Shukhi Jibon Learning Lab: Community-based Postpartum and Postabortion Family Planning

BACKGROUND
Bangladesh has affirmed its commitment to postpartum family planning (PPFP)—defined by the Ministry of Health and Family Welfare (MOHFW) as the postpartum period spanning up to one year after delivery—through its inclusion of PPFP activities in Bangladesh’s 4th Health, Population and Nutrition Sector Program Implementation Plan. However, several gaps must be addressed to ensure access to quality PPFP and postabortion family planning (PAC-FP) services for people who want to space or limit their pregnancies.

Bangladesh struggles with a high unintended pregnancy rate (21%) and a high proportion of adolescent mothers ages 15–19 with birth intervals less than 24 months (47%), despite a median birth interval of almost 56 months for all women ages 15–49.

Demand for birth spacing of three years or longer is 78% among those who delivered recently. While the modern contraceptive prevalence rate (mCPR) for married women is 52%, 12% have an unmet need for family planning (FP)—5% to space births and 7% to limit births. Innovation is needed to increase access to PPFP and PAC-FP to reduce unmet need and increase the mCPR.

In Bangladesh, while FP information and services are typically delivered at both the facility and community levels, in many cases, PPFP is not. National operational plans primarily focus on providing PPFP information and services to women at the facility level, despite recommendations from the World Health Organization (WHO) to provide PPFP in facilities and communities, including PPFP counseling during facility-based antenatal care, postnatal care, and community-based pregnancy screening. In a country where 52% of deliveries occur at home, and approximately 38% of mothers receive no postnatal care, it is critical to close this gap by reaching postpartum women who deliver at home with an extensive intervention package.

Bangladesh’s bifurcated health delivery system (see note on Page 2) requires closer coordination, particularly between the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services (DGHS) to increase access to community-centered pregnancy screening, facility delivery, and PPFP and PAC-FP services. Pregnancy screening by DGHS field staff at the...
secondary and tertiary levels is comprehensive compared to that offered by DGFP field staff at the community level; however, DGFP field staff provide follow-up with pregnant women, including PPFP services.

**SHUKHI JIBON’S APPROACH TO COMMUNITY-BASED PPFP AND PAC-FP**

Shukhi Jibon begins its intervention at the community level—with community health workers registering pregnant women using a form approved by DGFP. The intervention also reaches women who do not give birth at facilities with PPFP messages before and after delivery. The project ensures these clients receive post-birth home visits to discuss PPFP and can access a short-acting method or a referral for a long-acting method if desired. Shukhi Jibon also reaches women who have undergone menstrual regulation (MR), abortion, or experienced a miscarriage with PAC-FP messages after MR and after abortion. The project ensures these clients receive post-MR or postabortion home visits to discuss FP and can access a short-acting contraceptive method or a referral for a long-acting method if desired. Shukhi Jibon also works to strengthen and increase referrals for voluntary FP services for women who undergo abortions at facilities.

To inform the design and launch of its community-based PPFP and PAC-FP intervention, Shukhi Jibon considered information from published reports and recommendations from consultants, and conducted a facility assessment. The project developed its community PPFP strategy through a series of consultative meetings with the DGFP and national experts. The team then developed a trainer’s manual and handbook for providers based on the national curriculum/guidelines and informed by learnings and adaptations from the project’s roll out of trainings of trainers (TOTs) and cascade trainings. Shukhi Jibon trained 24 trainers from the DGFP and DGHS on providing community-based PPFP and PAC-FP—including client screening, counseling, and making referrals—and then reached 280 providers, including health assistants, community health workers (CHWs), family welfare assistants (FWA), FP inspectors (FPI), and family welfare visitors (FWV) through cascade trainings.

**KEY COMPONENTS OF SHUKHI JIBON’S PPFP AND PAC-FP APPROACH**

- **Involvement of members of the field-level workforce** (for example, FPIs in monitoring activities and coordinating meetings, and health assistants [HAs] and assistant health inspectors [AHIs] in PPFP counseling and referrals)
- **Inclusion of local public representatives** (women union parishad members) in biweekly meetings to encourage demand generation
- **Facility readiness**, including PPFP equipment and supplies
- **Commodity security** to ensure that APON (progestin-only pills) are available for FWAs to distribute to postpartum clients who want them
- **Use of virtual platforms** during COVID-19-related movement restrictions
- **Coordination between DGFP and DGHS staff**
- **Task sharing** with DGHS providers ensured through coordination at satellite clinics and fortnightly meetings
- **PAC-FP messaging** for pregnant women during PPFP counseling
- **Improved record-keeping** (for example, adaption of the DGFP’s existing pregnancy registration tool to record whether clients received voluntary PPFP after delivery and record PAC-FP client interactions)

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A NOTE ABOUT BANGLADESH’S BIFURCATED HEALTH DELIVERY SYSTEM

The MOHFW has a split public-sector health service delivery system. The DGFP provides district- and community-level FP, maternal and child health, and nutrition services, whereas the DGHS provides district- and community-level curative and preventive services through higher level health facilities. DGFP and DGHS staff work independently at health care facilities and in the community. Enhanced coordination is essential for expanding access to and uptake of PPFP.
Shukhi Jibon helped arrange and support 125 union-level biweekly meetings with a total of 1,068 participants to monitor and follow up on activities for pregnancy registration; home visits; antenatal care visits; counseling for facility delivery, PPFP, and PAC-FP; postnatal care visits; referrals; and PPFP commodity distribution. More than 60% of the attendees were CHWs (FWAs & FPIs), 20% were facility-level providers, 8% were managers and supervisors, and the rest were DGHS staff and community leaders. Through these meetings, the project sought to reinforce process accountability, monitoring, and supervision. These biweekly meetings were crucial in promoting task sharing—collaboration between the DGFP and DGHS—data sharing, data usage, client follow-up, internal coordination among field and facility-based staff, and more.

**PPFP LEARNING LAB**

In 2019, Shukhi Jibon set out to address five common challenges that pervade development assistance and stand in the way of the project’s goal—to contribute to improved health and human capital in Bangladesh by increasing use of voluntary FP services. Using a Learning Lab approach, based on USAID’s Collaborating, Learning, and Adapting (CLA) framework, and with strong commitments from the Government of Bangladesh (GOB) and USAID, Shukhi Jibon implemented five innovative interventions in 39 test sites across 6 learning districts. Today, this robust Learning Lab experience provides a roadmap for continuous learning and demonstrates Shukhi Jibon’s progress in rapidly testing, refining, and documenting innovations during a pilot phase before effectively scaling them to achieve greater impact.

Shukhi Jibon implemented its PPFP and PAC-FP intervention between September 2019 and March 2021 in 21 Learning Lab sites—government health facilities—and adjacent communities in 5 districts (Dhaka, Faridpur, Mymensingh, Chattogram, and Sylhet). Health facilities included Union Health and Family Welfare Center (UH&FWC), and Upazila Health Complex (UHC) (Sadar Clinic and MCH unit), selected from the DGFP service delivery and management system.

**KEY LEARNING QUESTIONS THIS INITIATIVE AIMED TO ANSWER**

- What percent of pregnant women in the FWA catchment area were registered for pregnancy-related services, including PPFP?
- What percent of women who delivered at home adopted PPFP through project efforts?
- How many and what percent of PAC clients receive FP at home or a facility?
- What implementation lessons will inform scale-up to other Shukhi Jibon project areas?

**FIGURE 1: ILLUSTRATION OF THE SHUKHI JIBON LEARNING LAB ECOSYSTEM**

Learning Labs consist of a network of facilities within a portion of a district, with representation from each level of the system: a regional population training institute or regional training centers and a maternal and child welfare centers at the district level; UHCs at the upazila level; a UH&FWC at the union level; and CHWs (such as FWAs) in the catchment areas of these facilities.

**FIGURE 2: PPFP AND PAC FP LEARNING INTERVENTION CONTINUUM**
APPLICATION OF LEARNING LAB FINDINGS

Stakeholder consultations and implementation learning guided the community-based PPFP and PAC-FP process (See Figure 2) and conceptual framework (See Figure 3), including adaptations. From Learning Lab pilot sites, the project observed the following:

- Making trainings and biweekly meetings more inclusive by integrating DGHS field staff and local government representatives (female union parishad members) enabled these attendees to better support FWAs in identifying pregnant women not recorded in the FWA pregnancy registry and reaching clients with PPFP and PAC-FP messages, particularly during antenatal and postnatal care visits.

- Shukhi Jibon enhanced DGFP capacity through a collaborative approach that improved service center readiness by ensuring sufficient PPFP equipment; a manual and trained staff; job aids, information, education, and communication materials; as well as social and behavior change materials for the facilities and for field staff. Appropriate forecasting and requisition of APON (progestin-only pills) for community distribution to pregnant mothers reduced stockouts.
• Strengthening trainers’ facilitation skills through trainings of trainers (TOTs), especially TOTs focused on adult learning methodologies and techniques, facilitated a smooth cascade training process that included DGHS field staff. Integrated training created a bond among field staff that is conducive to teamwork.

• Finalizing the user handbook was a lengthy process, as the project adapted its initial learnings on postabortion client counseling and care. The project modified PPFP and PAC-FP client counseling sections to address the challenges of postabortion client tracking and referral to facilities for FP services.

• The project noted a tension between the desire to provide the intervention widely across the upazila as opposed to Learning Lab sites exclusively. To increase cost effectiveness, DGFP suggested covering the whole upazila and surrounding communities rather than only specific sites.

• In Learning Lab sites and surrounding communities, the project focused on enhancing the tracking of pregnancies and supporting supervisors and field staff to ensure all pregnancies are recorded. A comparison of the estimated number of annual pregnancies to the actual number of annual registered pregnancies revealed that, on average, project-supported field workers registered between 70–81% of all pregnancies. Actual pregnancy registration numbers also showed that new pregnancy registrations were lower (23%) during the first wave of COVID-19 (April 2020), increased after few months (41% in September 2020), and then remained mostly consistent.

• The project made progress in enhancing collaboration among and with field workers through the help of biweekly meetings. Shukhi Jibon discovered that when local government officials collaborate to plan such events, it can stimulate field-level task sharing mechanisms, particularly in places where FWA vacancies have resulted in a significant increase in workload for individuals with additional responsibilities.

• When Shukhi jibon-supported field workers counseled pregnant women, they emphasized the benefits of delivering at a facility, offering their clients more opportunities to access and adopt a PPFP method. Between 2014 and 2017–18, the facility delivery rate in Bangladesh increased from 37% to 50%. Most of this increase occurred in private health facilities (from 22% to 32%). The DGFP recorded an average home delivery rate in Learning Lab sites of 29% from October 2019–June 2021, indicating a higher number of facility deliveries in intervention areas.

• One Learning Lab objective was to ensure women who underwent abortion or MR, or experience a miscarriage, were able to access voluntary FP to prevent pregnancy for at least six months. Identifying and following up with these women proved difficult. They often face harmful stigma in their homes and communities and, as a result, may choose to conceal their experience from others and try to become pregnant again without delay. Facing these complications, the project struggled to identify and track these women for PAC-FP services. The Learning Lab’s community-based model, with its limited scope for community engagement and community referral, may not be appropriate for ensuring FP coverage for this particular population. Bolstering community-based demand generation activities may help address these challenges.

**At biweekly meeting in the Rangamati district, service providers—Fahmina Akter, Dipu Rani, and Mousumi Rani—complete pregnant women registration forms | Photo: Ifsana Khan**
FACILITATORS OF THE APPROACH

• **Relationships.** Each member of the intervention team served as a coordinator at the divisional headquarters and oversaw the operation on the ground, sharing up-to-date information and outputs of interventions with—and inspiring the action of—authorities at the district and upazila levels. District-level officers oversaw the intervention process; motivated service providers; followed up on trainings with monitoring; and held regular meetings, as well as virtual sessions during the pandemic. These officers served as important contacts in the district, regularly reporting on the progress of activities to upazila and district officials. Networking and nurturing existing relationships with FP specialists, especially in the DGFP, helped smooth the process, enabling teams to quickly detect any difficulties in the Learning Lab sites, which aided project implementation.

• **Biweekly meetings and support.** Shukhi Jibon’s support for bi-weekly meetings—which featured pregnancy registration follow-up, ANC-PNC follow-up, and pregnancy list-sharing with supervisors and facility-based providers—proved beneficial in numerous ways. For example: thoroughly reviewing the pregnancy registry at the biweekly meetings help boost the number of antenatal care visits, counseling for facility deliveries, and PPFP counseling in ANC and PNC visits. In addition, Shukhi Jibon arranged shared lunch for participants, creating a festive atmosphere that helped motivate participants.

• **Training and support.** Training for service providers and field staff, technical support for physical and virtual biweekly meetings, regular follow-up, promotion of local solutions, and communication and cooperation with higher authorities contributed to the smooth, successful implementation of the intervention. To cultivate local ownership and collaboration, Shukhi Jibon identified local authorities as trainers and prepared them to conduct practical trainings. Training activities at the Learning Lab sites elevated FPIs, encouraging them to see themselves as essential, and cultivated their sense of responsibility for supervising the activities.

CHALLENGES AND RESPONSES

**COVID-19**

**Challenge:** On a wide scale, the pandemic disrupted Shukhi Jibon’s efforts, halting training events, physical follow-up, biweekly meetings, facility-based service delivery, and home visits by FWAs for 65 days (see Figure 4). Virtual meetings for providers and managers were initially difficult to arrange at some facilities. To reestablish the service delivery system after the first wave of COVID-19, the project team conducted infection prevention training for facility-based providers. The project was unable to directly provide infection prevention and control training for FWAs and FPIs in the field; instead, project-trained facility-level providers were tasked with transferring this knowledge to field staff.

**Response:** Shukhi Jibon extended its intervention period by three months. Project staff encouraged FWAs and FPIs with meals, assistance, and virtual events; followed up on pregnancy registration and PPFP via virtual biweekly meetings and digital communication; and provided COVID-19 prevention instructions by phone. After overcoming COVID-19-related service setbacks in facilities and communities, community-based PPFP and PAC-FP activities in Learning Lab regions resumed gradually. Shukhi Jibon personnel provided hands-on training for managers and field employees on using technology for virtual meetings and communications.
CHALLENGES AND RESPONSES (continued)

STAFFING SHORTAGES

Challenge: The most significant implementation challenge Shukhi Jibon faced was that most locations lacked the requisite number of FWVs, FWAs, and FPIs. Scarcity of field workers made activities—such as updating the pregnant women’s registration list and PPFP and PAC-FP data twice a month in preparation for biweekly meetings, conducting household and follow-up visits, and distributing PPFP methods—difficult to complete satisfactorily.

Response: As a result of district-level lobbying of the DGFP administration, several service centers at Learning Lab sites were able to hire new FWVs. Engaging HAs through task-sharing helped ensure services for areas with vacant FWA positions. Shukhi Jibon also reduced the required frequency of pregnancy list updates to monthly, which was easier for field employees to complete.

TRAINING AND SUPPORTING FIELD WORKERS

Challenge: Engaging DGHS field workers was difficult; planned TOTs and trainings had to be rescheduled multiple times. To date, not all DGHS personnel in upazilas have received training. COVID-19 and dengue outbreaks absorbed health managers’ time, while a month-long measles and rubella vaccination campaign occupied all field personnel. During these hard-hit periods, the government published a circular urging people to prioritize pandemic response and refrain from engaging in other interventions. Even after trainings, ensuring field worker participation in weekly meetings was difficult. Many upazila health and FP officers agreed to have field personnel participate one day a month.

Response: The project rearranged training schedules to accommodate DGHS staff. However, these adapted schedules extended beyond the Learning Lab intervention time frame.

FIGURE 4: COVID-19 DELAYS AND DISRUPTIONS

<table>
<thead>
<tr>
<th>65 Days</th>
<th>53 Days</th>
<th>48 Days</th>
<th>49 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 26–30 2020</td>
<td>February and March 2021</td>
<td>April 5–May 23 2021</td>
<td>June 22–August 10 2021</td>
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General holidays declared from 26 March to 30 May (including transport restriction), except some export agencies intermittently.

February 2021 saw countrywide vaccination drive and high case load of COVID in March 2021.

2nd phase lockdown started from April 5 and continued until May 23.

3rd phase lockdown began on June 22 in seven districts and continued to August 10 in different forms and scale.

Recap session during the second day of Training of Trainers on Community-based PPFP & PAC-FP Services facilitated by Ifsana Khan, FP Compliance Coordinator | Photo: Dr. Fahnina Khan
CHALLENGES AND RESPONSES (continued)

COMMODITY SHORTAGES

Challenge: The project discovered a shortage of APON in two upazilas. In most Learning Lab sites, forecasting, ordering, and last-mile delivery were not entirely functional.

Response: FWAs addressed this gap by distributing condoms to women who intended to give birth at home. In addition, the project strengthened the capacity of FWAs and FWVs to forecast demand and order APON accordingly, and the government recommended provision of condoms in cases when progestin-only pills were not available.

FACILITY PREPAREDNESS

Challenge: A shortage of skilled providers at some facilities posed challenges, particularly for postpartum IUD insertion and removal. Newly hired providers required specialized training on IUDs, implants, no-scalpel vasectomies, and tubectomy; others required refresher training. Some providers received PPFP training but were unable to deliver services because of a lack of maternity services and postnatal patient management capacity in their facility. In addition, some facility structures were in need of repair, and others did not offer delivery services 24 hours a day/7 days a week, and lacked adequate supplies for postpartum IUD provision.

Response: The government agreed to Shukhi Jibon’s request to upgrade about half of the facilities in the Learning Lab sites. Shukhi Jibon has continually worked with local facility managers and supervisors to close other gaps in facility preparedness.

PAC-FP

Challenge: The rate of PAC-FP uptake rose from 32% at baseline to 40%—a smaller increase than anticipated. With few exceptions, FWVs refrained from updating the template for tracking abortion clients, as abortion clients rarely came to facilities for services. The project observed that the stigma many women face after experiencing a miscarriage or spontaneous abortion often limits their willingness to discuss abortion, even with FWAs in their homes. They are often compelled to prepare for a second pregnancy without considering appropriate spacing following an abortion.

Response: Shukhi Jibon highlighted the importance of sensitive counseling for PPFP and PAC-FP clients in TOTs and subsequent trainings, encouraging FWVs and FWAs to inform pregnant women about PPFP and PAC-FP, abortion and abortion-related problems, and pregnancy spacing in accessible language. FPIs provided similar counseling to men during courtyard meetings.
LESSONS AND RECOMMENDATIONS

Shukhi Jibon’s implementation of PPFP and PAC-FP interventions yielded several valuable lessons.

EFFECTIVELY USING THE BIWEEKLY MEETINGS TO TRACK PREGNANT WOMEN INCREASES PPFP UPTAKE.
In the national FP system, when upazila-level managers do not regularly visit frontline workers, appropriate supervision mechanisms are lacking. The biweekly meetings, supported by Shukhi Jibon, addressed this gap, holding workers accountable to track every pregnant woman to ensure she receives essential care and support. Intervention sites saw an increase in PPFP uptake among women who delivered at home—from 50% at baseline to 83%—illustrating the value of using biweekly meetings to ensure pregnancy tracking and delivery of related services, including PPFP counseling, home-based method distribution, and referrals to facilities.

TASK SHARING IS AN EFFECTIVE SOLUTION TO REDUCE FWA WORKLOAD.
The register FWAs used to update the list of pregnant women was heavy and hard to carry to the field, creating delays in updating the pregnancy registration. Shukhi Jibon encouraged field workers to use charted pages to record pregnancy-related information, which were later combined. FWAs could easily carry these pages, update them as needed, and copy and share them with FPIs, FWVs, and HAs, to track clients during their activities. Another challenge was that, because HAs do not retain pregnant mothers’ records like FWAs do, gaps between HAs’ BCG** uptake list and FWAs’ pregnancy list made it difficult to track pregnant women who left the FWA pregnancy registration, especially in units with FWA vacancies. There is opportunity to create synergies in the field between the FWAs of the DGFP and the HAs of the DGHS. HAs can offer PPFP counseling to those on the FWA list and share information about mothers not on the FWA pregnancy registry.

INFECTION PREVENTION AND CONTROL MECHANISMS HELP CLIENTS MAINTAIN ACCESS TO SERVICES IN PANDEMICS AND EMERGENCIES.
Infection prevention and control trainings were effective in restarting facility-level services and home visits during the pandemic. Local DGFP managers reported that the training inspired service providers to offer services, made them feel comfortable, and assisted clients in receiving services safely.

PROVIDING SUPPORTIVE CARE TO CLIENTS WHO HAVE EXPERIENCED MISCARRIAGE CAN ENCOURAGE PLANNED PREGNANCY.
Literacy among pregnant women and their family members, including their husbands and in-laws, is important for encouraging healthy spacing of future pregnancies after miscarriage. FWAs, FWVs, and local government representatives should engage in social and behavior change (SBC) activities with family and community members that support women who have experienced miscarriage and want to delay their next pregnancy after abortion and MR but are not using FP.

** Bacille Calmette-Guerin, a tuberculosis vaccine

“By no means we don’t want to lose any ANC mothers. This is because the first time she comes to the service center is probably the first time she has had a urine test to see if she has become pregnant and she will be counseled by a visitor or other service provider for PPFP counseling.”

–IDI, Manager

“Prior to the training there was a special demand from all types of service providers that they could not be served without masks & PPE. In the training they learn how they can easily provide services by using their own safety equipment. After the training, the service provider gradually starts providing services. Maintaining a safe distance while providing services, wearing gloves and masks, washing hands frequently, or encouraging clients to wear their own masks or cover their face with other clothes.”

–IDI, Manager

“In counseling, they always say that in case of miscarriage, for any reason and at any time of miscarriage, you must have at least six months spacing so family planning method is used after miscarriage...”

–IDI, Manager
Shukhi Jibon’s PPFP Learning Lab experience demonstrates that when local field workers and their supervisors can strengthen their coordination, information-sharing, and accountability; enhance pregnancy registration; and ensure quality service provision during ANC and PNC; a community-based PPFP program can provide pregnant women—who deliver at home or in facilities—with a continuum of critical care they need. Such an intervention has the potential to reduce FWA burden through task-sharing strategies, in which health field professionals may devote time to exchanging information related to pregnant mothers with FWA and providing PPFP and PAC-FP counseling to clients. Additionally, women who experience miscarriages may benefit from additional care, support, and an enabling atmosphere, so they can make informed decisions about healthy timing and spacing of pregnancies.