shops and kiosks. In 2007, 45% of pill users used a social marketing brand, and 57% of condom users (BDHS, 2007).

To increase the role of the private sector in LA/PM service delivery, several steps would need to be undertaken:

1. Enhance the policy environment: The policy environment affects all aspects of contraceptive security and influences the private sector's activities and priorities. Knowledge of policies, laws, and regulations that affect private providers and commodity availability can help promote policy dialogue and determine needed policy reforms. An assessment of the policy and regulatory environment would help identify opportunities and challenges for both the public and the private sector.

   It is also critical to conduct a market assessment to understand the forces that drive various segments of the private sector. This market assessment can help to better understand the current role of the private sector and what role the private sector could play based on a profile of the consumers.

2. Recognize and define the private sector niche and target population: The private sector already plays an important role in delivering pills, condoms and injectables to those who can afford to purchase them. Now the public sector can work with the private sector to put in place an enabling environment that would enhance the private sector role in providing LA/PMs. The public sector can work with the private sector as a partner in planning, decision making and resource allocation to ensure that the private sector is not overlooked in planning and decision-making. As noted above, it is important to consider here that there are different categories of private sector, the pure private sector, NGOs and social marketing. In new policies and strategies it would be important to think about measures that would make it attractive for the commercial private sector to participate. This would include measures such as exempting contraceptive imports from tariffs and duties; relaxing price controls on commodities and relaxing laws governing the advertising of contraceptives.

3. Achieve a division of labor and communicate the role of the private sector: Partnerships help identify and use each sector's strength and resources to use a

common goal. Once a market segmentation analysis has been conducted, a division of labor between the public and private sector will help ensure the availability and accessibility of LA/PM for all segments of the population. Poor and disadvantaged groups can be targeted by the public sector, while wealthier clients can be encouraged to use the private sector. It will be important to put in place an extensive communication program to communicate to the target audiences where to go for services. LA/PM services in the private sector would need to be clearly recognizable for those looking for higher quality and be willing to pay for these. A logo and a name could be created for the private service providers offering LA/PM so that clients know where to go, and this could be communicated through mass media and other communication materials.

Ensuring Contraceptive Security

Introduction

Reproductive health commodity security exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever s/he needs them. The Bangladesh FP logistics system has many strong points, but obstacles to timely international procurement have created stock-outs, particularly for long-acting methods at a time when unmet demand for family planning needed to be met promptly.

Experience over the years has resulted in the development of detailed procurement lists and specifications of equipment, commodities and supplies needed for ensuring LA/PM services. On many occasions a lack of synchrony between placements of skilled service providers and the supply of commodities, drugs and equipment has hampered LA/PM services. A detailed procurement and distribution plan will need to be developed to match the human resource development plan to ensure synchrony. In-facility capacity in management of equipment, commodities, drugs and supplies should be strengthened. In the recent past there have been several instances of long stock-out of contraceptives including of IUD and Implant. Therefore, there is a strong need for strengthening the contraceptive commodity security and to ensure adequate supplies to all LA/PM service facilities.

Long-acting and permanent methods are by far the most effective methods of contraception available; they are also very safe and convenient. The methods have a very long lifespan, requiring fewer visits to health providers, which saves the clients time, effort and money, while at the same time easing the client load at the service sites. In addition, these methods do not require daily motivation or reminders on the part of the users, and thus have higher continuation and effectiveness rates. Long-acting and permanent methods of contraception are vital to fulfilling the Government of Bangladesh's goals of improving the health of its population and achieving national development goals, including reducing population growth. These methods also play an important role in the Government's plans towards achieving greater commodity security.

Specific Objective:

Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

Proposed Strategies:[2]

A. Increasing commodity self sufficiency
B. Strengthen forecasting and projecting
C. Promote public-private partnerships
D. Improve warehousing and storage
E. Improve monitoring and supervision

A. Increasing commodity self sufficiency

In order to ensure future commodity security, the Government would have to gradually move away from donor dependence to self sufficiency in RH commodities. This would entail the following measures:

- Adequate budgetary provisions for procurement of RH commodities;
- Promote and encourage local manufacturing of goods and reducing reliance on external suppliers;
- Improve forecasting and procurement procedures for reducing costs (economy of scale) and delays in procurement and supplies;
- Promote public private partnership and invite corporate houses to promote and support RHCS efforts

Already the Government is purchasing condoms produced in Bangladesh from Government resources. Similarly, a multi-national pharmaceutical company is producing oral pills in limited quantities which are sold in the market at a higher price compared to the products offered by SMC. Enhancement of preference for local manufacturers at the time of public sector procurement will help growth of private entrepreneurships to manufacture contraceptives locally. Local production and procurement of injectables and IUDs could be studied.

B. Strengthen forecasting and projecting

Bangladesh has the technical capability to prepare and/or update long-term projections for RH-commodities using BDHS data. The current set of projections up to 2015 was prepared in early 2000 using 1999-2000 BDHS data. To enable relatively accurate projections, the exercise should be undertaken once every four years just after completion of the BDHS.

The MOHFW, DGFP, and the World Bank take varying amounts of time to review and approve draft bidding and Tender Evaluation Reports (TERs). Delays occur at various stages of the process. Moreover, the high turnover of trained procurement staff as well as senior management creates a knowledge and experience gap that limits DGFP's ability to carry out timely and effective procurement.

[2] The strategies proposed here correspond with those proposed in the Reproductive Health Commodity Security National Strategy for Bangladesh. June 2010, final draft version.

C. *Promote public-private partnerships*

As described in Chapter 5, contraceptive security calls for comprehensive approaches that go beyond the public sector. Expanding private sector involvement is essential, not only in helping to respond to the growing demand, but also in ensuring equity in the market. Re-directing better-off clients to the private sector will free up limited donor and public resources for the poorest. The Government can create favourable conditions to induce more private providers to enter the family planning market. While the private sector in Bangladesh already plays a considerable role in providing temporary methods, they play a very limited role in the provision of LA/PM. To extend LA/PMs to more clients, public private partnerships should be further explored and expanded.

D. *Improve warehousing and storage*

The present central warehouse was built in late 1970's, while 21 regional warehouses and 210 Upazila stores were built in the late 1980's and early 1990's. Another 40 Upazila stores were constructed during the period 2001-2006. About half of the Upazilas do not have proper storage facilities. Upazilas that do not presently have their own constructed stores are keeping their supplies in a small room of the Upazila Health Complex (UHC) or at the Upazila Parisad building (Upazila administrative complex). With the increase of contraceptive prevalence rate, commodities and thus storage requirements are also increasing.

E. *Improve monitoring and supervision*

In order to improve the quality of care, and to ensure availability of commodities, it is important to strengthen the component of supervision, periodic monitoring and evaluation. These activities may also be utilized for providing on the job training to the staff as well as to strengthen programmatic linkages.

Creating an Enabling Environment

Introduction

In order for the strategies and activities outlined in the previous sections to become a reality, they will need to be supported by a conducive enabling policy environment. There already are a range of policies in place that support the further expansion of LA/PMs. However, there are also some regulations that impede access to certain family planning services, creating barriers for the further advancement of LA/PM information and services. Through this LA/PM Strategy, the Government of Bangladesh signals its commitment to work across sectors towards reducing these barriers to advance the further promotion of LA/PMs.

It is envisioned that a process will be set-up within the National Family Planning Advisory Committee to review existing policies and regulations, local data and research on LA/PM use, unmet need, service delivery issues and community knowledge, attitude and practices concerning LA/PMs and family planning to identify policy issues that need immediate attention.

Specific Objective:

Strengthen service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers including in underserved and hard-to-reach areas.

Proposed Strategies:

A. Ensure ownership and sustainability of LA/PMs through stakeholder participation.

B. Conduct local level advocacy to create an enabling environment for increased LA/PM use.

A. Ownership and Sustainability:

Advocacy at the national level is expected to include the following strategies:

- Ensure ownership and sustainability of LA/PMs through stakeholder participation: Stakeholders, like political leaders, religious and other opinion leaders, program managers, the medical community, clinic managers and LA/PM service providers, advocacy groups, community organizations, and satisfied male and female clients are important for the success of any FP program, in particular for a growing LA/PM Program. To increase the success of the LA/PM Program

these stakeholders need to be involved at every programmatic stage—in planning, designing, implementing, evaluating, and disseminating results and lessons learned. Engaging stakeholders will ensure that the LA/PM Program is context-specific, locally owned, and responsive to the needs and realities of the different constituents, and also increases the chances of program sustainability.

- Identify LA/PM policy barriers and initiate advocacy by leadership for policy changes: There are a variety of policy challenges in Bangladesh that impede access to LA/PM services. To address these barriers the National FP Advisory Committee can be used as a vehicle to identify, prioritize and work on policy and advocacy for change. Part of this process should be developing leaders and champions for policy changes; identifying high-priority policy and advocacy agenda items; and working to improve the policy, human and financial resource environments. Another key group to be involved here is the National Technical Committee (NTC) of the DGFP. Once issues have reached a high enough level of awareness, they can be presented at the NTC for their approval (see Appendix 6, for list of NTC participants). Possible actions include:

- Develop a human resources plan for the DGFP and DGHS that includes a career plan for the various cadres of staff. This Plan should include a bold vision for addressing the misdistribution and shortages of manpower, and propose new approaches for attracting and keeping staff in hard-to-reach areas. The Plan should also outline a career structure for various cadres within the current structures so that staffs have a career perspective upon entering their service.

- Prioritize changing medical and social eligibility policies that limit access to LA/PMs, and advocate with the appropriate bodies for changes. Many medical and social eligibility criteria are creating barriers for acceptance of LA/PMs. The following actions can be considered for policy favorable changes:
  - Develop advocates and utilize them to overcome LA/PM policy barriers;
  - Strengthen commitment and support of the political leaders;
  - Raise the prioritized policies impeding further expansion of LA/PM use in the National Technical Committee (NTC) and other appropriate Committee meetings;
  - Based on the recommendations of the Committees revise/adapt relevant medical eligibility criteria/policies.

- Use locally generated, context-specific data and other evidence to inform policy and other program decisions: It is important to use locally generated data specific to the social and cultural context to inform stakeholders as they develop the LA/PM strategies, policies, program designs, and interventions for implementation. Such evidence may result from needs assessments, quantitative baseline survey data, qualitative consumer research, operations research, or

evaluation of pilot projects. Local data may be supplemented by international standards and guidance (e.g., World Health Organization's Medical Eligibility Criteria and Selected Practice Recommendations) and by evidence-based practices, tools, or methods of LA/PM service delivery that have been effective in other settings. Continuous learning at national and district levels in Bangladesh on specific state-of-the-art work related to LA/PMs ensure continuous strengthening LA/PM services.

- Ensure adequate policy for flexibility and task shifting: Developing an appropriate policy for flexibility and task shifting is essential in further strengthening LA/PM service delivery. New and revised polices will require changes and updating of the standards, guidelines, training curricula. When new cadres of providers are added (task shifting), or a new technique or method is added, the training and orientation materials also need to be updated. Revision/updating, dissemination, and supporting use of the new standards, guidelines, and training curricula require involvement of all key stakeholders.

- Apply state-of-the-art lessons on LA/PM to improve access and use of quality LA/PM services: To increase access and use of quality LA/PM services the experiences and best practices on LA/PMs learned in the local and international environments need to be applied throughout the country to strengthen LA/PM service delivery at all sites.

- Strengthening of Inter-sectoral Linkages and Synergy: Further strengthening access and use of quality LA/PMs will require involvement of other sectors beyond the health sector, like the education and the social sector, and strong coordination among them. The National FP Advisory Committee will be an important conduit for coordination on LA/PM across sectors.

B. Local Level Advocacy

Decentralized advocacy should include outreach to the following audiences:

- FP coordination committees at district, upazila and union level to ensure multi-sectoral involvement, increase coordination, ensure a consistent supply of commodities, supplies and logistics, and to address administrative and policy barriers. Moreover, regular advocacy meetings should be organized with NGO and private sector professionals to increase their share of LA/PM services and for optimal utilization of their facilities in delivering LA/PM services.

- Local government officials, NGO workers, community leaders, religious leaders, the local elite, women leaders, and slum leaders influence the behavior of their community members. Not only do they hold positions of power, but also command

respect and trust. Programs should equip these leaders with information and communication techniques so they can play their roles more effectively and become involved in generating community support for LA/PMs, implementing BCC activities to promote LA/PMs, and initiate and undertake local level advocacy that benefit the health and wellbeing of those in their community.

- Imams and religious leaders can be key advocates involved in breaking the social and religious barriers around LA/PMs and help discuss these issues openly. They can create a positive environment for a small family norm and discuss family planning and LA/PMs at various fora. There are several materials that can be used in working with imams and religious leaders that provide information on family planning with an interpretation from the Koran, for example, Family Planning in the Light of Islam (EngenderHealth, 2006).

- Local elected bodies such as the UP chairman and vice chairmen, union parishad members, and ward commissioners can help in building community awareness on LA/PM services, dispel misconceptions and ensure service availability and accessibility. The participation of female ward commissioners/ union parishad members can be particularly important to draw in women.

- Satisfied clients include men and women who are using a specific family planning method, in particular NSV and IUD, and are content with it. Satisfied clients can turn into advocates, and their advocacy can be a very powerful tool. It can also help changing community norms and encourage others to adopt new practices. Satisfied clients should be identified by field workers and encouraged to act as role models to help reduce LA/PM related fears and misconceptions.

- Media is a powerful force and can play a key role for information dissemination through accurate and regular reporting. Journalists should be informed about LA/PMs so they in turn can educate the general public. A media advocacy forum for LA/PMs could be formed by involving journalists of print and electronic media and use the media coverage to address myths and misconceptions.

Apart from these specific groups of advocates which can be used for advocacy and community mobilization, it is important to identify champions at all levels and in all sectors: public, private, and NGO. Champions need to be supported with up-to-date information, tools, and approaches so they can effectively promote LA/PM.

Demand Creation and Community Mobilization

Introduction

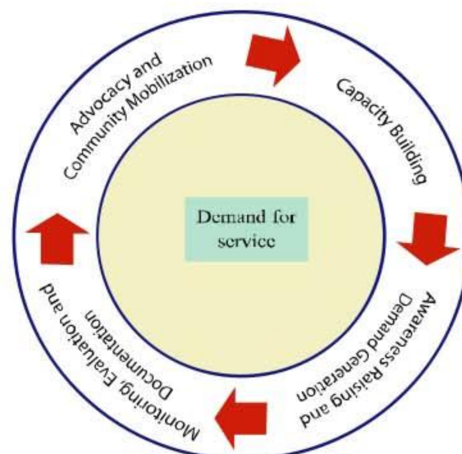
Behavior Change Communication (BCC) imparts educational information through established communication channels to foster positive changes in behaviors and practices. To change behavior and accept an LA/PM, potential clients need to have complete information about the services and know exactly where to go and what to do. Communication activities should be a continuous process. An effective communication program would be grassroots-based and focus on the specific needs of the different audiences and create awareness while conveying a clear benefit. Reinforcement of specific messages through a variety of credible sources and a multimedia approach that delivers consistent messages is vital for effective communication.

The LA/PM program has four main audience segments—potential clients, service providers, stakeholders and decision-makers—that require special communication efforts each of which contributes to a positive outcome, i.e. behavior change, change of the social norm, continuity and overall success. These are listed in Appendix 2.

It is proposed to use a systematic approach to behavior change communication that will:

- Advocate and mobilize communities to enhance LA/PMs as part of a comprehensive set of contraceptive choices by involving stakeholders at all tiers;
- Build community capacity to empower providers and stakeholders to perform efficiently;
- Create awareness by sharing tested and relevant information across channels maintaining consistency in message to address misconceptions and encourage potential clients to seek LA/PM services;
- Document and disseminate information among stakeholders at all levels (Mayer Hashi, 2011).

Figure 1: Strategic Approach



Source: Bangladesh Center for Communication Programs (BCCP), 2002

Specific Objective:

Increase the use of LA/PMs through demand creation and community mobilization among all couples wishing long-term spacing or limiting.

Proposed Strategies:

A. Strategic positioning of LA/PMs;
B. Message and theme development;
C. Implement BCC campaigns and promotion initiatives;
D. Development of BCC materials for multiple channels;
E. Capacity Building; and
F. Male involvement.

A. *Strategic Positioning of LA/PM*

Strategic positioning is developing a slogan based on what people value. All the campaign messages for the positioning of the LA/PM services should either "change" or reinforce existing positive behavior in different segments of the audience. This positioning will link the overall communication objectives in a way that serves both the beneficiaries and the providers.

B. *Message and Theme Development*

To develop messages for a campaign an LA/PM BCC Message Development Workshop can be organized with relevant professionals from DGFP, FP service delivery NGOs, creative professionals, and other key stakeholders to develop new messages on the IUD, Implant, NSV, Tubectomy and on LA/PM services as a whole for different audiences to address misconceptions and fears, and reinforce the effectiveness and benefits of the methods.

LA/PM BCC campaigns and promotion initiatives should be designed with potential clients in mind and provide correct information and facts. They should also address the fears of non-users about safety and effectiveness of the methods, stress the advantages, and encourage adoption of LA/PM services.

An intensive, multi-media, multi-level BCC campaign could be conducted nationally to create general awareness about LA/PM services and facilities among the target audiences, and motivate them to using the services. The media campaign should be linked with a local campaign that focuses on community engagement by incorporating advocacy and social mobilization programs, and integrates folk media and enter-educative components. Major intervention areas could be: upholding service providers' image as quality and caring providers; meeting with community leaders; forming and activating users' forum with the satisfied users; involving local youth clubs etc. The BCC activities should also inform people where to go for services, as studies show that many people do not

know this.

The BCC Campaign could utilize the existing GO/NGO health infrastructure and community networks such as those of the Ministry of Local Government and Rural Development Cooperation (MOLGRDC), Ministry of Women and Children Affairs (MOWCA), Ministry of Social Welfare (MOSW), Department of Mass Communication, Department of Ansar and VDP, Department of Youth Development, Ministry of Religious Affairs (MORA), NGOs etc. In addition it should explore new avenues. The existing community network can be strengthened for sustainable local level BCC programs and to advocate the use of LA/PM services. Local organizations, clubs, committees and voluntary groups can be encouraged to participate in campaign activities to create a momentum and encourage social and community ownership.

C. Development of BCC materials

BCC materials and job aids facilitate knowledge transfer. A limited number of BCC materials on specific LA/PM services have been produced over the years by GOB/NGOs for different campaigns/programs. These existing BCC materials could be revised or updated to serve the LA/PM program objectives. Based on a recent media preference study conducted by BCCP under the Mayer Hashi project among potential clients from different segments of the population (rural/urban, literate/low literate, slum/hard to reach, limiter/spacer, young married couple etc.) specific electronic media were preferred such as TVC, TV drama serial, TV talk/reality show, messages through mobile and print BCC materials such as FP flipcharts, and pictorial cards with FP information.

The assessment results (BCCP, 2010) suggested designing an LA/PM communication strategy considering the use of multiple channels such as television, mobile phone, print media and local level promotional activities including activities for the indigenous minority in their language and culture to increase the demand and sustained use of LA/PMs. The messages on LA/PMs need to be developed for and reach multiple audiences; including eligible couples, family members especially in-laws, and community leaders considering their language, and culture. The specific recommendations include:

- Disseminate messages on LA/PMs through TV as it is the preferred medium for both men and women. The study shows that women would prefer to get messages in the afternoon and men at night through BTV.
- Target audiences indicated that they would like to receive LA/PM messages through drama shows, preferably with famous actors.
- There is a need to identify young energetic role models and celebrities at national level who will disseminate the LA/PM messages, and local stars at the local level.
- Develop voice SMS on LA/PMs as this was also indicated as a preferred

channel of information. Mobile phone use in Bangladesh is quite universal, but voice SMS would be required as not everyone would be able to read regular SMS.

- Areas where people have little access to TV, radio, mobile phones, print media, or newspapers, can be reached through courtyard meetings, door-to-door visits, video shows, street dramas, and cultural programs in local dialects.
- The study target audiences requested calendars, leaflets and posters on LA/PMs as take-home materials. The service providers requested a flipchart, which they thought was the most comfortable material for them.

D. Multi-Channel Strategy

A multi-channel approach is important to ensure that clients hear the message from more then one source. In that case it is important to ensure consistency of messages. Strong linkages increase the reach of the campaign. Mass media will help set the stage, build awareness, increase knowledge, and call for behavior change through a firm call to action. In the mass-media category, television is unquestionably a strong channel to promote LA/PM services.

Mass media will form the backdrop of the campaign, once general awareness has been created, interpersonal communication and community-level activities and reinforce the messages, coordinated in a partnership between the GO and NGO through a well-synchronized BCC campaign. The various components of the BCC Campaign addressing separate target groups should be orchestrated in such a way to obtain synergy and optimal impact. Each campaign component will reinforce the standardized message through multiple channels in order to reach the maximum number of target audiences.

The campaign should be designed for sequential implementation, and combine a synergistic mix of different media for optimal impact. The sum total will reinforce one another for ultimate sustainability. Based on the above-cited and other studies, the recommended channels include:

i. National mass media (TV, radio) to inform the clients and empower the service providers, and create an enabling environment to promote LA/PMs through popularizing its positive image.

ii. ii. Local media (local cable channels, radio, outdoor, selected print) to inform and promote actions at the local levels.

iii. Community based media (meetings, social networks, folk media, local events, etc.) to link directly to the national campaign events and reinforce them to promote LA/PM services and providers at their specific locations.

iv. Interpersonal Communication & Counseling to provide counseling and answer questions; deal with misconceptions or LA/PM related side effects; follow up LA/PM acceptors; address gender issues and social barriers to

LA/PM seeking behavior; ensure clients' rights and referral to other facilities as necessary.

The proposed promotional activities to create awareness about LA/PM services would aim to: increase awareness on LA/PM among different audiences; expand reach of messages on LA/PMs at the community level; organize special days on IUD and NSV services at the public and private sector facilities (two methods that have a low current use but high potential for growth); encourage active participation of community members; increase demand for long acting methods among young married couples; increase demand of LA/PM service among urban slum populations; and increase acceptability of LA/PM services among post partum mothers.

E. Capacity building on BCC of service providers and stakeholders

As noted above, stronger behavior change communication/demand generation is essential for increasing the use of LA/PMs. Capacity building of program personnel (service providers from GOB, NGOs and private sectors) through training is essential for planning and managing behavior change communication (BCC) programs, using BCC materials efficiently, and conducting group meetings effectively; hence developing a critical mass of competent service providers with BCC skills. Training should be set up according to a cascade system starting with training of master trainers at the central level. The capacity building should not be limited to training alone. Even more important than the training is the follow-up of the trainees through coaching and facilitative supervision. Activities related to capacity building on demand creation and BCC may include:

BCC and demand generation training

- Strengthen the capacity of mid-level managers, supervisors and facility-based providers for GO and NGOs in interpersonal communication and counseling.
- Provide support to service providers to plan and manage BCC programs.
- Strengthen the capacity of service providers for community engagement and BCC.

Client –provider communication (IPC & Counseling) training

- Strengthen the capacity of service providers to integrate messages on LA/PMs in interpersonal communication and disseminate messages on LA/PMs at the community level.
- Strengthen the capacity of service providers to integrate messages on LA/PMs in interpersonal communication and disseminate messages on Post Partum Family Planning at the community level.
- Strengthen the capacity of service providers to integrate messages on LA/PMs in interpersonal communication and disseminate Family Planning messages that focus on Young Married Couples at the community level.
- Strengthen the capacity of GO and NGO field workers to effectively deliver correct messages on family planning including correct messages on Postpartum FP.

- Strengthen the capacity of GO and NGO fieldworkers to effectively deliver correct messages on LA/PMs that focus the Young Married Couples.

Capacity building of stakeholders

- Building communication capacity of all relevant stakeholders including community clinic support group members, union parishad members, peer educators, and community resource groups of FP service delivery facilities is essential to modify service providers' behavior and attitudes and ensure a more welcoming, 'client friendly' approach, including a more welcoming attitude to men and young married couples.

Local level advocacy training

- Build capacity of community resources and local advocates to deliver accurate information of LA/PM with a special focus on reducing myths and misconceptions.

Peer educator training

- Strengthen the capacity of peers to effectively deliver correct messages on LA/PM.

On-the-job coaching and facilitative supervision:

- Develop training materials/guidelines and job aids on facilitative supervision at all levels.
- Conduct TOTs on facilitative supervision and organize related training and mentoring of service providers. Joint planning with district level managers for training and ensuring joint reflection and problem solving, on-the-job training, coaching, and co-supervision with the district or upazila level supervisors or on-site supervisors are also important.
- Provide strong and consistent follow up and monitoring to ensure planned implementation of facilitative supervision plans.

F. Male Involvement

In Bangladesh men play a dominant role in health care decision making within the family, with 38% of women having no final say in decisions that concern their own health (BDHS, 2007). However, men often have limited knowledge of and are rarely directly involved served by reproductive health programs. Use of male contraceptive methods remains very low, with condoms making up only 5% of overall use, and vasectomy less than 1% (BDHS, 2007). Most health and family welfare centers are oriented towards women: there are no separate waiting areas for men, no separate toilets for men and little information materials for men. Sexual and reproductive health services are rarely available to men at the local level. Yet the reproductive health needs of men and women are best met by programs that address the needs of both.

Small-scale experience with communication efforts directed towards men to involve them in family planning and reproductive health have been encouraging. A male-friendly reproductive health project implemented by EngenderHealth (EngenderHealth, 2008) showed that men can be catalysts of change, both of their own reproductive health status and of their wives. Satisfied clients can play a major role in helping to educate and refer other men in the community, particularly in the promotion of vasectomy. It is very important that BCC materials are available that appeal to men with relevant information to them. A good approach is also organizing community meetings with men to discuss family planning issues.

Monitoring and Evaluation

Introduction

Monitoring and evaluation are important elements of implementing a strategy. The overall LA/PM Strategy and the various elements should be monitored and evaluated to measure the successes, or identify reasons for failure, so that the evaluation can help the next phase of action. The evaluation should focus on:

- Monitoring output, process and products of the LA/PM Strategy to guide future activities;
- Degree of involvement of stakeholders in implementing the LA/PM Strategy;
- Regular formative research to assess the changing needs of the LA/PM Program; and
- Sharing regular updates with stakeholders.

Currently the LA/PM performance is continuously monitored through the MIS of DG/FP. In addition, regular Demographic and Health Surveys are conducted every five years which provide information on the overall performance, including LA/PM.

These regular surveys, the MIS data, and data from other studies should inform the monitoring and evaluation plan for the LA/PM Strategy to ensure tracking of implementation status. Monitoring and evaluation are a continuous process. Information from this process should be used to improve program design and implementation and in turn to re-define implementation, if necessary, to more effectively contribute to the strategic results.

Indicators

An indicator refers to information on a particular circumstance that is measurable in some form. Indicators give an indication of the magnitude and direction of change over a period of time. The indicators given below are suggested indicators for each of the areas described in the Strategy.

Strengthening Service Capacity

- Trained service providers are available in all designated service delivery centers (Public, private & NGOs);
- Service delivery sites have required medical and surgical equipments for LA/PM service delivery;
- Service delivery sites have copies of latest circulars, standard guidelines, manuals; DGFP and DGHS system of medical monitoring and supervision is functioning.
- Senior to mid level FP managers and supervisors skills have been developed on

strategic communication;
- FP service providers and field workers of GO and NGO sectors are providing client friendly LA/PM services;

Quality of Care Indicators

- Service providers provide high quality LA/PM services according to standards;
- Clients are given information on all methods and are free to choose the methods they prefer;
- Clients are satisfied with the services and continue using the LA methods;
- Written medical guidelines, protocols, and standards are regularly updated and consistently implemented;
- Supervisors regularly conduct medical monitoring.

Advancing LA/PM in the private sector

- Circular on strengthening LA/PM service delivery by private sector issued and distributed;
- Increased LA/PM service delivery by private sector organizations;
- Method-specific contraceptive share (in particular LA/PM) for private sector increased in next BDHS.

Ensuring Commodity Security:

- FP commodities from local manufacturers are available in Public, Private and NGO facilities;
- Warehouse and storages are sufficient in number according to capacity and their interior decoration including environment meets the standard guideline of the storage system;
- A system of supervision, monitoring and evaluation for the commodity security process is in place;
- All FP commodities are available in each service delivery center as per requirement.

Creating an enabling environment:

- Different stakeholders are involved in at every programmatic stage of the Strategy
- New policies are adopted which remove policy barriers for strengthening LA/PM service delivery and increased performance;
- Policies and guidelines and in line with WHO medical eligibility criteria.
- Local FP Coordination Committee established/activated and functioning;
- Coordination improved between different stakeholders to best utilize their service facilities;
- Advocacy strengthened by the media, political leaders and community influentials;
- A motivated group of local elected members and religious leaders play a proactive

- role in creating an enabling environment at the community;
- Satisfied accepters act as local level advocates to reduce misconceptions;
- Established strong networking to utilize the community based resources in promoting LA/PM.
- Community level advocates have been trained;
- Community-based networks are utilized to establish linkages between community and FP service sites.

Demand creation and community mobilization:

- Target audience is aware of different categories of long acting and permanent methods of family planning;
- Increased awareness of potential clients and community about where LA/PM services are available;
- Reduced IUD related misconceptions among the potential clients;
- Reduced NSV related misconceptions among the potential clients;
- Increased use of LA by the young married couples;
- Increased use of postpartum FP.

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2. Bangladesh Demographic Health Survey, 2007: National Institute of Population Research and Training (NIPORT); Mitra and Associates; and Macro International;: March 2009.
3. Bangladesh National Strategy for Maternal Health. Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh. October 2001
4. Liz C. Creel, Justine C. Sass, and Nancy V. Yinger. Overview of Quality of Care in Reproductive Health: Definitions and Measurements of Quality.
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8. The National Communication Strategy for Family Planning and Reproductive Health. Ministry of Health and Family Welfare, Directorate General of Family Planning, Dhaka, Bangladesh. 2008
9. Directorate General of Family Planning, Dhaka, Bangladesh. 2008
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11. EngenderHealth, Family Planning in the Light of Islam, Dhaka, 2005.

Recommended List of Quality of Care Indicators:

Provider level

- Demonstrates good counseling skills,
- Uses comprehensive Job-aids for counseling
- Asks client about reproductive intentions (asking whether the client wants more children, and when)
- Gives accurate information on the method accepted (explaining its use, side effects, and possible complications)
- Discusses with client which method he or she would prefer
- Assures client of confidentiality
- Treats client with respect/courtesy
- Discusses methods for preventing pregnancy and sexually transmitted infections
- Tailors key information to the client's needs
- Gives instructions on when to return
- Follows infection control procedures outlined in guidelines
- Recognizes/identifies contraindications, consistent with guidelines
- Performs clinical procedures according to guidelines

Staff (other than provider) level

- Treats clients with dignity and respect

Client level

- Participates actively in discussion and selection of method
- Receives his or her method of choice
- Believes the provider will keep his or her information confidential

Facility level

- Has all (approved) LA/PMs available or knows where to refer
- Has basic items needed for delivery of methods offered by the facility (including sterilizing equipment, gloves, blood pressure cuffs, specula, adequate lighting, water)
- Offers privacy for pelvic exams/IUD insertions and other clinical procedures
- Has mechanisms to make programmatic changes based on client feedback
- Follows state-of-the-art clinical guidelines
- Has acceptable waiting time
- Has received a supervisory visit within a certain predetermined period
- Has adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) on premises and no stock-outs

Tools to Measure Improvements in Quality

To ensure quality of care the LA/PM service providers and the clinical supervisors should have appropriate tools to measure the quality of care, be it for improving provider's knowledge and skills, or for increasing clients' satisfaction, or for improving facilities for providing LA/PM services, or for understanding why clients do not use services. Tools for specific items include:

Improving provider knowledge and skills related to LA/PMs

- Pre- and post-tests; follow-up "post-post-tests"
- Provider observations
- Provider surveys
- "Mystery clients"
- Reviews of records

Increasing client satisfaction related to LA/PM services

- Client exit interviews
- Household interviews
- Focus group discussions
- Service statistics

Improving facilities' capability or readiness to provide quality LA/PM services

- Facility audits or assessments
- Provider surveys/focus group discussions
- Mystery clients
- Reviews of records
- Client flow analyses

Audience Segmentation for special communication efforts

The LA/PM program has four main audience segments that require special communication efforts—BCC, advocacy and community mobilization—each of which contributes to a positive outcome, i.e. behavior change, change of the social norm, continuity and overall success. Based on audience segmentation, the strategic communication approach will addresses the following four segments of audiences:

1. Potential clients—without whose increased awareness, motivation and active participation no program can be successful—the key audiences for this segment are:
   - Men and women of reproductive age with one or more children
   - Young married couples
   - Postpartum women

2. Service providers—without whose positive attitude and efficient service delivery it is not possible to ensure satisfied clients—the key audiences for this segment are:
   - Service providers
   - Frontline field workers
   - Program managers and Supervisors

3. The broader local community and stakeholders—without whose commitment and skills, programs will not get off the ground—the key audiences for this segment are:
   - Men and husbands
   - Family members
   - Youth
   - GOB, NGO and Community Networks
   - Local folk talent
   - Satisfied clients

4. Decision-makers, local influentials, implementing partners—without whose support little can be accomplished—the key audiences for this segment are:

   At the local level:

   - Representative of local government
   - Community and Local leaders (religious leader, teachers)
   - Community Support Group
   - Media -Print and electronic media

   At the policy level:

   - Officials from MOHFW, DGHS, DGFP

- Government officials of other sectors
- Development partners
- Political leaders
- Media representatives

List of Documents Reviewed

SL#	Topic/Text/ Message
1.	The National Communication Strategy for Family Planning and Reproductive Health *Published by: UNFPA, MOHFW & DGFP, 2008*
2.	NSDP National BCC Strategy for promoting Permanent and Long Term Methods in Bangladesh *Published by: BCCP, 2003*
3.	A study on Behavior change Communication(BCC) Strategy for urban reproductive health *Published by: UNFPA, 2001*
4.	Family Planning Unmeet Need in Bangladesh, Shaping of a client-oriented Strategy *Written by: Abul Barkat, Sushil Ranjan Howlader, Barkat- E- Khuda, John Aross, Manik Lal Bose, 1997.*
5.	Bangladesh Behavior Change Communications Strategy for Contraceptive Security *Published by : JSI/Deliver Bangladesh/USAID,2003*
6.	Creating a Space for Men and Youth at Health and Family Welfare Centers in Bangladesh: Demand-Based Reproductive Health Commodity Project *Published by: NIPORT, CIDA, UNFPA, RTM International & Population Council, 2009*
7.	ACQUIRE Evaluation and Research Studies: Bangladesh End line Evaluation-2008 *Published by: The ACQUIRE project, 2008*
8.	ACQUIRE Evaluation and Research Studies: IUD Use and Discontinuation in Bangladesh *Published by: The ACQUIRE project, 2007*
9.	Promoting Male-friendly Reproductive Health Services in Bangladesh: Results of a Pilot Effort *Published by: The ACQUIRE project, 2008*
10.	Choices in Family Planning: Informed and Voluntary Decision making realizing Rights and Sexual and Reproductive health Services *Published by: EngenderHealth, 2003*
11.	Male Involvement in Family Planning Experiences From Innovative Projects Final Report *Published by: Population Council, 1997*
12.	Bangladesh Demographic and Health Survey 2007 *Published by: NIPORT/Mitra and Associates/Macro International, 2009*

SL#	Topic/Text/ Message
13.	Bangladesh Urban Health Survey 2006 *Published by: NIPORT, 2006*
14.	National Media Survey 2002 *Published by: BCCP/SMC, 2002*
15.	An Exploratory Study: Knowing Customers' Insights about Permanent and Long Term Family Planning Methods *Published by: BCCP, 2003*
16.	The ACQUIRE Project Annual Report to USAID *Published by: USAID/ACQUIRE, 2005*
17.	Evaluation of the NSV Communication Campaign *Published by: USAID/ EngenderHealth, 2008*
18.	Behavior Change Communication & Marketing Strategy for second UPHCP *Published by: BCCP/Project Management Unit, UPHCP-II,2008*
19.	Assessment of the Reasons for Declining Trend in Sterilization Acceptance *Published by: Development and Evaluation Unit, IEM Division, 1995*
20.	Knowing Customers' Insight about PLTM *Conducted by :BCCP,2003*

List of BCC Materials Reviewed

SL#	Brochure
1.	NSV the easiest permanent contraceptive method for male
2.	NSV the easiest permanent contraceptive method for male
3.	LA/PM method- safe and hassle free
4.	LA/PM method- safe and hassle free
5.	Chose IUD-A long term contraceptive method for female
6.	Do you know which family planning method is appropriate for you?
7.	FAQ on contraceptive method and misconception
8.	Post delivery Tubectomy and IUD
9.	Permanent Family Planning Method
10.	Long term Family Planning Method- IUD
11.	Long term Family Planning Method- Norplant/ Implant

SL#	Leaflet
1.	Vasectomy and tubectomy-Permanent contraceptive method for married couple
2.	FAQ regarding contraceptive methods and misconception
3.	Sterilization and other clinical services strengthening project – LA/PM for male and female
4.	Leaflet on screening of customer for sterilization

SL#	Flipchart
	Comprehensive flip chart on RH for SSFP
	CLP primary health care- family planning project
	Comprehensive RH and FP flipchart for UPHCP
	Information guide on reproductive health, safe motherhood and gender

SL#	Booklet
1.	Behavior change communication to receive permanent and long term methods
2.	Family Planning Method

SL#	Poster
1.	Contraceptive method for male- NSV hassle free and safe - 29.5"x19.5"
2.	Choose appropriate Family Planning Method yourself - 32"x23"
3.	Select appropriate Family Planning Method by seeing, hearing and understanding - 29"x19"
4.	NSV-Permanent Contraceptive Method for male
5.	Easy, safe and hassle free - 29"x19"
6.	Do you know which contraceptive method is best for you (Tihart poster) – 33”x27”
7.	I am happy after performing Ligation (Tubectomy)
8.	NSV koro bhai, Love Chara khoti nai
9.	Shukher Chabi hater mudau **Copper T (IUD)**
10.	Non Scalpel permanent and safe contraceptive method for men (NSV)
11.	No tension for Norplant acceptors within five years
12.	NSV for the responsible male

SL#	Roman Banner
1.	VDifferent Family Planning Method
2.	Post partum IUD
3.	Post partum tubectomy
4.	Roman banner on NSV
5.	Roman banner on tubectomy
6.	Roman banner on NSV

SL#	TVC
1.	TVC on Family Planning and LA/PM
2.	Counseling on Family Planning Method
3.	TVC on NSV
4.	TVC on NSV
5.	TVC on NSV
6.	TVC on LTFP 50 sec.
7.	TVC on PLTM 60 sec.
8.	TVC on PLTM (GoB)
9.	TVC on NSV
10.	Enechhi Shurjer Hashi (TV Drama Serial) episode# 6 (IUD/Norplant), episode# 22& 23 (NSV/Tubectomy)

SL#	Photo Frame
1.	T Photo frame

SL#	Billboard
1.	Billboard on NSV

SL#	Flyer
1.	Flyer on Different types of Family Planning method

Participant List of Stakeholders in Divisional Workshop

13 December, 2009, Spectra Convention Center, Gulshan, Dhaka

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1.	Mohammad Abdul Quayum	Director General, Directorate General of Family Planning
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45.	Mohammed Azmal Hossain	Program Officer, EngenderHealth (Mayer Hashi Project)
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26 January, 2010, Conference room

Divisional Director of Family Planning Office, Sylhet

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4.	Ruby Fatema Islam	Chairman	Organization	Mohila Shongstha
5.	Shishir Kumar Roy	Deputy Director	Department of Youth Development	DYT
6.	Jahangir Kabir Ahmed	Deputy Director	DSHE	DSHE
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9.	Mufti Nazmuddin Asad	Chairman	Sylhet Jubo Academy	Sylhet Jubo Academy
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11.	Md. Alauddin	Project Manager	VARD	VARD
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16.	Fatema Shabnam	Team Leader (Mayer Hashi project)	Service Delivery & Trainjing	EngenderHealth-BCO
17.	Azmal Hossain	Program Officer (Mayer Hashi project)	Demand Generation Team	EngenderHealth-BCO
18.	Mamunur Rahman	Program Officer (Mayer Hashi project)	Demand Generation Team	EH-BCCP

National Technical Committee

(Translated Version)

Government of the People's Republic of Bangladesh

Ministry of Health and Family Welfare

Family Welfare-1 Wing

No-MOH&FW/FW-1/NTC/28/2002/402 Date: 22/12/2009

Circular

In order to provide strategic direction to the government in the activities relating to Maternal Welfare, Child Health and Family Welfare the National Technical Committee is reformed with the membership of the following persons:.

A. Formation of the Committee

1	Director General, Directorate General of Family Planning	Chairperson
2	Director (PHC) & Line Director (ESD), DGHS, Mohakhali, Dhaka	Member
3	Director General, Drug Administration, 105/106, Motijheel C/A, Dhaka	Member
4	Line Director (CCSDP), DGFP, 6 Kawran Bazar, Dhaka	Member
5	Director, MFSTC, Mohammadpur, Dhaka	Member
6	Superintendent, MCHTI, Azimpur, Dhaka.	Member
7	Professor and Head of the Department of Anesthesiology, Sir Salimullah Medical College and Mitford Hospital	Member
8	Professor and Head of the Department of Surgery, Dhaka Medical College	Member
9	Professor and Head of the Department of Obs & Gynae, Sir Salimullah Medical College and Mitford Hospital	Member
10	Professor and Head of the Department of Skin and Venereal Disease, Sir Salimullah Medical College and Mitford Hospital	Member
11	Professor Iffat Ara, Obs & Gynae Department, Dhaka Medical College	Member
12	Professor and Head of the Department, Pharmacology, Dhaka Medical College	Member
13	Professor and Head of the Department of Pathology, BSMMU, Dhaka	Member
14	Director, Shishu Hospital, Dhaka	
15	Director, Bangladesh Medical Research Council, Dhaka	Member
16	President/Secretary, Family Planning Govt. Doctors Association, Dhaka	Member
17	President/Secretary, BCS Family Planning Officers Association	Member
18	Prof. (Retd) Anwara Begum, 57/1 Chamalibagh, 36 Lane, Santibagh, Dhaka	Member
19	Prof. (Retd) M A Taher Khan, Principal, Mother & Child Medical College and Hospital, Agrabad, Chittagong	Member
20	Prof. Latifa Shamsuddin, Enam Medical College, Dhaka & Ex. President, BSMMU	Member
21	President/Secretary, OGSB	
22	President/Secretary, Bangladesh Medical Association	Member
23	President/Secretary, Bangladesh Neonatal Forum, Dhaka	Member
24	President/Secretary, Bangladesh Private Medical Practitioners Association	Member

25	President/Secretary, Society of Surgeons	Member
26	Country Director, Marie Stopes Clinic Society	Member
27	Country Representative, EngenderHealth, BCO	Member
28	Representative from NIPORT (Medical personnel), Azimpur, Dhaka	Member
29	Medical Representative, Population Council	Member
30	Director (MCH-Services) & Line Director (MCRH), DGFP	Member Secretary

The Scope of Work for the reformed National Technical Committee will remain same of those laid out during the formation of same committee on 27/10/2004.

B. Scope of Work of the Committee

1. This committee will provide suggestion to the Ministry on surgical rules and regulations, clinical management and strategies to prevent fertility.
2. This committee will provide suggestion on the implementation of the technical issues of maternal welfare, child health and family planning clinical issues.
3. This committee will thoroughly review and recommend for the approval before marketing any new hormonal family planning methods or before introducing those to the people by any government or non-government organizations.
4. This committee will provide suggestion to the government for the research and trial of controlling fertility or child reproduction process. After reviewing any research proposal's necessity, objectives, recommendations and opportunities of applying those in future, this committee will recommend accordingly.
5. This committee will recommend for developing supervisory and monitoring rules and regulations in order to apply field level activities of Family Planning and improvement of those.
6. This committee will meet once in every quarter.
7. This committee may co-opt any specialist, experts or policy official if they feel necessary
8. This committee will organize a meeting at least once in a year with the participation of the maternal welfare, child health and family planning experts, managers and relevant people in the sector.

Mahmuda Akter
Deputy Secretary (FW-1)
Phone: 7170109

Distribution:

1. Chairperson of the committee and all members
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   ....
2. Director General, Directorate General of Health Services, Mohakhali, Dhaka
3. Director General, NIPORT, Azimpur, Dhaka
4. President, BIRDEM, 122 Kazi Nazrul Islam Avenue, Shahbag, Dhaka

Copy for kind information:

1. PS to the Honorable Minister, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
2. PS to the Honorable State Minister, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
3. PS to the Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
4. PS to the Additional Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka

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