ASSESSMENT OF FAMILY PLANNING SERVICE DELIVERY AT SELECTED PUBLIC HEALTH FACILITIES IN BANGLADESH

Focusing Specifically on Adolescent Reproductive Health Services, Services for PPFP, PACFP, Post MR-FP, and Gender Responsiveness

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Shukhi Jibon

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Pathfinder International, in partnership with IntraHealth International, implements Shukhi Jibon (2018–2023), with strategic support from the Obstetrics-Gynecology Society of Bangladesh and the University of Dhaka. The goal of Shukhi Jibon is to contribute to improved health and human capital in Bangladesh by achieving increased use of family planning services.

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Acronyms

AD SYRINGE	Auto Disposable Syringe
ADCC	Assistant Director Clinical Contraceptive
AFWO	Assistant Family Welfare Officer
ANC	Ante natal Care
ARH	Adolescent Reproductive Health
AUAFP	Accelerating Universal Access to Family Planning
AUFPO	Assistant Upazila Family Planning Officer
AYFHS	Adolescent and Youth Friendly Health services
BHFS	Bangladesh Health Facility Survey
BP	Blood Pressure
BRAC	Bangladesh Rural Advancement Committee
CC	Community Clinic
CDCS	Country Development Cooperation Strategy
CHCP	Community health Care Provider
DDFP	Deputy Director of Family Planning
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DGNM	Director General of Nursing and Midwives
DH	District Hospital
DO	Development Objective
ECP	Emergency Contraceptive pill
EPI	Expanded Program of Immunization
FEFO	First Expired, First Out
FGD	Focus Group Discussion
FP	Family Planning
FPCS-QIT	Family Planning Clinical Services-Quality Improvement Team
FPI	Family Planning Inspector
FTP	First time parent
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
GBV	Gender Base Violence
GOB	Government of Bangladesh
HDRC	Human Development Research Centre
HIV-AIDS	Human Immunodeficiency Virus -Acquired Immune Deficiency Syndrome
HLD	High Level Disinfectant
HR	Human Resources
IEC	Information, Education, and Communication
IHE	Institute of Health Economics
INGO	International non-Government Organization
IP	Infection Prevention
IRB	Institutional Review Board
IUD	Intra Uterine Device
KII	Key Informant Interview
LAM	Lactational Amenorrhea Method
LARC	Long Acting Reversible Contraceptives
MA	Medical Assistant
MCH	Maternal and Child Health Services
MCPR	Modern Contraceptive Prevalence Rate
MCWC	Maternal and Child Welfare Centre
MDG	Millenium Development Goals
MGBV	Management of Gender Base Violence
MNCHFP	Maternal Neonatal Child health and Family Planning
MO	(MCH & FP) Medical Officer-Maternal and Child Health & Family Planning
MO CLINIC	Medical Officer-Clinic
MOCC	Medical Officer Clinical Contraceptive
MOH&FW	Ministry of Health and Family Welfare
MOS	Month of Supply
MR	Menstrual Regulation
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
NSV	Non-Scalpel Vasectomy
NVD	Normal Vaginal Delivery
OB/GYN	Obstetrician and Gynaecologist
OGSB	Obstetrics- Gynecology Society of Bangladesh
OCP	Oral Contraceptive pill
OPD	Outpatient Department
OT	Operation Theatre
PAC	Post Abortion Care
PAC-FP	Post Abortion Care Family Planning
PNC	Post Natal Care
POP	Progesterone Only pill
POST MR-FP	Post Menstrual Regulation Family Planning
PP	Postpartum
PPFP	Postpartum Family Planning
PP-IUD	Postpartum Intra Uterine Device
PV	Per Vagina
RH	Reproductive Health
RMO	Resident Medical officer
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SBCC	Social Behavioural Change Communication
SOP	Standard Operating Procedure
SP	Service Provider
SRH	Sexual and Reproductive health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TV	Television
UFPA	Upazila Family Planning Assistant
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

Executive Summary

Bangladesh has made considerable progress in improving the health status of its population, particularly in the last decade. This is evidenced by the progress made in Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (improving maternal health), with marked declines in maternal and child mortality[1]. Yet, Bangladesh's health service delivery has a long way to go in providing optimum services to its citizens. One of the primary concerns for the healthcare service delivery system has been the universal coverage of Family Planning (FP) services. Against this backdrop, USAID has launched the Accelerating Universal Access to FP (AUAFP) project in order to increase utilization of FP services through universal health coverage in Bangladesh. Pathfinder International, in partnership with IntraHealth International, will implement the project over five years. 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 levels. The ultimate aim of the AUAFP project, known as Shukhi Jibon in Bangladesh, is to reach those most in need of FP services and information—districts and divisions with lower modern contraceptive prevalence rates and populations facing some of the greatest barriers to accessing FP.

In this context, this rapid facility assessment was conducted to understand facility readiness for adolescent reproductive health (ARH) services, whether and how PPFP services are offered and by which cadres, the volume of services provided, quality of counseling and when it occurs (e.g., antenatal care, immunization visits), structural barriers to service provision, provider training, commodity availability, and community support dynamics. It was designed to gather in-depth information on mentioned services across 69 health facilities in 6 districts of Bangladesh. IPE Global and Human Development Research Center (HDRC) were commissioned by Pathfinder International to conduct this assessment.

The assessment revealed that the majority of facilities had an inadequate number of staffs present on the day of the survey. There was a lack of training on gender and adolescent and youth friendly health services (AYFHS) in the two years preceding the survey. There is scarcity of privacy and confidentiality in service provision. Basic amenities were available in 64% of facilities while basic client services were available in 55% of facilities. Moreover, only 33% of facilities provided all services relevant to general FP services. Among union health and family welfare centers (UH&FWCs), 70% had the necessary equipment for performing Normal Vaginal Delivery (NVDs). None of the health facilities surveyed reported stock-outs of FP commodities during the last three months. The availability of consent forms for particular FP procedures coincided with the availability of FP services in different facilities. However, infection control equipment and supplies were determined to be poor in 23% of UH&FWCs. A little more than half of the upazila health complexes (UHCs) and union health and family welfare centers (UH&FWCs) were able to show job-aids.

HIGHLIGHTS OF FACILITY ASSESSMENT

Staffing, Supplies, and General Service Provision

83%
of human resources are available compared to sanctioned posts

71%
of facilities had all six items to provide FP services

10%
of service providers trained for providing services to adolescents and youth

48% of facilities were prepared for infection control

16% of facilities took any action based on findings from a supervisory visit

55% of facilities had all eight basic amenities

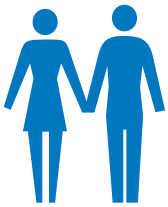
64% of facilities had at least five basic amenities

General Family Planning Services and Readiness

33%

of facilities were prepared to provide general FP services

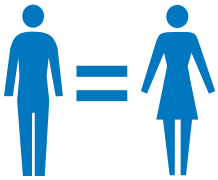
Adolescent Reproductive Health Services



59%

of service providers were aware of the guidelines for adolescents and youth

Gender Responsiveness of Health Facilities



13%

of facilities have separate seating arrangements for FP services to ensure privacy

6% **of facilities ensured privacy during counselling**

35% **of facilities served women who faced GVB**

All surveyed facilities reported having received supervisory visits within six months preceding the survey. Data suggest that there is provision of feedback and debriefing based on the supervisory visit. However, only 16% of the facilities reported taking any action based on the supervisory visits.

Findings from the key informant interviews (KIIs) with health facility managers and service providers suggest that there is an ardent need to provide adequate capacity building, especially on the use and availability of various FP methods and particularly for newly recruited staff. Service providers, in particular, noted that trainings were needed on postpartum FP (PPFP), post-abortion care FP (PAC-FP), and post-menstrual regulation FP (Post MR-FP), which they said would help them to increase the provision of long-acting reversible contraceptives (LARCs). Facility managers also supportd introducing of mentorship along with supportive supervision, though they did not have much prior idea about the concept of mentorship and said they would need training on this issue. Many of the providers said in the audit they do not use the existing long checklist for client screening due to time constraints. All of the managers and providers interviewed acknowledged the importance of adolescent health with a special focus on sexual and reproductive health, some providers recommended that hiring a separate counselor to attend to adolescents would be beneficial. Some also emphasized the need to appoint both male and female counselors to manage gender-specific issues better during FP counseling.

Focus Group Discussion (FGDs) with adolescents revealed that services related to FP are still limited to married women. Most male adolescents, both married and unmarried, are not currently inclined to seek FP services. One of the underlying reasons is the lack of awareness about the importance and availability of FP services for men. At the same time, several male respondents cited that male involvement in FP services is still low due to less effort to reach men by health workers, particularly family welfare assistants (FWAs), who are mainly women. They opined that if a male family welfare visitor (FWV) were appointed, male clients would likely feel more comfortable approaching him for FP services. Unmarried girls mentioned during FGDs that they do seek services from FWVs for abdominal pain, white discharge, menstrual health, nutritional recommendations, physical and mental health issues etc. Social stigma and fear of losing confidentiality often prevent unmarried adolescents to seek out FP services, as stated by the adolescents themselves during the group discussions. At the same time, most young unmarried adolescent girls had strong opinions that family planning services were not relevant for them and therefore they were hesitant to even discuss this matter.

At the time of this survey, the service delivery period was from 8:30 AM to 2:30 PM, which overlaps with school hours. This has been cited by adolescent participants of FGDs as one of the major hindrances to service uptake by young adolescents. Managers participating in KII mentioned that although the timing has been revised recently, this information is yet to be implemented at the field level.

Opinion leaders suggested that FP should be included in the standard academic syllabus in schools and madrasas so that adolescents will be more aware and less hesitant to make use of such services in the future.

Among the report's key recommendations are that a concerted and coordinated effort from the Government of Bangladesh (GOB) and other relevant sectors is essential in addressing the personnel shortages and staff capacity issues, which are two of the major challenges at health facilities at present. In particular, there is a strong need to strengthen FP-related counseling services at health facilities. Finally, there is a crucial need to undertake awareness raising initiatives at a much larger scale in order to increase outreach, reduce social stigma, and eventually improve uptake and utilization of adolescent-friendly FP services.

A. Background and Objectives

The Accelerating Universal Access to Family Planning Project

The Accelerating Universal Access to Family Planning (AUAFP) project is funded by United States Agency for International Development (USAID) under a Cooperative Agreement managed by Pathfinder International in partnership with Intra Health International, Inc. AUAFP is working together with the Government of Bangladesh (GOB) to further build upon the responsiveness of the health care system and contribute to improved health and human capital in Bangladesh by increasing the use of family planning (FP) services through universal health coverage.

The AUAFP project supports the strengthening and expansion of access to quality FP services through a collaborative health system capacity-building partnership with the GOB. The project uses a flexible implementation model led in partnership with the Ministry of Health and Family Welfare (MOH&FW), including the National Institute of Population Research and Training (NIPORT), the Directorate General of Family Planning (DGFP), and the Directorate General of Health Services (DGHS). Implementation is led by Pathfinder International and includes partner Intra Health and resource partners such as the Obstetrics- Gynecology Society of Bangladesh (OGSB), World Health Organization (WHO) and University of Dhaka.

The AUAFP project will operate in the divisions of Dhaka, Mymensingh, Sylhet, and Chattogram through a phased approach, beginning with six pilot districts, providing adaptive, needs-driven technical assistance (TA) and systems strengthening, and it will expand to all districts during the fourth and fifth project years. The project will reach individuals and communities most in need of quality FP services and information through innovative approaches tailored to reach areas with lower modern contraceptive prevalence rates (mCPR) and populations facing the greatest access barriers, such as unmarried adolescents, newlyweds, first-time parents (FTPs), and postpartum (PP), post-abortion care (PAC), and post-menstrual regulation (MR) clients.

AUAFP link to USAID/Bangladesh's Country Development Cooperation Strategy (CDCS)

AUAFP is designed to support the GOB's vision of becoming a middle-income country by 2021 while focusing on improving the lives of the poor, as indicated in the GOB's goal statement: "Bangladesh, a knowledge-based, healthy, food secure and climate resilient middle-income democracy."[2] In support of this GOB vision, USAID/Bangladesh developed the CDCS (2011–2016) with four development objectives (DOs) in its results framework: (DO1) citizen confidence in governance institutions increased, (DO2) food security improved, (DO3) health status improved, and (DO4) responsiveness to climate change improved.

AUAFP Objectives and Intended Results

The overall objective of the AUAFP project is to increase utilization of FP services through universal health coverage that will contribute to USAID/Bangladesh's CDCS goals and specifically DO3: health status improved.

To achieve its objective, the project will serve individuals and communities most in need of quality FP services and information—districts and divisions with lower FP use and populations facing the greatest access barriers, such as unmarried adolescents, newlyweds, FTPs, and PP, PAC, and post-MR clients.

Some pertinent information identified as part of the study focus areas in the literature review. The purpose of the literature review is to identify published evidence related to assessment, particularly where it relates to family planning, adolescent and youth reproductive health and services in government health facilities, responsiveness of the providers, and facility readiness for ensuring those services. This literature review followed standard methods that retrieved literature from different sources published between 2010 and 2019 in English language e.g., the most recent Bangladesh Health Facility Survey (BHFS) conducted in 2014. The sources of data for this review included: use of data (routine and service specific), service-based evaluations (visits and interviews with staff and patients), questionnaires (surveys, staff and patient questionnaires), and case reviews (medical record reviews and second opinions).

The BHFS 2014 assessed the general preparedness of health facilities to offer quality health services including FP, adolescent health services, PPFP, PAC-FP etc. along with general health services. According to WHO 2013 criteria the BHFS assessed basic amenities for client services, basic equipment to support quality health services, standard precaution for infection control in service delivery areas, capacity for adherence to standards for quality sterilization, diagnostic capacity, and availability of essential medicine. In BHFS 2014, only 10% of facilities had all six basic amenities, 45% of facilities had regular electricity, 50% maintained privacy during consultations, 33% had communication equipment, and 91% had an improved water

source. Only one out of ten facilities had the full range of amenities for clients' satisfaction. Union level health facilities were the least likely to have the full range of amenities.

In terms of FP services, the BHFS found that one in eight facilities prescribe, or counsel clients about at least one modern FP method. Three-quarters of facilities provide at least two temporary modern FP methods, and one-quarter of facilities provide at least four temporary modern FP methods. More than one-fourth (28%) of facilities in Bangladesh provide at least one type of long acting and permanent FP method to clients. Male or female sterilization services are provided in 5% of all facilities. FP services are less likely to be available at district hospitals, union sub-centers, and rural dispensaries. Over half of facilities (54%) that offer FP services have FP guidelines available at the service site. Only one in four of facilities that offer FP services is ready to provide FP services, i.e., the facility is equipped with FP guidelines, at least one trained staff, a blood pressure apparatus, and three modern contraceptive methods (oral pill, injectables, or condoms). 57% of providers received training on FP methods in any time of their service period whereas only 32% received training in the last 24 months. Some form of visual equipment, like an intra uterine device (IUD) pelvic model was available in 22% facilities.

Infection control in FP service provision was insufficient as only 54% facilities had any hand washing item, running water or soap or Alcohol based hand disinfectant. In addition to that any four items of barriers (cap, eye protector, musk, attire and gloves) were found in 40% facilities.

Only 6.5% of facilities received PAC FP service-related training in the last 24 months. More than two-fifths of providers had received in-service training service on post-partum FP, although only 15% of providers had received in-service training in post-partum FP during the 24 months before the survey. Nearly three in ten FP providers received recent in-service training and supervision. Almost all facilities (97%) have routine staff supervision but 73% received training on it according to BHFS 2014.

The Assessment Objectives

IPE Global under took this assessment in selected locations within the AUAFP project area (detailed in the methodology section) in consultation with Pathfinder International.

As a part of preparatory activities, the project planned to conduct a rapid facility assessment through a quantitative survey and direct observation along with FGDs and KIIs with different levels of service providers and community groups to understand the status and context of FP service provision at health facilities. The assessment therefore covered three main components: 1) adolescent reproductive health services; 2) integration of family planning into post-partum, post-abortion care, and post-MR services; and 3) gender responsiveness. In addition to these topics, some general conditions of the facilities were also assessed e.g., infrastructure, human resources (HR), training, ability to provide basic services etc. The following bulleted objectives illustrate the objectives of each of the three major components:

1. ADOLESCENT REPRODUCTIVE HEALTH SERVICES

- To examine facility infrastructure; providers' capacity, responsiveness, and quality of care against recommended standards; the availability and provision of FP services and commodities to adolescents; the availability of age- and sex-disaggregated data; and how data is used for decision-making.
- To identify potential drivers of provider bias against providing FP services to adolescents.
- To identify community-level barriers/biases that limit young peoples' access to FP, including the roles potentially played by religious leaders, teachers, elected public representatives, other influential community leaders, social workers, parents, peers etc.
- To understand the degree of FP integration with other adolescent health services for quality improvement e.g., in counseling services.

2. INTEGRATION OF FAMILY PLANNING INTO POST-PARTUM, POST-ABORTION CARE, AND POST-MR SERVICES

- To assess the quality of PPFP, PAC-FP and Post-MR-FP services at facilities and to examine structural barriers to quality services; the availability of contraceptive supplies; logistics; client flow; quality of education and counselling; and to assess the extent of follow up services
- To assess the status of PPFP, PAC-FP, and post-MR-FP service delivery to understand the degree of integration of FP within PP, PAC, and post-MR services and identify opportunities for quality improvement.

3. GENDER RESPONSIVENESS

- To assess the gender responsiveness of services at health facilities.
- To examine the integration of gender within FP services.

B. Assessment Methodology

Assessment methods

The assessment deployed both quantitative and qualitative methods for data collection. Primary data was collected across multiple sources, including a facility survey, key informant interviews (KII), and focus group discussions (FGD). The quantitative method—the facility survey—involved a structured questionnaire with 13 thematic sections to assess the health facilities through observations (e.g., of stocks of supplies or the state of equipment) as well as through face-to-face interviews with facility managers and service providers regarding staffing, training, operations, and other issues that could not be directly observed. The survey also provided some opportunities for open-ended responses or comments for certain questions.

The assessment not only generated evidence through quantitative data points, but also addressed the 'why' and 'how' questions through semi-structured KIIs and FGDs about the status of facilities, focusing specifically on adolescent health services and family planning services using a gender-responsive lens. FGDs covered married and unmarried adolescent boys and girls (in separate groups), as well as opinion leaders, while KIIs were conducted with service providers, facility managers, and administrative managers.

Assessment tools

The assessment included five different types of tools:

1. Structured facility questionnaire (including direct observation and in-person components)
2. FGD guide for adolescents
3. FGD guide for opinion leaders
4. KII guide for facility managers
5. KII guide for facility service providers

The questionnaire was primarily developed to reflect the latest national FP guidelines known as FP Manual of DGFP (2017) by the Shukhi Jibon project[3], then translated, and modified by the consulting firm after field testing, verification/validation with experts, etc. The tools were finalized in consultation with the tech- nical team of the project. Data collection conducted in April 2019.

Geographical Coverage and Sample Size

The Shukhi Jibon project planned to cover 32 districts across 4 divisions and specified six pilot districts to be covered under the assignment (Dhaka, Chattogram, Rangamati, Mymensigh, Faridpur, and Sylhet). These districts included 65 upazilas which held 59 upazila health complexes (UHCs). In discussion with Pathfinder International, the assignment was to cover at least half of the upazilas with UHCs, which rounded up to 30, covering 5 from each district. The assignment also covered district hospitals (DHs) and maternal and child welfare centers (MCWCs) in the sadar upazilas (sub-district). Each facility was observed following a checklist in conjunction with an interview of one of the service providers or facility managers to collect information on human resources, training, and service provision. Respondents included: Facility Managers of DH, Resident Medical Officer (RMO), Obstetrician/Gynaecologist (OB/GYN) consultant, MCWC- Medical Officer (Clinic), UHC-Medical Officer (MCH-FP), UH&FWC-Family Welfare Visitors (FWVs).

Selection Criteria and Recruitment and Informed Consent Process

The upazila health complexes (UHCs) and union health and family welfare centers (UH&FWC) within the districts were selected according to the following the criteria set by Pathfinder International:

SELECTION CRITERIA FOR UPAZILA HEALTH COMPLEXES (UHCS)

- Convenient transportation from the respective district
- Facilities have availability of electricity and internet connection
- Service statistics are being better maintained compared to other UHCs in the same district
- Presence/posting of upazila Family Planning Officer (UFPO) and/or Medical Officer (MCH-FP) and upazila Family Planning Assistant (UFPA) who maintain service statistics

TABLE 1: GEOGRAPHICAL COVERAGE OF THE ASSESSMENT

DISTRICT	TOTAL # OF UPAZILAS	# OF UPAZILAS SAMPLED	TOTAL # OF DHS	# OF DHS SAMPLED	TOTAL # OF MCWC	SAMPLE MCWC	TOTAL # OF UHCS	SAMPLE UHC	TOTAL # OF UH&FWC	SAMPLE UH&FWC	TOTAL NO. FACILITIES SURVEYED
Dhaka	6	5	1	-	1	1	7	5	64	5	11
Faridpur	9	5	1	1	1	1	9	5	79	5	12
Chattogram	15	5	1	1	1	1	16	5	229	5	12
Rangamati	10	3	1	1	1	1	10	3	45	5	10
Mymensingh	12	4	1	1	1	1	12	5	141	5	12
Sylhet	13	5	1	1	1	1	12	5	98	5	12
Total	**65**	**27**	**6**	**5**	**6**	**6**	**66**	**28**	**656**	**30**	**69**

TABLE 2: SELECTION PROCESS OF RESPONDENTS FOR KII AND FGD

METHODS	TYPE OF RESPONDENTS	SAMPLE SIZE	PROCESS OF SELECTION	CONSENT PROCESS
Key informant interviews (KII)	Managers*: DDFP, ADCC, FPCS-QIT, UH&FPO, UFPO	17	*Managers and service providers were selected randomly from those were posted for at least the last three years in the same district in the same position.*	*Individual written consent was collected*
	Service providers**: MO (MCH-FP), MOCC, MO Clinic, FWV	31		
Focus group discussions (FGD)	Female adolescents	6	*The FWVs or facility managers in each area coordinated with the the data collection team to successfully organizing FGD events. They helped in gathering local adolescent boys, girls and selection of local leaders for conducting FGDs.*	*Data collection teams who conducted the FGDs read the consent form at the beginning of the session and obtained a signature from one of the group members who was selected by the group*
	Male adolescents	6		
	Opinion leaders	6		

* DDFP-Deputy Director of Family Planning, ADCC-Assistant Director for Clinical Contraception, FPCS-QIT- Family Planning Clinical Supervision and Quality Improvement Teams, UH&FPO-Upazila Health & Family Planning Officer, UFPO—Upazila Family Planning Officer

** MO (MCH-FP)-Medical Officer for Maternal Child Health and Family Planning, MOCC-Medical Officer for Clinical Contraception, MO Clinic-Medical Officer Clinic, FWV-Family Welfare Visitor

SELECTION CRITERIA FOR UNION HEALTH & FAMILY WELFARE CENTERS (UH&FWCS)

- Better maintenance UH&FWC within the upazila of the selected UHC
- Presence and posting of FWV in UH&FWC availability of electricity in UH&FWC
- Convenient transportation from the respective UH&FWC to upazila

A total of 69 facilities of both UHCs and UH&FWCs (out of total 72 those were selected for the sample) were successfully visited for the facility assessments.

In addition, 48 KIIs were conducted with managers and healthcare service providers, 12 FGDs with adolescents (6 among boys and 6 among girls), and 6 FGDs with opinion leaders took place, as detailed in table 2. All KIIs were performed by the senior team members of IPE global and HDRC of the assessment team. FGDs were performed by selected data collection team members that had prior experience facilitating FGDs. All qualitative data collectors received an additional two days of training on the tools, probing areas, and facilitation techniques.

TABLE 3: RESULT OF FACILITY CONTACT, KII & FGD BY BACKGROUND CHARACTERISTICS

TYPE OF DATA COLLECTION ACTIVITY AND TARGET PARTICIPANT	TARGET SAMPLE	COMPLETED	DUPLICATION OF POSITION*	RESPONDENT NOT AVAILABLE	REFUSED	% OF TAGET SAMPLE REACHED
Facility type (total)	**72**	**69**	**-**	**2**	**1**	**96%**
DH	6	5	-	0	1	83%
MCWC	6	6	-	0	0	100%
UHC	30	28	-	2	0	93%
UH&FWC	30	30	-	0	0	100%
KIIs (total)		**48**	**10**	**1**	**1**	**80%**
Managers (DDFP, ADCC, FPCS-QIT, UFPO)	23	17	4	1	1	73%
Service Providers (MO, MCH-FP, MOCC, MO Clinic, FWV)	37	31	6	0	0	84%
FGDs (total)	**18**	**18**	**-**	**0**	**0**	**100%**
Female adolescent (married)	3	3	-	0	0	100%
Female adolescent (unmarried)	3	3	-	0	0	100%
Male adolescents (married)	3	3	-	0	0	100%
Male adolescent (unmarried)	3	3	-	0	0	100%
Opinion leaders	6	6	-	0	0	100%

* Additional charges from the adjacent station in absence of regular position.

Ethics Approval

Ethics approval was obtained from the Institutional Review Board of the Institute of Health Economics (IHE), University of Dhaka following appropriate procedures. Based on the initial application for ethical clearance, IHE made specific queries to IPE Global. Upon providing successful clarification to the queries, a certificate was issued in first week of April 2019, allowing the assessment to proceed. The certificate is attached in Annex 3.

Data Collection Timeline and Process

Field Team Structure: The field team was under close supervision of senior team members of HDRC. HDRC had the primary responsibility for collecting quantitative data along with the FGDs with adolescent girls, boys and local leaders, and some of the KIIs. IPE Global conducted the majority of the KIIs. The selected field personnel had previous experience with similar assessments and hold at least one post-secondary degree. The field team was divided into six teams, each containing three field enumerators. Each team was assigned to collect information from one district. Contact information of each team was circulated among HDRC, IPE Global, and Pathfinder officials. Each team was also provided with a field plan. These plans were shared with Pathfinder officials prior to field work. Pathfinder, IPE Global and HDRC also visited different data collection sites for spot-checking during data collection as a quality assurance measure.

Project Orientation: HDRC and IPE Global arranged a four-day long residential orientation at HDRC's training room in Dhaka. Core team members (the team leader and consultants) were present to provide greater insights into project activities, targets, and field level actors. Classroom sessions continued for three days. Following this, a field practice was arranged at a nearby health facility, to make sure the field personnel had sufficient experience collecting data in the field and to address any concerns that came up about the questionnaire design and methodology. The orientation ensured uniform understanding among survey staff members of the questionnaire, as well as the assignment objectives, approach, ethical considerations, and data verification processes.

Timelines: The data collection process started in March 2019 and ended in April including training of data collectors, processing of IRB (mentioned in 'Ethical Approval' section), data collection, and preliminary analysis.

KEY ACTIVITIES	TIMELINES
Develop methodology of facility assessment with tools/ instruments, data management and transcription	**MARCH** Second week
Training plan and materials for training of local staff in data collection	**MARCH** Third week
Received IRB approval	**APRIL** First week
Data collection	**APRIL** First week–third week
Data analysis plan sharing of preliminary presentation of key findings and recommendations	**APRIL** Last week

Quality Control Measures

Supervision and monitoring were deployed in all aspects, from the training of data collectors to data management. These were implemented by IPE global, HDRC, and the Pathfinder International team. IPE Global and HDRC deployed their own supervision system to minimize the error of training and data collection. Each team for data collection was comprised of one supervisor and two data collectors (one male and one female). Supervision and quality control were deployed during training, data collection and data management and analysis to minimize information discrepancy and errors during analysis and reporting.

The team from Pathfinder International attended training sessions for the data collection teams concerning quantitative and qualitative data collection methods. Ten percent of all facilities assessed were visited by the Pathfinder International monitoring and evaluation team during data collection and all data collection forms completed during those visits were revisited to check the validity and reliability of the information on the spot. Supervisors of the HDRC sub-teams looked after the daily collection process to ensure quality of information, after continuously cross-checking with the IPE and HDRC team of Dhaka for any query. In addition, five percent of completed forms were copied by the Pathfinder International team to check the paper copies and were compared against the electronic data entry during the data management period. In terms of the qualitative data collection, a few recordings of KIIs and FGDs were crossed-checked by the Pathfinder International team (those were bilingual) with the transcripts to ensure the accuracy of the simultaneously transcribed and translated of transcripts.

The Pathfinder International team also checked the raw data files after receiving preliminary frequency tables to check the reliability of the analysis. It should be mentioned here that all the checking and verifying of data were limited to those within the research team to maintain confidentiality of the assessment participants according to protocol approved by the IRB.

Data Analysis

Quantitative analysis: The primary unit of analysis of the assessment was the health facilities, with results summarized by districts. Data was analyzed using SPSS. Data analysis included distributions/descriptive statistics (numbers, proportions, and percentages), graphical representations, statistics (mean, median, mode etc.), and cross-tabulations. Data analysis followed analysis methods from multiple readiness assessments including facility assessments of Pathfinder International in other countries and the BHFS 2014.

Qualitative analysis: The qualitative discussions were transcribed. Content analysis was performed manually according to the themes to draw conclusions. The qualitative data analysis followed the steps: (1) Documentation/transcribe; (2) Organization/categorization; (3) Connection between information for validation; (4) Corroboration/legitimization; and (5) Reporting the findings.

TABLE 4: AVAILABILITY OF HUMAN RESOURCES AND THEIR PRESENCE ON SURVEY DATE

FACILITIES	PROVIDERS OF RESPECTIVE FACILITIES	# OF SANCTIONED PROVIDERS POST(S)	# OF PROVIDER(S) POST FILLED	# OF PROVIDERS PRESENT ON SURVEY DATE	% OF SANCTIONED POSTS THAT ARE FILLED BY SERVICE PROVIDER(S)	% OF PROVIDERS PRESENT ON DAY OF SURVEY FROM ALL FILLED POSTS
DH	OB/GYN, Nurse, Midwife, Cleaner	59	57	41	96.6%	71.9%
MCWC	MO-Clinic, MOMCH, FWV, Midwife, Aya	63	71	53	112.7%	74.6%
UHC	RMO, MOMCH-FP, UFPO, AUFPO, FWV	183	144	86	78.7%	59.7%
UH&FWC	MO-FW, SACMO, FWV, FPI, FWA	223	166	101	74.4%	60.8%

Triangulation: Content analysis was performed for making replicable and valid inferences from information to their context, with the purpose of generating new insights, ensuring proper representation of the data, and informing a practical guide for action. The quantitative data analysis and qualitative information were performed separately, and their findings were synthesized.

Limitations of The Assessment

There were some limitations of this assessment like any other survey. Most of the limitations were around implementation of methodology of the assessment. However, there were some limitations around sample selection. The sample estimation might be conservative and underestimated the full length of facility status of the respective divisions. Details are as follows:

- Training information of service providers was collected for the previous two years in consideration of possible recall bias. It might underestimate the status of training received by the providers.
- In 20% of cases, managers or service providers selected for KIIs were responsible for additional duties/roles within the health facility; as a result, fewer KIIs than anticipated were conducted, as multiple posts were filled by a single manager or provider.
- The selection strategy for the health facilities was purposive (explained earlier in this section) and may not provide a generalizable picture of performance or accessibility. Since the facilities were chosen in part because they were closer to urban centers and more accessible. It is possible that the remote facilities not included might have poorer performance or accessibility.
- The overall sample size of surveyed facilities is large enough to provide credible estimates in percentages. However, the sample sizes of tertiary level facilities (district hospital: 5 and MCWC: 6) are too small to provide credible estimates.
- Whether FP method-specific equipment was observed as available and functional was established on the basis of observation and limited to counting the sets of instruments on display but not the functionality. This may not reflect the actual availability of functional status of these supplies.

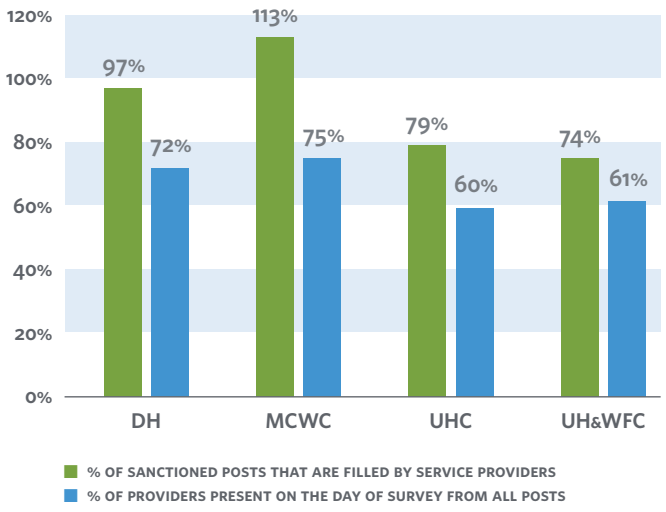
C. Findings

C1. Findings on Staffing, Supplies, and General Service Provision at Health Facilities

C1.1 HUMAN RESOURCES

The facility assessment found serious shortages in human resources (HR) for health. Across the health facilities surveyed for the assessment, 83% of the sanctioned posts were reportedly filled. Just 64% of the providers were present on the day of the survey. The HR availability problem was less severe in facilities in urban settings. Surveyed district hospitals (DHs) and mother and child welfare centers (MCWCs) had a greater proportion of service providers available relative to sanctioned posts than upazila health complexes (UHCs) and union health and family welfare centers (UH&FWCs). The health centers in urban settings were also running with service providers on temporary re-stationed (deputation) from upazila- and union-level health facilities, meaning that these facilities (UHCs and UH&FWCs) lacked adequate numbers of service providers. Absence of filled positions of health service provider is also a key area of concern as the absence of service providers on UHC and UH&FWC on the day of survey was estimated as 40% and 39% respectively.

FIGURE 1: AVAILABILITY OF HUMAN RESOURCES AND THEIR PRESENCE ON SURVEY DATE



C1.2 TRAINING

The training histories of each service facility were ascertained from interviews with the managers and one of the providers of the facility. He/she gave the responses according to the training file kept in the facilities for all providers. In addition, he/she also checked with respective providers if there was any missing/incomplete information found in the file. The facility survey found that the most commonly received training within the two previous years was on supervision, followed by PPFP, IUDs, and FP counseling. Trainings on PPFP, IUDs, and FP counseling had most often been completed by FWVs/AFWOs (Assistant Family Welfare Officers), while training on supervisions had primarily been completed by UFPOs and MO (MCH-FPs).

Across all the facilities surveyed, a total number of 87 FWVs/AFWOs (considered as one category of service providers) received the largest 13 number of trainings, followed by MOs (MCH-FP) and UFPOs/AUFPOs, while OB/GYNs and RMOs receiving the least number of trainings. Among the types of training identified in the survey, the most commonly reported for providers was on PPFP, followed by training on IUDs and counseling. The least commonly reported training completed by providers were on gender, followed by PAC. Among all reported trainings, 80% were received by workers in UHCs and UH&FWCs while workers in tertiary-level facilities received only 20% of all types of the available trainings.

The largest share of the trainings (those were listed in the assessment checklist) that providers reported having received and completed were related to FP service provision. The number of trainings relevant to thematic issues (i.e., gender, services geared towards adolescents/youth) and supervision was very low.

The KIIs with the managers and service providers revealed mixed feelings with regard to training provision. Most managers expressed concern over irregularity and gaps in service provision when service providers, who are already short in number, were sent off to trainings on an ad-hoc basis. While the majority of managers did feel there is a need to provide adequate capacity building to newly-recruited providers, especially on the use and availability of various family planning methods, they did not feel the same was necessary for providers who had already been on the job for some time, as they felt these individuals were already skilled at their jobs. Managers noted that DGFP has a plan to promote the use of LARCs among clients in order to prevent unplanned pregnancies; to implement this, they noted it would be essential to provide adequate trainings to service providers on the associated methods. The service providers who took part in KIIs (MO, MCH-FP, and FWVs) expressed a need to receive trainings on PPFP, PAC-FP, and post-MR-FP. These service providers noted that since trainings on FP methods include technical training on the use of LARCs, including implants and IUDs, such trainings would eventually help them to promote and thereby increase the use of LARCs within the community.

TABLE 5: NUMBER OF TRAININGS REPORTEDLY COMPLETED BY STAFF FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES IN THE PREVIOUS TWO YEARS

	TYPES OF CLINICAL TRAINED PROVIDER								
BACKGROUND CHARACTERISTICS	OB/GYN	RMO	MO (MCH-FP)	MO-CLINIC	FWV/ NURSE/ MIDWIFE/ SR. FWV/ AFWO	SACMO/ MA	UFPO/ AUFPO	FPI	FWA
Training Types									
IUD	0	1	3	0	21	0	0	0	0
PP IUD	0	0	0	1	1	0	0	0	4
PPFP	1	0	1	0	24	0	1	1	0
Implant	0	0	7	0	4	0	1	0	0
Vasectomy	0	0	2	0	2	0	0	0	0
Tubectomy	1	0	0	0	2	0	0	0	0
Short-acting FP method	1	0	1	0	4	0	1	0	0
Counseling-FP	0	0	2	0	10	0	4	1	5
PAC	0	0	1	0	3	0	0	0	0
Infection Prevention	0	1	1	1	6	2	0	0	0
RTIs/STIs	0	0	0	0	3	2	1	0	2
Adolescents & Youth FHS	0	0	2	2	5	3	3	0	2
Gender	0	0	0	0	0	1	0	0	2
Supervision	0	1	5	0	2	0	5	3	0
Total	**3**	**3**	**25**	**4**	**87**	**8**	**16**	**5**	**15**

TABLE 6: AVAILABILITY OF BASIC AMENITIES FOR CLIENT SERVICES

% AND NUMBER OF FACILITIES SURVEYED THAT HAD BASIC AMENITIES AVAILABLE: % (N)	FACILITY TYPES % (N)				
BASIC AMENITIES DH (N=5)	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	TOTAL
Regular electricity	100 (5)	100 (6)	100 (28)	87 (26)	94 (65)
Improved water source	100 (5)	100 (6)	100 (28)	77 (23)	90 (62)
Visual and auditory privacy while counseling	20 (1)	83 (5)	43 (12)	50 (15)	48 (33)
Client latrine	100 (5)	100 (6)	100 (28)	100 (30)	100 (69)
Communication equipment	80 (4)	67 (4)	79 (22)	23 (7)	54 (37)
Computer with internet	40 (2)	33 (2)	64 (18)	0 (0)	32 (22)
Emergency transport	80 (4)	83 (5)	61 (17)	0 (0)	38 (26)
Separate latrine for female clients	100 (5)	100 (6)	100 (28)	0 (0)	57 (39)
Any 5-basic amenities (per BFHS)	100 (5)	100 (6)	96 (27)	20 (6)	64 (44)
No. of facilities	5	6	28	30	69

Managers who took part in the KIIs brought up that basic trainings for managers and for FWAs and FWVs conducted by NIPORT had long been underway. They noted there was no pre-determined timelines for these trainings. As per operations plans, DGFP plans the trainings and asks NIPORT to organize them. When trainings are planned, NIPORT sends participant lists to the relevant facilities to notify them of who will participate. Managers complained that they were not consulted about the timing of trainings or the selection of participants, adding that once trainings were scheduled, they had no choice but to agree to let providers at their facilities attend these trainings according to NIPORT's schedule.

Several managers stressed the importance of addressing counselling skills to motivate the clients during trainings. This recommendation was notable to the assessment team given the managers in the KIIs stressed the fact that existing staff were overburdened with work, leaving them little time for counseling, and that many service providers did not necessarily view counseling as an integral part of service provision. Service providers who took part in the KIIs mentioned that they would sometimes organize group counselling on a specific issue when there was not enough time for one-on-one counseling, as evidenced by feedback from one female provider: ***"Group counselling is provided and there is no separate counsellor."***

Managers also spoke in favor of introducing the practice of mentorship as a supervision mechanism. However, since the concept of mentorship was still very new, managers did not have much to say on this subject other than that they looked forward to receiving the project's planned training on mentorship.

C1.3 BASIC SERVICES

Availability of Basic Amenities

The facilities were assessed for availability of basic amenities following the criteria laid out in the Bangladesh Health Facility Survey (BHFS)[4]. The eight basic amenities are: 1) regular electricity, 2) an improved water source (running water supply), 3) a space that provides visual and auditory privacy for clients during a consultation, 4) a client latrine, 5) communication equipment (phone/mobile), 6) a computer with internet access, 7) emergency transport (ambulance/vehicle to carry patients in emergency), and 8) a separate latrine for female clients.

Electricity, an improved water source, and a client latrine were available in almost all of the facilities surveyed. A separate latrine for female clients was not available in any of the UH&FWCs. The least commonly available amenities in the facilities were a computer with internet access (available in only 32% of the facilities surveyed) and emergency transport (available in 38% of facilities surveyed). Another key amenity that most facilities lacked was a private space used for counseling. With the exception of MCWCs, where the rates were somewhat better, few facilities were able to provide privacy to their clients for counseling (48% of surveyed facilities overall). Among the types of facilities surveyed, the overall availability of at least five` basic amenities is highest in MCWCs, and DHs followed by UHCs.

FIGURE 2: ANY 5-BASIC AMENITIES (PER BFHS)

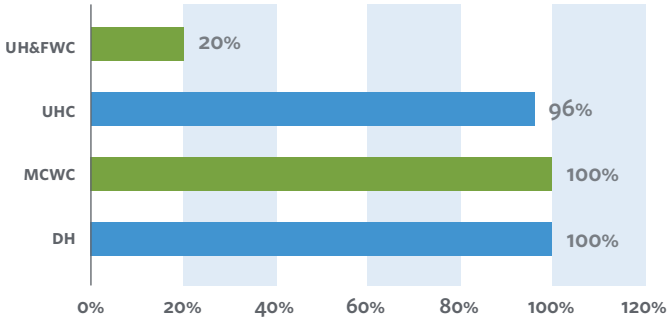


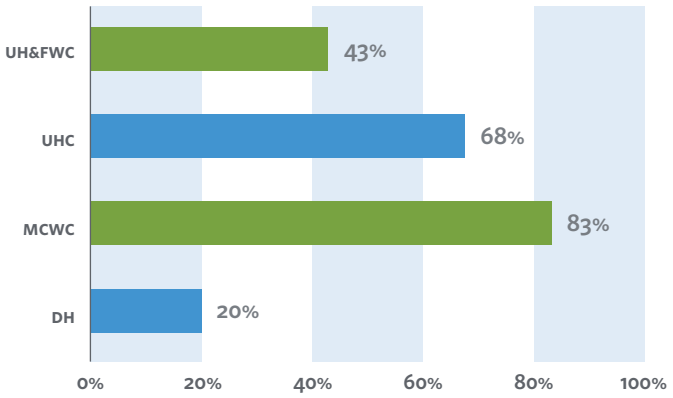
TABLE 7: AVAILABILITY OF BASIC CLIENT SERVICES

NUMBER AND PERCENTAGE OF FACILITIES SURVEYED THAT HAD BASIC CLIENT SERVICES AVAILABLE: % (N)	FACILITY TYPES % (N)				
BASIC CLIENT SERVICES	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	TOTAL
Any modern FP methods	100% (5)	100% (6)	100 (28)	100 (30)	100 (69)
MCH services	100 (5)	100 (6)	100 (28)	100 (30)	100 (69)
ANC	100 (5)	100 (6)	100 (28)	100 (30)	100 (69)
Normal Delivery	80 (4)	100 (6)	100 (28)	70 (21)	86 (59)
PNC	80 (4)	100 (6)	100 (28)	100 (30)	97 (68)
Adolescent Health	100 (5)	100 (6)	93 (26)	93 (28)	94 (65)
PAC-FP	80 (4)	100 (6)	75 (21)	63 (19)	73 (50)
Post MR-FP	40 (2)	83 (5)	89 (25)	80 (24)	81 (56)
All basic client services	20 (1)	83 (5)	68 (19)	43 (13)	55 (38)
No. of facilities	**5**	**6**	**28**	**30**	**69**

Availability of basic client services

In addition to basic amenities, the assessment examined whether the eight basic client services were available. Basic services Include the following eight services were offered: 1) providing any modern FP methods, 2) MCH services, 3) ante natal care (ANC) services, 4) normal vaginal delivery (NVD) services, 5) post-natal care (PNC) services, 6) adolescent health services, 7) PAC-FP services, and 8) Post-MR services. The survey found that modern FP methods, MCH services, and ANC services were available in all facilities. PNC services and adolescent health services were also commonly available. FP services within the context of post-abortion care was the least commonly available basic client service. All eight basic client services were available in only 55% of the facilities. Due to unavailability of services like post MR and NVD (in Sylhet district hospital) and calculated within only 5 DHs, the proportion of NVD, PNC, PAC-FP and Post MR-FP has gone down . And for the UH&FWC NVD, PAC FP and Post MR services are not available due to poor readiness.

FIGURE 3: ALL BASIC CLIENT SERVICES



C1.4 READINESS FOR INFECTION PREVENTION

The readiness for infection control was assessed following the criteria defined in BHFS 2014. The availability of six items was inspected to assess whether the facilities met a minimum threshold for readiness to ensure effective infection control. Four out of five DHs and five out of six MCWCs had all six items for infection prevention. However, only 64% of UHCs and 23% of UH&FWCs possess all six items for infection prevention. Though 77% of UH&FWCs surveyed had an improved water source, only 57% had running water. There is also lack of availability of alcohol-based hand disinfectant, probably because the authorities recently discontinued stocking it. Infection control is an integral part of quality service delivery. Accordingly, readiness of facilities for infection control is a priority. Hence, UHCs and UH&FWCs require special attention to improve their readiness.

TABLE 8: READINESS FOR INFECTION CONTROL (%)

	FACILITY TYPES % (N)			
ITEMS FOR INFECTION CONTROL	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)
Soap	80	100	100.0	93.3
Running water	80	100.0	92.9	56.7
Alcohol based hand disinfectant	80	83.3	92.9	56.7
Latex gloves	80	100.0	82.1	73.3
Sharps container	80	100.0	96.4	73.3
Waste receptacle	80	100.0	96.4	80.0
All 6 items available	**80**	**83.3**	**64.3**	**23.3**

TABLE 9: PRESENT STATUS OF INFECTION PREVENTION SERVICES (%)

ITEMS FOR INFECTION PREVENTION	FACILITY TYPES % (N)			
	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)
Decontamination	80	100	100	90
Cleaning of Instruments	60	67	46	23
High Level Disinfection (HLD) or Sterilization	40	67	29	7
Boiling	40	67	43	17
Autoclaving	60	83	46	7
Hand Washing	80	100	100	77
Barriers	80	100	93	83
Storage and Disposal	20	33	11	0
Handling Specimens and instruments	80	100	89	80

C1.5 SBCC MATERIALS

The majority of the surveyed facilities were found to be equipped with various types of posters regarding FP methods to be used as job aids and for information communication and promotional activities. Overall, hanging banners were less common than posters. Posters were more commonly seen in UHCs comparing to other types of facilities. Banners were more common in UH&FWCs. Despite the availability, the placement of the banner was not always convenient for the purpose. The UHCs and UH&FWCs have limited space to accommodate all sorts of banners and posters that have been provided by different agencies and there was overlap sometimes. Banners and posters should be place more intentionally according to the topic and intended purpose to optimize their visibility.

Similar concerns were raised during the focus group discussions with the adolescents. None of the adolescent respondents had come across communication materials (such as pamphlets) at health facilities to bring back home. Some have noticed a few posters on FP practices on the walls inside and outside the health facilities. However, they could not describe much about the content of these posters. None of the adolescents participating in the FGDs could recall any piece of information from any of the SBCC materials they were exposed to. Although they alleged that they are aware of digital devices and social media, none of them were familiar with the use of electronic devices, mobile apps, or digital media for family planning related information and services. None of them knew about the existence of a dedicated health line. Despite the implementation of several SBCC approaches, the failure of reaching this key population needs further investigation to devise a more effective SBCC strategy to motivate adolescents to reach out to providers for information and services, to foster a culture of inclusive family planning decision making discussions among family members and do so in a gender responsive manner.

About one third of the facilities kept booklets/leaflets in easily accessible and visible places. There was greater availability in UHCs and less in UH&FWCs. However, less than twenty percent of the facilities allowed clients/visitors to collect them. There was a significant amount of SBCC material displayed for long acting methods, followed by permanent methods such as tubectomy and non-scalpel vasectomy (NSV). Information about implant methods were the most common.

Around 50% of the service providers in UHCs and UH&FWCs had job-aids (i.e., flipcharts, pictorials) when providing FP services. This proportion is a little higher among service providers in DHs and MCWCs (60% and 83% respectively).

Job aids were designed to improve performance of the provider through reduction of errors and improved understanding of the client through the visuals; low level of use of job-aids are of certain concerns here.

TABLE 10: AVAILABILITY OF SBCC MATERIALS (%)

TYPE OF SBCC MATERIALS	METHODS	TYPE OF HEALTH FACILITY %				
		DH (N=5)	MCWC (N=6)	UHC (N=28)	UH& FWC (N=30)	TOTAL
Facility had billboard(s)/ banner(s) of	IUD	40.0	50.0	32.1	56.7	44.9
	Implants	40.0	66.7	39.3	53.3	47.8
	Tubectomy	60.0	50.0	35.7	46.7	43.5
	NSV	40.0	50.0	35.7	40.0	39.1
	Injectable	40.0	33.3	28.6	46.7	37.7
	Pill	40.0	33.3	25.0	53.3	39.1
	Condom	40.0	33.3	25.0	53.3	39.1
Facility had posters of	IUD	40.0	83.3	78.6	76.7	75.4
	Implants	60.0	83.3	78.6	70.0	73.9
	Tubectomy	40.0	66.7	78.6	60.0	66.7
	NSV	40.0	66.7	75.0	60.0	65.2
	Injectable	40.0	66.7	78.6	70.0	71.0
	Pill	60.0	66.7	75.0	70.0	71.0
	Condom	40.0	66.7	75.0	70.0	69.6
Facility kept leaflets/ booklets in easily visible places regarding	IUD	40.0	33.3	35.7	30.0	33.3
	Implants	40.0	33.3	35.7	23.3	30.4
	Tubectomy	40.0	33.3	35.7	23.3	30.4
	NSV	20.0	33.3	32.1	23.3	27.5
	Injectable	20.0	16.7	32.1	23.3	26.1
	Pill	20.0	33.3	32.1	23.3	27.5
	Condom	20.0	33.3	32.1	23.3	27.5
Facility allowed clients/ visitors to take the leaflets/ booklets with them regarding	IUD	0.0	16.7	17.9	26.7	20.3
	Implants	0.0	16.7	17.9	20.0	17.4
	Tubectomy	0.0	16.7	17.9	13.3	14.5
	NSV	0.0	16.7	17.9	13.3	14.5
	Injectable	0.0	16.7	17.9	20.0	17.4
	Pill	0.0	16.7	17.9	23.3	18.8
	Condom	0.0	16.7	17.9	23.3	18.8
Facility had job-aids for the use of the service provider regarding	IUD	60.0	83.3	53.6	53.3	56.5
	Implants	60.0	83.3	53.6	40.0	50.7
	Tubectomy	60.0	66.7	53.6	36.7	47.8
	NSV	60.0	66.7	53.6	36.7	47.8
	Injectable	60.0	83.3	53.6	53.3	56.5
	Pill	60.0	83.3	53.6	50.0	55.1
	Condom	60.0	83.3	53.6	50.0	55.1

In response to the question regarding use of tablet-based information, education, and communication (IEC) materials, managers and service providers both welcomed the introduction of tablet-based IEC materials, but they feel that the process of replacing existing IEC materials with tablet-based IEC materials should be gradual and supported with adequate training in order to make the transition effective. Since most service providers are not technically advanced, managers urged for training on how to use tablets appropriately and thus prepare them gradually to accept the new technology and communication tools.

C1.6 SUPERVISION AND QUALITY IMPROVEMENT

According to the assessment, all the facilities received a visit from the supervisor, managers, or from other high officials within 6 months prior to the survey. However, the term 'visit' and 'supervisory visit' was found to be synonymous in most instances. Facilities are commonly visited by GOB official, social elites, local leaders, high officials from donors or NGOs, and these were also reported as a supervisory visit by some providers on various occasions. Among the surveyed facilities, 55% reported that they received supervisory visits on a monthly basis. However, in 19% of the facilities, visits were irregular and didn't follow a specific time pattern.

FIGURE 4: FREQUENCY OF SUPERVISORY VISIT (%)

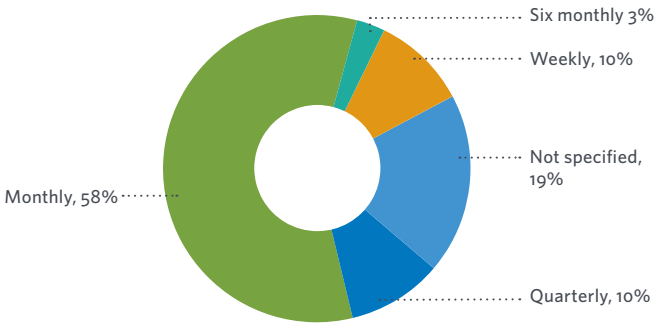
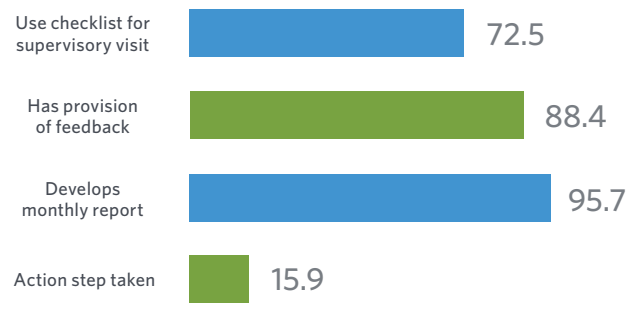


FIGURE 5: MEANS OF SUPERVISION (%)



Around 26% of participants responded that they refrained from using the checklist during their supervisory visits. According to the respondent, the supervisory checklist is too lengthy to be used regularly and appropriately. In 95% of cases, the supervisory visit was to develop and monitor the monthly action plan. The definition of 'action plan' in these cases was simply to disucuss the goals for distribution of activities (targets) during monthly meetings without

suggestion or instruction on how to complete the activities (fulfill the targets). 84.1% of surveyed facilities had provision of written feedback from the visitor. However, the written comments as well as the verbal ones were not found to be an effective means as they were seldom followed up on later. Data reflected that only 16% of the feedback was taken into account to develop an action plan.

This assessment reached out to managers to understand the concept of supervision and mentoring used in practice. It was revealed that although all are aware of the supervisory system, the details of it varied. It was found to be a common practice to write the findings in a supervisory notebook and to use the notes during follow up visits to provide feedback. The majority of managers stated that they find it quite essential and useful to maintain a level of supervision as it improves quality and constructive feedback often results in improved performance of their supervisee. A number of the managers prepare monthly supervisory plans and share them centrally. However, it was also pointed out that excessive workload often leaves little time to conduct supervision as per the work plan. Some have introduced their own supervisory checklist as well. However, no regular practice of giving feedback to the supervisee was found. Service providers also view supervision positively and expressed that it helps them to improve their performance.

Among the providers and managers who took part in KIIs, everyone was open to the idea of introducing mentoring as a supervision practice. However, since it's a new concept for all, both managers and service providers alike said that they would require significant training on it.

The majority of the managers preferred onsite as opposed to offsite supervision methods. However, they also expressed that offsite methods can also be effective to complement the onsite supervision. There is equally divided opinion and preference when it comes to surprise visits and planned visits. Many managers still consider sudden visits as supervisory visits. Those in favor of surprise visits feel that this reveals the real scenario, and hence is more valuable. Some managers prefer planned visits, particularly in remote areas where there is staff shortage. A planned visit would ensure the presence of the staff during the visit in such areas. Other managers prefer planned visits as they feel that these visits will at least trigger the staff to improve their services at that point, which would hopefully result in good practices in the long run.

C1.7 COMPLETION OF RECORDS AND ARRANGEMENTS FOR REPORTING COMPILATIONS

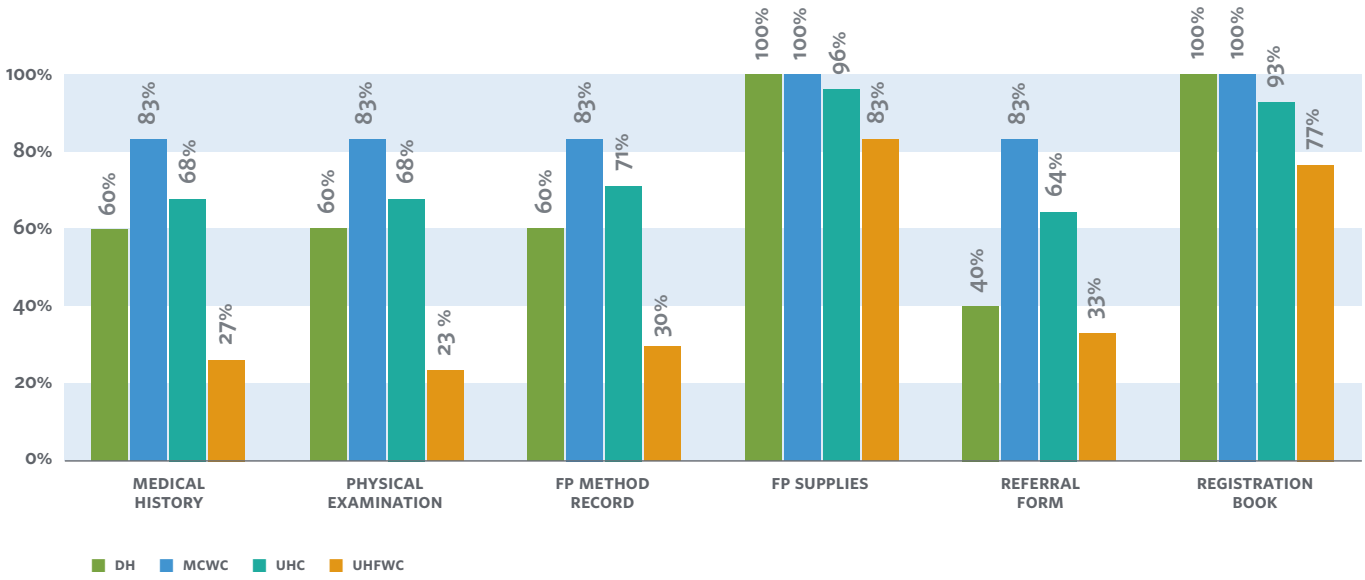
According to the survey, the records for registration and FP supplies (receiving and distribution) are most well managed, while the records for referral warrants improvement. A similar pattern was identified for medical history, physical examination history, and FP method use history within specific type of facilities. On a general note, the record management was found to be weakest in UH&FWCs.

The majority of the surveyed facilities have arrangements for reporting as well as recording FP related complications. Almost all facilities that have established a process to report FP related complications have the necessary arrangements to deal with the complications. However, the records were found to be incomplete and inconsistence rendering them less effective for the purposes.

TABLE 11: STATUS OF RECORD KEEPING AND COMPILATION OF RECORDS (%)

INDICATORS	TYPE OF HEALTH FACILITY %				
	DH	MCWC	UHC	UHFWC	TOTAL
Arrangement for general record keeping					
Facility had staff member to do data entry	40.0	50.0	67.9	0.0	36.2
Used client medical record	100.0	100.0	100.0	73.3	88.4
Gave record card of visiting facility to client	100.0	100.0	92.9	80.0	88.4
Had a system for filing clients' record and retrieval	100.0	100.0	100.0	86.7	94.2
Records can retrieve easily	100.0	100.0	82.1	83.3	85.5
Entered required data by the end of each day	80.0	83.3	92.9	70.0	81.2
Use computer/mobile/tablet for record keeping and reporting	40.0	83.3	78.6	13.3	47.8
Availability and completion of records					
Availability of Informed Consent Form for IUD	60.0	100.0	100.0	96.7	95.7
Availability of Informed Consent Form for Implant	60.0	100.0	100.0	33.3	68.1
Availability of Informed Consent Form for Tubectomy	80.0	100.0	96.4	13.3	59.4
Availability of Informed Consent Form for Vasectomy	20.0	100.0	96.4	13.3	55.1
Availability of Informed Consent Form for Injectable	40.0	83.3	50.0	33.3	44.9
Completeness of Medical History	60.0	83.3	67.9	26.7	50.7
Completeness of Physical Examination	60.0	83.3	67.9	23.3	49.3
Completeness of FP Method Record	60.0	83.3	71.4	30.0	53.6
Completeness of Number of FP Supplies	100.0	100.0	96.4	83.3	91.3
Completeness of Referral Form	40.0	83.3	64.3	33.3	50.7
Completeness of Registration book	100.0	100.0	92.9	76.7	87.0
Arrangements for reporting and recording					
Has arrangement for solving complications/problems related to contraceptive use	80.0	83.3	96.4	73.3	84.1
Has place for reporting and recording the complications	100.0	83.3	100.0	70.0	85.5
Has most recent version of written guidelines and protocols for delivering FP services	80.0	100.0	78.6	56.7	71.0

FIGURE 6: STATUS OF RECORD COMPLETION (%)

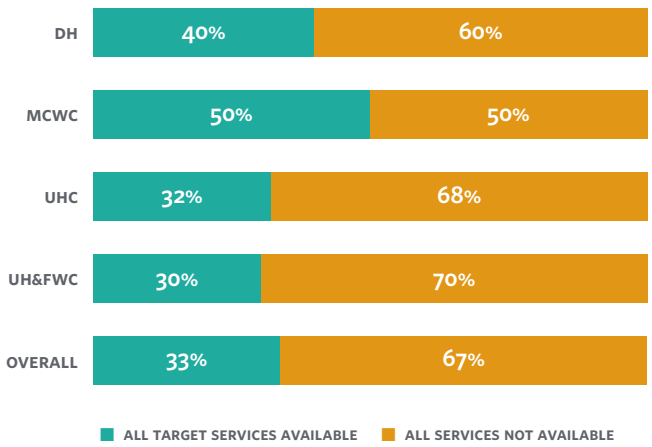


All managers and service providers who participated in the survey stated that, there is a reporting system where reports are generated and discussed on a monthly basis, at various levels. Estimates, specifically to increase the coverage of LARCs, are set per facility and distributed among relevant personnel. However, managers stated that they do not make an extensive use of service statistics to aid decision-making. Managers urged that there is an opportunity to generate more insights and use analytics to understand the community health seeking behavior through digitally equipping the field forces to collect data from the grass root level. Managers also suggested that there is a need to focus on process improvement in data collection and driving data analytics for better program monitoring and reporting.

c2. Findings on General Family Planning Services and Readiness to Provide these Services

C2.1 AVAILABILITY OF GENERAL RH AND FP SERVICES

FIGURE 7: AVAILABILITY OF GENERAL FP SERVICES (%)



The facility survey assessed whether the following categories of FP services were offered at the given facility: 1) adolescent and youth health services, 2) counseling for FP, 3) PAC-, 4) PPFP, 5) management of gender-based violence (MGBV), 6) FP services, 7) RTI/STI management, and 8) MCH services[5].

Data suggests that most of the services were offered in MCWCs with the exception of MGBV services. MGBV services, among the categories specified in the assessment, was the least available service category. Most of the service providers were unaware of appropriate MGBV services. Also there is a possible gap in the conception of MGBV services (Annex 4, Table 1). Counseling and commodity services on family planning as well as ANC and PNC services were available in all of the surveyed facilities. Interestingly, 70% of UH&FWCs reported the availability of normal vaginal delivery (NVD). Further inspection revealed that the centers are prepared for NVD but there is lack of 24x7 service provider availability; however, every UH&FWC is supposed to offer NVD services in Bangladesh.

C2.2 AVAILABILITY OF FP COMMODITIES

The availability of FP commodities was assessed for modern contraceptive methods, which consisted of oral contraceptive pills (OCPs), male condoms, IUDs, injectables, implants, permanent methods, and the emergency contraceptive pill. The availability of short- and long-acting methods was recorded based on observation of supplies in stock, while the availability of permanent methods (Tubectomy, NSV) was assessed based on availability of equipment and a qualified provider to perform the necessary procedures.

Across the surveyed facilities, most FP commodities were commonly available, with the exception of implants and permanent methods. The overall proportion of facilities that lacked implants and permanent methods may have been brought down by particularly low rates of their availability in UH&FWCs, as neither of these methods is provided at these types of facilities.

Condoms and injectables were the most common FP method available in the facilities, followed by pills. There is hardly reporting of stock out. According to the KII with MO (MCH-FPs), they perform sterilization in camp mode (gathering clients in the facilities on a specific day in UHC generally) for sterilization and implant according to their action plan calendars. The service providers reported availability of those services in UH&FWC based on such camps which is a limitation of understanding on their part.

C2.3 READINESS OF FACILITIES TO PROVIDE GENERAL FP SERVICES

The readiness to provide FP services was assessed using a set of six indicators following the BHFS 2014 criteria: 1) availability of staff (any) trained in FP, 2) availability of FP guidelines provided by the GOB, 3) availability of necessary equipment (blood pressure (BP) machine), and 4) availability of pills, injectables, and condoms. The facility assessment found that all surveyed facilities had trained staff as well as a BP machine. In some of the facilities (29%), the service providers were not able to show the guidelines when requested to show them during the survey. The section on availability of FP commodities already revealed that condoms and injectables were available in all surveyed facilities but one. The key issue hindering facilities' ability to demonstrate readiness to provide FP services was the lack of availability of OCPs. However, discussions with

FIGURE 8: AVAILABILITY OF FP COMMODITIES (%)

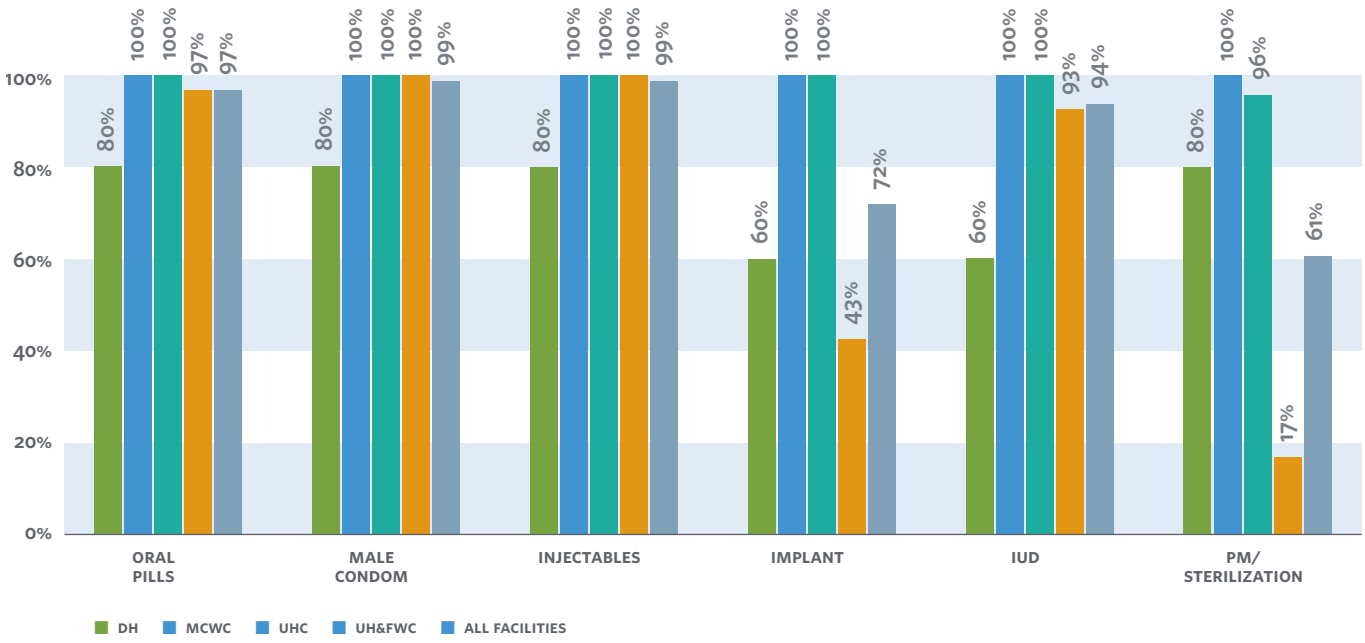


TABLE 12: AVAILABILITY OF FAMILY PLANNING COMMODITIES AND SUPPLIES

FP COMMODITIES AND SUPPLIES AVAILABLE: % (N)	FACILITY TYPES % (N) DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	TOTAL
Combined or progestin only oral pills	80% (4)	100% (6)	100 (28)	97 (29)	97 (67)
Male Condoms	80 (4)	100 (6)	100 (28)	100 (30)	99 (68)
Progestin-only Injectables	80 (4)	100 (6)	100 (28)	100 (30)	99 (68)
Implants	60 (3)	100 (6)	100 (28)	43 (13)	72 (50)
IUDs	60 (3)	100 (6)	100 (28)	93 (28)	94 (65)
PMs/ Sterilization	80 (4)	100 (6)	96 (27)	17 (5)*	61 (42)
No. of facilities	**5**	**6**	**28**	**30**	**69**

* Response error

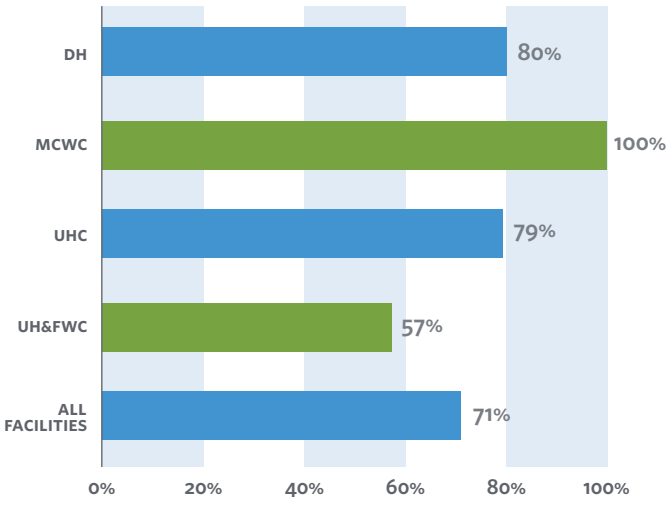
TABLE 13: FP TREATMENT GUIDELINES, PROCEDURES, AND PROTOCOLS

NAME OF GUIDELINES, PROCEDURES AND PROTOCOLS	TYPES OF FACILITY %				TOTAL
	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	
Guidelines and SOPs for FP available on site	80.0	100.0	71.4	86.7	81.2
Service delivery procedures for FP services available	100.0	100.0	96.4	100.0	98.6
Service delivery guidelines for serving adolescent clients available	60.0	83.3	53.6	60.0	59.4
The protocols followed routinely	100.0	100.0	82.1	73.3	81.2
PAC treatment guidelines, procedures and protocols exist and are followed	100.0	83.3	78.6	56.7	71.0

TABLE 14: READINESS OF HEALTH FACILITIES TO PROVIDE FAMILY PLANNING SERVICES

READINESS CRITERIA TO PROVIDE FP SERVICES	FACILITY TYPE % (N)				TOTAL
	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	
Guidelines on Family planning	80 (4)	100 (6)	79 (22)	57 (17)	71 (49)
Staff trained in family planning any time	100 (5)	100 (6)	100 (28)	100 (30)	100 (69)
Pills	80 (4)	100 (6)	100 (28)	97 (29)	97 (67)
Male condom	80 (4)	100 (6)	100 (28)	100 (30)	99 (68)
Progestin-only Injectables	80 (4)	100 (6)	100 (28)	100 (30)	99 (68)
Blood pressure apparatus	100 (5)	100 (6)	100 (28)	100 (30)	100 (69)
All 6 criteria met	80 (4)	100 (6)	79 (22)	57 (17)	71 (49)

FIGURE 9: READINESS OF HEALTH FACILITIES TO PROVIDE FP SERVICES (%)



key informants revealed that the lack of the availability of this particular commodity was in fact a unique situation which was the result of the recent national election. Logistic management of DGFP had been interrupted, which is a common situation during national elections.

The overall readiness of surveyed facilities (i.e., ability to meet all the criteria) was 71% which is higher compared to the national estimates (21%)[6]. This may be due to the fact that the surveyed facilities were not randomly selected but rather were the result of convenience sampling, which led to the inclusion of facilities that were easier to reach and may have less difficulty stocking up on supplies or recruiting qualified staff.

C2.4 AVAILABILITY OF INFORMED CONSENT FORM

Informed consent forms for IUD insertions were available in most of the surveyed facilities. The finding was more consistent in MCWCs and UHCs. DHs and UH&FWCs had low availability of consent forms, particularly for injectables and permanent methods. There is large gap in availability of consent forms compared to service availability of injectables (consent forms were available in 45% facilities while services were provided in 99% of facilitie). However, as permanent methods at UH&FWCs are done through camps it may coincide with low availability of the consent form for PMs in the UH&FWCs on a regular basis.

TABLE 15: AVAILABILITY OF INFORMED CONSENT FORM BY FACILITY

INFORMED CONSENT FORM AVAILABLE FOR SPECIFIC FP SERVICES	FACILITY TYPE %(N)				TOTAL
	DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	
IUD	60 (3)	100 (6)	100 (28)	97 (29)	96 (66)
Implant	60 (3)	100 (6)	100 (28)	33 (10)	68 (47)
Tubectomy	80 (4)	100 (6)	96 (27)	13 (4)	59 (41)
NSV	20 (1)	100 (6)	96 (27)	13 (4)	55 (38)
Injectables	40 (2)	83 (5)	50 (14)	33 (10)	45 (31)

In response to the question about the popularity of various available FP methods, managers and service providers across all districts included in the study, mentioned oral pill is still the most widely used method, followed by implant and injection, where one method is more commonly used in certain upazillas over others. According to the managers and service providers, IUD is yet to reach the level of implant or injection. Among the two available FP methods for men, NSV is the least in demand, as informed by both managers and service providers we interviewed.

While screening clients for FP services, many of the providers interviewed alleged that they do not use the long checklist as they don't have enough time. Some respondents also opined that since they have been in this profession for a long time, they do not necessarily need to use the checklist and can easily conduct the screening based on their own experience and skill. ***"Checklist is available but due to shortage of counselling time it is not followed"*** — ONE OF THE SERVICE PROVIDERS.

The "Citizen Charter" was viewed as a helpful means by the facility Managers to inform the clients about the services offered.

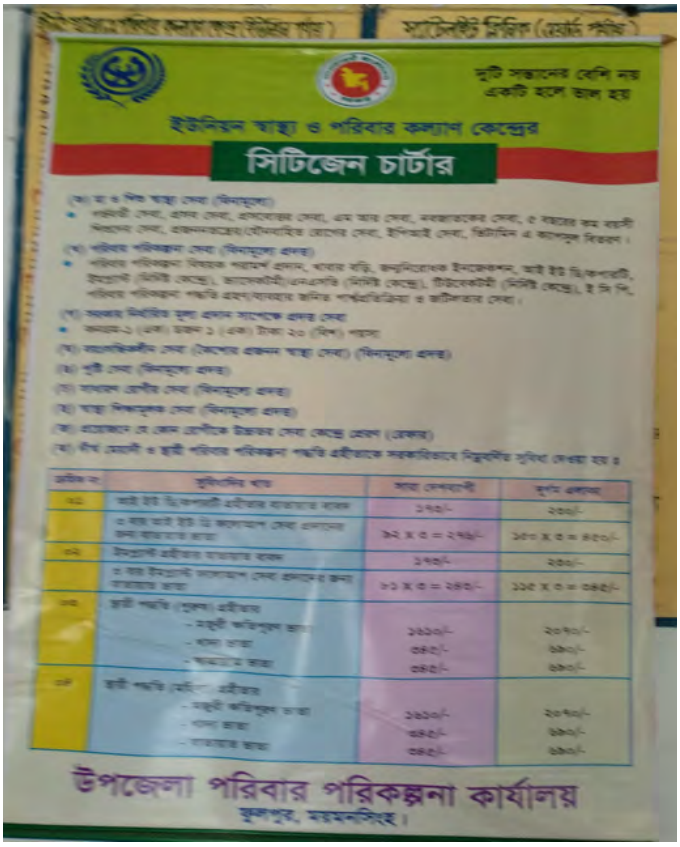
C2.5 FP METHOD SPECIFIC AVAILABILITY OF EQUIPMENT

The availability of equipment was assessed for long acting (IUD and Implant) and permanent method procedures. The majority of equipment/supplies necessary for long acting methods (IUD and implant) were available in facilities down to to the UHC level. But data from UH&FWC reveal a gap in availability. It is notable that there is not much evidence of non-functionality (despite availability) of equipment/supplies.

The UH&FWCs were not equipped with any operation theatre (OT) or room to perform procedures for permanent method and the majority of UHCs share an OT with family planning health service providers. All surveyed facilities have equipment for preparatory activities like autoclaving, cleaning, and setting of laboratory equipment.

The details of availability and functionality of necessary equipment for method specific FP services is provided in Annex 4 (Tables 11-15).

FIGURE 10: SAMPLE OF A CITIZEN CHARTER



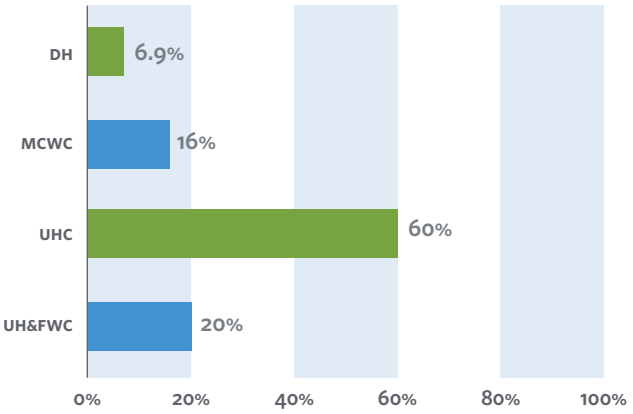
The "Citizen Charter" was viewed as a helpful means by the facility Managers to inform the clients about the services offered.

C2.6 SEATING ARRANGEMENTS FOR FP CLIENTS AND TIME TO AVAIL FP SERVICES

Most respondents expressed dissatisfaction about infrastructural arrangements in the facilities; waiting space in most facilities is inadequate to accommodate clients and their attendants. The survey found that for the most part, the health facilities had no distinct seating arrangement available for FP clients; this was the case in 80% of DHs, 40% of MCWCs, 84% UHCs, and 93% UH&FWCs (Figure 7). On average, FP clients had to wait 48

minutes for FP services in all types of facilities; the average wait time was highest in UHCs (60 minutes) and lowest in UH&FWCs (36 minutes) for FP services. The wait time was reported to vary according to the FP method the clients were receiving. Clients for PMs reportedly spent nearly 78 minutes to avail services while clients for pills and condoms only spent 12 minutes.

FIGURE 11: AVAILABILITY OF SEPARATE SEATING ARRANGEMENT (%)



c3. Findings on Adolescent Reproductive Health Services

Key concerns relating to adolescent services are confidentiality and privacy. As discussed in the section on the availability of basic amenities, a lack of visual and auditory privacy for clients, whether adults or young people, was found across most of the facilities visited. However, the findings concerning confidentiality of registration information and health records were more promising.

In an effort to create spaces that are specifically oriented to young people and to give them more private and comfortable access to health services, the GOB has begun creating "adolescent-friendly corners". However, this approach has yet to be implemented consistently. Only 12 out of 69 surveyed facilities (17%) had built an adolescent corner, even though they were providing limited or no services to adolescents at the time the assessment took place. Key informants in UHCs noted that they were told to build adolescent corners within UHCs.

The assessment identified a lack of visual and 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. Service providers acknowledged that taking clients' personal and health history, screenings, and reasons for their visit—that is, the taking of private information—typically took place in public parts of the health facility, where other clients could overhear. In addition, the providers indicated that unnecessary interruptions happen frequently, irrespective of facility type. Though there were written procedures for ensuring client privacy, the existing infrastructure did not support the operationalization of these procedures. However, once the records are written, they are properly stored, maintaining confidentiality (although this is of limited benefit once others have already overheard).

The survey showed that more than half of the service providers (52%) were not aware of service delivery guidelines covering services for adolescents and youth, and 55% of service providers thought there was a minimum age for providing contraceptive or PAC services to clients. This is a misconception, as GOB

FIGURE 12: CONFIDENTIALITY AND PRIVACY STATUS FOR ADOLESCENT AND YOUNG CLIENTS

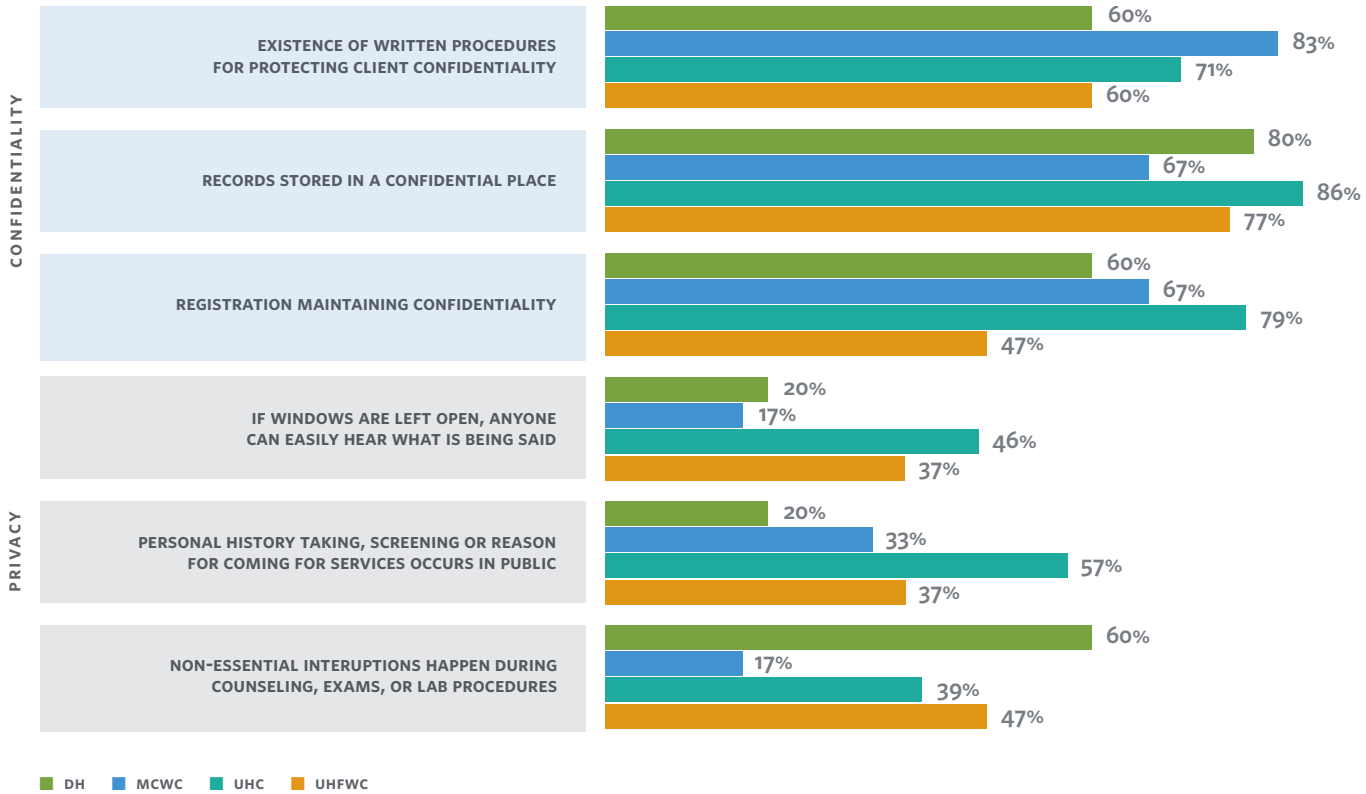


TABLE 16: SERVICE AVAILABILITY AND PREPAREDNESS TO PROVIDE SERVICES TO ADOLESCENTS (%)

INDICATORS	FACILITY TYPE % (N) DH (N=5)	MCWC (N=6)	UHC (N=28)	UH&FWC (N=30)	TOTAL
Provider's knowledge on services for adolescents regardless of age and marital status					
Clear written guidelines exist for serving youth	20.0	100.0	42.9	46.7	47.8
Require a minimum age for contraceptive or PAC services	40.0	66.7	39.3	46.7	44.9
Requires spousal consent	60.0	100.0	85.7	90.0	87.0

guidelines for FP or PAC services at public health facilities specify that the client must be married but make no mention of a minimum age. In addition, 87% of service providers mentioned the necessity of spousal consent. A written copy of the service delivery guidelines was almost uniformly available (99%) and it is reported that the guideline is followed in the majority of instances (81%). In reality, the manual of service delivery guidelines (FP-manual) includes specific instructions for providing services to adolescents and youth. However, only 59% of service providers could recall that the manual contained those instructions.

Health facility managers and service providers who took part in KIIs stated that young adolescents are able to access the facilities easily. However, they noted, unmarried adolescents are unable to receive any FP methods, as the government considers only married individuals to be eligible for FP services at public health facilities. It was also clear from the qualitative interviews that the majority of managers and service providers were themselves not comfortable with the notion of providing FP methods to unmarried adolescents.

"Those who are unmarried, they are taking the service from the pharmacy. But being a government employee, we have to register the couple, [we] cannot serve the unmarried."

—ONE OF THE MANAGERS

A signboard that indicating adolescent health care services at different public health facilities

All the managers and providers who took part in the KIIs enthusiastically acknowledged the need to address adolescent health as its own area of focus or specialization. Providers felt there is a need for facilities to appoint a separate counsellor to deal specifically with adolescents, something that does not currently exist. Some of those interviewed also emphasized the need to appoint both male and female counselors to better reach adolescents and youth, who may be more comfortable speaking with a provider of the same gender and to better address gender-specific issues. Managers emphasized the need to appoint younger counselors, who they believed would be more at ease than older counselors with discussing topics like FP with adolescents and youth and would be more open to the idea of providing FP related counselling to adolescents and youth. The managers noted older service providers were often hesitant, shy, and resistant to the concept of providing such services to youth and adolescents.

When asked about accessibility during the KIIs, service providers informed the assessment team that adolescents were often uncomfortable and hesitant to come in to seek services during peak hours, i.e. 10:00 a.m. to 1:00 p.m., and they usually preferred to come at times when facilities were less likely to be crowded.

As per the guideline issues by the government, separate "adolescent-friendly corners" are being established in all the health centers. This is being done on a planned phase-by-phase basis. At the same time, trainings on youth- and adolescent-friendly health services to the service providers are also being conducted in phases by DGFP.

Many service providers who took part in the KIIs felt that the previous hours for service delivery at health facilities, from 8:30 a.m. to 2:30 p.m., was a constraint for reaching adolescents, as this timeframe overlapped with school and college hours. The timing has recently been revised to 9:00 a.m. to 3:30 p.m by DGFP. Both managers and service providers expressed that the service delivery and service uptake rate by adolescents would significantly improve.

The focus of FGDs with adolescents (grouped into married or unmarried young men or young women) and with opinion leaders revolved around exploring knowledge and awareness of reproductive health and family planning services that currently exist for adolescents within the communities. Participants were requested to comment on the following:

- First person they would choose to contact for any health-related information.
- The availability of health services in the community.
- Sources of information about the health services available in the community.

- The availability of family planning services in the community.
- The cost of available family planning services in the community.
- The most frequently accessed facilities for RH and/or FP services.
- The RH and/or FP services adolescents and youth were believed to most frequently access at public health facilities.
- Which RH and FP services were available to unmarried adolescents at public health facilities.

When asked about the availability of health services for adolescents, participants in the FGDs noted that several private and public facilities are available to their communities that provide primary, secondary, and tertiary healthcare services. Most adolescents who took part in the FGDs said that they received health related information from local health facilities, which include UHCs, Family Welfare Centers (FWCs) and Community Clinics (CCs). When asked about the first person they contacted

for any health-related information, they mentioned workers for health service provision NGOs (e.g., BRAC, Smiling Sun) and pharmacy sales persons. Some of them also mentioned they go to the village doctors, local health care providers at local public health care facilities as well as local seniors, guardians, and family members. For common health ailments like fevers, colds, etc., adolescents said they preferred to visit local doctors based in UHCs and FWCs. For specialized treatment, they preferred to visit district hospitals owing to the affordability factor. With regard to the availability of FP services, the majority of adolescent FGD participants said that while these services were readily available through FWAs and UH&FWCs, it was mainly married women who availed these services. The male adolescents as well as the unmarried female adolescents who took part in the FGDs said that they themselves hardly ever availed these services, and most felt these were appropriate only for married women.

Among the adolescent girls who took part in the FGDs, both married and unmarried, many were fairly educated about and aware of FP-related matters and practices. In terms of health seeking behavior for maternal care, they said that pregnant women are informed and educated about safe pregnancies, nutrition, and maternal care. These services are mainly provided by FWAs who visit them on a regular basis at home. Unmarried adolescents who took part in the FGDs said that they usually visited FWCs to seek services related to such health issues as lower abdominal pain, menstrual care, white discharge, headaches, Tetanus Toxoid (TT) injections, Expanded Program of Immunization (EPI) for children, and dietary advice, as well as services related to physical and mental health issues. They noted that most of these services are largely subsidized by the government.

Feedback from the adolescent clients however highlights that medicines for common illnesses are not provided to them often due to shortage of supply in the facilities. This shows a great need to address medicine supply issues and find means to improve the supply of adequate medicines in order to better serve the clients.

Adolescents who took part in the FGDs pointed to social stigma and fear of ruining reputations as important factors that prevent unmarried adolescents from seeking FP services. At the same time, most of the young unmarried adolescent girls who took part in these discussions themselves held strong opinions that FP services were not relevant to them and were therefore hesitant to even discuss this matter.

Like the providers who were interviewed, the adolescents who took part in FGDs cited the service delivery hours that are still in-place of 8:30 a.m. to 2:30 p.m., overlapping with school hours, as one of the major hindrances to service uptake by adolescents and youth. Managers in their KII mentioned that although the operating hours had been revised recently, this information was yet to be communicated at the UH&FWC level.

Opinion leaders suggested that FP should be included as a separate subject in academic syllabi in schools and madrasas so that adolescents would be more aware and less hesitant to avail such services in the future.

C4. Integration of Family Planning into Postpartum, Post-abortion care, and Post-MR services

C4.1 READINESS OF FACILITIES TO PROVIDE POSTPARTUM FP SERVICES

The readiness of health facilities to provide PPFP services was assessed by asking whether the facility had a provider trained on PPFP available, the availability of OCPs, and the existence of referral services in the facility.

PPFP services were found to be available in the majority of the surveyed facilities. Below figure suggests that pills and referral services were available in the majority of the facilities. As the survey asked only about training that had been provided in the two years prior to the survey, the overall rates of PPFP training may appear low; it is possible that many service providers received training on PPFP more than two years before the survey.

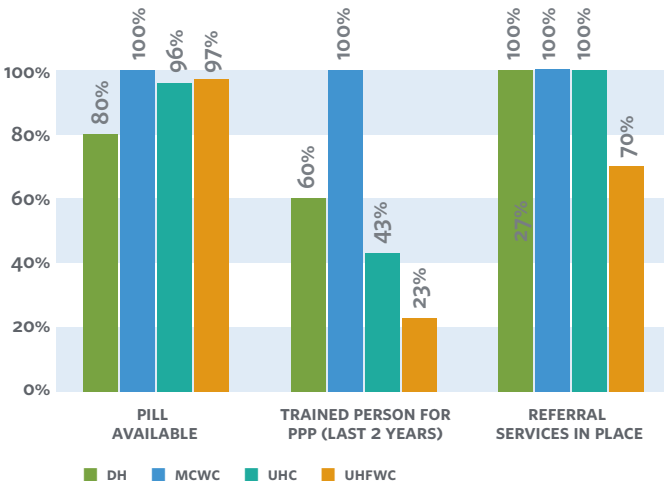
TABLE 17: GENDER RESPONSIVENESS AT SURVEYED FACILITIES (%)

INDICATORS	SEX	FACILITY TYPE DH (N=5)	MCWC (N=6)	UHC (N=28)	FWC (N=30)	TOTAL
Sex distribution of Facility Manager (#)	Male	1	3	4	15	23
	Female	4	3	24	15	46
Service provision environment of the facility						
Women clients faced security problem to receive service		20	0	4	10	7
Clients shared any story related to physical, psychological or emotional trauma when they come to receive service		100	67	89	77	83
Woman, victim of gender-based violence received services		60	17	46	23	35
Women faced difficulties in receiving service		0	0	7	10	7
Data collection and reporting						
Facility maintained sex disaggregated service information		60	67	71	43	58
Gender related accomplishments reported in the monthly report		20	33	50	40	42

TABLE 18: GENDER BALANCE ADMINISTRATION AND STAFFING

ADMINISTRATION AND STAFFING	SEX	FACILITY TYPE DH	MCWC	UHC	FWC	TOTAL
Average number of management Staff	Male	2	1	1	1	1
	Female	1	1	3	1	2
Average number of technical Staff	Male	5	9	2	3	3
	Female	2	2	1	0	1
Average number of support Staff	Male	1	3	1	1	1
	Female	0	2	1	1	1

FIGURE 13: READINESS TO PROVIDE PPFD SERVICES (%)



C5. Gender Responsiveness of Health Facilities and Staff

Gender responsiveness is an area that is yet to be grasped properly by the service providers. To begin with, few service providers received training on gender responsiveness. And it is doubtful whether they were able to perceive the issue properly. This assumption is driven by the fact that the majority of the facilities seems to have made sure that clients who were victims of Gender Based Violence (GBV) received appropriate services. The reality however, is that the service providers briefly listened to the story and provided verbal comfort or suggested medication, but they commonly did not notify legal authority or suggested the client seek legal advises from appropriate places.

The Managers and Service Providers that participated in the KIIs stressed that family planning related service is open to all, irrespective of gender. They, however, went on to say that male participation in family planning is limited as most of them consider family planning services to be for women only. It was also stressed that the service hours coincide with the work hour of men limiting their access to the facility and they also had little interest in taking part in family planning discussions. Their lack of participation can also be attributed to the fact that the service providers, including FWVs and FWAs, are all women and men do not necessarily feel comfortable discussing such intimate matters with them. Managers went on to say that the service providers themselves hardly ever reached out to potential male clients and there is limited awareness building activities targeting men.

"Even male clients don't come to collect condom for themselves, since all our providers are female they don't feel comfortable"

—A FACILITY MANAGER

Shukhi Jibon

"Even male clients don't come to collect condom for themselves, since all our providers are female they don't feel comfortable"

—A FACILITY MANAGER

The survey also reached out to adolescents and opinion leaders to explore the level of gender responsiveness in health facilities included in the study. The discussions revealed that the family planning services are limited to married women. Most male adolescents, both married and unmarried, do not currently seek out family planning services to a good extent. At the same time, several male respondents voiced the lack of initiative from health workers, especially FWAs to reach out to men. They have opined that if a male FWV is appointed, then male clients would feel much more comfortable to approach him for FP services. However, they do receive some family planning related advice from UHCs and FWCs. These services are usually free.

Seating arrangements were also pointed out as a demotivating factor to seek care from facilities, particularly at the UH&FWCs. Boys and girls, men and women need to share common waiting space which prevents many from availing services from the facilities as they want to maintain a level of privacy following local customs. Amenities like a separate toilet for males and females, cleanliness, along with regular and adequate supply were also mentioned as limitations.

According to the opinion leaders, the community perceives that family planning methods should ideally be adopted by women and not men. Some went on to justify this statement by saying that men need to work long hours to earn a living and since they might become weak and unproductive as a side effect of adopting family planning methods, it's best they avoid these altogether.

"Men will become weak and even impotzent as a side effect of taking family planning methods, and hence it's best for men to avoid these as they have to work outside to earn a living."

—OPINION LEADER

A few opinion leaders, though, have expressed that FP methods are equally applicable to both genders.

The KIIs conducted also revealed that managers and service providers are not involved in policy-making. However, this has not been expressed as a complaint since the majority feel that policy-making decisions should ideally be made at a higher, central level. The majority of respondents mentioned that whenever new family planning related policies and guidelines (FP manual, FP training guideline etc.) is issued by the government of Bangladesh, these usually reach their districts within 1-2 weeks after publication/revision. And although hard copies often take time to reach the facilities, this is not seen as a problem since notices and memos are distributed immediately via email.

C6. Way Forward

This assessment revealed some major areas of concern that need immediate attention of public sectors. A lack of proper counselling services regarding FP, lack of uptake of family planning services by young adolescents (especially boys), low motivation level among managers and service providers were the key health and social challenges at the community level.

Advocacy

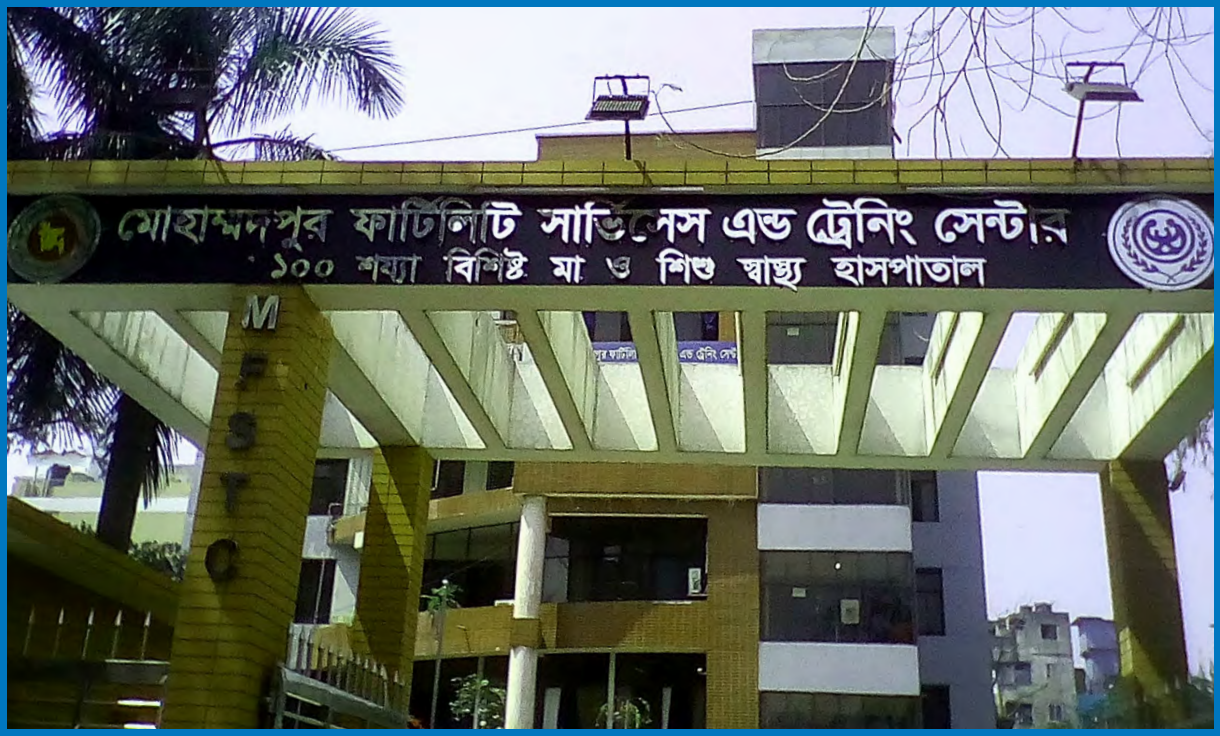
Advocacy efforts should be extended towards addressing the human resources shortage, which is one of the major challenges at present. Advocacy should also address poor provider attendance as well as limited male participation in FP services.

Adolescent services

Whole-site orientations on AYFHS are 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 AYFHS and help reduce barriers to accessing services from health facilities.

Annex-1.1: Health Facilities

Photograph of UHC, Bhaluka, Mymensingh and MCWC, Sylhet

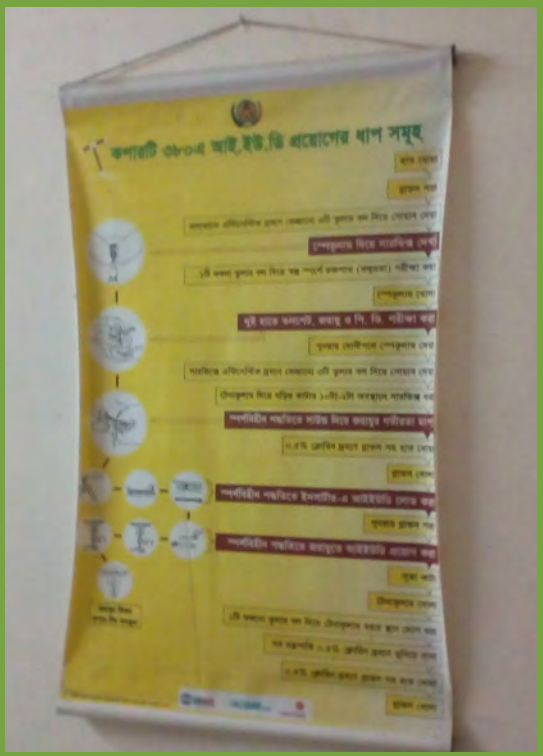


Annex-1.1: Washroom Facilities

Photograph of washroom, UHC, Bhaluka, Mymensingh

Annex-1.3: Materials BCC

Samples of Family Planning SBCC Materials



Annex-1.4: FGD

Left and below: FGD with adolescent boys and girls, above: FGD with opinion leaders

FACILITY ASSESSMENT TOOL
USAID SHUKHI JIBON (AUAFP) PROJECT

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

FP managers

(DDFP, ADCC, FPCST-QIT, UH&FPO, UFPO)

Facility Identification

1. Name of Key Person in Facility: .....

2. Location: **Division:** ..... **District:** .....

Upazila: ..... **Union:** .....

3. Type of Facility (USE CODES DH=1, MCWC=2, UHC=3, UHFWC=4): .....

4. Facility location (URBAN=1, RURAL =2)**:** .....

5. Facility Managing Authority (DGFP=1, DGHS =2)**:** .....

6. Extension of facility service (INPATIENT=1, OUTPATIENT=2, BOTH=3)**:** .....

7. Number of rooms (dealing with patients) in the facility: .....

8. How many days in a week does the facility usually remain open? .....

9. How many hours does the facility remain open every day (outdoor)? .....

Interviewer Visits

	DATE	INTERVIEWERS	RESULTS CODE*
Visit 1.	.....	.....	.....
Visit 2	.....	.....	.....
Visit 3	.....	.....	.....

*RESULT CODES: 1 = COMPLETED, 2 = NOT AVAILABLE, 3 = POSTPONED, 4 = REFUSED, 5 = PARTLY COMPLETED, 6 = OTHER ..... (PLEASE SPECIFY)

	INTV CODE	RESULTS	TOTAL NUMBER OF VISITS
Final Visit.	.....	.....	.....

Supervisor: ..... DATE: .....

Field Editor: ..... DATE: .....

Office Editor: ..... DATE: .....

Keyed By: ..... DATE: .....

A. Information on service providers/field workers involved in the provision, supervision, or mobilization of services

List all clinical staff / providers who are present today or will present on call in this facility. Compile this list as the team moves from one service area (or department) to another obtaining information on the services that the facility provides and for which inventory sections are being completed, and/ or for which client-provider observations are being done.

District Hospital (DH)

PROVIDER DESIGNATION	# OF SANCTIONED POST	# OF PROVIDER(S) AVAILABILITY	# OF PROVIDER(S) AT WORK TODAY
A1. Obstetrician and Gynecologist (OB/GYN)			
A2. Nurse (involved in FP work)			
A3. Midwife Nurse			
A4. Cleaner/Sweeper			

Maternal And Child Welfare Centre (MCWC)/Sadar FP Office

PROVIDER DESIGNATION	# OF SANCTIONED POST	# OF PROVIDER(S) AVAILABILITY	# OF PROVIDER(S) AT WORK TODAY
A5. Medical Officer-Clinic(MO-Clinic)			
A6. Medical Officer Maternal and Child health—Family Planning MO (MCH-FP)			
A7. Family Welfare Visitor (FWV)			
A8. Midwife Nurse			
A9. Aya			

Upazila Health Complex (UHC)

PROVIDER DESIGNATION	# OF SANCTIONED POST	# OF PROVIDER(S) AVAILABILITY	# OF PROVIDER(S) AT WORK TODAY
A10. Resident Medical Officer (RMO)			
A11. Medical Officer Maternal and Child health—Family Planning (MO-MCH-FP)			
A12. Upazila Family Planning officer (UFPO)			
A13. Assistant Upazila Family Planning officer (AUFPO)			
A14. Assistant Family Welfare Officer—Maternal and Child Health and Family Planning AFWO (MCH-FP)			
A15. Family Welfare Visitor (FWV)			

Union Health And Family Welfare Centre (UHFWC)

PROVIDER DESIGNATION	# OF SANCTIONED POST	# OF PROVIDER(S) AVAILABILITY	# OF PROVIDER(S) AT WORK TODAY
A16. Medical Officer –Family Welfare (MO-FW)			
A17. Sub-Assistant Community Medical Officer (SACMO)			
A18. Family Welfare Visitor (FWV)			
A19. Family Planning Inspector (FPI)			
A20. Family Welfare Assistant (FWA)			

B. Training:

This section gathers information on the staff providing services* at the facility and their training level. List all personnel involved in the provision of FP and PAC services including those providers who will offer integrated services (e.g., those offering delivery/PNC, ART, and immunization services) and the training they have received using the codes below. It may also make sense to collect training information on those providing safe delivery given the focus on postpartum contraception. *(Specify category) Response codes are specified below. (Instruction: If a provider has multiple trainings, then under the name of the provider, the other rows should be recorded in the other training information).

NAME	SEX	POSITION/ TITLE	TRAINING CODE	TRAINING			TRAINING CATEGORY CODE	TRAINING AGENCY	DO YOU HAVE SMART PHONE? (YES=1, NO=2)
				DAYS	MONTH	YEAR			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			
					/	/			

USE THE FOLLOWING CODES TO COMPLETE THE FORM ABOVE

SEX:

1 = MALE
2 = FEMALE
3 = 3RD GENDER

TRAINING CATEGORY CODE:

1 = PRE-SERVICE
2 = IN-SERVICE
3 = ON-THE-JOB

POSITION/TITLE CODE:

1 = OB/GYN
2 = RESIDENT MEDICAL OFFICER (RMO)
3 = MO (MCH-FP)
4 = MOCC
5 = UFPO
6 = AUFP
7 = NURSE (INVOLVED IN FP WORK)
8 = MIDWIFE/ NURSE
9 = FWV/SENIOR FWV/AFWO
10 = SACMO/MA
11 = FPI
12 = FWA (APPLICABLE FOR FWC)
13 = AYA (INVOLVED IN FP WORK)
14 = CLEANER/ SWEEPER (INVOLVED IN FP WORK)
15 = OTHER (SPECIFY)

TRAINING CODE:

1 = IUD (INTERVAL)
2 = PP (POSTPARTUM)
IUD3 = PPFP
4 = IMPLANT
5 = VASECTOMY (NSV)
6 = TUBECTOMY
7 = SHORT-ACTING FP METHOD (ORAL OCP, CONDOM, INJ.)
8 = COUNSELING-FP
9 = PAC
10 = INFECTION PREVENTION
11 = MANAGEMENT OF RTIS/STIS
12 = ADOLESCENT AND YOUTH-FRIENDLY HEALTH SERVICES
13 = GENDER
14 = SUPERVISION
15 = OTHER (SPECIFY)

C. Service availability

(INSTRUCTION: The services available in the facilities should be indicated below by a 'yes or no'. This refers to services provided at the facility e.g., every day or at least once a week. If there are any additional comments about the services, then it could be mentioned under the comment column).

Method: Ask (Facility Manager)

General Services/Services Offered		AVAILABLE	COMMENTS
C1.	Family Planning counseling (except ANC/PNC)	☐ YES ☐ NO	.....
C2.	Family Planning services	☐ YES ☐ NO	.....
C3.	Management of Gender-Based Violence (MGBV)	☐ YES ☐ NO	.....
C4.	Youth and Adolescent Friendly Reproductive Health Services	☐ YES ☐ NO	.....
C5.	Reproductive Tract Infection/Sexually Transmitted Infection (RTI/STI) services	☐ YES ☐ NO	.....
C6.	HIV Testing & Counseling services	☐ YES ☐ NO	.....
C7.	Cervical Cancer screening (VIA test)	☐ YES ☐ NO	.....
C8.	Post Abortion Care (PAC) – FP services	☐ YES ☐ NO	.....
C9.	Other Service (Specify):	☐ YES ☐ NO	.....

FP services offered

C10.	Oral Contraceptive pill (OCP)	☐ YES ☐ NO	.....
C11.	Progesterone only pill (POP)	☐ YES ☐ NO	.....
C12.	Condom	☐ YES ☐ NO	.....
C13.	Injectable	☐ YES ☐ NO	.....
C14.	Implant	☐ YES ☐ NO	.....
C15.	Intra uterine device (IUD)	☐ YES ☐ NO	.....
C16.	Non-Scalpel Vasectomy (NSV)	☐ YES ☐ NO	.....
C17.	Tubectomy	☐ YES ☐ NO	.....
C18.	Post-Partum Family Planning (PPFP)	☐ YES ☐ NO	.....
C19.	Post Abortion Care (PAC-FP)	☐ YES ☐ NO	.....
C20.	Post Menstrual Regulation- Family Planning (PMR-FP)	☐ YES ☐ NO	.....
C21.	Lactational Amenorrhea Method (LAM)	☐ YES ☐ NO	.....
C22.	Emergency Contraceptive pill (ECP)	☐ YES ☐ NO	.....

MCH Services

C23.	Antenatal Care (ANC)	☐ YES ☐ NO	.....
C24.	Normal Vaginal Delivery (NVD)	☐ YES ☐ NO	.....
C25.	C-Section Delivery	☐ YES ☐ NO	.....
C26.	Postnatal Care (PNC)	☐ YES ☐ NO	.....

Management of Gender Based Violence

C27.	Counseling	☐ YES ☐ NO	.....
C28.	Post GBV care with ECP	☐ YES ☐ NO	.....
C29.	Post GBV care with other service (specify)	☐ YES ☐ NO	.....
C30.	Refer to appropriate facilities	☐ YES ☐ NO	.....
C31.	What is the standard policy to handle the GBV case?	☐ YES ☐ NO	

Ante natal Care (ANC)

C32. Family Planning counseling ☐ YES ☐ NO .....

C33. Provision of condom for RTI/STI protection, if required ☐ YES ☐ NO .....

Safe Delivery (Normal Vaginal Delivery & C/Section)

C34. Family Planning counseling ☐ YES ☐ NO .....

C35. Post-delivery IUD ☐ YES ☐ NO .....

Post natal Care (PNC)

C36. Family Planning counseling ☐ YES ☐ NO .....

C37. Contraception/Dual Protection Include ☐ YES ☐ NO .....

Post Abortion Care-Family Planning (PAC-FP)

C38. Family Planning counseling ☐ YES ☐ NO .....

C39. Provision of Family Planning methods ☐ YES ☐ NO .....

D. Observation of Physical space, Equipment, and Commodity Storage

(INSTRUCTIONS: *This section requires observation rather than interaction with the respondent).*

A. Facility Characteristics

1 = AVAILABLE AND FUNCTIONAL 2 = AVAILABLE BUT NOT FUNCTIONAL 3 = NOT AVAILABLE 4 = NOT OBSERVED

Facilities

		STATUS	COMMENTS/ RECOMMENDATIONS
D1.	Are there any signs or directions available in the neighborhood or outside of the facility which help to locate the facility?	.....	.....
D2.	Does the facility have signboard that is visible?		

Outdoor Facilities

METHOD: OBSERVATION (ASK WHEN NECESSARY)		STATUS	COMMENTS/ RECOMMENDATIONS
D3.	Is there any breast-feeding corner?	.....	.....
D4.	Is there any adolescent corner?	.....	.....
D5.	Is there any client/visitor waiting room, area, or space in the facility?	.....	.....
D6.	Is there any visible sign that indicates the waiting room, area, or space?	.....	.....
D7.	Is there a Citizen Charter displayed in the facility?	.....	.....
D8.	Is there a price-list of services displayed in the facility?	.....	.....
D9.	Are performance statistics of the facility displayed?	.....	.....

continued...

D. Observation of Physical space, Equipment, and Commodity Storage *continued...*

Are comprehensive FP wall-charts/TIHRT chart are displayed in the clients waiting/counseling room?

		STATUS	COMMENTS/ RECOMMENDATIONS
D10.	waiting room	.....	.....
D11.	In counseling room	.....	.....
D12.	Elsewhere within the facility or on outside walls	.....	.....
D13.	Do you think this FP wall-chart/TIHRT chart is helpful in providing services to clients?	.....	.....
D14.	Is there any FP method specific projection chart displayed anywhere in the facility?	.....	.....
D15.	Is there a box/place where clients/patients can drop notes/letters with their comments/suggestions?	.....	.....
D16.	Is the box/place easily visible? (placed on way in, way out, in a location where anyone can see it)		

MO, FWV (will ask according to the facility)

METHOD: OBSERVATION (ASK WHEN NECESSARY)		STATUS	COMMENTS/ RECOMMENDATIONS
D17.	Is there any updated pregnant women list?	.....	.....
D18.	Is there a checklist(s) for FP client screening?	.....	.....
D19.	Is there any safety box for injectable dispose?	.....	.....
D20.	Does the facility have a FP manual?	.....	.....
D21.	Does the facility maintain client exit interview?	.....	.....
D22.	Did you/ facility managers or providers ever review any client feedback?	.....	.....
D23.	Did you ever review any feedback that brought any changes in clinic setting or services process?	.....	.....
D24.	Record keeping of the services are available	.....	.....
D25.	Reporting of the services are available	.....	.....
D26.	Is there any official phone for communication	.....	.....
D27.	Is there any Tablet /laptop in the facility?	.....	.....
D28.	What they actually do with tablets/laptop	.....	.....

B. Physical space

Does the clinic have dedicated space for each of the following purposes?

If so, rate them according to the following scale. If any of the areas need renovation, specify the necessary renovations in the "Comments/Recommendations" column of the following chart.

1 = AVAILABLE AND FUNCTIONAL 2 = AVAILABLE BUT NOT FUNCTIONAL 3 = NOT AVAILABLE 4 = NOT OBSERVED

Indoor facilities

METHOD: OBSERVE		STATUS	COMMENTS/ RECOMMENDATIONS
D29.	Separate room for the processing of equipment	.....	.....
D30.	Toilet for clients (functional)	.....	.....
D31.	Toilet for clients (clean)	.....	.....
D32.	Functioning sink	.....	.....
D33.	Separate room for the processing of equipment (sterilization process)	.....	.....
D34.	Place for medical waste disposal		

D35. Separate counseling area maintaining privacy .....

D36. Separate examination room .....

D37. Separate FP service site .....

D38. Specific Recovery area (e.g. PAC & sterilization clients) .....

Waiting area with space for all clients

D39. Male .....

D40. Female .....

D41. Adolescent/youth .....

Outdoor facilities — Waiting Room area with seating for client

D42. Male .....

D43. Female .....

D44. Adolescent/youth .....

D45. Private counseling .....

Examination area

D46. IE&C posters visible .....

D47. FP flip chart available .....

General service readiness

D48. Source of water .....

D49. Power supply .....

D50. Waste management (availability of Bin) .....

D51. Tiahrt Chart/FP wall chart .....

D52. Internet connection .....

C. Equipment and supply: Rate the presence and quality of the equipment and supplies at the site according to the following rating scale:

Does the facility/site have:

METHOD: ASK & OBSERVE (ASK TO FWV/STORE MANAGER)		STATUS: SUPPLY (NUMBER)	STATUS: FUNCTIONAL (NUMBER)	COMMENTS/RECOMMENDATIONS
D53.	Stethoscope			
D54.	Thermometer			
D55.	BP Machine			

Gynecology exam instruments

D56. Sim's Speculum .....

D57. Cusco's Speculum .....

D58. Sponge holding forceps .....

D59. Spotlight .....

D60. Kidney tray .....

D61. Gallipot .....

D62. Artery forceps .....

continued...

C. Equipment and supply: Rate the presence and quality of the equipment and supplies at the site according to the following rating scale:

Equipment Supplies for Implant

D63.	Soap			
D64.	Sterilized Marker			
D65.	Sterilized Gloves			
D66.	Sterilized cloths/Surgical drape, Leaky Surgical drape (for Jadelle)			
D67.	Antiseptic solution			
D68.	Gallipot			
D69.	Sponge holding forceps			
D70.	Surgical scalpel blade			
D71.	Sterilized cotton ball (3-5 pcs)			
D72.	Sterilized gauge			
D73.	AD/Disposable syringe			
D74.	Local anesthesia drugs (1% Lidocaine, adrenaline free)			
D75.	hydrocolloid dressing/band aid, general bandage			
D76.	Safety box			
D77.	Mosquito forceps (2 units)			
D78.	U Forceps			
D79.	Implant			

Equipment/Supplies for IUD

D80.	IUD in sterile packet			
D81.	Cusco's Speculum (Medium size)			
D82.	Tenaculum			
D83.	Uterine Sound			
D84.	Gallipot			
D85.	Artery forceps			
D86.	Scissors			
D87.	Sterilized cotton ball (3-5 pcs)			
D88.	Sterilized Gloves (2 pair)			
D89.	Povidone Iodine solution			
D90.	Spotlight or Torch light			
D91.	Draping sheet			

Physical/infrastructural facilities for the permanent sterilization
Reception room with facility for counseling and taking history of the patient

D92.	Chair and table for the counselor			
D93.	Chair or bench for sitting of the client and attendance			
D94.	Method specific client consent form with detail description and other materials and communication aid for counseling			
D95.	Discharge certificate for male and female sterilization			

Laboratory examination facility with physical examination Room

D96.	Chair and table for the service provider			
D97.	Chair for the client			
D98.	BP instrument with stethoscope			
D99.	Thermometer			
D100.	Weighing machine			
D101.	Spotlight and working torch light with battery			
D102.	Examination table for the client			
D103.	Gloves, speculum, sponge holding forceps, cotton, antiseptic solution (povidon) in a tray for P/V examination			
D104.	Hand washing basin with elbow tap and running water, soap, antiseptic solution (hexisol), and personal towel			
D105.	Urine examination equipment			
D106.	Test-tube/bottle for urine collection and test-tube holder			
D107.	Sugar, albumin and pregnancy test kit			
D108.	Uri-sticks with bottle			
D109.	Blood examination equipment			
D110.	Tallquist book for and disposable lancet			
D111.	Cotton, antiseptic solution in cup/gully pot (rectified spirit/hexisol or povidone iodine)			

Pre-Operative room

D112.	bed, mattress, bed-cover, pillow, mosquito net and rubber sheet			
D113.	water, soap, bucket, towel, bathing facility etc.			
D114.	BP instrument, stethoscope and thermometer			
D115.	Medicine: antibiotic and tablet diazepam			
D116.	Toilet facility			

Operation theater with the facility of dressing, hand-washing and autoclaving or IP space

D117.	Autoclave, autoclave indicator tape and register			
D118.	Kerosene four-burner pressure stove or gas burner or electric stove or electric connection socket			
D119.	Surgical drum, drum or tray for instrument & gloves			
D120.	Twofold cloth for tray-cover or trolley cover			
D121.	Autoclaving monitoring chart on the autoclaving room's wall			
D122.	Necessary instruments for disinfection: (plastic bucket, sieve, bleaching powder or liquid chlorine or chlorine tablet, stirrer, plastic mug, utility gloves etc.)			
D123.	Basin for washing and wiping of the instrument, detergent powder, brush & towel			
D124.	Table for drying, wrapping and keeping the instrument			
D125.	Hanger/clip for drying the gloves			

continued...

C. Equipment and supply: Rate the presence and quality of the equipment and supplies at the site according to the following rating scale *(continued)*:

Hand washing area attached with operation theater

D126.	Basin with elbow tap and running water (obviously outside the toilet) or as a substitute water tank or drum with tap can be placed in the wall of table/ stand or water filled bucket and mug can be used (in that case an assistant should poured the water)	.....	.....	.....
D127.	Hand washing soap, antiseptic solution	.....	.....	.....
D128.	Area for undressing the used cloth and wearing OT dress	.....	.....	.....
D129.	Clean and sterilized musk for all related to the service	.....	.....	.....
D130.	Boot or sandal for all related person in the OT	.....	.....	.....

Operation theater

D131.	Enough light	.....	.....	.....
D132.	Glass window	.....	.....	.....
D133.	Netting to prevent insect	.....	.....	.....
D134.	Air Conditioned	.....	.....	.....
D135.	wall made of tiles/mosaic up to 7 feet from the floor	.....	.....	.....

Supplies for the OT

D136.	OT table with plastic or rubber sheet	.....	.....	.....
D137.	OT light and to prevent electricity interruption working 3 battery torch or charger light	.....	.....	.....
D138.	Instrument trolley	.....	.....	.....
D139.	Small/ Maya trolley for keeping all other instrument for every operation	.....	.....	.....
D140.	BP instrument and stethoscope	.....	.....	.....
D141.	Essential instrument for emergency management in working condition	.....	.....	.....
D142.	Emergency drug for emergency situation	.....	.....	.....
D143.	For regular tubectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	.....	.....	.....
D144.	For regular vasectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	.....	.....	.....
D145.	OT register	.....	.....	.....

Post- operative room

D146.	Toilet facility	.....	.....	.....
D147.	Washing basin	.....	.....	.....
D148.	Bed, mattress, Bed-cover, pillow with cover, mosquito net and rubber sheet, hurricane, vessel, bucket, mug, glass,	.....	.....	.....
D149.	Stool, table, chair, hand fan	.....	.....	.....
D150.	BP instrument, stethoscope, Thermometer, 3 battery working torch	.....	.....	.....
D151.	Medicine—paracetamol, vitamin tablet	.....	.....	.....
D152.	Emergency medicine	.....	.....	.....

D. Storage conditions: Rate the facility's commodities storage procedures and facilities using the following rating scale:

RESPONSES: AVAILABLE/YES = 1, NOT AVAILABLE/NO = 2

Are the following systems in place?

METHOD: ASK AND OBSERVE (ASK TO STORE MANAGER)		STATUS	COMMENTS/ RECOMMENDATIONS
D153.	Does this facility store any medicines, or contraceptive commodities?	.....	.....
	Please mention how stored:	.....	.....
	Are contraceptive commodities generally stored in the service area, or are they stored in a common area with other medicines?	.....	.....
D154.	Stored in FP service area	.....	.....
D155.	Stored with other medicines	.....	.....
D156.	FP commodities not in stocked	.....	.....
D157.	Inventory of equipment and commodities	.....	.....
D158.	Storage system according to commodity expiration dates (FEFO) (first to expire, first out)	.....	.....
D159.	Supplies maintained in required condition (FEFO)	.....	.....
D160.	Expired contraceptives are destroyed	.....	.....
D161.	System for ordering/reordering (requisition) supplies	.....	.....

Storage facility protected from damage by

D162.	Rain	.....	.....
D163.	Sunshine	.....	.....
D164.	Rats and pests	.....	.....
D165.	Month of Supply (MoS) board displayed	.....	.....

E. Transport for emergencies

RESPONSES: AVAILABLE/YES = 1, NOT AVAILABLE/NO = 2

TRANSPORT FACILITIES ASK AND OBSERVE (ASK TO FACILITY MANAGER)		STATUS	COMMENTS/ RECOMMENDATIONS
E1.	Is there any Emergency Transportation of this facility available? i.e. Ambulance	.....	.....
E2.	If yes, is it functional?	.....	.....
E3.	Area of coverage of transport emergencies:	.....	Distance (in km): ..... Area: .....
E4.	In case of emergency, do you have any functional referral system for tertiary or higher-level facility including first contact person?	.....	.....

F. Management Committee

Management System

	ASK (ASK TO FACILITY MANAGER)	STATUS	COMMENTS/ RECOMMENDATIONS
F1	Is there any management committee existing for this facility?	☐ YES ☐ NO	.....
F2	Who are the members?		.....
F3	How frequently did they sit for meeting?	☐ MONTHLY ☐ BIMONTHLY ☐ QUARTERLY	.....
F4	How do they communicate with service providers?		.....

G. Referral flow from community

	QUERY TO ASK (ASK TO FWV)	RESPONSE
G1.	Are there any FP client referral system from the community to this facility?	☐ YES ☐ NO
G2.	If yes, other than the FWA, who are involved with this referral process? (multiple response possible)	☐ NGO WORKER ☐ COMMUNITY VOLUNTEER ☐ NGO CREDIT GROUP MEMBER ☐ OPINION LEADERS ☐ PUBLIC REPRESENTATIVE ☐ PRIVATE PRACTITIONER ☐ TRADITIONAL BIRTH ATTENDANTS (TBAS) ☐ QUACKS ☐ SATISFIED CLIENT ☐ OTHER (SPECIFY).....
G3.	What type of FP client do they (referrer, other than FWA) refer? (multiple response possible)	☐ PILL ☐ CONDOM ☐ INJECTABLE ☐ IUD ☐ IMPLANT ☐ VASECTOMY ☐ TUBECTOMY
G4.	Do they refer the following types of clients (referrer, other than FWA)?	☐ PPFP ☐ PAC-FP ☐ POST MR-FP
G5.	Do they (referrer, other than FWA) refer any adolescent FP client (10-19)?	☐ YES ☐ NO
G6.	If yes, what type of services are clients referred for? (multiple response possible)	☐ PILL ☐ CONDOM ☐ INJECTABLE ☐ IUD ☐ IMPLANT ☐ VASECTOMY ☐ TUBECTOMY
G7.	Do any of the referrers, other than FWAs, get a referral fee?	☐ YES ☐ NO
G8.	Have any referrers, other than FWAs who are involved in referral process received any training?	☐ YES ☐ NO
G9.	Are they (referrer, other than FWA) compensated for their time and work?	☐ YES ☐ NO
G10.	How are they (referrer, other than FWA) compensated for their time and work?	☐ FWA ☐ FPI ☐ FWA ☐ OTHER (SPECIFY) .....
G11.	Are they (referrer, other than FWA) under any supervision mechanism?	☐ YES ☐ NO
G12.	if yes, who are their (referrer, other than FWA) supervisor?	☐ YES ☐ NO
G13.	Does the facility have standard referral forms that are used? If so, please show	☐ YES ☐ NO
G14.	Are there any referral number tracking systems?	☐ YES ☐ NO
G15.	What are the strengths and weaknesses of the referral system you just described?	.....

H. Observation of Infection Prevention Practices**

This section provides information on a variety of infection prevention practices and procedures. The facility should work toward the highest possible standards of infection prevention. The best possible guidelines for infection prevention procedures should be in place and all contaminated instruments should be processed according to the established protocol.

***These tasks require observation of a practice and only need to be rated if the observer happens to be present at the time it is being done.*

INSTRUCTIONS: *Enter the appropriate status from the list below into the "Status" column of the monitoring chart. Please note any further remarks in the "Comments/Recommendations" column.*

Items

METHOD: ASK & OBSERVE (ASK TO AYA /FWV)		STATUS	COMMENTS/RECOMMENDATIONS
Decontamination			
H1.	0.5% chlorine solution available (powder or liquid bleach)	.....	.....
H2.	Instructions for mixing chlorine powder/preparing chlorine solutions are present & posted on wall	.....	.....
H3.	Alcohol hand rub available	.....	.....
H4.	Cap	.....	.....
H5.	Mask	.....	.....
H6.	Plastic apron	.....	.....
H7.	Shoe	.....	.....
H8.	Gown/mackintosh	.....	.....
H9.	Spectacles	.....	.....
H10.	Waste disposal	.....	.....
H11.	Soap	.....	.....
H12.	Water tap/running water supply	.....	.....
H13.	Clean bucket	.....	.....
H14.	Disposable shoe cover	.....	.....
H15.	Utility gloves	.....	.....
H16.	Water measuring pot	.....	.....
H17.	Bleaching powder container and measuring cup	.....	.....
H18.	Plastic strainer	.....	.....
H19.	Wooden nudge stick	.....	.....
H20.	Watch/timer	.....	.....
H21.	Cleaning equipment, detergent, & brushes available (List of equipment's)	.....	.....
H22.	Chlorine solution	.....	.....
H23.	Bleaching powder	.....	.....
H24.	Chlorine solution keeping bucket	.....	.....
H25.	Melamine spoon	.....	.....
H26.	Plastic bucket with green cover for clean water		
Cleaning of Instruments			
H27.	Basin with running water	.....	.....
H28.	Plastic bucket	.....	.....

continued...

Cleaning of Instruments *(continued)*

H29.	Detergent powder		
H30.	Brush		
H31.	Utility gloves		
H32.	Table/ plastic rack		
H33.	Towel		
H34.	Clean clothes		
H35.	Mask/ mackintosh		

High Level Disinfection (HLD) or Sterilization

Boiling

H36.	Sterilizer or covered steel bucket		
H37.	Timer		
H38.	Lifter		
H39.	Scalpel		
H40.	Blade		
H41.	Scissor		
H42.	Needle		
H43.	Availability of IUD sterilizer		
H44.	Stores equipment in dry HLD container		

Sterilization

Autoclaving

H45.	Functioning Autoclaving system with appropriate storage of instruments		
H46.	Storage of Lifter and Thermometer		
H47.	Autoclave machine		
H48.	Power source		
H49.	Surgical drum/ tray		
H50.	Timer / watch		
H51.	Supplies of other equipment		
H52.	Glutaraldehyde		
H53.	Autoclave indicator / autoclave tape		
	Hand Washing		
H54.	Soap available (Solid/Liquid)		
H55.	Clean towel available, or air dry		

Barriers

H56.	Gloves are put on properly		

Storage and Disposal

H57.	Antiseptic solutions are labeled		
H58.	Used needles and syringes are immediately disposed of in an appropriate container with no recapping		
H59.	HLD or sterilized equipment is stored in a dry HLD or sterile container		
H60.	Lifter stored in a dry HLD container or sterile container		

H61.	Thermometer is stored in a dry container		
H62.	Black waste disposal bucket		
H63.	White waste disposal bucket		
H64.	Green waste disposal bucket		
H65.	Red waste disposal bucket		
H66.	Blue waste disposal bucket		
H67.	Incinerator		

Handling Specimens and instruments

H68.	Utility gloves are available for handling specimens and instruments		

I. Observation of Record keeping and Treatment Protocols. In the following section, record the facility's record keeping status:

RESPONSES: AVAILABLE/YES = 1, NOT AVAILABLE/NO = 2

Where information beyond the status is needed or if you have recommendations for improvement, use the "Comments/Recommendations" column.

Activity

METHOD: ASK (ASK TO MO)		STATUS	COMMENTS/RECOMMENDATIONS

General Record keeping

I1.	Is there a staff member available to do data entry?		
I2.	Is a client medical record used in the clinic?		
I3.	Is the client given a card to record his/her visits to the facility?		
I4.	Is there a system for filing clients' record and retrieval?		
I5.	Can records be retrieved easily?		
I6.	Is the required data entered by the end of each day?		
I7.	Do they utilize computer/ mobile/ tablet for record keeping and reporting?		

Are the following records accurate and complete?

Informed Consent Form for:

I8.	IUD		
I9.	Implant		
I10.	Tubectomy		
I11.	Vasectomy		
I12.	Injectable		
I13.	Medical History		
I14.	Physical Examination		
I15.	FP Method Chosen		
I16.	Number of FP Supplies Given		
I17.	Referral Form		
I18.	Registration book		

continued...

Informed Consent Form for *(continued)*:

I19.	Is the collected data analyzed?	.....	.....
I20.	Who analyzes the data?	.....	.....
I21.	complications related to contraceptive use	.....	.....
I22.	Where are the complications reported and recorded?	.....	.....
I23.	The most recent version of written guidelines and protocols for delivering FP services are available	.....	.....

J. Management, Supervision and Quality

The following questions are related to management and supervision, which is an important factor for improving the quality of services. Both the clinic manager/supervisor, as well as providers should be interviewed to elicit answers to these questions:

Management

QUERY METHOD: ASK (ASK TO FACILITY MANAGER)		RESPONSE TYPE AND ANSWER
J1.	When do clients usually start coming?	TIME: .....
J2.	How long does the client stay at the clinic?	IN HOURS .....
J3.	Average waiting time for general client including FP	IN MINUTES .....
J4.	Number of clients that can be accommodated in waiting area	NUMBER OF SEATS AVAILABLE .....
J5.	Do any adolescent/youth clients come?	☐ YES ☐ NO ***(IF NO, GO TO I8)***
J6.	Where do they usually wait before getting service?	☐ SEPARATE ARRANGEMENT AVAILABLE — 01 ☐ WAIT ALONG WITH OTHER PATIENTS — 02 ☐ OTHER (SPECIFY) .....
J7.	Average waiting time for adolescent/youth client	IN MINUTES .....
J8.	Steps to take Services (According to the required service) • Client flow chart (Entry to Exit) • (Client à Facility à Waiting area à Counselor (if available) à Provider à Pathology à Washing à OT/procedure room à Post-operative à Exit)	VALIDATION OF MENTIONED PATHWAY: ☐ YES ☐ NO (DEVIATIONS: ....
J9.	Does client need any further contact beside above step	☐ YES ☐ NO

How much time is required to get the following service:

J10.	NSV	IN MINUTES .....
J11.	Tubectomy	IN MINUTES .....
J12.	Implant	IN MINUTES .....
J13.	IUD	IN MINUTES .....
J14.	Injectable	IN MINUTES .....
J15.	Pill	IN MINUTES .....
J16.	Condom	IN MINUTES .....
J17.	ECP	IN MINUTES .....
J18.	Who manage OT for IUD	DESIGNATED, RESPONSIBLE PERSON .....

J19. Do manager or provider allow other people who does not involve in any step between client entry to exit? ☐ YES ☐ NO

J20. If yes, what type of people? .....

Supervision & Quality Improvement

STATUS

J21. Does your supervisor conduct any supervision visits in this facility? ☐ YES ☐ NO

J22. If yes, how often does the supervisor conduct the visits?

☐ WEEKLY — (1)
☐ MONTHLY— (2)
☐ QUARTERLY — (3)
☐ MORE THAN SIX MONTH — (5)
☐ NOT SPECIFIED — (6)
☐ SIX MONTHLY — (4)
☐ OTHER (SPECIFY) — (9)

.....

J23. If supervisory visit is conducted, do they use any checklist? ☐ YES ☐ NO

J24. Is there any provision of debriefing/feedback/learning session after completion of the visit of the supervisor? ☐ YES ☐ NO

J25. If yes, do they use any checklists? ☐ YES ☐ NO

J26. Is there any provision of written feedback from the supervisor after completion of the visit? ☐ YES ☐ NO

J27. Can you please show any copy of the reports of the supervisory visit? (DETERMINE THIS FROM THE CHECKLIST) ☐ YES ☐ NO

J28 Is developing an action plan is part of the feedback system? ☐ YES ☐ NO

Quality Assurance

J29. Is there any routine visit for quality assurance held by any external supervisor/manager? ☐ YES ☐ NO

J30. If Yes, who is/are the visitors

☐ DGFP-OFFICER/FP CLINICAL SUPERVISION TEAM — (1)
☐ OTHER EXTERNAL QUALITY TEAM VISITS — (2)
☐ INTERNAL QUALITY TEAM — (3)
☐ QIC DQA SYSTEM — (4)
☐ QIC VISIT — (5)
☐ OTHER (SPECIFY):

.....

J31. If Yes, how often do external supervisor/ managers conduct visits?

☐ WEEKLY — (1)
☐ MONTHLY— (2)
☐ QUARTERLY — (3)
☐ MORE THAN SIX MONTH — (5)
☐ NOT SPECIFIED — (6)
☐ SIX MONTHLY — (4)
☐ OTHER (SPECIFY) — (9)

.....

J32. Is there any filled-in checklist on the assessment of quality of service for the period of last time? ☐ YES ☐ NO
(interviewer: collect one such filled-in checklist for your record.)

J33. Did they record the quality assessment information of service on the check list/visit book during the last visit? ☐ YES ☐ NO

J34. Is there any feedback from the supervisor? (DETERMINE THIS FROM THE CHECKLIST)

☐ YES, WRITTEN FEEDBACK — (1)
☐ YES, VERBAL FEE DBACK — (2)
☐ NO — (3)

J35. Has any action step taken so far based on the supervision/quality assurance visit? ☐ YES ☐ NO

K. Elements of Youth-Friendly Contraceptive and PAC Services

Essential Elements

METHOD : ASK (ASK TO COUNSELOR/FWV)		RESPONSE	COMMENTS/RECOMMENDATIONS
Confidentiality			
K1.	Do written procedures exists for protecting client confidentiality?	☐ YES ☐ NO	.....
K2.	Are records stored so that confidentiality is ensured?	☐ YES ☐ NO	.....
K3.	Is registration done in a manner that ensures confidentiality?	☐ YES ☐ NO	.....
Adolescents are served regardless of age or marital status			
K4.	Do clear written guidelines for serving youth exist?	☐ YES ☐ NO	.....
K5.	Is there a minimum age requirement for contraceptive or PAC services?	☐ YES ☐ NO	.....
K6.	Is spousal consent required?	☐ YES ☐ NO	.....
Comprehensive contraceptive counseling offered to all clients			
K7.	Do providers counsel on a range of methods (effectiveness advantages/disadvantages)?	☐ YES ☐ NO	.....
K8.	Do providers allow clients to choose a method, and then provide full information on that method including potential side effects?	☐ YES ☐ NO	.....
K9.	Do providers inform them on follow up visit?	☐ YES ☐ NO	.....
K10.	Is comprehensive contraceptive counseling offered routinely as post-abortion and postpartum clients?	☐ YES ☐ NO	.....
Range of contraceptive methods offered to all clients regardless of age, marital status, and HIV status			
K11.	What contraceptive methods are offered to clients? (multiple response)	☐ PILL ☐ CONDOM ☐ INJECTABLE ☐ IUD ☐ IMPLANT ☐ VASECTOMY ☐ TUBECTOMY	.....
K12.	Are there any contraceptive methods that youth cannot receive?	☐ YES ☐ NO	.....
K13.	Is there a minimum age requirement to receive certain methods?	☐ YES ☐ NO	.....
K14.	Are any FP methods provided to unmarried youth?	☐ YES ☐ NO	.....
K15.	Are there any methods that are not offered to HIV positive clients?	☐ YES ☐ NO	.....
Privacy during FP counselling			
K16.	Are there doors and are they shut during consultation?	☐ YES ☐ NO	.....
K17.	Are there curtains in the window?	☐ YES ☐ NO	.....
K18.	If windows are left open, can anyone easily hear what is being said?	☐ YES ☐ NO	.....
K19.	Are privacy screens used?	☐ YES ☐ NO	.....
K20.	Does personal history taking, screening or asking why the client has come for services occur in public?	☐ YES ☐ NO	.....
K21.	Are there any non-essential interruptions during counseling, exams, or lab procedures?	☐ YES ☐ NO	.....

FP treatment guidelines, procedures and protocols

K22. Are there guidelines and SOPs for FP available on site? ☐ YES ☐ NO .....

K23. Are there service delivery procedures for FP services (including treatment, counseling, and referrals) available? ☐ YES ☐ NO .....

K24. Are there service delivery guidelines for serving adolescent clients available? ☐ YES ☐ NO .....

K25. Are the protocols routinely followed? ☐ YES ☐ NO .....

K26. PAC treatment guidelines, procedures and protocols exist and are followed ☐ YES ☐ NO .....

L. Gender responsiveness of services

QUERY METHOD: ASK (ASK TO FACILITY MANAGER SPECIFY)

Administration and staffing

L1. Management Staff # FEMALE: ..... # MALE: ..... TOTAL: .....

L2. Technical Staff # FEMALE: ..... # MALE: ..... TOTAL: .....

L3. Support Staff # FEMALE: ..... # MALE: ..... TOTAL: .....

L4. Facility Manager ☐ FEMALE ☐ MALE

Program environment- a. Physical safety, Psychological/emotional safety, trauma-informed, holistic and culturally competent practices

QUARRY METHOD: ASK (ASK TO FACILITY MANAGER SPECIFY)		RESPONSE YES 1, NO 2	COMMENTS
L5.	Do women clients face any security problem to receive service from this facility?	.....	.....
L6.	Did any client share any story related to physical, psychological or emotional trauma when they come to receive service from this facility?	.....	.....
L7.	Did any woman who victim of gender-based violence receive services from this facility?	.....	.....
L8.	Are there any difficulties for women to receive service from this facility?	.....	.....

Service provisions

L9. Who are the service recipients from this facility? ☐ FEMALE ☐ MALE ☐ BOTH ☐ THIRD GENDER

L10. Did any staff receive any training/orientation on gender? ....

L11. Are there any gender related items included on the agenda in any meeting? ....

L12. Does any supervisor discuss issues related to gender when they visit the facility?

continued...

Data collection and reporting

L13. Does this facility maintain any sex disaggregated service information? ....

L14. Are there any gender related accomplishments in the monthly report? ....

SBCC materials Availability

QUESTION METHOD: OBSERVATION		IUD	IMPLANTS	TUBECTOMY	NSV	INJ.	PILL	CONDOM	MORE THAN ONE METHOD IN ONE MATERIAL
01	Are there any billboard(s)/ banner(s) in the premise of the facility?	☐	☐	☐	☐	☐	☐	☐	☐
02	Are there any posters at the facility?	☐	☐	☐	☐	☐	☐	☐	☐
03	Are there any leaflets/booklets are kept in easily visible places?	☐	☐	☐	☐	☐	☐	☐	☐
04	Are the clients/visitors allowed to take the leaflets/booklets with them?	☐	☐	☐	☐	☐	☐	☐	☐
05	Are there any job-aids which are used by the service provider?	☐	☐	☐	☐	☐	☐	☐	☐
06	Circle the job-aid that you observed. (Devices or tools (such as instruction cards, memory joggers, wall charts) that allow an individual to quickly access the information he or she needs to perform a task.)	☐	☐	☐	☐	☐	☐	☐	☐

FOCUS GROUP GUIDES

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

Opinion leaders

GENERAL INSTRUCTIONS: This guide provides the questions and topics that will be addressed in the FGD. The guiding questions are listed by subheadings related to program processes. Please adhere to the following instructions when facilitating this FGD:

Identifying leaders

It is important to note that identifying opinion leaders can take a lot of work and can be hard to validate. There are many ways to determine who might be considered likable, trustworthy and influential people. There are four ways to identify opinion leaders in a hospital or clinic.

- You can use an independent observer to identify opinion leaders within a group of professionals as they interact at work.
- Or ask members of a professional network whether they consider themselves to be an opinion leader.
- Or ask individuals to name the people they feel are the most influential.
- Or finally, ask members of a network to judge individuals according to the extent to which they have educational influence and whether they are knowledgeable.

1. Please begin by welcoming individuals as they arrive to the FGD and obtaining consent
2. Fill out **Part A: Background Information** after obtaining consent and before starting the FGD.
3. When it is time to begin, start the recorder, welcome participants as a group and read **Part B: Opening Script.**
4. Proceed with **Part C: Guiding Questions** and facilitate the discussion.
5. After the discussion concludes, thank the participants, stop the recorder, and dismiss the group. Record the end time on the **Part A: Background Information** table

Informed Consent

(Greet the group-Hello.....). My name is ..... I am representing the Shukji Jibon project of Pathfinder International, an international NGO. We are helping the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) of the Government of Bangladesh in improving Family Planning/Reproductive Health in Bangladesh. We are conducting an assessment which aims to improve family planning service focusing on adolescent and youth friendly services (AYFHS), post-partum family planning (PPFP), post-abortion care family planning (PAC FP), post-menstrual regulation family planning (MR FP), and gender responsiveness. We are interested to gather your understanding, perceptions, opinions, and suggestions on the best practices you have applied or seen in your district in regard to FP/RH. Your opinion is very important to us and will help the government make policy decisions to replicate the same model in other parts of the country.

I would like to ask your permission to participate in a small group discussion (7-11 people) on FP/RH practices in your area. The discussion will continue for about one and half hours. You can refuse to answer any questions, or you can keep silent, if you want. Your participation in this interview is completely voluntary. The risk for participating in the study is minimal. For your participation, you will not be paid any money. Your responses will be kept confidential. Your name will not appear on any report. We will not share your information with anyone or in your department, nor will we identify you individually in any way, if the results of this discussion are published as a report and journal articles. If you permit, the discussion will be tape recorded with voices only, to help us recall what has been discussed when preparing our report. The audiotapes will be given to the Monitoring, Evaluation and Learning Specialist at Pathfinder International, who will not share the tapes outside of the project staff. Only the researchers will have access to your responses, which they will utilize to prepare the report. All the data will be stored in a locked and secured place.

You may ask any questions or clarifications before giving your consent for this FGD, during or after the FGD.
You may also contact Md. Liaquat Ali (01711354106) for any questions after the FGD.

If you do not have any questions, do I have your permission to continue? ☐ Yes (1) ☐ No (2)

Moderator's name:	Signature of Moderator	Date

Part A: Background Information

1. FGD Code: .....

2. Facilitator name: .....

3. Date: ..... **4. Start Time:** ..... **5. End time:** .....

6. Location: **Division:** ..... **District:** .....

Upazila: ..... **Union:** .....

7. # of participants: .....

8. Description of Setting (Surroundings, general atmosphere, weather, observations before starting FGD):

.....

.....

Part A Continued: Participant Information

Please let's begin with everyone introducing themselves—please state your age, marital status and how long you have been living in this community.

FIELD	PARTICIPANT CODE	SEX	AGE	OCCUPATION/ROLE IN COMMUNITY	SPOUSE'S OCCUPATION	YEARS OF SCHOOLING
9.1						
9.2						
9.3						
9.4						
9.5						
9.6						
9.7						
9.8						
9.9						
9.10						
9.11						
9.12						

Part B: Opening Scripts

OPENING SCRIPT —GROUP INTERVIEW: Good morning/afternoon, I would like to thank you for giving the time to speak with us in this interview. We would like to learn more from you about your opinions related to the Family Planning services in this area. Firstly, let me introduce myself. I am [name] and my colleagues are [name] and [name] ..... We are here on behalf of the Shukhi Jibon project of Pathfinder Int. to conduct a study in collaboration with the Ministry of Health and Family Welfare in order to help improve service provisions and quality of Family Planning.

Today we are asking you to share your opinions—there are no right or wrong answers because you are only expected to share your experiences. In addition to that, let me say that the information that we share in this group should be considered confidential. Each of you has been given a number that will be used to record your comments, so you will not be identified by name. Please do not share the opinions of others outside of this group. We should respect each other's' opinions and give each other turns when speaking.

Part C: Guiding Questions

Theme: Perception about health and FP services

1. Perception about family planning methods. Community perception about FP services.
2. Necessary to provide FP methods for both men & women.
3. Working modality of FWA and PFI

Theme: Gender

1. Adequacy of public health facility to serve enough for both men and women. If adequate, quality of those services. If not, the challenges or gaps.

   PROBE: *distance, transportation facilities, date—time flexibility and comfortability for taking the services are suitable for women, adolescent also etc.*

2. Possible involvement of local leaders with health service delivery in this area.
   PROBE: *forming committees, increase providers accountability, periodic visits, generating funds from community, functional community referral, support facility readiness, advocacy for improving health seeking behavior etc.*
3. Gender as a barrier to avail MCH and FP services. If so, possible mitigation strategy.

Theme: Youth and Adolescents

1. Most popular health and family planning service provisions. Reason of popularity.
   PROBE: *provider is skilled and available, Facility is nearby, cheap, one stop service, influenced by other satisfied user, FWA influence for that, confidentiality to get the commodity or services etc.*
2. Availing services by young people irrespective of age/sex and marital status. If yes, describe.
   PROBE: *provider is skilled and available, Facility is nearby, cheap, one stope service, separate service for young people, compassionate, privacy and confidentiality, age specific counseling etc.*
3. Family planning services for adolescents and young people. If special services required, please describe.
   PROBE: *PAC, counseling, other services etc.*

Theme: Community engagement

1. Possible engagement of community leaders to enhance family planning services. If possible, please describe. If not possible, please share the barriers.
   PROBE: *supporting facilities through management committee, linking local elites for financial support, involving local govt' etc.*
2. Please tell us about the Community support group and community management committee of community clinic. Involvement of community with public health facility. If involved, please describe. If not, please share the barriers.
   PROBE: *familiar about any member of that group; their role; any involvement of yourself; any example etc.*

Theme: SBCC

1. Source of knowledge about any MNH and FP services. (Please probe to have a hierarchical list)
   PROBE: *please mention any message you can remember of family planning*
2. Please share your thoughts about existing SBCC activities (please explain…) in your area. Please share your thoughts on reaching community people more effectively.
   PROBE: *visual, audio, audiovisual etc.*
3. Please suggest media (electronic, print) that would be best to increase informed Family Planning messages. Please share the reason of your preference. Please share your thoughts about internet-based information for MNH and FP services.
   PROBE: *familiar with SBCC materials; Tiahrt poster; popular; accessible; women can reach etc.; any electronic device used; familiar with any apps, media etc.; what are those?*

Theme: referral

1. Please share with us the health service seeking behavior.
   PROBE: *whether they visited community level facility to district level tertiary level facility for getting any particular service by referral mechanism.*
2. Please describe of any existing social mechanism to help poor to reach public health facilities. If exists, please describe.
   PROBE: *How local elites can help, financial support, giving fair, arrange vehicle, help them contact with FWA, HA, NGO volunteers etc.*
3. Please share with us the first point of contact in your locality for health services.
   PROBE: *How she/he helps?*

Suggestion/Recommendation

1. Please share your recommendations to increase community involvements in MNCHFP services?
   PROBE: *(Please do not* **PROBE***)*

KII GUIDE FOR MANAGERS – 3

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

FP managers

(DDFP, ADCC, FPCST-QIT, UH&FPO, UFPO)

Identification of Respondents

1. Facility Name: .....

2. Code*: .....

3. Location: **Division*:** ..... **District*:** .....

Upazila*: ..... **Union*:** .....

3. Designation of provider: (FOR MANAGER–1, SERVICE PROVIDER–2) ..... **Code:** .....

4. IDNO#: .....

(FACILITY CODE + DIVISION CODE + DISTRICT CODE + UPAZILA CODE + UNION CODE + DESIGNATION CODE)

** (Please provide a unique code for each mentioned during processing of data and construct IDNO for each respondent)*

GENERAL INSTRUCTIONS: Interviewers, please read the following opening script to the respondent and then proceed with asking him/her the questions listed below. Some questions have specific probes, but please use your judgement to probe on additional points of interest to guide the discussion as needed.

Consent form

OPENING SCRIPT: Thank you for agreeing to participate in our study. My name is ....., I am representing the Shukhi Jibon project of Pathfinder International, an International NGO.

Introduction of the study and this interview:

We are conducting an assessment to improve the availability and quality of family planning services in your area. This interview is a part of that assessment.

The purpose of this interview is to gain a better understanding of how you are managing family planning services with other health services within the government health system, and what are the success and challenges that are encountered.

Why you are being asked to participate:

You are working as a Manager for Family Planning services here. Therefore, your view on this aspect will represent the opinion of other managers working for the same level facilities in this division. You have been selected as a respondent.

Procedures:

If you say yes, we will ask you to participate in the interview. Each interview will take approximately 1 hour to 1.5 hours. During the interview, we will ask you to further describe your experiences as a FP manager and the challenges that you encounter with your work. With your permission, the open-ended interview will be audio recorded and transcribed.

Risks/discomforts

There is no possible risk if you agree to participate in this study. Rather, it will benefit you by helping us to improve services in this facility. All the information that you provide will be kept strictly confidential; your name will not be used and you will not be identified in any way. Your current and future position at this facility will not be affected in any way.

Protecting data confidentiality

All research projects carry some risk that information about you may become known to people outside of the study. However, we will do our best to keep your responses confidential by assigning a code to documents with your responses and not including your name or other identifying information, such as your phone number or the name of your community, on the forms.

Benefits

There will be no personal benefit to you for participating. We may use the information that you provide to us to make recommendations to the MOHFW and partners about how to improve Family Planning services.

Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any questions during the interview; and you may stop the interview at any point. Please respond to these questions as honestly and as descriptively as possible. We will now begin!

Name of Provider: ..... Designation of Provider .....

What is the highest academic degree you have completed?

1 = Bachelor 2 = Masters 3 = Postgraduate Diploma 4 = Medical Doctor

At what year did you begin your service/job?

LOCATION: ☐ Division ☐ District ☐ Upazila ☐ Union

TYPE OF FACILITY: ☐ District Hospital ☐ UH&FWC ☐ Upazila Health Complex

Policies and guidelines:

1. Do all policies and guidelines issued by the government of Bangladesh reach to your districts immediately (within 1–2 weeks) after publication/revision?
2. How do you check on the most recent policies and guidelines in your facility?
3. Have you ever worked as a member of technical committee for developing guidelines?
   If yes, what guidelines did this technical committee work on?
   PROBE: *(FP manual, any FP training guidelines, etc.)*
4. What do you think of the current policies and guidelines in place and the process of how they are currently revised?
   PROBE: *(any feedback based on facing any issues in the field for policy formulation)*
   - involvement in implementation of any approved policy;
   - challenges faced in implementing policies;
   - proactiveness among providers, staff to implement new or existing policies
5. When a new staff member is hired, does the staff member immediately get foundation training?
   Why or why not?
6. How do you disseminate new policy/ guideline to providers/staff? Do your staff/ providers practice up to date policy/ guidelines for providing services or client screening? If no, why?

Training of providers

1. What do you think about skills of providers for providing FP services in different facilities in your district?
   PROBE: *at DH, MCWC, UHC and UH&FWC etc.*
2. What kind of training have most service providers working in the facilities received with respect to family planning?
   a. Can you describe what these trainings usually involve? Do you think they provide sufficient knowledge?
3. What are the major staffing challenges that service providers face in offering FP services to clients?
   PROBE: *Transfer, Lack of service providers and support staff, Lack of field workers, lack of trained staff*
4. What is the commodity and other logistic, supply related challenges that you are facing that hamper service provision?
   PROBE: *Lack of FP commodities, lack of imprest fund, lack of other logistics supply.*
   - Structural barriers (insufficient counseling space, IUD insertion space, waiting area, adolescent corner),
   - Working hours,
   - Problems with referrals from community/field, including low numbers of referrals
   - Poor client screening at the field level,
   - Low numbers of service providers at facility at times (due to leave/training/meeting)
   - Stigma
5. What kind of training and/or support would help service providers perform better in this facility?
   a. What do you think about providing mentorship and supportive supervision for continuous learning and skill development?
   b. What do you think about showing IEC materials to the clients on Tablets?

Responsiveness of FP services

1. Can you describe a typical FP/RH counselling session between a service provider and a client?
   What are the steps in the counselling process?
   PROBE: *Place where counselling takes place, use of materials, privacy, respect, informed choice, etc.*

a. What is your opinion of the quality of FP counselling that providers at your facility offer to clients?

PROBE: *Is the counselling effective? Informative for clients? Does provider accept repeated questions from client?*

2. What do you think about service hours of your facility?
   a. Do the operating date/hours meet the needs of clients?
   b. Do the operating date/hours meet the needs of staff members?

3. What is your opinion about the "citizen charter" used for your facility?

   PROBE: *visibility, language, appropriateness with services etc.*

4. What are the most popular FP methods in your district/upazila? (Please list 3–5 methods).
   a. Why are these FP methods the most Popular?

   PROBE: *availability/supply, providers' preferences, clients' preferences, role of market availability, role of media, other social reasons, convenience, side effects, etc.*

5. What are the least popular FP methods in your district/upazila?
   a. Why these are methods less popular?

   PROBE: *availability/supply, providers' preferences, clients' preferences, role of market availability, role of media, other social reasons, convenience, side effects, etc.)*

Integration of FP with MCH and other SRH services across directorates i.e. DGHS and DGFP

1. What do you think about providing FP services for adolescents (11–19 years)?
   a. In your opinion, is it appropriate to provide FP services to young people? At what age?
   b. In your opinion, is it appropriate to provide FP services to adolescent boys? What about adolescent girls?
   c. Is the marital status of the adolescent relevant for providing FP services?

   PROBE: *accessibility, appropriateness, age specific training etc.)*

2. Does your facility offer family planning services to adolescents (ages 11–19)?
   a. Are these services generally accessible to young people?
   b. Do the facility's operating hours match the times of day when adolescents, especially students, can typically come into the facility?

3. In what ways do you think that FP services in your district/upazila could be improved to meet the needs of adolescents?

4. What do you think about the qualifications of the service providers in your facility to provide FP services for adolescents?
   a. What age and sex are the service providers who provide FP services for young people? Do you think this is appropriate and meets young people's needs?
   b. Do you think the providers at your facility have the appropriate training to provide FP services to adolescents? How so?
   c. Do you think the providers at your facility have the appropriate skills to provide FP services to adolescents? How so?

Management/ role of GOB

1. What do you think of the relationship between the DGFP and the DGHS?
   a. How do you think coordination between DGFP and DGHS could be improved?
   b. At which management/service level are there scopes to improve DGFP-DGHS coordination? Please describe briefly
2. Is there any role of the Director General of Nursing and Midwives (DGNM) in providing FP service in health facilities?
   a. If so, what type of role does it play and in what FP services? How?
3. Are there any levels of management/services where there are challenges? Please describe briefly
   (What are the other challenges that relate to the larger level government role/ministry role?)

Supervision and accountability

1. Is there any system to check progress of provider performance? If so, provide a brief description
2. Only for DGFP providers: What do you think about the supervision system of FP service providers and managers in DGFP?
   PROBE: *way of supervision (distant vs. in person), supportiveness/sympathetic, frequency, methods, tools etc.)*
   a. How could the supervision system for FP service providers and managers in DGFP be improved?
3. Only for DGHS providers: What do you think about the supervision system of FP service providers and managers in DGHS?
   PROBE: *way of supervision (distant vs. in person), supportiveness/sympathetic, frequency, method, tools etc.)*
   a. How could the supervision system for FP service providers and managers in DGHS be improved?
4. What are the major challenges of supervision for FP services at DGFP?
   PROBE *for different providers and services, administrative, clinical, hands on coaching, general service or performance related, FP compliance*
5. What are the major challenges of supervision for FP services at DGHS?
   PROBE *for different providers and services, administrative, clinical, hands on coaching, general service or performance related, FP compliance*
6. How is supervision data used?
   a. Please share instances where supervision data was used for improving quality of services, facility readiness, FP compliance etc.
7. What do you think about the dynamics of the supervision of FP services in terms of gender?
   a. Have you ever encountered instances in which a male supervisor interacts differently with a male service provider than with a female service provider? Can you describe this? What happened? If this is a problem, how can it be improved?
   b. Have you ever encountered instances in which a female supervisor interacts differently when a male service provider than with a female service provider? Can you describe this? What happened? If this is a problem, how can it be improved?
   c. Have you encountered instances in which a supervisor interacts differently when a younger or older age provider? Can you describe this? What happened?
   d. How this can be improved?
8. What do you think of effectiveness of supervision by on-site and off-site supervisors? How do they differ? Which is more effective? Why?
9. What are the major supervision needs for FP service provision?
   PROBE: *skills (clinical skills, record keeping, client screening skill, counseling skill, follow up skill, logistical management, etc.), management, client interactions, interpersonal interactions, etc.*

10. How frequently do service providers conduct follow up for FP service receivers?
    a. What could be the standard time period (each specific method) for client follow up?
11. In the case of any clinical or management related issue/ emergency, whom do you ask for support or consult to solve any problem related to clinical knowledge and skill (method specific)? Why?
    PROBE: *Do you think he or she has mastery in specific clinical field/ method or management related knowledge and skill?*

Mentorship

1. Are you familiar with the concept of mentoring? This is the definition of mentoring that we use: Mentoring is a positive developmental partnership, where an experienced, proficient and empathetic person (a mentor) teaches and coaches another individual (mentee) or group of individuals (mentees), in person and/or virtually, to ensure competent workplace performance and provide ongoing professional development.
    a. What do you think about Mentoring in the context of a health facility?
2. Have you ever been mentored at your current role? If yes, by whom and how?
3. If Mentoring is introduced to FP services, how would you like to see it in practice?
    PROBE: *prospective mentors, mentee, matching, location of mentor-on-site/ off-site, priority skill areas for mentoring etc.)*
4. Do you think, mentoring, if introduced, may support supervision and capacity building of service providers? If yes, how?

Gender responsiveness

1. Are women and men who come to this facility equally able to access FP services at this health facility?
    a. Why/why not?
    b. What barriers might women face in accessing FP services at this facility?
    PROBE: *extent of privacy, feeling uncomfortable, pressure or bias from others at the facility (family, other patients, providers), male provider etc.*
    c. What barriers might men face in accessing FP services at this facility?
    PROBE: *extent of privacy, feeling uncomfortable, pressure or bias from others at the facility (family, other patients, providers), female provider etc.*
2. When you counsel women about their FP options, are they usually by themselves or with their husbands?
    a. What is the role that men play when it comes to women accessing FP services?
    PROBE: *Do they make the final decision about whether to use FP/which method to choose? Do they consult with their wives and the decision is made jointly? Do the men talk with the provider, too?*
    b. What do you think about male participation in FP services (supporting in taking decision by partner)?
3. Are there any differences in how you interact with female patients compared to male patients who come to talk to you about their FP options?
    PROBE: *Inquiring about marital status or permission before going forward with recommending options*
4. What can be done to improve FP services for women?
    a. What can be done to improve FP services for men?
5. Do you think FP services at your facilities are responsive to youth and adolescent? How? How this can be improved?

Use of service statistics for making decisions

1. How is performance data currently captured and utilized?
    a. Is performance data shared with providers?
    b. Is this data shared in a performance report?
    c. If yes, is the performance report easy to read and understand? How so?
    i. What do you think about the existing performance monitoring system?
    ii. Do you think DGFP MIS system is enough to support your monitoring system in your management area?

PROBE: *Do you feel confident to use that data? Sometimes people from outside raise questions about the data quality. Sometimes, DGHS and private facility data are not captured in DGFP MIS, especially PPFP service information.*

a. Why or why not?

iii. How can the use of performance data can be improved in your district/upazila?

iv. Do you have any scope to take decision from existing performance monitoring system? If yes where and how?

v. Have you ever used the DGFP MIS data for planning of you district? If yes, what are those?

PROBE: *stock data, FWV reports etc.*

vi. Where are the scopes to use data for quick decision making and planning?

vii. Have you ever used age and sex-disaggregated data for FP services during district/upazila planning (**PROBE**-)?

i. If yes, do you ever use this? If yes, why?

viii. What do you think about the reporting system of DGFP? Please describe

Use of electronic devices

1. Do providers use smart devices (i.e., smartphone, tablets) for work?

a. If yes, how? what are the common applications used for work?

PROBE: *Facebook, Facebook messenger, WhatsApp, IMO, Viber, emails etc.)*

KII GUIDE FOR SERVICE PROVIDERS—4
TOOL FOR KII

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

Service provider

(MOMCH; MO-Clinic; OBGYN Consultant; FWV; Nurse; Midwife Nurse)

Identification of Respondents

1. Facility Name: .....

2. Code*: .....

3. Location: **Division:** ..... **District:** .....

Upazila: ..... **Union:** .....

3. Designation of provider: (FOR MANAGER–1, SERVICE PROVIDER–2) ..... **Code:** .....

4. IDNO#: .....
(FACILITY CODE + DIVISION CODE + DISTRICT CODE + UPAZILA CODE + UNION CODE + DESIGNATION CODE)

GENERAL INSTRUCTIONS: Interviewers, please read the following opening script to the respondent and then proceed with asking him/her the questions listed below. Some questions have specific probes, but please use your judgement to probe on additional points of interest to guide the discussion as needed.

Consent form

OPENING SCRIPT: Thank you for agreeing to participate in our study. My name is....., I am representing the Shukhi Jibon project of Pathfinder International, an International NGO.

Introduction of the study and this interview:

We are conducting an assessment to improve the availability and quality of family planning services in your area. This interview is a part of that assessment.

The purpose of this interview is to gain a better understanding of how you are managing family planning services with other health services within the government health system, and what are the success and challenges that are encountered.

Why you are being asked to participate:

You are working as a Service Provider here. Therefore, your views on how Family Planning services are provided in this facility will valuable. You have been selected randomly as a respondent.

Procedures:

If you say yes, we will ask you to participate in the interview. Each interview will take approximately 1 hour to 1.5 hours. During the interview, interview, we will ask you to further describe your experiences as a FP manager and the challenges that you encounter with your work. With your permission, the open-ended interview will be audio recorded and transcribed.

RISKS/DISCOMFORTS: There is no possible risk if you agree to participate in this study. Rather, it will benefit you by helping us to improve services in this facility. All the information that you provide will be kept strictly confidential; your name will not be used, and you will not be identified in any way. Your current and future position at this facility will not be affected in any way.

Protecting data confidentiality

All research projects carry some risk that information about you may become known to people outside of the study. However, we will do our best to keep your responses confidential by assigning a code to documents with your responses and not including your name or other identifying information, such as your phone number or the name of your community, on the forms.

Benefits

There will be no personal benefit to you for participating. We may use the information that you provide to us to make recommendations to the MOHFW and partners about how to improve Family Planning services.

Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any questions in the interview; and you may stop the interview at any point. Please respond to these questions as honestly and descriptively as possible. We will now begin!

There will be no personal benefit to you for participating. We may use the information that you provide to us to make recommendations to the MOHFW and partners about how to improve Family Planning services.

Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any questions in the interview; and you may stop the interview at any point. Please respond to these questions as honestly and descriptively as possible. We will now begin!

Name of Provider: ..... Designation of Provider .....

What is the highest academic degree you have completed?

1 = Bachelor 2 = Masters 3 = Postgraduate Diploma 4 = Medical Doctor

At what year did you begin your service/job?

LOCATION: ☐ Division ☐ District ☐ Upazila ☐ Union

TYPE OF FACILITY: ☐ District Hospital ☐ UH&FWC ☐ Upazila Health Complex

GENERAL INSTRUCTIONS: Interviewers; please read the following opening script to the respondent and then proceed with asking him/her the questions listed below. Some questions have specific probes; but please use your judgement probe on additional points of interest to guide the discussion as needed.

Providers Capacity:

1. What do you think about the clinical skills of service providers for providing FP services at your facility?
   PROBE: *(Considering all providers of your facility who are supposed to provide specific FP services)*
2. Please describe about the training on different issues for service providers.
   *(***PROBE**: *trainee selection process; training management & quality; enough scope to deal real client in practicum; sharing sufficient training material; any strength or weakness; organizational barrier; individual barriers; whether interactive; major challenges; trainee follow-up).*
3. What do you think about the interpersonal skills of service providers at your facility?
   PROBE: *(patience; empathy to client; attentiveness; knowledge about services; time management; understand the client's needs; client screening, follow up services).*

4. What are some of the major challenges that service providers face in providing FP services?

   PROBE:

   - Staffing issues: Transfer of staff; absence of new recruitment; shortage of service providers at facility (due to leave/ training/meeting; lack of service providers and support staff;
   - Facility/management issues: supervision system; quality assurance; supplies and commodity
   - Structural barriers: working hours; insufficient referrals from community/ field, poor screening at the field level stigma etc.

5. How can service providers perform better in this facility?

   PROBE: *(client-provider relation; stewardship function; analyzing service provision based on service data; knows about the challenges of services; showing IEC materials in Tab, accountability of the referrer/ field worker/provider etc.)*

6. What are the areas of competency that providers may require support for capacity building?

   PROBE: *specific FP methods e.g., PPFP, PAC-FP, Post MR-FP (clinical skill and its challenges; counseling; screening; follow up; record keeping; serving adolescents; youths etc.)*

Responsiveness

7. How do service providers generally do counselling?

   PROBE: *(Place; use of materials; privacy & confidentiality; respect; inform choice etc.)*

8. What do you think about service hours of your facility?

   PROBE: *(days for specific methods; whether it is suitable for all level of clients, especially adolescent and youth male and female)*

9. Can school/college students come to the facility due to contradiction with school hours? How?

10. What is your opinion about the "citizen charter" used for your facility?

    PROBE: *(visibility; language; appropriateness with services etc.)*

11. What do you think about the process of screening/FP service selection by provider in your facility?

    PROBE: *(availability of checklist for each FP method; tendency of using checklist)*

12. What are the challenges of counselling here?

    PROBE: *(staff capacity; insufficient staff; space; privacy in both auditory and visual; time; sex of client; comfortability of dealing male client by female provider or same for male provider of dealing female client etc.)*

13. What do you think about the waiting area and time for clients in your facility?

14. How frequently do service providers conduct follow up for FP service receivers? What could be the standard for client follow up mechanism?

15. In the case of any clinical or management related issue/ emergency, whom do you ask for support or consult to solve any problem? Why? Do you think he or she has mastery in specific clinical field/method or management related knowledge and skill?

    PROBE: *(related to clinical knowledge and method specific skill)*

Youth and adolescent FP services:

16. What do you think about FP services for adolescents?

    PROBE: *(accessibility; appropriateness; age specific and marital status specific services; suitable environment; providers' readiness with training and logistics and supplies; any adolescent corner etc.)*

17. What and how could FP services in your facility be better for youth and adolescents?

    PROBE: *(Physical set-up; designated service provider; any adolescent age specific record keeping system for both FP and other services; enough communication materials)*

18. Do any young boys and girls have provision of access in your facility? If yes, why; when; from where? (generally, /most of the time)
19. Do any school students come to your facility who referred from school health program? If yes, what is the frequency? If no, why?
20. What do you think about age; sex and skill appropriateness of providers for adolescents FP services in your facility?
21. Do you think providers of this facility act differently towards FP clients that are young? If yes; how?
    Probe: (maintain confidentiality; involve different SP; follow different methods and materials; time etc.)

Supervision and Mentoring:

22. Is there any supervision and monitoring system to check progress of SP performance? If so; provide a brief description
23. What do you think about the supervision system of this facility?
    PROBE: *(way of supervision distant/close; on-site/ off-site; supervisor-supervisee interaction process; facilitative; frequency, what issues considered during supervision i.e., administrative, hands on coaching, other etc.)*
24. Does the service provider of this facility face any supervision? If yes, how? How can this be improved?
    PROBE: *(any supervision schedule informed to supervisees; checklist used; formal sharing process; sharing through technology or using social media like Facebook, WhatsApp, etc. challenges)*
25. How do providers implement recommended actions received by supervision system?
26. Please share an example of how supervision helped resolve an issue about FP services provision?
27. Is there any practice of mentorship in your facility?
    INSTRUCTION FOR INTERVIEWER: (please read out the definition: Mentoring is a positive developmental partnership; where an experienced; proficient and empathetic person (a mentor) teaches and coaches another individual (mentee) or group of individuals (mentees); in person and/or virtually; to ensure competent workplace performance and provide ongoing professional development).
28. If no, how would you like to see Mentorship introduced to FP services?
    PROBE: *(who could be prospective mentors; mentee; matching; location of mentor; priority skill areas etc.)*
29. Do you think sex status of a supervisor can affect supervision? If yes; how? How can this be mitigated?
30. Do you think position/ years of experience can affect supervision?
31. Do you think sex status of a supervisee can affect supervision? If yes; how? How can this be mitigated?
32. What are the major challenges of supervision and mentorship here?

Gender

33. Are there any types of people whom the facility does not provide services to?
    PROBE: *(refugees/internally displaced persons; male; transgenders; disabled etc.)*
34. Does the facility require approval/consent for any kind of services a patient receives? If yes; why; from whom?
35. Are there any barriers, which prevents women / men (specific age / marital status) accessing to the facility? If Yes; what are those?
    PROBE: *(distance; timing; gender; age and availability of providers etc.)*
36. Did any client share any story related to physical, psychological or emotional trauma when they come to receive service from this facility?

Use of data/information

37. Who is mainly responsible to keep information about performance of your facility? Do you ever look at your performance? If yes; how and why describe briefly
38. Do you think; record keeping is helpful to enhance your performance? If no; why? if yes; how
39. Are age and sex-disaggregated data for FP available in your facility? If yes; do you ever use this? If yes; why?

Use of electronic devices

40. Do providers use smart devices i.e. smartphone; tablets? If yes; how? What are the common purposes?
41. Do providers use smart devices for work? If yes; how? what are the common applications used for work?
    PROBE: *(Facebook messenger; WhatsApp; IMO; Viber; emails etc.)*

FGD GUIDE FOR ADOLESCENTS—5

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

Adolescents (Married/ Unmarried boys, Married/Unmarried girls, Young couples)

GENERAL INSTRUCTIONS: This guide provides the questions and topics that will be addressed in the FGD. The guiding questions are listed by subheadings related to program processes. As a reminder, FGDs should allow for open discussion and not require round-robin short answers from all the participants. Allow the conversations to flow naturally, allow enough time/pauses for participants to digest questions and think about their answers (this includes allowing for silence), and make sure no one dominates the conversation. Instructions to the facilitator throughout this guide (after this section) are italicized.

In most legal contexts, those under 18 cannot give consent, so rather, we ask for their assent and usually are required to get consent from the parents. Adolescents who are married are typically no longer considered adolescents, but it's worth discussing as a group—whether or not this activity is deemed human subjects research requiring IRB review to protect the rights, confidentiality, and privacy of young people, whether or not they are legally or culturally considered minors.

Please adhere to the following instructions when facilitating this FGD:

1. Please begin by welcoming individuals as they arrive to the FGD and obtaining consent.
2. Fill out **Part A: Background Information** after obtaining consent and before starting the FGD.
3. When it is time to begin, start the recorder, welcome participants as a group and read **Part B: Opening Script.**
4. Proceed with **Part C: Guiding Questions** and facilitate the discussion.
5. After the discussion concludes, thank the caregivers for their participation, stop the recorder, and dismiss the participants. Record the end time on the **Part A: Background Information table.**

Informed Consent

(Greet the person-Hello.....). My name is....., I am representing the Shukji Jibon project of Pathfinder International, an international NGO. We are helping the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) of the Government of Bangladesh in improving the Family Planning/Rerproductive Health in Bangladesh. We are conducting an assessment which aims to improve family planning service focusing on adolescent and youth friendly services (AYFHS), PPFP, PAC FP, Post MR FP and gender responsiveness. We are interested to gather your understanding, perception, opinions, and suggestions on the best practices you have applied or seen your district in regard to FP/RH. Your opinion is very important to us and will help the government to make policy decision to replicate the same model in other parts of the country.

I would like to ask your permission to participate in a small group discussion (7-11 persons) on FP/RH practices in your area. The discussion will continue for about one and half hours. You can refuse to answer any questions, or you can keep silent, if you want. Your participation in this interview is completely voluntary. The risk for participating in the study is minimal. For your participation, you will not be paid any money of any other form of compensation. Your responses will be kept confidential. Your name will not appear on any report. We will not share your information with anyone, nor will we identify you individually in any way, if the results of this discussion are published as a report or in journal articles. If you permit, the discussion will be tape recorded with voices only, to help us recall what has been discussed when preparing our report. The audiotapes will be given to the Monitoring, Evaluation and Learning Specialist at Pathfinder International, who will not share the tapes outside of the project staff. Only the researchers will have access to your responses, which they will utilize to prepare the report. All the data will be stored in a locked and secured place.

You may ask any questions or clarifications before giving your consent for FGD, during or after the FGD. You can leave anytime. You may also contact Md. Liaquat Ali (01711354106) for any questions after the FGD.

If you do not have any question, do I have your permission to continue? ☐ Yes (1) ☐ No (2)

Moderator's name: ..... Signature of Moderator ..... Date .....

Part A: Background Information

1. FGD Code: .....

2. Facilitator name: .....

3. Date: ..... 4. Start Time: ..... 5. End time: .....

6. Location: Division: ..... District: .....

Upazila: ..... Union: .....

7. # of participants: .....

8. Description of Setting (Surroundings, general atmosphere, weather, observations before starting FGD):

.....

.....

Part A Continued: Participant Information

Please let's begin with everyone introducing themselves—please state your age, marital status and how long you have been living in this community.

FIELD	PARTICIPANT CODE	SEX	AGE	MARITAL STATUS	YEARS YOU ARE LIVING IN THIS COMMUNITY	OTHER DEMOGRAPHIC VARIABLE (SPECIFY)
8.1						
8.2						
8.3						
8.4						
8.5						
8.6						
8.7						
8.8						
8.9						
8.10						
8.11						
8.12						

Part B: Opening Scripts

OPENING SCRIPT—GROUP INTERVIEW. READ ALOUD: Good morning/afternoon, I would like to thank you for giving the time to speak with us. We would like to learn more from you about your experiences with health and family planning services available in your area.

Today we are asking you to share your opinions—there are no right or wrong answers because you are only expected to share your thoughts. In addition to that, let me say that the information that we share in this group should be considered confidential. Each of you has been given a number that will be used to record your comments, so you will not be identified by name. Please do not share anything discussed today with others outside of this group to protect everyone's privacy. We should respect each other's opinions and give each other turns when speaking.

Please remember you are not required to participate and should feel free to refuse to answer any question if you are uncomfortable or do not want to speak, and you may leave at any time. Nothing you do or say today will in any way affect your ability to access or benefit from any of the services we talk about today.

Part C: Guiding Themes and Questions

Theme: Knowledge/awareness of reproductive health and family planning (RH/FP) services available

1. First person to contact for any health-related information.
2. Available health services in your community. Source of information of the services.
3. Available family planning services in your area.
4. Cost of available family planning services in your area.

Theme: Gender responsiveness in health facility

1. **FOR MALE PARTICIPANTS:** Please describe a typical experience of a young man who goes to a health facility to seek family planning services.

   FOR FEMALE PARTICIPANTS: Please describe a typical experience of a young woman of your age who goes to a health facility to seek family planning services?

2. **FOR MALE PARTICIPANTS:** Comfort in accessing family planning services. If not comfortable, please state reason.

   FOR FEMALE PARTICIPANTS: Comfort in accessing family planning services as young woman. If not comfortable, please state reason.

Theme: Provision of FP services availability and accessibility

1. Please tell us about the most frequently accessed government run facility for family planning services. Please describe the facility as much as you can.
2. Please tell us about the most frequently accessed facility for RH&FP services. Please describe the RH and FP services available in that facility.
3. Please describe the typical reproductive health / family planning related services people around youth and adolescent age (15-19 years) usually avail from a public health facility.
4. Services specifically available related to RH/FP for unmarried adolescents at public health facilities.

   Services (RH/FP) specifically for young couples available at health facilities.

5. Interaction with RH/FP service providers at community level.
   a. How often does a FWA/FWV/CHCP usually visit a community?
   b. What are some of the reasons that a young person might want to meet with a community health worker? What kind of services might be requested?

Theme: SBCC materials

1. Communication materials (such as pamphlets) available at health facilities to take home. Please share with us the usefulness of the communication materials
2. Experience of electronic devices used during counseling; familiarization with any apps, media etc.
   (**INTERVIEWER'S INSTRUCTION:** In some areas, FWAs provide information and education on FP and RH by using electronic devices, which are very useful. Is there anything like that in this locality?)

Theme: Accessibility of health and FP service information

1. Aside from health facilities and community health workers, other ways in which people in this community can access information about health and specifically about reproductive health and family planning
   a. What are most convenient ways for young people such as yourselves to access information about health and family planning? Why?
   b. What RH/FP related information would be most helpful for young people to be able to access through these means? What kinds of information are they most in need of?

Theme: Barriers to access FP services at community and facility

1. Type of RH/FP Services available and offered
   a. Do young people ever face any problems accessing RH/FP services? How so?
2. Lack of access of young people (i.e., unmarried adolescents) from availing services from local public health facilities. If so, describe the services
   a. Any particular challenges when trying to access FP-related services.
   b. Any particular challenges when trying to access GBV-related services.
   c. Any differences between trying to access general health-related services, FP-related services, and GBV-related services? What are they?
3. Reasons for these challenges exist. Suggestions to overcome the challenges.

Theme: Scopes to access FP services at community and facility

1. What can health facilities and health providers do to make it easier and better for young people such as yourselves to access health and family planning services?
   (Possible action points by health facilities, possible action points by health providers)

ANNEX

USAID
FROM THE AMERICAN PEOPLE

Shukhi Jibon

TABLE 1: OVERALL AVAILABILITY OF CLIENT SERVICES [%)]

SERVICES	TYPE OF HEALTH FACILITY (#) DH %(N)	MCWC %(N)	UHC %(N)	UH&FWC %(N)
Services				
AYHS	100 (5)	100 (6)	92.9 (26)	93.3 (28)
FP counseling	100 (5)	100 (6)	100 (28)	100 (30)
PAC-FP	80 (4)	100 (6)	75 (21)	63.3 (19)
MGBV	40 (2)	50 (3)	35.7 (10)	60.0 (18)
PPFP	60 (3)	100 (6)	96.4 (27)	86.7 (26)
FP services	100 (5)	100 (6)	100 (28)	100 (30)
RTI/STI	80 (4)	100 (6)	96.4 (27)	90 (27)
MCH services				
Ante natal Care (ANC)	100 (5)	100 (6)	100 (28)	100 (30)
Normal Vaginal Delivery (NVD)	80 (4)	100 (6)	100 (28)	70 (21)
C-Section Delivery	80 (4)	100 (6)	28.6 (8)	0 (0)
Postnatal Care (PNC)	80 (4)	100 (6)	100 (28)	100 (30)
All services	40 (2)	50 (3)	32.1	(9)

TABLE 2: TRAINING IN 2 YEARS PRECEDING THE SURVEY (FREQUENCY)

POSITION/TITLE	NUMBER OF TRAINING PROVIDED: IUD (INTERVAL)	PP IUD (POSTPARTUM)	PPFP	IMPLANT	VASECTOMY (NSV)	TUBECTOMY	SHORT-ACTING FP METHOD	COUNSELING-FP	PAC	INFECTION PREVENTION	MANAGEMENT OF RTIS/STIS	SUPERVISION	ADOLESCENT AND YOUTH-FRIENDLY HEALTH	GENDER ISSUES
District Hospital (DH)														
OB/GYN	0	0	1	0	0	1	1	0	0	0	0	0	0	0
Nurse	0	0	0	2	1	1	0	1	0	0	0	0	0	0
Midwife-Nurse	0	0	0	0	0	0	0	0	0	0	0	1	0	0
FWV/Senior FWV/ AFWO	2	0	2	0	0	0	0	1	1	1	1	0	0	0
MCWC														
MO (MCH-FP)	0	0	0	1	0	0	0	0	0	0	0	0	1	0
MOCC	0	1	0	0	0	0	0	0	0	1	0	0	2	0
Nurse	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Midwife-Nurse	0	0	0	0	0	0	1	0	0	0	0	0	0	0
FWV/Senior FWV/ AFWO	4	0	6	0	0	0	1	0	0	1	0	0	0	0
UHC														
RMO	1	0	0	0	0	0	0	0	0	1	0	1	0	0
MO (MCH-FP)	3	0	1	4	2	0	1	2	1	1	0	5	0	0
UFPO	0	0	0	1	0	0	1	2	0	0	1	3	2	0
AUFPO	0	0	1	0	0	0	0	2	0	0	0	2	1	0
FWV/Senior FWV/ AFWO	7	1	10	0	1	0	1	7	2	1	0	0	2	0
FMA	1	0	0	0	0	0	0	0	0	0	0	4	0	0

TABLE 2: TRAINING IN 2 YEARS PRECEDING THE SURVEY (FREQUENCY), CONTINUED...

POSITION/TITLE	NUMBER OF TRAINING PROVIDED													
	IUD (INTERVAL)	PP IUD (POSTPARTUM)	PPFP	IMPLANT	VASECTOMY (NSV)	TUBECTOMY	SHORT-ACTING FP METHOD	COUNSELING-FP	PAC	INFECTION PREVENTION	MANAGEMENT OF RTIS/STIS	SUPERVISION	ADOLESCENT AND YOUTH-FRIENDLY HEALTH	GENDER ISSUES
District Hospital (DH)														
UFPA	0	0	0	0	0	0	0	0	0	0	0	9	0	0
Office Assistant	0	0	0	0	0	0	0	0	0	0	0	1	0	0
FPC	0	0	0	0	0	0	0	1	0	0	0	0	0	0
UHFWC														
MO (MCH-FP)	0	0	0	2	0	0	0	0	0	0	0	0	1	0
FWV/Senior FWV/ AFWO	8	0	6	2	0	1	1	1	0	3	1	1	3	0
SACMO/MA	0	0	0	0	0	0	0	0	0	2	2	0	3	1
FPI	0	0	1	0	0	0	0	1	0	0	0	3	0	0
FWA	0	4	0	0	0	0	0	5	0	0	2	0	2	2

TABLE 3: OVERALL AVAILABILITY OF SERVICE PROVIDERS

BACKGROUND CHARACTERISTICS	DH			MCWC			UHC			UH&FWC		
	# OF SANCTIONED POST(S)	# OF PROVIDER(S) FILLED	# OF PROVIDERS PRESENT ON SURVEY DATE	# OF SANCTIONED POST(S)	# OF PROVIDER(S) FILLED	# OF PROVIDERS PRESENT ON SURVEY DATE	# OF SANCTIONED POST(S)	# OF PROVIDER(S) FILLED	# OF PROVIDERS PRESENT ON SURVEY DATE	# OF SANCTIONED POST(S)	# OF PROVIDER(S) FILLED	# OF PROVIDERS PRESENT ON SURVEY DATE
Provider Type												
OB/GYN	14	16	15	.	.	.	.	.	.	.	.	.
Nurse	10	13	10	.	.	.	.	.	.	.	.	.
Midwife Nurse	19	19	10	10	11	6	.	.	.	.	.	.
MO-Clinic	.	.	.	5	5	4	.	.	.	.	.	.
MO (MCH-FP)	.	.	.	16	16	13	44	37	16	.	.	.
FWV	.	.	.	15	19	14	35	32	26	35	33	28
RMO	.	.	.	.	.	.	22	21	16	.	.	.
UFPO	.	.	.	.	.	.	28	21	11	.	.	.
AUFPO	.	.	.	.	.	.	27	20	9	.	.	.
AFWO (MCH-FP)	.	.	.	.	.	.	27	13	8	.	.	.
MO-FW	.	.	.	.	.	.	.	.	.	25	3	1
SACMO	.	.	.	.	.	.	.	.	.	30	22	17
FPI	.	.	.	.	.	.	.	.	.	30	29	17
FWA	.	.	.	.	.	.	.	.	.	103	79	38
Cleaner/ Sweeper	16	9	6	.	.	.	.	.	.	.	.	.
Aya	.	.	.	17	20	16	.	.	.	.		.
Total	**59**	**57**	**41**	**63**	**71**	**53**	**183**	**144**	**86**	**223**	**166**	**101**

TABLE 4: AVAILABILITY OF BASIC AMENITIES FOR CLIENT SERVICES [N(%)]

FACILITY TYPE	REGULAR ELECTRICITY% (N)	IMPROVED WATER SOURCE % (N)	VISUAL AND AUDITORY PRIVACY WHILE COUNSELING % (N)	CLIENT LATRINE % (N)	COMMUNICATION EQUIPMENT % (N)	COMPUTER WITH INTERNET % (N)	EMERGENCY TRANSPORT % (N)	SEPARATE LATRINE FOR FEMALE CLIENTS	ANY 5 BASIC AMENITY
DH	100 (5)	100 (5)	20 (1)	100 (5)	80 (4)	40 (2)	80 (4)	100 (5)	80 (4)
MCWC	100 (6)	100 (6)	83.3 (5)	100 (6)	66.7 (4)	33.3 (2)	100 (6)	100 (6)	100 (6)
UHC	100 (28)	100 (28)	42.9 (12)	96.4 (27)	78.6 (22)	64.3 (18)	60.7 (17)	96.4 27)	60.7 (26)
UH&FWC	86.7 (26)	76.7 (23)	50 (15)	93.3 (28)	23.3 (7)	0 (0)	0 (0)	0 (0)	.

TABLE 5: AVAILABILITY OF FGP SERVICE COMMODITIES (FREQUENCY)

	FP SERVICES (FREQUENCY)						
FACILITY TYPE	OCP	POP	INJECTABLE	LARC	PM/ STERILIZATION	PPFP	ECP
DH	2	4	4	4	4	3	0
MCWC	4	6	6	6	6	6	6
UHC	8	27	28	28	27	27	23
UH&FWC	9	29	30	29	5	26	22

TABLE 6: READINESS TO PROVIDE FP SERVICES (FREQUENCY)

	READINESS (FREQUENCY)			
FACILITY TYPE	TRAINED STAFF	GUIDELINE	EQUIPMENT	COMMODITIES
DH	5	4	5	4
MCWC	6	6	6	6
UHC	28	22	28	28
UH&FWC	30	17	30	29
Total	**69**	**49**	**69**	**67**

TABLE 7: READINESS TO INFECTION PREVENTION (FREQUENCY)

FACILITY TYPE	SOAP	RUNNING WATER	SOAP AND RUNNING WATER	ALCOHOL BASED HAND DISINFECTANT	RUNNING WATER OR ELSE ALCOHOL BASED DISINFECTANT	LATEX GLOVES	SHARPS CONTAINER	WASTE RECEPTACLE	ALL 6 ITEMS AVAILABLE
DH	4	4	4	4	4	4	4	4	4
MCWC	6	6	6	5	5	6	6	6	5
UHC	28	26	26	26	24	23	27	27	18
UH&FWC	28	17	17	17	9	22	22	24	7

TABLE 8: RECORD KEEPING AND TREATMENT PROTOCOLS (%)

	TYPE OF HEALTH FACILITY (#)				
INDICATORS	DH	MCWC	UHC	FWC	TOTAL
Arrangement for general record keeping					
Facility had staff member to do data entry	40.0	50.0	67.9	0.0	36.2
Used client medical record	100.0	100.0	100.0	73.3	88.4
Gave record card of visiting facility to client	100.0	100.0	92.9	80.0	88.4
Had a system for filing clients' record and retrieval	100.0	100.0	100.0	86.7	94.2
Records can retrieve easily	100.0	100.0	82.1	83.3	85.5
Entered required data by the end of each day	80.0	83.3	92.9	70.0	81.2
Use computer/ mobile/ tablet for record keeping and reporting	40.0	83.3	78.6	13.3	47.8
Accuracy and completion of records					
Availability of Informed Consent Form for IUD	60.0	100.0	100.0	96.7	95.7
Availability of Informed Consent Form for Implant	60.0	100.0	100.0	33.3	68.1
Availability of Informed Consent Form for Tubectomy	80.0	100.0	96.4	13.3	59.4
Availability of Informed Consent Form for Vasectomy	20.0	100.0	96.4	13.3	55.1
Availability of Informed Consent Form for Injectable	40.0	83.3	50.0	33.3	44.9
Completeness of Medical History	60.0	83.3	67.9	26.7	50.7
Completeness of Physical Examination	60.0	83.3	67.9	23.3	49.3
Completeness of FP Method Record	60.0	83.3	71.4	30.0	53.6
Completeness of Number of FP Supplies	100.0	100.0	96.4	83.3	91.3
Completeness of Referral Form	40.0	83.3	64.3	33.3	50.7
Completeness of Registration book	100.0	100.0	92.9	76.7	87.0
Arrangements for reporting and recording					
Has arrangement for solving complications/ problems related to contraceptive use	80.0	83.3	96.4	73.3	84.1
Has place for reporting and recording the complications	100.0	83.3	100.0	70.0	85.5
Has most recent version of written guidelines and protocols for delivering FP services	80.0	100.0	78.6	56.7	71.0

TABLE 9: AVAILABILITY OF YOUTH-FRIENDLY CONTRACEPTIVE AND PAC SERVICE INSTRUMENTS (%)

	TYPE OF HEALTH FACILITY (#)				
INDICATORS	DH	MCWC	UHC	FWC	TOTAL
Confidentiality					
Existence of written procedures for protecting client confidentiality	60.0	83.3	71.4	60.0	66.7
Records stored in a confidential place	80.0	66.7	85.7	76.7	79.7
Registration maintaining confidentiality	60.0	66.7	78.6	46.7	62.3
Services for adolescents regardless of age and marital status					
Clear written guidelines exit for serving youth	20.0	100.0	42.9	46.7	47.8
Require a minimum age for contraceptive or PAC services	40.0	66.7	39.3	46.7	44.9
Requires spousal consent	60.0	100.0	85.7	90.0	87.0
FP treatment guidelines, procedures and protocols					
Guidelines and SOPs for FP available on site	80.0	100.0	71.4	86.7	81.2
Service delivery procedures for FP services available	100.0	100.0	96.4	100.0	98.6
Service delivery guidelines for serving adolescent clients available	60.0	83.3	53.6	60.0	59.4
The protocols followed routinely	100.0	100.0	82.1	73.3	81.2
PAC treatment guidelines, procedures and protocols exist and are followed	100.0	83.3	78.6	56.7	71.0

TABLE 10: PRIVACY DURING FP COUNSELING (%)

	TYPE OF HEALTH FACILITY (#)				
INDICATORS	DH	MCWC	UHC	FWC	TOTAL
Doors available and remain shut during consultation	60.0	83.3	67.9	80.0	73.9
Curtains in the window available	60.0	100.0	82.1	86.7	84.1
If windows are left open, anyone can easily hear what is being said	20.0	16.7	46.4	36.7	37.7
Use privacy screens	80.0	100.0	75.0	86.7	82.6
Personal history taking, screening or reason of coming for services occurs in public	20.0	33.3	57.1	36.7	43.5
Non-essential interruptions happen during counseling, exams, or lab procedures	60.0	16.7	39.3	46.7	42.0

TABLE 11: METHOD SPECIFIC AVAILABILITY OF FP EQUIPMENT (IMPLANT) (%)

	DH		MCWC		UHC		UHFWC	
EQUIPMENT	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
Soap	0.0	20.0	0.0	0.0	0.0	7.1	0.0	43.3
Sterilized Marker	0.0	40.0	0.0	0.0	0.0	21.1	0.0	83.3
Sterilized Gloves	0.0	20.0	0.0	0.0	0.0	3.6	0.0	60.0
Sterilized cloths/Surgical drape, Leaky Surgical drape (for Jadelle)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	76.7
Antiseptic solution	0.0	20.0	0.0	0.0	0.0	3.6	0.0	63.3
Gallipot	0.0	20.0	0.0	0.0	0.0	0.0	0.0	46.7
Sponge holding forceps	0.0	20.0	0.0	0.0	0.0	0.0	0.0	43.3
Surgical scalpel blade	0.0	20.0	0.0	0.0	0.0	3.6	0.0	73.3
Sterilized cotton ball (3-5 pcs)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	46.7
Sterilized gauge	0.0	20.0	0.0	0.0	0.0	3.6	0.0	53.3
AD/Disposable syringe	0.0	20.0	0.0	0.0	0.0	0.0	0.0	43.3
Local anesthesia drugs (1% Lidocaine, adrenaline free)	0.0	20.0	0.0	0.0	0.0	7.1	0.0	73.3
hydrocolloid dressing/band aid, general bandage	0.0	20.0	0.0	0.0	0.0	3.6	0.0	60.0
Safety box	0.0	20.0	0.0	0.0	0.0	0.0	0.0	46.7
Mosquito forceps (2 units)	0.0	20.0	0.0	0.0	0.0	0.0	0.0	76.7
U Forceps	0.0	40.0	0.0	0.0	0.0	10.7	3.3	83.3
Implant	0.0	40.0	0.0	0.0	0.0	0.0	0.0	80.0

TABLE 12: METHOD SPECIFIC AVAILABILITY OF FP EQUIPMENT (IUD) (%)

	DH		MCWC		UHC		UHFWC	
EQUIPMENT	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
IUD in sterile packet	0.0	40.0	0.0	0.0	0.0	0.0	0.0	10.0
Cusco's Speculum (Medium size)	0.0	20.0	0.0	0.0	0.0	0.0	0.0	6.7
Tenaculum	0.0	20.0	0.0	0.0	0.0	3.6	0.0	13.3
Uterine Sound	0.0	20.0	0.0	0.0	0.0	10.7	0.0	13.3
Gallipot	0.0	20.0	0.0	0.0	0.0	0.0	0.0	6.7
Artery forceps	0.0	20.0	0.0	0.0	0.0	0.0	0.0	10.0
Scissors	0.0	20.0	0.0	0.0	0.0	3.6	0.0	6.7
Sterilized cotton ball (3-5 pcs)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	6.7
Sterilized Gloves (2 pair)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	16.7
Povidone Iodine solution	0.0	20.0	0.0	16.7	0.0	0.0	0.0	20.0
Spotlight or Torch light	0.0	20.0	0.0	0.0	7.1	3.6	10.0	30.0
Draping sheet	0.0	20.0	0.0	0.0	0.0	0.0	6.7	46.7

TABLE 14: METHOD SPECIFIC AVAILABILITY OF FP EQUIPMENT (PERMANENT METHOD: OPERATION THEATRE) (%)

EQUIPMENT	DH		MCWC		UHC		UHFWC	
	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
Physical/infrastructural facilities for the permanent sterilization, Reception room with facility for counseling and taking history of the patient								
Method specific client consent form with detail description and other materials and communication aid for counseling	0.0	40.0	0.0	0.0	0.0	0.0	0.0	16.7
Discharge certificate for male and female sterilization	0.0	20.0	0.0	0.0	3.6	3.6	0.0	80.0
Laboratory examination facility with physical examination Room								
BP instrument with stethoscope	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.7
Thermometer	0.0	20.0	0.0	0.0	0.0	0.0	0.0	33.3
Weighing machine	0.0	20.0	0.0	0.0	0.0	0.0	6.7	13.3
Spotlight and working torch light with battery	20.0	20.0	0.0	0.0	3.6	14.3	6.7	40.0
Examination table for the client	0.0	0.0	0.0	0.0	0.0	7.1	0.0	20.0
Gloves, speculum, sponge holding forceps, cotton, antiseptic solution (povidon) in a tray for P/V examination	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0
Hand washing basin with elbow tap and running water, soap, antiseptic solution (hexisol), and personal towel	0.0	0.0	0.0	0.0	0.0	7.1	0.0	30.0
Urine examination equipment								
Test-tube/bottle for urine collection and test-tube holder	0.0	0.0	0.0	16.7	0.0	10.7	0.0	50.0
Sugar, albumin and pregnancy test kit	0.0	0.0	0.0	16.7	0.0	14.3	0.0	56.7
Uri-sticks with bottle	0.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0
Blood examination equipment								
Tallquist book for and disposable lancet	0.0	20.0	0.0	0.0	0.0	7.1	0.0	43.3
Cotton, antiseptic solution in cup/ gully pot (rectified spirit/ hexisol or povidone iodine)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	33.3

TABLE 14: METHOD SPECIFIC AVAILABILITY OF FP EQUIPMENT (PERMANENT METHOD: OPERATION THEATRE) (%)

EQUIPMENT	DH		MCWC		UHC		UHFWC	
	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
Pre-Operative room								
bed, mattress, bed-cover, pillow, mosquito net and rubber sheet	0.0	40.0	0.0	16.7	0.0	42.9	3.3	60.0
water, soap, bucket, towel, bathing facility etc.	0.0	60.0	0.0	16.7	0.0	35.7	0.0	53.3
BP instrument, stethoscope and thermometer	0.0	40.0	0.0	16.7	0.0	35.7	0.0	46.7
Medicine: antibiotic and tablet diazepam	0.0	40.0	0.0	16.7	3.6	35.7	0.0	53.3
Toilet facility	0.0	40.0	0.0	16.7	0.0	46.4	0.0	50.0

TABLE 14: METHOD SPECIFIC AVAILABILITY OF FP EQUIPMENT (PERMANENT METHOD: OPERATION THEATRE) (%), CONTINUED...

EQUIPMENT	DH		MCWC		UHC		UHFWC	
	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
Operation theater with the facility of dressing, hand-washing and autoclaving or IP space								
Autoclave, autoclave indicator tape and register	0.0	20.0	0.0	0.0	0.0	0.0	6.7	70.0
Kerosene four-burner pressure stove or gas burner or electric stove or electric connection socket	0.0	40.0	0.0	0.0	0.0	10.7	0.0	16.7
Surgical drum, drum or tray for instrument & gloves	0.0	20.0	0.0	0.0	0.0	0.0	3.3	26.7
Twofold cloth for tray-cover or trolley cover	0.0	20.0	0.0	0.0	0.0	3.6	0.0	63.3
Autoclaving monitoring chart on the autoclaving room's wall	0.0	80.0	0.0	33.3	0.0	39.3	0.0	90.0
Necessary instruments for disinfection: (plastic bucket, sieve, bleaching powder or liquid chlorine or chlorine tablet, stirrer, plastic mug, utility gloves etc.)	0.0	20.0	0.0	0.0	0.0	3.6	3.3	20.0
Basin for washing and wiping of the instrument, detergent powder, brush & towel	0.0	20.0	0.0	0.0	0.0	3.6	0.0	16.7
Table for drying, wrapping and keeping the instrument	0.0	20.0	0.0	0.0	0.0	10.7	3.3	26.7
Hanger/clip for drying the gloves	0.0	20.0	0.0	16.7	0.0	35.7	0.0	53.3
Hand washing area attached with operation theater								
Basin with elbow tap and running water (obviously outside the toilet) or as a substitute water tank or drum with tap can be placed in the wall of table/stand or water filled bucket and mug can be used (in that case an assistant should poured the water)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	46.7
Hand washing soap, antiseptic solution	0.0	20.0	0.0	0.0	0.0	3.6	0.0	20.0
Area for undressing the used cloth and wearing OT dress	0.0	60.0	0.0	33.3	0.0	39.3	0.0	80.0
Clean and sterilized musk for all related to the service	0.0	20.0	0.0	0.0	0.0	10.7	3.3	50.0
Boot or sandal for all related person in the OT	0.0	20.0	0.0	16.7	0.0	25.0	0.0	73.3
Operation theater								
Enough light	0.0	20.0	0.0	0.0	0.0	3.6	0.0	26.7
Glass window	0.0	20.0	0.0	0.0	7.1	14.3	0.0	50.0
Netting to prevent insect	0.0	80.0	0.0	0.0	0.0	35.7	3.3	80.0
Air Conditioned	20.0	60.0	0.0	16.7	7.1	50.0	0.0	93.3
wall made of tiles/mosaic up to 7 feet from the floor	0.0	20.0	0.0	0.0	0.0	28.6	0.0	76.7
Supplies for the OT								
OT table with plastic or rubber sheet	0.0	20.0	0.0	0.0	0.0	7.1	0.0	40.0
OT light and to prevent electricity interruption working 3 battery torch or charger light	0.0	20.0	0.0	0.0	0.0	17.9	0.0	46.7
Instrument trolley	0.0	20.0	0.0	0.0	0.0	7.1	0.0	66.7
Small/ maya trolley for keeping all other instrument for every operation	0.0	20.0	0.0	0.0	0.0	32.1	0.0	86.7
BP instrument and stethoscope	0.0	20.0	0.0	0.0	0.0	3.6	0.0	33.3
Essential instrument for emergency management in working condition	0.0	20.0	0.0	0.0	0.0	10.7	0.0	43.3
Emergency drug for emergency situation	0.0	20.0	0.0	0.0	0.0	7.1	0.0	46.7
For regular tubectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	0.0	20.0	0.0	0.0	0.0	7.1	0.0	90.0
For regular vasectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	20.0	60.0	0.0	0.0	0.0	7.1	0.0	93.3
OT register	0.0	40.0	0.0	0.0	0.0	3.6	0.0	86.7

EQUIPMENT	DH		MCWC		UHC		UHFWC	
	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE	AVAILABLE, NOT FUNCTIONAL	NOT AVAILABLE
Post- operative room								
Toilet facility	20.0	40.0	0.0	16.7	7.1	35.7	3.3	73.3
Washing basin	20.0	60.0	0.0	16.7	36.0	32.1	0.0	73.3
Bed, mattress, Bed-cover, pillow with cover, mosquito net and rubber sheet, hurricane, vessel, bucket, mug, glass,	20.0	40.0	16.7	16.7	0.0	46.3	3.3	53.3
Stool, table, chair, hand fan	20.0	40.0	0.0	33.3	0.0	50.0	0.0	66.7
BP instrument, stethoscope, Thermometer, 3 battery working torch	0.0	40.0	0.0	16.7	3.6	28.6	0.0	63.3
Medicine—paracetamol, vitamin tablet	0.0	40.0	0.0	16.7	0.0	35.7	0.0	63.3
Emergency medicine	0.0	40.0	0.0	16.7	0.0	32.1	0.0	70.0

TABLE 15: AVAILABILITY AND FUNCTIONALITY OF GYNECOLOGY EXAM EQUIPMENT (FREQUENCY)

INDICATORS	STATUS	TYPE OF HEALTH FACILITY (#)				
		DH	MCWC	UHC	UHFWC	TOTAL
Sim's Speculum	Available	4	6	28	16	54
	Functional	4	6	28	16	54
Cusco's Speculum	Available	4	6	27	25	62
	Functional	4	6	27	25	62
Sponge holding forceps	Available	4	6	28	26	64
	Functional	4	6	28	26	64
Spot light	Available	4	6	25	15	50
	Functional	4	6	22	12	44
Kidney tray	Available	4	6	27	25	62
	Functional	4	6	27	25	62
Gallipot	Available	4	6	28	25	63
	Functional	4	6	28	25	63
Artery forceps	Available	4	6	27	25	62
	Functional	4	6	27	25	62
	N	5	6	28	30	69

TABLE 16: MANAGEMENT OF HEALTH FACILITY

	TYPE OF HEALTH FACILITY (#)				
INDICATORS	DH	MCWC	UHC	FWC	TOTAL
General Client					
Average time client stays at the clinic	50.00	38.33	63.36	34.93	47.86
Average waiting time (all clients)	30.20	29.17	26.00	23.67	25.57
Average number of clients can be accommodated in waiting area	18.80	22.50	14.07	14.97	15.54
N	5	6	28	30	69
Adolescent/Youth Client come to receive services					
Average waiting time (adolescents/youth clients)	26.25	21.00	18.60	12.07	16.27
Adolescent/Youth Client come to receive services (#)	4	5	25	29	63
N	5	6	28	30	69
Sitting arrangement for Adolescent/Youth Client before getting services (n)					
Separate arrangement available (#)	1	3	4	2	9
Wait along with other patients (#)	4	2	21	27	54
N	5	5	25	29	63

TABLE 17: SUPERVISION SYSTEM FOR QUALITY IMPROVEMENT (%)

	TYPE OF HEALTH FACILITY (#)				
INDICATORS	DH	MCWC	UHC	FWC	TOTAL
Supervisor conducted supervision visit	100.0	100.0	100.0	100.0	100.0
N	5	6	28	30	69
Frequency of supervision					
Weekly	0	0	21	3	10
Monthly	60	83	46	63	58
Quarterly	20	17	0	17	10
Six monthly	20	0	0	3	3
Not specified	0	0	32	13	19
N	5	6	28	30	69
Use of checklist and feedback in supervision					
Used checklist for supervisory visit	100	67	68	73	77
Had provision of debriefing/feedback/ learning session after completion of the visit of the supervisor	100	83	89	87	90
Used checklist in debriefing/feedback/ learning session	80	67	75	73	74
Had provision of written feedback from the supervisor after completion of the visit	80	83	71	90	81
Seen copy of the reports of the supervisory visit	20	83	54	67	56
Developing an action plan is part of the feedback system	100	100	96	93	97
N	5	6	28	30	69

TABLE 18: ROUTINE VISIT TO QUALITY IMPROVEMENT (%)

INDICATORS		TYPE OF HEALTH FACILITY (#)				
		DH	MCWC	UHC	FWC	TOTAL
External supervisor/manager conducted routine visits		100.0	100.0	96.4	93.3	95.7
	n	5	6	28	30	69
Team related to external supervision						
• DGFP-officer/FP Clinical Supervision Team		80.0	100.0	100.0	92.9	95.5
• Other external quality team		20.0	33.3	59.3	42.9	47.0
• QIC DQA system		20.0	16.7	11.1	0.0	7.6
• QIC visit		0.0	33.3	22.2	0.0	12.1
• AFWO		0.0	0.0	0.0	3.6	1.5
	N	5	6	27	28	66
Frequency of routine visits for quality assurance						
• Monthly		60.0	33.3	18.5	25.9	26.2
• Quarterly		20.0	33.3	22.2	25.9	24.6
• Six monthly		20.0	0.0	3.7	11.1	7.7
• More than six months		0.0	0.0	11.1	14.8	10.8
• Not specified		0.0	33.3	44.4	22.2	30.8
	N	5	6	27	27	65
Checklist						
Seen filled-in checklist on the assessment of quality of service for the period of last time		40.0	50.0	57.1	58.6	55.9
Record the quality assessment information of service		80.0	66.7	82.1	82.8	80.9
Have feedback from the supervisor						
Yes, written feedback		60.0	66.7	71.4	69.0	69.1
Yes, verbal feedback		40.0	33.3	28.6	31.0	30.9
Action						
Action step taken so far based on the supervision/quality assurance visit		20.0	16.7	17.9	13.8	16.2
	N	5	6	28	29	68

Endnotes

[1] The Millennium Development Goals Report, United Nations

[2] USAID (2019). BANGLADESH Country Development Cooperation Strategy (CDCS) FY2011–FY2019. [online] USAID. Available at: https://www.usaid.gov/sites/default/files/documents/1860/Bangladesh_CDCS_2011-20192.pdf [Accessed 11 Sep. 2019].

[3] Family Planning Manual, Clinical Contraceptive Services Delivery Program (CCSDP), DGFP, MOH&FW, June 2018

[4] National Institute of Population Research and Training (NIPORT), Associates for Community and Population Research (ACPR), and ICF International. 2016. Bangladesh Health Facility Survey 2014. Dhaka, Bangladesh: NIPORT, ACPR, and ICF International.

[5] C-Section delivery service is not available in UH&FWC

[6] National Institute of Population Research and Training (NIPORT), Associates for Community and Population Research (ACPR), and ICF International. 2016. Bangladesh Health Facility Survey 2014. Dhaka, Bangladesh: NIPORT, ACPR, and ICF International.

CONTACT:
For general questions or inquiries,
email communications@pathfinder.org.

PATHFINDER INTERNATIONAL
9 Galen Street
Watertown, MA 02472, USA
+1 617 924 7200

PATHFINDER INTERNATIONAL BANGLADESH
Shezad Palace, 5th Floor
32 Gulshan Avenue North C/A
Dhaka - 1212

Pathfinder INTERNATIONAL
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