Introducing and Scaling up EC in the National Family Planning Program: Lessons Learned from Bangladesh

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135th Annual General Meeting, APHA
7th November 2007, Washington DC

The context

In each year in Bangladesh

- **No. of unplanned pregnancy 1.3 million (30%)**
  - **Most terminated by MR/abortion**
- **No. of MR/abortion 800,000**
- **No. of maternal death 1,2000-1,5000**
  - **25 % are due to complications of MR/abortion**

(BDHS 2004; BMMS 2003)

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Presentation structure

Share our experiences on the-

- **Approval**
- **Introduction**
- **Scale up**
- **Current status**
- **Lessons learned from ECP program in Bangladesh**

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Understand the Context

We looked into the following aspects before initiating ECP project in the country:

- **What is the legal status and availability of ECP?**
- **Whether policy change is required to introduce ECP?**
- **What will be the easiest approach for change?**
- **What are the opinions of program managers?**
- **Is there any evidence of ECP need?**

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Review findings indicated the approaches for introduction of ECP

- ECP was available in market
- Positive attitude of the program managers toward ECP
- Concerns prevailed on the number of unplanned pregnancies, MR/abortions and maternal deaths
- Policy approval was required to introduce ECP
- Feasibility study was warranted and MoHFW requested
  - to establish the need of ECP and
  - to look into operational details

☞ Process took six months to
  - make DGFP partner and PI of the study and
  - receiving country's ethical review committee approval

☞ OR was carried out in both rural and urban areas

Operations research revealed (2000-2002)

- Unprotected sex is common and frequent
- EC is an unmet need of couples
- High acceptability of EC and valued over MR/abortion
- Most women were ready to pay between 10-20 Taka
- CBD can be easily trained for providing EC services
- ECP use was 5 times higher in prophylactic distribution
- Most EC users were users of spacing methods
- Repeated use was negligible over 9 months

OR conducted in collaboration with MoH, Pathfinder International & JSI

Approval of ECP to introduce in the National FP Program

- **Ministry approved ECP introduction on Dec. 29, 2001 depending on OR findings. Recommendations included:**
  - **introduce ECP in phased manner**
  - **train all FP workers in addition to paramedics**
  - **include NGOs to introduce ECP in their programs**
  - **distribute ECP through all FP clinics and all FP workers**
  - **charge Taka 8 (US$0.12) for a packet of ECP**
  - **monitor closely and review program implementation**
  - **use only tested teaching and IEC materials**
  - **seek financial assistance from UNFPA and TA from FRONTIERS**
- **Introduction started in Dhaka division- Sept. (Khan et al. 2001; Khan et al. 2005)**

Facilitating factors in approving ECP

- Involving DGFP in all stages of study (Made PI)
- Topic had immediate program relevance
- Partnering with other stakeholders
- Creating supportive environment through
  - Presenting findings to media and medical communities
  - Publishing articles on newspapers
  - Catering information needs of policy makers
- Commitment of financial support for training and ECP supp



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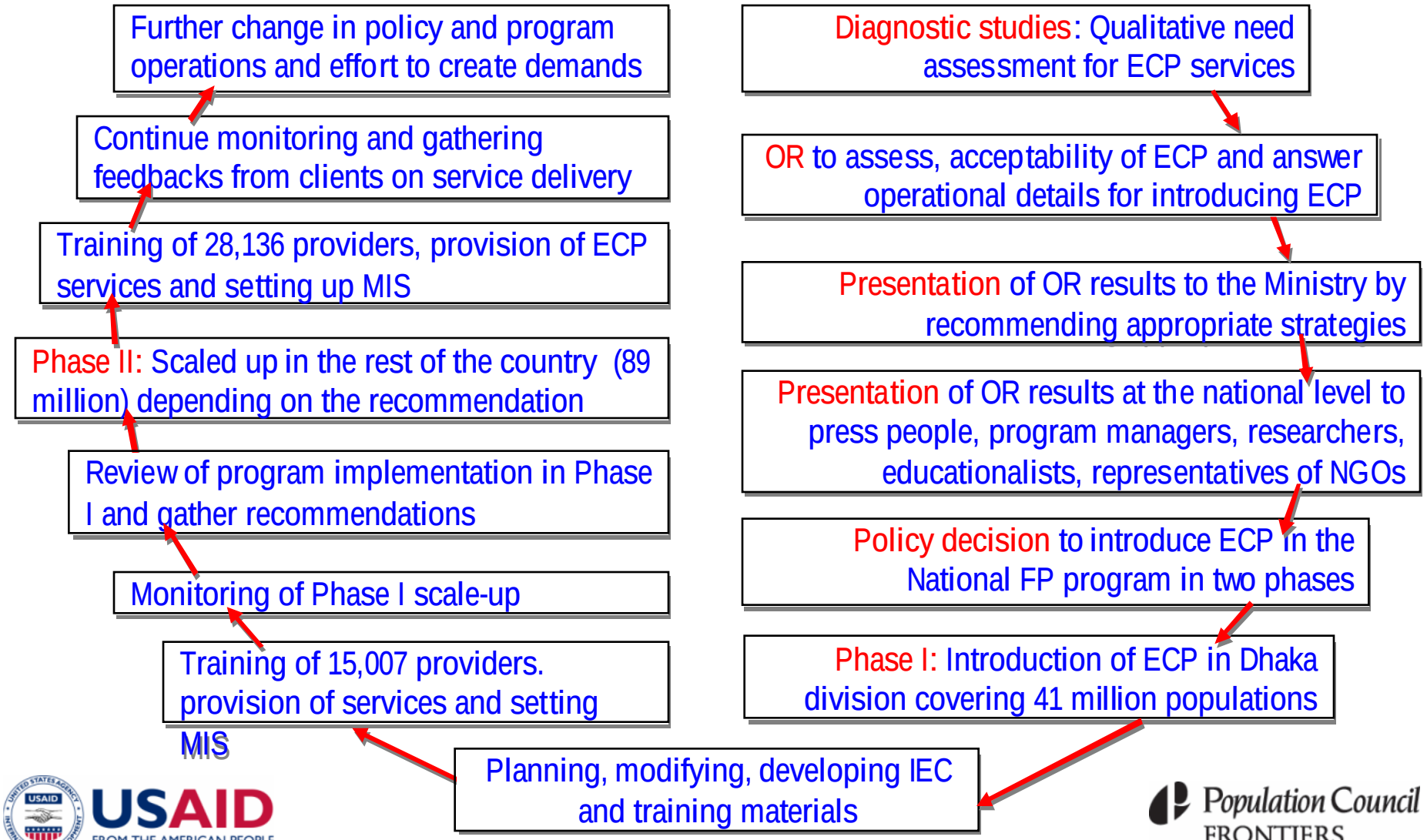
Process of introduction and scale up ECP in the National FP Program of Bangladesh



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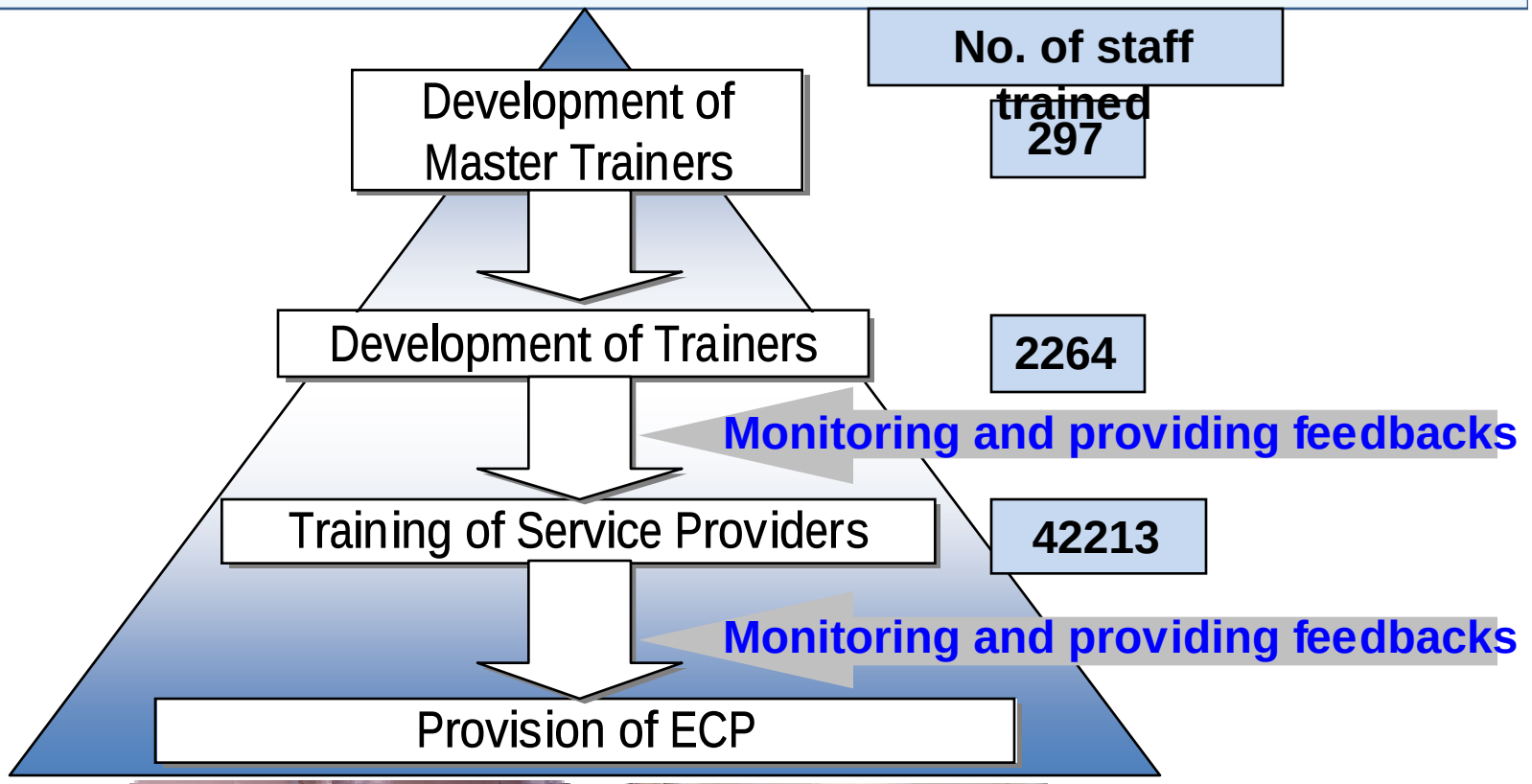
Facilitating factors in successful scaling up in the national FP program

- **Positive** attitudes and flexibility of DGFP
- **Assurance** of supply and training expenses by UNFPA
- **Assurance** of TA from FRONTIERS
- **Close/informal** working relationship among partners
- **Positive** attitudes to perform campaign in mass media
- **Less negative** attitudes among the providers
- **Perceived potentiality** in reducing unplanned pregnancy
- **Good demand** of ECP and training among the

Program's capacity building: Process of training implementation



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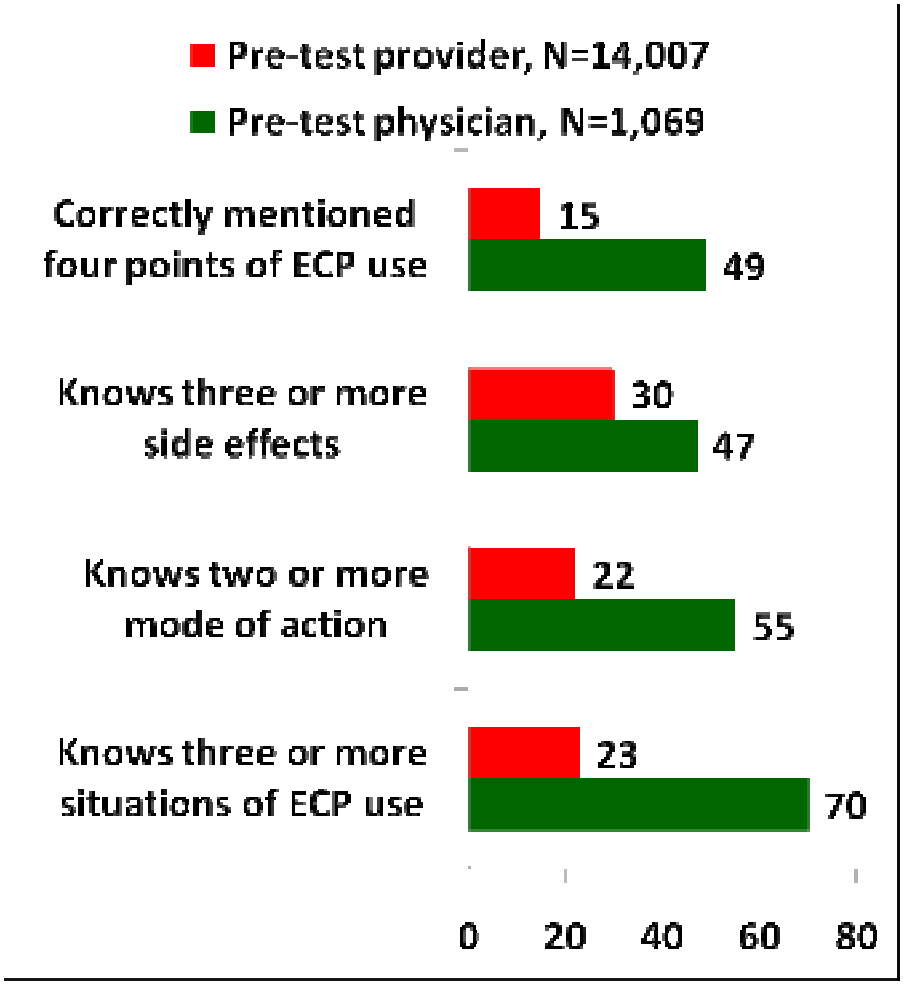
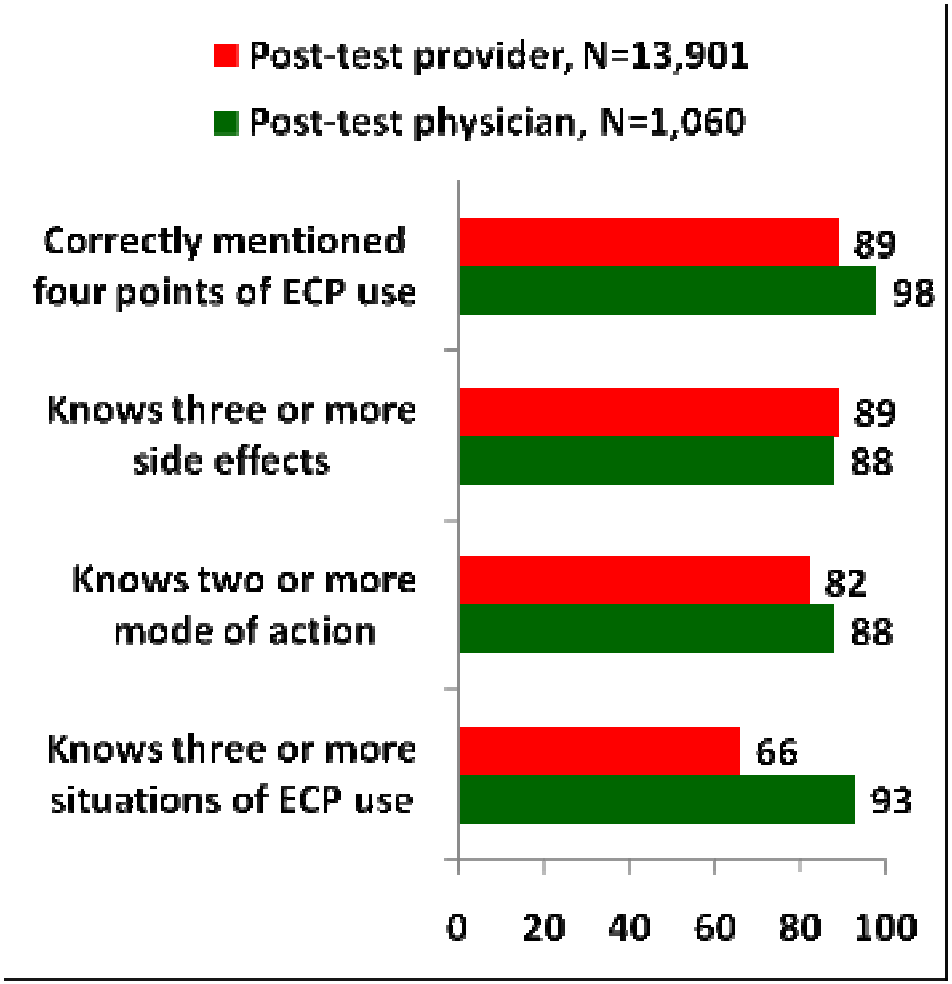
Correct knowledge of providers and physicians on ECP before and after training





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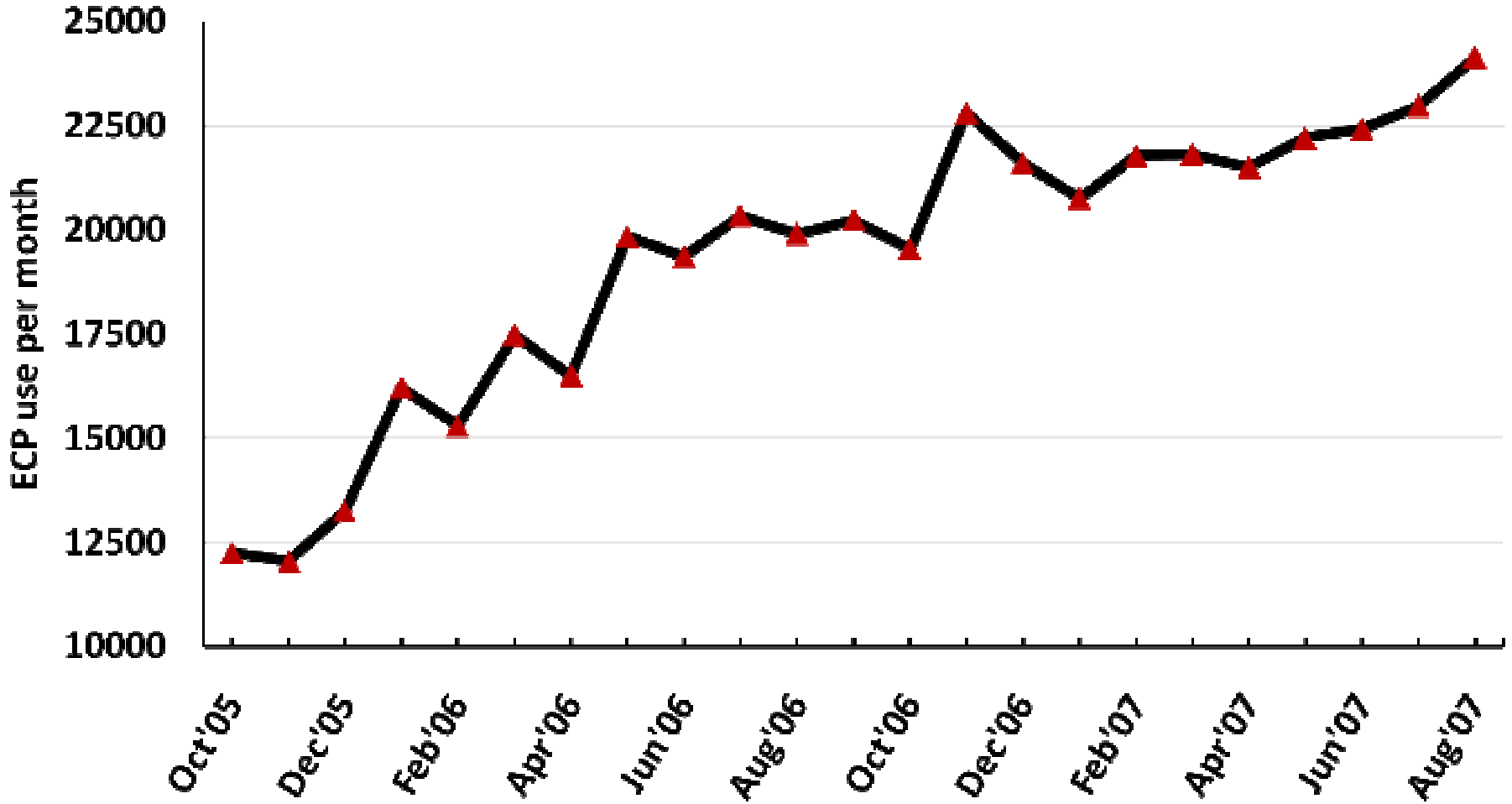
ECP use per month in the country over the last two years



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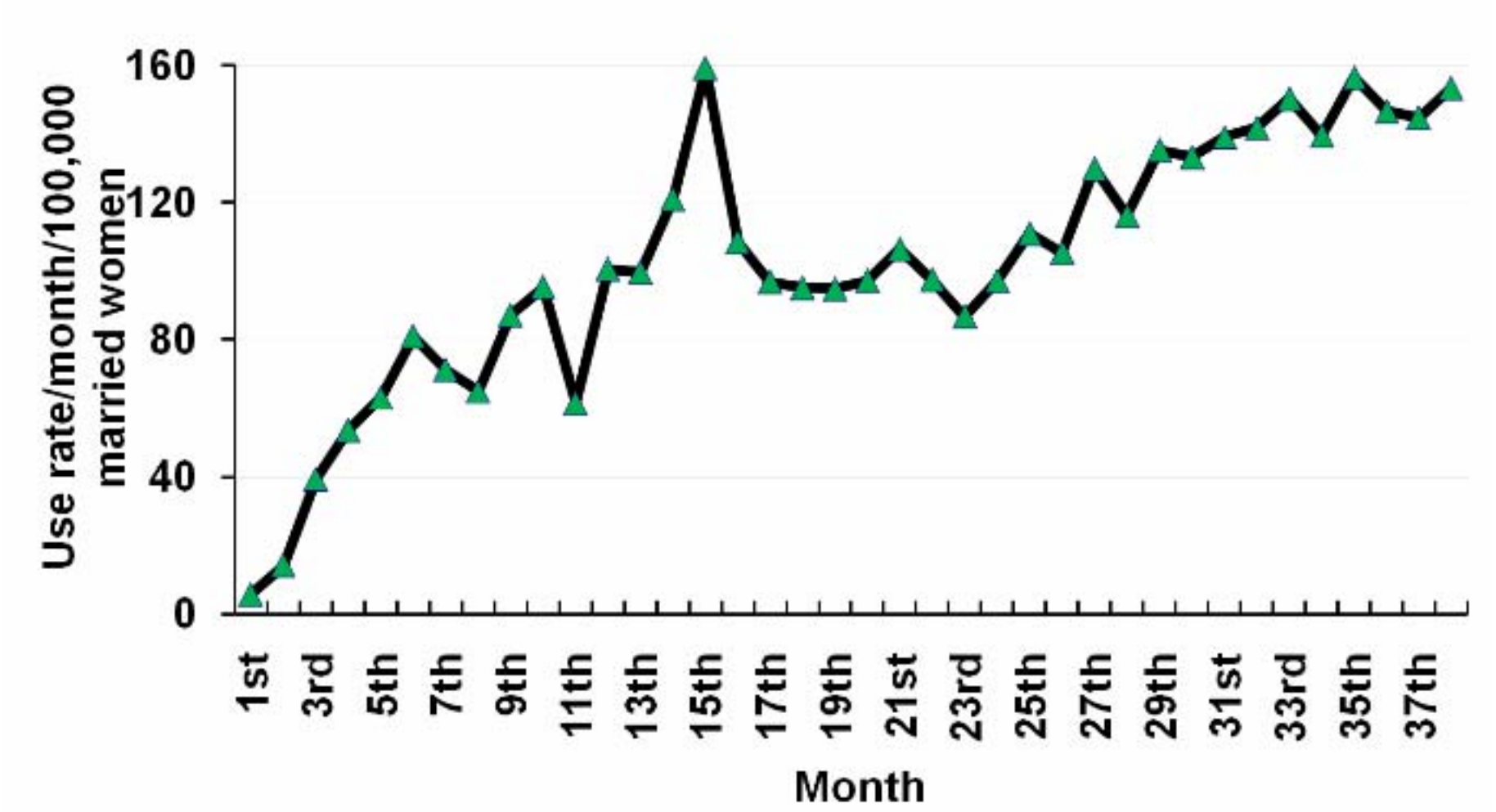
ECP use/month/100,000 married women



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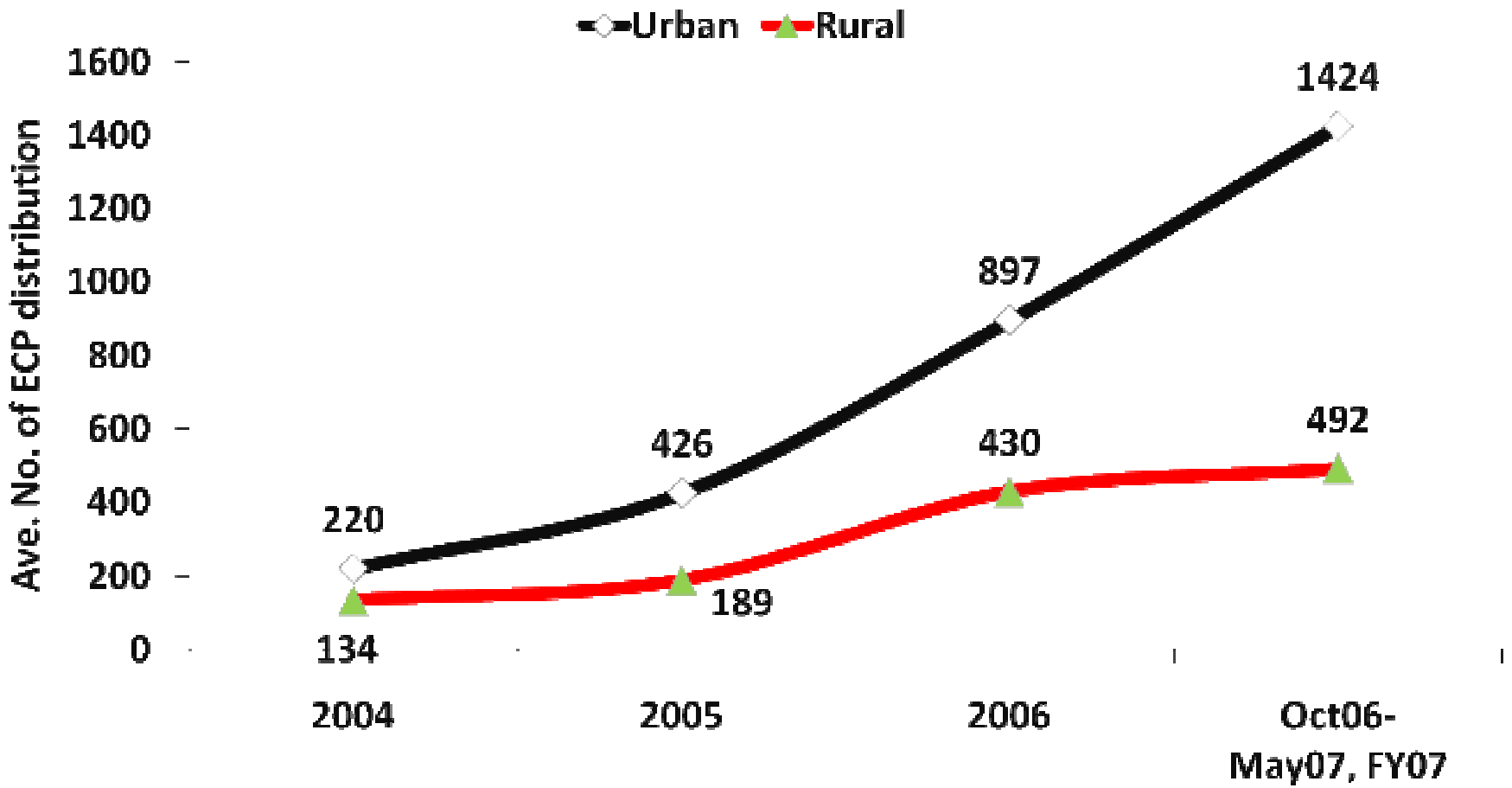
Monthly ECP distribution in the USAID supported NGOs clinics by year



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(NSDP, 2007)

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Reasons and frequencies of ECP use

Reasons for ECP use	Percent
Failed to take OCP for 3 consecutive days	38.1
Condom leakage	19.6
Intercourse without FP method	16.7
Unexpected visit by husband	6.8
Miscalculation of infertile period	5.6
Missed injection due date and had sex	5.4
Failed withdrawal	2.5
Force sex by husband	0.2
Others	10.2
Frequency of ECP use in the preceding 12 months	
One time	89.6
Two times	7.9
More than two times	2.5
N	444

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(Sharif and Khan 2007)

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Percentage of contraceptive use before and after ECP use

Contraceptive use	Before unprotected sex	After ECP use
Rate of contraceptive use	72.0	92.6
N	443	443
Type of contraceptive methods use		
Oral pill	55.8	48.3
Condom	33.9	33.7
Safe period	8.5	12.0
Injectables	3.8	9.3
Withdrawal	3.8	3.2
Copper-T	0.6	2.7
Natural methods	0.6	0.2
Norplant	-	0.2
Sterilization	-	1.0
N	319	410

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(Sharif and Khan 2007)

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Quality of ECP services: Observation from 144 Mystery Clients

- Majority providers suggested ECP spontaneously
- Half of providers offered ECP
- Few providers had no stock of ECPs and referred
- One-third of providers offered brochures
- ECP offer was mostly to method failure cases
- Newly-weds wer information on ECP
- ECP is not yet fu nto overall FP counseling

N=44 clinics

(Sharif and Khan 2007)

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Current status of ECP program

- **Fully integrated** in the national program & routine MIS
- Program charges 8 *Taka* (US$0.12)/packet
- Recently changed provision from:
  - on demand to **prophylactic** dose (implemented)
  - two doses regimen to **single dose** (not yet implemented)
- Slowly increasing use– **22,000** packets/month
- **Local** pharmaceutical started manufacturing ECP
- **Poor** diffusion of ECP knowledge among potential users
- IEC campaign is a **missing link**

FRONTIERS efforts in implementing ECP program

Technical assistance lasted for four years

- Developed training manual, IECs and counseling aids
- Provided TA in training and its evaluation (45,000 staff)
- Assisted in printing 3 m. brochures & 50,000 posters
- Ensured continuous monitoring and provided feedback to DG[illegible] through field visits, inte[illegible] surveys, m[illegible] [illegible]ce statistics

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Lessons learned from introduction and scale up

- **Building capacity** of public system is essential
- Public system needs **long-term** TA
- **Partnering** is important and funding is essential
- **Creating demand** and educating clients is a challenge
- Radio campaign could not reach most of the couples
- Women **do not use** ECP repeatedly
- **Prophylactic** distribution is a better option
- Setting MIS is **tim** **ning**
- Bridging role of F **served but needs further work**

Challenges

- Slower increase in ECP use than anticipated
- Lack of IEC efforts kept most potential users unaware
- Conflict of interest for those who perform abortion
- Confusions with pills for MR/abortion prevail
- Recently married couples are not given ECP information
- ECP yet to be integrated in the counseling of all spacing methods
- 8 *Taka* (US$0.12) as price of ECP is considered high

Thanks for Joining with Us

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