Research Update

August 2005 *No.3*

Building National Capacity to Deliver Emergency Contraception Services in Bangladesh

The Context

Contraceptive prevalence rate among the currently married women rose from 7.7 percent to 58 percent in Bangladesh over the last three decades .The unmet need for family planning services however, has remained around 15 percent during the last 10 years (NIPORT et al. 2000). Further, each year about one-third of the four million pregnancies in Bangladesh are unplanned or unwanted (NIPORT et al. 2004). Beside non-use of contraceptive, error in methods used, are thought to account for the overwhelming majority of unintended pregnancies among contraceptives users, particularly for the developing world including Bangladesh (Haishan et al. 1999).

To give women a last chance to save themselves from unwanted pregnancies, in 2001 the Government of Bangladesh (GOB) decided to introduce Emergency Contraceptive Pills in the National Family Planning Program. It was also decided to provide ECP service through grass-root workers, NGOs and community-based workers. The Government's decisions were based on findings from an operations research (OR) undertook by the FRONTIERS Program of Population Council in collaboration with the Directorate General of Family Planning (DGFP), Pathfinder International and JSI in Bangladesh. The study showed big unmet need of ECP and women's willingness to use it as a back up support to the existing contraceptive methods. It also revealed no significant variation in the level of knowledge gain, retention of knowledge and provision of services of ECP between physicians and the service providers after the training. The study also demonstrated service provider's ability to retain enough knowledge and skills on ECP after four months of training (Khan et al. 2005).

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Emergency contraceptive pills being a new technological innovation for Bangladesh, most of the providers, including majority of doctors and program managers, were unaware of the method and its administration. Hence, training of the entire cadre of the National Family Planning Delivery System in provision of ECP services was considered critical as well as a major operational challenge. Based on OR experience of introducing ECP in the existing program, DGFP staff in collaboration with FRONTIERS and UNFPA worked a three-tier training program for training of a cadre of Master Trainers (MTs), training of trainers (TOT) and then training of service providers (grass-root workers of public sector and community based workers of NGOs). It was also felt that before actual training of the providers, senior program managers of the Directorate and district level officials should also be oriented on ECP. Thus, to build the national capacity of the Family Planning Program to deliver ECP services, a total of 44,774 persons were trained in two phases (Table 1).

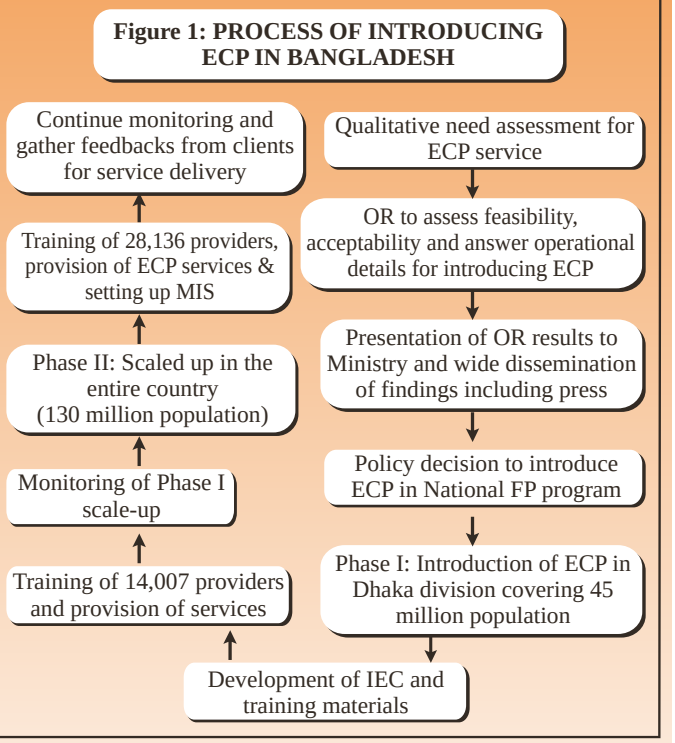
Table 1: Number of Family Planning Personnel Trained on ECP

Level of persons oriented or trained	Number trained
Senior program managers	**70**
Master trainers	**297**
Trainers including NGOs	**2,264**
Providers	**40,009**
NGO workers	**2,134**
Total	**44,774**

In Phase I (2003-2004), ECP was introduced in the Dhaka Division covering 17 districts and about 41 million population. In Phase II, from September 2004, ECP scale up was introduced in the rest of the country, covering the remaining 47 districts and about 89 million population.

The implementation of ECP program in the country is a joint effort of DGFP, FRONTIERS Program of the Population Council and UNFPA. DGFP implemented the entire program, FRONTIERS provided technical assistance while UNFPA provided financial support for both training and purchase of ECP. This Update provides an overview of the processes involved in building national capacity to provide ECP services and lessons learned in training the entire workforce involved in delivering FP services in the country. Figure 1 describes the processes that were involved in the introduction of ECP in the National Family Planning Program.

Figure 1: PROCESS OF INTRODUCING ECP IN BANGLADESH



Implementation of Phase I of ECP scale up took considerable time. Major time was spent in finalizing training materials and preparing the training program. Significant amount of time was also spent in developing tools and procedures for monitoring quality of the training program.

Based on the experiences from the Phase I, the DGFP in consultation with the FRONTIERS and UNFPA developed a comprehensive training program for the Phase II, covering the remaining five divisions of the country including, Barisal, Khulna, Rajshahi, Sylhet and Chittagong. These divisions are all geographically diverse and the expected number of staff that need to be trained was huge (around 28,000). Yet, implementation of the Phase II of scale up was relatively easier and took less time.

Box 1: Flowchart for Program Implementation

Orientation of senior Directorate & Divisional Program Manager on ECP

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Development of MT

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Training of Trainers

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Training of Service Providers

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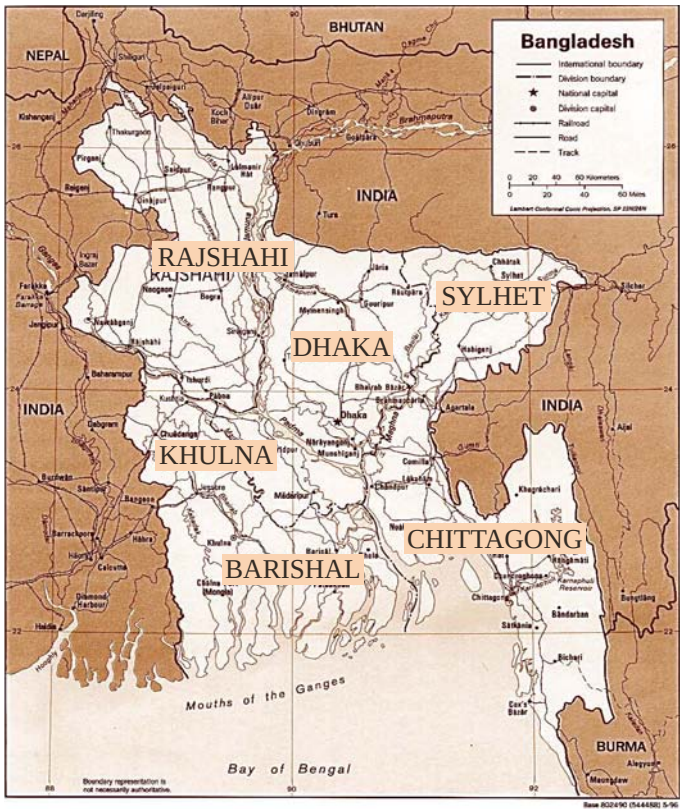
Provision of ECP

The key points discussed in the planning meeting were: number of Master Trainers (MTs), trainers and workers to be trained in each division, place of training and other logistics support required. In the light of the experiences from Phase I, all the training materials were reviewed and finalized. The trainer's manual in English was translated in Bengali and printed. Other programmatic decisions that were taken during the planning meetings were:

- The training would be conducted in stages (see Box 1). First, Master Trainers (MTs) to be trained, who in turn, would conduct training of trainers and in the third stage, these Trainers would train the grass root family planning providers.
- The MTs would be drawn from all parts of the Divisions, so that the training of trainers could be organized simultaneously in different parts of the country, without putting a lot of travel constrains on MTs.
- For better logistic management, training would be organized in four locations instead of six divisional headquarters.
- As family planning program and health services were again disintegrated into vertical program, only family planning officials and providers would be trained.
- In all levels of training (MT, trainers and service providers), participants from NGO's would also be included.
- Selected officials who had worked as MTs in Phase I would be listed as National Resource Persons to provide back-up support in the training of MTs and trainers.



Sensitization of Senior Program Managers

In Phase I before conducting the MT training, a batch of 70 Program Managers (PM) were oriented on ECP and were informed about the operational details of introducing ECP in the National Family Planning Program. The program managers who received the orientation included Civil Surgeons/Deputy Civil Surgeons, Divisional Director of Dhaka Division and Deputy Directors (Family Planning). In the Phase II, to reduce the burden of training, most of the program managers were included in the MT training sessions. Therefore, no separate orientation for program managers was organized in the Phase II of the scale up.

Training of Master Trainers

The total number of government officials who were trained as MTs was 198. Out of these, 46 were trained in Phase I and 152 in Phase II of the scale up. In addition, 102 MTs, mostly (98) from Dhaka Division were trained from NGOs. Three persons were selected from each district as MT. The distribution of officials trained as MT in Phase I and Phase II of scale up is presented in Table 2.

Table 2: Distribution of Master Trainers Trained by Phases

Phase	Division	District	Number of Participants		Total
			Govt.	NGO	
Phase I:	Dhaka	17	47	98	**145**
Phase II:	Khulna	10	32	2	**34**
	Barisal	6	22		**22**
	Rajshahi	16	50	2	**52**
	Sylhet	4	18		**18**
	Chittagong	11	26		**26**
Total	**6**	**64**	**195**	**102**	**297**

Criteria for Selecting Master Trainers:

The selected MTs were the regular trainers of the DGFP. It included Deputy Directors (Family Planning), Assistant Directors (Family Planning), and Assistant Directors (Clinical Contraception) / FPCST & Quality Assurance Team Supervisors. In few places, where some of the above positions were vacant, competent Medical Officers (Clinical Contraception) from district levels and Medical Officers (MCH-FP) from upazila levels were included as Master Trainers. In Phase I, Deputy Civil Surgeons were also included as MTs. Most of these officials work as trainers for various government-run family planning and reproductive health programs. Moreover, they manage and supervise family planning program at the district and upazila levels. The MTs included both medical and non-medical professionals. The non-medical professional included Deputy Directors (Family Planning) and Assistant Directors (Family Planning).

Training Duration and Batch Size:

A daylong training session was found sufficient to train the MTs. During the planning exercise, various sessions of the training, the number of trainees to be trained per batch, possible dates of training in each district and the logistics support required for the training program were discussed and finalized. In each training batch, 20-25 MTs were trained. At each training site, two batches of MT training were organized. The selected MT trainees were formally informed about the training well in advance by the DGFP and were requested to attend the scheduled training.

Content of Training: The curriculum of the MT's training was developed and tested by the FRONTIERS Program of the Population Council during operations research. The training covered the following aspects of ECP services:

- Demographic scenario of Bangladesh and role of ECP as a reproductive health intervention
- Technical details of ECP e.g. What is ECP? How it works?
- Service delivery guidelines
- Counseling
- Monitoring and logistics management

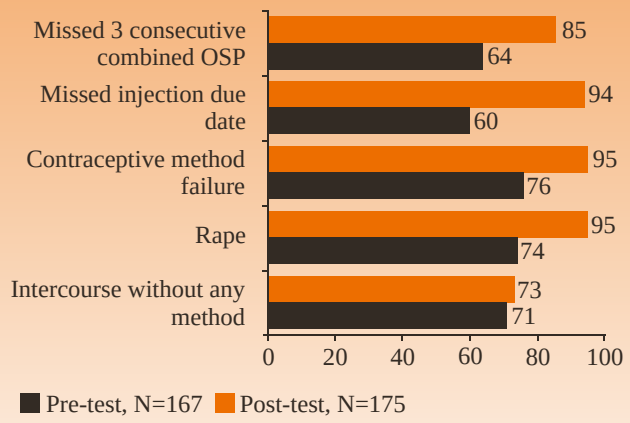
Each session had a short presentation followed by discussion. Substantial time was allocated for such discussion. During the training the MTs were also told and explained about the teaching aids and IEC materials that were provided to them to use during training of trainers. In all these trainings, senior officials from DGFP, FRONTIERS Program and UNFPA were present to observe the training processes and provide back-up support, if required.

Resource Persons:

In the first phase of scale up, the FRONTIERS staff primarily trained the National Resource Persons and MTs. "Logistic management and reporting of ECP" was taken by Deliver Bangladesh. By the end of this phase, the national program had developed adequate capacity to take the training responsibility of training Master Trainers on ECP. Thus, in Phase II, with limited support from FRONTIERS and UNFPA staff, the MTs were largely trained by the DGFP officials.

To evaluate the impact of the training, pre-and posttraining tests were conducted. Analysis of these assessments shows that even prior to the training, most of the MT trainees (98 percent) knew that ECP could be used after unprotected intercourse to avoid unplanned pregnancy. However, a significant number of the MT trainees (one-third) lacked proper understanding of the method and were not aware of all different conditions under which women could use ECP to protect themselves from unwanted pregnancy (e.g. unprotected intercourse due to missing three consecutive oral contraceptive pills, condom burst or leakage and missing DMPA due date, etc.). Changes in knowledge of the MTs about ECP use before and after the training are presented in Figure 2. Findings show that the training increased their knowledge of ECP and practically all MTs became aware of the situations when ECP should be used. However, a few trainees did not acquire the same level of understanding (Figure 2).

Figure 2: MTs Knowledge Before and After Training on when to Use ECP



Correct use of ECP depends on correct knowledge of four important aspects of ECP use: maximum time gap within which ECP must be initiated after unprotected intercourse, the number of ECP doses to be taken, the interval between two doses and the number of pills per dose. Findings indicate that before the training, about 40-80 percent of the MT trainees had correct knowledge of these four aspects of ECP use. The corresponding percentages after training increased to almost 100 for each of these aspects of ECP use (Table 3). Further analysis shows that the percentage of trainees who had correct knowledge of all the four aspects of ECP use, increased from 40 percent before the training to 98 percent after the training.

Table 3: Percentage of MT Having Correct Knowledge on ECP Use Before and After Training

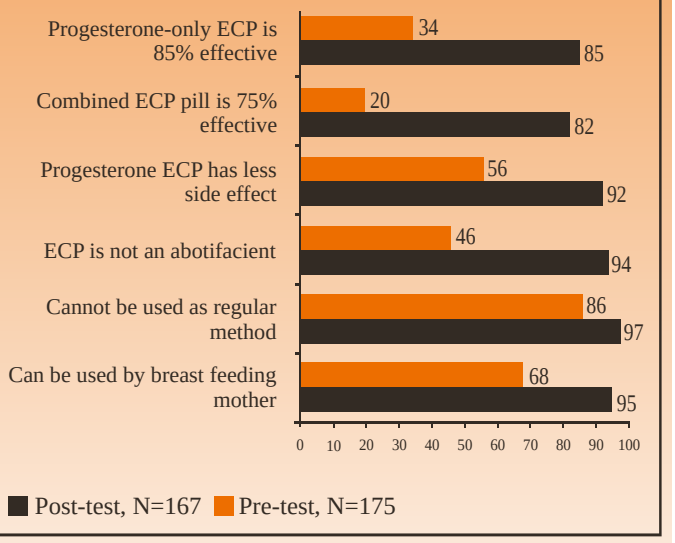
	Before	After
Timing for initiating ECP	75	98
Number of dose	80	98
Number of pill per dose	45	100
Interval between doses	79	100
Knows all correctly*	**40**	**98**
N	**167**	**175**

*Take 1st dose of ECP within 72 hours of unprotected intercourse; take two doses at an interval of 12 hours and one pill in each dose.

A series of other questions that were asked to the MT trainees about ECP also showed significant improvement in their knowledge (See Figure 3). Pre- and post-training data reveal that a substantial number of the MT trainees had misconceptions about ECP before the training. For example, relative

effectiveness of combined and progesterone-only pills or the issue of ECP as an abortifacient. These misconceptions were removed through the training.

Figure 3: MTs Knowledge Before and After Training on ECP Use



Training of Trainers (tot)

The Phase I of the TOT, covering 17 districts of Dhaka Division was completed in August-September 2003. Similarly, in Phase II, the entire TOT in the remaining five divisions consisting of 47 districts was completed in two months (October November 2004). This shows that by the end of Phase I, the Directorate had acquired the requisite capacity to undertake the training of trainers in all the five divisions, simultaneously. MTs trained a total of 2,264 trainers from 494 upazilas. Out of these trainers, about 20 percent were from NGO (Table 4).

Table 4: Number of Upazila Officials Trained as Trainer in Six Divisions

Divisions	Number of District	Number of Upazila	Number of trainer*
Dhaka	17	122	809
Barisal	6	39	144
Khulna	10	65	241
Rajshahi	16	128	530
Sylhet	4	36	165
Chittagong	11	104	375
Total	64	494	2,264

*Including 20% NGOs trainers

In each district, at least one official from each leading NGO's, providing reproductive and family planning services, was included in the training.

Three officers were identified as a trainer from each upazila. They included: Upazila Health and Family Planning Officer, Medical Officer- (MCH-FP) and Upazila Family Planning Officer. As in case of MT, the trainers were also selected both from medical and non-medical professionals, responsible for family planning work in the upazila including training. In Phase I, Assistant Upazila Family Planning Officer and Senior Family Welfare Assistant were also included as trainers. However, considering their knowledge gain during the training and subsequent performance as trainers in Phase II they were not included as trainer.

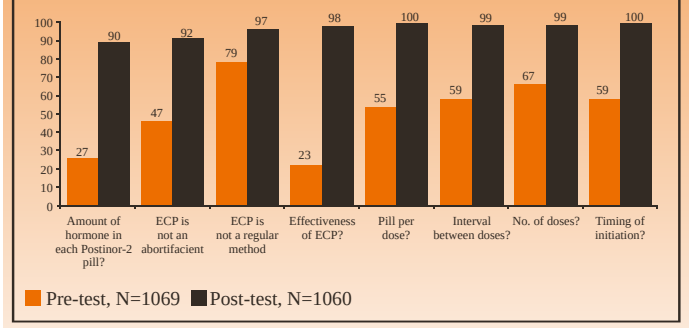
The MTs conducted the training of trainers. To make the training uniform all over the country, each MT was provided with several training materials to be used during TOT. It included: a training manual on ECP, a transparency set for each session, a big size flipchart on the different sessions that could be used in case of power failure or due to the unavailability of a overhead projector, and a set of pre- and post-training test questionnaire to be administrated in each batch of TOT training. In addition, a copy of two brochures - one for service providers (service delivery guidelines) and another for clients were also distributed to the trainees. All these teaching aids were developed and tested by the FRONTIERS Program.

Flipchart was not provided in Phase I. However, in view of the problem faced because of the non-availability of overhead projector and /or power failure, large size flip charts were developed and

supplied in Phase II. Experience suggests that it was a good decision and the flipcharts were extensively used as power failure or non-availability of overhead projector remained a major problem in the peripheral upazilas.

Pre- and post-training tests were administered to all the trainees to assess how far the training had achieved its objectives. Analysis of the data sets shows that the training sessions were successful in imparting correct knowledge about ECP use (Figure 4). For instance, before training only 49 percent of the trainees knew how to use ECP correctly (i.e. had correct knowledge of all the four critical aspects of ECP use- timing, dose, interval and pill per dose correctly) which increased to 98 percent after the training.

Figure 4:Percentage of Trainers Who Gave Correct Answer in Pre-and Post-training Tests (All Divisions)



In Phase I, FRONTIERS staff in collaboration with the DGFP officials analyzed the data of the pre- and post-training tests. The findings were immediately communicated to the district authorities and the trainers. In this way, it was ensured that the trainers could see the impact of their training effort and improve their performance further, if required. In the process, an effort was also made to build the capacity of the DGFP officials and the MTs to undertake such evaluation independently without any TA from FRONTIERS staff.

In Phase II, the entire responsibility of training of the trainers was left on the DGFP officials (MTs). The National Resource Persons consisting of senior officials of DGFP, FRONTIERS and UNFPA occasionally visited the training sessions and provided backup support, if required. This occasion was also used to observe the performance of the MTs. For each training batch of trainers MTs themselves conducted the pre- and post-training tests, analyzed the data and used it for further improvement of the training. A comparison of the findings of pre-post training assessments of the Phase I and random sample of pre-post assessments drawn from 10 districts in Phase II, showed no difference in the quality of training or knowledge gained by the trainees. This is an encouraging result and shows that over the time DGFP had built its capacity to conduct and carry out ECP training program effectively and efficiently.

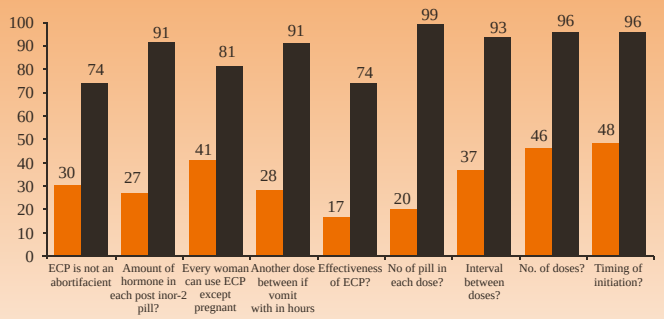
Training of Service Providers

A total of 14,007 service providers, including field workers, were trained in Phase I covering 17 districts of Dhaka division. From December 2004, training of the service providers in other five divisions started simultaneously. By the end of July 2005, all the family planning providers of the country were trained. The total FP work force trained stands at around 44,774, of which 13 percent comprise of NGO providers.

Assessment of the impact of ECP training on the service providers in Phase I was done by DGFP officials with the technical assistance from FRONTIERS Program. However, in Phase II this responsibility was left on the trainers. Random visits by the National Resource Persons showed that the trainers carried out the work systematically and quality of the training was satisfactory.

The analysis of the pre- and post-training assessments of 14,007 service providers in Phase I is presented in Figure 5. The analysis shows significant increase in ECP knowledge of the providers. While only about one-third of the service providers had some knowledge of ECP before the training, it increased to over 90 percent after the training. Similarly, while only 15 percent of the service providers had correct knowledge of all the four key aspects of correct use of ECP (i.e. timing, doses, pills per dose and interval between doses) before the training, it increased to 81 percent after the training. All these findings indicate that trainers had successfully conducted the training and achieved their training objectives- to impart competency-based training to the providers on the correct use of ECP and its services.

Figure 5: Correct Knowledge of Service Providers on ECP use: Findings from Pre and Post-test assessments in Dhaka Division



Monitoring of Training

To monitor the quality of trainings, senior officials from the DGFP, FRONTIERS Program and UNFPA visited different districts during the training of trainers as well as service providers. It was planned that after each visit the visiting official would write a two-page note on the observations made on the training sessions. These notes were analyzed and feedback was given to the DGFP. The observations revealed that in most of the places training was organized efficiently and the trainees actively participated in the discussion. In majority of the cases, the trainers came well prepared to conduct the sessions. In few places where the trainers were not well prepared, they faced difficulties in answering queries from the trainees.

The observations also revealed some limitations in logistic management that were immediately addressed. For example, in some places, particularly in Sadar upazilas, the training room was very small and congested for 25-30 persons. Similarly in some other places, due to the lack of overhead projector, lack of power, and/or lack of spare bulb of the overhead projector, the transparencies provided for conducting sessions could not be used. In Phase II the problem was successfully addressed by providing big flipcharts for the training sessions when use of overhead projector was not possible. Yet another common problem observed was delay in starting the session or taking too much time in inaugurating the training program. Discussion on these issues at the Directorate level helped in minimizing these delays.

While the descriptive notes on the observations of training sessions were useful for monitoring and understanding the training process, many of the officials due to their time constraint were reluctant to write or even read notes prepared by others. In view of this, during Phase II, a monitoring checklist was developed and introduced to record the observations during the training. The checklist covered both quality aspects of the training and organizational/logistic issues. A total of 39 trainings conducted by different MTs and trainers were observed. The findings of the observations are presented in Table 5 and Table 6. Tables show that the trainings were well organized and quality of training was good. The average duration of the training session was four hours.

Table 5: Observation Made on Quality of ECP Trainings (Percentage)

Quality issues	Technical part	Service delivery guideline	Counseling	Logistic management
Presentation was clear	92	100	87	95
Provided information in details	92	92	85	97
Trainers came well prepared	92	97	74	97
Provided enough time for discussion	74	87	64	79
Clarified trainee's doubts	92	90	74	92
Sessions were interactive	90	92	82	92
N	**39**	**39**	**39**	**39**

The observations confirmed that some of the limitations observed in Phase I were adequately addressed in Phase II. It was encouraging to observe

Table 6: Observation made on logistic and management aspects of ECP trainings

Issues	Percentage
No delay in inauguration	77
Number of trainees exceeded 25	49
Teaching aids used	92
Venue was comfortable	87
3 resource persons were used to conduct training	72
Monitor rated quality of training as good	95
Number of training observed	39

that unlike Phase I, in Phase II the trainings were well organized by the DGFP with only limited technical assistance from the FRONTIERS Program. However, a point of concern that continued in Phase II also was larger number of trainees per batch. In the planning meeting it was agreed that to ensure good interaction and quality training, the number of trainees per batch should not exceed 25. Out of 39 trainings observed, in 19 places the number exceeded 25. Of these, in 10 cases number varied between 30-34.

Evaluation of Training by Trainees

In the post-training test, each participant was also asked to evaluate the quality of training they had received. Evaluation of the trainings by trainees (MTs, trainers and service providers) was encouraging. It shows that in general the presentations were appreciated and positively evaluated by most of the trainees (Table 7). However,

Table 7: Percent Distribution of Trainees Evaluation of Training Sessions as Excellent or Good

Clarity of the presentation on ECP	Excellent/Good		
	Master trainer*	Training of trainer**	Service provider***
Technical part	90	82	66
Service delivery guidelines	89	81	65
Counseling	89	83	65
N	175	794	13901

*10-11% did not respond, **9-12% did not respond, ***32-33% did not

a significant percentage of trainees (about 30 percent) did not respond to the evaluation questions. The non-response rate was much higher among the providers (32-33 percent) than among the MTs/trainers (9-12 percent). The lack of response may be due to insufficient time to complete the questionnaire at the end of the day and/or participants' unwillingness to answer the questions.

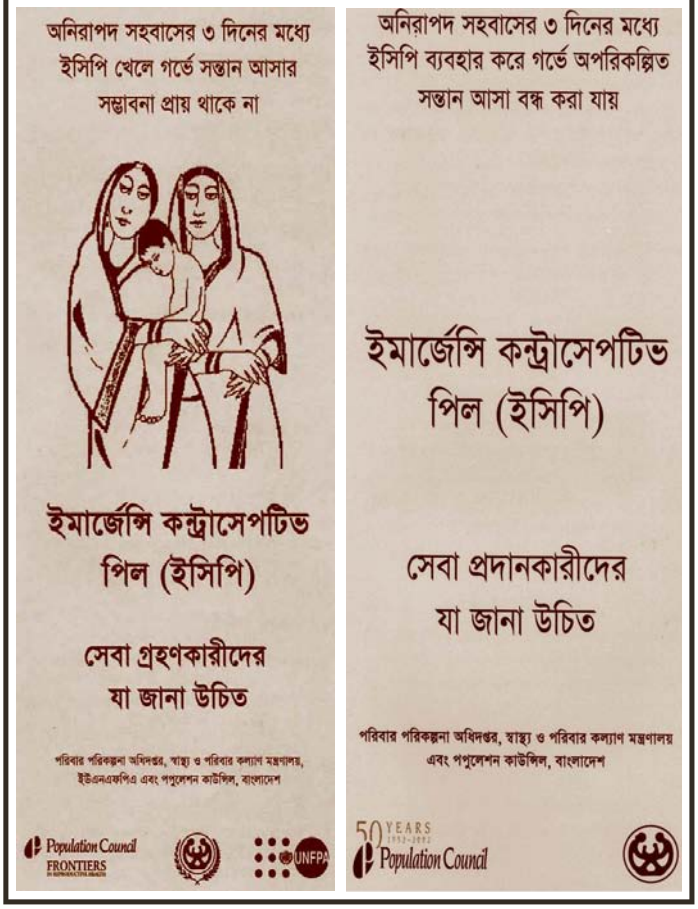
Conclusions and Recommendations

The successful scale up of ECP in the National Family Planning Program indicates that it could be a good example of policy research and its utilization. The program started with an operations research to develop, test and document the experiences of introduction of emergency contraception. It was then scaled up in the entire country in phases. Bangladesh is perhaps the only country in the world, which introduced ECP in the National Family Planning Program in such a systematic way and where ECP services are being provided by grass root family planning service providers as well as community-based workers. We strongly feel that this model of introducing ECP could be easily replicated in any other country, particularly in the South Asia region. In fact, this model is being replicated in the sate of Uttaranchal, India, as an example of implementing best practices. The Government of Uttraranchal, Ministry of Health and Family Welfare, Government of India, WHO and FRONTIERS Program, are jointly working on this initiative.

Some of the key lessons learned in implementing ECP program in Bangladesh include:

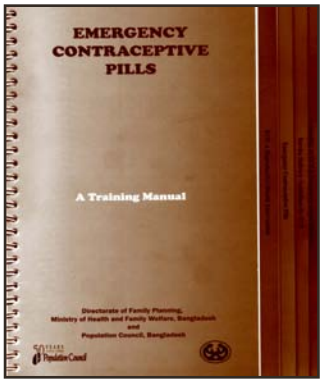
- Scaling up of any innovation (e.g. introduction of ECP) to the entire country should be done in phases. A modest start and a close monitoring in the first phase helps in understanding possible operational difficulties and logistic management issues which the program has to manage when the program is scaled up in large areas simultaneously.
- Building capacity of the delivery system should be an integral part of the phase I scale-up. This helps the delivery system to take the responsibility of scaling up in Phase II with minimum technical assistance from collaborating research organizations. In Bangladesh, FRONTIERS Program provided extensive technical assistance in Phase I, but in Phase II, primarily the DGFP officials did the scaling up of ECP in the remaining 47 districts.

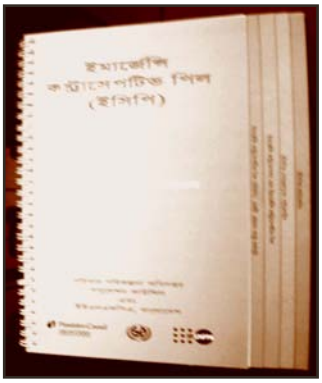
Leaflets Prepared for Clients and Providers



- A scale up of such magnitude if done in partnership, the chances of its successful implementation are much higher than when done alone. The introduction of ECP program in the country was a joint effort of the DGFP, FRONTIERS Program of the Population Council and UNFPA. The experience clearly demonstrates that this collaboration played a crucial complementing role in successfully introducing ECP in the country.
- One of the biggest challenges of the scale up was maintaining uniformity and quality of training that involved a large number of trainers (e.g. about 2500 trainers). The strategy of providing standard set of transparencies/flipchart for each session and ensuring that trainers followed the same teaching aids, turned out to be quite effective in maintaining the quality and uniformity of training.
- Experience of continuous and sustained large monitoring of the training program, quick analysis of the observations and its feedback to the system to improve the functioning was rewarding and critical to the successful implementation of the ECP program. Use of a simple checklist for monitoring purpose, covering both technical as well as organizational aspects of the training, was found more useful than descriptive and elaborate notes on the observations made on the training. Monitoring system that demands detailed write-up or time-consuming analysis, may provide good insight on the process but may not be feasible in such large scale up, introducing new services.
- Introducing even minor modification in the existing monitoring system, for instance inclusion of information on number of ECP dispensed every month in the monthly reporting of service statistics, takes time and effort. Thus, it is critical that such modifications should be planned and discussed with the concerned program manager right at the beginning of the scale up activity and should be monitored for some time, both for its accuracy and demonstrating its utility and purpose.
- The study suggests that grass root level workers are competent enough to provide quality ECP services. Comparative findings from a huge sample of service providers and doctors on knowledge gain after training, show that the service providers are equally competent to acquire competency base knowledge from ECP training and can retain sufficient knowledge to provide quality ECP services. The scale up of ECP in Bangladesh clearly advocates inclusion of all grass root workers in ECP service provision. It will enhance accessibility to ECP services many folds. Occasional checking of their technical knowledge during supervisory visit or monthly meetings could be beneficial for the program.
- A training session of more than 25 participants should be discouraged. Twenty to 25 participants per batch are the maximum number to keep such training interactive and effective.

Training Manual for Master Trainers





References

Haishan Fu, Jacqueline E. Darroch, Taylor Haas and Nalini Ranjit. 1999. "Contraceptive Failure Rates: New Estimates from the 1995 National Survey of Family Growth." Family Planning Perspectives 31(2): 56-63.

Khan, M. E., Sharif Mohammed Ismail Hossain and Moshiur Rahman. 2004. "Introducing Emergency Contraceptive Pills in Bangladesh: Using Operations Research for Policy Decisions." Final Report. Washington D.C.: Population Council / FRONTIERS.

Khan, M. E., and Sharif Mohammed Ismail Hossain. 2002. "Training Service Providers on Emergency Contraception: Lessons Learned from an OR study." Research Update 2. Dhaka: Population Council /FRONTIERS.

NIPORT, Mitra and Associates and Measure / DHS+IRCMacro International Inc. 2000. Bangladesh Demographic and Health Survey 1999-2000. Dhaka: NIPORT, Mitra and Associates and Measure/DHS+ ORC-Macro International Inc.

NIPORT, Mitra and Associates and Measure / DHS+IRCMacro International Inc. 2004. Bangladesh Demographic and Health Survey 2004. Dhaka: NIPORT, Mitra and Associates and Measure/DHS+ ORC-Macro International Inc.

Waris, Syeeda Tazneen and Sharif Mohammed Ismail Hossain. 2005. "Master Trainers Training on Emergency Contraceptive Pills (ECPs) of the Government Officials of Rajshahi, Khulna, Sylhet, Barishal and Chittagong Divisions." Dhaka: Directorate General of Family Planning.

Suggested Citation

Khan, M. E., Sharif Mohammed Ismail Hossain and Md. Nizamuddin Bhuiyan. "Building National Capacity to Deliver Emergency Contraception Services in Bangladesh" Research Update 3, August 2005. New Delhi: Population Council / FRONTIERS.

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The scaling up of ECP program was implemented by the Directorate General of Family Planning (led by Dr. Jafar Ahmad Hakim and Dr. Syeda Tazneen Waris), Ministry of Health and Family Welfare, Government of Bangladesh with technical assistance from FRONTIERS / Population Council and financial and logistics support from the UNFPA, Bangladesh (represented by Dr. Jebun Nessa Rahman and Dr. Wali Ahmad Fateh).

This publication was made possible by the U. S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) under the terms of the Frontiers in Reproductive Health Program Cooperative Agreement No. HRN-A-00- 98-00012-00, and In-house Project No. 5800 53066 502. The opinions expressed herein are those of author (s) and do not necessarily reflect the views of USAID.

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Frontiers in Reproductive Health Program is funded by the UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) under the terms of Cooperative Agreement Number HRN-A-00-98-00012-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the view of USAID.

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