

REPORT SUMMARY
SEPTEMBER 2019

ASSESSMENT OF FAMILY PLANNING SERVICE DELIVERY AT SELECTED PUBLIC HEALTH FACILITIES IN BANGLADESH: FOCUSING SPECIFICALLY ON ADOLESCENT REPRODUCTIVE HEALTH SERVICES, PPFP, PAC-FP AND GENDER RESPONSIVENESS

INTRODUCTION

Bangladesh has made remarkable progress in improving the health status of its population. However, in order to reach the government of Bangladesh's goal for universal access to family planning, the public sector service delivery system needs to be strengthened.

In response, USAID launched the Accelerating Universal Access to Family Planning (AUAFP) project, also known as Shukhi Jibon which means 'happy life', in order to increase utilization of family planning (FP) services through universal health coverage in Bangladesh. Pathfinder International, in partnership with IntraHealth International, will implement the project over five years (2018 - 2023).



USAID
আমেরিকার জনগণের পক্ষ থেকে

Shukhi Jibon



Pathfinder
INTERNATIONAL
Sexual and reproductive health
without fear or boundary

In partnership with the Ministry of Health and Family Welfare, this project will provide adaptive, needs-driven technical assistance and systems strengthening at national, divisional, district, and upazila (sub-district) levels.

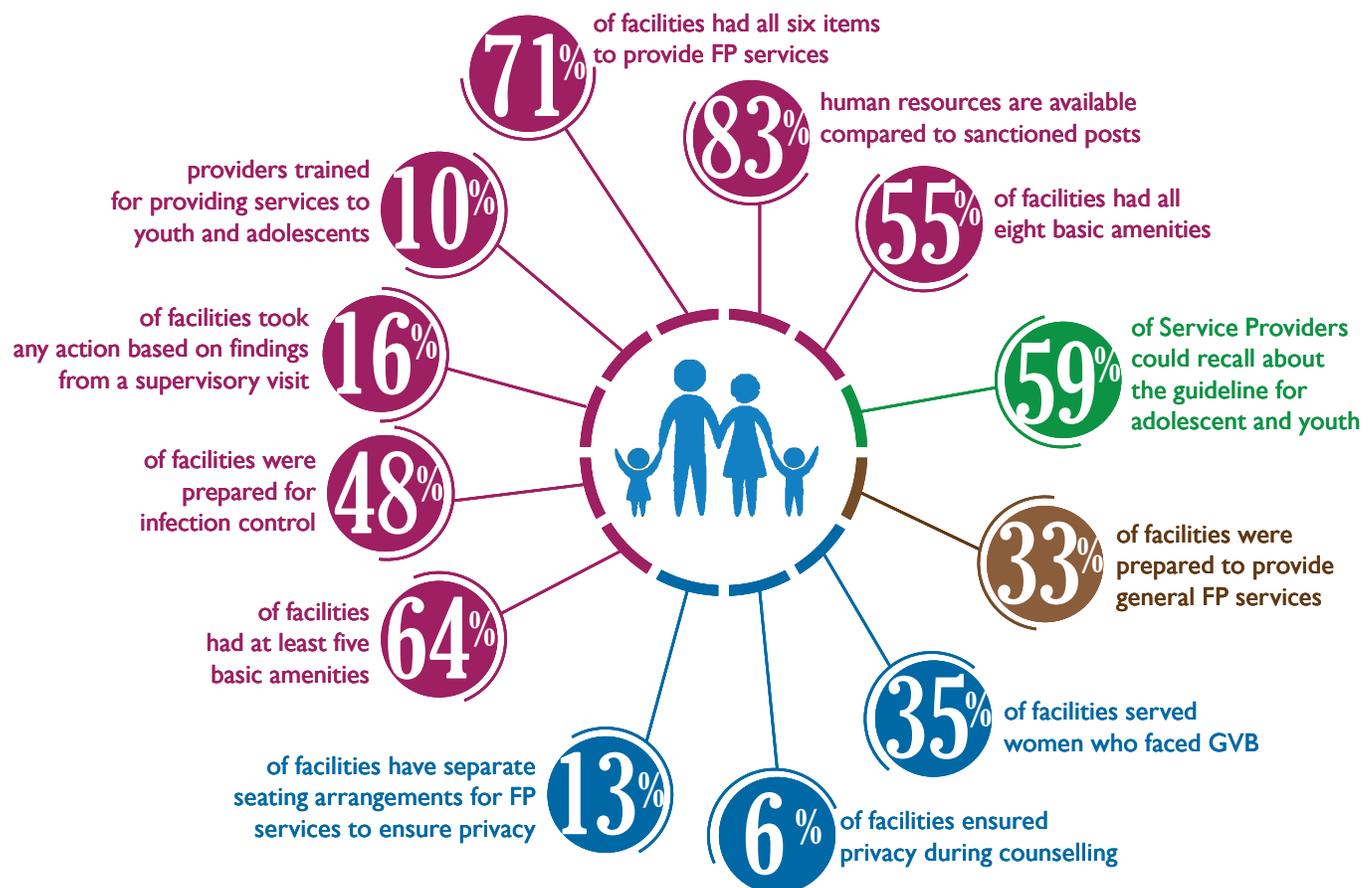
The aim of Shukhi Jibon is to reach those most in need of FP services and information in districts and divisions with lower modern contraceptive prevalence rates and populations facing some of the greatest barriers to accessing FP services.

The Facility Assessment was designed to gather in-depth information on a variety of aspects of the existing health facilities and family planning services in 6 districts of 4 divisions of Bangladesh, that will be covered

by Shukhi Jibon (Chattogram, Dhaka, Mymensingh, and Sylhet). It has also garnered extensive data to understand the existing models of FP service delivery at local health facilities, gap in infrastructure and technology, personnel capacity development requirements, local community perspectives, and managers' and service providers' experience in health and family planning service provision. This assessment provides a baseline to understand how family planning services are delivered in the intervention areas. In addition, the project gathered information from other key assessments, such as the Bangladesh Health Facilities Survey (BHFS), so that the Shukhi Jibon assessment made an important contribution by collecting data not found elsewhere.

HIGHLIGHTS

STAFFING, SUPPLIES, AND GENERAL SERVICE PROVISION



GENDER RESPONSIVENESS OF HEALTH FACILITIES

ADOLESCENT REPRODUCTIVE HEALTH SERVICES

GENERAL FAMILY PLANNING SERVICES & READINESS

OBJECTIVES

The objectives of the assessment covered three broad areas:

Adolescent Reproductive Health Services

- Examine facility infrastructure; provider capacity, responsiveness, and quality of care against recommended standards; availability and provision of FP services and commodities to adolescents; and availability of age and sex disaggregated data
- Identify potential drivers of provider barriers and bias to provide FP services to adolescents
- Identify community-level barriers including biases that limit young people's access to FP that includes the roles potentially played by religious leaders, teachers, elected public representatives, other influential community leaders, social workers, parents and peers
- Understand the degree of integration of FP with other adolescent health services for quality improvement

Post-Partum Family Planning (PPFP) and Post-Abortion Care - Family Planning (PAC-FP)

- Assess the quality of PPFP and PAC-FP services at facilities and examine structural barriers to quality services; availability of contraceptive supplies; logistics; client flow; quality of education and counseling; and follow-up services
- Assess the status of PPFP and PAC-FP service delivery to understand the degree of integration of FP within PP and PAC services and identify opportunities for quality improvement

Gender Responsiveness

- Assess gender responsiveness at facility level
- Examine integration of gender in FP services

METHODOLOGY

The assessment included existing health facilities and family planning services across 69 health facilities in six pilot districts of Bangladesh. A total of six District Hospitals (DH), six Maternal and Child Welfare Centers (MCWC), 30 Upazila Health Complexes (UHC) and 30 Union Health and Family Welfare Centers (UH&FWC) were selected.

To detect variances within the area covered by Shukhi Jibon, purposive sampling was used. The assessment

included facilities that were more easily accessible and had electricity and internet connections. In addition, they had better performance coverage compared to other facilities from the same level and district and they had a facility manager for maintaining service statistics.

Table: Data Collection Methods and Sample

Assessment areas	Assessment procedure	Type of respondents	Sample size
Service provisions, Facility readiness, Staff training, Infection prevention status, Gender responsiveness, Supervision and reporting status	Observation and interview followed by structured questionnaire	MOMCH-FP, MO Clinic, FWV, SACMO	69
Facility Management, Staff Capacity, Gender Responsiveness, Supervision System, and Scope and Challenges for FP service provisions	Key informant interview (KII)	Managers: DDFP, ADCC, FPCST-QIT, UH&FPO, UFPO	17
		Service providers: MOMCH-FP, MOCC, MO Clinic, FWV	31
Gender perceptions, Adolescent health, Community engagement and SBCC	Focus group discussion (FGD)	Female Adolescents	6
		Male Adolescents	6
		Opinion leaders	6

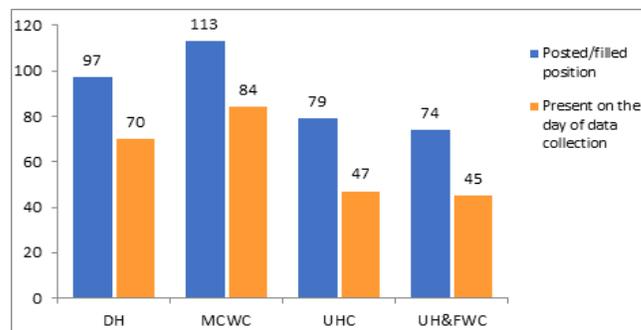
FINIDINGS

POS-TPARTUM AND POST-ABORTION CARE AND SERVICES

Human Resources

Approximately 83% of sanctioned positions are filled due to shortages in human resource availability. The HR availability problem was less severe in urban facilities than in rural settings. Surveyed District Hospitals (DH) and Mother and Child Welfare Centers (MCWCs) had a greater proportion of service providers available relative to sanctioned posts, while Upazila Health Complexes (UHCs) and Union Health and Family Welfare Centers (UH&FWCs) lacked adequate numbers of service providers. Absence of service providers at UHCs and UH&FWCs on the day of the survey was estimated as 53% and 55%, respectively.

Availability of human resources and presence on survey (%)



Training

Across all facilities, Family Welfare Volunteers (FWVs) and Assistant Family Welfare Officer (AFWOs) reported having received the greatest number of trainings (87) in the previous two years, followed by Medical Officers (MOs) [Maternal and Child Health - Family Planning (MCH-FP)] and Upazila Family Planning Officers (UFPOs) and AUFPOs, while Obstetrician-Gynecologists (OB/GYNs) and Residential Medical Officers (RMOs) received the least number of trainings. The most commonly reported training topic involved PFP, followed by Intra-Uterine Device (IUD) service provision, and counseling. The least common training subject reported was gender, followed by PAC-FP. Among all reported trainings, 80% were completed by health cadres in UHCs and UH&FWCs, compared to 20% completed by health cadres in tertiary level facilities (MCWCs and DHs). Most of the trainings were relevant to FP service provision. The number of trainings relevant to thematic issues (e.g., gender, adolescent/Youth) and supervision are very low.

In qualitative interviews, health facility managers observed that adequate trainings were essential to ensure service providers had the necessary knowledge and skills to provide quality FP services, including long-acting reversible contraceptives (LARCs). Service providers who took part in interviews (MOMCH-FPs and FWVs) noted they needed trainings on PFP and PAC-FP. The service providers said that since such trainings would include technical trainings on LARCs, including implants and IUD insertion, these trainings would eventually help them to promote and thereby increase the use of LARCs within the community.

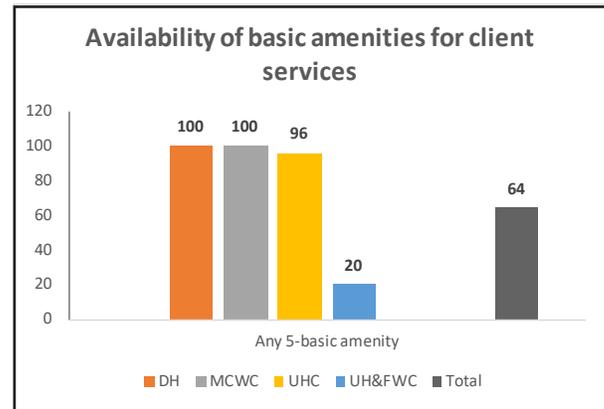
The National Institute of Population Research and Training (NIPORT) organizes basic training for managers, FWVs and FWAs. There is not established timeline for these trainings. As per demand, the Director General of Family Planning (DGFP) asks NIPORT to organize the trainings according to their given schedule.

We are not consulted about the timing of training or the selection of participants. Once trainings are scheduled, we have no choice but to agree to let providers at their facilities attend these trainings as per given schedule.

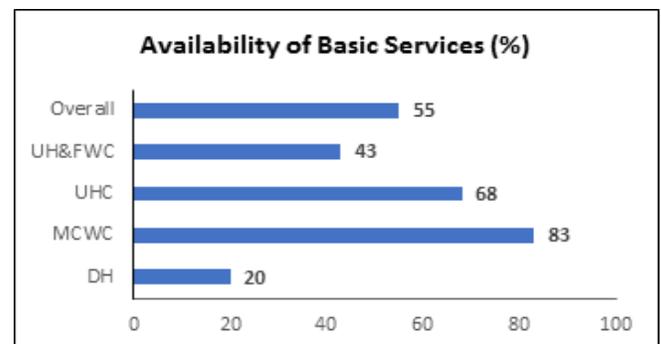
- One of the Managers

Basic Amenities and Services

The availability of at least 5 basic amenities for providing health services was found to be most common in MCWCs, followed by UHCs and DHs. The assessment of basic services included: 1) provision of any modern FP



method, 2) MCH services, 3) ANC services, 4) normal delivery services, 5) PNC services, 6) adolescent health services 7) PAC-FP services and 8) Post-MR services. Modern FP methods, MCH services, and ANC services are available in all facilities. PNC services and Adolescent Health services were available in many of the facilities. PAC-FP is the least commonly available service. All eight basic client services are offered in only 55% of the facilities.



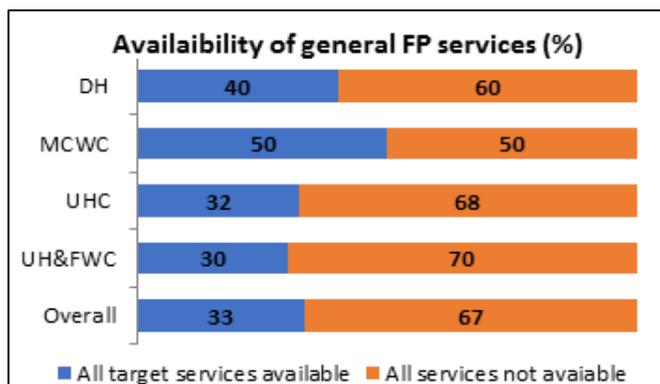
Family Planning and Other Reproductive Services

The assessment asked whether the following categories of FP services were provided at the given facility: 1) Adolescent and Youth Health Services, 2) Counseling for Family Planning, 3) Post Abortion Care-Family Planning, 4) Post-partum Family Planning, 5) Management of Gender Based Violence (GBV), 6) Family Planning Services, 7) Reproductive Tract Infection (RTI)/ Sexually Transmitted Infection (STI) Management, and 8) Maternal and Child Health Services.

The assessment found that all eight FP/RH services were most often available in MCWCs, though this was still only the case in half of the MCWCs surveyed. Among the categories specified in the assessment, management of GBV was the least available service category. Most of the service providers reported they were unaware of what

services were appropriate for the management of GBV. Counseling services on family planning as well as ANC and PNC services were reported to be available in all surveyed facilities. Services for Normal Vaginal Deliveries (NVDs) were reported to be available in 70% of UH&FWCs. Further inspection revealed that these facilities provide services for NVDs but lacked service providers to provide these services 24 hours a day, seven days a week.

According to the facility managers who took part in KIIs, youth and adolescents could access the facilities easily. However, they noted unmarried adolescents are restricted from receiving any FP methods, as the government considers only married individuals to be eligible to receive such services. KIIs with managers and service providers revealed that the majority of them were not willing to say that unmarried adolescents might need FP methods.



Those who are unmarried they are taking the service from the pharmacy but being a government employee, we have to register couples; we cannot serve the unmarried

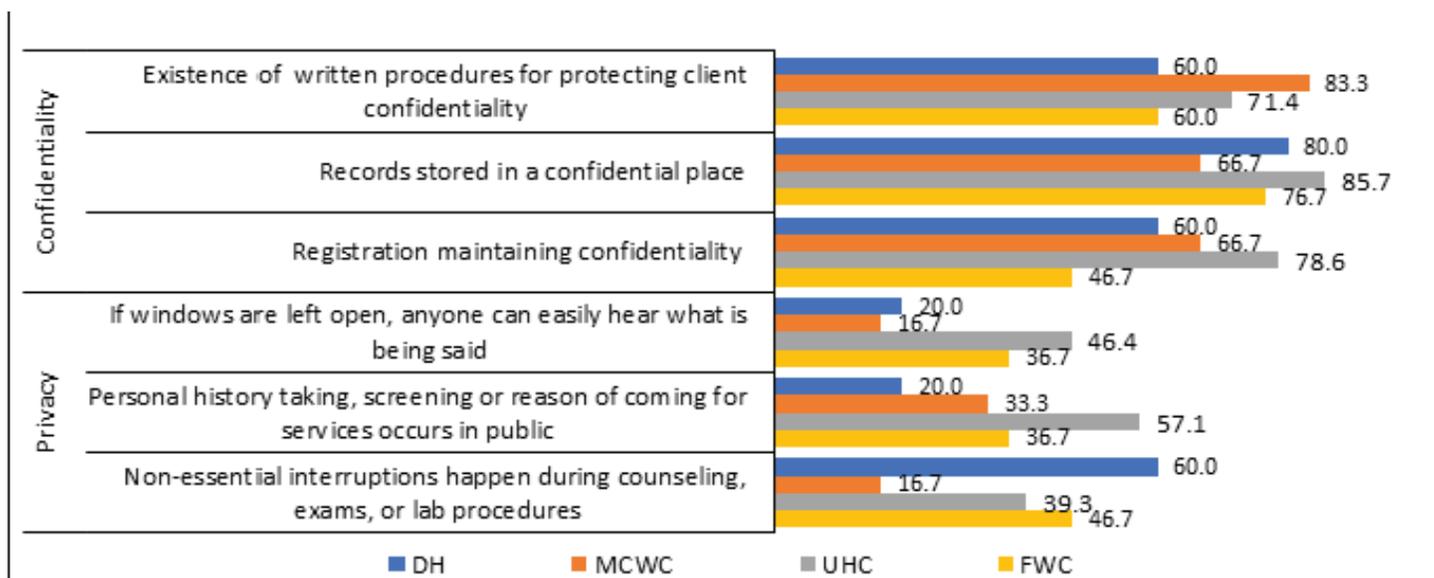
- One of the FWVs

ADOLESCENT REPRODUCTIVE HEALTH SERVICES

Key concerns relating to providing health services to adolescents and youth, particularly in the case of services perceived as sensitive, like FP and RH, are ensuring their confidentiality and privacy. The assessment identified a lack of visual and

Regarding FP services for adolescents and youth, the majority of adolescents who participated in FGDs said that while these services are readily available through FWAs and at UH&FWCs, it is mainly married women who use these services. Unmarried adolescent boys and girls noted that they hardly ever used FP services themselves, and most said they felt these services were appropriate for married women.

The FGDs with unmarried adolescents revealed that the hours during which services were available at health facilities—from 8:30 AM to 2:30 PM, overlapped with



auditory privacy for clients, whether adults or young people, across most of the facilities visited. However, observation revealed providers did a better job of maintaining confidentiality of clients during registration and recordkeeping.

school hours and were among the major hindrances to service uptake by young adolescents.

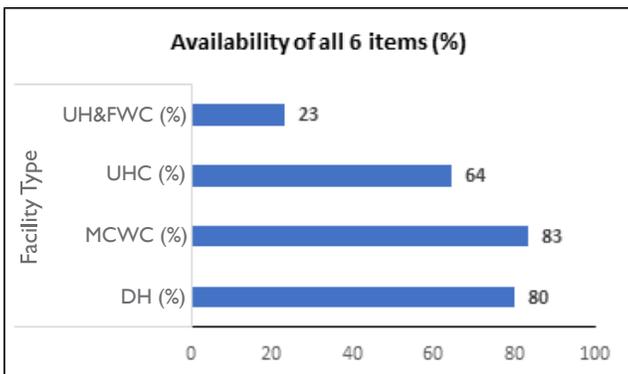
When asked about Adolescent and Youth Friendly Services (AYFS) opinion leaders who took part in FGDs suggested that FP should be included as a separate subject in the academic syllabi of schools and madrasas

so that adolescents would be more aware and less hesitant to take advantage of such services in the future.

More than half (52%) of the service providers surveyed were not aware of guidelines for serving adolescents and youth. Also, 55% of service providers believed there was a minimum age to provide contraceptive or PAC services; this is a misconception, as the guidelines only mention marital status. In addition, 87% of the service providers recalled the necessity of spousal consent for FP. Observation showed the service delivery guideline was found to be almost uniformly available across health facilities (99%), and 81% of providers reported that the guidelines are followed the majority of the time. While the service delivery guidelines (FP manual) includes specific instructions for providing services to adolescents and youth, only 59% of service providers could recall anything about the instructions.

QUALITY IMPROVEMENT AND SUPERVISION Infection Prevention

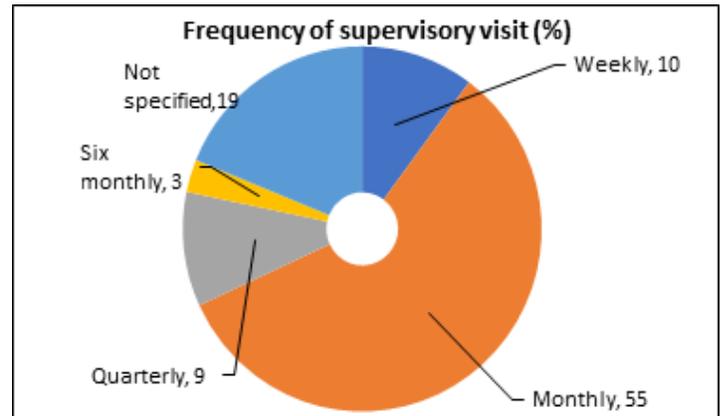
The availability of six items (soap, running water, alcohol based hand disinfectant, latex gloves, sharps container waste receptacle) were observed to assess whether the facilities met a minimum threshold to ensure effective infection control. Only 64% of UHCs and 23% UH&FWC possess all six items for infection prevention. Though 77% of UH&FWCs surveyed had an improved water source, only 57% had running water. The assessment also identified limited availability of alcohol-based hand disinfectant.



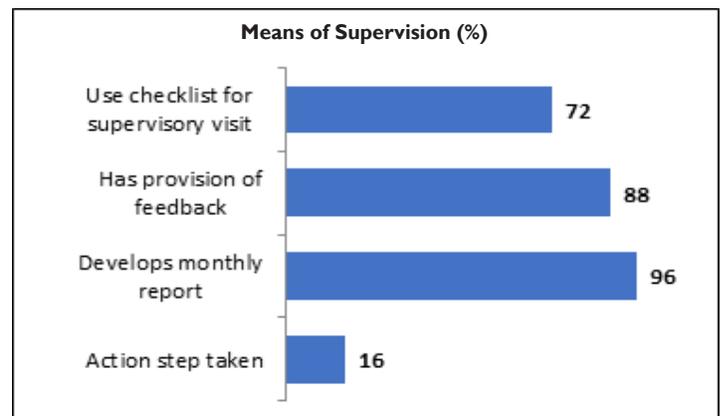
Supervision

The assessment found that half of the facilities reported receiving supervisory visits on a monthly basis (55%). Only about one-fourth (26%) of the facilities reported that a checklist was used during

supervisory visits, a tool meant to ensure verification of key criteria during visits. Participants in KIs suggested that the length of the supervisory checklist might discourage supervisors from using them regularly/appropriately. The assessment found that in 95% of the facilities, an action plan was developed. The definition of 'action plan' is simply the assignment of targets/activities to service providers for the following month, without suggestions or instructions on how to complete the activities.



Furthermore, written feedback was provided to 88.4% of surveyed facilities. This written feedback was in the form of a written report in the visitor's book kept at the facility. KIs also revealed that in most instances, the writing in the visitor's book did not include suggestion about facility improvement. In addition, service providers noted that verbal feedback was often forgotten, because follow-up visits usually did not take place.



Most managers who took part in KIs stated that they found supervision useful for service providers, even essential, as they felt that supervision brought discipline to work and that provision of constructive feedback often resulted in improved performance among their subordinates. Quite a few managers said that they developed a supervisory action plan on a monthly basis and shared it centrally. Some had introduced their own supervisory checklist, as well. However, the assessment found no regular practice of giving

feedback to subordinates. Service providers who took part in KIIs viewed supervision positively and said that they found concrete feedback from their supervisors helpful to improving their performance.

GENDER RESPONSIVENESS

The managers from most of the facilities (46 out of 69) surveyed were women; this was also true for overall management staff. However, men accounted for the greater proportion of technical/clinical staff.

In addition, in most of the facilities (57 out of 69), staff reported that female clients had disclosed abuse or violence to providers, and some of the facilities (24 out of 69) reported that they provided some services to respond to GBV. A larger proportion of DHs and MCWCs reported providing such services compared with UHCs and UH&FWCs.

According to managers, women clients generally do not face security problems or difficulties to avail FP services at the surveyed facilities. Nevertheless, seven out of 69 facilities stated some clients do face such challenges.

All managers and service providers interviewed emphasized that FP-related service is open to all, irrespective of gender. However, they said that male participation in FP was typically limited, since most men believe that FP is a topic that is relevant only to women. According to managers and service providers, male clients remain busy with work during the service hours and have little interest in taking part in

Even male clients don't come to collect condom[s] for themselves. Since all our providers are female, they don't feel comfortable.

- One of the UFPOs

discussions about FP, or seeking or taking up any relevant services. These KII participants added that men's lack of participation in FP discussions and services might also be attributed to the fact that community-level service providers, particularly FWVs and FWAs, are women, and men do not necessarily feel comfortable discussing intimate matters with women. Managers went on to say that service providers hardly ever reach out to potential male clients and that there is limited awareness-raising targeted towards men about the importance of FP and available methods.

THE WAY FORWARD

Advocacy: Advocacy efforts should be extended towards addressing the human resources shortage, which is one of the major challenges at present. Advocacy should also

address poor provider attendance as well as limited male participation in FP services.

Adolescent services: Whole-site orientation on AYFS is required to ensure a conducive environment for these services at the facility level, especially FP services to adolescent newlyweds and first-time parents. Improved provider interaction with adolescent clients is key to attracting adolescents to facilities. In addition, attention needs to be given to engaging communities so that gatekeepers as well as adolescents are supportive of AYFS and help reduce barriers to accessing services from health facilities.

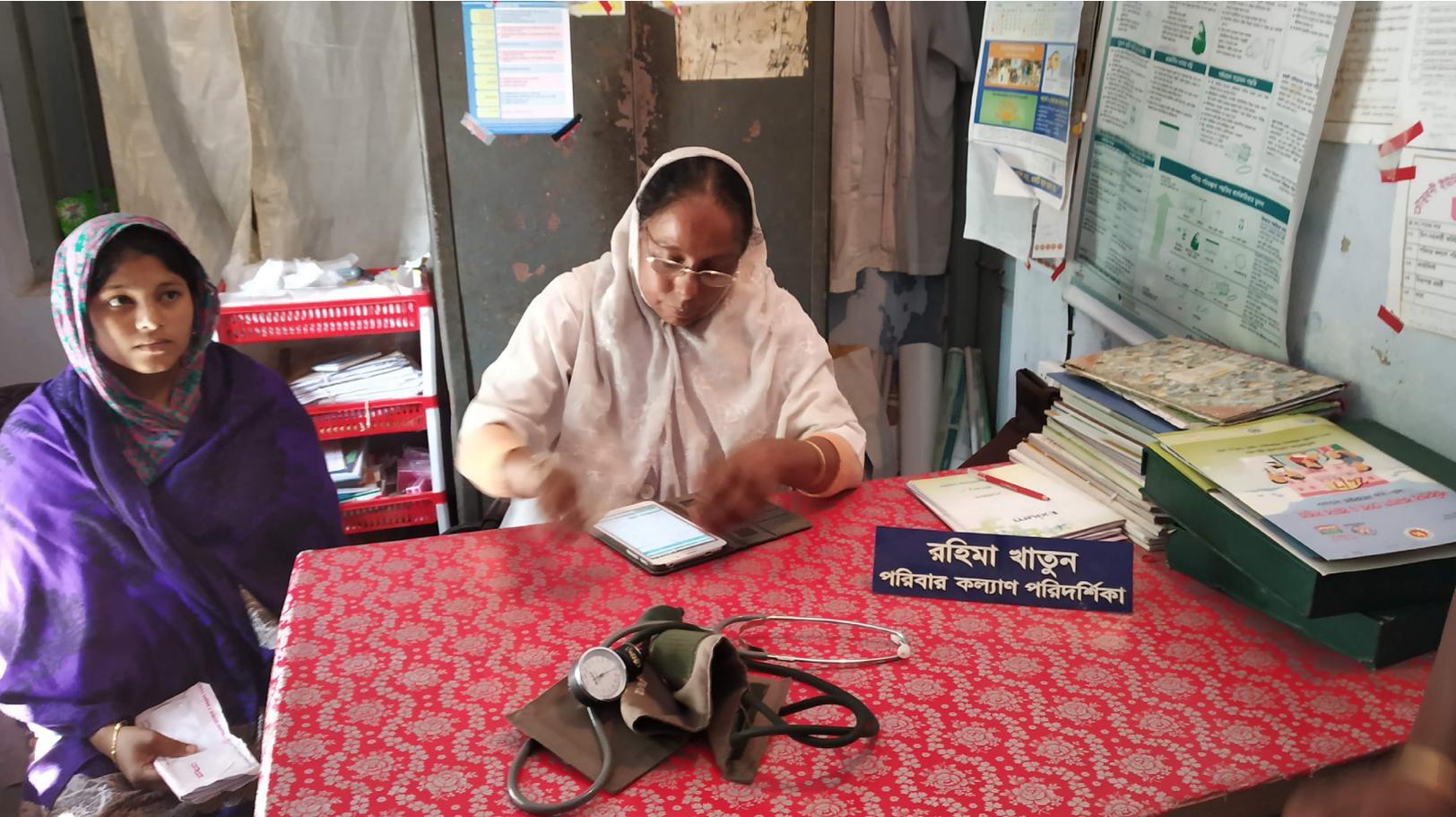
Manager's capacity: Clinical manager capacity to provide effective supervision should be improved so that they, in turn, can ensure improved delivery of high-quality services. Managers also need to be well equipped to use data for decision making.

Facility readiness: Structural readiness to provide quality FP services should be one of the priority areas for implementation of a sector plan. Coordination between DGFP and DGHS will be needed to improve the situation.

Gender integrated services: Screening, counseling, and service provision should be friendly for all genders, which requires supportive environments at health facilities and trained providers who are gender sensitive.

LIMITATIONS OF THE ASSESSMENT

Training information of service providers was collected for the previous two years only, considering possible recall bias. The selection strategy of facilities was purposive and may not provide a generalized picture of where performance or access is poorer compared to the selected facilities. The overall sample size of surveyed facilities is large enough to provide credible estimates in percentages. However, the sample size of tertiary level facilities is very low, which limits the ability to provide credible estimates regarding these specific types of facilities. FP method-specific equipment was identified as available and functional based on observation and was limited to counting the set of instruments, which might not reflect the actual situation.



Accelerating Universal Access to Family Planning Project (AUAFP)

Accelerating Universal Access to Family Planning (AUAFP), also known as Shukhi Jibon, is a United States Agency for International Development (USAID)-funded project in Bangladesh, implemented by Pathfinder International in partnership with IntraHealth International, along with strategic support from the Obstetrical and Gynecological Society of Bangladesh, the World Health Organization, and the University of Dhaka. The main objectives of this project are to increase the qualified family planning (FP) workforce and to expand access to quality FP services through a collaborative health system capacity-building partnership with the Government of Bangladesh. Shukhi Jibon works in four geographic divisions (Chattogram, Dhaka, Mymensingh and Sylhet) where key challenges, including inequalities, are overwhelming. According to the Bangladesh Health Facility Survey in 2014, these divisions are lagging in achieving the national targets for mCPR and having clinics with trained FP service providers.

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