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PROJECT BRIEF
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Mayer Hashi Project

Introducing Postpartum Family Planning in Maternal Health Services in Low-Performing Areas of Bangladesh

BACKGROUND

Bangladesh is a densely populated country of about 150 million people; its total fertility rate (TFR) is 2.3 lifetime births per woman, and the contraceptive prevalence rate (CPR) is 61%. The most popular modern contraceptive methods used by married women are the pill and the injectable. Only 8% of currently married couples use a long-acting or permanent method of contraception (LA/PM). In 2011, the unmet need for family planning (FP) was 14% (8.1% for limiting and 5.4% for spacing births). The 2011 Bangladesh Demographic and Health Survey (BDHS) shows that 68% of women receive at least one antenatal care check-up from any type of health care provider, 29% of births take place at a health care facility, and 27% of women have a postnatal check-up with a trained provider. The government sector remains the major provider of contraceptive methods, providing services to more than half of all users (52%). Public-sector facilities are the main source for sterilizations, intrauterine devices (IUDs), hormonal implants, and injectables. The private sector supplies contraceptives to 43% of all users, with pharmacies contributing 33% (NIPORT et al., 2013).

Postpartum women are less likely to use an FP method than are all women. BDHS data also show that exclusive breastfeeding sharply declines and sexual activity increases in the first 3–6 months postpartum. One analysis using 2007 BDHS data shows that during the first year following the birth of a child (i.e., the "extended" postpartum period), nearly 60% of Bangladeshi women had an unmet need for FP (Borda & Winfrey, 2010). The World Health Organization recommends that women wait at least 24 months before attempting another pregnancy, to reduce the risk of maternal and newborn complications. Birth intervals in Bangladesh are increasing and relatively long, with a median interval of 47 months in 2011, compared with 44 months in 2007 and 39 months in 2004. Nevertheless, 12% of births occur less than 24 months after a preceding birth, and another 20% occur between 24 and 35 months (NIPORT et al., 2013). These data show a need for postpartum FP (PPFP), as well as a lack of PPFP services.

THE INTERVENTION

Introducing PPFP

PPFP services were introduced in Bangladesh at some facilities in the early 1980s, yet until recently, PPFP did not draw significant attention of policymakers and program managers. In recent years, several nongovernmental organizations (NGOs) led PPFP initiatives, including ACQUIRE/Bangladesh, ACCESS-FP, and the Mamoni

Project, but the services were not mainstreamed. Public-sector responsibility for providing maternal health and FP services falls under two directorates of the Ministry of Health and Family Welfare (MOHFW). The Directorate General of Family Planning (DGFP) provides the full range of contraceptive services, yet no PPFP. The Directorate General of Health Services (DGHS) provides all health care services, including maternal and child health care, yet its facilities do not offer FP, with the exception of tubal ligation after cesarean section. Based on the NGO project experiences from ACQUIRE and others, the DGFP and the DGHS requested the USAID-funded Mayer Hashi project[1] to initiate PPFP.

For the PPFP intervention, the Mayer Hashi project applied EngenderHealth's comprehensive Supply–Enabling Environment–Demand (SEED) programming model (EngenderHealth, 2011). This model states that programs will be more successful if supply, demand, and the enabling environment are addressed comprehensively. The PPFP interventions focused on the district headquarters and Sadar upazilas (main subdistricts) of the 21 disadvantaged Mayer Hashi project districts (in Barisal, Chittagong, and Sylhet divisions), where the facilities with the highest delivery caseloads are located. Between June 2009 and September 2013, a total of 111 facilities introduced PPFP services where these were previously not available: nine medical colleges; 22 district hospitals; 24 mother and child welfare centers (MCWCs); seven upazila health complexes; 14 NGO clinics; 33 private hospitals/clinics; and two national training institutes.

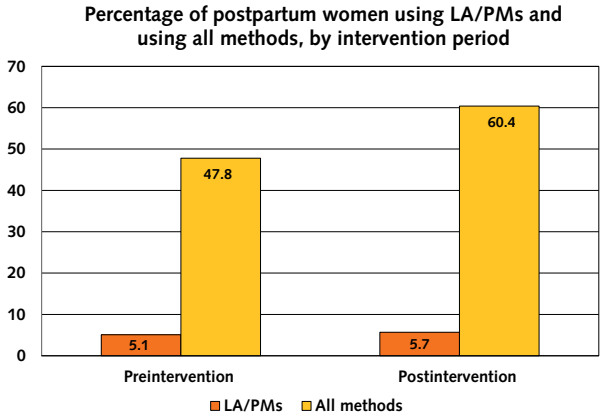
Improving the enabling environment

Interventions to improve the enabling environment for PPFP included:

- **Advocacy for policy change:** As a result of national-level advocacy, in May 2010 the DGFP's National Technical Committee approved a proposal to allow trained nurses of the DGHS and the private sector to provide IUDs. This measure vastly expanded the available workforce for the provision of IUD services, which up to that point were provided by family welfare visitors (FWVs) at DGFP facilities and by paramedics at NGO facilities. While nurses are more qualified than FWVs and paramedics, they were not assigned to provide FP services and therefore were not trained. With the

Introducing PPFP at lower level facilities

Mayer Hashi also implemented a PPFP pilot project in Debidwar Upazila of Comilla District. While PPFP activities were introduced in other areas, in this subdistrict PPFP services were introduced at facilities *below the subdistrict level*, and the approach was monitored more closely for process documentation. Data collection efforts included PPFP uptake in the first year postpartum, while in other districts only immediate postpartum FP uptake could be measured from the regular MIS records. Interventions in Debidwar were comparable to the other areas, yet intensified. Emphasis was placed on providing PPFP information to potential clients during antenatal, postnatal, and infant immunization sessions, to reach women at any time when they are in contact with the health system. Data were collected from the FWA service delivery records at the start and end of the intervention, looking specifically at women with a child aged 0–12 months. Data were collected from 2,915 women at baseline and from 3,736 at endline.



As shown in the chart, at the end of the intervention, uptake of long-acting and permanent methods of contraception (LA/PMs) among women in the extended postpartum period increased slightly, from 5.1% at baseline to 5.7%, while overall uptake of modern contraceptives increased from 47.8% to 60.4%.

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

integration of FP into maternal health services at their facilities, training nurses became a necessity.

A second policy approved by DGFP and DGHS in 2011 states that DGHS-registered facilities, both private and NGO, do not require separate registration and acknowledgment from the DGFP to receive FP commodities and funds. Given the cumbersome DGFP registration procedure, this policy change was crucial for greater private-sector involvement.

- **Enhancing local coordination:** District-level coordination meetings were organized to improve local cooperation between the DGFP, the DGHS, and the private sector and to ensure a flow of FP commodities and funds. Based on field experience at DGHS and private-sector sites, the Directors General of DGHS and DGFP signed a joint circular in April 2011 with detailed instructions on implementation of PPFP at non-DGFP sites.
- **Improving monitoring:** To ensure consistent monitoring of PPFP service uptake in the national management information system (MIS), PPFP was included as a separated indicator in revised DGFP MIS forms circulated in January 2013. The DGHS MIS Unit has committed that they will do the same in the next revision of their MIS.

Building capacity and ensuring quality of services

Interventions to strengthen provider capacity and ensure quality PPFP services included:

- **Curriculum development:** A PPFP training curriculum was developed for various levels of facility-based service providers and was approved by DGFP and DGHS.
- **Capacity building:** Central-level training of trainers was conducted with 81 trainers of the DGFP, the DGHS, and the private sector. These individuals trained 249 physicians, 144 FWVs, and 80 nurses. After the training, the providers were given coaching, while facilitative supervision was strengthened. Facility-wide orientations were conducted to ensure that all staff at the new PPFP facilities were aware of PPFP and could refer clients. District-level obstetrician-gynecologists and district managers were oriented to ensure their support and involvement.
- **Provision of instruments:** All facilities where PPFP was introduced received instruments necessary for the postpartum provision of the IUD, as well as a signboard to place in front of the facility, indicating the availability of PPFP services.

Creating demand

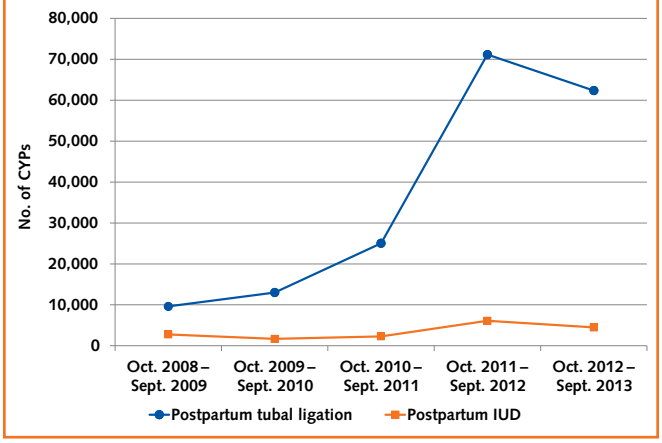
To ensure that potential clients and their families are informed about PPFP, local-level behavior change communication (BCC) campaigns were implemented in the 21 Sadar upazilas (subdistricts) where the facility-based interventions also took place. Activities included:

- **Curriculum development:** A PPFP training curriculum was developed for community-based fieldworkers, with a focus on communicating about PPFP.
- **Capacity building:** Twenty-three district pools of local trainers subsequently trained 2,390 health and FP fieldworkers on PPFP communication.
- **Provision of BCC materials:** The trained health and FP fieldworkers and health facilities were provided with PPFP BCC materials (leaflets, roman banners, an FP flipchart, and an antenatal care calendar). In addition, 33 street dramas on postpartum FP were performed; these were attended by 17,000 men and women.

RESULTS

Mayer Hashi introduced PPFP services from the third year of the project; by the end of the fifth year, 111 facilities were covered. Couple-years of protection (CYPs) as a result of the uptake in postpartum bilateral tubal ligation and postpartum IUD use are reflected in Figure 1. Uptake of PPFP services increased over time, due both to increased demand and to greater service availability at more facilities.

FIGURE 1. CYPS AMONG PPFP ACCEPTORS AT MAYER HASHI–SUPPORTED SITES, 2008–2013



CHALLENGES AND OPPORTUNITIES

A number of challenges remain to be addressed to help increase the success of PPFP in Bangladesh. A key **policy** issue is the bifurcation of the health system between the DGFP and DGHS and the resulting coordination issues, yet this is an overall systems challenge. On the **demand** side, the relatively low rate of institutional deliveries and the limited use of postpartum care inhibit the uptake of PPFP services. It will be important to continue emphasizing the creation of a women-friendly environment, as well as to continue using all contact opportunities with the health care system to inform women about PPFP. On the **supply** side, not all providers address PPFP yet, and it should be included in all relevant training. Once trained, all providers should integrate PPFP counseling and services into antenatal and postnatal care.

While there are many challenges, there are also opportunities. Though institutional delivery is still low, its use has already increased from 12% to 29% of births between 2004 and 2011 and is expected to increase further as more facilities offer delivery care and service quality improves. Antenatal and postnatal care rates are also increasing. DGFP and DGHS have included PPFP in their next five-year operational plans, with necessary budget allocations. The DGFP is expected to scale up PPFP soon. Members of the Obstetric and Gynecological Society of Bangladesh have also started providing PPFP services. PPFP is incorporated in the national LA/PM curriculum, while the full PPFP curriculum has already been approved by both DGFP and DGHS.

CONCLUSIONS

As shown, PPFP services can be made available through government, NGO, and private-sector facilities. These services can contribute significantly to increasing postpartum contraceptive use, thus helping to meet the high unmet need expressed by women in their first year postpartum. This integration of services will also contribute to further improving maternal health, family well-being, and national development.

REFERENCES

Borda, M., and Winfrey, W. 2010. *Postpartum fertility and contraception: An analysis of findings from 17 countries*. Baltimore, MD: Jhpiego (ACCESS-FP).

EngenderHealth. 2011. *SEED™ assessment guide for family planning programming*. New York.

National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh, and Calverton, MD.

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